

**Destructive Thinking within Religion:
A Psycho-Pastoral Approach**

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The crest of Stellenbosch University is centered behind the text. It features a shield with various symbols, including a book and a lamp, surrounded by a decorative border. Below the shield is a motto scroll with the Latin text "Pastora solentur cillio recti".

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March 2013

DECLARATION

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ABSTRACT

As humans we are thinking beings. This thesis introduces the topic of “destructive thinking.” This is described rather broadly as any type of thinking that is considered counterproductive, harmful, and maladaptive or has a damaging and negative effect on the individual’s identity, relationships, social context and worldview. Of particular interest to this study are cognitive distortions; thinking errors; irrational beliefs; and inappropriate God-images. It was noted that most of our everyday thinking takes place unconsciously and that cognitive distortions or thinking errors are common occurrences. These are of particular interest to this study since destructive thoughts are viewed as facilitating emotional distress, psychopathology, inappropriate God-images and faith pathology. Sometimes we fall into a negative rut or just get stuck in our ways of thinking, feeling and acting. The idea of changing cognitions to change feelings is a central feature of this thesis. The primary goal is to facilitate the restructuring of destructive thoughts.

The main focus of this thesis is on developing a theological understanding and perspective of ‘destructive thinking’ in the context of pastoral care. I therefore explore the type of thoughts that the pastoral caregiver should look for that could pose as ‘risk factors’ inhibiting spiritual growth and spiritual well-being. I identify and encourage the development of thoughts that are more likely to promote spiritual healing, spiritual growth and a mature faith. To accomplish this task, I begin with an exploration of ‘destructive thinking’ in the Cognitive Behaviour Therapy literature (CT & REBT respectively) (Chapter 2). This is followed by an exploration of ‘destructive thinking’ within the interplay between Religion and Christian Spirituality (Chapter 3). I then propose a pastoral model of spiritual healing and wholeness that could assist pastoral caregivers to understand and address “destructive thinking” in a constructive and responsible way (Chapter 4).

This study concluded that thoughts are at the centre of our functioning as thinking beings. If our thinking is ‘destructive’, the consequence on our spiritual and psychological lives may be devastating. Our thoughts have the ability to destroy and transform. In reviewing the potential impact of destructive thoughts on the individual’s spirituality and spiritual well-being, a number of destructive types of religious thinking are identified, such as inappropriate God-images. In assessing the relationship between one’s God-image and psychological and spiritual well-being, a link between one’s thoughts (cognitions), spiritual and psychological well-being is suggested.

As an outcome of this research, I propose a holistic approach to destructive thinking that takes into account one’s faith, spiritual maturity, beliefs, cognitions and relationships (with oneself, others and God). The psycho-pastoral approach proposed takes the role of cognition seriously. It offers an excellent and practical method to understanding and managing destructive thinking, that promotes healing and

wholeness, through the reframing and restructuring of destructive thoughts. The intention is to assist individuals to become more responsible and aware of their own thinking, as well as more knowledgeable about cognition in general, so as to act on this awareness. This includes the ability to monitor one's own thinking, recognize errors and minimize destructive thoughts. The objective of this thesis is to explore the constructive contribution that pastoral care can make to destructive thinking.

OPSOMMING

Ons as mense is denkende wesens. Hierdie tesis handel oor die onderwerp ‘destruktiwe denkwyses’. In die breë sin beteken dit enige denke wat beskou word as teen-produktief, skadelik, wanaanpassings of wat ’n vernietigende en negatiewe uitwerking het op die persoon se identiteit, verhoudings, sosiale konteks en wêreldbeskouing. Van besondere belang tot hierdie studie is wanpersepsies, irrasionele gelowe en onvanpaste Godsbeelde (afgode). Daar is gevind dat ons alledaagse denke onbewustelik plaasvind en dat verkeerde opvattinge en wanindrukke algemeen plaasvind. Hierdie gebeurlikhede is van besondere belang met betrekking tot hierdie studie, aangesien destruktiwe denkwyses makliker lei tot emosionele lyding, geestesstoornisse, onvanpaste afgodery en geloofsafwykings. Somtyds beland ons in ’n negatiewe patroon of raak vasgevang in ons manier van denke, gevoelens en optrede. Die idee om persepsies te verander om sodoende gevoelens te verander, is die sentrale fokus van hierdie tesis. Die primêre doel is om die heropbouing van destruktiwe denke te vergemaklik.

Die sentrale fokus van hierdie tesis is ’n teologiese ontwikkeling van begrip en perspektief van destruktiwe denke in die konteks van pastorale sorg. Dus ondersoek ek die tipe gedagtes waarna die pastorale versorger moet soek – wat beskou kan word as risiko faktore wat spirituele groei en welstand kan inhibeer. Ek identifiseer en moedig die ontwikkeling van gedagtes aan vir spirituele groei en ’n volwasse geloof. Om hierdie taak te bereik, begin ek met ’n ondersoek na destruktiwe denke in die *Cognitive Behaviour Therapy Literature (CT & REBT)* onderskeidelik – Hoofstuk 2). Dit word opgevolg deur ’n ondersoek na ‘destruktiwe denke’ met die interaksie tussen geloofs- en Christelike spiritualiteit (Hoofstuk 3). Ek stel dan ’n pastorale model van spirituele heling voor wat pastorale versorgers kan help om destruktiwe denkwyses te verstaan en aan te spreek in ’n konstruktiewe en verantwoordelike wyse (Hoofstuk 4).

Die gevolgtrekking volgens hierdie studie is dat ons gedagtes die middelpunt van ons handeling as denkende wesens is. Destruktiwe gedagtes kan ’n ontstellende uitwerking op ons spirituele en psigologiese lewens hê. Ons gedagtes het die vermoë om ons te vernietig en te verander. Met nabetraging van die potensiële impak van destruktiwe gedagtes op die individu se spiritualiteit en spirituele welstand, word ’n paar godsdienstige denkrigtings geïdentifiseer – soos onvanpaste afgode. Met bepaling van die verhouding tussen ’n mens se Godsbeeld en psigologiese en spirituele welstand, word voorgestel dat daar ’n verband is tussen ’n mens se persepsies en spirituele en psigologiese welstand.

Gevolgtlik stel ek voor dat daar ’n holistiese benadering tot destruktiwe denkwyses, met inagneming van ’n persoon se geloof, spirituele volwassenheid, godsdienste, persepsies en verhoudings met homself, andere en God, moet wees. Die voorgestelde psigo-pastorale benadering maak erns met die rol van

persepsie. Dit bied 'n uitstekende en praktiese metode aan vir begrip en beheer van destruktiewe denke. Dit bevorder heling deur die heropbouing van destruktiewe denke. Die plan is om persone te help om meer bewus en ingelig te wees oor hulle eie denke en persepsies in die algemeen en meer verantwoordelik op te tree. Dit sluit die vermoë in om jou eie gedagtes te monitor, flaters te herken en destruktiewe denke te verminder. Die doel van hierdie tesis is om die konstruktiewe bydrae wat pastorale sorg tot destruktiewe denke kan maak, te ondersoek.

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TABLE OF CONTENTS

TITLE PAGE	i
DECLARATION OF AUTHENTICITY	ii
ABSTRACT	iii
OPSOMMING	v
ACKNOWLEDGEMENTS	vii
CHAPTER 1	
1.1 TITLE OF THESIS	1
INTRODUCTION	1
1.2 BACKGROUND TO THE STUDY	3
1.2.1. THE RESEARCHERS INTEREST IN COGNITIVE BEHAVIOUR THERAPY	3
1.2.2. COGNITIVE BEHAVIOUR THERAPY	4
• <i>The cognitive and behavioural dimensions of CBT</i>	5
• <i>The different CBT models</i>	6
• <i>Generic elements of the CBT approach</i>	7
• <i>The thought - feeling – behaviour connection in CBT</i>	9
• <i>Clarifying the difference between thoughts and feelings</i>	11
• <i>The role of interpretation and meanings</i>	12
• <i>Efficacy of cognitive behavioural therapy</i>	12
• <i>CBT is a learning based approach</i>	13
• <i>Effect of CBT on the brain</i>	13
• <i>Neuroplasticity</i>	14
1.2.3. INCORPORATING SPIRITUALITY/RELIGION INTO CBT	15
1.3. DEFINING THE CONCEPTS	16
• <i>Theology</i>	16
• <i>Practical Theology</i>	16
• <i>Pastoral care</i>	17
• <i>Spiritual care</i>	18
• <i>Pastoral counseling</i>	18
• <i>Spirituality & Religion</i>	18
• <i>Christian Spirituality</i>	20
• <i>Religion/Religiosity</i>	22
• <i>My working definition</i>	22
1.4. ‘DESTRUCTIVE THINKING’	23
• <i>“Constructive thinking” and “destructive thinking” described in the literature</i>	23
• <i>Good and poor constructive thinking</i>	24
• <i>Constructive thinking & stress</i>	24
• <i>“Destructive” thinking defined in the literature</i>	24
• <i>Destructive thinking in Christian Spirituality</i>	25
• <i>My working definition</i>	26
1.5. RESEARCH PROBLEM & OBJECTIVES	26
1.5.1 The research question	26
1.5.2 The research problem	27
1.5.3 The Research Assumption	29
1.5.4 Research objectives	29
1.5.5 Research methodology	30
1.6 OUTLINE OF CHAPTERS	31
CHAPTER 2: “DESTRUCTIVE THINKING” IN COGNITIVE BEHAVIOUR THERAPY (CT & REBT)	32
INTRODUCTION	32

2.1.	DESTRUCTIVE THINKING IN CBT	32
2.1.1.	DESTRUCTIVE THINKING IN COGNITIVE THERAPY (CT)	32
•	<i>Cognitive distortions or “thinking errors”</i>	33
•	<i>Clusters of thinking errors</i>	35
•	<i>Clarification of the term “destructive thinking”</i>	36
•	<i>Levels of thinking in Cognitive Therapy (CT)</i>	36
○	<i>Automatic thoughts</i>	36
○	<i>Intermediate beliefs</i>	39
○	<i>Core beliefs and Schemas</i>	39
•	<i>Coping or compensatory strategies</i>	44
2.1.2.	DESTRUCTIVE THINKING IN RATIONAL EMOTIVE BEHAVIOR THERAPY (REBT)	44
•	<i>Rational and irrational beliefs in REBT</i>	45
•	<i>Description of rational and irrational beliefs</i>	47
•	<i>A list of illogical, irrational and self defeating beliefs</i>	49
•	<i>Irrational beliefs, REBT and the Religious/Spiritual client</i>	51
•	<i>The religious dimension: basic irrational beliefs</i>	53
•	<i>Rigidity</i>	57
•	<i>The biological basis of human irrationality</i>	57
•	<i>Choice</i>	57
•	<i>The ABC Model</i>	58
2.2.	COMPATIBILITY OF CBT AND RELIGION	63
2.2.1.	COMPATIBILITY OF CT and RELIGION	63
2.2.1.1.	Arguments supporting the compatibility of Cognitive Therapy and Religion	63
2.2.1.2.	Points of contradiction between Cognitive Therapy and Religion	68
2.2.2.	COMPATIBILITY OF REBT and RELIGION	72
2.2.2.1.	Arguments supporting the compatibility of REBT and Religion	75
2.2.2.2.	Points of contradiction between REBT and Religion	78
2.3.	AN EVALUATION OF DESTRUCTIVE THINKING IN CBT LITERATURE	80
2.3.1.	An evaluation of destructive thinking in Cognitive Therapy (CT)	80
2.3.2.	An evaluation of destructive thinking in REBT	83
2.4.	CONCLUSION	84
CHAPTER 3: DESTRUCTIVE THINKING WITHIN THE INTERPLAY BETWEEN RELIGION AND CHRISTIAN SPIRITUALITY		86
	INTRODUCTION	86
3.1.	DESTRUCTIVE TYPES OF RELIGIOUS THINKING	87
•	When spirituality and religion become ‘sick’	87
•	When our thinking about God becomes fractured	87
3.2.	THE ROLE OF GOD-IMAGES IN DESTRUCTIVE THINKING	88
•	God-images and God Concepts defined and distinguished	89
	God-images	89
	God Concepts	91
•	Multiple God-images	92
•	Metaphoric Theology	92
•	The Correlation between God-images and Psychological well-being	93
•	The Correlation between God-images and Spiritual well-being	93
•	The Impact of Destructive Thinking on God-images	94
3.3.	THE IMPACT OF DESTRUCTIVE THINKING WITHIN THE REALM OF BELIEF SYSTEMS	96
•	Destructive thinking in belief systems	96
•	Destructive thinking within the pastoral context	99
•	Pathology of faith	100

3.4.	SPIRITUAL FORMATION AND DESTRUCTIVE TYPES OF RELIGIOUS THINKING	100
	• Spiritual formation	101
	• Destructive types of thinking in religion	101
	• Probing into cognitive patterns of thinking in pastoral care	106
3.5.	SPIRITUAL MATURITY WITHIN THE CHRISTIAN FAITH	108
	• Spiritual well-being	108
	• Spiritual maturity	109
	• Maturity in faith	109
3.6.	CONCLUSION	111
 CHAPTER 4: DESTRUCTIVE THINKING IN RELIGION: TOWARDS A PASTORAL MODEL OF SPIRITUAL HEALING AND WHOLENESS		113
	INTRODUCTION	113
4.1.	THE INTERPLAY BETWEEN RELIGION, PSYCHOLOGY (CBT) AND PASTORAL CARE	114
	• <i>Worldview defined</i>	115
	• <i>Clifford Geertz's definition of religion/worldview</i>	115
	• <i>A Christian worldview</i>	116
	• <i>Worldview relates to pastoral/spiritual care</i>	116
	• <i>The notion of meaning in cognition</i>	117
	• <i>The centrality of spirituality</i>	117
4.2.	THE CONTRIBUTION OF PASTORAL CARE AND CHRISTIAN SPIRITUALITY TO RESTRUCTURING DESTRUCTIVE THINKING	118
	• <i>Healing and wholeness in pastoral care</i>	119
	• <i>Health in pastoral terms</i>	120
	• <i>Spiritual brokenness</i>	122
	• <i>Spiritual trauma</i>	122
	• <i>Spiritual struggles</i>	123
	• <i>The contribution of spiritual and pastoral care to restructuring destructive thoughts</i>	124
	• <i>The cognitive dimension in healing and wholeness</i>	125
4.3.	THE CONTRIBUTION OF 'CHRISTIAN THINKING' TO RESTRUCTURING DESTRUCTIVE THOUGHTS	126
	• <i>The Bible and 'thinking'</i>	127
	• <i>What does it mean to think like a Christian?</i>	127
	• <i>Transformation and growth</i>	128
	• <i>Developing a Christian mind and worldview</i>	128
	• <i>The ongoing use of the mind</i>	129
	• <i>Cross and the resurrection</i>	130
	• <i>Christian understanding of God</i>	130
	• <i>Thinking to discover meaning</i>	130
	• <i>God knows our thoughts</i>	131
4.4.	DESTRUCTIVE THINKING: TOWARDS AN HOLISTIC APPROACH IN SPIRITUAL CARE-GIVING	132
4.5.	CONCLUSION	135
 CHAPTER 5: SUMMARY OF FINDINGS AND CONCLUSION		137
5.1.	Summary of findings	137
5.2.	Conclusion	143
 BIBLIOGRAPHY		145

CHAPTER 1

1.1 TITLE OF THESIS

Destructive thinking within Religion: A Psycho-Pastoral Approach

INTRODUCTION

“Funny-is it not?-how the mind has a mind of its own, thinking for you even when you think it is not” (Thomas R. McDaniel 1998). As McDaniel here implies, thoughts are constantly streaming through our minds, and these thoughts, give rise to more thoughts. Humans cannot *not* think (Jones 1996:4). Our minds are constantly at work, even though we are not always aware of this (Winterowd et al. 2003). In the thinking process we are faced with various options, from which we have to choose or decide. Just as we cannot *not* think, we cannot *not* choose (Jones 1996). Therefore, we land up making choices based on our thinking. Sometimes however, our thoughts can be destructive or ‘dysfunctional’ (Beck, J. 1995:105). As humans we have the ability to think ourselves into and out of difficulty (Jones 1996:1). We can learn to control our thinking, and make better thinking choices. According to Jones, focusing on our thinking choices gives us a ‘handle’ to combat a range of unwanted feelings. By thinking more effectively we in turn will feel better and therefore, more likely to act in self enhancing rather than in self defeating ways (Jones 1996:1). Norman Vincent Peale once wrote, “Change your thoughts and you change everything” (Peale 2003:230). The kind of thoughts one habitually thinks determines one’s life, and not the circumstances that surround one. Clinging to habitual, destructive thoughts, keeps one mired in old unhealthy life patterns. “You are not what you think you are, but what you think, you are” (Peale 2003:232). Max Lucado (2011:1475) also writes: “What do you do with such thoughts? No one knows me. No one's near me. No one needs me. How do you cope with such cries for significance?” To this he replies, “Some stay busy; others stay drunk. Some buy pets; others buy lovers. Some seek therapy. And a few seek God”. In some instances, people seek therapy because of the unpleasant way they are feeling or because they are seeking symptom relief from some sort of problem or difficulty they are experiencing. Often though, when individuals seek therapy, their attention is focused on others or events beyond themselves for which they can blame for their problems. Very seldom are they conscious of their own thoughts and the role these play in the emotional difficulty that they are experiencing (Neenan and Dryden 2006).

To understand the impact of one’s thoughts, take a look at depression, as an example. Intense negative thinking almost always accompanies a depressive episode (or any painful emotion for that matter). When a person feels depressed, their thoughts are overwhelmed by negativity and they see themselves and everything around them through these dark coloured lenses. According to Burns, these pervasive

negative thoughts are the cause of self-defeating emotions: “These thoughts are what keep you lethargic and make you feel inadequate. Your negative thoughts, or cognitions, are the most frequently overlooked symptoms of your depression. These cognitions contain the key to relief and are therefore your most important symptoms. Because these thoughts have actually created your bad mood, by learning to restructure them, you can change your mood” (Burns 1999).

Can theology and psychology be integrated? I personally support the notion of integration, but this should not be at the loss of theological competency among pastoral counselors. Pastoral caregivers must not lose or abandon their distinctive professional identity by embracing new psychological perspectives. My aim therefore is not to lose confidence in my own theological perspective, nor to replace theological thinking with psychological ways of thinking, but to rather use the insights from CBT to inform the theological task of helping the Christian counselee to guard his or her heart and mind in Christ Jesus. Certain questions may arise with integration. Can theology and psychology be successfully integrated? In what way can pastoral counselors connect their theological and psychology training? Should they combine their learning into a unified system of thought? Or should they be kept separate? Should they view each as making a unique/special hermeneutical contribution to the task at hand? What does it mean to bring a theological perspective to the task of thinking? To answer these questions, I reflect on Louw’s account of the interdisciplinary relationship between theology and the human sciences (i.e. psychology). According to Louw, the difference between these two disciplines should be understood in terms of perspectivism and not dualism (a theory of two opposing concepts). In that both work with the same object (the human being) but within different contexts (Louw 1998:100). Louw further explains the differing paradigms from which each discipline operates, i.e. Pastoral theology operates from a predominantly faith paradigm; Psychology from an observational, phenomenological, behavioural and empirical paradigm (Louw 1998:100). Reinforcing the idea of why these differences should be interpreted in terms of perspectivism and not dualism. When taking into account perspectivism, the method of correlation and correspondence (methodologically) is automatically taken for granted with each still retaining their own identity (Louw 1998:100). Pastoral counseling is described by Van Deusen Hunsinger (1995:1) as being essentially interdisciplinary. Van Deusen Hunsinger (1995:1) also notes, to be fully equipped for ministry, pastoral counselors need to have had both psychological and theological training, which equips them to develop both psychological and theological perspectives with a variety of emotional and spiritual problems. “While pastoral counselors will necessarily possess psychological expertise, the distinctiveness of the profession depends upon its ability to combine such expertise with a theological perspective” (Van Deusen Hunsinger 1995:2).

Therefore, I support an openness to learning from other disciplines, but not at the expense of losing one’s own distinctive professional identity. I also recognize the need when adopting various psychological perspectives to first critically evaluate these in the light of one’s theological standpoint and faith. Van

Deusen Hunsinger (1995:4) notes, “Pastors need psychology, but their psychology needs to be compatible with their theological convictions. Such compatibility could be tested only through critical conversation between the disciplines”. I therefore seek clarity about the relationship of the disciplines of psychology and theology to the overall task of pastoral care giving in general, and to an understanding of destructive thinking in particular. This thesis then, seeks to shed light, from a particular theological point of view, on the task of interpreting destructive thoughts in a pastoral context. The specific focus may be: how will the interplay between theology and psychology help one to understand the psychological theory (CBT) in relation to theological aims (pastoral care) and both in relation to the individual seeking help (destructive thinking). After identifying the various destructive types of thought, I go on to use these to bring theology and psychology into relationship. How would understanding the relationship between these two fields help one to deal with psychological problems, as well as with important questions of faith? As the goals of psychotherapy have not always fitted well with the aims of the Christian faith. In this thesis, I propose a holistic approach, keeping in mind the pastoral counselor’s distinctive task. My hope through this research is to help the ordinary person through their everyday problems of living. Having introduced the significant impact of one’s thoughts on their lives, I continue into the next section with a background to this study.

1.2 BACKGROUND TO THE STUDY

1.2.1. THE RESEARCHERS INTEREST IN COGNITIVE BEHAVIOUR THERAPY

I should, however, at this point clarify that my thesis is not on Cognitive Behavioural Therapy per se, but rather on the insight that these therapies provide on understanding cognition, cognitive processes and destructive thoughts/thought patterns. According to Rosmarin et al., insights from cognitive theory over the last few years has enhanced our understanding of anxiety, depression, personality disorders and even psychosis (Rosmarin et al. 2011). CBT’s emphasis on cognition as a key determining factor on how people feel and behave is of significant importance to this research. A basic assumption in CBT is that feelings and behaviours stem largely from the way situations are interpreted. People tend to respond to their cognitive representations of events, rather than to the actual events themselves. Consequently, information may be processed in a way that is not in accord with reality, resulting in cognitive distortions such as those commonly found in the CBT literature. The way reality is interpreted plays an important role in determining whether emotional distress or psychological disorders are formed or maintained. Another point of interest is that cognitive behavioural therapies in recent years have also been adapted for use with religious beliefs and practices.

CBT is based on the theory that self-destructive thinking styles are learned and for this reason, can also be unlearned or restructured. Restructuring destructive thinking is central to cognitive therapy, as well as

to pastoral counseling in general. Scriptures such as, “As a man thinketh in his heart so is he” (Proverbs 23:7); “Be transformed by the renewing of your mind” (Rom. 12:2), “I thought on my ways and turned my feet” (Ps. 119:59), provide scriptural grounding for the use of basic CBT principles. The following aspects of the CBT approach are of particular interest to this study:

CBT -

- emphasizes cognitive processes and cognitive functioning
- provides a framework for working through cognitive distortions; analyzing distorted thinking; and establishing more constructive patterns of thinking
- facilitates the development of cognitive and behavioural skills
- recognizes the active role individuals play in constructing their own reality
- recognizes the reciprocal relationship between cognition, affect and behaviour (how we think, feel and behave forms a feedback loop that maintains destructive behaviour)
- cognition is knowable and accessible (it is possible to access one’s thoughts)
- cognitive change is possible; and a prerequisite for meaningful emotional and behavioural change
- is a non drug therapy/treatment;
- may also be more cost effective for use by the average individual
- the basic principles of cognitive therapy can be readily applied outside of therapy
- is suitable as a form of self help

1.2.2. COGNITIVE BEHAVIOUR THERAPY

Cognitive Behaviour Therapy (hereafter referred to as CBT) teaches that one can choose the way they think. Healthy thinking is viewed as a choice. It is also possible for one to change their deeply ingrained thinking habits. A number of different therapies are classified as CBT’s, including Rational-Emotive-Behavior-Therapy (REBT) and Cognitive Therapy (CT). The two influential pioneers of Cognitive Behavioural Therapy are Aaron T. Beck and Albert Ellis. Both started off as followers of Freud practicing as psychoanalytic therapists, but eventually rejected psychotherapy in favour of what later became known as the cognitive approach. Round about the same time that Ellis developed his REBT, Beck developed his CT, although they seemed to have developed their approaches independent of one another. Despite the many similarities between these two approaches, there are also a number of significant differences. Analyzing destructive types of thinking in CBT literature will be the focus of the next chapter (Chapter two). My research here will concentrate mainly on the two CBT therapies of Aaron T. Beck (Cognitive Therapy) and Albert Ellis (REBT).

Albert Ellis and REBT: Albert Ellis (1913 – 2007) was a clinical psychologist originally trained in Freudian psychoanalysis. He became dissatisfied with this type of therapy and eventually developed his

own method, which after many years and modifications became known as Rational Emotive Behaviour Therapy (REBT). It was originally known as ‘‘Rational Therapy’’ (RT); Ellis later changed it to Rational-Emotive Therapy (RET) in 1961; and finally to Rational Emotive Behavior Therapy (REBT) in June 1993 (Dryden 2012). Ellis changed the name so that it would more accurately reflect the interaction between the thought, feeling and behaviour components of the theory. Ellis recognized the role of thoughts and beliefs in causing psychological problems. He argued that irrational thinking was at the root of many psychological problems and that by learning to think more rationally, such problems could be resolved. He also acknowledged the role of behaviour in determining how one feels. Ellis proposed that irrational beliefs about oneself, others, and the world, are what lead to self defeating emotions and behaviours (Gregas 2009:24).

Aaron T. Beck and Cognitive Therapy: Aaron T. Beck (1921 -) is a psychiatrist and was also initially trained in psychoanalysis. He too became dissatisfied with traditional psychoanalysis and later developed what became known as Cognitive Therapy. Beck’s Cognitive Therapy initially began with his research on depression. He noticed that depressed people have faulty or distorted thinking patterns, which stem from what he called schemas. He defined schemas as core beliefs that bias the way a person perceives and interprets their experiences. He understood these as operating like templates that one uses to make sense of the world and their experiences. Negative schemas give rise to faulty thinking which causes psychological problems, such as pessimism, depression, guilt, etc. The aim of therapy is therefore to modify faulty thinking which should improve mood, feelings and psychological well-being. Beck is also well known for his negative ‘cognitive triad’ theory. He strongly believes that the negative beliefs depressed people held about themselves, the world, and the future, could be the reason for their depressed symptoms.

- ***The cognitive and behavioural dimensions of CBT***

Cognitive Behaviour Therapy is described as a combination of Behaviour Therapy and Cognitive Therapy into one integrated, comprehensive theory. Both Ellis and Beck’s cognitive approaches are still widely used today, and in some instances, these have been adapted or modified for use with a variety of problems and disorders. Even though there are differences between some of the techniques and terminology used by the various cognitive behavioural therapies (even between followers of Beck and Ellis themselves), all CBT approaches have two components in common: a cognitive and a behavioural component. The **cognitive component** of CBT focuses on cognitions, or thoughts, i.e. the thoughts and emotions that underlie a symptom or behaviour. It tries to identify whether these thoughts are inaccurate or distorted. It inquires about the way the individual thinks and creates meaning about events in their life; and links these to their deeper underlying beliefs about themselves, others and the world. The **behavioural component** of CBT focuses on the individual’s actions and behaviours, and tries to establish how these are connected to the individual’s thoughts. It looks at what the person is doing i.e.

behaviours that may worsen or maintain the problem, such as avoidance or acting out. This component of CBT makes use of behaviour modification to promote specific behaviours that will decrease a symptom or behaviour.

Combining these two components in therapy enables both cognitions and behaviours to be addressed, the aim being to weaken the connection between destructive (automatic) thoughts and their resulting behavioural responses. The role of interpretation (the subjective cognitive response) the individual gives to an event is also considered. In that, for behavioural change to occur, cognitive change first needs to take place. Cognitive change becomes a prerequisite for behavioural change. CBT recognizes this inter-relationship between thoughts, feelings and behaviours, and attempts to control destructive thoughts that lead to destructive behaviours.

- ***The different CBT models***

Psychotherapies that center their attention on individuals' thoughts and behaviours are generally known as Cognitive-Behavioural Therapies (CBT's). There are a number of different types of CBT approaches in existence today. Due to their differences it is difficult to talk about these as a single group. To complicate matters, they are also constantly evolving and changing over time. Ayers et al. (2007:340) says, to think of CBT as a singular unitary entity is misleading. Towl et al. (2010:249) and Johnstone (2006:18) describe CBT as a broad church of related approaches. Van Bilsen & Thomson (2011:16) illustrate CBT as a huge tree made up of many branches. They list Ellis's Rational Emotive Behaviour Therapy (REBT), Dialectical Behaviour Therapy, Acceptance and Commitment Therapy (ACT), Mindfulness Based CBT and Compassionate Based CBT, as examples of cognitive behaviour therapies. All these various approaches are described as belonging to the family of Cognitive Behaviour Therapy. Owing to the numerous approaches under the umbrella of CBT, Dryden (2010:1) describes CBT as a therapeutic tradition rather than a therapeutic approach. The CBT approaches all share the view that emotional problems are closely linked to how one thinks about them self, others and the world; and a person's actions are based on such thinking (Dryden 2010:1). Lehmann & Coady (2001:166) explain that the various CBT approaches each place a different degree of emphasis on cognitions or behaviours, but almost all acknowledge the effectiveness of assessing and intervening in both domains. Lowinson (2005:723) states, some CBT approaches attend mainly to cognitive processes, others to behavioural processes, while others are equally attentive to both.

Despite the commonalities between the CBT approaches, there are also significant differences. For example, they differ with regard to the processes that underpin change and the procedures that bring about change. Van Bilsen & Thomson (2011:18) make it clear that within the CBT framework there are variations with regards to processes and procedures. For example, some approaches seek to change behaviours through skills training; others focus on the changing of distortions of existing beliefs; while

others address perceived deficits in cognitive skills. They also differ to the extent that they incorporate imagery strategies, behavioural components and cognitive interventions. Of all the CBT approaches, Dobson and Block (quoted in Lowinson 2005:723) recognize Ellis and Beck as introducing the first CBT approaches - Rational Emotive Behaviour Therapy and Cognitive Therapy, respectively. C. George Boeree writes, "If Ellis is the grandfather of cognitive-style-therapies, then Beck is the father" (<http://webpace.ship.edu/cgboer/ellis.html>). Both Beck and Ellis's approaches have been very influential in the therapeutic field, and both are still widely used today. For these reasons, I have selected these two CBT approaches for this study. Although both these theorists share similar views with regards to the crucial role of maladaptive, dysfunctional thinking in the development of psychopathology or emotional disorders, there are also some significant differences between the two. However, it is beyond the scope of this study to discuss these differences in more detail, as my focus here is on the contribution of each to understanding destructive types of thinking.

- ***Generic elements of the CBT approach***

While often taken to be a single entity, CBT actually comprises a broad group of approaches that are unified by several underlying principles. CBT is identifiable by the presence of the following key principles or elements:

Cognitive therapy starts with conceptualizing the individual's problem by means of *the cognitive model*. The cognitive model is based on the notion that cognitions (which include our thoughts, beliefs, and the manner in which we perceive a situation) have an impact on thoughts, emotions, behaviours and even physiological processes. As a working model, it directs attention to the relationship among thoughts, emotions, and behaviours. CBT is based on the cognitive model. Basic to the cognitive model is that the way one responds to an event depends largely on the way the event is perceived or interpreted by the individual. In that, one tends to respond to the cognitive representation of the event rather than to the actual event itself. When one's interpretation is not based on the facts or reality, it often leads to destructive types of thinking. This means, the way one thinks about the situation or event largely determines one's affective and behavioural response. A *reciprocal relationship* thus take place between one's thoughts, feelings and behaviour. Changes in the one, results in changes in the other. This is at the heart of the cognitive model.

The three levels of cognition that are of significance in the cognitive model are core beliefs, intermediate beliefs and automatic thoughts, these shall be discussed in the following chapter. Cognition can be described as an *information-processing system* that consists of different levels, structures and processes. Matson et al. (2009:57) describe the three components of this system as being one's automatic thoughts, intermediate beliefs and schemas. An active information processing system selectively attends to the environment, filters any incoming information, and then interprets this information impinging on the

individual. From a CBT perspective, all acts of perception, learning and knowing are seen as products of such an information processing system. Particular aspects of the information processing system may become distorted, biased or maladaptive, giving rise to experiences of emotional, behavioural and relational distress. In CBT, a high priority is placed on achieving change in cognitive content, processes and structures. Such an outcome is seen as the most effective means of achieving clinically significant change.

CBT is based on the notion that dysfunctional situations result when a '**bias**' (e.g. dysfunctional thoughts) occurs in the processing of information. One of the goals of CBT is to help individuals to develop a more accurate style of information processing. Individuals are thus taught to recognize and examine their negative or distorted beliefs and understand that improved information processing skills can relieve distress and help them to cope more effectively with life's challenges.

Beck's cognitive *content-specificity hypothesis* means that each emotional state and psychological disorder has a specific cognitive profile. E.g. according to this model, cognitive processes in depression center on loss, hopelessness, and failure; and cognitive processes in anxiety focus on perceived threat, danger and uncontrollability (Matson et al. 2009:57).

According to the CBT model, most emotional and behavioural reactions are *learned*. This means, that destructive ways of thinking and behaving can be unlearned and replaced with new, healthier patterns. CBT is based on the notion that *learning and thinking* play a role in how emotional and behavioural problems emerge and are maintained. Therefore, much emphasis is placed on the role of thinking in how one feels and behaves. In order to get rid of unwanted feelings and behaviours, one needs to identify the thinking behind these feelings or behaviours and learn to replace these with thoughts that lead to more desirable reactions (Newman et al. 2007:148). CBT attributes the individual's problems to inadequate ways of thinking (i.e. irrational, dysfunctional or distorted thinking styles) or to a lack of thinking skills. *Skills acquisition* is therefore viewed as a crucial component in human functioning and as an important therapeutic technique in CBT (Ronen & Freeman 2007). Therapy aims to reduce distress by unlearning maladaptive habits, changing maladaptive beliefs and providing new information processing skills (Van Bilsen & Thomson 2011:16). CBT therapists believe that people change when they learn to think differently. They therefore focus on teaching new thinking skills that the individual can use once counseling is over.

Because we are unique human beings, says Ellis, we can think about our thinking...and think about thinking about our thinking (Ellis 2001:8). Through CBT, individuals become more and more skilled in *meta-cognition*, that is, thinking about their own thinking. They are also taught cognitive and

behavioural strategies that can help them modify their thinking (particularly destructive, irrational or distorted thinking) (Matson et al. 2009:57).

To best fulfil the goals of CBT, one must consider the individual's total functioning (e.g. cognitive, affective, behavioural) within their *context*. Biological, cultural, social and environmental factors should all be considered when taking into account the contextual influences impinging upon the individual (Matson et al. 2009:57). In the next chapter, I add spirituality and religion to this mix.

CBT does not tell people how they should feel. But it does recognize that when confronted with undesirable circumstances, individuals can benefit from feeling calm under such circumstances. Getting upset means the person actually lands up with two problems – the problem itself and their emotional state about the problem (Newman et al. 2007:148). Stress also causes certain beliefs (that were previously lying dormant in a person's life) to re-emerge. Ellis says (2001:39) "Adversities frequently happen, blocking you from getting what you really desire and delivering what you abhor. Rarely do you have control over these adversities. What you almost always do have control over is your thinking and feeling and behaving about them. Even when you are so shocked that you momentarily lose control and respond in a devastating manner, you almost always have the ability to reflect and change your reacting, and thereby responding much differently. Clearly note that you have – and can use – this constructive ability".

- ***The thought - feeling – behaviour connection in CBT***

"Being a human, you think, feel and act" (Ellis 2001:14). Feelings and emotions are fundamental to the human condition (Ellis 2001:19). A reciprocal relationship exists between these three components - thinking, feeling and behaving, interacting and affecting each other. What we think influences how we feel, which in turn has an impact on our behaviour. How we feel therefore affects what we think and influences what we do. Our behaviour in turn also affects how we feel and what we think.

Kinsella (2008:3) states that at a very basic level, CBT looks at the inter-relationship between five elements: environment, thoughts, feelings, physical sensations and behaviour, which form a vicious circle. Kinsella reckons (2008:3) that in CBT, all disorder specific models (e.g. panic disorder) are presented as a vicious circle with these five elements present. This vicious circle connects events in the environment with our thoughts, feelings, physical sensations and behaviour. Greenberger and Padesky (quoted in Wanberg et al. 2005:91) suggest that the environment and the individual's physiological responses are equally important components in this reciprocal process. External (or internal) events are important in bringing on certain thoughts based on the individual's beliefs and attitudes. As well, initial physiological responses (i.e. rapid heartbeat) to these events or thoughts, emotions and behaviours are also important focuses in the change processes. Greenberger and Padesky (quoted in Wanberg et al.

2005:91) conclude that change in any one of the five components – the environment, thoughts, attitudes/beliefs, emotions and behaviour – can have an impact on the other four.

According to the cognitive model, emotions and behaviours are influenced or determined by how one perceives an event and not by the actual event itself. For instance, if an event gives rise to a certain emotion, then whoever experiences the same event, should also experience the same emotion. We know in reality that this is not so and people often react differently to similar events, even producing different emotional states. Therefore, something else must be at play in how people feel and behave other than the event. Kennerly et al. (2011:4) ascribes this influence to the role of cognition, i.e. the interpretation or meaning that the person places on an event. This is evident when two people experience the same event but react to it differently because they have assigned different meanings or interpretations to it. Basically, in CBT, the way a person feels is a result of the way they interpret and think about a situation rather than by the situation itself. Judith Beck (1995:75) notes, some events may be perceived as universally upsetting, e.g. a personal assault, rejection or failure.

Scott Ventrella (2001:30, 37) uses the Belief-Thought-Feeling-Action (B-T-F-A) Chain to explain the relationship between beliefs, thoughts, feelings and actions. He points out that a person's actions result from their feelings, which result from their thoughts, which result from their beliefs. By grasping how this chain works and the relationship between these four concepts, one can begin to exert more control over their destructive thoughts/feelings/emotions and actions/behaviours. "The fact," says Ventrella (2001:36), "that our thoughts emanate from our individual beliefs about the world and life in general provides us with tremendous insight into how we can change negative actions into positive actions".

The CBT model is not based on a linear process in which thinking leads to emotions and actions (Neenan and Dryden; quoted in Wanberg et al. 2005:91). Emotions and moods are also thought to lead to certain thoughts and actions, therefore influencing how one thinks or feels. Destructive thinking, says Van Bilsen & Thomson (2011:39), raises the likelihood of strong and unhealthy negative feelings which promotes self defeating behaviour.

Quoting Bertrand Russell, Ellis remarks (2001:39) "... anyone who thinks that happiness comes completely from within had better be condemned to spend a night in a raging storm in rags in sub zero weather! But if you acknowledge that you have considerable choice about how you feel under adverse conditions, and use your knowledge to help yourself cope with them, you can react with disappointment and regret, instead of holy horrorizing". Thoughts can be changed to help the individual feel better or behave more effectively, especially in undesirable situations. And even if the situation cannot be changed, the individual can learn to feel less distress by revising their way of thinking and adopting a new outlook (Newman et al. 2007:148). Ellis encourages one to develop healthy rather than unhealthy

negative feelings – those he says, that help one to get more of what they want rather than what they don't want. This can be accomplished by training oneself to feel in a healthier manner (Ellis 2001:149). One can learn to change their destructive feelings into healthy negative emotions. Just as one constructs their unhealthy feelings, so too, can they learn to reconstruct healthy ones again (Ellis 2001:150). For example, one can train them self to feel the healthy feelings of sorrow and regret, rather than the unhealthy feeling of rage. And these will then become automatic (Ellis 2001:150). Wanberg et al. (2005:91) explains the basics of the change model in CBT: “Yet, the change model as utilized in most CBT approaches is premised on the idea that we start with identifying the thinking, and the underlying beliefs, that lead to certain emotional and behavioural outcomes. In order to prevent dysfunctional emotional and behavioural outcomes, we then make efforts to change the thinking and the underlying beliefs as to increase the probability of more favourable and functional emotional and behavioural outcomes”.

Curwen et al. (2011:20) describes the role of one's thoughts on guiding behaviour, emotions and (in some instances) physiological responses, as the cornerstone of CBT. People often assume that certain events cause them to feel a certain way. Rarely do they consider that it is their thinking (or beliefs) that have caused their feelings or behaviour. Therefore, depending on the nature of the problem or difficulty experienced, overcoming emotional or psychological problems may require one to work on their automatic thoughts, intermediate thoughts (rules and assumptions) or core beliefs in therapy. Dispenza (2007:34) expands on these concepts further when he writes, “When the body responds to a thought by having a feeling, this initiates a response in the brain. The brain, which constantly monitors and evaluates the status of the body, notices that the body is feeling a certain way. In response to that bodily feeling, the brain generates thoughts that produce corresponding chemical messengers; you begin to think the way you are feeling. Thinking creates feeling, and then feeling creates thinking, in a continuous cycle. This loop eventually creates a particular state in the body that determines the general nature of how we feel and behave. We will call this state of being”. He then explains further, “a person who wants to improve his health has to change entire patterns in how he thinks, and these new thought patterns or attitudes will eventually change his state of being. To do this, he must break free of perpetual loops of detrimental thinking and feeling, feeling and thinking, and replace them with new, beneficial ones” (Dispenza 2007:44). People with psychological disorders often misinterpret neutral or even positive situations, therefore, correcting such errors in thinking usually results in the person feeling better.

- ***Clarifying the difference between thoughts and feelings***

However, it is necessary to clarify the difference between thoughts and feelings because we often confuse the two or use them interchangeably, when in fact they should be distinguished, i.e. when we say “I feel” but actually mean “I think.” If I say, “I feel no one cares about me,” the word ‘feel’ does not actually identify my feelings, but instead, that of my views, thoughts or beliefs. Hepworth et al. (2010:391)

explains that thoughts per se, completely lack feelings, but may accompany and generate feelings or emotions. Feelings consist of emotions such as sadness, joy, disappointment. Moods should be able to be expressed in a single descriptive word e.g. anxiety, depression. Using more than one word may actually be describing a thought. Judith Beck (1995:109) says that emotions are often easier to change indirectly (rather than directly), through changing thoughts and behaviours.

- ***The role of interpretation and meanings***

In cognitive therapy, one's thoughts, feelings and beliefs are acknowledged as affecting how one sees the world around them. But it is the way one interprets events and the meanings that the individual assigns to these (rather than the actual events themselves) that determines how one feels and behaves. Wilson & Branch (2006) confirms this when they say, the more negative the meaning assigned to an event, the more negative the individual's feelings will be, and the more likely the person will act in ways to maintain these feelings, the outcome being the production of even more negative thoughts. Therefore, as Neenan and Dryden (2004:3) explain, it is possible for one to change their feelings about an event by changing the way they think about it. This means that people are actively involved in constructing their own reality and are not merely passive recipients of the world.

Wilson and Branch (2006:12) substantiate that it is one's thoughts, beliefs and the meanings that the person assigns to an event that produces their emotional and behavioural responses. In other words, it is the meaning that a person attaches to an event that influences their emotional response. Further, positive events usually evoke positive feelings, i.e. happiness; whereas negative events, usually bring about negative feelings, i.e. sadness. When the meanings attached to certain negative events are not completely accurate or realistic, or are unhelpful, the person is left feeling disturbed. Wilson and Branch describe "disturbed" here, as being "emotional responses that are unhelpful," that cause "significant discomfort" to the individual, which hinders the individual from being able to cope with the negative event (Wilson and Branch 2006:13). Thus, one's thoughts and feelings, to a large extent, determine how they behave, i.e. the way they will act. Wilson and Branch (2006:13) list the following types of problematic behaviours: self-destructive behaviours; isolating and mood depressing behaviours; and avoidance behaviours.

- ***Efficacy of Cognitive Behavioural Therapy***

CBT theory is a well developed and empirically supported therapy (Aubele 2011:73). It has had enormous popularity and success with a wide variety of problems, with people from all walks of life and of all ages (children, adolescents and adults). There is substantial evidence supporting the successful application of CBT in therapeutic practice in the treatment of various clinical problems and disorders, such as depression, generalized anxiety disorder, panic disorder, agoraphobia, social phobia, posttraumatic stress disorder, chronic pain, marital distress, to name but a few (Froggatt 2006).

- ***CBT is a learning based approach***

The basic premise of the cognitive model is that one's emotions and behaviours result from their cognitive processes; and that by learning to modify these one can achieve a different way of feeling or behaving (Froggatt 2006). An important goal of CBT is to correct faulty thinking that the individual has learned. Cognitive restructuring is a method of learning used to identify and modify dysfunctional or destructive thinking. One of the defining features of CBT is that it is educative. The vehicle for change is seen as the skills that one acquires during treatment and puts into practice outside of sessions (Wanberg et al. 2005:67, 95). Learning the new skills taught in CBT should lead to more positive adjustment, and through reinforcement and continual practice, become part of one's daily living.

People can and do change, and because beliefs, feelings and behaviours are learned, what has been learned can also be modified or unlearned (Phillipey 1983). Burns reckons that people can learn to change the way that they think, as well as their basic values and beliefs. Changing these may produce lasting changes in one's mood, outlook and productivity (Burns 2000: xix). CBT seeks to bring about change through helping individuals identify and regulate their emotions, connect their thoughts with their behaviours, reduce maladaptive thoughts and beliefs and educate people about their cognitive processes (Freeman:416). Epstein (1998:134) writes, "As you think, so shall you feel" and says that certain ways of thinking are associated with good personal adjustment and life satisfaction, while other ways are associated with maladjustment and misery.

As these authors above propose, I too believe that cognitive change is possible. Therefore, my goal is to help individuals to help themselves, by bringing about change through transforming "destructive" habits of thinking.

- ***Effect of CBT on the brain***

Burns makes an interesting statement when he writes, "cognitive behavioural therapy may actually help people by changing their brain chemistry and architecture of the human brain" (Burns 2000: xxii). In what follows, I briefly refer to some of the literature that shares this view, several of which have empirical data to support their findings. Some of the recent studies documenting changes to the brain following CBT are for depression (Goldapple 2004); post traumatic stress disorder (Rabe et al. 2008); specific phobia (Straube et al. 2006); obsessive compulsive disorder (Saxena et al. 2009); spider phobia (Paquette et al. 2003); anxiety disorders (Porto et al. 2009); and psychosis (Kumari et al. 2011). Each of these studies reported brain changes after CBT treatment, followed by symptom reduction.

In a systematic review by Porto et al. (2009) it was found that changes in brain activity occurred following CBT. The aim of this study was to investigate changes in brain activity as a result of CBT in anxiety disorders, namely: obsessive compulsive disorder (OCD); posttraumatic stress disorder (PTSD);

specific phobia, panic disorder and social phobia. Neuroimaging techniques were used to assess neurobiological changes in the brain. This particular review focused solely on CBT and anxiety disorders. After analyzing the changes in brain activity, it was concluded that CBT can promote neurobiological changes in anxiety disorders. For example, as part of Porto et al.'s review was an analysis of two separate studies on spider phobia. It was noted that even though these two researchers (Piquette and Straube) obtained different results for brain areas involved before treatment, both reported a reduction of symptoms after CBT treatment and modification of dysfunctional neuronal circuits (Porto et al. 2009:117).

In their investigation of the effect of CBT on brain changes in major depressive disorder (in comparison to the use of antidepressant medication), Goldapple et al. (2004) found through the use of brain imaging technology, that antidepressants and CBT affected different parts of the brain, thus, impacting different systems. Antidepressants, they found, reduced activity in the limbic system (which is considered the emotional center of the brain), causing a reduction in emotions. CBT calmed activity in the cortex (the reasoning part of the brain). This resulted in emotions being processed in a much healthier way. This process explains why combined treatment may be beneficial; or the high possibility of relapse after stopping medication (i.e. due to an influx of negative emotions). Learning the skills of CBT enables one to learn to respond to their emotions more appropriately and effectively, thereby reducing the chances of relapse.

In a study (Kumari et al. 2011) that was designed to examine functional brain changes following CBT for psychosis, functional magnetic resonance imaging (fMRI) revealed that brain changes did occur. There was reduced activation of the inferior frontal, insula, thalamus, putamen and occipital areas to fearful and angry expressions at treatment follow-up, as compared with baseline. These changes correlate directly with symptom improvement. Those treated with CBT showed significant clinical symptom improvement compared to those who did not receive CBT (they showed no change at follow up). Kumari et al. (2011:2396) states, "cognitive behaviour therapy for psychosis attenuates brain responses to threatening stimuli and suggests that cognitive behaviour therapy for psychosis may mediate symptom reduction by promoting processing of threats in a less distressing way".

- ***Neuroplasticity***

The traditional understanding of the human brain was that once the individual reached the age of seventeen, brain growth no longer occurred and it became a fixed, static organ (Craig 2011:64). Research in the field of neuroscience has since revealed that the brain is a "highly dynamic" organ. It is a "constantly reorganizing system capable of being shaped and reshaped across an entire lifespan" (Fernandez 2009:6). Neural pathways keep changing and grow in response to stimuli (Craig 2011:64). The words "neuroplasticity" and "neurogenesis" describes this process. I do not want to deviate and go

into too much detail about this here, but I am urged to mention just the following few points. Neuroplasticity is defined by Fernandez as: “the lifelong capacity of the brain to change and rewire itself in response to the stimulation of learning and experience” (Fernandez 2009:6). Neurogenesis is defined as: “the ability to create new neurons and connections between neurons throughout a lifetime” (Fernandez 2009:6). The point I want to illuminate here, is that this means that the brain has the potential for change and development throughout one’s life and is not a fixed, unchangeable system as once thought. Neuroscientists have acknowledged this potential for plastic changes in the adult human brain. As one learns new things, it becomes part of one’s neural network in the brain. New learning causes new neural pathways to be laid and new neural connections to be formed in the brain. These changes in turn, affect one’s brain chemistry. Fernandez describes learning as: “the physical process of changing our brains” (Fernandez 2009:8). Learning increases connections between neurons. When we learn, we create physical changes inside our brain.

Eric Kandel, won the Nobel Prize in 2000 in medicine, for showing that within an hour of repeated stimulation, the number of connections in a neural bundle can double (Craig 2011:65). He proved that new wiring occurred very rapidly within the brain. Continuous practicing of a new skill/action/ thought increases stimulation in a particular area of the brain, strengthening existing neural connections and creating new ones. Conversely, if we don’t use a neural pathway, it will reduce in size (shrink) (Craig 2011:65). Arden (2009:96) explains that as one repeats an action or thinks in a particular way, the more likely these become habits, developed at the synaptic level through neuroplasticity; and re-wiring has taken place. Craig uses an illustration of the brain as being like ‘putty’ to explain how it is shaped and reshaped, by the thoughts, feelings and experiences it processes (Craig 2011:65).

CBT is about challenging (destructive) thoughts and helping one to develop new thoughts. Thus, as one learns new cognitive methods, strategies and concepts, new neural pathways begin to grow and one’s feelings, beliefs, and thoughts begin to change too. CBT is about replacing old, destructive patterns of thinking (and behaviour) with new, healthier thinking (and behaviour). As a result of the newly acquired CBT skills or healthier ways of thinking (i.e. through cognitive restructuring), new healthy neural pathways can be laid, or laid over old unhealthy pathways. By learning to change one’s thinking, CBT offers the opportunity to bring about positive and beneficial changes through the rewiring of our neuroplastic brains. Changing thinking can thus change the brain. This significant finding reveals the powerful influence of one’s thoughts/cognitions over one’s life and the reason why to attend to them when they have become faulty/distorted/dysfunctional.

1.2.3. INCORPORATING SPIRITUALITY/RELIGION INTO CBT

The literature review here reveals that incorporating spirituality/religion into cognitive psychotherapies is not something new. Theorists/researchers have also written on how cognitive therapies can accommodate the religious faith and beliefs of clients, i.e. David Phillipy (1983) and Sasan Vasegh (2011). There is evidence of successful treatment of depressed clients using Christian Cognitive-Behavioural Therapies (Propst, Ostom, Watkins, Dean & Mashburn 1992). David Hodge claims that by incorporating spirituality into traditional CBT in alcohol treatment, the outcomes obtained are either similar or superior to the outcomes obtained with traditional CBT (Hodge2011). In another study where religiously oriented cognitive therapy (RCT) was provided by both believing and non-believing therapists to Christian depressed individuals, a later follow-up showed that the RCT provided by the non-believing therapists was not substandard to that provided by the believing therapists (Hank Robb2002).

1.3 DEFINING THE CONCEPTS

Within the context of this study, that which is destructive in pastoral thinking is not necessarily the same as that which is destructive in psychological thinking (particularly CBT). Spirituality, the notion of the pastorate and pastoral theology, cannot be separated from religion as these are all linked. There is however, a distinction between religion and spirituality. Pastoral care and counseling is also another discipline and another category. The different concepts are therefore defined in this section. Destructive thinking is then placed within the background of religion and then pastoral care.

- ***Theology***

Hodgson (1994:3; quoted in Louw 1998:101) gives the following definition of Theology: “Theology is a discourse about God and an interpretation of God as well as the encounter between God and human beings. The ultimate subject matter of theology is God (theos). In its most basic sense, theology means ‘language or thought (logos) about God (theos)’. Louw (1998:101) describes the language of theology as a particular sort of language – “it is the language of faith, seeking ways of understanding and ways of conversing or communication”. In addition, “The process of seeking for meaning and truth is in terms of a Christian understanding of theology, inevitably linked to the saving acts of God as revealed in the person and work of Jesus Christ as well as actual intervention of God through his Spirit” (Louw 1998:101). Another definition given by Tracy (1983:62; quoted in Louw 1998:94) “the discipline that articulates mutually critical correlations between the meaning and truth of an interpretation of the Christian faith and the meaning and truth of an interpretation of the contemporary situation”.

- ***Practical Theology***

Louw reminds us, that Practical Theology is essentially theology and not sociology and psychology (Louw 2008:17). It is more than simply communicative actions of faith and the behaviour of people within ministry (Louw 2008:17). “It reflects on and deals with the praxis of God as related to the praxis

of faith within a vivid social, cultural and contextual encounter between God and human beings” (Louw 2008:17).

- ***Pastoral care***

Pastoral care is related to Practical Theology. It deals very specifically with the Christian religion. Pastoral, refers to the compassion and comfort of God. It is about how we understand God in the Christian context. The different Christian confessions each have different emphases of these. Van Arkel (2000:160) identifies four distinctive forms of pastoral work. These are mutual care; pastoral care; pastoral counseling; and pastoral therapy. In this study, I am particularly interested in the second level, that is, pastoral care. To quote Van Arkel (2000:162) “Pastoral care has to do mainly with officially strengthening and caring for the people of the congregation. It works toward ‘building up’ people in the congregation primarily through a dialogical caring action. It contributes to building ethically, spiritually and psychologically mature congregations where healing, caring and transformation take place”. “Pastoral care and counseling has largely focused on care that is sensitive and responsive to the religious traditions and spiritual resources in those who openly seek the help of caregivers who represent the faith community” (Van Katwyk 2002:110).

“Pastoral care assists people with their everyday affairs as well as their deeper existential problems (though without going into the full complexity of these). It is not problem centred, but solution focused and growth oriented. In pastoral care, we ask people how they are. It provides an opportunity for Christian people to talk about themselves as Christians. Pastoral care nurtures the development of ordinary, relatively healthy people. Its primary focus is on caring for all God’s people through the ups and downs of everyday life, and creating caring environments in which all people can grow and develop to the fullest potential” (Gerkin 1997:88; quoted in Van Arkel 2000: 162).

The essential function of pastoral care is *cura animarum* - cure of human souls (Louw 1998:1). This describes care for the whole person, specifically from a spiritual perspective (Louw 1998:20). Louw says, “As part of practical theology, pastoral care deals with God’s involvement with our being human and our spiritual journey through life. Essentially, it is engaged with the human search for meaning and our quest for significance, purposefulness and humanity. As a theological discipline, pastoral care focuses on the meaning of such concepts as care, help and comfort from the perspective of the Christian faith. It deals with the process of communicating the Gospel and the encounter and discourse between God and persons. This encounter is based on the notion of stewardship and the covenantal partnership between God and human beings” (Louw 1999:5).

The ministry of pastoral care is not merely directed to the inner life of the person, but also to the spiritual care of the total person in all the psycho-physical and psycho-social dimensions (Louw 1998:20). Louw

describes that in the past: “Pastoral care commuted between either a theological reduction (our basic problem is sin – one is in need of redemption) or a psychological reduction (our basic problem is blocked, inner potentialities – one is in need of self realization). What had been understood by pastoral care was often more psychotherapy within a Christian context than spiritual direction or *cura animarum*” (Louw 1999:5). “Pastoral care should thus overcome the impasse between a theological and psychological reduction” (Louw 1999:16). In trying to understand the role of pastoral care, Louw lists the following metaphors of the pastoral caregiver that are used in the pastoral encounter. These are the 4 metaphors of what is meant by a pastoral caregiver: shepherd; servant; the wise fool; paraklesis (Louw 1998:39). These convey and express God’s compassion and identification with one’s suffering. But Louw proposes the image of God as Friend (Friendship) as a comprehensive metaphor, which he says, depicts God in terms of companionship, partnership, communion, communality and community (Louw 1998:120).

- ***Spiritual care***

“Spiritual Care is a much broader and more inclusive concept (than pastoral care), with a focus on universal and essential qualities of the human spirit and basic existential values such as giving and receiving love, making meaning in life, and pursuing something larger than oneself. Such a sweeping scope democratizes spiritual care: it constitutes the daily expression of ordinary life rather than a religious speciality of care or a professional function of counseling” (Van Katwyk 2002:110). “The assumption of spiritual care is that, despite all the evidence to the contrary, the world is a place for caring. Spiritual care embodies the spirit in ordinary human flesh and weaves the sacred into the fabric of everyday life” (Van Katwyk 2002:111). Van Katwyk also notes that pastoral care and counseling can be seen as spiritual practice.

- ***Pastoral counseling***

With regards to pastoral counseling, Eliason et al. (2001:77) say that pastoral counseling is becoming recognized as a unique field, but it will always be influenced by its shared history with psychology, counseling, and religion. Pastoral counseling is defined by the American Association of Pastoral Counselors as “a process in which a pastoral counselor utilizes insights and principles derived from the disciplines of theology and the behavioral sciences in working with individuals, couples, families, groups, and social systems toward the achievement of wholeness and health” (AAPC, 1998, online; quoted in Eliason et al. 2001:77). “Pastoral counseling is defined as the interdisciplinary use of theology and psychology for the task of mediating care” (Browning 1993:12; quoted in Eliason et al. 2001:77).

- ***Spirituality & Religion***

I have found the terms ‘spirituality’ and ‘religion’ to be used quite interchangeably in the literature. At times there seems to be an unclear distinction between their usage, with many different understandings

and definitions existing in the literature. There seems to be different understandings of what is meant by spirituality and different religious traditions describe spirituality in varied ways. Some people claim to be 'spiritual but not religious' or 'spiritual without a focus upon God'. I therefore discuss these concepts further below:

Spirituality is broader than religion

Religion and Spirituality have been described as being "set in opposition" to one another (with "religion" referring primarily to institutional faith and "spirituality" to matters of personal faith) (Driskill 2006:74). They have also been viewed as "different but connected concepts" (Weaver Pargament, Flannelly & Oppenheimer 2006:210; quoted in Egan et al. 2011:308). Religion has been described as being 'disentwined from spirituality' (Arai & Ariarajah 1989; Koenig 2008; quoted in Egan et al. 2011:308). Religion has been placed within the broader category of spirituality" (Speck (2004:124; quoted in Egan et al. 2011:308). Koenig (2005:44) explains Spirituality as being "much broader than religion and less distinctive".

Definitions of spirituality in the literature

The literature is full of numerous and varied definitions of spirituality. **Paukert et al.** (2009:103) defines Spirituality as "a spiritual relationship with a higher being;" Spirituality "involves a more generic personal quest for understanding answers to ultimate questions about life and its meaning, and while concerned with a relationship to the sacred or transcendent, may or may not lead to religious beliefs, rituals, or the formation of a community. Spirituality is more individualistic, more focused on emotion, more inwardly directed and subjective, and has less definable boundaries, which also makes it more difficult to measure. Finally, spirituality tends to be less authoritarian and less doctrine oriented, and may even be entirely divorced from religion, without involving belief in God but rather focusing more on connections with nature, art, or other humanistic values and concerns (as in earlier pagan cultures)" (**Koenig**2005:44). **John K. Testerman** (1997) lists the following characteristics of Spirituality: "Spirituality implies there is a deeper dimension to human life, an inner world of the soul. It assumes that humans are fundamentally spiritual beings living in a spiritual, as well as physical, universe. Spirituality is about "the inner life or spirit of each of us as it relates to the unseen world of Spirit or of God. It is the name we give to the dimension of seeing and living that goes far beyond the material world to deeper truths and eternal values thus it is about "the search for the sacred". In distinguishing between religion and spirituality, Testerman (1997) writes: "As the search for, encounter and response to God, spirituality is an inner, personal experience, universal and without boundaries. Religion, however, is communal, particular and defined by boundaries. It is spirituality incarnated at the social and cultural level. Religion takes the boundless and binds it into the limitations of language and culture, even as it may also transform culture". Spirituality has been described as: "a transcendent relationship with a higher being, which often goes beyond a religious affiliation (Dein 2004; quoted in Magaldi-Dopman et al.

2011:287). The term ‘spirituality’ for some may mean: “‘spiritual but not religious’”. Individuals who consider themselves ‘spiritual but not religious’ tend to view spirituality and religiosity as distinct concepts; they are also less likely to attend church/religious services (Zinnbauer et al. 1997; quoted in **Magaldi-Dopman et al.** 2011:287). Spirituality has been associated with a rejection of traditional, collective, organized religion in favor of a less-traditional, individualized spirituality (Hill et al. 2000; quoted in Magaldi-Dopman et al. 2011:287). **MacKinlay (1998)** describes Spirituality as “that which lies at the core of each person’s being, an essential dimension which brings meaning to life. It is acknowledged that spirituality is not constituted only by religious practices, but must be understood more broadly, as relationship with God, however God or ultimate meaning is perceived by the person, and in relationship with other people” (MacKinlay 1998:36; quoted in MacKinlay 2008:140). Spirituality has also been defined in broader terms such as: “a search for existential meaning; a force that impels humans forward into living, which is not always expressed through religion” (Labun 1988; Saunders 1988; Carson 1989; Cobb & Robshaw 1998; Kellehear 2000; quoted in Carroll 2001:83).

The nature of spirituality

Reich (2000:125) analyzed four articles considering the nature of spirituality: (Pargament (1999 and 1999b), Emmons and Crumpler (1999), and Stifoss-Hanssen (1999), and described the following different/contrasting views: “The sacred” was at the center of spirituality for Pargament; and “existentiality” or “view of life” for Stifoss-Hansen (quoted in Reich 2000:125). For Emmons and Crumpler “the sacred” was also at the center of spirituality but they suggested a differentiation: “Sacralization is to refer to sanctification in the external sense of objects, places, or persons, and sanctification is to be reserved for the inner process of transformation. They also made the point that spirituality cannot be discussed without reference to the particular underlying image of God” (Reich 2000:125). For Pargament (1999b), religion is the wider concept and spirituality part of religion. Stifoss-Hanssen (1999) saw the two concepts as distinct but overlapping. Reich et al. (1999:12) also saw the two concepts as distinct but overlapping but differentiated further. They distinguished among religion, religious spirituality, and natural spirituality. That view results from their conceptualization of spirituality (quoted in Reich 2000:126).

Dimensions of spirituality

The following dimensions of spirituality have been listed: life, meaning and purpose, transcendence, relationship and hope (Koenig et al. 2001; Swinton 2001; MacKinlay 2006; quoted in MacKinlay 2008:140).

- **Christian Spirituality**

These studies above have so far described a very broad definition of spirituality, with no specific reference to religion; and as being a more inclusive and universal construct than religion/religiosity. But what is 'Christian Spirituality'? And how does it differ from this general understanding of spirituality?

Descriptions of Christian spirituality

"From a Christian perspective, spirituality refers to the subjective side of human life, to personal discerning and experiencing the presence and movement of the Spirit of God in the here and now. It touches the searching and questioning aspects of life orientation through the 'why' and 'for what' of life (Heitink 1998:166) and attempting to apply what is discovered and learned in that way to one's own life, sharing it with people around one, applying it to the communities one belongs to, and to the society of which one is part" (Van den Blink 1999:5; quoted in Van Arkel 2000:153). Christian Spirituality is described as, "a vivid and lived experience of the Christian faith" and "refers to the impact of faith (as directed towards and by God) on the religious consciousness of people as well as on their religious praxis, the motivation and intention of acts and practices of faith" (McGinn 1993:21; quoted in Louw 2008:49). Spirituality as a 'lived experience' refers to the function and impact of the content of faith or belief systems on religious experiences (Louw 2008:49). "Our lived experience of God in the multiple contexts of life" enables us to discover the transcendent meaning of everyday life (including our work, relationships and life in the church and world) (Stevens and Green (2003:x; quoted in Louw 2008:49). **Waijman** (2003:59; quoted in Louw 2008:50) identifies the following aspects of spirituality: "Convictions of faith with reference to the transcendent dimension of life, to the ultimate and to God"; "awe and wonder;" "the acknowledgment of a spiritual realm and world;" "Significance and search for meaning".

In these definitions God's grace is applied to the everyday field of experience and to current social problems (and not just to justification and salvation only as in the reformed approach). Spirituality is thus described as an awareness of transcendence in the midst of existential and social conflicts (Louw 2008:51). Christian spirituality was defined by Louw as: "practicing the Christian faith in such a way that it creates an awareness of God's presence. It is a devout obedience within which the believer gradually becomes that which he/she already is in Christ. Spirituality thus aims to embody faith and to develop a congruency between faith content and daily life. It also attempts to strengthen the 'being' functions of the believer with the view to preventing problems" (Louw 1998:19; quoted in Van Arkel 2000:153). Spirituality expresses a strong desire for 'significance' and 'the transcendence' in our lives. This transcendent quality helps give meaning to our lives, but it should also be "practical". Its concern with real life and experience directly links spirituality to experiencing God's presence in the world and practicing the Christian faith (Oates 1986; quoted in Louw 2008:51). Brenner (1988:103) sees Christian Spirituality as involvement with life. He describes spirituality as "the response to a deep and mysterious human yearning for self transcendence and surrender" (1988:104; quoted in Louw 2008:51). Spirituality

has also been linked to the quality of our being human. Louw (2008:53) states, “Spirituality thus becomes a term which links, as well as constructively integrates, a psychological understanding of maturity with a theological understanding of maturity. Of paramount importance to this link is the notion that spirituality should be understood in terms of human relationships”. “True Christian Spirituality is living a human life in union with God” (Richards 1987:244; quoted in Louw 2008:53). Spirituality is experienced within human relationships (Louw 2008:53). Spirituality should lead to an integration of the various aspects of being human (Dorr 1990). An integrated spirituality should improve the quality of human dignity. The presence of God in a person’s life should contribute to life’s meaning and humanity. It should link the inner and private dimensions to the external dimensions of public life and our social context (Louw 2008:54). Christian Spirituality focuses on the compassion and comfort of God.

- **Religion/Religiosity**

Religion has been described more narrowly than spirituality.

Definitions of religion

Paukert et al. (2009:103) defines Religion as, “beliefs and behaviours shared by a community”. They also note that religious beliefs and behaviours are more clearly defined and quantifiable than spirituality. **Koenig** gives a broader definition as follows: Religion is “an organized system of beliefs, practices, and rituals of a community. Religion is designed to increase a sense of closeness to the sacred or transcendent (whether that be God, a higher power, or ultimate truth/reality), and to promote an understanding of one’s relationship to and responsibility for others living together in a community. Religion then, is community focused (organized into formal practices that are observable and measurable), may be authoritarian in terms of behaviours and responsibilities, and is often concerned with beliefs and doctrines that, among other goals, seek to separate good from evil” (Koenig 2005:44). Thus, Religion has to do with how people relate life issues to the transcendental/ultimate. Referring to how exercised in terms of very specific rituals/ modes of worship/ religious groups express themselves in religious structures ultimate, transcendence, specific belief systems. Religion refers to a more formal, institutionalized structure (Worthington & Sandage 2001), including belonging to an organized church or religious institution (Shafranske 1996). Within a given religion, the steps toward the search for the sacred are often prescribed and there is a sacred book that is shared by the religious group. Engagement in the search for the sacred is shared by the group and considered “legitimated” (Hill et al. 2000; quoted in Dopman et al. 2011:288). How spirituality and religiousness are defined, and whether these definitions overlap or differ, are influenced by other factors including religious heritage, culture, generation, and nationality (Gall et al. 2011:180).

- ***My Working definition***

Religion was more readily defined in the literature as: beliefs about God; organizational or more structured beliefs and practices; a commitment to a specific organized religion. Spirituality, on the other hand, had a more personalized and individualized dimension on beliefs and relationship with God. Spirituality includes the many means that people use to incorporate sacred elements into their lives. For some people there seems to be no link between these two concepts and for others a strong link. Some have argued for a complete separation of religion and spirituality. I think there is a strong link between spirituality and religion, particularly in Christianity. I therefore argue for a relationship between the two. Religion is part of spirituality. Not everyone engages in religious practices, but everyone has a spiritual dimension as we are spiritual beings. There are different facets or dimensions of religiosity and spirituality. People may have integrated religious as well as spiritual aspects in their lives. Spirituality and religion are linked, and this link with religion cannot be ignored. The definition of spirituality I will be using in this thesis is focused on the lived experience of faith and one's relationship with God. I have used the terms religion/religious and spiritual interchangeably when referred to as such in the cited literature; as well as with particular reference to non-secular/traditional, adapted versions of CBT.

1.4 'DESTRUCTIVE THINKING'

In this section, I define the concepts: "constructive" and "destructive" thinking. Each has their own distinguishing characteristics. I am however, particularly interested in understanding "destructive thinking" in this thesis.

- *"Constructive thinking" and "destructive thinking" described in the literature*

Seymour Epstein offers some interesting points here. According to his Cognitive-Experiential Self Test Theory (CEST), people operate by means of two information processing systems, a rational system and an experiential system. These two systems are said to operate in parallel and are considered interactive. Constructive thinking is measured by the Constructive Thinking Inventory (CTI) which contains a global scale and six subscales (Stroebe 1993:123). Constructive thinking is defined by **Epstein** as "the degree to which a person's automatic thinking – the thinking that occurs without deliberate intention – facilitates solving problems in everyday life at a minimum cost in stress" (Epstein 1998:26). **Stroebe et al.** (1993:123) describes constructive thinking within this theory as a form of intelligence that takes place automatically at the preconscious, experiential level, which is contrasted with abstract thinking or intelligence that takes place within the rational system. **Sentowski** explains constructive thinking as a form of "common sense" i.e. information acquired through experience; which reflects one's ability to deal with problems that arise by using different thinking styles and coping strategies (Sentowski 2007:184). Constructive thinking does not end one's pain, frustration or hurt, but it does allow one to channel these into more constructive alternatives. Constructive thinking is also not the same as positive thinking, even though it may contain elements of positive thinking. Global constructive thinking, says

Stroebe (1993:123) is more of a flexible thinking and realistic optimism than positive thinking. This review of the literature shows, that thoughts can be put to good use, even in challenging situations (Wal 2006:158).

- ***Good and poor constructive thinking***

Epstein provides the following characteristics of **good constructive thinking**: Viewing situations as challenges rather than as threats; considering failures and rejections as unfortunate but not the end of the world; and seeing the positive side of things, but not unrealistically. **Poor constructive thinking** is described as: Dwelling on negative events; thinking in extremely categorical ways; over generalizing; worrying needlessly; thinking in ways that increase unhappiness without accomplishing anything worthwhile (Epstein 1998:26). Poor constructive thinkers, according to Epstein, harbour more negative emotions, are more depressed, more angry, more anxious, more tense, more disorganized, have fewer positive emotions, are less happy, less affectionate, less enthusiastic, worry more and are less energetic, than good constructive thinkers (Epstein 1998:137).

- ***Constructive thinking and stress***

Good constructive thinkers, says Epstein, also experience less stress than poor constructive thinkers, even when taking on more demanding workloads and exposing themselves to more challenging situations (Epstein 1998:138). The more constructive one thinks, the happier they will feel and the better their emotional adjustment will be. On the other hand, the less constructively one thinks, the more unhappy they will feel and the greater their risk of suffering from an emotional disorder. Thus, constructive and destructive thinking is related to mental and physical well being (Epstein 1998:142).

However, is “less stress” an appropriate indicator of constructive thinking? And why is it that constructive thinkers experience less stress? We now know that two people can experience the same event in different ways, depending on how they appraise/interpret the event. Albert Ellis maintained that a person feels the way they think (Weiten 2012:115). This is because the appraisal phase in the stress process is a subjective one. Albert Ellis believed that people could short circuit their emotional reactions to stress by modifying their appraisals of stressful events (Weiten 2012:115). According to Sentowski, a person who has healthier coping strategies and thinking, can perceive, manage and survive difficult circumstances more efficiently than those who don't (Sentowski 2007:186). Good constructive thinking thus empowers one to deal more effectively with stress. Wal asserts that constructive thinkers tend to be happier people; they cope better with stress and adversity; make better decisions and are more productive (Wal 2006:141). Constructive thinking contributes to the effective management of change and adversity and effective problem solving (Wal 2006:161).

- ***“Destructive” thinking defined in the literature***

Destructive thinking, contributes to poorer decision making and problem solving, reduced productivity, and frustrating attempts to accomplish tasks (Wal 2006:161). Thoughts that lead to negative reactions, emotions and moods can be considered destructive (Cobert 2009:64). Destructive thoughts can be inaccurate, distorted, self defeating and result in destructive behaviour. Thoughts also affect self esteem and coping skills. Constructive thoughts contribute to positive self esteem and resilience; whereas destructive thoughts contribute to a poor self esteem and vulnerability to change and adversity (Wal 2006:161).

Features of destructive thinking are not confined to psychological disorders and may occur in the lives of ordinary people in everyday living. People can easily fall into the habit of thinking destructively and should therefore, at least be aware of how such thinking contributes to (or causes) disturbing emotions. Epstein reckons, people who think in self destructive ways tend to experience more headaches, stomach aches, back pains, as well as frequent health facilities more often. Destructive thinking though, is not only associated with minor, everyday symptoms, but is also associated with more serious diseases such as heart disease and cancer. Different forms of destructive thinking, with their accompanying emotions, may contribute to bringing about different diseases, e.g. intense drawn out anger may increase one's vulnerability to cardiovascular disorders; helplessness and depression may weaken the immune system, making one susceptible to infectious diseases or cancer. Constructive thinking can help prevent both of these diseases as well as aid in the recovery of some cases (Epstein 1998:144). In a study to find out how health and style of thinking are related, Epstein (1998:142) provides the following example of a 40 year study conducted on 95 male graduates. The study revealed that up until the age of 45, health was unrelated to style of thinking. After the age 45, however, those with a more negative way of thinking demonstrated poorer health than those with a more self enhancing way of thinking. These findings reveal that serious illness brought about by destructive thinking may only present later on in life. Thus, says Epstein, one's body may get away with destructive thinking when they are younger, but not when they are older.

- ***Destructive Thinking in Christian Spirituality***

This topic will be dealt with more extensively in chapter 3. A brief introduction will suffice for now. Destructive thinking in Christian Spirituality is summed up by Louw (2008) when he writes about spirituality and religion becoming "sick" and "the pathology of intoxicated faith." He asks: "When does religion become sick? What is meant by a pathology of faith? When does faith become idolatrous and distorted?" (Louw 2008:138). Here, in my opinion, Louw draws a link between unhealthy God concepts and destructive thinking and behavior. Louw states, "For the purpose of pastoral care for patients, it can be stated that religion and faith become sick because of rigid views with a strong moralistic undertone. An attempt to manipulate God in the light of selfish needs also causes a distortion of faith. Usually a

negative concept of God is the underlying cause of a sick religion and a distorted faith, which correlates with negative personal behavior and thought” (Louw 2008:139).

According to Sasan Vasegh, religious beliefs can be important in both psychotherapy and psychopathology of religious patients, in that many times psychopathological thoughts have religious content. Though, some individual’s seem to recover faster when religious techniques, cognitions and behaviors are added to usual psychotherapy (Vasegh 2011). In the pastoral care context, it may be necessary at some stage to explore the individual’s God-image and God concept (as well as other religious experiences), as destructive God concepts/God-images have been linked to emotional disturbance. Louw says, “helping the counselee develop from inappropriate God-images towards appropriate God-images is based on the assumption that an appropriate God-image promotes more constructive and purposeful actions, instills hope and contributes towards the eventual therapeutic effect of pastoral ministry” (Louw 1998:249). Research on the God-image can assist pastoral caregivers in selecting appropriate interventions to help counselee’s move towards spiritual well-being. Christopher Grimes writes, “Researchers continue to find evidence of a relationship between spiritual belief, religious practice, and psychological well-being; and knowledge gained from research of the God-image can guide therapeutic interventions in order to move individuals toward psychological wellness and spiritual wholeness” (Grimes 2008).

In CBT literature, core beliefs and schemas are viewed as biasing one’s perception and interpretation of their experiences, including their experiences of God. The pastoral caregiver should thus assess the way the individual thinks about God (God concepts) and experiences God (God-images) as many counsees project their core beliefs onto their religious views and these in turn influence the way they view God.

- ***My working definition***

The term “destructive thinking” in the remainder of this study shall be used rather broadly to refer to any type of thinking that is counterproductive, harmful, maladaptive or has a damaging and negative effect on the individuals identity, relationships, social context and worldview.

1.5 RESEARCH PROBLEM AND OBJECTIVES

1.5.1 The research question

What is meant by ‘destructive thinking’ within a pastoral context; and how is such thinking manifested? What is the link between ‘destructive thinking’ and pathology within the realm of Christian faith? To what extent should pastoral and spiritual care-giving probe into cognitive patterns of thinking and its connection to conceptualization in pastoral care, very specifically to the experiences of faith and their connection to God-images? How can the proposed psycho-pastoral approach assist pastoral caregivers to

understand and deal with destructive thinking in a constructive and responsible way that will lead to spiritual healing and wholeness?

1.5.2 The research problem

Cognition, or thinking, is a topic of interest in various fields of study, including Cognitive Psychology and Theology. Thoughts or ‘cognitions’ are described by Dr David Burns (2000) as being the way a person looks at things – their perceptions, mental attitudes and beliefs, and includes interpretation, that is, what you say about something or someone to yourself. A literature review reveals an extensive body of research on the topic of ‘cognition, thoughts and various types of destructive thinking’ particularly within the field of Cognitive Behavioral Therapy. CBT has a particular emphasis on changing thoughts in order to change the way one feels and behaves. Here, thinking is viewed as an unconscious process and cognitive distortions/thinking errors are common occurrences in everyday thinking. Thoughts are viewed as having an impact on one’s psychological, emotional, and even spiritual well-being. Of particular interest to this study are ‘destructive’ thoughts, such as cognitive distortions; thinking errors; irrational beliefs; and inappropriate God-images. Destructive thoughts are viewed as facilitating emotional distress, psychopathology, inappropriate God-images and faith pathology. Recent research into neuroscience also reveals that the human brain has the ability to rewire itself through the changing of thoughts. A review of ‘thoughts’ in the light of the Scriptures shows cognition as being a theological issue as well. Theological reflection on destructive thinking brings to light a number of scholarly articles and books that address cognition in the form of i.e. God-images and God concepts, including appropriate and inappropriate God-images. There are also a number of cognitive behavioural therapies that incorporate spiritual, religious or Christian elements into their therapy. These are briefly discussed in my exploration of destructive thinking in a theological context, for instance, how such destructive thoughts are identified, presented, understood in the literature.

The idea of changing cognitions to change feelings is not a new idea – it has been around for a long time! Even the Apostle Paul in the New Testament promoted such practice when he wrote, “Do not conform any longer to the pattern of this world, but be transformed by the renewing of your mind...” (Rom 12:2; NIV); and when he gave instructions on thinking, “Finally, brothers, whatever is true, whatever is noble, whatever is right, whatever is pure, whatever is lovely, whatever is admirable – if anything is excellent or praiseworthy – think about such things” (Philippians 4:8; NIV). Cognitive theorists such as Aaron T. Beck and Albert Ellis simplified these concepts so that they could be easily used in today’s times. The main focus of this thesis however, is on developing a theological understanding and perspective of ‘destructive thinking’ in a theological context of pastoral care. For example, if a pastoral counselor only wanted to focus on the cognitive aspect in a pastoral care setting, what kind of common (destructive) thoughts could he/she expect from the Christian counselee? What type of thoughts should the pastoral care giver look for that could pose as ‘risk factors’ for spiritual growth and spiritual well-being? In other

words, what types of thoughts are more than likely to contribute to spiritual healing, spiritual growth and a mature faith in a pastoral context? In what way can a psycho-pastoral model that focuses on cognition contribute towards a holistic approach to healing and wholeness; boost therapeutic outcomes; reduce destructive thoughts; and enhance a more constructive, mature thinking?

In this study therefore, I seek to develop an understanding of ‘destructive thinking’ particularly in the field of pastoral care and counseling. In doing so, I begin with an exploration of ‘destructive thinking’ in the Cognitive Behaviour Therapy literature (CT & REBT respectively) (Chapter 2). This is followed by an exploration of ‘destructive thinking’ within the interplay between Religion and Christian Spirituality (Chapter 3). I then propose a pastoral model of spiritual healing and wholeness that could assist pastoral caregivers to understand and address ‘destructive thinking’ in a constructive and responsible way (Chapter 4).

The following aspects are examined with regards to formulating a deeper understanding of destructive thinking within the context of pastoral care: cognitive and emotional experiences of God; inappropriate God-images/concepts; spiritual dysfunction/pathology; destructive thinking within the realm of belief systems; spiritual formation and destructive types of religious thinking; and spiritual maturity within the Christian faith. My research explores destructive types of thinking that pose as ‘risk factors’ for one’s faith development, psychological and spiritual well-being. As well as the potential negative implications that may result from destructive types of religious thinking on spiritual and faith maturity. I seek answers to questions such as: What is meant by “destructive thinking” in the Pastoral Care and Counseling context? What happens when one’s thinking about God becomes fractured or distorted? Can destructive/unhelpful God-images be identified? What is meant by an appropriate/inappropriate God-image? What is the role of God-images in destructive thinking? What are the consequences of an inaccurate or false representation/perception of God? What is the link between “destructive thinking” and pathology within the realm of Christian faith? Is there a relationship between one’s thinking about God (image of God) and psychological well-being? What are the effects of destructive thinking about God (God-images) on one’s spiritual well-being? Does one’s perception of God have a direct impact on their spiritual and psychological well-being? What is the impact of destructive thinking within the realm of belief systems? I therefore review destructive thinking within the pastoral context and realm of the Christian faith, with the expectation of putting together a more constructive way of thinking that will enhance spiritual formation and faith development. The hoped for outcome is spiritual healing and wholeness.

The following keywords/phrases are of significance to this study:

- cognition; thoughts; patterns of thinking; destructive thoughts
- cognitive behaviour therapy (CBT); cognitive therapy (CT); REBT

- cognitive/thinking errors; cognitive distortions
- core beliefs
- schemas; the role of schemas in how one perceives and experiences God
- spiritual and psychological well-being
- God-images; inappropriate God-images
- Christian Spirituality; the Christian faith
- A mature faith; faith pathology; faith development
- theology; pastoral; pastoral care; pastoral context

The exploratory direction that this research will take will hopefully generate noteworthy questions for further investigation. The hope is that a theological exploration will contribute to a better understanding of destructive thinking, how to produce constructive thinking habits and draw the connection between thoughts, psychological and spiritual well-being.

1.5.3 The Research Assumption

The underlying assumption of this thesis is that spiritual pathology resulting from ‘destructive thinking’ is a deviation from the norm of healthy spiritual development. Many theological approaches focused on the role of emotion and experience in spiritual development. In this study, I am shifting the focus to the cognitive dimension. This is because there is more at stake than the affective state, which is however, related to the cognitive. One’s spirituality is connected to their mental (i.e. thinking) and emotional life. Thinking, experience and understanding of issues such as death, illness, trauma, despair, joy, hope, identity, and so on, are relevant to one’s spirituality. Particular destructive thoughts may provoke spiritual questions/struggles which lead to psychological and spiritual pathology (thus, demonstrating the effect of destructive thinking). I can go so far as to say, that even church doctrines should be made more clear, as these too may contribute to spiritual pathology, but this is a whole new topic that will be reserved for further study.

1.5.4 The research objectives

The research objectives of this study are to:

- 1) Define, and
- 2) Develop an understanding of “destructive thinking” particularly within the realm of pastoral care and counseling, reflecting on the insights from the various cognitive behavioural psychotherapies and pastoral counseling literature.
- 3) Examine “destructive thinking” in Cognitive Behaviour Therapy (CT & REBT) literature, as well as
- 4) Examine “destructive thinking” within the interplay between Religion and Christian Spirituality.

- 5) Develop a Psycho-Pastoral Approach that focuses on cognition, towards healing and wholeness in the pastoral care and counseling context, and
- 6) Promote further research and interest in this field.

Due to the integrative nature of this study, it is both a ‘psycho’ and ‘pastoral’ approach. That is, it draws and reflects on theories and insights from the fields of Psychology, as well as Theology (pastoral care and counseling) in developing an holistic approach that focuses on cognition. In that both fields of interest are invaluable for understanding ‘destructive thinking’ and for enhancing well-being.

These objectives imply the following:

- 1) develop an informed understanding and working definition of destructive thinking in the pastoral context;
- 2) identify and evaluate destructive types of thinking in the pastoral care literature;
- 3) discover the interplay between Psychology (CBT), religion and Christian spirituality, with regards to destructive thinking
- 4) Propose a holistic approach to deal with destructive thinking in a pastoral context.

This research will be both descriptive and exploratory, in that, through the literature study, the researcher will describe scholarly positions on destructive thinking and its related concepts. It will also be exploratory through reflecting on these concepts theologically. The proposed outcome of this study is a pastoral approach that will help the pastoral caregiver to identify, evaluate and transform destructive thoughts that have a negative effect on the counselee’s spiritual growth, faith development as well as psychological, emotional and spiritual well-being.

1.5.5 Research methodology

The basis for this research project will be that of a **literature study**. Secondary data on the topic (books, theses, scholarly articles, internet searches) will be located and analyzed to reflect on the research question and objectives. The methodology therefore includes a measure of **critical reflection**. The unit of analysis in this study will be references to cognition, thinking, thought patterns, destructive thinking, cognitive behavior therapy, Christian Spirituality, God-images, faith pathology/development and pastoral care/counseling. This research is also **hermeneutical**.

A few additional words about the principles that guide this thesis: “Indeed, hermeneutics is about the most fundamental ways in which we perceive the world, think, and understand. It has a philosophical root in what we call epistemology – that is, the problem of how we come to know anything at all, and actually how we think and legitimate the claims we make to know the truth” (David Jasper 2004:3). Interpretation and reflection are two important methods in a hermeneutical approach. In my research I reflect on the assumptions, beliefs and pre-understandings of cognition (thoughts and thinking),

particularly those associated with destructive thinking. I also probe the importance of God-images and one's view of God, and the effect of these on one's spirituality and well-being. Since I assess the meaning of concepts, this also makes my approach a hermeneutical one. My aim of interpreting is to discover connections between one's thoughts and spiritual/psychological well-being. "A hermeneutics of pastoral care deals with the interpretation of the presence of God within human relationships and social contexts. It also tries to interpret existential issues from the perspective of the Christian Faith. Central to a hermeneutical approach in pastoral care is dealing with different metaphors which reveal God's compassion and care. Hence the importance of God-images and the interpretation of experiences of faith. In short, a pastoral hermeneutics of care and counseling is about religious experiences which give an indication of believer's perception of God and their interpretation of the significance of their existence; hence the quest for spirituality in a pastoral strategy for counseling" (Louw 1999:7). "Pastoral hermeneutics attempts to clarify the significance and existential implications of the encounter between God and humankind, thereby focusing its attention on the discovery of meaning and on fostering the growth of faith" (Louw 1999:242). In acknowledging the limitations of this study, the researcher aims to explore, organize and integrate the existing literature on the above research elements, and to arrive at interpretive insights. Such insights will need to be subject to further enquiry and investigation.

1.6 OUTLINE OF CHAPTERS

CHAPTER 1

Introduction and background to the study; description of research framework, design and methodology used; as well as research questions and objectives.

CHAPTER 2

Destructive thinking in Cognitive Behaviour Therapy (CT & REBT) literature.

CHAPTER 3

Destructive thinking within the interplay between religion and Christian Spirituality.

CHAPTER 4

Destructive thinking in religion: towards a pastoral model of Spiritual healing and wholeness.

CHAPTER 5

Summary of findings and conclusion.

CHAPTER 2

“DESTRUCTIVE THINKING” IN COGNITIVE BEHAVIOUR THERAPY (CT & REBT)

INTRODUCTION

Our mind is constantly at work (Winterowd et al. 2003). Sometimes we attend to the thoughts that are streaming through our minds, and at other times we don't. These thoughts may also be dysfunctional or harmful to us. Cognitive therapy teaches that we can choose the way we think, that healthy thinking is a choice, and that it is possible to change our deeply ingrained thinking habits. These insights will be discussed further in this chapter.

2.1. DESTRUCTIVE THINKING IN CBT

Destructive types of thinking and their ensuing consequences not only reduce the quality of one's life but also cause the individual to experience unnecessary emotional distress. There is a huge accruing body of knowledge on this subject in CBT literature. Many scientific articles have been written in CBT detailing the effect of destructive types of thinking, i.e. irrational beliefs, cognitive distortions, and so on. Cognitive theorists have made a major contribution in defining the role of thoughts on one's life. I will therefore continue to review these destructive ways of thinking further in the CBT literature. My focus is on people's thoughts (cognitions), particularly thoughts that are destructive.

According to Dispenza (2007:46) conscious thoughts that are repeated often enough, become unconscious thinking. They start off as conscious thoughts but by continually repeating these in one's mind, they become unconscious, automatic thoughts. Such unconscious ways of thinking, then becomes our conscious way of being. This again affects our lives as our conscious thoughts do. Dispenza (2007:46) explains, “Just as all thoughts set off biochemical reactions that lead to behaviour, our repetitive, unconscious thoughts produce automatic, acquired patterns of behaviour that are almost involuntary. These behaviour patterns are habits and most surely, they become neurologically hardwired in the brain”. He continues, “Since we know from neuroscience that thoughts produce chemical reactions in the brain, it would make sense, then, that our thoughts would have some effect on our physical body by changing our internal state. Not only do our thoughts matter in how we live out our life, but our thoughts become matter right within our own body. Thoughts ... matter” (Dispenza 2007:46). In the remainder of this chapter, I continue my review of destructive thinking in CBT literature, focusing specifically on Cognitive Therapy (CT) and REBT respectively.

2.1.1. DESTRUCTIVE THINKING IN COGNITIVE THERAPY (CT)

Thinking involves statements that people make to themselves, i.e. it is their inner dialogue (Hepworth et al. 2010:391). As humans, from time to time, we are more than likely to make errors in our thinking, even if we do not intend to, or are unaware of doing so. McKay (2009:100) says, “Even the sanest, most rational person on earth operates at some distance from reality. It’s unavoidable, given the built in programming of the human mind and senses”. Thus, one may be surprised at how much their thinking is actually the result of conditioning and habit.

Cognitive distortions or “thinking errors”

“Cognitive distortions change the very nature of the universe you live in” (McKay 2009:108). Thinking errors are also called cognitive distortions in CBT literature. Identifying and recognizing thinking errors plays a large role in CBT as distorted and unrealistic thinking often accompanies negative moods and emotional distress. Cognitive distortions have been identified as playing an important role in the maintenance of emotional disorders. Wilson and Branch (2006) claim that thinking in unhealthy ways often leads to emotional problems. “Unhealthy” thinking here is defined as inappropriate and destructive thoughts (Wilson and Branch 2006). Curwen et al. (2000:12) states that, “Cognitive distortions are common to all humankind, but proliferate with emotional distress”. Wilson and Branch (2006) say that thinking errors has become such a normal and common human practice that clinicians and researchers have been able to put them into clear categories. But just because thinking errors are common occurrences, this does not mean that they are harmless. One of the aims of CBT is to help the individual recognize when their thinking is ‘skewed and crooked’, and then to readjust such thinking.

Matthew McKay (2009:106) describes cognitive distortions as “bad habits – habits of thought that you consistently use to interpret reality in an unreal way.” He says these are “habits of thinking that get you into trouble.” Cognitive distortions are regarded by Wilson and Branch (2006:19) as being “slips in thinking.” These prohibit one from accurately assessing the world around them, the outcome of which may be misunderstandings, jumping to conclusions, assuming the worst and distorting the facts. Hepworth et al. (2010:390) defines cognitive distortions as being “irrational thoughts derived from negative schemas that lead to unrealistic interpretations of people, events or circumstances”. Problems arise when one is trying to process incoming information and their beliefs (and faulty reasoning) keeps distorting their automatic thoughts. Cognitive distortions although irrational, tend to make logical sense to the individual. These also reinforce negative thinking and negative emotions (Hepworth et al. 2010:391).

The following characteristics have been assigned to cognitive distortions by McKay (2009:106):

- They are judgmental in nature (they cause one to automatically apply labels to people/events without fully evaluating them);

- They are inaccurate and imprecise (they are general in scope and application, overlooking special circumstances and characteristics);
- They offer a one sided and unbalanced view of the world;
- They are based on emotional rather than rational processes.

Cognitive distortions can be directed at oneself or others. They can also be positive or negative in nature (Rasmussen 2010:57). Deeper processes, such as one’s core beliefs, intermediate beliefs, and various other personality attributes play a role in determining the conclusion an individual draws and to whom that conclusion is directed (Rasmussen 2010:58). Distortions seem to orient the individual to deeper levels of thinking and interpretation and sets off compelling emotional reactions (Rasmussen 2010:58).

A number of cognitive distortions are usually present in depressive thinking. “Depressive thinking” is the kind of thinking that precedes and accompanies depression. These thoughts are characterized by Knaus at al. (2006:4) as “pessimistic, demoralizing and motivation-sapping” in nature. Examples include, “I am a loser” (labelling) or “My future is hopeless” (fortune telling). Beck, in his research found that depression involved distorted thinking or thinking errors about one’s self, one’s future and the world. To these three cognitive distortions he gave the term the “cognitive triad” (Knaus et al. 2006:104). Getting rid of depressive thoughts becomes a lot easier once the individual realizes that these thoughts are located in their mind and can be challenged as they do not represent an unchangeable reality. Freeing oneself of such thinking helps lessen depression (Knaus at al. 2006:4). Below is a list of common faulty and unhelpful ways of thinking identified in cognitive therapy literature.

Figure 2.1 Common thinking errors found in CBT literature

Arbitrary Inference (Jumping to Conclusions)	The individual believes a particular outcome will be negative, without having any evidence or even possessing evidence to the contrary. The two main types of this thinking error are mind reading and fortune telling (Curwen et al. 2000:15).
Mind Reading	The individual thinks they know what someone else is thinking or feeling, without any concrete evidence and without considering other possibilities (McGovern & Edelstein 2009:97; Beck, J. 1995:119; Blume 2005:198).
Catastrophizing (also called fortune telling)	Predicts the future will turn out badly. Expects that the worst possible thing that can happen, will happen (Beck, J. 1995:119; Blume 2005:195; Curwen et al. 2000:13).
Tunnel Vision	Focuses only on the negative aspects a situation, completely ignoring any positives (McGovern & Edelstein 2009:96; Beck, J. 1995:119).
All-or-nothing thinking (also called dichotomous;	This is a very rigid pattern of thinking in which the individual views them self, others, situations or the world in terms of extreme categories (“black

Black-and-White; or polarized Thinking)	or	or white”) instead of on a continuum (“shades of grey”) (McGovern & Edelstein 2009:96; Beck, J. 1995:119; Blume 2005:193; Curwen et al 2000:12).
Emotional Reasoning		This type of reasoning places intuition and gut feeling above evidence (Blume 2005:196). The person draws conclusions based entirely upon feelings, believing something to be true simply because they “feel” it is true, ignoring any evidence to the contrary (Beck, J. 1995:119; Curwen et al. 2000:13).
Labelling		Assigns a derogatory (overarching) label to oneself or others based on one thought, feeling or action (McGovern & Edelstein 2009:96; Curwen et al. 2000:14).
Magnification/ minimization		Magnifies/exaggerates the negatives and minimizes/downplays the positives when evaluating oneself, other people or situations (McGovern & Edelstein 2009:96; Beck, J. 1995:119; Curwen et al. 2000:14).
Perfectionism		Perfectionists often scan for negatives in other people (Blume 2005:197).
Overgeneralization		Makes sweeping generalizations or universal conclusions, as a result of one single negative event (Blume 2005:198).
Disqualifying or discounting the Positive	or	Positive events, experiences or qualities are ignored or refuted because they are believed not to count (McGovern & Edelstein 2009:96; Beck, J. 1995:119).
Personalization.		The person assumes blame for all bad things that happen, even when they have no control over events.
Selective Abstraction (also called mental filter or negative thinking filters)		Dwells only on negative aspects in one’s environment, without seeing the whole/larger picture and overlooking any positive aspects (McGovern & Edelstein 2009:96; Beck, J. 1995:119; Blume 2005:197; Curwen et al. 2000:14).
“Should” or “must” Statements (also called imperatives)		The individual has preset/predetermined ideas about how they or others should behave; or how things are supposed to be, and overestimate how bad it is when these expectations are not met. Preferences and expectations here have become rigid demands (McGovern & Edelstein 2009:96; Beck, J. 1995:119; Blume 2005:200; Curwen et al. 2000:13).

Clusters of thinking errors

A person may frequently use a cluster of thinking errors i.e. jumping to conclusions, ‘should or must’ statements, emotional reasoning, etc (Curwen et al. 2000:15). Also, certain emotional problems such as

anxiety, depression or guilt, tend to be surrounded by a cluster of cognitive distortions or thinking errors. This means that a particular cluster of thinking errors tend to be common to certain emotional problems.

Clarification of the term “destructive thinking”

Some of the terms used by cognitive theorists, therapists and researchers to denote different kinds of ‘destructive or problematic’ thinking are: ‘irrational thinking’, ‘negative thinking’, ‘faulty thinking’, ‘maladaptive thinking’, ‘unhelpful thinking’, ‘self-defeating cognitions’, ‘negative automatic thoughts’, ‘thinking errors’, ‘counterfactual thinking’, ‘self-talk’, ‘pessimism’, ‘hot thoughts’, ‘rumination,’ and so on. In my thesis, I therefore make use of the term “destructive thinking.” I use the term rather broadly to refer to types of thinking that are counterproductive, harmful, maladaptive, or has a damaging or negative effect on the individual.

Levels of thinking in Cognitive Therapy (CT)

In Cognitive Therapy it is understood that an individual holds core beliefs, which contribute to a variety of automatic thoughts and deeper intermediate beliefs. Empirical research in cognitive psychology has revealed a number of levels of cognition and the need to distinguish between the effects of thoughts and emotions at these various levels. The highest level of cognition is consciousness, described by Wright et al. (2006:7) as a state of awareness in which decisions can be made on a rational basis. Conscious attention, according to Wright et al. (2006:7) allows one to:

- (1) Monitor and assess interactions with the environment;
- (2) Link past memories with present experiences; and
- (3) Control and plan future actions.

In CBT, individuals are encouraged to develop and make use of adaptive conscious thought processes i.e. rational thinking and problem solving. The literature shows that CBT usually distinguishes between three different levels of thinking, organized in a hierarchy with each level being differentiated by degree of accessibility. These are discussed next:

o Automatic Thoughts

We all have automatic thoughts. Automatic thoughts form part of a stream of cognitive processing just below the surface of our fully conscious mind (Wright et al. 2006:7). This type of thinking characterizes much of our everyday thinking. Automatic thoughts are the cognitions that stream rapidly through our minds while we are in the midst of situations or recalling events (Wright et al. 2006:7). It is the running commentary in our minds during our daily activities (Klykylo & Kay 2005:133). Although these thoughts lie closest to our conscious awareness, we are not usually aware of them. Automatic thoughts are preconscious (Milkman & Sunderwirth 2010:320). If attention is focused on them, they can be recognized, understood and brought to one’s attention. They are thus the easiest to gain access to and can

be made conscious. People can be trained to monitor and identify their automatic thoughts. We may not always be aware of our automatic thoughts, but the presence of a strong emotion is often a signal that an important thought is present.

Automatic thoughts are typically private or unspoken (Wright et al. 2006:7); and can be positive, neutral or negative in nature. Negative automatic thoughts (NAT's) are usually the kind focused on in CBT. Kennerly et al. (2011:8) describe NAT's as, "negatively tinged appraisals or interpretations – meanings we take from what happens around us or within us". NAT's occur automatically and without much effort. They are also difficult to "shut off" (Austin 2010:264). These thoughts are not usually the result of careful deliberation or reasoning but tend to occur rather spontaneously and rapidly. They are inclined to be situation specific and are regarded by the individual as plausible and accurate. They may also take the form of self-talk, images or pictures. NAT's are the direct product of our core beliefs and rules for living and represent how we make sense of our experiences in everyday situations (Kinsella 2008:4). Two significant aspects of NAT's include (1) thought content (that is, what we think), and (2) thought processes, that is, how we think (Kinsella 2008:4). As a result of his extensive research on depression, Beck theorized that specific automatic thoughts (and core beliefs) were indicative of specific mental and emotional problems/disorders. He grouped the content of these thoughts into themes related to the (1) self; (2) world; (3) future, which he referred to as the 'negative cognitive triad'. These themes could be used to infer the individual's deeper levels of cognition, i.e. beliefs, rules, schemas. Automatic thoughts can be logically sound and represent accurate reflections of reality, but they can also be illogical. Identifying and evaluating automatic thoughts is an important aspect of CBT. Automatic thoughts are common to all human experience and are not confined to individual's suffering from psychological disorders. However, people suffering from depression or anxiety do often experience more maladaptive and distorted types of automatic thoughts that give way to a host of painful emotional reactions and dysfunctional behaviours that are guided by the individual's underlying schemas or core beliefs. Milkman & Sunderwirth (2010:320) explain that maladaptive schemas may remain dormant until a stressful life event occurs, that activates the core belief. When activated by distress, it generates strong emotional reactions and dysfunctional behaviour. Negative and unrealistic thoughts often result in emotional disturbances. According to Beck, the type of emotional disturbance produced depends on the content of one's thoughts. For example, anxiety is usually produced when danger or threat is the dominant theme; and depression results when the theme of loss prevails.

CBT focuses on actively identifying and exploring automatic thoughts, inferences and assumptions. The goal of CBT is to change the way one thinks by using their automatic thoughts to identify core schemas and to achieve cognitive restructuring. Interventions are targeted at decreasing negative schemas. The literature also suggests that treatment should focus on decreasing cognitive distortions and rigidity so as to help individual's develop more adaptive views of themselves, others and the world (i.e. the cognitive

triad) (Lizardi 2010:124). Beck and colleagues list a number of cognitive distortions that are reflected in automatic thoughts, e.g. arbitrary inference, selective abstraction, and so on. When these dominate one's thinking, one tends to jump to quick cognitive conclusions, the validity of which is seldom scrutinized (Rasmussen 2010:57). This habit tends to have problematic consequences for the individual.

Reflecting on automatic thoughts and cognitive distortions, religious/spiritual individuals are not exempt from making cognitive errors. These individuals may too hold cognitive distortions and dysfunctional schemas. In some ways, their style of thinking may also contribute to or alleviate their problems. Distortions of beliefs or cognitive errors can be created at any time, i.e. when one over-generalizes, personalizes, thinks only in terms of absolutes (black and white), or confuses fact with opinion. In situations such as these, one's reaction (emotion or behavioral) tends to obstruct goal attainment and is considered dysfunctional (quoted in Natale 1986:52). Southwick et al. (2011:98) warns of spiritual "red flags" that may pose as a hindrance to therapeutic outcomes. For example, the loss of faith and cognitive distortions about lack of forgiveness and guilt may inhibit trauma recovery, or even the use of positive religious and other coping practices that may have brought about recovery.

In CBT therapy, most of the intervention strategies employed with religious individuals are those that are employed with non religious or secular individuals. The cognitive pastoral counselor will however be in tune to religious values and beliefs, and apply these principles with sensitivity. Keeping in mind how a distortion of these may contribute to or exacerbate one's problem. Besides eliminating cognitive distortions, therapeutic goals with the Christian client also aim to increase clarity and understanding so as to bring about metanoia or conversion (quoted in Natale 1986:52). A strong relationship exists between psychological health and spiritual wholeness. Working through the "psychological brush," or inappropriate thinking and cognitive distortions, orients one to respond to God as a member of the church and live a full, Christian life (quoted in Natale 1986:52). Particularly if these cognitive errors contain theological inaccuracies i.e. the person may think that God doesn't love them because they are sinful – and therefore, neither can anyone else? Or, as another example, one who thinks that loneliness is something that God has willed on them, and therefore they must simply endure it. Through the use of CBT techniques, the religious individual who is consumed with loneliness can be helped to re-label and redefine their situation. This is done by challenging their thoughts of aloneness, as well as their underlying beliefs that they absolutely cannot be alone. New ways of productively, and positively, utilizing their times of aloneness can be encouraged. Moments of social isolation can become times of reflection, integration, and prayer; and as opportunities for solitude. At the same time the individual is assisted toward a fuller understanding of, and communion with God, self, and the world (quoted in Natale 1986:55). This helps alleviate the pain of social isolation. Also, picturing (imaging) Christ as he spent time alone in prayer and fellowship with the Father is a helpful example here.

○ ***Intermediate Beliefs***

The intermediate level of thinking lies between one's automatic thoughts and core beliefs, out of one's conscious awareness. Often intermediate beliefs contribute substantially to the nature and maintenance of automatic thoughts. Intermediate beliefs consist of underlying attitudes, rules and assumptions. Our intermediate beliefs are often not articulated thoughts (but implicit thoughts) that trigger emotional reactions that compel behavioural reactions. Kennerley et al. (2011:10) regard these types of thoughts as providing the 'soil' from which NAT's sprout. This level of thinking is referred to by Beck et al. as dysfunctional assumptions and by Greenberger and Padesky as conditional beliefs (quoted in Kinsella 2008:8). Intermediate beliefs tend to be conditional in nature and consist of one's attitudes, rules, and assumptions. Each person has their own idiosyncratic rules or assumptions, and these influence how one thinks, feels, and behaves. They often take the form of "If...then" propositions or "should/must" statements. They are not very flexible, and tend to be over generalized. People adhere to these rules quite rigidly. Often, it is this inflexibility that is problematic, rather than the content of the rule itself. We all have rules that guide our behavioural choices. Rules for living tend to operate across situations and therefore exert an influence over several areas of a person's life. They are derived from our upbringing i.e. from direct teaching or observation of important others early on in our lives; and also reflect our culturally shared values i.e. from family, school, religion, social class and the like. Cultural background has a large influence on what is considered acceptable and what is tolerated.

According to Kinsella (2008:9) one's rules for living (and core beliefs) represent a psychological vulnerability to depression and anxiety. In that, beliefs may lie dormant until activated by critical events that are related to them. Rules for living and core beliefs thus represent a trait cognitive vulnerability to depression and anxiety disorders.

Note the following distinctions between NATs and rules for living: (1) NATs are situation specific; rules for living apply across situations; (2) NATs are biased in terms of content and process; rules for living are value judgments, which rather than being inherently right or wrong are to a greater or lesser degree helpful or unhelpful (Kinsella 2008:8).

○ ***Core Beliefs and Schemas***

Core beliefs

Core beliefs are the most fundamental and deepest level of thought. Core beliefs are the basic beliefs people hold about themselves, their world and their future (Winterowd 2003). They are not immediately accessible to consciousness and have to be inferred through one's characteristic thoughts and behaviours (Kennerley et al. 2011:10). These are critical to the development of one's thinking processes, and ultimately determine how one lives in the world. Core beliefs are presented as general and absolute

statements e.g. “People are not to be trusted”. People tend to process information that fits into their core beliefs. There is little variance across time and situations. People tend to hold them as unquestionable truths that apply to all situations (Kennerley et al. 2011:10). People hold a range of core beliefs, which may be both positive and negative. Positive core beliefs lead towards positive ways of living, and negative core beliefs lead to negative and dysfunctional ways of living (Neukrug 2011:318). Healthy positive core beliefs facilitate adjustment to negative life circumstances; promotes positive self opinion; and contributes to the formation of rewarding relationships (Wilson and Branch 2006). When negative core beliefs dominate, the individual usually experiences some form of distress. Often when stressed, negative core beliefs dominate for awhile. The consequences of unhealthy negative core beliefs are: insufficient problem solving abilities; poor adjustment to negative circumstances; low self esteem; and relationship difficulties (Wilson and Branch 2006). Through the use of CBT, more positive and helpful beliefs can be brought back into operation.

Core beliefs assist the individual to process incoming information and to retrieve information in accord with their beliefs. They therefore play a role in evaluating and assigning meaning to events, thereby influencing subsequent affective and behavioural responses. As a result, core beliefs are largely unspoken, abstract regulators of behaviour.

Core beliefs are generally formed in childhood and early life. They are a product of one’s general environment, influenced through repeated messages received from others and this environment. Core beliefs consist of a mixture of beneficial and negative experiences. Core beliefs develop as we grow and influence how we ultimately think, act and feel (Neukrug 2011:318). Early negative childhood experiences, i.e. poor parenting, death of loved one, abuse, contribute to the development of unhealthy core beliefs (Wilson and Branch 2006).

According to Beck’s cognitive specificity hypothesis, a distinct cognitive profile exists for each specific psychological disorder. That is, distinct cognitive processes exist for varying disorders. Thus, a relationship is established between certain mental disorders and specific core beliefs, intermediate beliefs, and automatic thoughts. By accurately assessing the individual’s disorder, their specific automatic thoughts, intermediate thoughts and core beliefs can also be inferred. Matching the treatment plan with the specific disorder and cognitive processes that parallel the disorder increases the likelihood of therapy being successful.

Beck suggests that depressive individuals have dysfunctional thoughts or schemas that result in depressive emotions and behaviours. He argued that errors in thinking and dysfunctional cognitions caused the depression and unhealthy behaviours that maintain the dysfunctional thoughts and depressive mood. CBT therefore seeks to correct errors in thinking. Hence, the process of exploring and disputing

maladaptive automatic thoughts and core beliefs plays a crucial role in therapy. Beck also put forward a diathesis stress model of mental disorders. This means that there is a genetic predisposition (diathesis) toward certain disorders that manifests under stressful conditions. A combination of factors (genetics, biological and experiences) combine to produce specific schemas and core beliefs. These lay dormant for a period of time and then reappear as a result of a stressful situation (Neukrug 2011:318). Negative core beliefs tend to be activated when the person is experiencing emotional distress. Their thoughts are thus directly related to their emotional distress and unproductive behaviours. In order to bring about change, dysfunctional cognitions will first need to be dealt with, so that negative emotions and behaviours can be modified.

According to Beck, most individuals are unaware of their core beliefs. Core beliefs become the underlying means through which intermediate beliefs are formed. These lay down the attitudes, rules, expectations, and assumptions by which one lives. These are often inferred from the individual's automatic thoughts. They can be understood by observing the individual's automatic thoughts and their resulting behaviours, feelings and physiological responses that end up reinforcing the core beliefs, thus creating a perpetuating cycle (Neukrug 2011:318). Beck stated that there are two broad categories of core beliefs that contribute to dysfunctional thoughts and schemas: "I am helpless" and "I am unlovable". Core beliefs thus fall into two categories: helplessness or unlovable (Lidardi 2010:129).

With regards to core beliefs and the religious client, core beliefs are associated with one's attitude toward the self, the world and the future (the cognitive triad). One's religious beliefs influence what one considers to be acceptable behaviour and thoughts. The individual may struggle to control these.

Schemas

Beck differentiates between schemas and core beliefs by suggesting that schemas are cognitive structures within the mind, the specific content of which are core beliefs (Neukrug 2011:321). Core beliefs, are thus stored within, and also make up the content of schemas. Beck originally defined a cognitive schema as a "structure for screening, coding, and evaluating the stimuli that impinge on the organism" (1967:283; quoted in Neukrug 2011:320). Schemas are described by Winterowd et al. (2003) as hypothetical structures in the brain that help one to organize incoming information. They can be likened to a filing cabinet that is used to store information and organize one's experiences in a meaningful way, helping one to make sense of their world (Winterowd et al. 2003). Daniel McIntosh defines a schema as "a cognitive mental structure or representation containing organized prior knowledge about a particular domain, including a specification of the relations among its attributes" (McIntosh 1995:2; quoted in Hood, Hill, Spilka 2009:199). He explains people have different schemas for many domains. Hepworth et al. (2010:393) describe schemas as "shortcuts in thinking". Instead of processing information, the individual quickly assess repeatable content in their mindset without evaluating events or interactions any further.

Schemas, according to Salkovsis (1996) are taken for granted, implicit, unconditional and unquestionable themes held by individuals. They serve as a template to assist the individual in processing their experiences, defining their behaviours, thoughts, feelings and relationships with other people. They thus act as filters through which one processes information and experiences. Milkman & Sunderwirth (2010:308) describe schemas as core mental structures that guide automatic thinking. They are enduring principles of thinking that are formed in early childhood and are influenced by one's life experiences (such as, parental teaching and modelling, formal and informal educational activities, peer experiences, traumas and successes (Milkman & Sunderwirth 2010:308). Neukrug (2011:318) illustrates schemas as functioning as a master plan of the mind that can turn certain core beliefs on or off. Schemas also exert power over how an individual responds to events in the world. For example, one individual's schemas will allow them to interpret events in a positive way, while another's schemas will cause them to interpret the same event negatively. Negative schemas contribute to debilitating, depressing, anger-evoking, anxiety-producing, and dysfunctional ways of living (Neukrug 2011:320).

Schemas are formed in early childhood. Once a particular belief is formed, it may influence the formation of new and related beliefs. Persistent beliefs are incorporated into these enduring cognitive structures or schemas. Core beliefs embedded in schemas influence one's thinking style. Schemas of well adjusted people allow for realistic appraisals, while those of maladjusted individuals lead to distortions of reality and cognitive errors. Schemas may be latent or active. They become activated by particular situations similar to those that caused their development. Associated with these dysfunctional core beliefs are one's conditional intermediate beliefs (assumptions and rules). The activation of these schemas causes one's reasoning to be impaired and reduces their ability to appraise events objectively. Schemas influence what we perceive, speed up the cognitive processing of information; offer meaning in difficult situations by filling in the gaps in our knowledge; familiarize us to the world and the problems with which we must cope; help us adapt to problematic circumstances (Hood, Hill, Spilka 2009:199). Cognitive distortions usually accompany dysfunctional schemas and may provide temporary relief, but in the long run they reinforce and worsen dysfunctional beliefs. Wright et al. (2006:10) explains schemas as basic templates or rules for information processing that underlie the more superficial layer of automatic thoughts. According to Bowlby, humans need to develop schemas so that they can manage the large amounts of information they encounter each day so that they can make timely and appropriate decisions (quoted in Wright et al. 2006:10).

The relationship between schemas and automatic thoughts are understood according to the diathesis-stress hypothesis (Wright et al. 2006:12). In depression (and other conditions of mental disturbance), maladaptive schemas (diathesis, i.e. mental predisposition) may remain dormant until a condition of stress arises that activates the core beliefs (Milkman & Sunderwirth 2010:308). The maladaptive schema is then strengthened to the point that it stimulates and drives the more superficial stream of negative

automatic thoughts. In terms of irrational and maladaptive thinking, CBT teaches clients to recognize and change their response to pathological thinking on two levels: automatic thoughts & schemas (Milkman & Sunderwirth 2010:308). All people have a mixture of adaptive (healthy) schemas and maladaptive core beliefs. CBT seeks to identify and build up the adaptive schemas while attempting to modify or reduce the influence of maladaptive schemas.

McIntosh describes **religion as a ‘cognitive schema’** (McIntosh 1997:173). Kelly (1955) says, one way to understand personal religiosity is in terms of cognitive schemata (or habitual ways of thinking) (quoted in Ladd 2007:452). A religious cognitive structure helps guide thinking when encountering difficult situations (Ozorak 2005; quoted in Ladd 2007:469) particularly during times of ambiguity and threat. Even though peripheral cognitive schemata have their use, it is well-developed, persistent thought patterns that usually dominate when interpreting events under conditions of threat and ambiguity (Ladd, 1990; McIntosh, 1993; quoted in Ladd 2007:452). With respect to religion, the degree to which religious schema dominate correspond with the degree to which one’s faith orientation is central to their self understanding and worldview. Religious schema may be one of a number of powerful ways of organizing thoughts (Ladd 2007:452). Depending on the circumstance at hand, different schemas may compete for priority. Ladd (2007:452) explains, “A parenthood schema, a psychological schema, or a musical schema could all vie for priority under different conditions. If, however, a religious schema predominates, then the individual will have a tendency to perceive religious order in even the smallest events; in such cases, religion has established a ‘meta-schema’ that offers a distinctly unique way to view life”.

Strongly held religious beliefs can function as an important part of the definition of one’s identity. In this way, these beliefs function as a meta-schema within which to address any desire for structure (Ladd 2007:462). Such religious meta-schematic frameworks filter incoming information and organize outgoing responses. Thereby helping one to figure out their life experiences (McCauley & Lawson 2002; quoted in Ladd 2007:452). This is one of the critical aspects of faith, that it can provide a sense of structure in the midst of daily life or during chaotic situations (Ladd 2007:452).

Coe & Hall (2010; quoted in Clinton & Hawkins 2011) claim that many of the beliefs and behaviors in religion are due to schemas. They explain: “The God-image can be thought of as (an often unconscious) mental representation of God which is often similar to a valued adult parent figure in early life. The person has reacted emotionally to the figure with the sense of attachment. Because the actual parent is not always around, the person might transfer the emotional attachments to a God concept or God-image. Importantly, the person might later develop core beliefs about God. Usually, those core beliefs – which are important to the organization of the entire personality – are often somewhat inconsistent with the schema of God. This is not always the case, and much emotional dissonance can be experienced when the God schema and core beliefs disagree. Christian counselors often help sort out the dissonance,

especially when it interferes with the emotional equanimity of clients or prevents them from achieving important goals” (Everett L. Worthington Jr; Gartner, Aubrey L; Jennings II, David J p484; quoted in Clinton & Hawkins 2011:484).

An example of a religious schema is a belief in an afterlife. Such a belief has been associated with greater recovery from bereavement (regardless of the cause of death) (Smith et al. 1991-1992:222; quoted in Hood, Hill, Spilka 2009:199). Doubt in the existence of an afterlife, has been associated with poor general well being; poorer recovery from the bereavement in particular; and greater efforts to avoid thinking about the death in question (Hood, Hill, Spilka 2009:199). Another example demonstrating religious schemas is in the work of McIntosh et al. (1993), on how parents cope with the death of an infant from sudden infant death syndrome (SIDS). McIntosh et al. (1993) demonstrated how parent’s faith, through the use of religious schemas, indirectly facilitated their adjustment by making the death meaningful and supporting efforts to come to terms with the loss (Hood, Hill, Spilka 2009:199). Cognitively, religious importance contributed to a more positive mental processing and helped reduce distress (Hood, Hill, Spilka 2009:199). Religious schemata provide certain standards of behavior for confronting death, and these rules of order are made clear, either explicitly or implicitly, as people observe the deaths of those in their community (Williams 2004). Maintaining a strong religious schema was linked to increased positive and decreased negative death attitudes (quoted in Ladd 2007:469). Cognitive therapy attempts to modify beliefs at the level of negative automatic thoughts and schemas. In religiously based CBT, religious or spiritual beliefs are drawn upon to shift a person’s core assumptions, or the basic beliefs that predispose a person to experience, e.g. anxiety or depression.

Coping or compensatory strategies

In order to protect themselves from their negative core beliefs and its resulting pain, individuals develop coping strategies (also known as compensatory strategies) (Neukrug 2011:325). These usually develop early in life and allow the individual to avoid dealing with the strong negative feelings associated with their negative core beliefs. These behaviours do not eradicate the negative core beliefs, and often over time, become problematic themselves, as they become increasingly maladaptive for the individual. As the individual learns to apply the cognitive model to themselves they gain a deep understanding of the relationship between their thoughts, feelings, behaviours, intermediate beliefs, and the more entrenched core beliefs.

2.1.2. DESTRUCTIVE THINKING IN RATIONAL EMOTIVE BEHAVIOR THERAPY (REBT)

Rational and irrational beliefs in REBT

While other cognitive therapies rely on concepts such as “cognitive errors” (Beck) and “dysfunctional thinking” (Mahoney), the concepts “irrational beliefs” (IBs) and “rational beliefs” (RBs) are central to REBT. Much of Ellis’s work in REBT focuses on disputing irrational beliefs. But what exactly is meant by rational/irrational and rational beliefs/irrational beliefs? Some of the **definitions** defining these terms in the REBT literature are as follows:

○ ***Irrational***

“By irrationality I mean any thought, emotion, or behaviour that leads to self-defeating or self destructive consequences that significantly interfere with the survival and happiness of the organism” (Ellis, 1997, p15, quoted in O’Donohue et al. 1996:306).

“...self defeating...” (Ellis 2002).

“Given that humans will tend to be goal directed “...‘irrational’ means that which prevents them from achieving these goals and purposes” (Dryden, 1984:238; quoted in Ellis & Dryden 1997:4).

○ ***Rational***

“...self-helping...” (Ellis 2002).

“...that which helps people to achieve their basic goals and purposes” (Dryden 1984:238; quoted in Ellis & Dryden 1997:4).

“It can be assumed that almost all humans have the basic goals of wanting to survive, to be relatively happy, to get along with members of their social group, and to relate intimately to a few selected members of this group. Once their basic values are assumed, anything that aids them is rational or appropriate and anything that sabotages them is irrational and inappropriate” (Ellis, 1974:195; quoted in O’Donohue et al. 1996:306).

“The term ‘rational’, as used in RET, refers to people’s (a) setting up or choosing for themselves certain basic value, purposes, goals, or ideals and then (b) using efficient, flexible, scientific, logico-empirical ways of attempting to achieve such values and goals and to avoid contradictory and self defeating results” (Ellis & Whitely 1979:40; quoted in O’Donohue et al. 1996:306).

“....rational not only means based in or derived from reason but also means efficiently aiding human happiness” (Ellis, 1989a:p116; quoted in O’Donohue et al. 1996:306).

Pucci (2006:45) points out that rational thinking is not (necessarily) positive thinking, in that, positive thinking is thinking that does not necessarily consider facts, but is ‘thought’ simply to feel better.

○ ***Rational beliefs***

‘Rational Beliefs’ are evaluative cognitions of personal significance that are preferential (i.e., non absolute) in nature. They are expressed in the form of “desires”, “preferences”, “wishes”, “likes” and “dislikes” (Ellis & Dryden 1997:5).

“...a reasonable or realistic belief...” (Ellis 1973:57; quoted in O’Donohue et al. 1996:306).

“...can be supported by empirical data and is appropriate to the reality that is occurring, or may occur, at Point A” (Ellis 1973:57; quoted in O’Donohue et al. 1996:306).

“Rational Beliefs in RET mean those cognitions, ideas, and philosophies that aid and abet people’s fulfilling their basic, or most important, Goals” (Ellis 1984:20; quoted in O’Donohue et al. 1996:306).

“Rational thoughts (or rational ideas or beliefs) are defined in RET as those thoughts that help people live longer and happier, particularly by: (1) setting up or choosing for themselves certain (presumably) happiness-producing values, purposes, goals, or ideals; and, (2) Using efficient, flexible, scientific, logico-empirical ways of (presumably) achieving these values and goals and of avoiding contradictory or self defeating results” (Ellis & Bernard, 1985:5-6; quoted in O’Donohue et al. 1996:306).

“...are either flexible (e.g. non-dogmatic preferences) or non-extreme (i.e. non awfulizing beliefs, discomfort tolerance beliefs – also known as high frustration tolerance beliefs – or acceptance beliefs” (Dryden 2012).

○ ***Irrational beliefs***

“In REBT, irrational beliefs are not merely defined as those that are unrealistic (anti-factual) or illogical (do not follow from one’s premises), but include those that are usually unrealistic and illogical and also do harm to you and/or your social group (sabotage your goals and desires) (Ellis 2003:26).

“...cannot be supported by any empirical evidence and is inappropriate to the reality that is occurring, or may occur, at point A” (Ellis, 1973:57; quoted in O’Donohue et al. 1996:306).

“...not all irrational Beliefs include should or must; some of them merely consist of unempirical or unrealistic statements” (Ellis 1977:8; quoted in O’Donohue et al. 1996:306).

“Irrational Beliefs are those cognitions, ideas, and philosophies that sabotage and block people’s fulfilling their basic, or most important, Goals” (Ellis 1984:20; quoted in O’Donohue et al. 1996:306).

“...almost invariable consist of absolutistic, dogmatic, illogical, unrealistic Beliefs. Instead of being expressions of flexible desire and preference, they are inflexible, rigid ought’s, musts and necessities” (Ellis, 1985:136; quoted in O’Donohue et al. 1996:306).

“...beliefs are judged to be irrational when they express unconditional and absolutistic demands that do not help the individual remain happy and goal achieving” (Ellis & Bernard 1985:11; quoted in O’Donohue et al. 1996:306).

“...are self defeating and seriously interfere with your basic goals and desires – especially your goals of surviving and being happy” (Crawford and Ellis 1989:4; quoted in O’Donohue et al. 1996:306).

“...are absolutistic, highly exaggerated, rigid, and dogmatic. They consist of unconditional shoulds, ought’s, musts, commands, demands, and insistentcies that you lay upon yourself, on other people, and on the conditions under which you live” (Crawford and Ellis 1989:4-5; quoted in O’Donohue et al. 1996:306).

“...are unrealistic and contradict the facts of life” (Crawford & Ellis 1989:5; quoted in O’Donohue et al. 1996:306).

“...are illogical and contradictory. They are inconsistent with each other. Or they do not follow from normal premises. Or they logically follow from false premises” (Crawford & Ellis 1989:5; quoted in O’Donohue et al. 1996:306).

“...thoughts, feelings and actions that people create or construct that frequently defeat or sabotage their own personal goals, values and interests” (Ellis 1990:176; quoted in O’Donohue et al. 1996:306).

“...are either rigid (e.g. demands) or extreme (i.e. awfulizing beliefs, discomfort intolerance beliefs – also known as low frustration tolerance beliefs – or depreciation beliefs)” (Dryden 2012).

Description of rational and irrational Beliefs

Ellis identified two kinds of beliefs that are central to our emotional responses to various situations: (1) the first of these are “rational beliefs”. These are characterized as being flexible, adaptable to life events, and come in the form of wishes, wants, hopes, preferences and desires (Ellis et al. 1997:188). Rational beliefs are seen as logical, realistic, practical; goal oriented and encourages the individual to strive for a

philosophy of self acceptance as a fallible human being (Ellis et al. 1997:188). (2) The second are “irrational beliefs”. These are characterized as being inflexible, dogmatic, and come in the form of absolute musts, shoulds, have to’s, got to’s, and ought’s. These are demands and commands we make on ourselves, others and the world. When these are not met, they lead to ‘awful’ consequences (what we imagine the worst to be) including self damnation and self rejection (Ellis et al. 1997:188). Irrational beliefs are also described as being illogical, unrealistic, of bringing undesirable practical consequences, producing extensive emotional unhappiness, and getting in the way of achieving life goals. In REBT, irrational beliefs are targeted for disputing to reduce or remove (unhealthy or self defeating) emotional disturbance (Ellis et al. 1997:188). According to Ellis, the four main beliefs that underpin psychological disturbance are: (1) demands, (2) awfulizing beliefs, (3) discomfort intolerance beliefs, (4) self-, other - and life- depreciation beliefs. Demands are recognized as being primary, as the other three are derived from the demands. These are then viewed as being secondary (Dryden 2012).

Irrational beliefs differ from rational beliefs in 2 ways: (1) they are absolute (or dogmatic) in nature and are expressed in the form of ‘musts’, ‘shoulds’, ‘ought’s’, ‘have to’s’, etc; (2) they give rise to negative emotions that impede goal pursuit and attainment (e.g. depression, anxiety, guilt, anger) (Ellis & Dryden 1997:5). According to REBT theory, there are four beliefs that underpin psychological health. Of these (1) non-dogmatic preferences, are considered (1) primary, and the other three: (2) non-awfulizing beliefs, (3) discomfort tolerance beliefs and (4) self-, other- and life-acceptance beliefs, are secondary, as these are derived from the non-dogmatic preferences (Dryden 2012). Rational beliefs are viewed as being either flexible (e.g. non-dogmatic preferences) or non-extreme (i.e. non- awfulizing beliefs, discomfort tolerance beliefs (also called high frustration tolerance beliefs or depreciation beliefs) (Dryden 2012).

According to Ellis & Dryden (1997:5) rational beliefs are ‘evaluative cognitions of personal significance that are preferential (i.e. non-absolute) in nature’. These are expressed in the form of ‘desires,’ ‘preferences’, ‘wishes’, ‘likes’ and ‘dislikes.’ When people get what they desire, they experience positive feelings of pleasure and satisfaction; and when they don’t get what they desire, they experience negative feelings of displeasure and dissatisfaction, such as sadness, concern, regret, annoyance. These negative feelings are considered to be healthy responses to negative events and don’t significantly hamper achieving one’s goals and purposes. These Beliefs, then, are “rational” in two respects: (1) they are flexible, and (2) they do not impede the attainment of basic goals and purposes (Ellis & Dryden 1997:5). Irrational beliefs, on the other hand, are absolute (or dogmatic) and are expressed as rigid “musts”, “should”, “ought’s” “have to’s”, etc. They are destructive in that they lead to negative emotions that largely interfere with goal pursuit and attainment (e.g. depression, anxiety, guilt, anger) (Ellis & Dryden 1997:5). To sum up, healthy Beliefs reinforce functional behaviours, whereas unhealthy beliefs strengthen dysfunctional behaviours, i.e. withdrawal, procrastination, alcoholism and substance abuse (Ellis & Dryden 1997:6).

Dryden (2012) notes when the word “must” appears in a sentence it does not necessarily indicate the presence of an irrational belief. Some “musts” are conditional, whereas the musts that underpin disturbance are unconditional. Confusion may occur over the use of the word “should” to denote an irrational belief. Dryden (2012) notes that the word “should” has several different meanings and it is only the ‘absolute should’ that is deemed to be irrational in REBT. Dryden emphasizes that in REBT theory, rational beliefs are qualitatively (rather than quantitatively) different from irrational beliefs. Rational beliefs therefore do not lessen disturbance; but rather facilitate the acquirement of a healthily negative, but undisturbed set of responses to life’s adversities (Dryden 2009; Ellis 1994; quoted in Dryden 2011). Dryden also points out that a rational belief is not a fact (Dryden 2012). Even though, he says, a rational belief may be factual; it still has to take the form of a flexible belief or a non extreme belief. REBT theory states that a flexible belief is at the core of a healthy response to an adversity at “A”.

A list of illogical, irrational and self defeating beliefs:

Ellis’ original work proposes 11 irrational beliefs. Other REBT theorists have since added to these irrational beliefs. But all irrational beliefs can basically be categorized into the following four categories (of irrational, dysfunctional/maladaptive cognitive processes):

- **Demandingness (DEM)** refers to absolutistic requirements expressed in the form of “musts,” “shoulds’ and “ought’s.” It also includes an evaluative component (how desirable is this?) and a reality component (what should I expect?) (David et al. 2005:181).
- **Awfulizing (AWF)** refers to one evaluating a situation as more than 100% bad, and considering that it is the worst thing that could happen to him/her (David et al. 2005:181).
- **Global Evaluation/Self-Downing (GE/SD)** appears when individuals tend to be excessively critical of themselves (i.e. make global negative evaluations of themselves; others and life conditions (David et al. 2005:181).
- **Frustration Intolerance (FI)** refers to individuals’ beliefs that they cannot endure, or envision being able to endure, a given situation, as well as their belief that they will have no happiness at all if what they demand should not exist, actually exists (David et al. 2005:181).

According to Ellis (1962, 1994, quoted in David et al. 2005:181), DEM is the core irrational belief, and all other irrational beliefs are derived from it.

A list of 10 irrational beliefs as identified by Ellis and other REBT theorists:

- 1) “The idea that you must – yes, must – have love or approval from all the significant people in your life” (Ellis 2003:23). It is a dire necessity for adult humans to be loved or approved by virtually

every significant other person in their community (Brandell 2011:193). I must be loved and approved of by almost every significant person in my life or its awful and I'm worthless (Coon 2006: 546).

2) "The idea that you absolutely must be thoroughly competent, adequate and achieving" (Ellis 2003:23). One absolutely must be competent, adequate, and achieving in all important respects, or else one is an inadequate, worthless person (Brandell 2011:193). I should be completely competent and achieving in all ways to be a worthwhile person (Coon 2006: 546).

3) "The idea that people absolutely must not act obnoxiously and unfairly, and you should blame and damn them, and see them as bad, wicked, or rotten individuals" (Ellis 2003:23). People absolutely must act considerately and fairly, and they are damnable villains if they do not. They are their bad acts (Brandell 2011:193). Certain people I must deal with are thoroughly bad and should be severely blamed and punished for it (Coon 2006: 546).

4) "The idea that you have to see things as being awful, terrible, horrible and catastrophic when you are seriously frustrated or treated unfairly" (Ellis 2003:23). It is awful and terrible when things are not the way one would very much like them to be (Brandell 2011:193). It is awful and upsetting when things are not the way I would like them to be. (Coon 2006: 546).

5) "The idea you must be miserable when you have pressures and difficult experiences; and that you have little ability to control, and cannot change, your disturbed feelings" (Ellis 2003:23). Emotional disturbance is mainly externally caused, and people have little or no ability to increase or decrease their dysfunctional feelings and behaviours (Brandell 2011:193). My unhappiness is always caused by external events (Coon 2006: 546).

6) "The idea that if something is dangerous or fearsome, you must obsess about it and frantically try to escape from it" (Ellis 2003:23). If something is or may be dangerous or fearsome, one should be constantly and excessively concerned about it and should keep Dwelling on the possibility of its occurring (Brandell 2011:193). If something unpleasant might happen I should keep dwelling on it (Coon 2006: 546).

7) "The idea that you can easily avoid facing many difficulties and self responsibilities and still lead a highly fulfilling existence" (Ellis 2003:24). One cannot and must not face life's responsibilities and difficulties; it is easier to avoid them (Brandell 2011:193). It is easier to avoid difficulties and responsibilities than to face them (Coon 2006:546).

8) “The idea that you can achieve maximum human happiness by inertia and inaction or by passively and uncommittedly “enjoying yourself” (Ellis 2003:24).

9) “The idea that your past remains all important and that because something once strongly influenced your life, it has to keep determining your behaviours and feelings today” (Ellis 2003: 24). One’s history is an all-important determiner of one’s present behaviour; if something once strongly affected one’s life, it should indefinitely have a similar effect (Brandell 2011:193). Because something once strongly affected my life, it will do so indefinitely (Coon 2006: 546).

10) “The idea that people and things absolutely must be better than they are and that it is awful and horrible if you cannot change life’s grim facts to suit you” (Ellis 2003:24).

Irrational beliefs, REBT and the Religious/Spiritual Client

To confront or change irrational beliefs, REBT therapists usually make use of a technique known as ‘**disputation**,’ which debates or challenges the client's irrational belief system (Johnson 2001:42). The goal of the disputation process is to help the individual internalize a new philosophy, by examining and challenging their present ways of thinking and adopting more functional ways of thinking (Walen et al. 1992:154; quoted in Johnson 2001:42). In his article, “To Dispute or Not to Dispute: Ethical REBT with religious clients” (2001), **W. Brad Johnson** addresses some of the ethical concerns that may arise in the disputational process when using REBT with religious clients. Johnson distinguishes between two subtypes of irrational thinking – **irrational evaluative beliefs** and **irrational core beliefs** (Johnson 2001:42). (1) The first of these, is the most common target of intervention and commonly includes demandingness, low frustration tolerance, human worth ratings, and awfulizing (Johnson 2001:42). (2) The second, is described by Johnson (2001:42) as “fundamental and pervasive beliefs that clients often adopt as unarticulated life philosophies”.

General disputation focuses on the first type of irrational belief. Here, the evaluative and demanding qualities of the religious beliefs are disputed. This process does not dispute core religious beliefs. The question Johnson asks here is, "How does this client's style of thinking about God and his or her religion make him or her distressed?" (Johnson 2001:44). If the general approach is ineffectual; the more **advanced (specialized) disputation process may be required**. This step directly challenges and seeks to modify the (core or foundational) elements of the individual’s religious beliefs, particularly those that are inconsistent with their actual stated faith and religious practice (Johnson 2001:45). This intervention however carries much ethical risk and should be a last resort.

To what extent can the client's religious beliefs be challenged in the disputational process? According to Johnson (2001:45) there are times when individuals present with idiosyncratic or distorted

understandings of doctrine, Scripture, or religious practice, making this approach necessary. To directly dispute the content of the one's religious beliefs may cause concern about ethical and professional practice; but not if the irrational nature of their beliefs are disputed (rather than the content of their beliefs itself) (Johnson 2001:46). Johnson (2001:46) makes it clear, "Those with specialized training in psychotherapy with religious clients generally, and those with a strong understanding of the client's religious community, might also engage in higher-order disputation designed to correct selective abstractions or distortions of religious doctrine and Scripture". Most often, incomplete or inaccurate interpretations of Scripture are caused by what DiGiuseppe et al. (1990:358) refer to as **selective abstraction**. They say, "People do not become disturbed because of their belief in religion: rather, their disturbance is related to their tendency to selectively abstract certain elements of their religion to the exclusion of attending to others" (DiGiuseppe et al. 1990:358).

Two important considerations in the disputation process of religious clients identified by **Nielsen, Johnson & Ellis** (2001:112) are the role of religion in clients' Activating events and the role of religion in client's evaluative Beliefs – that is, religion in A's and religion in B's. Two approaches to disputing the irrational beliefs of religious clients follow from the distinction between Activating events and Beliefs: First **accommodating** religious beliefs when they appear as Activating events; and second, **integration** of religious material with disputations, when religion appears in core irrational beliefs (Nielsen, Johnson & Ellis 2001:112). When REBT therapists **accommodate** religious beliefs, they treat religious elements of a client's problems/concerns the same as other Activating events (specifics elements are still attended to, but these here, are less important than the evaluative and demanding nature of the client's beliefs) (Nielsen, Johnson & Ellis 2001:112).

Nielsen, Johnson & Ellis (2001:112) state, that the specifics of an activating event facing clients are less important than client's evaluative Beliefs about Activating events. Thus, the focus is not so much on whether the Activating event really is as the client says it is, but rather on whether the client's evaluation of the Activating event is absolutistic and therefore irrational (Nielsen, Johnson & Ellis 2001:112). Characteristic of the accommodative perspective, the therapist respectfully, humbly and collaboratively explores and seeks to understand the client's religious values, beliefs and practices without attempting to change any of these (Nielsen, Johnson & Ellis 2001:113). Rather than address specific religious beliefs, the accommodative therapist disputes the demanding and unhealthy evaluative nature of the religious client's beliefs. So the question here becomes, "How does this client's style of thinking about God and his/her relationship to God make him/her distressed? (Nielsen, Johnson & Ellis 2001:113). From an accommodative perspective, the focus is on Beliefs and not Activating events (i.e. B's, not A's) (Nielsen, Johnson & Ellis 2001:113). In contrast to accommodating religious beliefs, a REBT therapist may purposely **integrate** the client's religious beliefs with disputations. By doing so, it is assumed that the elements of a religious client's belief tradition may function as a potential solution to

their irrational beliefs. Elements of the client's religious beliefs that set off absolutistic, evaluative beliefs about self and circumstance are used during disputation of Activating beliefs of all kinds.

Nielsen, Johnson & Ellis (2001:125) explain, that in some cases, REBT therapists may go further than mere accommodation of client religiousness, to intentional utilization and integration of religious material in the REBT disputational process. This process is an advanced or specialized approach to disputation, posing greater risk to the religious client, as well as greater potential for effective and lasting change (Nielsen, Johnson & Ellis 2001:125). Because Scriptures, biblical examples, and faith based practices such as scripture reading, resonate with religious clients, these may be particularly effective in the integrative disputation process. The outcome of which may actually be the strengthening of one's religious faith, and not lessening of it (Nielsen, Johnson & Ellis 2001:125). In this disputation process, the individual is reintroduced to neglected components of their own faith; problematic/inaccurate/incomplete/ readings of Scriptures are reinterpreted; and idiosyncratic religious beliefs are questioned (particularly if they are contrary to the individuals stated religious denomination) (Nielsen, Johnson & Ellis 2001:125). To sum up these two approaches, Nielsen, Johnson & Ellis (2001:112) note, that the key to both rational emotive approaches for treating religious clients - is rational emotive theory's goal of changing absolutistic, evaluative beliefs.

The religious dimension: basic irrational beliefs

According to Ellis and REBT theorists, irrational beliefs are at the core of psychopathology, and cognitive errors are central to psychological distress. **Beliefs are defined as irrational if** they are illogical, inconsistent with empirical reality, and/or do not help clients reach their goals (DiGiuseppe; Robin; Dryden 1990:357). **The four main irrational beliefs as** summed up by Ellis are -absolutistic demandingness; human worth/rating; awfulizing; low frustration tolerance (DiGiuseppe; Robin; Dryden 1990:357). Rational thinking encourages goal attainment, whereas irrational thinking is more than likely to set in motion distressing emotions and dysfunctional behavioural consequences. Despite the lack of evidence linking religious beliefs with psychopathology, it is not uncommon to see people disturbed by their religious beliefs. DiGiuseppe; Robin; Dryden (1990) found that these disturbances were usually the result of the individual's tendency to selectively abstract certain elements of their religion, and not due to their belief in religion itself. The individual thus rigidly adheres to one aspect of their religion, neglecting others. In the section to follow, I will discuss the 4 main irrational beliefs, with regards to the religious client.

Demandingness

"Demandingness is reflected in the beliefs that an individual must do well and be approved of, that one must be treated kindly and considerately by everyone, and that conditions of life should always be the way one wants them to be" (Warnock 1989:265). DiGiuseppe; Robin; Dryden (1990:358) state, that the

two main irrational beliefs that clients with strong religious beliefs usually present with in therapy are demandingness and human ratings. Disputing these, may help to reorient the individual to their Judeo-Christian belief system.

Nielsen, Johnson & Ellis (2001:240) list the following examples of demanding irrational beliefs commonly expressed by (protestant) religious clients: “I must be perfect as Christ Jesus was perfect;” “I have to show God that I am deserving of grace by never having sinful thoughts or behaviour;” “Living the way God wants me to live must not be so hard;” “Other people ought to believe what I do or they must suffer in hell;” “If I obey God’s laws, pray and ask to be forgiven for my sin, I must go to heaven” (Nielsen, Johnson & Ellis 2001:240). And commonly expressed by catholic religious clients: “My life ought to be free of sin;” “I must confess each and every sin I commit;” “I absolutely should have attend mass this week” (Nielsen, Johnson & Ellis 2001:243). A distinct characteristic of Catholic clients are their demands for perfect behaviour. As a result, they tend to have well rehearsed demanding beliefs regarding correct thinking, behaving, avoidance of sin, confession of sin, penance, and fear or shame related to full experience of pleasure (Nielsen, Johnson & Ellis 2001:243).

Reflecting on the Scriptures, Warnock (1989:265) explains that on many occasions Jesus was rejected and disapproved of by others. His rejection was so great, that it ultimately led to him being crucified. And in all of this, Jesus accepted his situation as it was, rather than impose his demands on it (e.g. Luke 22:42, when Jesus was praying in the garden of Gethsemane just before his crucifixion. Despite all he went and was still to go through, his words still lacked demandingness “not my will, however, but your (Gods) will be done”. Even during this trying time, he did not hold this irrational belief when he prayed in Gethsemane).

Awfulizing

Awfulizing is derived from demandingness; and may center on catastrophic thinking about oneself, others, or the world (Nielsen, Johnson & Ellis 2001:240). When Christian clients view their behaviour as “sinful” (i.e. lustful thoughts or acts of adultery) or contrary to biblical requirements, they tend to catastrophize their behaviour, “I have sinned before God, which I absolutely should not have done. My sin is awful and terrible and I may not be forgiven for it. I am certainly in danger of going to hell, and that possibility is catastrophic!” (Nielsen, Johnson & Ellis 2001:240). Similarly, the behaviour of others or situations in the world may be awfulized.

Nielsen, Johnson & Ellis (2001:240) list the following examples of awfulizing irrational beliefs commonly expressed by (protestant) religious clients: “It is terrible that others ridicule us for our religious beliefs and practices;” “Society is becoming less God-fearing by the second. It is awful that so many people seem to ignore God’s requirements for righteousness;” “I am a complete failure as a

Christian because I can't seem to stop coveting things others have". Religious clients tend to awfulize situations and events that cause them to doubt (their faith) or believe they have committed very bad sins. Nielsen, Johnson & Ellis (2001:243) give the following example of a case of divorce: "In the Catholic Church, divorce will typically mean that the client is not able to fully participate in the church's sacraments (e.g. communion). In response, an irrational belief might be, "it is terrible and awful that the church will no longer let me practice as a full member and I can imagine nothing worse than my spouse leaving me and causing me this pain."

Rating of human worth

Reflecting on rating human worth, Scripture and the religious client, Warnock (1989:267) reminds us of the words and actions of Jesus', that on many occasions, He did not blame or condemn others when their behavior was judged as less than acceptable according to their societal standards. For example, with regards to the outcast Samaritan woman at the well, Warnock notes, instead of condemning her, Jesus offered her "living water" (John 4:1- 30). And the woman who was caught in the act of adultery, Jesus said to her, he did not condemn her either, and that she should go and sin no more (John 8:1-11).

Nielsen, Johnson & Ellis (2001:241) warn that when using scriptures (or doctrinal beliefs) out of context, it may result in making generalized evaluations or unfair criticisms of people (themselves and others). For example, individual's who focus only on scriptures urging them to "be perfect," ignoring any Scriptures to the contrary i.e. those rendering all human beings as "fallen," "sinful," and like "filthy rags" (Nielsen, Johnson & Ellis 2001:241). This is problematic for individuals who have a vulnerability to negative self evaluation or automatic negative thoughts regarding self, sermons emphasizing fire, brimstone, and complete purity or "righteousness" in thought and behaviour (Nielsen, Johnson & Ellis 2001:241).

It seems certain religious clients (i.e. Protestants) from more fundamentalistic backgrounds are susceptible to (unrealistic) perfectionistic self demands. And when they fail to reach these high expectations, the end result is some sort of self downing (Nielsen, Johnson & Ellis 2001:241). Nielsen, Johnson & Ellis (2001:241) list the following examples of human worth ratings (commonly expressed by Protestant religious clients): "God could never really love someone who has sinned as grievously as I"; "Because I seem to fail so completely to abide by biblical principles and commandments, it proves that I am evil and despised by God"; "Because my life is miserable and difficult, God is withholding His blessings. I am completely undeserving"; "I deserve to suffer eternally for the awful thing I have done" (Nielsen, Johnson & Ellis 2001:241).

Low frustration tolerance

Low frustration tolerance is illustrated with the following statements: “I can’t stand it”, or “I can’t take it anymore”. Warnock (1989:267) reminds us, that with all that Jesus had to endure (rejection, persecution, crucifixion, etc) he still did not utter any of these words, and instead, displayed just the opposite in his attitude, accepting his coming suffering and betrayal by Judas. Religious clients are not exempt from convincing themselves that they cannot stand life’s discomforts and inconveniences. Certain activating events that may add to frustration intolerance include: changes in the structure or content of church services; failure to work/be “productive” in some way; and disagreement with doctrine or practices that are contrary to the teachings of the church (Nielsen, Johnson & Ellis 2001:242). Nielsen, Johnson & Ellis (2001:242) illustrate frustration intolerance among religious (Protestant) clients with the following argument: “One might make the case that the multitude of small Protestant denominational groups may in itself be a testament of sorts to the tendency for descendants of the Protestant Reformation to engage in low frustration tolerance. Specifically, Protestants may at times be quite intolerant of diverging beliefs regarding issues such as the necessity of baptism in order to receive salvation or requirements for qualifications to pastor. Church splitting and denominational fragmentation are often indicative of poor frustration tolerance within churches over time”.

The **connection** I would like to make here, between these irrational beliefs as listed in REBT theory and the religious individual, is that individuals (whether religious or not) can at any time be under the control of any of these irrational beliefs (awfulizing, low frustration tolerance, and so on). On a positive note, REBT theory teaches that individuals are in control of their own thoughts and cognitive processes. Even for the more spiritual or religious client, this means that long-held religious beliefs can be challenged and changed. That such change is possible is summed up in Warnock’s reflection of Luke 16:16-17: “Jesus indicated that the religious leaders had made the people slaves to the Law. These beliefs were so deeply ingrained that their lives were narrowed by them. In Galatians 3:13, the apostle Paul even referred to the religious Law as a "curse." Jesus said that he was going to explain the religious law in the way it was intended (Matthew 5:17-20). He spoke of subjects such as anger, adultery, divorce, vows, revenge and love. In Matthew 5:21-22, he said, "You have heard that people were told in the past But now I tell you...." In Matthew 5:27-28, he said, "You have heard that it was said But now I tell you...." In Matthew 5:31-32, 5:38-39, and 5:43-44, he said, "It was also said But now I tell you...." In Matthew 5:33 he said, "You have also heard that people were told in the past.... But now I tell you...." (Warnock 1989:269, 270). An essential idea conveyed in this passage is that Jesus encouraged the people to change their enslaving thoughts. This idea may have been very challenging to the people of that time, but Jesus knew they were in charge of their own thoughts and beliefs, and had the power to change their old (and irrational) beliefs. He therefore made the effort to challenging their thought patterns, old concepts and encourage the development of new concepts. Jesus went to all this trouble because he knew that they were in control of their own lives and well-being (Warnock 1989: 270).

Rigidity

According to REBT theory, people naturally have desires (i.e. we want certain things to happen and other things not to happen) but we also have a strong tendency to turn these desires into demands, musts, absolute shoulds, etc (Neenan & Dryden 2011:4). According to Dryden (2012), the most distinctive feature of REBT theory is the central role given to rigid beliefs i.e. demands, musts, absolute shoulds, etc. in accounting for psychological disturbance. Thus, in REBT, rigidity is seen as being at the core of psychological disturbance and flexibility, on the other hand, is essential to psychological health (Neenan & Dryden 2011:4).

The biological basis of human irrationality

According to Ellis, humans are predisposed toward irrationality regardless of whether they have had a rational upbringing or not. Humans are thus inclined toward irrationality. They are biologically predisposed to think irrationally, and this tendency contributes towards psychological disturbance. Most CBT approaches are based on social learning theories which explain psychological disturbance to result from faulty learning, but REBT on the other hand, stresses a strong biological basis to psychological disturbance (Neenan & Dryden 2011:8). It is this innate, biologically inclined, destructive nature that causes us to choose to indulge in our emotional problems. Our biology and upbringing may push us in this direction and our self defeating tendencies are also usually more powerful and frequent. But despite our natural destructive tendencies to harm ourselves, we still have considerable ability to control our neurotic tendencies and to reduce them (Ellis 1999:5). Even though people have a strong tendency to irrational thinking, they also have a tendency to rational thinking (Neenan & Dryden 2011:8). We are also born with the tendency to deal constructively with the many problems that we face during our lives. For this reason Ellis said, “keep this in mind: you largely make yourself disturbed, and you make yourself happy” (Ellis 1999:21). “You do not passively get or become upset. No, you largely consciously and unconsciously manufacture your own disturbances. You make yourself upset and you have the ability and power to “unupset” yourself” (Ellis 1999:21).

Choice

REBT theory holds that humans also have a second constructivist biological tendency, other than their biologically inclined destructive nature. They also have the ability to exercise the power of human choice and rid themselves of dysfunctional thinking and acting. Thus, according to Ellis & Dryden (1997:7) individual's (1) have the ability to see that they make themselves disturbed by the irrational views they bring to situations; (2), the ability to see that they can change their thinking, and (3) the ability to actively and continually work toward changing this thinking and behaving by the application of cognitive, emotive and behavioral methods. So even though humans have strong biological tendencies to think dysfunctionally, they are by no means slaves to this inclination and can rise above its effects (Ellis & Dryden 1997:7). Despite our biological tendencies, we can choose whether to construct rigid beliefs from

our preferences or to keep these beliefs flexible (i.e. by recognizing that we do not have to get what we want). If our rigid beliefs are entrenched, we can still choose to change them by questioning these irrational beliefs and acting and thinking in ways that are consistent with our chosen rational beliefs. However, to do so, we need to go against the grain of our irrational beliefs and put up with the discomfort of doing so. REBT theory holds that people disturb themselves about life's adversities because they hold irrational beliefs about these adversities. Therefore the goal of therapy is to change irrational beliefs to rational beliefs. REBT therapists focus on automatic thoughts and distorted inferences that individual's disclose, to help them as quickly as possible identify and change the irrational beliefs that generated these cognitions. So REBT advocates an early focus on irrational cognitive schemas whereas other approaches to CBT will tend to focus on more surface cognitions before dealing with underlying schemas. Perhaps the most distinctive feature of REBT practice is the efforts that REBT therapists make to help clients change their irrational (rigid and extreme) beliefs to rational (flexible and non extreme) beliefs.

The ABC Model

REBT is known for its ABC model of human disturbance. Ellis believed in a rational approach to therapy and in 1962, developed the ABC model of neurotic symptoms. According to Dryden (2012) several versions of the ABC model exist today, the most frequent version holds that 'A' stands for 'Activating' event; 'B' for 'Beliefs'; and 'C' for 'Consequences'. Ellis proposed that beliefs (B) about life events (A) influence affective symptoms (C) (Snyder 2000:110). He later expanded his model to include 'D' (disputing) and 'E', to become the 'A-B-C-D-E' model. His A-B-C-D-E model posits that restructuring the beliefs at 'B', which means changing from irrational to rational thinking through disputation – 'D' - will produce greater Emotional well being/effect – 'E' (Brandell 2011:192). Coombs (2005:344) explains that the first three letters "ABC" represents the core theory, and the letters after C, represent the therapeutic process that REBT follows to assist the individual to deal with their irrational beliefs.

Dryden notes, REBT theorists prefer not to say that "B" causes "C". The more ideal terms to use are: "B largely determines C"; "B" underpins "C" or "B" is at the core of "C" (Dryden 2012). This is because "A", "B" and "C" are inter-related, rather than separate processes, therefore "B" cannot cause "C" since this would imply they are separate.

○ ***A – Activating Event***

In the ABC model, the 'A' stands for the activating event or 'trigger'. This is what 'triggers' one's unhelpful feelings and emotions. Coombs (2005:344) reckons that the activating event can be people, places or things - that bring on painful associations. Wilson and Branch (2006:15, 42) describe the activating event as either being: (1) an external stimulus (i.e. something real that has actually taken place in the past or is happening right now; it could refer to an object, person or place) (2) an Internal stimulus

(in one's mind i.e. an image, memory or dream); (3) Futuristic (i.e. an event that still has to take place); (4) Physical (i.e. a physical sensation such as an increased heart rate). Dryden distinguishes between the "situational 'A'" and the "critical 'A'". He described the "situational A" as representing the situation in which the person disturbed him/herself; and the "critical A," as that aspect of the situation about which the person was most disturbed. The term "activating event" is nonetheless problematic and confusing, because it can mean the situation in which the person experienced his/her disturbed feelings (situational A) or it can be the precise part of the situation to which the person responds with disturbance (critical "A"), mediated by the person's irrational beliefs. "A" stands for the latter and this is its modern usage, but many authors get confused and refer to the former (Dryden 2012). The distinguishing difference between the two is that the critical "A" is inferential in nature, while the situational "A" is not (Dryden 2011). It is necessary to make a clear distinction between the situation in which an episode of disturbance occurs (the "Situation") and what the person is most disturbed about (critical "A") so as to reduce confusion with respect to "A". Dryden (2011) reckons, it is important to distinguish between 'critical' and 'situational' 'A's, particularly when considering "C". When "A" is situational, many "Cs" can be experienced, but it is not clear what these emotions are about. However, when "A" is critical, only one "C" can be experienced and there is a theme in the "A" that is representation of that emotion (Dryden 2012). It follows therefore that a number of critical "A's" can be found within one situational "A".

o ***B – Beliefs***

'B' refers to one's 'Beliefs' about 'A'. Wilson and Branch (2006:15) describe beliefs as being one's thoughts, personal rules, demands (made on oneself, the world, other people) and the meaning that one attaches to external and internal events. When an undesirable activating event (A) occurs, the individual holds either rational or irrational beliefs (B) about the event - these lead to emotional, behavioural and cognitive consequences (C). The type of belief one has, determines the (C). In that, rational beliefs lead to functional consequences; while irrational beliefs lead to dysfunctional consequences (David et al. 2005:176). Even though beliefs may be extreme, distorted or unhelpful, they are perceived by the individual to be fact. Faulty thinking and irrational beliefs lie at the root of human problems (Coombs 2005:44). These become programmed and automatic over time. Irrational beliefs directly influence how one operates and responds to the world. For the most part then, emotional disturbance can be explained as being caused by the irrational beliefs that the person holds in the situation in which the disturbance is experienced; and it can be deduced, that the person needs to hold an alternative set of rational beliefs to respond healthily to the same situation.

o ***C – Consequences***

"C" stands for the consequences of the beliefs held at "B" about "A". In other words, "A" x "B" = "C". Neenan and Dryden (2012:19) explain 'C' as referring to the emotional, behavioural and cognitive consequences of the interaction between 'A' and 'B'. 'C', according to Wilson and Branch (2006:15) is

basically how one feels and acts after the event. It is the self defeating behaviors and disturbing emotions attached to one's beliefs in response to an activating event (Coombs 2005:344). Once generated, these consequences 'C' can become activating events 'A' themselves, producing secondary (meta) consequences (e.g. meta-emotions, depression about being depressed) through secondary rational beliefs and irrational beliefs (David et al. 2005:176). For this reason, irrational beliefs should be actively disputed 'D' (i.e. restructured) and more efficient (E), rational beliefs adopted, so as to have a more positive impact on the individuals emotional, cognitive and behavioural responses.

- ***The three consequences at "C" are emotional, behavioural and cognitive:***

Emotional "C's"

This section covers the emotional consequences of irrational beliefs. In REBT theory, healthy negative emotions can be distinguished from unhealthy negative emotions. When responding to an adversity at "A," a constructive emotional response is usually negative in tone and healthy in its effects. This is why it is called a healthy negative emotion (or HNE). Healthy negative emotions develop from rational beliefs and unhealthy negative emotions (UNEs), from irrational beliefs. HNEs have constructive alternatives to UNEs. Dryden (2006) lists the following: concern (as opposed to anxiety); sadness (as opposed to depression); remorse (as opposed to guilt); disappointment (as opposed to shame); sorrow (as opposed to hurt); healthy anger (as opposed to unhealthy anger); healthy jealousy (as opposed to unhealthy jealousy); and healthy envy (as opposed to unhealthy envy).

Characteristic to REBT is the theory of emotions being a qualitative, rather than a quantitative one. Here, HNEs and UNEs are viewed as occurring on a separate, rather than on a single continuum of intensity (Dryden 2012). But not all REBT theorists agree how to measure these. For example, Ellis (1994; quoted in Dryden 2012) understands these to be of the same length - HNEs can be as intense at their peak as UNEs. But Dryden disagrees somewhat from this position, and states that the HNE intensity continuum is shorter than the UNE continuum. Basically, UNEs are more intense than HNEs at their peak, and illustrates this with the following example of blind rage. At its height of intensity blind rage will be more intense than healthy anger at its highest (Dryden 2012). This understanding of UNEs and HNEs as being qualitatively, and not quantitatively different, distinguishes REBT from other CBT approaches (Dryden 2009; quoted in Dryden 2012).

A feature of the quantitative model is that the difference between a UNE and a HNE is in its level of intensity. UNEs and HNEs are thus placed on the same continuum of intensity level. In the qualitative model, these are placed on a separate continua of intensity level. REBT therefore puts forward a set of healthy negative emotions (HNEs) which are considered to be constructive alternatives to unhealthy

negative emotions (UNEs). The REBT model of emotions is based on the ideas that emotions are largely determined by the beliefs held (at ‘B’) about adversities at ‘A’.

Previously, Ellis used the terms “appropriate” and “inappropriate” negative emotions before changing these to “healthy” and “unhealthy” negative emotions, respectively. The problem with the previous usage was that it suggested that emotions are judged as appropriate or inappropriate to the situations in which they are experienced rather than in response to the beliefs held about prominent features of these situations (Dryden 2012).

When describing common emotional “C” errors, Dryden points out that there cannot be more than one “C” in an “ABC”. This is why, he says, it is important to distinguish between the situational “A” and the critical “A,” because of its implication on “C”. When “A” is situational, many “C”s can be experienced, but it is not clear what these emotions are about. When ‘A’ is critical, only one ‘C’ can be experienced and there is a theme in the ‘A’ that is representation of that emotion. A number of critical ‘A’s can be found within one situational ‘A’ (Dryden 2012).

Behavioural “Cs”

This section covers the behavioural consequences of irrational beliefs. Dryden distinguishes between (1) overt behaviour and, (2) action tendencies - these concern an impulse to act in a certain way, but without that impulse being converted into overt action. This distinction is important for we know that individuals suppress their action tendencies and can manage to act healthily despite holding irrational beliefs. Thus, by their behaviour they appear to hold rational beliefs, but their suppressed action tendencies reveal that, in fact, they are holding irrational beliefs (Dryden 2012).

Cognitive “Cs”

This section covers the cognitive consequences of irrational beliefs. Ellis and Dryden (REBT theorists) argue that the cognitive distortions identified by cognitive therapists such as Beck and Burns, are the product irrational thinking and not the tendency to think distortedly (Dryden 2012). According to REBT theory, irrational thinking is characterized by rigid and extreme thinking, while distorted thinking is largely inferential in nature. The REBT position is that when thinking is distorted (as in the cognitive distortions outlined by cognitive therapists), these stem from rigid and extreme thinking.

The Relationship Between “B” and “C”

Dryden (2011) states, REBT theory has both a **general** and a **specific** model about the relationship between ‘B’ and ‘C’. Based on the general model, ‘C’ is largely determined by *cognitive* factors at ‘B’. At the heart of the specific model, ‘C’ is largely determined by *beliefs* at ‘B’. This is a

distinctive feature of REBT (Dryden 2012). Therefore, it would be a misrepresentation to state only the general model and imply that it is REBT's position on the relationship between "B" and "C".

The relationship between "B" and psychological disturbance is thus viewed as being supported or determined by irrational beliefs at "C" (Dryden 2012). Most people assume 'A' causes 'C' (the "A-C" connection). But in the ABC model, people have a choice as to how they behave or react 'C.' Here, the in-between role of 'cognition' is recognized and 'A' by itself is not seen as causing 'C'. Instead, the person's reaction 'C' is determined by 'B' what they believe (the "B-C" connection). If the person's beliefs are dysfunctional, then their behaviour is also likely to be dysfunctional (Ciarrochi et al. 2008:52).

Understanding the effect of beliefs (the B-C connection) aids the individual in understanding and changing the source of their self defeating distress. As well as recognize the part irrational beliefs have played in causing their self defeating emotions and behaviours. Therefore, in the B-C connection, the first step is to identify unhelpful beliefs 'B' and, the specific situation 'A' in which they are triggered. The second is to modifying these beliefs 'B' and associated behaviours 'C'. Lastly, the individual needs to test their (negative) automatic thoughts of threat 'B' and develop (healthy) helpful alternatives (Uys 2010:341).

o *'D' Disputing and 'E' Effect*

According to Ellis, it is not the circumstance that causes the distress but rather the irrational belief. He says, it is possible to recognize the erroneous belief, and challenge these, so that they have less of a hold over one. REBT includes forceful disputing of irrational beliefs. In the disputing process, the individual learns to: (1) detect their irrational beliefs i.e. their absolutist "shoulds", "musts", "awfulizing" etc; (2) debate their dysfunctional beliefs (by challenging irrational beliefs); (3) and discriminate irrational (self defeating) beliefs from rational beliefs (Ellis 1994, quoted by Jones Smith). Thus, once the individual has learnt to identify beliefs and self talk statements that result in emotional overreactions, the next step is to change these so as to reduce or avoid overreactions (Abrams 2003:190). The key to detecting irrational beliefs is to look for "should", "musts" and "ought to" statements. Although not all irrational beliefs include these terms, most do. To change one's emotional Consequence 'C', Beliefs 'B' about the Activating events 'A' will need to be Disputed 'D'. Beliefs that are irrational or destructive need to be disputed and changed (Abrams 2003:190). This can be done by arguing against the belief, for example, by asking oneself questions such as: what is the evidence for the belief? What are the alternative views? What is the worst that could happen? And so on. This can lead to new, more constructive beliefs that will better fit the situation and promote more positive feelings.

To sum up

The ABC model is useful for decreasing overreactions to problems and difficulties. In that, we often have no control over the Activating Events, 'A', but we do have control over our Beliefs 'B' about these 'As'. Thus, one can control their emotional Consequences 'C's' that largely follow from their B's (Ellis 1999:33). Consequently, when undesirable A's occur, the individual can exert more control by saying to themselves, at point B, "I don't like this undesirable A, let me see if I can change or remove it. If I can't, too bad, I will gracefully deal with what I can't change". The individual is therefore encouraged to accept responsibility, not for the undesirable things that happen to them (A's), but for their Beliefs (B's) about these A's. And come to view their Beliefs 'Bs' as preferences, rather than as absolute demands. 'E' – stands for new emotional consequence or effect. An added 'F' – refers to further action.

By demanding that unfortunate A's absolutely 'must not be' as bad as they actually are, one generates disturbed, dysfunctional feelings and behaviours. For example, strongly believing one 'must absolutely not' lose so and so's approval, promotes unhealthy depressed feelings rather than healthy disappointment, when such approval is lost. By raising ones desires to a 'dire necessity' one sets them self up for a fall. REBT teaches, we cannot change the Adversities (A's) that we dislike; but we can almost always importantly change our Beliefs (B) and feelings (C's) about these A's.

Destructive or dysfunctional thinking can become so much a part of one's mindset and everyday life that it is taken for granted. The ABC model allows one to determine whether or not a person's belief system is distorted. It enables them to map their own thinking and counteract any destructive thoughts. Applying the ABC model helps one to avoid making the mistake of repeatedly upsetting oneself over the same or similar issues.

2.2. COMPATIBILITY OF CBT AND RELIGION

2.2.1. COMPATIBILITY OF CT AND RELIGION

2.2.1.1. Arguments supporting the compatibility of Cognitive Therapy and Religion

The following features in the literature review point towards the compatibility of CT/CBT and religion.

A review of the literature reveals a number of studies that have endeavoured to integrate religious and spiritual values with CT and more broadly, CBT. The following discussion shows that numerous attempts to integrate spirituality/religion into cognitive behavioral therapy have been met with success.

In their study, **Hawkins, Tan, and Turk** (1999) found Christian cognitive behavioural therapy (CCBT) to be more effective than traditional CBT with inpatient Christian adults. This study supports the idea that matching client religious values (compared with therapies that ignore these) enhances therapeutic outcomes. Hawkins et al. (1999) list the following characteristics of a spiritually-modified CBT: biblical scripture to guide behaviors and thought processing, prayer, worship, seeking fulfilment through God versus personal autonomy, and the acknowledgement of important Christian factors (i.e. history, theology, family and society). They say, adding these techniques to traditional CBT when treating religious persons may prove more helpful.

Another study supporting the idea of matching religious views in patient-treatment was by the **Princeton Religious Research Center** (1996) who found that the majority of adults in America (96%) report they believe in God (Ano & Vasconcelles 2005; quoted in Dobson 2010:103). Ano & Vasconcelles (2005) also found that positive and negative forms of religious coping were associated, respectively, with positive and negative psychological adjustment to stress (quoted Dobson 2010:103).

McMinn and Campbell (2007) also developed a treatment model that integrated CBT with a Christian approach to therapy. **Peucher & Edwards** (1984) in their study, using a Beckian CT, compared Christian accommodative and secular versions of cognitive therapy (quoted in Norcross 2002:391). Their study consisted of student volunteers from a Christian college, who scored in the depressed range on the Beck Depression Inventory (BDI), the Hamilton Rating Scale for Depression (HRSD), and a single visual analogue observer rating scale. The participants were matched on the severity of their depression and randomly assigned to one of three groups: a secular CBT, religious CBT, or a wait list control (WLC) group. Treatment for both consisted of eight 50 minute sessions of individualized psychotherapy (based on Beck's CBT approach). The religious CBT incorporated religious beliefs into the therapeutic strategies (e.g. adjusting self statements to those such as "God loves, accepts, and values us just as we are"). Their findings showed no difference in outcomes in the other two treatments; but a marked reduction in depression compared to the WLC group at a post treatment and one month follow up (quoted in Norcross 2002:391).

Note the following study by **Propst et al.** (1992) in which the efficacy of Beckian CBT was compared with a religion accommodative version of CBT. These authors gave Christian religious rationales for their procedures; religious arguments were used to counter irrational thoughts; and religious imagery techniques were also used. Those who participated in this study came from the community; and scored in the clinical depression range (on the HRSD) and moderate range of religious commitment. Those who participated were randomly assigned to one of four groups: nonreligious CBT; religious CBT; pastoral counseling treatment; or WLC (wait list control). The CBT therapists consisted of five religious and five

non religious graduate students. The religiosity of the therapists and the two CBT treatments were crossed, creating four combinations:

1. religious CBT-religious therapist
2. religious CBT-non religious therapist
3. non religious CBT – religious therapist
4. non religious CBT – non religious therapist

The results of this study showed that the depressed religious individual's who had participated in the religious CBT or pastoral counseling, reported lower post treatment depression scores than those in the nonreligious CBT or WLC conditions. Those who had participated in the religiously adapted CBT with nonreligious therapists reported the most gain; and those by the non religious therapists doing standard CBT showed the least gain. The PCT condition recorded a more superior performance compared to standard versions of CBT on measures of depression at post treatment.

Another study demonstrating the effectiveness of integrating religion into CBT is by **Paukert et al** (2009). These authors reviewed a number of studies that examined the effects of integrating religion into CBT for depression and anxiety in older adults. Their findings showed an improvement in depressive and anxiety symptoms when CBT incorporates religion earlier in treatment. They note: "Religion has been reported to speed up the effects of CBT in younger depressed or anxious populations and both epidemiological and experimental literature indicate it is important in helping older adults cope with stress" (Paukert et al. 2009:110). Their recommendations are thus, for clinicians to consider "the integration of religion into psychotherapy for older adults with depression or anxiety and that studies be conducted to examine the added benefit of incorporating religion into CBT for the treatment of depression and anxiety in older adults" (Paukert et al. 2009:106).

Rosmarin et al. (2011), in a pilot study, successfully developed and implemented a spiritually integrated CBT approach in an acute psychiatric setting. They stated, "In the context of an intensive treatment program for patients with severe psychopathology, our protocol enables the delivery of respectful, skill-based, spiritually integrated CBT, serving an important patient need" (Rosmarin et al. 2011:301). **Ronen & Freeman** (2007) say that religious or spiritual faith may be incorporated into CBT methods. They say, CBT interventions may include religious/spiritual elements including prayer, scriptures, meditations, psalms, quotations, song, and so on (Ronen & Freeman 2007).

Beliefs and behaviors may be significantly influenced by religious/spiritual beliefs and rules, and become part of one's schema. The individual's repertoire of coping strategies may include prayer, song, rehearsal of religious readings, requests to a higher power or religious figure for strength in addressing problematic thoughts and behaviours, to name a few (Ronen & Freeman 2007). Scripture can also be used with Christian clients to challenge their negative automatic, or irrational thoughts, thus functioning as a

yardstick/standard, to measure “truth” (Ronen & Freeman 2007). Encouraging religious/spiritual clients to include particular concerns and issues in their prayers, also gives them the opportunity to reflect on the issues at hand. McNair, (1996:345) says, “Prayer may be an alternative to the written prose, in order to explore thoughts and feelings and find the answer within” (quoted in Ronen & Freeman 2007).

According to **Neil Pembroke** (2007:76) Cognitive therapy can be integrated with core gospel principles and values.

The following studies provide **further evidence** for spiritually based treatments to be more effective for various symptoms, particularly for religious patients: Oman, Hedberg & Thoresen (2006); Propst, Ostrom, Watkins, Dean & Mashburn (1992); Rosmarin, Pargament, Pirutinsky & Mahoney (2010). Some studies have shown a spiritually integrated treatment to be more effective than established secular therapies. In their research on the efficacy of religious and spiritual therapies, Hook et al. (2010:68-69) note that their research findings “suggest that R/S (Religious/Spiritual) therapies may work for treating psychological problems for R/S clients, and these therapies may work as well and, in a few cases, better than comparable secular therapies”. They do however acknowledge the need for more empirical research. Smith, Bartz & Richards (2007) found that interventions with spiritual components produced a .51 greater reduction in symptoms than those without, across 16 experimental and quasi-experimental studies. They therefore suggest that “spiritually oriented psychotherapy approaches may be beneficial to individuals with certain psychological problems (e.g., depression, anxiety, stress, eating disorders)” (Smith, Bartz & Richards 2007:643).

“Right thinking”

There is a common valuing of “right thinking” in both, but in different ways. Cognitive therapy grounds itself in the ability of humans to rationally analyze their thought processes and belief systems. The Christian faith also emphasizes the importance of thinking rightly, but that of orienting one’s mind to God and to God’s teaching (i.e. Proverbs 23:7, “As a person thinks in his heart, so he is”).

Bad mental habits

In cognitive therapy there is an optimistic view that bad mental habits can be discarded and replaced by healthier ones. In the Bible we find a similarly optimistic view of the human potential for a positive construction of the mind. Paul talks about renewing the mind so that it conforms more closely to the mind of Christ (Rom 12:2). The implication is that the disciples of Christ are able to learn his core principles and values and apply them in the various circumstances they find themselves in. In a word, Christianity values rationality.

Self acceptance

There is also a general affinity between the Christian tradition and cognitive therapy in relation to self acceptance. As we have seen, a common irrational tendency identified by cognitive therapists is that of making negative judgments concerning the worth of the self as a global entity. It is legitimate for a person to evaluate some of her actions negatively, but a leap from judgments about isolated actions to a condemnation of the self as a whole is unwarranted. In a Christian understanding, we are called upon to critically evaluate our actions and seek God's forgiveness when we judge that we have morally transgressed. A judgment that one has sinned will always result in a temporary drop in self esteem. But the knowledge that God accepts us unconditionally, that God loves us with all our imperfections and failings, serves as a powerful reminder that a pattern of self condemnation is contrary to God's intention. The fact that God loves us and accepts us in spite of our frailty gives us every reason to love and accept ourselves.

Effectiveness

Different frameworks exist for classifying the effectiveness of interventions. Of these, a spiritually modified CBT meets the stated criteria developed by the APA Division 12, recognizing it as an empirically validated, well-established and effective treatment model, for Christians struggling with depression (David Hodge 2011). The positive outcomes of these studies support and validate a spiritually/religious modified CBT. Thus, when treating a Christian/religious client, one can structure interventions to be consistent with the counselee's biblical worldview/interpretations.

Models of psychotherapy

CT shares the focus of a combined behavioural and cognitive emphasis, as can be found in the Scriptures. Scriptures such as Philippians 3-4 or Ephesians 4, exhort one to think new thoughts and engage in new deeds so as to grow in one's faith and spiritual maturity (Jones & Butman 2011:246). In this understanding, actions and thoughts play a role in maturity. In the CT approach, it is often assumed that challenges in one's daily living are the result of a lack of basic skills, providing the correct tools can help the client to gain mastery over their thoughts and behaviours. In this way, therapy can help correct these deficits.

Strengths

Jones & Butman (2011:252) list the following strengths: "Cognitive therapy has the following strengths when evaluated from a Christian perspective: "It posits limited freedom for the person, though the formal understanding of that freedom is incompatible with a Christian understanding of human responsibility. Cognitive therapy appreciates the embodied, human aspect of our existence and has a well articulated understanding of at least some of the person variables and processes that seem foundational to human action. The ideographic assumptions seem respectful of human uniqueness. An appreciation of the influence of the environment on behaviour (though not environmental determinism) seems appropriate

from a Christian perspective. The humbling and broad understanding of human motivation as basically selfish but complex is a strength. Cognitive therapy's high view of rationality is a plus, though the standards of rationality must be modified for the Christian. The view of the centrality of habits of thought and action to making life adjustments seems realistic. The relatively shallow view of personality, as reflected in its amorality and lack of vision of maturity, makes it a somewhat more adaptable tool for the Christian therapist than some other approaches to therapy. New adaptations of cognitive therapy are sensitive to childhood and cultural issues, yet without going as far toward developmental determinism as psychoanalysis. Finally, cognitive therapy emphasizes empirical accountability in all aspects of its practice, and, for Christians, this accords well with a commitment to good stewardship of time and energies, and with commitment to honesty".

2.2.1.2. Points of contradiction between Cognitive Therapy and Religion

The following features in the literature demonstrate incompatibility or points of difference/conflict between CT/CBT & religion:

Conscious control

CT assumes that humans can develop self awareness and have the ability to change their views of self in relation to the world (Jones & Butman 2011:233). Similar views have been found in Scripture, i.e. in the writings of the Apostle Paul (Rom 12:1-2; Rom 6:1-14). But this similarity however is limited to how the change process is received. In that, fundamental differences exist in each of their goals. The objective of CT is to help people feel and function better on their own terms and by their own definitions. Whereas Paul's aim was to help people form an identity in Christ; progress toward growth and holiness; and become more Christlike (Jones & Butman 2011:233).

Relativism

CT and Christianity have incompatible views on relativism. In the *Christian view* - truth is established and revealed by God. In the *CT view* - truth and meaning are human construction (and not revealed by God) (Jones & Butman 2011:235). Christians ultimately reject relativism, because of its claims that 'all truth is relative' and that there are 'no absolute truths'. It denies there is a God of absolute truth.

Sanctification

When people come to faith in Jesus Christ, there is usually an acknowledgment that they need to undergo some change in their present way of thinking and living so as to start to live in a new way. Sanctification is the process in which the individual is "set apart," "made holy," that is, the state of being sanctified. Some similarities have been recognized between the Christian process of sanctification and the way people change in cognitive therapy (Edwards 1976; Peucheur 1978; quoted in Jones & Butman

2011:239). Romans 8:5, points to the process of sanctification: “Those who live according to the sinful nature have their minds set on what that nature desires; but those who live in accordance with the Spirit have their minds set on what the Spirit desires”. There are cognitive and behavioural elements, emphasizing a change in thought and actions found in this scripture (Peucheur 1978; quoted in Jones & Butman 2011:239). There is a parallel between the processes of sanctification and the therapeutic process of growth. But, there is a difference in the fundamental identity between sanctification and therapy generally, or cognitive therapy in particular (Jones & Butman 2011:239). Cognitive and behavioural change also clashes with the charismatic understanding of spiritual growth, where a direct experience of God’s grace is emphasized (Jones & Butman 2011:239).

Health

CT therapists commonly assume that healthy people are basically rational. But a closer scrutiny often reveals information to the contrary. “Even the healthiest individuals have distorted perceptions of themselves and the world around them (Maroney 2000; quoted in Jones & Butman 2011:240).

Human motivation

The desire to become more logical and rational is what motivates one to grow and change in the CT model. For Christians, what motivates one is the desire for a restored relationship with God and others.

Rational change versus therapeutic relationship

In the CT model, rational change is elevated above the therapeutic relationship. A Christian view sees the importance of both rationality and relationality in how people change, and views the two as almost always intertwined in the healthy life (Jones & Butman 2011:241).

Culture and context

Cognitive therapy’s emphasis on rationality can be quite insensitive to culture and context. What is viewed as rational to one therapist or client in one culture/gender, may be viewed as less rational by someone from a different background. For Christians, the Gospel contains universal truths for all people of all time, and also many examples in Scripture of Christ and his followers understanding and respecting the cultural context of their time (Jones & Butman 2011:241).

Fundamental human problem

For Cognitive therapists, irrationality is a fundamental human problem. This view however, is not fully compatible with Christianity. The basic problem facing humanity for Christians is sin (both personal and brokenness of our world). Sin goes beyond our rationality; touching every aspect of human nature (Berkouwer 1971; McMinn 2008; quoted in Jones & Butman 2011:239).

Distorted standard of rationality

The goal of the CT therapist is to get rid of pathological emotional reactions. Beliefs or cognitions therefore tend to be judged by their usefulness rather than by their truthfulness. Jones & Butman (2011:242) give the following scenario to demonstrate this point. “Someone with a recurrent thought: “I am a sinner whose righteousness is as filthy rags before the lord; I am wholly without merit before him” brought substantial distress to its thinker, including loss of sleep and loss of enjoyment and worldly success”. In response, the secular therapist would challenge the belief by helping the client modify or eradicate such a thought, because it bothers the client. But the religious counselor may consider the negative emotional reaction to be appropriate because of the validity of the thoughts themselves, and then look for other explanations to explain the emotional agitation. “A time of true repentance and grieving over our sinfulness is a healthy part of the Christian life, and might be a rational response under these conditions” (Jones & Butman 2011:242).

Elevated cognition

Some CT therapies elevate cognition above emotion, thereby dismissing the essential role of emotion. The Christian approach recognizes the value of emotions as an important part of God’s image revealed in humanity. “All through Scripture we see that God experiences various emotions, including those we deem positive and those we deem negative. Jesus, the “image of the invisible God (Col 1:15), certainly experienced and expressed a diverse array of emotion – joy, sadness, anger, dread, grief, to name a few” (Jones & Butman 2011:242).

Focus of therapy

Secular cognitive therapy’s main emphasis is on psychological change. Spiritual and religious matters have no central or vital part in the model. Secular CBT therapists are trained to de-emphasize spiritual dimensions during the assessment, diagnosis and treatment process. Psychological manifestations of spirituality are usually ignored. Little importance is attached to a lack of spirituality; this is generally not viewed as requiring intervention.

‘Amorality’ of CT

From a Christian point of view, the ‘**amorality**’ of CT may be seen as problematic. In CT, therapy is governed by the client’s goals and values, as these have a bearing on the course of therapy. But CT lacks a clear theoretical vision for who a person should become. As explained by Jones & Butman (2011:246), “Because CT has a less well developed notion of the ideal human state than such theories as person-centred therapy, it is difficult for CT to be a growth psychotherapy – there is no built in compass pointing out the direction of growth”. CT’s lack of prescriptive focus allows for comfortable use by the Christian. The lack of value surrounding its techniques makes it more effectively adapted for use by the religious therapist.

The CT literature gives the impression that growth means the absence of anxiety, depression and discomfort; to be fully human therefore means to be without pain (Jones & Butman 2011:246). These assumptions lead to a shallow view of healing and growth.

Human maturity

CT therapists seem to be adept at helping one reduce their suffering, but less capable of producing growth. Jones & Butman (2011:248) describe this as a “superficial and anemic view of human maturity”. A pastoral approach seeks promotion of growth.

Healing versus growth

CT aims at symptom reduction. It is therefore viewed as more cost effective from an insurance company point of view. Thus, from an economic perspective to a short term symptom focused therapy is preferred, but, for a Christian the goals of psychotherapy are inevitably more complex than helping a person feel better. It would be a loss for Christian therapists to be so influenced by economic forces that they fail to explore newer depth oriented models of CT. But, it is also worth considering risks of emphasizing spiritual growth as a primary goal for psychotherapists. Christian therapists attempting to blend psychotherapy and spiritual direction face a number of ethical challenges (Jones & Butman 2011:248).

A pastoral approach however will offer spiritual direction with therapy, which helps clients look beneath immediate symptoms to see their deeper wounds and questions about life (Jones & Butman 2011:248).

Christian forms of cognitive therapy

One criticism of Christian forms of cognitive therapy is the superficial adding of religious imagery or Scriptures to mainstream approaches.

Therapy outcomes

Most cognitive therapists aim for symptom reduction as the primary outcome of therapy. But symptom reduction may not be that crucial for the Christian. “Perhaps some clients grow in depth of character and maturity through suffering even if they do not show dramatic decreases in symptom patterns. Conversely, some clients may show striking reductions in symptoms while avoiding the deeper issues of character development that need to be addressed” (Jones & Butman 2011:251).

Evaluation

Concerning some criticisms regarding CT and the Christian, Jones & Butman (2011:251) write: “.... one is left with a clear sense that there is much more to human beings than cognitive therapy would lead us to believe. Where is transcendence and spirituality? How do we understand self deception or evil? Does this view really plumb the profound depths of relationships and the terrific impact we have on one another.

Isn't emotion more than the output of cognitive habits? What about the conflict within the person; isn't this inevitable and indeed helpful to our understanding what it means to be truly human? How are we to grow? Are there any important regularities to the way we develop as human beings? Cognitive therapy's silence on each of these questions is disconcerting. It seems likely that we are what cognitive therapy depicts us as being: thinking and acting creatures who act on and are acted on by our environments for the purpose of obtaining that which we value. But it also seems clear to the Christian that we are more than this". "Nevertheless, given its many strengths, cognitive therapy is likely to be one of the more fruitful models for Christians to explore for its integrative potentials" (Jones & Butman 2011:253).

2.2.2. COMPATIBILITY OF REBT and RELIGION

Ellis's view of Religion

In the book titled, "Counseling and Psychotherapy with Religious Persons. A Rational Emotive Behavior Therapy approach," Albert Ellis is described as a "probabilistic atheist". By this is meant, that "he does not insist that there is no God, but rather considers the likelihood that there is a God or Gods or some other higher, lower, or otherwise supernatural existence so remote that altering his life style against that particular chance is unreasonable" (Nielsen, Johnson & Ellis 2001:xiii). Ellis however, did shift his views on religion a number of times during his career.

In his early formulations, Ellis considered religious beliefs to be irrational and contributory to emotional disturbance (Ellis, 1960, 1971, 1973; quoted in Dryden 1995:307). He viewed religious beliefs as being rigid in nature; and rigid thinking as being related to psychopathology (DiGiuseppe; Robin; Dryden 1990:357). Ellis thus correlated belief in religion with psychopathology.

According to Verhagen et al. (2010:345), Ellis claimed that any theistic religion would 'almost by necessity' instil a sense of sinful worthlessness in the religionist; that 'the concept of sin is the direct and indirect cause of virtually neurotic disturbance;' and that it is the task of psychotherapists to 'uninvent' God in their patient's lives. Consequently, many viewed REBT and religion as incompatible.

Johnson (2001:40) notes, in Ellis' early development of RET (when it was not yet renamed to REBT) he remained opposed to any notion of a positive or "healthy" manifestation of religious belief and behaviour (Ellis, 1960, 1971, 1973). During this time Ellis boldly claimed religious belief to be synonymous with emotional disturbance; and that there was a direct and linear relationship between degree of orthodoxy (religious commitment) and disturbance (Ellis, 1971; quoted in Johnson 2001:40). Ellis noted, "When and if humans fully accept the reality that there is no supernatural 'force' in the universe that gives a damn about them and ever will, they will then be truly humanistic" (1973:16) and "It (RET) is one of the

few systems of psychotherapy that will truly have no truck whatever with any kind of miraculous cause or cure, any kind of God or Devil, or any kind of sacredness” (1973:16; quoted in Johnson 2001:40).

In his later writings, Ellis moderated his views somewhat. It was no longer a belief in religion per se which led to psychopathology, but rather the absolutistic, rigid belief in any creed, whether it be a religious system or a socio-political philosophy. Ellis (1983) referred to any dogmatic adherence to a creed as "religiosity" (quoted in DiGiuseppe; Robin; Dryden (1990:357). So then, during this stage of his career, Ellis did not view religion itself to be the problem, but rather devout religiosity. Ellis defined religiosity as a devout, dogmatic, absolutist and rigid belief in a theological religion (e.g. Christianity or Judaism) or in a secular religion (e.g. Communism or Facism) (Ellis 1981, 1987b; quoted in Dryden 1995:307). Verhagen et al. (2010:345) states that even though Ellis continued to advocate that clients would greatly benefit from discarding religious beliefs, that ‘the less religious they are, the more emotionally healthy they will tend to be,’ he also said, that if clients refused to give up their religious beliefs, they can still live comfortably and healthily with a religion of the more liberal, non-absolutist variety.

In the 1980’s, Ellis modified his universal rejection of all religiousness as pathologic and acknowledged that some religious belief may not cause emotional disturbance (Ellis 1980, 1983; quoted in Johnson 2001:40). Calling himself a “probabilistic atheist,” he contrasted “mild” religiousness (moderate, liberal, or non orthodox belief) with orthodox, pious and devout religiosity (Ellis 1980). In his various writings, Ellis suggested that devout religiousness was often correlated with the following characteristics and symptoms: low self esteem; dependency; masochism; intolerance; rigidity; narcissism; hostility compulsivity; paranoia; depression; self hate; powerlessness, grandiosity; bigotry, suicidal terrorism, and lying (Johnson 1994; quoted in Johnson 2001:40).

Ellis again, reviewed his position on religion and mental health. This time declaring that one could be a practicing religionist and still be mentally healthy, and that even those who practice some form of absolutist and devout religiosity may be highly functioning people (Verhagen et al. 2010:345). In 2000, Ellis wrote: “Although I have, in the past, taken a negative attitude toward religion, and especially toward people who devoutly hold religious views, I now see that absolutistic religious views can sometimes lead to emotionally healthy behavior. Accordingly, I have attempted to describe some of the basic constructive philosophies of REBT and to indicate how they are similar to and compatible with basic religious philosophies. This appears to be particularly true of some of the REBT and benevolent religious philosophies of self control and change, unconditional self acceptance, high frustration tolerance, unconditional acceptance of others, the desire rather than the dire need for achievement and for approval, the acceptance of responsibility, the acceptance of self direction, the acceptance of life’s dangers, the philosophy of non perfectionism, and the philosophy accepting disturbance. There are many remarkable

similarities in some of the major religious and REBT attitudes” (2000:31; quoted in Dowd et al. 2006:11). This excerpt discloses a great deal about the complexity of Ellis’ thought on the nature of religion and the modification of his attitude toward the relationship between religion and mental health.

Ellis himself eventually co-authored a lengthy book/treatment manual for religiously oriented REBT titled, “Counseling and psychotherapy with religious persons. A Rational Emotive Behavior Therapy Approach” (Nielsen, Johnson & Ellis 2001). In this book, Nielsen, Johnson & Ellis (2001:3) describe REBT as an “Elegant Psychotherapy for Religious Clients”. They claim REBT to be “uniquely and exceptionally well suited to treating the problems and concerns of religious clients” and that “REBT can accommodate clients’ religious beliefs” (Nielsen, Johnson, Ellis 2001:3). They explain that REBT can accommodate the individual’s religious beliefs even when their religious orientation differs from that of the therapist. For this reason, a devoutly religious person they can still be treated by a nonreligious, atheistic, REBT therapist (Nielsen, Johnson, Ellis 2001:3). “Neither accommodating clients’ religious beliefs during therapy or integrating their religious beliefs in rational emotive interventions are at all foreign to the preferred practice of REBT. Because REBT is essentially a constructivist psychotherapy, it is both accommodative and integrative of client values and beliefs, including religious beliefs” (Nielsen, Johnson, Ellis 2001:3). “Although REBT can and usually does approach most problems from a neutral, constructivist perspective, its fundamental principles are quite sympathetic with most religious beliefs and may actually be closer to the Judeo-Christian position than most other systems of psychotherapy” (DiGiuseppe, Robin, & Dryden 1990:362).

This shows that some significant changes took place in Ellis’ view on religion and mental health. Ellis wrote (2000:29), “These writings have afforded me another opportunity to review some of my older views about devout religiosity being antithetical to good mental health and effective therapy and to bring them up-to-date and once again reverse some of them. Because I agree with Johnson, Ridley, and Nielsen (2000), and others, I had better review my former contention that dogmatic and absolutistic religiousness—or what I called “devout religiosity”—tends to be emotionally harmful (Ellis, 1983)”. “REBT, as I have said for many years, is highly compatible with liberal and non-absolutistic religion (Ellis, 1983, 1992, 1994a, 1994b). I now also see, however, that it can be compatible with some forms of absolutistic and devout religiosity” (Ellis 2000:30).

Ellis acknowledged the open-mindedness and emotional well adjustment of many religious people. He also noted some significant compatibilities between rational- emotive principles and many of the tenets of Judeo- Christian religions and endorsed the therapeutic benefits of Scripture and some Christian doctrines. Ellis even spoken favorably of the Bible saying, “The Judeo-Christian Bible is a self- help book that has probably enabled more people to make more extensive and intensive personality and behavioral changes than all professional therapists combined” (Ellis 1993:336;

quoted in Johnson 2001:40). Johnson (2001:41) writes, “Ellis (2000) even translated some of the primary tenants of REBT into what he refers to as the "God-oriented" language of Christian clients and acknowledged striking congruence between REBT and Christian doctrine”. This passage demonstrates Ellis’ evolving perspective on the compatibility of religiousness and REBT during his career. And of course, these changes were welcomed by those who viewed REBT as compatible with religion and as being an effective approach to handling religious problems in therapy.

2.2.2.1. Arguments supporting the compatibility of REBT and Religion

In my review of the literature, one of the first articles favouring the integration of religion (pastoral counseling) with RET (not yet named REBT) was way back in 1982, by **Lawrence and Huber**, titled “Strange Bedfellows? Rational-Emotive Therapy and Pastoral Counseling”. These authors advocated the use of REBT in the pastoral counseling context. They attempted to bridge the gap between psychotherapy and pastoral counseling and thereby proposed a form of RET with biblical precepts as a basis for their therapy (Lawrence and Huber 1982:212). They proposed this could be used by those seeking a more religious based psychotherapeutic approach. They viewed RET as being thoroughly based on a biblical premise - summed up by Proverbs 23:7, “As a man thinketh in his heart, so is he.” With regards to disputing irrational beliefs, they included scripture and the Bible in the disputation procedure, which they described as being “more therapeutically effective than when based on secular reasoning alone” (Lawrence and Huber 1982:211). They also identified a number of biblical quotes which could be used to dispute clients' irrational beliefs (DiGiuseppe; Robin; Dryden 1990: 356).

Sandra D. M. Warnock (1989) notes the helpfulness and harmfulness of religious beliefs. When irrational religious beliefs are highly valued, it may be necessary to confront these. Religious traditions often present logical and rational teachings that can be used to counteract such irrational beliefs. Warnock shows how Christian beliefs can be applied to RET for use with Christian individual’s (Reich & Hall 2005). She explains that RET therapists can deal with Christian clients by using the teachings and actions of Jesus to help them recognize that their irrational beliefs as not valid (Warnock 1989:263; 273). According to Warnock, a review of the New Testament reveals the logical and rational thoughts and behaviors of Jesus - which she uses to confront the individual’s irrational beliefs. In her 1989 article, “Rational-Emotive Therapy and the Christian Client”, she relates the behaviours and teachings of Jesus to the four basic irrational beliefs of demandingness; awfulizing; low frustration tolerance; and condemnation; as well as to eleven predominant, underlying irrational beliefs, thus using the Scriptures to dispute each of these irrational beliefs (Warnock 1989:265).

Young (1989:78) described how he used REBT with “Bible-belt Christians” (quoted in Dryden 1995:309). **DiGiuseppe, Robin & Dryden**, (1990) sought to show a compatibility between REBT with

Judeo-Christian philosophy (Robb 2001:23). They explain that three of the irrational thought processes assumed to produce psychopathology in REBT - demandingness, human worth and low frustration tolerance - have been presented as being inconsistent with Judeo-Christian philosophy. But, they put forward specific clinical strategies found to be useful when working with religious clients to change these three irrational beliefs (DiGiuseppe; Robin, Dryden 1990:355). They thus proposed that disputing irrational beliefs and establishing more rational philosophies is consistent with Judeo-Christian philosophy (DiGiuseppe; Robin, Dryden 1990:355).

DiGiuseppe; Robin, Dryden (1990:356, 357) found Ellis' personal philosophy, his writings on the relationship between religious beliefs and psychopathology, and his position on ethics, to be some of the reasons why RET was viewed so negatively with regards to religion. In his writings, Ellis claimed that irrational beliefs are at the core of psychopathology. Considering beliefs to be irrational if they met one or more of the following criteria: 1) illogical, 2) inconsistent with empirical reality, and 3) obstruct goal attainment (DiGiuseppe; Robin, Dryden 1990:357). Ellis lists the following 4 main irrational beliefs: demandingness, human worth, awfulizing and low frustration tolerance (DiGiuseppe; Robin, Dryden 1990:357). Of these, according to DiGiuseppe; Robin, Dryden (1990:356, 357) demandingness and human ratings, are the two irrational beliefs religious clients are most likely to present in therapy. They say, it is when disputing these, that psychotherapists are most likely to claim the incompatibility of RET with the Judeo-Christian religion. They also found that clients struggling to adhere to their religious or moral code usually present with low frustration tolerance beliefs.

Despite the lack of evidence linking religious beliefs with psychopathology, DiGiuseppe; Robin, Dryden (1990:358) noticed people frequently disturbed by their religious beliefs. They noticed that people do not become disturbed because of their belief in religion; instead their disturbance is the result of selectively abstracting certain elements of their religion to the exclusion of others. People rigidly adhere to one aspect of their religion, ignoring others. Disputing irrational beliefs (concerning demandingness and human worth) may thus actually help clients become re-aware of their Judeo-Christian belief system (DiGiuseppe; Robin, Dryden 1990:358). These authors thus support the compatibility of RET and Judeo-Christian philosophy. When employing REBT with religious clients, their belief system or moral values need not be challenged. DiGiuseppe; Robin, Dryden (1990:366) explain that the therapeutic interventions they present do not violate the clients' religious value systems nor impose the therapists' personal value systems upon the clients. The reason for compatibility with Judeo-Christian belief systems is due to RET working directly to change core philosophical beliefs; and disturbance resulting from misconstruing some of the philosophical core of religious beliefs (DiGiuseppe; Robin, Dryden 1990:366).

Another instance of compatibility between REBT and religion was described in the case excerpt and case study of **Nielsen, Johnson & Ridley** (2000). These authors proposed a religiously sensitive REBT (a

therapy that integrates religious belief with REBT). They identified a number of congruencies in the theoretical assumptions, existential, and philosophical natures of organized religion and REBT (Nielsen, Johnson and Ridley (2000:21). Given the similarities and congruencies between the two, these authors thought to use this opportunity to enhance the effectiveness of their psychotherapeutic interventions with religious clients.

Harold Robb (2001:29) combined the principles and practices of REBT and religious beliefs to reduce psychological dysfunction associated with *supernatural belief* systems. Robb expanded on the extent to which REBT could be used with supernatural belief systems, “REBT can work in concert with supernatural beliefs and practices that, over the long term, reduce or avoid feeling and behavioural disturbances and enhance joyful living (Robb 2001a:33). In a separate article, he spoke about REBT as a source of spiritual transformation (Robb 2001b:153; quoted in Robb 2001:29).

Other theorists have also written on the compatibility between REBT with Judeo-Christian philosophy i.e. in their case reports (Lawrence, 1987); or empirically (Johnson 1992; Johnson, Devries, Ridley, Pettorini & Peterson, 1994; quoted in Robb 2001:23). Several other writings on the profound similarities between the premises of REBT and Christian theology include: Beeman, 1978; Beit-Hallahmi, 1980; Carter, 1986; W.B. Johnson 1992; Jones 1989; Lawrence, 1987; Nielsen, 1994; Young, 1984; quoted in Nielsen, Johnson, Ellis 2001:4). The controlled clinical trials by Johnson, Devries, & Ridley (1994; quoted in Dowd et al. 2006:10) and Johnson & Ridley (1992) support the efficacy of integrating Christian scripture with REBT. Those committed to developing Christian versions of REBT include: Hauck, 1972 (quoted in Jones & Butman 2011:214); as well as Backus 1985; Johnson, W.B. 1993; Powell 1976; Robb 1988; Stoop 1982; Thurman 1989 (quoted in Nielsen, Johnson, Ellis 2001:4); Nielsen, S. L.; Johnson, W.B. & Ridley, C. R. 2000; Johnson & Ridley 1992.

Jones & Butman (2011:214) describe Ellis as a rather staunch atheist and hedonist. But, despite this, they reckon that REBT interventions need not be rooted in the worldview assumptions of its founder. One can use Christian principles instead of hedonistic principles to discern what is rational. Ellis (2000) eventually acknowledged this too (Jones & Butman 2011:214).

Nielsen, Johnson, Ellis (2001:4) in their argument for REBT as a suitable treatment approach for religious individuals, claim that most people are in some way, religious. Most people are religious and most psychotherapy clients will be religious. They say, that most people either belong to or participate in a church, temple or religious tradition; and believe in a deity or some other religious, mystical, supernatural, or spiritual principle or reality (Nielsen, Johnson, Ellis 2001:4). This then suggests that most individual’s seeking therapy will endorse some kind of religious faith or commitment. The problem

of this is that (as mentioned before) religious beliefs either contribute to one's problems or present possible solutions. This is the focus of this chapter.

2.2.2.2. Points of contradiction between REBT and Religion

In 1984, Richard Wessler wrote a critique titled, "A bridge too far: Incompatibilities of Rational Emotive Therapy and Pastoral Counseling." In this article he argued against the compatibility of pure RBT with pastoral counseling (RBT had not yet been renamed REBT). In this article, Wessler critiqued Ellis's view of religion, his atheistic view of ethical humanism and his dogmatic stance on 'must statements' - stating these as evidence for the incompatibility of RET and pastoral counseling (Wessler 1984:264). Wessler also critiqued Ellis's personal philosophy as being the basis for his theory of disturbance, rather than scientific evidence (Wessler 1984:264).

According to Wessler, Ellis inconsistently used the word 'must'. He writes, "Note that "must" means in one place "forbidden to do" and "unable to do" in another. Ellis apparently does not know much about Christian faith, because he assumed that one is unable to do what one is forbidden to do. This assumption ignores freedom of choice that in Christian faith is given by the same God that gives laws. It is difficult to see how a pastoral counseling approach can be reconciled with Ellis's views" (Wessler 1984:264). Wessler claimed that there was an emphasis on scientific thinking rather than religious thinking and Ellis required scientific evidence to support a 'must statement'. If this could not be done, Ellis regarded such a statement as being "unscientific, anti-empirical and irrational," which Wessler viewed as being antithetical to pastoral counseling (Wessler 1984:264). Wessler held that Ellis disputed client's musts inaccurately, that no empirical data supports Ellis's hypotheses of must; and that they solely stem from Ellis's atheistic views (Ellis 1984:266).

In addition, Ellis equated neurosis with religion, and espoused atheism as a cure for neurosis (Ellis, 1978, quoted in (Wessler 1984:264).

Wessler held that Ellis's RET was against client's religious beliefs (the disputing of irrational ideas) and as trying to convert clients to humanistic atheism or agnosticism (Wessler 1984:265).

Wessler held that Ellis attacked virtually all religious views and values, "Instead of working within client's value systems, Ellis actively attempted to convince them of their wrong headedness" (Wessler 1984:264). According to Wessler, Ellis clearly proclaimed irrational thinking as synonymous with religious thinking (Wessler 1984:265).

Thus, for Wessler, those concerned with pastoral counseling and spiritual aspects would find pure RET disappointing (Wessler 1984:265). He did however claim that certain aspects of RET are compatible with pastoral counseling and that one could build on these to bridge the gap between psychotherapy and religion (Wessler 1984:265). In doing so, Wessler proposed a modified version of RET, called Cognitive Appraisal Therapy (CAT), which he recommended as a replacement therapy that would be more compatible with pastoral counseling (Wessler 1984:264). Wessler claimed that his modified form of RET, significantly differs from RET (Ellis 1984:267).

In a later article, Ellis (1984) responded to Wessler's critique. He stated that Wessler himself had built a bridge too far, and in his defence, responded to each of Wessler's criticisms (Ellis 1984:266). Again, this was later followed by further back and forth commentary between the two, but I will not go into any of these details. My main point here was to highlight Wessler's critique of Ellis' RET (REBT).

Another point to support the incompatibility view is owing to **Ellis'** view on morality and ethics. According to Ellis, there are no absolute truths in the world and that moral rules were created by people and cultures. He also viewed these to be constantly changing and in flux. This view differed significantly from those of Religion. Religion's views are that moral and ethical guidelines are revealed by God and are absolutely true for all time. This caused disparity between REBT as being helpful for religious individuals (DiGiuseppe; Robin; Dryden (1990:357).

Ellis' personality and personal beliefs also contributed to the incompatibility view. The close ties between Ellis' personality and REBT theory gave the impression that REBT also includes all of Ellis' personal beliefs. To clarify this point, DiGiuseppe; Robin; Dryden (1990:356) explain that Ellis' writings include: 1) his personal philosophy; 2) a philosophy of living based upon stoic and existential philosophies; 3) a theory of psychopathology; 4) a theory of psychotherapy and behavior change.

Those who see only Ellis' personal philosophy, resist the idea of treating Christians with REBT. But these authors clarify, that despite Ellis' personal influence on REBT theory, these are not necessarily part of the rational emotive philosophy of life or theory of psychopathology (DiGiuseppe; Robin; Dryden 1990:356). For example, they point out that many pastoral counselors have been trained in psychoanalytic therapy despite Freud's atheism (DiGiuseppe; Robin; Dryden (1990:356). We are therefore reminded that Ellis and REBT as two distinct entities – the one being a person and the other a theory. Despite the difficulty of separating one's image of a theorist from the theory, they are however distinguishable (Dryden 1995:307). Along the same sentiment, Verhagen et al. (2010:345) writes, many religiously-active psychologists have embraced REBT, considering Ellis' personal anti-religious attitudes to be a separate issue from the therapeutic value of his method.

It seems, that even though Ellis himself was an atheist, there is nothing contraindicated about using REBT with religious clients. Stanton & Butman 2011:214 write, "...the theoretical shallowness of his approach (Ellis) means that REBT interventions need not be rooted in the worldview assumptions of its founder. One can use Christian principles instead of hedonistic principles to discern what is rational – something Ellis (2000) eventually acknowledged". Even though Ellis was always quite open about his view of religious beliefs (though these eventually changed somewhat), the literature shows other REBT therapists who also adopted irreverent approaches to religious beliefs. In his approach, **Young (1984)** disguised the principles of REBT in the religious language of the client. He also recommended that if the need arose, one lie to their clients about their religious affiliation. "If you are backed into a corner and nothing less than a straight 'yes' or 'no' answer is acceptable, I strongly recommend you lie and tell the client you are a firm believer" (p. 127; quoted in Johnson 2001:42). It was also not a problem to contradict the religious beliefs of the client by reinterpreting or making up scriptures, "I am not interested in whether or not I am biblically accurate, nor am I the least bit interested in checking up and finding out if what I have to say or even what the client has to say is actually found in the Bible" (p. 129; quoted in Johnson 2001:42).

Another criticism is who determines what is rational or irrational thinking? For example, some clinicians determine rationality themselves and then pass their values onto their client. This is a form of relativism that is highly vulnerable to error because it emerges out of one person's worldview. The problem with such an approach is that it is not subject to larger systems of determining truth from untruth and therefore remains unaccountable. Albert Ellis carried out such an approach when he formulated his lists of irrational beliefs (Jones & Butman 2011:209).

2.3. AN EVALUATION OF DESTRUCTIVE THINKING IN CBT LITERATURE

The section that follows seeks to describe "destructive thinking" in CT and REBT respectively. The aim is not to evaluate the actual therapeutic theories, but rather to evaluate destructive thinking within each theory; and to explore this further.

2.3.1. An evaluation of destructive thinking in Cognitive Therapy (CT)

We often think in unhelpful ways without even realizing it, for example, by jumping to conclusions, etc. The thinking process is filled with faulty assumptions and unexamined beliefs that cause the individual to experience unnecessary distress. Thinking errors are actually very common, but this does not mean that they are harmless. The way one thinks impacts how they feel and how they behave. This means, thinking in unhelpful ways, is more than likely to lead to emotional or behavioural difficulties.

In CT, cognition is viewed as occurring at different levels, organized in a hierarchy according to availability and accessibility to awareness. The least available to awareness and most stable cognitions are one's core beliefs - about self, the world and the future. To the CT theorist, core beliefs can either be reasonable or they reflect some degree of error in logic (Fall et al. 2010:270).

Beck devised the cognitive triad. The cognitive triad involves automatic negative thoughts about oneself, the world and the future. The following example illustrates destructive thinking as experienced by a depressive person, following the three main themes of the cognitive triad. CBT therapists argue that depressed people usually view (1) themselves as inadequate, incapable, abandoned, and valueless; (2) the world, as exceedingly demanding; (3) and the future, as hopeless, with very little improvement from their present negative conditions. This last perception is associated with the emotion of hopelessness and is considered a high predictor of suicide (Fall et al. 2010:273). When all the symptoms are combined - the motivational component of "paralysis of will;" the behavioural components of inactivity; eating and/or sleeping too little or too much; the cognitive component - a feedback loop is created that reinforces the depression (Fall et al. 2010:273). These thoughts focus the individual's attention on negative aspects of life and information processing. The more distorted their perception becomes, the more their selective attention is placed on failures and everything is processed and approached in a negative manner, albeit unconsciously.

CT therapists are usually attentive to biases in thinking. The less bias characterizing one's thinking, the healthier the person is considered to be. Fall et al. (2010:273) state, "The phenomenon of psychopathology.... are on the same continuum as normal reactions, but they are manifested in exaggerated and persistent ways". When individuals hold biased core beliefs, they tend to display rigid kinds of thinking (cognition). Take for example, a well adjusted individual who experiences a normal bout of worry or anxiety under normal life circumstances; and a poorly adjusted individual, who under the same circumstances, experiences their anxiety as being more intense, chronic and dysfunctional i.e. in the form of an anxiety disorder. The beliefs and schemas that people construct bring about dysfunctional and destructive patterns of thinking and living which give rise to emotional and behavioural difficulties. Fall et al. (2010:273) explains that individual's typically have one or more core beliefs that stray from the ideal range of the continuum. But when the individual has core beliefs that are located far (or very far) from the ideal range, these symptoms usually meet the criteria for DSM-IV-TR Axis I disorders and Axis II personality disorders, respectively.

The CT literature identifies a number of common cognitive distortions. Rhoads (2011:26) describes cognitive distortions as automatic thoughts that are often irrational, illogical and self-defeating. Those listed by Beck include: arbitrary inference; selective abstraction, overgeneralization, magnification and minimization, personalization, dichotomous thinking. Burns (quoted in Fall et al. 2010:275) added the

following to Beck's list: Jumping to conclusions, mental filter, blame, all or nothing thinking, disqualifying the positive, emotional reasoning, should statements, labelling and mislabelling. Disqualifying the positive and "should" statements are errors others have proposed (Freeman et al. 1990; quoted in Ford et al. 1998:398).

But one may wonder what makes these 'cognitive distortions' so problematic? Well, to start, they are located out of conscious awareness beneath the individual's voluntary thought (cognitive) system. That is, within the individual's automatic thoughts, intermediate thoughts and core beliefs (Fall et al. 2010:274). They are associated with distressing emotions and non adaptive behaviours, which form a feedback loop that perpetuates distorted thinking, self defeating feelings and behaviours (Fall et al. (2010:275). The greater the cognitive distortion, the greater the problem that is likely to develop, since their guiding schemas include these errors (Ford et al. 1998:398). Rhoads (2011:26) reckons, if cognitive distortions occur regularly, they can result in patterns of ineffective behaviour.

Schemas are located at a deeper level (of cognition). They are stable cognitive patterns, based on early life events, that function as a template through which one organizes their experiences in a meaningful way. After regular reinforcement, these schemas become very rigid and new information becomes processed in accordance with the schema. If the schema is distorted, the false belief is confirmed. Brandell (2011:485) claims that all schemas involve some degree of distortion; and that the more distorted they are, the greater the risk that they will lead to serious misinterpretation of real life events and, consequently, to depression. This shows that once distorted schemas exist and function, incoming information is usually distorted, misrepresented, or biased to fit them (Robns & Hayes 1995; quoted in Ford et al. 1998:398). However, the presence of maladaptive schemas does not automatically lead to depression (Friedman and Thase 2006; quoted in Brendell 2011:35) some schemas can remain dormant or silent for many years.

Nevertheless, once cognitive patterns are constructed, they tend to become habitual and automatic, but out of conscious awareness. They usually influence the individual's behaviour without them even being aware of it. People are usually unaware of their underlying assumptions, beliefs, expectations or schemas and how these determine the way they perceive events, choose their actions and evaluate the consequences of their actions (Ford et al. 1998:393). As explained by Coombs (2005:347) when one lives by dysfunctional schemas, these negatively impact their view of the world and potentially their mental health. Rhoads (2011:26) reckons, emotional distress is the result of faulty habits of thought, which in turn produce dysfunctional attitudes and behaviours.

Even though people are generally aware of what they are doing and how they are feeling, they typically do not pay too much attention to, or think about, the ideas that are organizing their behaviour. They do

not express to themselves the rules and concepts that guide their interpretations and reactions. The disadvantage of this, is that people unknowingly behave in ways that may be harmful or detrimental to themselves and their goals (Ford et al. 1998:393). Through therapy, these habitual beliefs and schemas can be made conscious and changed (Ford et al. 1998:393).

Despite the existence of reality, people tend to select and interpret what they consider to be real, and by doing so, produce interpretations that vary with degrees of accuracy. The conclusions they form (about themselves, others and the future) are therefore inclined to be absolutistic, overgeneralized, or illogical (Beck et al. 1979; quoted in Ford et al. 1998:398). CT therapists are of the opinion that people create their own unhappiness and distress, which they say, can be traced back to the way one thinks. Faulty thought processes are therefore viewed as the cause of problematic behaviours and emotions. Ford et al. (1998:398) states, “The psychological wounds from which they suffer are primarily self-inflicted, the emotional sufferings they undergo are their own doing, and their behavioural inefficiency and ineffectiveness their own creation”.

2.3.2. An evaluation of destructive thinking in REBT

In this section, I evaluate destructive thinking in REBT literature. REBT theory provides us with several powerful insights on destructive thinking. For instance, Corsini et al. (2010:198) explains that most neurotic problems in REBT involve unrealistic, illogical or self defeating thinking. In REBT, the individual's belief system is considered the core of maladjustment. Irrational beliefs, originate from constructing a “musturbatory” belief system or ideology. “Demandingness” cognitions are the primary mediators of emotional disturbance. REBT suggests that cognitions associated with emotional disturbance and psychopathology stem from these “demanding” beliefs (Reinecke et al. 2002:223). These are the “musts,” “shoulds,” “ought's” and “have-to's,” that commonly comprise our beliefs. Such beliefs are based upon dogmatic, rigidly held schemas that the world must be how one wants it to be. These beliefs are considered irrational because they insist in a kind of magical way that something ‘should’, ‘ought or ‘must’ be different from the way it is. Ellis et al. (1997:189) describes irrational beliefs as illogical, unrealistic, bringing undesirable practical consequences; the cause of extensive emotional unhappiness and the cause for blocking one from achieving their goals in life.

Coombs (2005:343) says, a major downside of irrational beliefs is that, if left alone, they become the primary filter through which one interprets the world. If this filter is not corrected, the risk of developing mental health problems, such as anxiety and depression, increases.

Thus, another possible consequence of ‘absolutistic musturbation’ is anxiety and depression (Ellis 1975; quoted in Reinecke et al. 2002:223). When the individual ‘prefers’, ‘wishes’ or ‘desires’ to accomplish

particular goals but fails to achieve these, they may experience sadness and regret, but not clinical depression. But when they escalate these preferences into dogmatic demands, and convince themselves that they absolutely 'should', 'must' and 'ought to' achieve these goals, they become susceptible to depression (Reinecke et al. 2002:223). Examples of irrational musturbatory derivative thoughts include: "awfulizing," "I-can't-stand-it-it-is," "damnation", "always and never thinking" (Fall et al. 2010:304). These thoughts can be distinguished from rational thoughts, by their qualities of extremeness and rigidity. Since they are so rigid and unrealistic, they tend not to withstand rational scrutiny. A problem of holding such irrational beliefs and thoughts is that people tend to re-indoctrinate or reconfirm these beliefs to themselves. And by doing so, they perpetuate the irrational belief cycle, making it very resistant to change (Fall et al. 2010:305).

Secondary disturbance is another reason why irrational beliefs are considered problematic. Fall et al. (2010:305) describe secondary disturbance as taking place when people lay a second disturbance over a primary one, and include the following as examples: becoming anxious about being anxious; feeling hopeless about depression; and worrying about insomnia (Fall et al. 2010:305). Secondary disturbances tend to make the primary problem worse and more difficult to treat. They form a barrier between rational disputation and the primary problem. They also prevent treatment of the primary disturbance, increase the level of irrationality, and increase the amount of psychological disturbance (Fall et al. 2010:305).

With regards to examining destructive thinking in REBT theory, it should however be noted, that not all negative emotions are considered unhealthy and not all positive emotions are healthy. Fall et al. (2010:305) claim it is the extremeness and rigidity of these and their consequent emotions and behaviours that are the determining factors. This can be illustrated by the following example: when one incurs a loss, feelings of sadness may result. But when these progress into debilitating depression, this is considered an unhealthy reaction. Rigid beliefs about activating events give way to self defeat, whereas flexible beliefs about activating events give way to more self actualizing consequences (Fall et al. 2010:305).

2.4. CONCLUSION

The aim of this chapter was to grasp the reality of how real our thoughts actually are. In doing so, to foster a better understanding of the effect of destructive thoughts and the way our thinking affects our health and well being. The continuous experience of destructive and toxic thinking has a negative impact on our general well being and functioning as an individual and as a society. For this reason, I have largely focused on understanding destructive thinking.

Understanding our thought patterns reveals a lot about our moods. Much psychological distress also often goes unrecognized, untreated or undertreated. Thoughts can be managed and harmful ways of thinking eliminated. This is a crucial insight, that our thoughts are controllable. We can choose to be free and take control of our thinking. The significance of this chapter can be summed up by the words of Dispenza (2007:44), “What we think about and the energy and intensity of these thoughts directly influences our health, the choices we make, and ultimately our quality of life;” And “If we wait until we feel like changing, we’ll never change” (Baker 2007).

In the next chapter “destructive thinking” is explored further within the Pastoral Care and Counseling context. My inquiry here is to discover what types of destructive thinking is commonly experienced by the Christian counselee. In addition, I reflect on a number of issues that need to be considered when analyzing destructive thoughts from a Christian perspective, such as inappropriate God images, spiritual maturity and faith pathology. Furthermore, I take a closer look at destructive types of religious thinking; and destructive thinking within the realm of belief systems. As I continue to probe these concepts i.e. faith pathology; inappropriate God images; spiritual and faith formation, and so on, I hope to find the connection between these and one’s thoughts/thought patterns. These ideas will be explored further in chapter three.

CHAPTER 3

DESTRUCTIVE THINKING WITHIN THE INTERPLAY BETWEEN RELIGION AND CHRISTIAN SPIRITUALITY

INTRODUCTION

In the previous chapter, destructive thinking was explored within the CBT psychotherapeutic approach. A number of destructive types of thinking were identified i.e. common thinking errors or cognitive distortions, such as all or nothing thing thinking or Catastrophizing, in the CT literature. In REBT, irrational beliefs such as awfulizing or low frustration tolerance were listed, to mention a few. Besides these identified in the CBT literature, I now seek to explore the kinds of ‘destructive thinking’ that may present itself within the pastoral care and counseling context. This will be the focus of the current chapter and will include a discussion of the unique interplay between religion, Christian spirituality and destructive thinking.

In my endeavour to understand destructive thinking from a pastoral or Christian point of view, I begin by looking at the types of destructive religious thinking found within the pastoral care literature. For instance, I explore the notion of when spirituality and religion become ‘sick’ and what it means to be thinking in destructive ways about God. At this point, my attention is drawn to appropriate and inappropriate God-images. I examine one’s cognitive and emotional experience of God, particularly when these have ‘gone wrong’ i.e. in the form of inappropriate God-images. The reason for my continuous probing here is to link together these destructive types of religious thinking with spiritual dysfunction and faith pathology. The assumption here is that destructive types of religious thinking have an adverse effect on the individual, those around them, and their relationship with God. The effect of these thoughts on one’s spiritual journey will therefore be explored further, as well as their potential consequence on one’s health, relationships, and sense of God’s presence and grace in their lives. A study of this nature represents a worthy pursuit because of the potential impact of one’s thoughts on their life, well-being, spiritual maturity and larger faith community. I continue with an exploration of destructive thinking within the realm of belief systems. Various types of ‘destructive religious thinking’ and their impact on spiritual formation, spiritual maturity and faith maturity within the Christian faith are also discussed here. The purpose of this latter section is to determine which destructive types of religious thinking pose as ‘risk factors’ for faith development, psychological and spiritual well-being. I am sure, that in my own approach to the current chapter and interpretation of the relevant literature, I will be influenced by my own personal Christian faith tradition and beliefs. My hope is that this literature review and critical discussion will contribute to the growing body of pastoral care and counseling literature. As well as address the theological challenges raised by the literature on destructive types of thinking in the

pastoral care and counseling context. The knowledge gained from this research will be useful for those working in a theological or pastoral context to guide individuals and faith communities towards spiritual wholeness and 'a mature faith'. In the next chapter, I move towards a pastoral model of spiritual healing and wholeness.

3.1. DESTUCTIVE TYPES OF RELIGIOUS THINKING

When spirituality and religion become 'sick'

According to Louw, it is possible for religion and faith to become 'sick.' This is particularly the case when one holds rigid views characterized by a strong, underlying moralistic undertone (Louw 2008:140). Louw writes: "An attempt to manipulate God in the light of selfish needs also causes a distortion of faith. Usually a negative concept of God is the underlying cause of a sick religion and a distorted faith, which correlates with negative personal behaviour and thought. Fear and anxiety are also underlying factors, so that religious acts are not motivated by gratitude, but by an exaggerated fear and a search for security against feelings of being threatened. This exaggerated need for security, driven by perfectionism, soon denigrates into pathology. Such an existential form of anxiety is the result of a threat of loss, death, guilt and ultimate meaninglessness" (Louw 2008:140). The consequence of an inaccurate or false representation of God may be a 'distorted and sick faith' (Louw 2008:140). "A misrepresentation of God has at its root a fallacy of thinking, which creates a distortion of God in one's mind (one then does not take into account that in the case of suffering, faith does not know why in terms of the immediate, but it knows why it trusts God, who knows why in terms of the ultimate (meaning). An unfounded judgment of the situation is then made. The fallacy grows into the problem of making a judgment on God" (Louw 2008:141). Further, "The real temptation to doubt does not come in not believing God but in believing what is not God. The danger is that we press judgment too far and our speculation creates such a distorted picture of God that we cannot continue to believe in good faith. To believe the wrong thing is always halfway to believing nothing. Our misrepresentations of God are so pathetically inadequate or monstrously hideous that to believe in Him any longer is unnecessary or repugnant" (Guinness 1976:203; quoted in Louw 2008:141).

When our thinking about God becomes fractured

The link between one's thoughts (cognitions) and spiritual and psychological well-being becomes clear when one considers the nature of an individual's relationship with God. What happens when one's thinking about God becomes fractured? What happens when one feels unable or unwilling to forgive God for disappointing or hurtful events they think were caused by God? According to Strelan et al. (2009:204) religious individuals who attribute certain events to God may experience a reduction in psychological and spiritual well-being. But religious beliefs are usually thought to be associated with enhanced well-being. The distinguishing difference here may be the level of one's spiritual maturity. Spiritual maturity seems

to be related to better coping, particularly with regards to disappointment and hurt that the individual attributes to God (Hall & Edwards 1996; quoted in Strelan et al. 2009:204). When one harbours anger, disappointment or an unwillingness to forgive God - these have been found to be related to poorer mental health outcomes i.e. depression and anxiety (Strelan et al. 2009:203).

Some religious individuals have unknowingly sabotaged their recovery in a hospital setting, by becoming upset with God or believing that God has abandoned them. Powell et al. (2003) explain that cognitions such as these have a 'negative impact on mortality, morbidity, and disability' (quoted in Strelan et al. 2009:203). Individuals who have a more mature faith have a better understanding of the dynamics of human relationships, i.e. that relationships are never perfect and have their ups and downs. So are relationships with God. Disappointments and hurts that occur too need to be negotiated and resolved, a relationship with God requires reciprocity (Strelan et al. 2009:204). These individuals are able to be constructively critical of the nature of their relationship with God; cope better with being disappointed with God; and, consequently, experience more enhanced well-being (Strelan et al. 2009:204). Individuals who are more spiritually immature tend to view God's role in their relationship in an uncritical, black-and-white, and rather simplistic manner. They find it difficult to reconcile ambiguity in their spiritual lives; have very little or no trust in God; and view God as unloving. These negatively impact on their coping, particularly when disappointing and hurtful events are attributable to God (Hall & Edwards 1996; quoted in Strelan et al. 2009:204).

The relationship between disappointment with God, psychological and spiritual well-being may be better explained, by looking at one's commitment to a relationship with God, level of spiritual maturity, and extent to which one has a forgiving disposition (Strelan et al. 2009:210). "A religious person may be disappointed with God, but the greater his or her level of spiritual maturity and the more predisposed he or she is to forgive, the less likely he or she is to report depressive symptoms; people disappointed with God are less likely to experience stress if they are spiritually mature. Furthermore, a commitment to a relationship with God and a predisposition to forgive suggests an explanation for why individuals disappointed with God are still able to experience spiritual well-being" (Strelan et al. 2009:210).

3.2. THE ROLE OF GOD-IMAGES IN DESTRUCTIVE THINKING

The research seeks to clarify here, what is "destructive thinking" in the Pastoral Care and Counseling context? Can destructive or unhelpful God-images be identified? Is there a relationship between one's thinking about God (image of God) and psychological well-being? What are the effects of destructive thinking about God (God-images) on one's spiritual well-being? Does one's perception of God have a direct impact on their spiritual and psychological well-being? What is meant by an appropriate God-image? What is the role of God-images in destructive thinking? Answers to questions such as these are

pertinent in developing an understanding of destructive thinking in a pastoral care context. According to M.E. Cavanagh, how Christians perceive God has a significant influence on how they live each day. A lot of the problems people present to ministers are actually caused by or contributed to, their unhelpful perceptions of God that are psycho spiritually ‘unhelpful or damaging’ (1992:80, 75; quoted in Louw 1998:233). Examples of unhelpful God perceptions listed by Cavanagh include: God as vengeful; God as needy; God as our caretaker and God is our tutor (quoted in Louw 1998:233). All humans have some form of a representation of God, whether they have a faith or not (Jones 1995; Rizzuto 1979). By claiming not to have faith, means to not have faith in some particular representation (Jones 1995; quoted in Peloso 2008:16).

The literature review reveals a relation between God-images and various aspects of psychological and spiritual well-being. The central theme here is to confirm the link between one’s thoughts (destructive thinking) about God (God-images) and psychological and spiritual well-being. This is of particular importance to this field of study and sets it apart from being just another human science interested in the phenomenon of religion. Most psychotherapy also tries to avoid dealing directly with images of God (Goldberg 1996; quoted in Stone 2005:2). But Pastoral counselors cannot afford do so, as they are in the unique position to relate to and assist in the transformation of destructive or inappropriate God-images.

God-Images and God Concepts defined and distinguished

Ana-Maria Rizzuto in her research distinguished between the God concept and God-image (Lawrence 1997:214). God-images and God concepts are distinct concepts that should be distinguished from one another (Hoffman 2011). Together, these two concepts form the God representation (Jonker et al. 2008:502). In much of the current scientific literature the two concepts God-image and God concept are used synonymously. But they seem to have taken on a broader meaning than Rizzuto originally intended (Jonker et al. 2008:502). Many researchers have not distinguished between these two concepts, sometimes using the terms “God-image” and “God concept” interchangeably (Grimes 2008). According to Hoffman (2010) God-images and God concepts can be in contradiction to one another, i.e. when one believes God to be loving and compassionate, while at the same time experiences God as being cold and distant.

o God-Images

The God-image, according to Hoffman (2005) refers to how a person conceptualizes or thinks of God; feels toward God, and how the person believes God feels about them i.e. it is their emotional or relational experience of God. The God-image has a predominantly affective quality (Jonker et al. 2008:502). It is an unconscious phenomenon, and it is distinct from the God concept. God-images, according to Steenwyk et al. (2010:86) are personal schemas that people hold about the nature and characteristics of God. These have been described as being negative and positive, loving and controlling, rejecting and

accepting, and maternal and paternal (Benson & Spilka, 1973; Dickie et al. 1997; Krejci 1998; Nelson, Cheek, & Au 1985; Vergote et al. 1969; quoted in Steenwyk et al. 2010:86). God-images are described in Davis (2009:22) as: “internal working models of a specific divine attachment figure (DAF) e.g. God, Allah, Jesus, Mary, Buddha, Krishna, and many others, and the self as experienced in relationship with the DAF” (Badenoch 2008); “Relational and emotion schemas that underlies a person’s actual emotional experience in relationship with the DAF” (Baldwin 1992; Bucci 1997). They reflect the person’s ‘heart knowledge’ of the DAF (Gibson 2006); described as ‘implicational religious cognitions’ that correspond to the DAF as personally experienced (Gibson 2006; Teasdale & Barnard 1993); ‘emotion laden mental representations’ consisting mainly of implicit thoughts, memories, and knowledge (particularly implicit relational knowledge) (Noffke & Hall 2007; Kihlstrom 2008; Lyons-ruth et al. 1998; quoted in Davis 2009:22).

God-images are learnt through implicit, emotional, and incidental learning (Davis 2009:23). Their function is to guide and integrate how a person experiences the DAF at an emotional, physiological, largely nonverbal, and usually implicit level or outside of conscious awareness (Noffke & Hall 2007; quoted in Davis 2009:23). God-images are activated when certain learned intrapersonal cues (e.g. active moods, schemas, needs, goals) and situational cues (e.g. features of the religious/spiritual environment and relationship partners who are present; occur (Mischel & Shoda 2008; quoted in Davis 2009:23). God-images are processed by (a) the emotional-experiential information processing system (Epstein 1994); (b) Using right hemispheric, cortical-subcortical brain circuitry (Garzon 2007; Badenoch 2008); (c) Within the psychological unconscious and preconscious (Hall et al. 2005; Kihlstrom 2008); (d) In a reflexive, fast, automatic, stimulus-driven, and holistic manner (Gibson 2006; Epstein 1994 Metcalfe & Jacobs 1998); (e) Via parallel distributed processing systems (Gibson 2006; Bucci 1997); and (f) At the sub symbolic and nonverbal-symbolic levels (Noffke & Hall 2007; Bucci 1997; quoted in Davis 2009:23).

When an individual’s experience of God is inaccurate and distorted, change may be called for. Louw says, “Without a clear understanding of the appropriateness of one’s God-image, one’s Christian faith can even become a confusing matter rather than playing a helpful and healing role” (Louw 1998:249). It is possible for one to change their God-image. Garzon’s theory explains the God-image to be an emotionally laden concept, connected with the function of the right brain. Therefore, interventions targeted at this part of the brain through emotional connections with the God concept may be successful in producing change in one’s problematic God-image (Thomas 2009:21). Therapy may thus have a positive influence on one’s God-image. “The therapeutic relationship in a positive counseling experiences may change the composition of neural networks associated with authority figures and thus change one’s God-image even when God is not brought up directly” (Garzon p.143; quoted in Thomas 2009:22). Noffke and Hall (2007) proposed spiritual imagery as inner healing exercises to help individuals repair their God-image and develop new neural pathways necessary to experience God as

loving, safe and intimate (Thomas 2009:22). A person's God-image will thus change over time to meet his or her ongoing needs. The God-image also helps one to learn and negotiate in the world and provide consistent soothing and comfort (quoted in Gravitt 2011:303). God-images are important sources for understanding how an individual builds a foundation of faith and engages in the world spiritually (Peloso 2008:15). Gerkin writes: "a shift in pastoral theology must take place in the way God is perceived: away from images of power and apatheia, towards images of pathos and suffering" (Gerkin 1991:109; quoted in Louw 1998:16).

o **God Concepts**

Jonker et al. (2008:502) describe the God concept as having a predominantly rational/cognitive quality. The God concept refers to one's cognitive understanding or beliefs about God. It is largely conscious and rational, based upon what a person is taught about God, and is influenced by one's parents or teacher's religious teachings (Hoffman 2005). The God concepts is described in Davis (2009:23) as a: "theological set of beliefs about a specific divine attachment figure's (DAF) traits; about how that DAF related with, thinks about, and feels toward humans (including the self); and about how humans (including the self) should relate with, think about, and feel toward the DAF". These (doctrinal schemas) underlie a person's conscious, linear knowledge about the DAF. That is, they reflect the person's 'head knowledge' of the DAF and can therefore be described as 'propositional religious cognitions' that correspond to the DAF as theologically understood" (i.e. knowledge about, Gibson 2006; Teasdale & Barnard 1993; quoted in Davis 2009:23). God concepts are 'emotion-neutral mental representations' that are comprised primarily of explicit thoughts, memories, and knowledge, particularly explicit declarative knowledge (Siegal 1999; quoted in Davis 2009:23).

God concepts are learnt through explicit and intentional learning (Davis 2009:23). The function of God concepts are to guide and integrate how a person thinks and talks about a DAF at an abstract, theological, conceptual, and usually explicit level. This is inside conscious awareness (quoted in Davis 2009:24). God concepts are activated when certain learned intrapersonal cues (e.g. active doctrinal schemas and verbal scripts) and situational cues (e.g. features of the religious/spiritual environment and relationship partners who are present; Mischel & Shoda 2008) take place (quoted in Davis 2009:24). God concepts are processed by (a) By the rational information-processing system (Epstein, 1994); (b) Using left hemispheric, cortical brain circuitry (Garzon 2007; Badenoch 2008); (c) Within the psychological conscious (Hall et al. 2005; Kihlstrom 2008); (d) In a reflective, slow, controlled, self driven, and analytic manner (Gibson 2006; Epstein 1994; Metcalfe & Jacobs, 1998); (e) Via sequential processing systems (Gibson 2006; Bucci 1997); and (f) At the verbal-symbolic level (Noffke & Hall 2007; Bucci 1997; quoted in Davis 2009:24).

Multiple God-images

Individuals may have multiple God-images; that vary in complexity; and some being more dominant depending on their frequency of usage, degree of over learning, and extent of neuro-connectivity (Gibson (2006, 2007; quoted in Davis 2009:129). God-images also seem to be hierarchically organized, depending on their relation to each other and their relation to other types of schemas (e.g. self, person, emotion, and relational schemas). Gibson (2006, 2007; quoted in Davis 2009:129). More than one God-image may be activated at a given time (Gibson, 2007; Badenoch 2008; quoted in Davis 2009:129). The way one thinks about God is also influenced by the constraint of mood and situation (Gibson 2007; quoted in Davis 2009:129). It is important to look at images of God held by individuals in order to gain insight into faith development. The growth and development of images seems to play an important role in the transition of faith, spirituality and concept of religion (Peloso 2008:29). Since talk of God is indirect, metaphoric language is often used.

Metaphoric Theology

The reason why I mention the use of metaphors here is because as Peloso (2008:15) says, in order to appreciate faith development, one must look at the metaphors and images used by individuals to bring coherence to their life. Understanding images of God are essential pieces in understanding individual spirituality. Metaphoric theology is described by Louw as an attempt to understand the presence of God within existential life issues (Louw 1998:234). McFague (1987:34; quoted in Louw 1998:234) writes, “No words or phrases refer directly to God, for God language can refer only through the detour of a description that properly belongs elsewhere”. Metaphoric language allows the individual to assimilate and accommodate new information into structures of meaning (McFague 1982; Parks 1989) and express something that cannot be exactly described (McFague 1982; McFague 1993). Metaphors and symbols are therefore used when talking about God i.e. a known system is used - the contextuality of speech and language. In this way, Gods engagement with people can be described in an indirect and figurative way (quoted in Louw 1998:234). Metaphor is a tool to finding meaning.

With regards to its relevance in this study, the function of a metaphor in the context of pastoral care is to “connect God’s purpose for human existence with real life situations” (1998:139). A pastoral metaphor thus attempts to convey the connection between faith and our lives. What common metaphors and images do people hold for God in pastoral care? The shepherd metaphor; the servant metaphor; the wisdom metaphor; and the paraclete metaphor (Louw 1998:238); and the following categories for God images: monarchic images (these portray God as Judge or king, in terms of a hierarchical structure); family images (these describe God as father or Patriarch); covenantal images (dealing with issues such as commitment, fellowship, communication; faithfulness, and identification); personal images (which reveal vital existential categories of life such as love, liberation, reconciliation, forgiveness and compassion) (Louw 1998:238). Louw also proposes another metaphor, God as our Partner for Life (Louw 1998:238).

The correlation between God-Images and Psychological well-being

A review of the literature shows that one's perception of God (God-image) has an influence/effect on their psychological well-being. A number of studies have indicated a relation between God-image and psychological well-being. For instance, Cheston et al. (2003:105) in their research found a relationship between image of God and psychological symptoms. They therefore regard integrating image of God work into the therapeutic process as essential because of its potential for predicting psychological well-being over time. They note a relation between one's image of God and therapeutic change. Benson and Spilka (1973) found a positive correlation between self esteem and loving-accepting God-images; and a negative correlation with rejecting images (quoted in Steenwyk et al. 2010:87). Francis et al. (2001) found a positive relationship between self-worth and God as loving and forgiving. A negative relationship existed between self-worth and God as cruel and like a judge who punishes (quoted in Steenwyk et al. 2010:87).

An exploration in the area of religiosity and well-being suggests that positive or healthy ways of relating to God are related to higher levels of psychological well-being (Commerford & Reznikoff 1996; Francis & Kaldor 2002; Jensen et al. 1993; Knox et al. 1998; quoted in Steenwyk et al. 2010:91). One's image of God also seems to have an influence on psychological stability. According to Rizzuto (1980; quoted in Cheston et al. 2003:104) when one experiences a disturbance in their relationship with God, this may exacerbate or even create psychological symptoms. Therefore, ignoring an individual's spirituality in treatment may not be as helpful in alleviating symptoms as treatment that focuses on spirituality because the root of the problem is not addressed.

It has also been reported in another study that survivors of sexual abuse, experienced decreased spiritual well-being and held more negative images of God than those without a history of sexual abuse (e.g. Hall 1995; Kane, Cheston & Greer 1993; Pritt 1998; quoted in Swank & Pargament 2005:192). Spiritual struggles i.e. feeling punished or abandoned by God, have been associated with poor mental health, impaired physical health, and mortality (e.g. Koenig et al., 1998; Pargament, Smith, Koenig & Perez 1998; Pargament et al. 2001). Spiritual struggles may thus lead to poorer physical health and psychological well-being. Anger towards God and alienation from God have been associated with increased depression and anxiety (Exline, Yali & Lobel 1999; Exline, Yali & Sanderson 2000; quoted in Swank & Pargament 2005: 192). The results above show the significance of attending to the role of God-images in psychological well-being so as to aid in their process of mental, physical and spiritual recovery.

The correlation between God-images and Spiritual well-being

I briefly consider here the connection between one's God-image and spiritual well-being. Louw refers to the use of appropriate or inappropriate God-images rather than correct or incorrect God-images.

Inappropriate God-images, he says, can lead to pathology and “spiritual illness” (Louw 2008:92). It has also been noted by Louw, that a distorted perception of God can produce a pathology of faith (Louw 1998:12). The effects of such can be destructive and negative on a person’s life. Constructive and positive perceptions of God have a more positive contribution to the development of faith and mental health (Louw 1998:12). The quality and nature of one’s maturity in faith (which is determined by one’s understanding of God) has an influence on one’s spiritual health. Thus, one’s image and concept of God plays a crucial role in the process of developing a spiritual maturity (Louw 1998:12) as well as in the “healthy” functioning of a mature faith (Louw 2008:92).

This section shows the necessity of a theological assessment as part of pastoral care. A pastoral analysis, says Louw, examines the person’s concepts, portrayal, images, and views of God and the pastoral diagnosis determines and assesses the character or quality of a person’s faith (Louw 1998:99). Analyzing a person’s God-images helps the pastoral caregiver to make a diagnosis of their faith (Louw 1998:120) and understand the meaning of their God-images and role in their faith. The Pastor also needs to consider the following factors: personality, relationships and cultural contexts, because says Louw, these reflect the meaning of God-images on a personal, existential and contextual level (Louw 2008:92).

The impact of destructive thinking on God-images

In this section I seek to explore the influence of destructive thinking on one’s God-image. In the previous chapter, it was shown that our thinking is not always as accurate as we “think” it is! For example, one may recall that filtering is a cognitive distortion that occurs when one focuses mainly on the negative, filtering out all positives. With regards to the God-image, filtering happens when one’s God-image focuses only on the individual’s weaknesses and mistakes, ignoring any of their strengths and victories (Thomas 2009:121). Schemas and core beliefs can also preserve a person’s negative thinking as well as influence their experience of God. According to Thomas (2009:123) the core beliefs we hold are often reflected in our God-image. Our God-image may be paralleled in our pattern of thinking. Harmful God-image schema’s can be changed by identifying and then renegotiating personal agreements with God (Beck et al. 1979; quoted in Thomas 2009:123).

People’s concepts of God are also described as being an integral element of their faith and psychic structure. “God-images in people are internal components of our human psychic structure. They should therefore not be viewed separately or assessed as something apart (Rebel 1988:165; quoted in Louw 1998:243). The close association between psychic structure and God-images is an important factor which pastoral care should consider most seriously in the development of faith towards maturity. The pastor will thus have to work very carefully when attempting to change people’s God-images. A theological correction immediately applies interference in a person’s psychic structure. It does not merely alter concepts on a cognitive level; it also affects a person’s experiences of security and identity. Changes to

God-images are thus a painful process, which could meet with strong opposition. This opposition could be accompanied by negative God-images, which have originated in childhood. Paternal and maternal symbols could provide an important source for religious concepts which, at a later stage, become the filters for an understanding of God. This process of formation is also affected by other factors, such as negative associations from catechism, or being exposed to excessive punishment and aggression in the paternal home or within a Christian context". "In order to alert people to the link between their disorders and God-images, they should be encouraged to describe the nature of their God-image and expectations. These are expressed in faith concepts. Sometimes it may be necessary for people to describe how authoritarian figures acted towards them during their childhood, as well as any traumatic experiences which evoke associations with God. People could also be asked to write a sketch about God or to draw their representation of God. The purpose of these tasks is to identify inappropriate God-images and then to proceed towards discovering appropriate God-images which could be linked to scriptural metaphors such as Father, Friend and Saviour" (Louw 1998:244).

When one is uncertain or lacks clarity about the appropriateness of one's God-image, confusion may arise with regards to one's Christian faith. Instead the desired outcome is for faith to play a helpful and healing role. This is another reason for the importance of assessing God-images, so as to improve the functionality of religious experiences and develop our perceptions of God. The pastoral approach seeks to help people replace or change their **inappropriate God-images (infantile faith)** with **appropriate God-images (mature faith)**. Appropriate God-image's are the more desirable, as these promote more constructive and purposeful actions; instil hope; and contribute towards the eventual therapeutic effect of pastoral ministry (Louw 1999:249).

But when does a God-image become inappropriate? One's image of God is viewed as problematic if it makes one "rigoristic, feel trapped, inhuman, or anxious, and if it creates delusions" (Lindijer 1990:9; quoted in Louw 1998:235). Louw (1998:235) writes, "...pastoral care is a theological science which tries to convey the meaning of humanity from the perspective of the Christian faith. The latter is predominantly determined by the eschatological perspective (the fulfilled promises of God in terms of salvation/new creation, which implies the tension of a vital hope: the already and not yet of our new being in Christ). The eschatological stance in a theology of pastoral care inevitable addresses the problem of meaning (significance and purposefulness) and spirituality (an awareness of the presence of God within crucial life issues – to live *Coram Deo*). An appropriate God-image should reckon with this theological perspective".

Reflecting on emotional and physical pain and the God-image, Louw (2008:94) writes: "patients experience God as far away because their emotional and physical pain places God at a distance. Patients then experience God as uninvolved and disinterested. Actually, God is not really absent or distant; the

nucleus of the problem is that patients' emotional and rational filters are so affected by insecurity or suffering, that God is experienced emotionally as absent. This results in a perception of God as apathetic". When one undergoes painful and emotional experiences or ill-health certain concepts of God become relevant. Needs and frustrations are projected onto God. Louw (2008:94) illustrates this as follows: "God may be seen as a tyrant after an experience of injustice; as a bully because of anger and frustration; as a spoilsport after disappointment; as Father Christmas or an insurance agent because of the notion that God is a guarantee against disaster and loss". In a pastoral model, 'health' is measured as the extent to which one can make use of their specific understanding and concept of God, so as to react constructively and positively and cope meaningfully with suffering (Louw 2008:94).

Changing inappropriate God-images or destructive ways of thinking about God is possible. Moriarty (2006; quoted in Thomas 2009:22) provides several cognitive techniques that can be used to gain more harmony between one's God-image and God concept, in which irrational God-image statements are replaced with a more accurate responses. Through cognitive disputation, Johnson (2007) shows how irrational beliefs, which lead to undesired consequences (such as experiencing God as harsh or judgmental) can be changed. His approach challenges the individual to adopt a more accurate appraisal of him/herself and God, and thus experience resolution (Thomas 2009:22). The results of this section introduce the reader to the impact of destructive thinking in the person-God relationship.

3.3. THE IMPACT OF DESTRUCTIVE THINKING WITHIN THE REALM OF BELIEF SYSTEMS

Destructive thinking in belief systems

According to Russell & Pargament (quoted in McNamara 2006:91) a great deal of the recent research on religion and mental health, has found a positive correlation between religion and health and well-being. But, according to these authors, many of these studies measured global indicators of religiousness thus limiting their research findings. Therefore, these authors claim, a closer assessment will reveal that there is also a darker side to religion and spirituality. This means, some religious expressions may actually be more harmful than helpful. A few empirical studies have begun to identify "religious risk factors" for poorer health (Russell & Pargament; quoted in McNamara 2006:91, 108). I therefore dedicate this section to exploring the more destructive side of religion in the form of 'destructive thinking' as experienced by the religious/spiritual individual, owing to its harmful effect upon the individual.

For the devout Christian/religious person, religious beliefs form part of their everyday lives, and affect their life goals, daily thoughts and activities. Religious beliefs can have a powerful impact on how one perceives, thinks about, and responds to their problems. Each religious belief or activity has its benefits and consequences. Thus, religious beliefs can have a powerful influence over one, for either good or bad.

Certain types of religious thinking and beliefs may be beneficial; others are associated with decreased mental health. This may be illustrated by the individual who believes they are being punished by God, which has been found in some cases to increase psychiatric symptoms (Paukert et al. 2009:105). There are findings that show that negative emotions such as despair, loneliness, resentment, helplessness, shame, guilt, can cause disease due to their harmful effects upon the body's endocrine, immune, and autonomic nervous systems (Haris & De Angelis 2008; Mookadam & Arthur 2004; Koenig 1998; quoted in Griffith 2010:7). There is also evidence showing that certain medical diseases are made worse by physiological changes associated with negative emotions. Psychiatric disorders can also be activated by prolonged negative emotions. Griffith (2010:7) states, religious faith might sometimes weaken such negative emotions, but this is not always so, and in some cases, religious faith has made them worse. Religious beliefs have also been found to spawn negative emotions in one's life, for example, by experiencing exaggerated guilt for personal sins; believing one's illness to be a punishment from God; or feeling abandoned by God in a crisis (Pargament, Koenig & Tarakashwar 2001, 2004; quoted in Griffith 2010:7).

The following discussion illustrates the powerful influence of religious beliefs over the individual. Religious beliefs influence what the individual deems to be real, thus defining, ordering, and assigning meaning to everything within its scope or range, excluding any alternatives (Griffith 2010:7). Religion can sometimes stir up strong emotions that sets off mood, anxiety, and psychotic symptoms (particularly emotions associated with vulnerability, uncertainty, and threat) (Griffith 2010:8). Religious zeal can also trigger the onset of psychiatric illness or exacerbate its intensity (Griffith 2010:8). Religious beliefs can affect one suffering from a psychiatric illness (by adding meaning to their thoughts, feelings, and behaviours). Religious beliefs can (irrationally) magnify guilt, apathy, or self hatred in a person suffering from depression (Griffith 2010:8). Some of the negative effects of religious beliefs are summarized by Griffith (2010:8) as follows, religious beliefs can: amplify the intensity of intrusive thoughts in obsessive compulsive disorder (OCD); intensify any anxiety disorder (particularly if they generate a sense of fear or uncertainty); set off somatization and medically unexplained physical symptoms (especially if one's religious beliefs silence expressions of felt distress; transform delusions and hallucinations in dramatic and destructive ways among those with schizophrenia or psychoses; have lethal consequences when used to justify suicidal or homicidal impulses (Griffith 2010:8). People with psychiatric disorders suffer daily; often those around them are unaware of their suffering. Religious faith sometimes exacerbates this suffering instead of reduces it (Griffith 2010:8).

Koenig (2009:283) states, "Religious beliefs and practices have long been linked to hysteria, neurosis, and psychotic delusions. However, recent studies have identified another side of religion that may serve as a psychological and social resource for coping with stress. While religious beliefs and practices can represent powerful sources of comfort, hope, and meaning, they are often intricately entangled with

neurotic and psychotic disorders, sometimes making it difficult to determine whether they are a resource or a liability” (Koenig 2009:283). It is illustrated here that in some cases, religious beliefs and practices may serve as a resource for coping with illness, and in other cases, contribute to mental pathology. Often people turn to religion hoping to find refuge, comfort, hope and meaning when they are experiencing suffering, pain, mental illness, emotional problems, or situational difficulties. When they do, sometimes they are helped, and other times not. In some instances (especially in the emotionally vulnerable) religious beliefs and doctrines may reinforce neurotic tendencies, enhance fears or guilt, and restrict life rather than enhance it. Here, religious beliefs are used in primitive and defensive ways to avoid making necessary life changes (Koenig 2009:289).

Not all studies link religion to better coping, greater well-being, or positive emotions and personality traits. Some studies report worse mental health among those who are more religious (Koenig 2005:70). But Koenig (2009:289) recognizes that not all research supports the argument that religious involvement has an adverse effect on mental health. There is also evidence that religious involvement is related to better coping with stress and less depression, suicide, anxiety, and substance abuse (Koenig 2009:289). Paukert et al. (2009:107) also note religious beliefs as providing relief from stress, “Religion may decrease stress by reducing the perceived harm associated with stressful situations and promoting the thought that one will be able to cope effectively. Beliefs such as, “God is a just and benevolent God,” “God is one’s partner through suffering,” “Religious rituals provide a sense of security,” and “Religion provides support,” can help people cope in difficult circumstances by encouraging a sense of meaning, purpose, and self-esteem. Without such coping responses, significant life stressors may cause the person to feel that all hope is lost”. Religious beliefs can also help one see a situation from a different perspective, e.g. by encouraging one to consider the role God in their daily life. If they believe God is actively present in their life, guided imagery can be used to help them sense the presence of God while in distress. Or by thinking about God and religion, one may feel they are never alone. Consequently, these improve mood and coping responses (Paukert et al. 2009:107). By reflecting on how life problems are conceptualized in one’s religion, individuals can learn to change the way they perceive stressors. E.g. coming to view stressors as tests of faith; acts of God (the reasons for which cannot be known to the individual); or a pathway to a better life. In this way, religion has the potential to increase hope, optimism, and feelings of self-worth, even in the face of life-threatening illness (Paukert et al. 2009:107). Understanding one’s religious and spiritual beliefs allow the individual to appreciate this value as a resource for healthy mental and social functioning; and recognize when their beliefs are distorted or limiting.

In CBT theory, problems such as anxiety and depression result from maladaptive thoughts and behaviours. Modifying these helps to reduce the anxiety and depression. Challenging irrational thoughts and engaging in activities that provide opportunities for positive reinforcement also have a positive

effect. Paukert et al. (2009:106) states, incorporating religious beliefs into the process of challenging irrational thoughts and increasing the frequency of religious behaviours may increase the effectiveness of CBT, especially with older religious adults. One's beliefs, tradition and values, can provide their very reason for being, but these can also be the reason for their experienced distress and suffering (quoted in Natale 1986:51). Immaturely misinterpreting or rigidly and uncritically holding onto one's beliefs can be the cause of distress or suffering (quoted in Natale 1986:51). Religious influences can thus be constructive (health promoting), as well as destructive (Griffith 2010:3). According to Wilson & Creswell (1999:134) religious beliefs can create dysfunctional cognitive processes, negative emotions, or maladaptive behaviours, such as distorted perceptions of reality, pathological guilt, or self destructive behaviours, thereby contributing to stress. Religious beliefs can influence attitudes and habits that affect health i.e. they can influence the timing for when someone seeks treatment (Griffith 2010:6).

Destructive thinking within the pastoral context

What is meant by destructive thinking within a pastoral context? Here, I would like to explore the link between "destructive thinking" and pathology within the realm of Christian faith. I look at the way in which pastoral care can help people to deal with and understand life's problems through their relationship with God. I also inquire about the role that faith plays when dealing with life problems. As human beings we are confronted with and need to deal with daily hassles, frustrations, and demands. The problems we encounter, however, are not limited to physical, economic and material issues. As spiritual beings, we are also confronted with spiritual issues. People are more than just the sum total of their physical, psychological and social components (Louw 1998:20). Therefore, the care and cure given to humans as spiritual beings should help them to (meaningfully) address these issues that affect their daily lives as well. The essential function of pastoral care is described as 'cura animarum' - cure of human souls (Louw 1998:1). This entails care for the whole person, but from a specifically spiritual perspective (Louw 1998:20). As spiritual beings, we also search to know the meaning of life (Louw 1998:20). A theological approach to pastoral care seeks to know how "the good news of the kingdom of God and salvation should be interpreted in terms of human experience/reality and social context so that the substance of our Christian faith may contribute to a life of meaning and quality" (Louw 1998:1).

The concepts discussed throughout this chapter become important here, i.e. inappropriate God-images, a pathological faith, and so on. The issue here is to understand the inhibiting effects of these destructive thoughts/cognitions on the individual's religious beliefs, God-images; spiritual formation, faith formation, and spiritual well-being. It is about identifying, examining and reframing cognitive errors and destructive thoughts that lead to inappropriate God-images, spiritual and faith pathology. It has become clear that our understanding and image of God influences our daily life and experiences. Here, I seek to explore experiences of faith and perceptions of God from the perspective of the Christian faith. Assessing the impact and function of God-images is an important part of pastoral counseling. A person's concepts

and images are crucial in the process of developing spiritual maturity (Louw 1998:12). When one holds distorted perceptions of God, it may cause faith pathology, which has destructive and negative effects on a person's life. The intended desire is for the development of a more constructive and positive perception of God as these contribute positively to the development of faith and mental health (Louw 1998:12). Pastoral therapy is therefore about developing a constructive concept and understanding of God in order to encourage growth in faith and to impart meaning and hope (Louw 1998:12). The ultimate purpose of pastoral therapy then is to foster a mature faith and spirituality (Louw 1998:19). My research here is aimed at understanding God in order to convey God's comfort and to instil meaning and hope. Louw (1998:5) describes the following effect, influence and change envisaged by pastoral care: "Pastoral care involves intervention, generating support resources, change, renewal, growth and decision making".

Pathology of faith

Louw (1998:241) describes faith as becoming pathological when "the focus on God and the interest in faith contents alienates people from their immediate reality, so that their faculties of discernment are blinded by either an artificial identification with God, or an obsessive, and thus unilateral identification, with God" (Louw 1998:241). Louw (1998:243) states: "A pathology of faith is also connected to the misuse of religion (when God is used for selfish purposes or when religion is practiced to manipulate God); fanatical actions, resulting in loss of contact with reality; legalistic approaches which are strongly prescriptive and demanding; ascetic behaviour which is damaging to life; artificial commitments and pietistic exclusivism. An analysis of these elements reveals that the following fundamental problem often lurks below all such pathologies: there is a continual interaction between a neurotic personality structure and a false or inappropriate perception and image of God. It is extremely difficult, however, to determine whether an inappropriate image of God gave rise to the disorder or vice versa". Pruyser distinguishes between a pathology of faith caused by a psychiatric factor/psychic dysfunction; and faith pathology as the product of a distorted interaction between the content of faith and faith behaviour (quoted in Louw 1998:241).

This discussion so far has sought to link "destructive thinking" i.e. faith pathology and inappropriate God-images, within the realm of the Christian faith so as to foster a more constructive, mature faith and faith development. This thesis then draws on the basic components of pastoral care, so as to develop a suitable theory and approach that can be applied to a wide variety of human problems and crises.

3.4. SPIRITUAL FORMATION AND DESTRUCTIVE TYPES OF RELIGIOUS THINKING

In this section, I discuss various types of 'destructive religious thinking' and their impact on spiritual formation. As well as the extent to which pastoral and spiritual care-giving should probe into cognitive

patterns of thinking and its connection to conceptualization in pastoral care, very specifically to the experiences of faith and their connection to God-images.

Spiritual Formation

The definition of spiritual formation varies according to one's faith and religious background. D. Adams (2008:135) defines spiritual formation as the process of recognizing and realizing God's unique purpose in one's life. Spiritual formation is described as continuous, evolving and taking shape throughout the life cycle (Adams 2008:131). We are thus not passive and malleable "blank slates" in the faith formation process, upon which teachers and those with superior knowledge imprint their knowledge (Driskill 2006:74).

Destructive types of thinking in religion

In this section, I discuss a number of destructive types thinking that the Christian/Religious counselee may at times struggle with. The reason for my focus here is summed up by Koenig (2005:70) as follows: "religion has been correlated with dogmatic thinking, obsessive traits, and perfectionism. It may be used to deny the facts and encourage magical, unrealistic thinking, or inappropriate pacifism or dependency. Religion can promote negative attitudes toward psychiatric care, replace psychiatric care, delay diagnosis and impede effective treatment, and justify non compliance". I do acknowledge that each of the categories I list below also have constructive elements associated with them, within the context of this study, I focus mainly only the destructive effects of each and their associated cognitions.

o Unforgiveness

McCullough, Bono and Root (2007) define forgiveness as: "a suite of prosocial changes in one's motivations toward an interpersonal transgressor such that one becomes less avoidant of and less vengeful toward the transgressor (and, perhaps, more benevolent as well," McCullough, Worthington & Rachal 1997:491; quoted in Sandage & Jankowski 2010:168). Most religious and spiritual traditions teach one to have forgiving attitudes and behaviours. It is a topic that has a long history of being reflected upon across many religious traditions. Forgiveness has thus been linked to religion. So for some, forgiveness is intricately related to their religion/spirituality (Koenig 2005:62). Forgiveness is a core concept in the Christian faith.

According to Philip H. Friedman (2009:17) individuals with unforgiving dispositions tend to experience emotional distress in general, and higher levels of depression, anxiety, guilt, anger and resentment in particular. They are also more likely to be hostile, vengeful, and vulnerable and to frequently ruminate and obsess over perceived hurts. They also have more physical symptoms, and are more interpersonally and emotionally sensitive than forgiving people. Witvliet, Ludwig & Van der Laan (2001) say forgiveness may be linked with better physical and mental health, because of its tendency to reduce

rumination and enhance positive emotions. They also say, forgiving thoughts have been linked with greater perceived control and somewhat lower physiological stress responses. Unforgiving thoughts have been linked with aversive emotions, as well as much higher facial tension, skin conductance, heart rate, and blood pressure (Witvliet, Ludwig & Van der Laan 2001). Paloutzian & Park (2005:447) state that health benefits of forgiveness may arise from reductions in excessive self focus and angry rumination, more adaptive coping, and overall enhancements of mental and social health. According to Koenig, there are studies linking forgiveness with better physical health, i.e. reduced heart rate, lower blood pressure, slowed skin conductance and greater muscle relaxation, lower cortisol levels, and better immune function (Koenig 2005:61). There have also been reports of a connection between forgiveness and less frequent substance abuse and adult antisocial personality disorder (quoted in Koenig 2005:61).

From a CBT framework, individuals are helped to reinterpret their maladaptive thoughts associated with unforgiveness (e.g. feelings of resentment or a desire to seek revenge). Forgiveness is a form of emotional reframing or reattribution of vengeful thoughts with positive emotions (Hill 2005; quoted in Gallagher-Thompson et al. 2008:317). In this way, forgiveness is understood as a cognitive skill that enhances one's satisfaction by allowing them to free themselves of resentment.

The hurt and disappointment resulting from a transgression can often translate into a state of unforgiveness (Worthington 2001); this in turn has been related to decreased psychological and physical well-being, including reduced hope and self-esteem and increased anger, bitterness, depression, dysfunction, distress, physiological stress, and coronary heart disease (quoted in Strelan et al. 2009:203). A considerable number of studies indicate a positive relationship between religious beliefs and psychological outcomes (Larson, Swyers & McCullough 1997; McCullough, Hoyt, Larson, Koenig & Thoresen 2000; quoted in Strelan et al. 2009:203). For example, religious people are more likely to report higher levels of self-esteem, life satisfaction, hopefulness (Ayele, Mulligan, Gheorghiu & Reyes-Ortiz 1999) and physical health (George, Ellison & Larson 2002) and are less likely to experience periods of psychological distress (Larson et al. 1992; quoted in Strelan et al. 2009:203). Some individuals are also more predisposed to forgive than others are (Berry et al. 2005; quoted in Strelan et al. 2009:204). A forgiving disposition has been found to be related to better psychological well-being (Thompson et al. 2005), including increased hope; improved self-esteem (McCullough 2001); greater life satisfaction (Brown & Phillips 2005); and decreased anger, hostility, neuroticism, anxiety, and depression (Berry et al. 2005; quoted in Strelan et al. 2009:205). In their research study, Strelan et al. (2009:205) found that the more predisposed an individual is to forgive, the less likely his or her disappointment with God would translate into negative well-being outcomes. Of the participants in their study who had experienced the most difficulty forgiving God, the most powerful incidents concerned: the death of a child, parent, or friend (41.5%); marriage and / or family relationship breakdown (22.5%); chronic illness and disease (14%); vocational and financial difficulties (12%); sexual abuse (5%); and feeling let down by God (5%)

(Strelan et al. 2009:207). Those who felt the need to forgive God for these events, and as a consequence experienced changed cognitions about the nature of their relationship with God (Strelan et al. 2009:207). A relation has been found between the personality disposition toward forgiving others and physical and mental health (Harris & Thoresen 2005; Toussaint & Webb 2005; Witvliet 2005; quoted in Sandage & Jankowski 2010:168). However, Tsang et al. (2005) found a connection between forgiveness and compassionate/retributive forms of religion. Those with forgiving or merciful God-images were positively associated with forgiving others; and negatively associated with avoidant motivations of unforgiveness (Sandage & Jankowski 2010:169). Similarly, Webb et al. found loving God concepts were positively correlated with dispositional forgiveness while controlling God concepts showed the inverse effect (Sandage & Jankowski 2010:169).

o **Guilt**

One does not have to be a religiously committed person to experience guilt. Nielsen, Johnson & Ellis (2001:207) note guilt to be a common theme in psychotherapy. They explain that, “like most emotional experiences, guilt usually includes complex cognitive, emotional, and behavioural components” and will therefore “likely include helpful, as well as self defeating, cognitive, emotional, and behavioural components” (Nielsen, Johnson & Ellis 2001:207). Religious belief systems usually include religious doctrines and rules for living around which the religious client organizes their lives. Religious belief systems may restrict behaviours that are not restricted outside of one’s religious belief system (Nielsen, Johnson & Ellis 2001:210). When the individual however, feels they have violated any of these rules for living, guilt usually results (Nielsen, Johnson & Ellis 2001:210). The more one believes in or is devoted to their religious tradition, the more intense feeling of guilt will be experienced (Nielsen, Johnson & Ellis 2001:211).

Keeping up the values and beliefs of one’s religious group may require a certain amount of self sacrifice, non participation in certain kinds of activities, or avoidance of certain kinds of people (Koenig 2005:70). One’s social group or culture at large may frown upon such behaviour, causing the individual to be ridiculed or excluded. This may create a struggle for the individual, between the desire to serve God and a need to be approved and included by others (Koenig 2005:70). Failing to live up to one’s religious values, i.e. honesty, generosity, forgiveness, humility, or kindness, may produce self condemnation, hopelessness or excessive guilt. Failure may be due to one’s limited capacity for self control or discipline, and may cause the individual to give up on or reject these values as unobtainable. If they hold strongly to these religious beliefs, such failures may produce negative emotions or a drop in self esteem (Koenig 2005:70). Thus, says Koenig (2005:70) “devout religious belief, striving toward religious belief or sudden changes in religious belief can all create intrapsychic stress and social tension that lead to mental distress or worsen a pre-existing psychiatric disorder. The person with mental disorder may be particularly sensitive to stresses and strains due to an already low self esteem, exaggerated sense of guilt,

or compulsive and perfectionist nature. As important as they are, areas of religious stress and strain remain largely unexplored today”.

The aim of cognitive therapy is not to help one get rid of their guilt feelings by minimizing their misbehaviour or religious beliefs about right and wrong. But rather to use these unpleasant emotions associated with the misbehaviour (and subsequent guilt) to prevent future misbehaviour.

o **Sin**

Some people hold catastrophic views of God and sin that may even be inconsistent with their own religious doctrine (Griffith 2010:168). Despite religious teachings about God’s unconditional love; repentance of sins and forgiveness, for some God is petulant (bad tempered), easily angered, and vengeful (Griffith 2010:168). Such extreme beliefs and fearful view of God may cause one to practice religion out of fear of punishment. Jones & Butman (2011:242) write: “...there should come a time where believers come to see their sinfulness in the context of the marvellous provision of salvation from God, and where our remorse becomes secondary to our love for this marvellous redeeming God who desires us to worship him and serve him, and to our celebration of his grace. So in the case of a protracted and overly severe preoccupation with one’s own sinfulness, the Christian cognitive therapist would regard the thoughts as true but perhaps not in their proper context among other Christian beliefs, and hence might see the emotional response as problematic. Thus the Christian counselor would not be using the pragmatic standard for judging beliefs. The therapist’s method would not be to undermine the belief, but to put it in proper perspective among other beliefs”.

o **Depression**

When religion and depression interact a number of problems may surface. For example, suffering may increase; the individual may not seek or adhere to much needed psychiatric treatment; self neglect may take place; and even suicide (Griffith 2010:200). It seems that depressed religious individuals tend to dwell endlessly on their sins against God, wrongs committed against other people, and failures to fulfil expectations for their lives. Therefore, says Griffith (2010:200) religious thinking can possibly contribute to cognitive distortions and catastrophic thinking. People who are consumed by their negative emotions find it difficult to engage in religious activities (especially if they are suffering from a mental disorder). For those who are socially withdrawn or weighed down by their own negativity, fitting into a faith community can be challenging, especially if they are expected to be highly social or positive people. This may cause them to avoid religious services altogether (particularly persons with psychiatric disorders i.e. schizophrenia or depression). Their symptoms may also interfere with their ability to pray, read the Bible, or to engage in other religious activities (Koenig 2005:80).

Koenig (2009:285) however, notes a number of studies that have found a more positive relation between religion and depression: among 93 observational studies, two-thirds found significantly lower rates of depressive disorder or fewer depressive symptoms among the more religious (Koenig 2009:285). Among 8 RCTs, 5 found that religious-based psychological interventions resulted in faster symptom improvement, compared with secular-based therapy or with control subjects (Koenig 2009:285). In a study of 1000 depressed patients, investigators followed 865 for 12 to 24 weeks, examining factors influencing speed of remission from depression. Those who were most religious (those who attended religious services at least weekly, prayed at least daily, read the Bible or other religious scriptures at least 3 times weekly, and scored high on intrinsic religiosity), their depression decreased more than 50% faster than other patients (Koenig 2009:286). Several other studies have similarly shown a positive impact for religion on course of depression (Koenig 2009:286).

Koenig (2005:102) says, rather than religion per se, it may be the type of relationship one has with God (particularly if medically ill) that influences whether religion leads to or protects from depression. Noting a study conducted by Levin that examined the association between a “loving relationship with God” and depressive symptoms in a sample of 205 medical outpatients, Levin found a statistically significant inverse correlation between a loving relationship with God and feelings of depression. Levin concluded, “One’s relationship with God thus may represent an important personal resource for mitigating the emotional consequences of poor health and other deleterious life circumstances, as well as a marker for successful religious coping” (p379; quoted in Koenig 2005:103).

○ **Anxiety**

Religious teachings can sometimes exacerbate feelings of guilt and fear, and thereby reduce one’s quality of life or human functioning. But, religious beliefs and practices can also comfort those who are fearful or anxious, increase their sense of control, enhance feelings of security, and boost self-confidence (Koenig 2009:287). The anxiety aroused by religious beliefs can prevent behaviours harmful to others and motivate pro-social behaviours (Koenig 2009:287). Religious involvement may also interact with certain forms of psychotherapy to enhance response to therapy (Koenig 2009:287). Koenig (2009:287) says, while positive forms of religious coping may reduce anxiety in highly stressful circumstances, negative forms of religious conflict may exacerbate it. Ventis (1995) noted that religion that is internalized and fully lived as a central organizing principle of one’s life is associated with freedom from anxiety, guilt, and worry (quoted in Salsman & Carlson 2005:207).

○ **Obsessive thinking**

There have been studies linking religious persons with a tendency toward obsessive thinking. Koenig (2005:74) notes a study by Raphael and colleagues, who examined three groups of 50 psychiatric patients: 50 with obsessive compulsive disorder (OCD), 48 consecutive referrals to psychotherapy group,

and 51 consecutive referrals to general adult psychiatric services. In this study, religious affiliation was the only religious characteristic measured. The findings show, the percentage of subjects with a religious affiliation was highest in the OCD group. It was thus concluded that religious affiliation may be a factor in the development or maintenance of OCD (Koenig 2005:74).

○ **Suicide**

The following points support the idea of religion as a deterrent to suicide. When religious beliefs and practices mobilize a sense of hope, purpose, agency, and gratitude, that individual is protected from a sense of demoralization that drives them toward suicide (Griffith 2010:203). When individuals feel comforted by God's presence in their lives or sense God's purpose in their lives, this may serve as a protective factor from suicide. Thus, quality of relationship with God is also a factor to consider (Griffith 2010:203). Another factor is when individuals believe suicide to be a sinful.

According to Koenig (2005:104) research shows that individuals with strong religious beliefs, and those in supportive religious communities, consistently have more negative attitudes toward suicide, fewer suicidal thoughts, and are at lower risk for committing suicide. Koenig (2005:104) refers to a study conducted at John Hopkins, with a sample of 835 elderly African American adults (average age 73 years), who's findings shed light on the relation between religion and suicide prevention. In this sample individuals were assessed for active and passive suicidal ideation. The characteristics of subjects with suicidal ideation included elevated anxiety, social dysfunction, somatic symptoms, low social support, absence of a confidante, older age, lower education, more depressive symptoms, and poorer cognitive functioning. Their analyses showed that only two variables uniquely predicted suicidal ideation: depressive symptoms and low religiosity were associated with passive suicidal ideation, and only low life satisfaction and low religiosity were predictive of active suicidal ideation (Koenig 2005:104). Religiosity in this study was measured using a single question: "Are religious or spiritual beliefs a source of support and comfort?" (Koenig 2005:104).

Probing into cognitive patterns of thinking in pastoral care

To what extent should pastoral and spiritual care-giving probe into cognitive patterns of thinking and its connection to conceptualization in pastoral care, very specifically to the experiences of faith and their connection to God-images?

Psychotherapy that incorporates religious beliefs and activities has in certain cases proved more effective than traditional, secular psychotherapy (i.e. in relieving depression in religious persons) (Koenig & Weaver 1997:80; quoted in Adams2008:134). DeHoff (1998:344) explains that psychotherapy and spiritual direction should be seen as companions, and not competitors (quoted in Adams 2008:132).

Pastoral counselors play a significant role in the development of spiritual formation. They need to assist in forwarding the spiritual direction of the counselee i.e. by helping the counselee to create meaning and purpose in their life; and develop a strong faith and build a deeper, personal relationship with God. The pastoral counselor transmits hope, offers direction, normalizes feelings and faulty cognitions. Because of the problem focused orientation of so many of the counseling therapies, Adams (2008:136) explains such approaches keep one mired in their problem/s, often creating helplessness and hopelessness. Whereas in my view, a pastoral approach reveals hope, vision, and Christ's power of salvation and healing. The Lord Jesus Christ desires for each of us to be healthy and whole (Adams 2008:136). Hope recognizes the role of religion in dealing with emotional distress (Adams 2008:139). Research has found that religion "comes to the foreground as a coping strategy, offering hope, control, and meaning through an ultimate perspective" (Rogers 1942:164). Indeed, for the Christian, hope is fulfilled in Jesus Christ. It is through His redemptive act that all may have hope and healing (Adams 2008:139)

In understanding the human being, the spiritual functioning has at least equal relevance to the physical, mental and emotional functioning of our lives and cannot be isolated from the other components. Therefore, increasing recognition should be given to the part of spirituality. The pastoral caregiver provides spiritual and emotional support, at the same time addressing one's religious/spiritual needs.

Pastoral care often takes place in settings outside the church communities and in secular societies. In some contexts, it may be more relevant to focus on spiritual issues. In pastoral ministry, the first and central task is to journey with the person to assist them to uncover the source of meaning in their life. The spiritual dimension becomes more important, especially in life meaning issues.

For those who have an image of God, pastoral care begins with an exploration of this image. Understanding the image a person holds is going to provide a starting point for pastoral care (MacKinlay 2003:140). For example: "If the person holds an image of a judgmental God, they will respond to life from this perspective, expecting to be punished, feeling unworthy, and perhaps lacking in a sense of hope, perhaps becoming depressed. A person may believe in a distant God, that cannot be reached, or believe there is no God. The person who can believe in a personal and loving God will respond to life out of a sense of hope" (MacKinlay; quoted in MacKinlay 2003:140).

M. Sarot (1995:185) writes that pastoral counselors should concentrate on helping people to overcome inadequate conceptions of God (quoted in Louw 1998:234). The counselor should also be attentive and able to distinguish between the symptoms of clinical depression and spiritual malaise, as the symptoms of spiritual malaise may imitate the symptoms of depression. "The responses of someone who is simply bored with religion, church life, and often God, can imitate the symptoms of depression in many older counselees" (Thibault 1993; quoted in Adams 2008:134).

This study hopes to provide a foundation upon which the pastoral caregiver can build; produce a knowledge base of destructive thinking within Christian spirituality; and function as a resource for effective spiritual care within the pastoral care and counseling context.

3.5. SPIRITUAL MATURITY WITHIN THE CHRISTIAN FAITH

Spiritual well-being

Spiritual well-being can be measured by the Spiritual Well-Being Scale (SWBS), developed by Ellison and Paloutzian, which aims to measure the quality of one's spiritual health (Unterrainer et al. 2011:117). But what exactly is spiritual well-being? Ellison and Paloutzian (1982) conceptualized Spiritual well-being as a two-dimensional construct - by identifying vertical "religious well-being" (RWB) and horizontal "existential well-being" (EWB) dimensions of the construct (Fee & Ingram 2004:106). On a vertical dimension, Religious Well-Being (RWB) describes our well-being as it relates to God or even to a transcendent dimension (quoted in Unterrainer et al. 2011:117). Fee & Ingram (2004:106) describe the vertical dimension as referring to one's sense of well-being in relationship to God. On a horizontal dimension Existential Well-Being (EWB) considers our well-being as it relates to a sense of life purpose and life satisfaction, without any specific reference to a higher power (Ledbetter, Smith, Vosler -Hunter & Fischer 1991; quoted in Unterrainer et al. 2011:117). The horizontal dimension is concerned with the overall sense of life purpose and satisfaction. Fisher (2010:324) describes spiritual well-being (SWB) as "the affirmation of life in a relationship with God, self, community and environment that nurtures and celebrates wholeness" (National Interfaith Coalition on Aging [NICA] 1975)".

The research shows a protective relationship between spiritual well-being and general mental health (Taliaferro et al. 2009:84). Spiritual health provides a sense of meaning and purpose to one's existence and offers an ethical path to personal fulfilment. Meaning and purpose in life represent key components of good mental health (Taliaferro et al. 2009:84). Spirituality may increase one's capacity to find meaning and purpose in life (Taliaferro et al. 2009:84). Thus according to Taliaferro et al. (2009:88) research suggests that spirituality contributes significantly to the promotion of mental health, and mental health positively influences spiritual life. They also found that frequent involvement in church services/activities was related to reduced suicidal ideation, compared with no involvement. Students with higher levels of religious, existential, and total spiritual well-being also reported lower levels of suicidal ideation (Taliaferro et al. 2009:88). The point to note here is the sense of meaning and purpose in life that religious and spiritual beliefs can provide. Spirituality strengthens one's sense of meaning and purpose in life, playing a part in the link between spiritual well-being and one's thought patterns. **In that, spiritual well-being enhances one's capacity to frame and reframe meaning (note the significant role of cognitions here).**

Spiritual maturity

Majerus & Sandage (2010:41) reflecting on Hebrews chapter 6 verse 1 claim a Divine call to pursue maturity. They say, the ultimate expression of Christian maturity, and its ongoing developmental process, is related to becoming the image of Christ (Rom 8:29). “Spirituality implies practicing the Christian faith in such a way that it creates an awareness of God’s presence. It is the devout obedience within which the believer gradually becomes that which he/she already is in Christ. Spirituality thus aims to embody faith and to develop a congruency between faith content and daily life. It also attempts to strengthen the ‘being’ functions of the believer with the view to preventing problems” (Louw 1998:19).

Maturity in faith

The present study considers the concept of faith in terms of the Christian experience. Faith is a basic expression of this experience. Faith influences the way one views life and derives meaning. It also controls ones values, perceptions, and exercise of power (Downs 1994; quoted Oberholster et al. 2000:35). Fowler (1981, 1986) perceived faith as being a multi-dimensional and extremely complex phenomenon (Oberholster et al. 2000:35). Faith maturity can be measured by the Faith Maturity Scale (FMS) designed to assess “the degree to which a person embodies the priorities, commitments, and perspectives characteristic of vibrant and life-transforming faith” (Benson, Donahue and Erickson 1993:3; quoted in Salsman & Carlson 2005:203). A vertical and horizontal concept of faith maturity can also be distinguished. The former refers to a secure relationship with God; and the latter to an emphasis on service to humanity. Harrowfield& Gardner (2012:208) explain that these dimensions coincide with the most dominant themes in Christianity—love of God and love of one’s ‘neighbour.’

Louw (1998:185) defines a mature faith as follows: “Maturity is a comprehensive concept, which includes both psychological and theological components. Yet, the concept of maturity is more fundamental for the Christian faith than for psychology. Although the two are closely related and influence each other reciprocally, mature faith nevertheless has a unique character, which must not be confused with what is understood by psychological maturity. While it is inevitable that a mature faith will incorporate and reflect traits of a general psychological understanding of maturity, the two are not analogous (p186). A psychological understanding of maturity ought to influence and stimulate the development of faith. In turn, a mature faith should heighten the quality of a psychological understanding of maturity. Nevertheless, we have chosen the concept ‘maturity in faith’ or ‘mature faith’ because in theology, maturity cannot be assessed and understood apart from its eschatological context. ‘Maturity in faith’ describes salvation in terms of a pastoral anthropology which operates with both Christology and Pneumatology” (Louw 1998:186). Louw uses the term ‘a mature faith’, to describe how Christian spirituality is understood in terms of the content of faith and counseling (Louw 1998:184).

Faith maturity is defined by Benson, Donahue & Erickson (1993) as the extent to which a person is truly living out his or her religion in the way it was intended to be lived and in such a way that it can be evidenced day to day (quoted in Harrowfield & Gardner 2012:208). The term 'a mature faith' also explains the unique contribution which pastoral care can make to counseling and therapy, which distinguishes it from psychology (Louw 1998:184). The psychological understanding of a mature faith however is not necessarily the same as is understood in the pastoral context. It has a totally different understanding in the psychological context.

The strength and security of one's relationship with God, their commitment to faith, and the integration of their faith into daily life are aspects that reveal one's maturity of faith (Benson et al. 1993; Sanders 1998; quoted in Harrowfield & Gardner 2012:208).

Louw (1998:19) lists the following aspects of a **mature faith**:

- change – Soteriology
- responsible choice of behaviour – ethos and ethics
- growth – sanctification
- empowerment and spiritual support – koinonia
- anticipation – eschatological hope.

A mature faith can also be reflected through socially responsible behaviour (and not only in an individual's relationships with a transcendent being) (Benson, Donahue and Erickson 1993; quoted in Salsman & Carlson 2005:202). This definition acknowledges acts of love and service to all humankind as an essential part of spiritual maturity. Benson, Donahue and Erickson's (1993) notion of mature faith emphasizes attitudes and behaviour, integrating faith as a system of beliefs with a mature faith expressed in actions (quoted in Salsman & Carlson 2005:202).

When encountering a stressor, having a mature faith does not lessen or overemphasize the threat/harm, but instead the individual is linked with an increased awareness of positive opportunities in difficult situations. A mature faith enables one to see stressors from an encouraging religious perspective, without ignoring the fact that a negative or life-changing situation has occurred (Pargament 1997; quoted in Harrowfield & Gardner 2012:208). Positive religious coping methods i.e. religious forgiveness and seeking spiritual support; have been related to decreased psychological distress and increased spiritual growth (Pargament, Smith, Koenig and Perez 1998; quoted in Harrowfield & Gardner 2012:209). Whereas negative religious coping i.e. spiritual discontent, has been linked to emotional distress and lowered quality of life. A person whose faith is mature may be more likely to engage in religious coping in a stressful situation than someone with a less mature faith (Pargament 1997; Roesch & Ano 2003; quoted in Harrowfield & Gardner 2012:209). Positive religious coping reflects a more secure relationship with God, so greater faith maturity is associated with positive religious coping. Negative religious coping

is associated with a weaker relationship with God, so lower levels of faith maturity are associated with negative religious coping (Harrowfield & Gardner 2012:209). Research findings also show that people with a more mature faith experienced greater stress-related growth than those with lower levels of faith maturity (Harrowfield & Gardner 2012:214). Lower faith maturity was associated with increased levels of negative emotions, perhaps due to the use of negative religious coping methods (Harrowfield & Gardner 2012:215). In a study of people recovering from substance abuse (Pardini et al. 2000) higher levels of religious faith were associated with higher resilience to stress and lower levels of anxiety (quoted in Salsman & Carlson 2005:202). In another study examining the strength of religious faith and mental health outcomes among university students (Plante et al. 2000) faith was associated with coping with stress and low anxiety (quoted in Salsman & Carlson 2005:202).

3.6. CONCLUSION

In the previous chapter, destructive thinking was explored within the CBT literature. In this chapter, destructive thinking was explored within the realm of religion and Christian spirituality. The reader was introduced to destructive types of thinking within the pastoral care and counseling context. A number of types of destructive thinking were discussed, but this list was in no way inclusive. The idea was to establish the potential impact of these type of thoughts on the individual's spirituality and spiritual well-being. Another goal was to locate the interplay between one's God-image, psychological and spiritual well-being. A link between these concepts is clear. Destructive thinking in belief systems was also explored. A reciprocal relationship was indicated between one's thoughts and belief systems, with an influence on well-being. Within the context of this study, the extent to which pastoral and spiritual care-giving should probe into cognitive patterns of thinking and its connection to conceptualization in pastoral care, very specifically to the experiences of faith and their connection to God-images was also discussed. It was decided that pastoral care has a significant role to play in the probing of cognitive patterns of thinking. Various outcomes were described such as the pivotal role of the pastoral counselor in providing spiritual direction and in the development of spiritual formation.

The aim of this thesis then is to produce a deeper understanding of destructive thinking within the pastoral context and discover the contribution that pastoral care can make to minimizing destructive thinking and fostering spiritual healing, growth and well-being. In the next chapter I therefore continue with an exploration of destructive thinking in religion, working towards a pastoral model of spiritual healing and wholeness. I discuss the interplay between religion, psychology (CBT) and pastoral care – and elaborate on cognition, worldviews and paradigms as being central concepts in this interplay. I relate worldview to pastoral/spiritual care and discuss the notion of meaning as connected to cognition. Spirituality as a central feature in pastoral care is also reflected on. I describe healing and wholeness from a pastoral perspective; and elaborate on the contribution that Christian thinking and Christian worldview

can make in reducing destructive thinking. I finally propose a holistic approach to destructive thinking in pastoral care that takes into account one's (faith and spiritual) maturity; beliefs and cognitions; and relationships (with themselves, others and God).

CHAPTER 4

DESTRUCTIVE THINKING IN RELIGION: TOWARDS A PASTORAL MODEL OF SPIRITUAL HEALING AND WHOLENESS

INTRODUCTION

As humans, we are all at times confronted with difficult situations and circumstances that cause us to suddenly feel overwhelmed by negative thoughts and emotions. In some cases, these thoughts may be justified and at other times they may be out of proportion. One moment we may feel in control of our lives, and the next moment, sad, angry, depressed, guilty, ashamed, and so on. As our thoughts fluctuate, we may go from behaving and thinking in a reasonable way to behaving and thinking in a destructive manner. Recognizing that one can be taken hostage by their thoughts is a necessary first step. It is hard work and it takes a lot of dedication to learn how not to be controlled by one's thoughts. The aim is to restructure destructive thinking when presented with undesirable events/situations that are not life threatening or that throw us off balance. We can then approach them in a mature manner. In this way we will be able to liberate ourselves from continual destructive thinking and behavioural patterns. These insights can help pastoral caregivers to deal with actions and reactions that are irrational or out of proportion.

The main focus of this thesis has been on understanding the cognitive component, that is, our 'thinking' (particularly destructive thinking). Information, facts and ideas have revolved around providing knowledge about cognition. The intention is to assist individuals to become more responsible and aware of their own thinking; as well as more knowledgeable about cognition in general, so that they can act on this awareness. This includes the ability to monitor their own thinking and recognize errors in their thinking.

The focus in the first two chapters was on identifying, understanding, and changing unwanted destructive thoughts in CBT (Chapter 2) and pastoral care/Christian spirituality (Chapter 3), respectively. The third chapter integrated Christian spirituality in the transformation process. The current chapter (Chapter 4) seeks to describe the outcome of such cognitive change - through working towards a model of spiritual healing and wholeness. Here, I inquire about the contribution that pastoral care can make when one becomes 'stuck' in their way of thinking? Even in pastoral counseling contexts, it is difficult to help people change or encourage them to see or do things differently. Old patterns of thinking and behaving strongly influence our actions. Sometimes we fall into a negative rut or just get stuck in our ways of thinking, feeling and acting. I will reflect on worldviews when exploring this point further. In the next

section, however, I begin with a reflection of the interplay between CBT/Psychology (Chapter 2); and pastoral care and religion/Christian spirituality (Chapter 3).

4.1. THE INTERPLAY BETWEEN RELIGION, PSYCHOLOGY (CBT) AND PASTORAL CARE

What is the interplay between religion, psychology (CBT) and pastoral care in the context of this study (destructive thinking)? The concepts central to this interplay are: **cognitions, worldviews and paradigms**. These will be discussed throughout the chapter.

I begin with a discussion on the topic of suffering. Everybody has suffered some sort of hurt or harm during the course of their life. Suffering is an existential problem that raises questions about the meaning of life. Geertz sees suffering as a distinctive problem for worldviews (Smeets 2012:31). Worldviews can make experiences of suffering meaningful. This does not mean denying their reality. It is “not how to avoid suffering but how to suffer, how to make physical pain, personal loss, worldly defeat, or the helpless contemplation of other’s agony something bearable, supportable – something, as we say, sufferable” (Geertz 1973, 104; quoted in Smeets 2012:31). The experience of suffering in religious worldviews brings up the ‘theodicy’ debate - which deals with religious beliefs related to the meaning of suffering. Questions such as: “how can belief in God be justified in the face of suffering, or how can the experience of suffering be reconciled with belief in an omnipotent, benevolent creator?” come to the fore here (quoted in Smeets 2012:31). In exploring experiences and cognitions of suffering, the spiritual caregivers can work together with other caregivers (who focus on physical, psychological, social and mental health) while remaining true to their own domain. “This is where spiritual caregivers’ expert knowledge of worldviews provides a framework for such communication with patients, since worldviews explore the tragedy of suffering” (Smeets 2012:52). Malcol Hamilton (2001:180) writes, “in short, religion tackles the problems of bafflement, suffering and evil by recognizing them and by denying that they are fundamentally characteristic of the world as a whole – by relating them to a wider sphere of reality within which they become meaningful”.

The three schools of thought - psychology, religion and pastoral care - differ somewhat from each other, yet all three have a contribution to make to the role of care giving. It is here that I call for an interdisciplinary and holistic approach to offering pastoral care to the individual. Secular psychology in general finds the material sphere adequate. It does not recognize the role of God in human happiness and well-being. It does not acknowledge that a turning away from God may be the cause of genuine unhappiness (as a pastoral approach would). Generally, psychology has been deaf to the spiritual side of the person. Spiritual beliefs can directly influence how individuals think about themselves, the world, and

their future. Spiritual problems may result from distortions of belief and worldviews. In the end, there really is no way to avoid religion. But religion is also only one perspective on the world among others. Malcol Hamilton (2001:180) writes, “What is distinctive about the religious perspective, is that it is characterized by faith. The scientific perspective is essentially sceptical, it is always putting its ideas to the test. The religious perspective does the opposite, it tries to establish its ideas as being true beyond doubt or beyond evidence”. Knowledge about the possible dynamics behind our thoughts, behaviour and spirituality can lead to more helpful and mature reactions and interactions in one’s life. It also helps one to better understand them self, get in touch with their own feelings and thoughts and pay more attention to their own inner world. These insights are valuable for self-knowledge, personal and spiritual growth. This illustrates a relationship between personal growth and spiritual development.

But is this interplay merely about ‘thought’? The interplay in the context of this study can thus be described narrowly as concerning (1) “thought” (or cognition); but more broadly as relating to (2) “worldviews” and (3) paradigms. This brings me to define the concept of worldview and Christian worldview. I also reflect on how these relate to pastoral/spiritual care. I consider the role of thoughts (cognitions) in one’s worldview; and the impact of one’s worldview on their thoughts.

Worldview defined

The dominant worldview of a people, colors their thoughts, behaviours and beliefs (Brockelman 1992:30). A worldview is defined by Cosgrove (2006:19) as “a set of assumptions or beliefs about reality that affect how we think and how we live”. The ideas and beliefs we hold **affect how we think** and how we live (Cosgrove 2006:26). Even if we do not know it, everyone has a worldview, which can negatively affect their whole life (Cosgrove 2006:29). These assumptions are usually unconsciously held beliefs. The quandary is that we may have learned a way of thinking or acting that is wrong or that does not fit with reality. In so doing, we could be living in a world and culture that holds to many strongly held beliefs that could be incorrect (Cosgrove 2006:29). Dockery & Thornbury (2002:2) say the following about a worldview: “Some worldviews are incoherent, being merely a smorgasbord of options from natural, supernatural, pre-modern, modern, and postmodern options. An examined and thoughtful worldview, however, is more than a private personal viewpoint; it is a comprehensive life system that seeks to answer the basic questions of life”.

Clifford Geertz’s definition of religion/worldview

Clifford Geertz’s defines religion/worldview as (quoted in Robert L. Winzeler 2000:11; Smeets 2012:27): Religion is a (1) “system of symbols which acts to (2) establish powerful, pervasive and long lasting moods and motivations in men by (3) formulating conceptions of a general order of existence and (4) clothing these in conceptions in such an order (aura) of factuality that (5) the moods and motivations seem uniquely realistic (Geertz 1973:4)”. Smeets (2012:27) lists the following dimensions contained in

Geertz's definition of a worldview: **Worldview related culture:** "worldview related culture comprises elements pertaining to worldviews that people encounter in their living environment and their social relations with others in time" (Smeets 2012:27). **Worldview related meaning:** "worldview related meaning concerns the way individuals symbolically construe a worldview in relation to the general order of existence" (Smeets 2012:27). **Worldview related rituals:** "worldview related rituals refer to symbolic actions that establish a link between everyday reality and a symbolic order" (Smeets 2012:27). I am particularly interested in his discussion of worldview related meaning, and will elaborate on this below. For now, however, I continue with a definition of a Christian worldview.

A Christian worldview

A Christian worldview is "not just one's personal faith expression, not just a theory. It is an all consuming way of life, applicable to all spheres of life. A Christian worldview is not just piety added to secular thinking, nor is it merely research that takes place in a Christian environment" (Dockery & Thornbury 2002:12). "A worldview is not just a list of beliefs but a living view; not just an academic endeavour but a personal one as well. Your Christian beliefs are first and foremost personal, affecting not just your mind but all of you and your daily life" (Cosgrove 2006:19). "Christianity is not just a set of rules and religious practices. It is a world and life view" (Cosgrove 2006:28). I reflect on the characteristics of a Christian worldview later again in this chapter.

Worldview relates to pastoral/spiritual care

'Worldview' is described as the substance of spiritual care (Smeets 2012:23). (This term covers a broader field than religion, whose content presupposes a viewpoint on the existence of an ultimate reality). Smeets notes worldviews as being the special domain of spiritual care: "Worldview is considered to be crucial, the cardinal domain of spiritual care" (Smeets 2012:23). In their research they relate the goal of spiritual care to the goals of worldviews and health care and especially the overlap between these two goals. "In the first place then, we see the goal of spiritual care as worldview related. Earlier the aim of pastoral work was conceptualized in the perspective of communication theory. By the same token the aim of spiritual care may be seen as worldview communication, which may focus on diverse aspects – like pastoral work – have diverse accents depending on the context. Secondly, we see the aim of spiritual care as promoting human health". (Here they differ from those who define the goal of spiritual care exclusively in terms of religious coping or mental health). The goal is what the spiritual caregivers hopes to achieve with their activities, which can be summed up as follows: "promoting the physical, mental and social well-being of people by means of the communication on worldviews, or worldview related communication as a contribution to physical, mental and social well-being;" and to promote "the spiritual dimension of health" (the ultimate goal) (Smeets 2012:35). Goals such as these give the profession a distinctive orientation and structure in health care (Smeets 2012:23).

The notion of meaning in cognition

Clifford Geertz's approach to religion stresses meaning. **Here, the notion of meaning is connected to cognition (and emotion).** To recap, the culture we live in bestows the individual with a broad framework within which they assign meaning to the world in terms of their worldviews (Smeets 2012:30). The individual meanings here are embedded in the worldview of that culture and make it real. Geertz notes these individual meanings to have a cognitive and an affective side to them. Smeets (2012:30) summarizes this as follows: "Cognitions are ideas that are fundamental to human life and the world. Geertz calls worldview related ideas symbolic transformations of reality. Adherents of a particular worldview believe in the reality of their symbolic transformations, hence Geertz refers to them as beliefs. In part these beliefs are descriptive models of reality, but they also offer normative models for reality. Such beliefs counteract chaos and are considered to bring or restore order to human life. Beliefs create an affective orientation. Geertz associates the affective side of worldview related meaning with moods and motivations that a worldview engenders in people. By motivations he means fairly permanent emotional orientations to certain actions. Beliefs create a motivation to continue seeing the symbolized models of reality as meaningful and to concretize the symbolized models for reality in actions. Moods, on the other hand, are determined by particular conditions. Motivations have an orientation, moods merely have a certain intensity. Geertz describes motivations and moods as powerful, profound and lasting. Together with moods, motivations colour people's cognitive slant on reality; they make beliefs convincing. Worldview related meanings provide the only meaningful way of coping with reality, especially in boundary situations". He goes on to discuss individual meanings such as ultimate reality; suffering and death (Smeets 2012:30).

The centrality of spirituality

Reflection on spirituality is a central feature of this work. Many therapists are unaware of, or unprepared to deal with this dimension in treatment. This study has shown that spirituality and psychotherapy can be integrated in treatment. A noteworthy article by Adrian Andreescu (2012:23) that reflects on the interplay between psychology, religion/spirituality (prayer) and health is worth mentioning here. In his brief literature review of cancer survival trials, he explores the psychological dimension of prayer in health research. He theorizes about the following concepts: one's worldview, intentional normative dissociation (IND), and psychosomatic plasticity-proneness (PPP); and uses the psychological dimension of prayer to unite these concepts. His premise is that these factors significantly impact the outcome of health if used together with Christian prayer (Andreescu 2012:25). Andreescu's ideas on worldview are of particular relevance to the context of my study. He explains the influence that one's worldview has on healing. Worldviews define the boundaries of what one can do himself or herself towards healing (with and without additional support - medical, spiritual, etc.). They also shape the way one perceives disease and healing. There are implicit assumptions regarding healing and illness embedded in our dominant cultural models. Andreescu adds, "Maintaining psychological well-being during serious illness is both

challenging and difficult for the patient (Folkman & Greer 2000; Lepore & Revenson 2007), so the illness narratives of cancer survivors should stimulate further exploration of their worldview and of the related inner resources one could use to create order and coherence in the face of a threatening disease” (Andreescu 2012:27).

A person’s worldview may be deeply shaped and reinforced by their religious tradition and personal spiritual experience. To this, Andreescu (2012:29) writes: “In the case of Christianity, this might require a familiarity with relevant Christian scripture and the conviction that God is permanently present in his or her life, thus providing a sense of existential security. If a devoted Christian believer accepts as truth the above mentioned scriptural verse and decides to act according to it, then it might entail embodying the desired wellness by assumption, suspending disbelief to such extent that he or she is able to “imagine” his or her own health or, according to this word’s Latin roots, to “conceive” it within, to become pregnant with it”. This means their spiritual identity can modify their illness narrative, and in so doing liberate the individual from psycho-emotional, internalized constraints blocking their healing. This psychological act of imagining the desired state of health is considered an essential act in healing. Prayer accompanied by faith, is also a meaningful act that will help reincorporate health into one’s life (Andreescu 2012:29). But this involves more than just accepting some type of religious convictions at the cognitive level (Andreescu 2012:30). “Faith seen as worldview should be a deeply inhabited aspect of one’s life” (Andreescu 2012:30). “Health has already been restored at a subjective level and with persistent confidence will grow objectively visible according to the strength of one’s faith and the discretion of divine grace (Andreescu 2012:30). Any type of worldview, be it religious, spiritual, or secular, lies an intricate web of constructed meanings” (Andreescu 2012:30).

So far, I have sought to discover what contribution psychology, religion and pastoral care can make to the task of “thinking”. But as the above research reveals, this may entail much more than just revising simple ‘thinking’; perhaps a paradigmatic exchange would be a more appropriate suggestion?

4.2. THE CONTRIBUTION OF PASTORAL CARE AND CHRISTIAN SPIRITUALITY TO RESTRUCTURING DESTRUCTIVE THINKING

It is now clear, that certain thoughts are "toxic" due to their power to perpetuate or exacerbate certain experiences. In the previous chapters a number of destructive types of thinking were identified, such as inappropriate God-images; cognitive distortions i.e. Catastrophizing, all or nothing thinking, and so on. In reviewing the contribution that pastoral care and Christian spirituality can make to reducing destructive thinking, I take a look at what is meant by ‘health, healing and wholeness’ in the context of pastoral care.

Healing and wholeness in pastoral care

There are different perspectives on health, healing and wholeness in the literature. The meaning of healing and wholeness in pastoral care also differs to that found in psychology. Van Beek (2010:480) explains the task of pastoral care (and pastoral ministry) as ‘**wholemaking**’: “*Pastoral counseling* is a focused, highly structured act or series of acts of spiritually motivated caring that require a high skill level and a significant strategy; *pastoral care*, although informed by the insights from pastoral counseling, is an act or number of acts of spiritually motivated caring that can take place at anytime and anywhere; *pastoral ministry* is the work of general professional church ministry informed by the insights of pastoral care and counseling and manifested in spiritually motivated acts of caring. *Pastoral theology* makes theological statements about pastoral counseling, pastoral care and pastoral ministry”. “Whether we speak of pastoral counseling specifically or pastoral care more generally or pastoral church ministry as even wider, they all seek to participate in the work of wholemaking” (van Beek 2010:471).

Glenn H. Jr Asquith (2010) in “The Concise Dictionary of Pastoral Care and Counseling” describes **healing** as: “The process of being restored to bodily wholeness, emotional well being, mental functioning, and spiritual aliveness. Christian modes of healing have always distinguished themselves as achieving a spiritual advance in connection with the healing process. Healing may also refer to the process of reconciling broken human relationships and to achieve the development of a just social and political order among races and nations. In recent times, healing and wholeness have become metaphors for religious views and salvation”.

In his approach to health and illness, Louw describes health and ill health as “two dynamic concepts on the continuum of personal responses, human development and psychophysical processes of growth that take place throughout all stages of life” (Louw 2008:23). He does not view sickness and health as two separate and independent entities. “Sickness must not be seen as the negative component of health, nor health as the antithesis to ill health or merely the constructive component of sickness. Good health, however, consists of more than the absence of sickness” (Louw 2008:23). To understand illness and health, Louw proposes a spiral model. The difference between a spiral and circular model is that in a circular model, healthy people move from ill health, back to health; and in a spiral model, movement is reflexive, circular and spiral (Louw 2008:23). Due to the qualitative nature of the spiral model, factors such as the lifestyle, behavior, quality of maturity/spirituality and ability to grow, learn and adapt, have an impact on sickness, health and quality of health. Illness is often out of a person’s control, but their attitude and disposition towards illness is not. Louw reckons this will depend on the degree and quality of a person’s maturity, the nature of their faith, their normative frame of reference, support systems, and quality of networking (Louw 2008:24). That “human beings are able to bear suffering and pain meaningfully” is the underlying assumption of this model (Louw 2008:24). Louw uses his dynamic spiral model as the point of departure in formulating and defining health. In Louw’s model, “the quality of

patient’s maturity, the content of their belief system, the nature of their relationships (their relationships with themselves, their fellow humans, their relationship to nature and the environment, their relationship to their culture and their relationship with God) all play a decisive role” (Louw 2008:43).

Culturally, health is regarded as the “normal and natural state;” and illness as “abnormal and unnatural” (Louw 2008:43). This definition views health as the absence of sickness. In Louw’s definition health is considered “more than the absence of infirmity” and therefore, “to see health only against the shadow of illness is one side” (Louw 2008:43). In contrast, the WHO defines health as a state of perfect physical, psychological and social well-being (quoted in Louw 2008:43). To sum up Louw writes: “Our point of departure further implies that in our understanding of both illness and health the following issues are important: maturity, our human quest for meaning, the quality of relationships; our philosophy of life, the different schemata of interpretation determining attitude and disposition, as well the quality of the spiritual dimension and its connectedness to appropriate God-images. Sickness and health are relational entities and refer to fundamental life and existential issues. They do not denote fixed concepts” (Louw 2008:44).

Health in pastoral terms

Health in pastoral terms can be measured by the degree to which one’s faith enables them to live with meaning. The more mature their faith, the more their understanding of God will enable a meaningful life. “By “mature faith” is meant the congruency between that which one believes of God (content) and how one acts in the awareness of God’s presence (witness)” (Louw 2008:47). Louw’s description of health includes more physical restoration. It also includes spiritual wholeness. “Health includes responsible medical practices as well as the utilization of spiritual, cultural, psychological and social sources” (Louw 2008:47). He says, “In pastoral care, we need to start speaking of ‘human wholeness’. The reason for this is that health in a biblical sense points to life and salvation” (Louw 2008:47). In his theological approach to understanding Christian spiritual healing, Louw (2008:62) promotes the following theological interpretation of healing:

Table 4.1

Theological perspective:	Description
spiritual healing as a new state of being	healing represents the fact that “if anyone is in Christ, he is a new creation” (2 Cor 5:17)
spiritual healing as a new state of mind	Shalom describes a contentedness with god and life. “For he himself is our peace” (Eph 2:14).
spiritual healing as a new attitude and way of doing and living	“Live by the Spirit... the fruit of the Spirit is love, joy, peace, patience, kindness, goodness, faithfulness, gentleness, and self control” (Gal 5:16:22-23)

spiritual healing as wholeness, purposefulness and direction	“For in this hope we were saved” (Rom 8:24).
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Louw says that spiritual healing (with its dimensions of peace (shalom), healing (habitus) and wholeness (telos, meaning), should take place within the realm of existential, life issues (Louw 2008:62) and then lists the following existential issues (Louw 2008:63):

- the existential threat of anxiety
- the existential threat of guilt
- the existential threat of despair
- the existential threat of helplessness and vulnerability
- the existential threat of disillusionment, frustration, anger and unfilled needs

These “5 viruses” listed below pose as risk factors to spiritual health (Louw 2008:65):

- anxiety
- guilt, guilt feelings and shame
- despair
- helplessness and vulnerability
- frustration and disillusionment

The significance of these existential issues as listed above, is that by connecting these with the content of one’s faith in such a way that meaning is discovered and introduced, enables spiritual healing to take place (Louw 2008:66). Such healing means “that one understands God and relates one’s God-image to life in order to live the problems in an appropriate and responsible way” (Louw 2008:66). This does not mean that all of one’s problems in life are eliminated. Linking an appropriate understanding of God to the basic issues in life creates the opportunity for spiritual healing. “Healing is about the encounter between life and God, and the quality of our being functions which emanate from such an encounter as well as an awareness of the presence of God that inspires and motivates faith. Inspired faith is a pneumatological event that fosters a directed courage to be and leads to inspiring and transforming actions of hope. The categories of meaning and destiny (telos) are essential in spiritual healing” (Louw 2008:66).

“The discovery of meaning and spiritual healing in this existential schema of life issues in pastoral care (faith care as life care) implies that, through the content of the Christian faith, appropriate God-images are related to fear/anxiety in such a way that intimacy is experienced: that guilt, guilt feelings and shame are related to freedom; that despair is addressed by eschatology and hope; that helplessness and vulnerability are connected to the concreteness of diakonia and koinonia; and that frustration and anger are met by the fulfilled promises of God and ethical acts of structural and contextual transformation” (Louw 2008:66).

When one's relationship with God is shattered or 'broken', healing is obstructed from taking place. Such a broken relationship prevents a clear view of God. I therefore discuss what it meant by 'spiritual brokenness' and 'spiritual trauma' in the section that follows.

Spiritual brokenness

What does it mean to be spiritually broken? Brokenness is a condition characterized by disease or disruption of energy flow for daily life and health (Flory 1983:105). The person who looks for reasons why God is making them depressed or is causing them to suffer, indicates that their relationship with God is broken. This type of relationship obstructs healing. Through wholistic ministry healing can be brought to a situation of brokenness (Flory 1983:106).

Spiritual trauma

Stressful events are never pleasant. They can be unpredictable and have devastating consequences. Those who view stressful events as also being **negative spiritual experiences** suffer what is termed '**spiritual trauma**' (Joseph & Linley 2008:105). Spiritual trauma has a devastating impact on the life of the person, attacking not only the very core of their being; but also their relationship to God, and their relationship to them self. For them, the meaning and purpose of their life becomes vague, confused or lost and they seem to lose the ability to connect with nature, people, and God. Joseph & Linley (2008:107) explain spiritual trauma to be "an event that severely disrupts the individual's spiritual orienting system, which refers to a generalized set of spiritual beliefs, practices, and relationships". These authors recognize that a **person's appraisal of an event shapes the degree to which that event is experienced as traumatic** (my emphasis). This definition shows the role of one's thoughts in experiencing trauma. "Thus, a spiritual trauma occurs to the degree to which an event is viewed as threatening and damaging to an individual's core spiritual values and goals (primary coping appraisal), accompanied by an appraisal of spiritual resources available to manage the stressor (secondary coping appraisal)" (Joseph & Linley 2008:107).

The following description also shows the effect of spirituality on trauma: "There is evidence showing that **people who view their tragedies through a negative spiritual lens** are likely to report higher levels of distress" (Joseph & Linley 2008:111). Krumrei et al. (2007) in their study on divorce found that experiencing a spiritual trauma is tied to greater distress. "The more divorcing individuals viewed their divorce as a sacred loss or desecration, the greater their experience of depression, posttraumatic anxiety, anger, and spiritual distress. Qualitatively, participants also relayed in their own words that viewing their divorce through a negative sacred lens heightened their distress" (quoted in Joseph & Linley 2008:111).

Another negative effect of a spiritual trauma is the disruptive consequence it has on a person's spiritual orienting system (or generalized set of spiritual beliefs, practices, relationships and values). When one's spiritual orienting system is under stress, "spiritual struggles" may arise.

Spiritual struggles

Spiritual struggles are described by Joseph & Linley (2008:115) as efforts to conserve or transform a spirituality that has been threatened or harmed; which include "expressions of conflict, question, and doubt regarding matters of faith, God, and religious relationships" (McConnell, Pargament, Ellison & Flannelly 2006:1470). High levels of spiritual struggles have been strongly tied to greater depression, anger, and post traumatic anxiety symptoms (Joseph & Linley 2008:115). "Although research has shown that religious coping is often associated with beneficial outcomes, stressful events can also lead individuals to struggle with their religious beliefs, religious institution, or relationship with the divine. Spiritual struggles have been consistently associated with anxiety and depression in the research literature" (McConnell, Pargament, Ellison & Flannelly 2006:1470).

Three types of spiritual struggles described in the literature are:

- ***Divine spiritual struggles:*** These center on an individual's relationship, **thoughts** and feelings toward God (Joseph & Linley 2008:111). Any traumatic event can pose a threat to views of God as an all loving, omnipotent being who ensures that good things will happen to good people. In response to a crisis, the individual may feel abandoned or betrayed by God, feel angry with God, punished by an angry God, or question God's power. These struggles may be especially potent for spiritual traumas that bring expectations about God under fire (Joseph & Linley 2008:112).
- ***Intrapersonal Spiritual struggles:*** These refer to internal questions, doubts, and uncertainties about spiritual matters. Although any crisis may trigger intrapersonal struggles, perceptions of sacred loss and desecration exacerbate spiritual struggles within the self. Intrapersonal spiritual struggles focus on questions about one's ultimate purpose in life and religious systems of belief and practice (Joseph & Linley 2008:112).
- ***Interpersonal spiritual struggles:*** These involve spiritual tensions and conflicts with family, friends, congregations and communities, and may be especially prominent during interpersonal crises. Interpersonal spiritual struggles can occur when members of one's social system disagree with that person's spiritual interpretation of, or response to, trauma. Interpersonal disagreements may be especially toxic when people receive the sacred in different ways. Less spiritually oriented family members may be unable to grasp that a divorce experience experiences (Joseph & Linley 2008:112).
- ***Interplay among spiritual struggles:*** An interplay exists between these three types of spiritual struggles, as they are likely to co-occur and interact in complex ways (Joseph & Linley 2008:113).

Spiritual struggles have been linked to various psychological problems. McConnell, Pargament, Ellison & Flannelly (2006:1482) suggest that identifying and resolving spiritual struggles before they become problematic may help to reduce the risk of psychopathology and promote greater psychological well-being.

Post traumatic growth after a traumatic event has also been described in the literature. Loiselle et al. (2011:64) explains, “In addition to commonly recognized negative effects such as posttraumatic stress symptoms (PTSS), there may also be positive personal developmental change, including posttraumatic growth (PTG), which occurs in conjunction with or in the aftermath of a traumatic experience. PTG has been defined as “positive psychological change experienced as a result of the struggle with highly challenging life circumstances or traumatic events (Calhoun & Tedeschi, 1999, p. 1)”. The Posttraumatic Growth Inventory is used to assess positive outcomes after a traumatic event. It consists of a 21-item scale that includes the following factors: New Possibilities, Relating to Others, Personal Strength, Spiritual Change, and Appreciation of Life (Calhoun and Tedeschi 1996). Characteristics of positive traumatic growth thus include psychological, social, and spiritual growth, i.e. by becoming stronger personally; deepening connections to other people; and growth in faith.

However, overcoming spiritual stressors is difficult, especially when spirituality itself is seen as a roadblock i.e. when the traumatic event itself is interpreted as a violation or a loss of something sacred to the individual (Joseph & Linley 2008:105). Spiritual trauma’s can keep people stuck in painful spiritual struggles; but they can also motivate them to seek out or draw on spiritual resources rather than abandon the spiritual realm altogether, thus facilitating psychological and spiritual growth in the healing process (Joseph & Linley 2008:105). Thus, **spirituality has the potential to facilitate growth when disaster strikes** (Joseph & Linley 2008:106). Therapists then can help guide counselee’s out of such spiritual situations and toward growth when faced with devastation (Joseph & Linley 2008:106). As **spiritual healing** occurs, the individual moves beyond the event into greater maturity and understanding. As emotional and psychological wounds heal, there is a growth in character as well. Even though one may rebound as future hurts and losses inevitably occur, character development is enhanced by gaining spiritual insight and healing.

The contribution of spiritual and pastoral care to restructuring destructive thoughts

The **adaptive use of spiritual resources** (positive spiritual coping methods) when faced with a host of life stressors (i.e. the death of a loved one, terminal illness, major surgery, imprisonment, physical abuse, war, racism, flooding, car accidents, and adjustment to college) has been found to **decrease emotional stress, and increase well-being and spiritual growth** (Joseph & Linley 2008:115). Spirituality can also be a place to turn to recover from spiritual traumas.

Joseph & Linley (2008:115) however describe a paradox surrounding spiritual resources. “At the time of a crisis, greater use of spiritual resources is often linked with greater psychological distress (e.g. anxiety, depression, and anger) and spiritual struggles (e.g. anger or doubts about God). This effect has been coined a stress mobilization effect. Nevertheless, even at the time of a crisis, greater positive spiritual coping is tied to self reports of stress-related psychological and spiritual growth (the individual’s perception that a particular stressor has been helpful in making positive changes in life). Taken together, these findings indicate that psychic and spiritual struggles motivate many people to turn their as a means to grow through their pain”.

Spiritual struggles are often triggered by spiritual traumas. But, such perceptions can also facilitate psychological and spiritual growth. Under such circumstances, sometimes individuals may be motivated to grow rather than totally abandon their spiritual frame of reference (Joseph & Linley 2008:119). In this way, spirituality offers numerous adaptive resources to help an individual recover from spiritual traumas and overcome the suffering associated with spiritual struggles (Joseph & Linley 2008:119).

The cognitive dimension in healing and wholeness

A. van Dyk (2005:92-94) emphasizes the **role of attitude** in bringing about behavioural change and healing (quoted in Louw 2008:25). Here Louw adds: “In order to change people’s mindset, it is indeed necessary to change the cognitive structures that govern specific behaviour. However, to promote health the counselor should establish a person’s attitude towards the specific behaviour that needs to be changed before the change can be expected to occur” (Louw 2008:25). Therefore, the attitude and position one takes has an effect on a spiritual approach to health and healing. Louw writes: “Healing and health are therefore closely related to the way we respond to what befalls us. The way we position ourselves according to the norms and values of our belief systems is often more fundamental in healing and therapy than psychoanalysis, psychotherapy and changes in the inner or personal structures of the psyche” (Louw 2008:26). Thoughts, beliefs and faith are therefore critical aspects in spiritual healing and wholeness. They help the individual to re-frame and re-vision their lives, so that the road to wholeness is reopened.

But when do our thoughts destroy and when do they transform? People have all kinds of beliefs about what causes their emotional and spiritual pain, and they have attached various meanings to these. To varying degrees these meanings reflect fundamental beliefs about self, life, and God. How do these beliefs affect how a person handles their pain, suffering, struggles or life’s difficulties? How do beliefs alter one’s understanding of God? Who is God to them? In such a way, our thoughts can alienate us from God. Unwarranted anger directed at God is usually accompanied by a crisis in faith. It is important to define a pastoral response for people who believe God is punishing them for their behaviour.

We are conditioned to think a certain way due to our heritage, upbringing, culture and own minds. We develop faulty beliefs based on this conditioning and come to believe this is an accurate account of reality. But by **discovering alternative images of God** can be a liberating experience for some. Spiritual healing and renewal can be validated by a new or diverse expression of who or what God may be, and thus inspire hope for new meaning. The path to complete restoration includes spiritual healing and encompasses growth and development at many levels. To bring attention to these things, questioning faulty beliefs and allowing our thoughts to be transformed, is an essential part of coming home to our true selves, healing, understanding and growing. The intention of healing is to bring awareness to ways in which we feel, think and act from a place of separation, illusion and fragmentation. This awareness facilitates healing and the return to wholeness.

But what does it mean to bring a theological perspective to the task of thinking? By using theological language and reflection to interpret suffering and healing, indicates that one interprets dimensions of their life and experience in terms of an underlying theological perspective. Examining one's theology could empower and transform their theological perspective and thereby alleviate suffering.

The objective of this thesis is to explore the constructive contribution that pastoral care can make to destructive thinking from a Christian and theological point of view. Sometimes one's internalized theologies and religious practices contribute to attitudes and behaviours that maintain their distress. Thus, for the "healing to take place may require considerable theological reworking at the dynamic level of the personality" (Glenn H. Jr Asquith 2010). Because we are whole persons with many facets - cognitive, behavioral, emotional, spiritual and existential beings, a Christian spiritual approach includes a spiritual dimension in its therapeutic practice. An essential outcome of such an approach is healing and wholeness. The pastoral caregiver is called to care and to minister wherever adversity threatens to shatter a persons' sense of self and their faith in God. In this journey towards healing, some people will be confronting theological issues (i.e. religious core beliefs; destructive religious thoughts; attitudes toward God, inappropriate God-images, and so on). Healing was also central to the public ministry of Jesus Christ. The Gospel stories are rich in stories of people seeking to find meaning in their lives. For some the Bible functions as a source of help and inspiration, and for others, a means of exacerbating their guilt or oppression. It should be noted, that all influences that seek to obstruct wellness and spiritual growth are in contradiction to God's will - which ultimately seeks the restoration of people.

4.3. THE CONTRIBUTION OF 'CHRISTIAN THINKING' TO RESTRUCTURING DESTRUCTIVE THOUGHTS

The Bible and 'thinking'

The Bible is an important book for Christians. "The Christian Bible can be seen as the most important religious book for a Christian believer, a book whose words are intended presumably to form and shape that person's life" (Andreescu 2012:30). "...its inspired teachings allow us to develop a cohesive and defensible worldview from which we can speak to any subject or issue in our lives and culture. The Christian faith, therefore, is personal. It speaks of a life lived in relationship with God, in the wholeness of our being – intellect, emotions, and will" (Cosgrove 2006:28) A pastoral theology of thought must recognize our responsibility for choosing when and what we think, and how we express these in actions. The following Bible passages stress the importance of Christian thinking: Matthew 22:37 (NIV) "Jesus replied: "Love the Lord your God with all your heart and with all your soul and with all your mind;" and Romans 12:2 (NIV) "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". "In Matt 22:3-40, we are told to love God not only with our hearts and souls but also with our minds. Jesus' words refer to the wholehearted devotion to God with every aspect of our being, from whatever angle we choose to consider it – emotionally, volitionally, or cognitively. This kind of love for God results in taking every thought captive to make it obedient to Christ (2 Cor 10:5). A wholehearted devotion to distinctively Christian thinking. This means being able to see life from a Christian vantage point; it means thinking with the mind of Christ" (Dockery & Thornbury 2002:3).

What does it mean to think like a Christian?

As humans we have the capacity to think, this is what sets us apart from the rest of the created world. But, what does it mean to think like a Christian? And what specific role do our thoughts play in our Christian lives? What type of thinking would benefit us in our search for personal meaning and spiritual wholeness? As Christians, we are to strive to have the mind of Christ and to live by the principles of the "Word of God.". The Christian faith holds to a belief system that has a significant effect on one's entire life. "Thus, faith cannot be separated from ordinary ways of learning or made into a separate, detached, religious learning process. This means that faith cannot be considered an anti-intellectual, spiritual journey to knowing truth but that it is an intellectual and personal journey into areas within and beyond our understanding. Faith should not be considered a separate, unusual form of "otherworldly" knowing that bypasses traditional knowledge but one that participates in all our normal ways of knowing" (Cosgrove 2006:37). Dockery & Thornbury (2002:4) states that to think wrongly about God is idolatry (Ps 50:21); and that to think rightly about God is eternal life (John 17:3). The latter should be the believer's life objective (Jer 9:23-24). "Right thinking" is a central tenet of the Christian faith.

As Christians, we are taught that even though we **are fallen creatures** (i.e. the story of the Fall) God intervened to restore us to himself through the death and resurrection of Jesus Christ. Conversion takes place when we turn to God in faith. Hollinger (2005:39) writes, "The word for repentance in the NT

(metanoia) literally means to change one's mind, and this is a significant part of conversion. Of course conversion always involves more than the mind, but without the mind there is no true conversion". The head/mind plays a vital role in conversion. The Apostle Paul showed us that **coming to faith** in Christ is a process that always involves both head and heart, "if you confess with your lips..." (Romans 10). This confessing with the lips involves a public declaration and a cognitive dimension. Hollinger (2005:40) writes, "It is not merely a feeling one has about Christ or even a will to follow him in life. There is certain content that is embraced – "Jesus is Lord". To affirm cognitively that Jesus is Lord doesn't bring salvation, but without it there is no salvation".

Transformation and growth

Being a Christian is much more than just a personal, private relationship with God. It influences every aspect of your life and how you relate to others, including how you think and structure your thoughts. But just as the mind and our thoughts play a role in coming to Christ, so too do they play a role in growing in grace and living out the life of Christ. Christian growth is an experience in growing closer to the living God and thereby being transformed into divine likeness. Hollinger (2005:41) says a key element in that transformative process is our thinking. He explains that transformation and growth doesn't come only by understanding more of the Bible or having greater insights of theology. The renewing of our minds will never be a purely cognitive enterprise. But, we need biblically informed thought for transformation. Therefore, what goes into the mind is a significant part of this transformation process, e.g. If we fill our minds with things that dishonour God, others and self (i.e. sin) we will reap negative results in our affections and actions. If we fill our minds with the good things of God, mediated through his Word, we will reap a "harvest of righteousness" (Phil 1:11) in all dimensions of life (Hollinger 2005:41). Spirituality and Christian growth are not primarily an inward reality, but how we think here also plays a key role. Hollinger (2005:42) explains, "With the mind we understand something of the triune God we follow in life. With the mind we understand the patterns, designs, virtues and key spiritual disciplines that go into the spiritual growth process. And with the mind there is an actual direction and empowerment toward that process. Because ideas have consequences, the head clearly is vital to the Christian life, as it impacts both the affectional and behavioural dimensions of life".

In the light of the above passages it becomes clear that the contribution of 'Christian thinking' to restructuring destructive thoughts entails much more than mere cognition. A Christian worldview takes every thought captive to the lordship of Jesus Christ (Dockery & Thornbury 2002:15) thus directing the believer's entire life.

Developing a Christian mind and worldview

In a previous section I described that everyone has a worldview. Sometimes we become so absorbed in the environment around us that we don't see the effect of such a secular worldview on our spirituality and

thoughts. Dockery & Thornbury (2002:2) states: “Some worldviews are incoherent, being merely a smorgasbord of options from natural, supernatural, pre-modern, modern, and postmodern options. An examined and thoughtful worldview, however, is more than a private personal viewpoint; it is a comprehensive life system that seeks to answer the basic questions of life”. A Christian worldview will help to ‘think more Christianly’ and live out the truth of Christian faith. Dockery & Thornbury (2002:12) describe a Christian worldview as “not just one’s personal faith expression, not just a theory. It is an all consuming way of life, applicable to all spheres of life. A Christian worldview is not just piety added to secular thinking, nor is it merely research that takes place in a Christian environment”. In a Christian worldview, there is a definite Christian view of things. A Christian worldview also acknowledges that God is the sovereign and almighty. “A Christian worldview becomes a driving force in life, giving us a sense of God’s plan and purpose for this world. Our identity is shaped by this worldview. We no longer see ourselves as alienated sinners. A Christian worldview is not escapism but is an energizing motivation for godly and faithful thinking and living in the here and now. It also gives us confidence and hope for the future. In the midst of life’s challenges and struggles, a Christian worldview helps to stabilize, anchoring us to God’s faithfulness and steadfastness” (Dockery & Thornbury 2002:12).

What happens when thinking is neglected in Christian thought and life? What does a faith with very little thinking produce? Faith with very little thinking produces an “incomplete faith” (Hollinger 2005:58) because we are called to love God with all our mind (Matthew 22:37 (NIV) “Jesus replied: “Love the Lord your God with all your heart and with all your soul and with all your mind”). “A faith without the mind tends to be a shallow and ill equipped to cope with the inevitable realities and hard questions of life. Headless Christians usually resort to a faith dominated by feelings alone and become spiritually dependent on their own emotional state or on a series of peak “spiritual experiences” which they seek to continually replicate” (Hollinger 2005:58). Therefore, without the mind, faith will not be sustained, “for it will lack a compass, a grounded worldview and the motivations and sustaining guidance necessary for facing life’s challenges and disappointments” (Hollinger 2005:58).

The ongoing use of the mind

The **ongoing use of the mind** is a key factor in its growth. Our thinking is nurtured by studying Scripture, Christian worldview issues and theological understandings (Hollinger 2005:68). “Without cognitive reflection, there is a tendency to view the world in either – or categories, unable to recognize and sort through the complexity of reality. Thus it will be difficult to view culture in such way that one can discern to those elements that are compatible with Christian faith, those that are clearly incompatible, and those that are somewhere in between” (Hollinger 2005:72). “A Christian worldview is needed to confront an ever changing culture. Instead, of allowing our thoughts to be captive to culture, we must take every thought captive to Jesus Christ” (Dockery & Thornbury 2002:12). Williams (2002:18) writes, Christians “do not want to be schizophrenic in their thinking. Rather, they want their whole mind to

revolve around their Christian beliefs”. “They want to avoid inconsistencies that seep into their thinking due to immersion in a secular culture and they want to connect what they know to be the basic truths of Christianity – that God created everything, that humans have sinned against God, and that God has provided a way to be redeemed from sin”.

We must realize the work of God in our minds and pay attention to what a ‘Christ like’ mind might look like. As our saviour has said, “Love the Lord your God with all your heart and with all your soul and with all your mind” (Matt 22:37). To do this, we need to keep at developing a Christian mind.

Cross and the resurrection

Jesus’ death on the cross for our salvation is absolutely central to the Christian faith. On the cross, Jesus made atonement for the sins of the world and opened the way for fallen, sinful, rebellious, mankind to be brought back into a right relationship with God. This is “Atonement”. Through Jesus’ crucifixion, mankind, separated from God by sin, is re-united with God and they are made one again (Summerall 2009:122). By-holding the cross and the resurrection together in one theological vision, Christian thinking can be both one of compassion and one of dynamic restoration. Both aspects are essential to a faithful witness to the nature of God. Ministries that sustain in inspiring ways as they heal in meaningful ways witness to the grace of God. They give expression to an integral mission of the God who suffers with and for, and who gives life in this existence and beyond what we can here know. This proposal points in the direction of a theology of wholeness which combines a theology of the cross and a theology of the resurrection (Underwood 2006:11).

Christian understanding of God

Christian faith and spirituality call for the significance and appropriateness of a Christian understanding of God. But how should God be interpreted and portrayed in Christian Spirituality? What God-images are fitting for the Christian counselee? Though the human race fell into sin and human thinking was marred and distorted, we continue to reflect the image of God by our ability to think (Hollinger 2005:37). At a spiritual level, suffering unmasks **inappropriate God-images**. Fundamentally, suffering thus becomes a ‘theological’ issue (Louw 2000:11). Not all that results from suffering is negative. Suffering can also generate patience and endurance (Louw 2000:11).

Thinking to discover meaning

One significant motive for thinking is to discover **meaning**. We want to know our place in the universe, in history, and in society. We want to discover values by which we can judge the importance of what we do. We desire to know what the significance of our life is. And although Christians have a sense of this significance, they want to know how everything else is connected to it (Williams 2002:23). A worldview must seek to answer questions like: where did we come from? Who are we? What has gone wrong with

the world? What solution can be offered to fix it? (Dockery & Thornbury 2002:3). It must seek to answer the key questions of life. A Christian worldview offers a new way of thinking and doing, based on a new way of being. It also provides a framework for ethical thinking. “Fear about the future, suffering, disease, and poverty are informed by a Christian worldview grounded in the redemptive work of Christ and the grandeur of God. As opposed to the meaningless and purposeless nihilistic perspectives of F Nietzsche, E Hemingway, or J. Cage, a Christian worldview offers meaning and purpose for all aspects of life” (Dockery & Thornbury 2002:10).

God knows our thoughts

God knows our thoughts (Ps 94:11; 139:2). Jesus knew what people were thinking (Mt 9:4; 12:25; Mk 12:15; Lk 11:17). How you perceive God in your thoughts determines everything else in your life. The Apostle Paul is showing us in (2 Cor 10:4, 5) where the greatest warfare of the Christian life really takes place – the mind. We all develop habits of thought that contradict the Word of God (fear, worry, anger, bitterness, sexual sin, greed, selfishness, laziness). Are your thoughts focused on the things of God and His way of dealing with the issues you are facing? Or are you thinking on thoughts of anger, frustration, bitterness, anxiety and so forth? When problems do come, we face them with the Word and the Spirit of God, and we overcome them rather than being overcome by them. We have a new way of thinking, a new way of acting, a new outlook on life, and new strength and power. Spiritual and mental change occurs as we renew our minds. Therefore, stop the flow of toxic thinking and fill your mind with the truth of God’s Word, the beauty of creation and the encouragement of God’s people. We still have to fight for the victory over the negative thoughts that can fill our minds and control our lives. “Thus Christian thinking must surely subordinate all other endeavours to the improve of the mind in pursuit of truth, taking every thought captive to Jesus Christ (2 Cor 10:5). As three places in the book of 2 Cor, Paul reminds us that we cannot presume that our thinking is Christ centered. In 2 Cor 3:14, we learn that the minds of the Israelites were hardened. In 4:4 Paul says that the unregenerate mind is blinded by the god of this world. In 11:3 the apostle says that Satan has ensnared the Corinthians’ thoughts. So in 10:5, he calls for all our thinking to be liberated by coming under the lordship of Christ” (Dockery & Thornbury 2002:14).

One reason why we cling to our old habits of thinking is because they keep us in our comfort zone, even if that means blocking our ability to heal. Secondary gain is the term psychologists use to describe the payoff people get from clinging to a false belief that reinforces a particular pattern of behaviour or negative thought process. The belief allows you to stay in familiar territory but it threatens your ability to get well. A lazy negative mind comes naturally, but a sound disciplined mind takes work. And it is worth working on. Nothing, including the mind, gets better on its own.

4.4. DESTRUCTIVE THINKING: TOWARDS A HOLISTIC APPROACH IN SPIRITUAL CARE-GIVING

A spiritual approach inquires what the theological issues are when dealing with the problem of illness and health. But says Louw, in providing pastoral care to the individual, other approaches need to be considered as well. He therefore advocates a spiritual and integrative approach. “Within an integrative and team approach, the medical, psychological and social dimensions must be taken into consideration as well” (Louw 2008:36). Louw suggests that health care, medical science and all forms of assistance should utilize a systemic and holistic approach. “This means that a person should be regarded as a relational and social being acting within a cultural context. This, in turn means that medical science should take the psychosomatic and socio-cultural side of the illness/health continuum into account. A systemic and holistic approach rejects the view that the unique human being is a discrete entity within the totality of ongoing communication processes” (Louw 2008:42). Louw describes the following implications of a holistic approach: Firstly, the *being* part of a person is distinguished from the *function* of parts (and is considered more important). “A human person is a moral and spiritual social being within a dynamic process of generating meaning. And these three components – morality, spirituality/religiosity and giving meaning – cannot be limited to analytic rational categories” (Louw 2008:42). Secondly, it recognizes the need to heal the structures in society as well as the dynamics within relationships, in order for the individual person to be healed (i.e. the ubuntu principle) (Louw 2008:42).

My proposal of a pastoral psycho approach as a method of healing intervention integrates both psychotherapy (theory and methods) and theology (the pastoral dimension). The Christian pastoral caregiver is working towards the end goal of spiritual healing and wholeness. To achieve these goals, I am proposing an approach to pastoral care that trades on a cluster of CBT ideas and pastoral counseling ideas that draws on both CBT models of psychotherapy and pastoral care literature, in which CBT concepts are utilized and problematic patterns of thinking are identified and analyzed. Through this integration of CBT insights with pastoral counseling literature I work towards the development of a pastoral-psycho approach. Both schools of thought take seriously the role of cognition; and that we are thinking, feeling, experiencing and interpreting human beings. Both schools offer deconstructive (critical and analytic) methods that probe deeper into our thoughts/cognitions. I acknowledge that individual’s have a choice in their process of personal growth and in the correction of their destructive thinking patterns. While still valuing these other sources, the pastoral dimension will come first. It is thus a therapeutically oriented pastoral counseling paradigm.

This proposed approach may at times call into question some of our most cherished beliefs and assumptions. This is part of our discernment and continual spiritual formation. Pastoral care and

counseling's distinctiveness as a profession comes precisely from its theological understanding of the self. This is what makes Christian pastoral counseling unique.

Keeping in mind what Christ has done for us in his incarnation, death and resurrection, in what way can the pastoral caregiver facilitate this self-transforming action on the part of the believer? The pastoral caregiver is not only a participant in this process but also co-worker with the Holy Spirit.

In the New Testament the apostle Paul draws attention to the notion of the two personalities - the new self and the old self (Roberts C. Roberts 2001:137; essay in McMinn & Phillips 2001). Robert C. Roberts (2001:137) describes the “**new self**” as: “In Paul’s view, leading a good life is a matter of accessing and actualizing a personality (a set of traits that are expressed in behaviours and emotions) that has been created for and in believers by virtue of the incarnation, death and resurrection of Jesus Christ. This personality, which exists in believers whether or not they manifest it in behaviour and attitude, is called the “new humanity” or “new self’.” (Roberts 2001:137). The following virtues characterize this new personality: hope, love, rejoicing in God, peace, patience, kindness, faithfulness, gentleness, self control and humility. The new self is truthful, compassionate, forgiving, forbearing and thankful. “These are some of the characteristics of the new self that God has placed in believers (or that God has placed believers in) through the incarnation, death and resurrection of Jesus of Nazareth. It is a personality that is flourishing and promotes the flourishing of persons who are in close relationship with it – flourishing by Judeo-Christian standards” (Roberts 2001:137).

The new self stands in contrast and opposition to a dysfunctional personality that Paul named the “old self” (Roberts 2001:137). Robert C. Roberts (2001:137) describes the “**old self**” as “characterized by a set of concerns, desires, behaviours and patterns of thought and emotion: greed, malice, envy, murder, strife, deceit, slander, enmity of God, insolence, arrogance, and pretentiousness or pride. The old self is an inventor of evil, disobedient to parents, foolish, faithless, unloving and unmerciful. Its vices are jealousy, anger, selfishness, conceit, impurity, sexual immorality, sensuality, idolatry, sorcery, enmity, division or dissension, party spirit, drunkenness, carousing, conceit, provoking one another, bitterness, clamour, slander, indecent, foolish and dirty talk, passion, evil desire, shameful talk and lying to one another” (Roberts 2001:138). The old self died with Jesus Christ on the cross (Roberts 2001:138).

Even though we as believers are in possession of the new self, we often fail to manifest this in our thoughts (emotions and behaviours). Roberts (2001:138) states, “The standard Christian life is a battle for the supremacy of the new self over the old”. Those who overcome this battle and achieve healing are active participants in the process by which the new self comes to dominate and replace the old.

In developing my pastoral psycho approach, I have listed a number of different types of destructive thinking as identified in the CBT and Pastoral care literature. The person who comes for therapy is usually experiencing some type of problem in living or difficulty. Perhaps the person is anxious; depressed; in conflict with others or just stuck in a rut of negative thinking. Many of the dispositions we bring to therapy are causally connected with the personality profile of “the old self” (Roberts 2001:145). When presented with a problem, the pastoral caregiver will gradually and tentatively construct a pastoral interpretation and explanation of the counselee’s presenting problem. In my pastoral psycho approach, I particularly center my attention on destructive types of thinking. I am not saying that this is the only aspect/component that should be addressed in therapy, but it is the aspect that is the focus of this thesis. The pastoral caregiver may seek information about the client’s cognitive patterns from other sources as well. But once they feel reasonably comfortable recognizing and acknowledging destructive thoughts patterns, through this process they will better understand the sources of faith pathology, inappropriate God images and destructive thinking. And be better able to help the counselee transform from the “old self” to the “new self”, in this way teach the client ways “to think” in accord with Christian theology and beliefs.

A trait of the ‘**old self**’ are bad relationship to God; disobedience, distrust or disregard of God, idolatry or setting oneself in the place of God and so on (Roberts 2001:145). Deep distortion in a person’s concept of God can be an important aspect of the old self and a big hindrance to putting on the new self (Roberts 2001:145). The pastoral caregiver will therefore want to explore the client’s concept of God, especially if the therapist suspects that the client’s concept of God is significantly distorted. It is therefore clear that at the heart of pastoral care are the images we have of God. What does one’s image of God reveal about their thinking? God image is a “powerful combination of our thoughts and feelings/emotions, arising from experience and giving birth to our picture of God” (Chigbo 2011:23). It is therefore a vehicle of meaning through which one attempts to make sense of God. Our image of God can either help or harm us. Our God image could either prepare us to answer the questions that life poses to us or it makes us blame life for our own lack of responsibility (Chigbo 2011:24). By diagnosing inappropriate God images, the therapist can help the counselee see the discrepancy between the new self and the self that they are manifesting much of the time.

As the Christian counselee puts on the ‘**new self**’ in Christ, it does not mean that they will never again have negative experiences, disappointments, sadness, anger, and so on. “It is true that the new self is full of joy and hope, but it is also true that the new self is subject to grief’s and frustrations to which the old self was insensitive” (Roberts 2001:152). It should also be noted however, that not all painful emotions are manifestations of the old self.

Roberts (2001:163) makes an interesting statement when he says: “Psychotherapy is about people’s psychological nature and problems. Psychological change includes a change in behaviour, thought and emotion – not a change in a particular thought, behaviour or emotion, **but a change in disposition toward these things**. It is a difference in the type or pattern of one’s behaviours, thoughts and emotions, something like a **change of character**” (my emphasis). He also notes that spiritual change does not occur in a different part of the soul from psychological change. “It too is a dispositional change in thought, behaviour and emotion” (Roberts 2001:163). “Spiritual change, then, is a kind of psychological change, namely psychological change brought about by the proclamation of the gospel and the work of the Holy Spirit in the life of the believer. It is psychological change in which a person’s behaviours, thoughts and emotions are informed by God and reflect his ways” (Roberts 2001:163). This is the type of spiritual and psychological change that my pastoral approach aims to promote.

In this way the proposed psycho-pastoral approach can assist pastoral caregivers to understand and deal with destructive thinking in a constructive and responsible way; help to reduce destructive thoughts/thinking; and lead the counselee towards spiritual healing and wholeness. This discussion has shown the relevance of pastoral and spiritual care-giving probing into cognitive patterns of thinking and its connection to conceptualization in pastoral care, very specifically to the experiences of faith and their connection to God-images. This approach then shows that pastoral care not only focuses on problems, but also facilitates growth.

4.5. CONCLUSION

Through continuous reflection on destructive thinking within religion, the interplay between thinking, God-images and spiritual well-being became apparent. A definite link was established between these concepts. The impact of destructive thinking on spiritual well-being was made clear. Thoughts can alienate one from God. Therefore, discovering alternate God-images can open up the possibility for spiritual healing and spiritual renewal to take place. A reciprocal relationship was also located between one’s thoughts and belief systems. Sometimes our theologies and religious beliefs/practices contribute to or maintain our distress and faulty thinking.

The positive contribution that pastoral care can make to minimizing destructive thinking and fostering spiritual healing, spiritual growth and overall well-being was acknowledged. In the context of this study, developing Christian thinking and a Christian worldview also had a role to play in reducing destructive thinking. An holistic approach to destructive thinking in pastoral care holds an awareness in its purview of the critical role of thoughts/cognition in spiritual struggles, spiritual traumas, spiritual healing and wholeness. The type of thoughts that obstruct spiritual growth was discussed, as well as the types that prove to be more beneficial.

These findings here have been a valuable contribution to developing an understanding of destructive thinking within the pastoral context. Clarification of the dynamics of thoughts, have provided a clearer understanding of the sources of faith pathology; inappropriate God-images, and so on, which can be used to assist the counselee to move from the ‘old self’ to the ‘new self’ and learn ‘how to think’ in accord with Christian theology and beliefs. Thus, thinking needs to be nurtured – through scripture, Christian worldview, theological reflection, cognitive reflection, and through developing a Christ-like or Christian mind. A deeper understanding of destructive thinking within the pastoral context has therefore been accomplished. The pastoral and spiritual care-giver needs to continue to probe into cognitive patterns of thinking, as he/she plays a pivotal role in providing spiritual direction and mentoring to those under his/her care. Given these insights as listed above, focusing on the role of cognition should become a fundamental part of the pastoral care and counseling context.

CHAPTER 5

SUMMARY OF FINDINGS AND CONCLUSION

5.1. Summary of findings

This thesis titled “Destructive Thinking within Religion: A Psycho-Pastoral Approach” was organized around the following main objectives:

1. to define, and develop, an understanding of ‘destructive thinking’
2. and to formulate a psycho-pastoral approach to destructive thinking

In my endeavour to understand and describe “destructive thinking,” I began with an introductory chapter (**chapter 1**) to place this thesis in context. I gave reasons for my choice of therapeutic approach. In that, a literature review revealed an extensive body of research on the topic of ‘cognition, thoughts and various types of destructive thinking’ particularly within the field of Cognitive Behavioral Therapy. CBT has a particular emphasis on changing thoughts in order to change the way one feels and behaves. Due to its attentiveness to thought patterns and the cognitive component, I justified the applicability and suitability of selecting CBT for my theoretical basis and for exploring destructive thinking as my research topic. My review pointed me in the direction of two core CBT theories, that of Ellis (REBT) and Beck (CT). I therefore continued to investigate ‘destructive thinking’ within these two CBT approaches. After much questioning, I proposed the use of the term “destructive thinking” rather broadly to refer to any type of thinking that is considered counterproductive, harmful, and maladaptive or has a damaging and negative effect on the individual. A brief overview and outline of the Cognitive Behaviour Therapeutic approach is given in the first chapter which is then followed by a short description of the theoretical (theological) concepts that frequently reoccur throughout this thesis.

In my exploration and review of ‘destructive thinking’ in the Cognitive Behavior Therapy literature (**chapter 2**), I located an extensive body of research on cognition, thoughts and various types of destructive thinking. Much could be found in the literature on the different levels of thinking (automatic thoughts, intermediate beliefs, core beliefs and schemas). A number of common thinking errors/cognitive distortions were also identified. These were described as ‘distorted or unrealistic’ types of thinking that often accompany negative moods and give rise to emotional distress. There was therefore no dearth of information on the harmful effects and impact of these on the individual’s physical, psychological, emotional health and well-being. The goal of CBT was described as being aimed at changing the way one thinks by using their automatic thoughts to identify core schemas and to achieve cognitive restructuring. The literature also suggests that treatment should focus on decreasing cognitive distortions and rigidity in

thinking, so as to help individual's develop more adaptive views of themselves, others and the world (i.e. the cognitive triad).

Further findings supported a link between one's thoughts and psychopathology. On a more positive note however, there were also indications that individuals can learn to think themselves into health and well-being. This forms part of more current body of research that indicates that such processes can create new neural pathways in the brain.

I then continued to explore the compatibility/incompatibility of CBT (REBT and CT) within religion. These findings were of particular interest to me and of relevance to my study. In both views, there were arguments for and against the compatibility of REBT and CT with religion. A number of studies could be located that had integrated spirituality/religion into CBT approaches that had been met with much success. These findings demonstrated the effectiveness of integration of CBT with religion. A further literature search produced a number of arguments demonstrating the incompatibility or a conflict between integration. These findings create a point of conflict and confusion, as there seems to be much validity and value in both arguments. However, I have opted for an integrative and interdisciplinary approach to understanding destructive thinking in this research and thesis.

In surveying the pastoral care and counseling literature (**chapter 3**) I sought to identify, define and describe destructive thinking within this context. "Destructive thinking" here was reviewed in the light of Religion, Spirituality, Christian spirituality and pastoral care. As I set out to assess the potential impact of destructive thoughts on the individual's spirituality and spiritual well-being, a number of destructive types of religious thinking could be identified, such as inappropriate God-images. A closer inspection found a close relationship between one's God-image and psychological/spiritual well-being. These findings suggest a link between one's thoughts (cognitions), spiritual and psychological well-being; this finds much support in the literature, as there are numerous studies documenting a relationship between one's God-image and psychological/ spiritual well-being. Louw prefers the use of the term appropriate or inappropriate God-images rather than correct or incorrect God-images. Inappropriate God-images were described as being connected to a 'pathology of faith' and 'spiritual illness'. Destructive types of religious thinking were linked with spiritual dysfunction and faith pathology. The consequence of an inaccurate or false representation of God was described by Louw as a 'distorted and sick faith'.

Another important finding in this study was with regards to spiritual maturity/immaturity. Individuals, who were considered to be spiritually immature, were described as viewing God's role in their relationship in an uncritical, black-and-white, and rather simplistic manner. Spiritual maturity on the other hand, seemed to function as a protective factor, in that, it was related to better coping, particularly with regards to disappointment and hurt that the individual attributes to God. One's image and concept of

God was found to play a crucial role in the process of developing a spiritual maturity and mature faith. Other studies noted that a disturbance in one's experiences in their relationship with God exacerbated or even created psychological symptoms. Spiritual struggles may thus lead to poorer physical health and psychological well-being. Another important finding with regards to destructive thinking on God-images was that schemas and core beliefs can also preserve a person's negative thinking as well as influence their experience of God. Uncertainty or lack of clarity about the appropriateness of one's God-image was noted as causing confusion with regards to one's Christian faith. This study therefore supports the idea that appropriate God-image's are the more desirable, as these promote more constructive and purposeful actions; instil hope; and contribute towards the eventual therapeutic effect of pastoral ministry.

Another area explored in the literature, was the impact of destructive thinking within the realm of belief systems. A survey of the literature on religious beliefs found these to have a powerful influence over the individual, for either good or bad. Different views on religion could be observed. Some studies identified certain types of religious thinking and beliefs as being beneficial; others were associated with decreased mental health. Not all studies linked religion to better coping, greater well being, or positive emotions and personality traits. Other studies reported worse mental health among those who are more religious. But not all research argued that religious involvement had an adverse effect on mental health.

It was also noted that people often turn to religion when hoping to find refuge, comfort, hope and meaning especially when experiencing much suffering, pain, mental illness, emotional problems, or situational difficulties. Sometimes religion is found to help, but other times not. Some researchers found religious beliefs and doctrines to reinforce neurotic tendencies, enhance fears or guilt, and restrict life rather than enhance it. These findings supported the idea that religious influences can be destructive. Other researchers found religion to be a resource for coping with stress; and religious beliefs and practices as representing powerful sources of comfort, hope, and meaning. These findings supported the idea that religious influences can be constructive (health promoting). Immaturely misinterpreting or rigidly and uncritically holding onto one's beliefs was thought to be the cause of much distress or suffering. There was also research linking distorted perceptions of God with faith pathology, which in turn was said to have a destructive and negative effect on a person's life.

As I continued with my investigation, a number of destructive types of thinking that the Christian/Religious counselee may at times struggle with were identified. This list was in no way comprehensive. The idea here was to illustrate how cognitive errors and cognitive distortions could manifest in religious thinking, and the potential impact these may have on the individual's psychological, spiritual or general well-being.

Another question this research addressed was the extent to which pastoral and spiritual care-giving should probe into cognitive patterns of thinking and its connection to conceptualization in pastoral care, very specifically to the experiences of faith and their connection to God-images? To answer this question, I see pastoral care giving as the unique and relevant profession to deal with faith related issues such as those that have been discussed here. It is their calling and responsibility as a faith representative to purposely and constructively provide guidance to the 'troubled' counselee concerning spiritual and faith related matters. This, in my opinion, includes the component of cognition particularly when thoughts are destructive leading to i.e. inappropriate God-images as part of one's worldview.

Another important finding was with regards to spiritual formation and destructive types of religious thinking. Here it was found, for example, that if the person holds an image of a judgmental God, they will respond to life from this perspective, expecting to be punished, feeling unworthy, and perhaps lacking in a sense of hope, perhaps becoming depressed. But the person who believes in a personal and loving God will respond to life out of a sense of hope

A number of studies confirmed a protective relationship between spiritual well-being and general mental health. Spiritual health was viewed as providing a sense of meaning and purpose to one's existence and offering an ethical path to personal fulfilment. Meaning and purpose in life was listed as representing key components of good mental health. Spirituality was said to increase one's capacity to find meaning and purpose in life. An important point to note here is the sense of meaning and purpose in life that religious and spiritual beliefs can provide. Spirituality seems to strengthen one's sense of meaning and purpose in life, playing a part in the link between spiritual well-being and one's thought patterns. Also interesting to note here is that spiritual well-being enhances one's capacity to frame and reframe meaning (this reflects the significant role of cognition and worldview).

On the topic of spiritual maturity and maturity in faith, this study found that maturity is a comprehensive concept that includes both psychological and theological components. A mature faith however, describes how Christian spirituality is understood in terms of the content of faith and counseling (Louw 1998:184). Of significance here, is that when encountering a stressor, a mature faith links the individual with an increased awareness of positive opportunities in difficult situations. A mature faith enables one to see stressors from an encouraging religious perspective, without ignoring the fact that a negative or life-changing situation has occurred. This finding has important implications for developing a deeper understanding of destructive thinking within the realm of pastoral care. It reveals the contribution that pastoral care can make to (reducing) destructive thinking and to fostering spiritual healing, spiritual growth and spiritual well-being. The results of this chapter have provided a foundation and knowledge base upon which destructive thinking within Christian spirituality can be understood and defined; and upon which pastoral caregivers can continue to build on, research and explore.

At this point in the discussion, the desired goal has been achieved, that of identifying, describing and defining “destructive thinking” within the pastoral context. This research is in no way exhausted, I have merely broached the subject. These insights should be viewed as a valuable resource in fostering a more constructive approach to pastoral care that focuses on the cognitive element and has faith development and spiritual health as its vision.

Continuous research made it possible for me to start moving in the direction of a pastoral psycho approach that deals with cognition (destructive thinking) in a pastoral context (**chapter 4**). These ideas developed from the research outcome and exploration of destructive thinking in the CBT literature in chapter 2; and pastoral/religious care literature of chapter 3.

In Chapter 4 I began with an exploration of the relationship (interplay) between psychology, religion and pastoral care with regards to ‘destructive thoughts’. Each field had its own contribution to make, as well as short comings. For example, secular psychology has generally shown very little interest in the spiritual side of the person. Contrary to this outlook, a theological perspective views spiritual beliefs as having a direct influence on how the individual thinks about them self, the world, and their future.

Another issue that I wrestled with in this chapter, was defining the concepts of ‘health’ and ‘wholeness’ in the pastoral literature to assist pastoral caregivers in understanding “destructive thinking” in a constructive and responsible way. Health was described in the literature as being more than mere physical health. It was expanded to include the spiritual dimension as well. I also briefly review the concepts of ‘spiritual trauma’ and ‘spiritual struggles’ in the context of this study, and the impact that these have on the individual and their thinking. However, in the literature these are not totally viewed in a negative sense; their potential for emotional, psychological and spiritual growth are also recognized.

My plan in this section was to explore destructive thinking in religion, with the idea of working towards a pastoral model of spiritual healing and wholeness. In doing so, I review and discuss the interplay between religion, psychology (CBT) and pastoral care – and elaborate on cognition, worldviews and paradigms as being central concepts in this interplay. I relate worldview to pastoral/spiritual care and discuss the notion of meaning as connected to cognition.

Spirituality is described in the literature as a central feature in pastoral care. In this section I incorporate much of the writings of Louw, as he makes a significant contribution to understanding healing and wholeness in a pastoral context. These findings also had important implications for my work.

Another important finding was the contribution that Christian thinking and Christian worldview can make to reducing destructive thinking. The worldviews that people hold are said to color their thoughts,

behaviours and beliefs. Therefore, the ideas and beliefs that people therefore hold to affect how they think and live. And as Cosgrove says, everyone has a worldview, which can negatively affect their whole life (Cosgrove 2006:29). I therefore see the valuable contribution that a Christian worldview can make to shaping one's thoughts, behaviours and beliefs, and in turn, entire life. Such a worldview is based on the fundamental and core principles of the Christian faith; it views God as sovereign and almighty; and has an ethical and moral foundation. Christian beliefs are first and foremost personal, affecting not just your mind but all of you and your daily life.

The main focus of this thesis has been on understanding the cognitive component, that is, our 'thinking' (particularly destructive thinking). Information, facts and ideas have revolved around providing knowledge about cognition. The intention here is to assist individuals to become more responsible and aware of their own thinking; as well as more knowledgeable about cognition in general, so that they can act on this awareness. This includes the ability to monitor their own thinking and recognize errors in their thinking. In my view, this thesis so far has achieved this goal.

"Hermeneutics refers to the understanding of different narratives and life stories within the existential reality of pain, suffering, anxiety, guilt and despair, as well as our human need for meaning, hope, liberation, care and compassion" (Louw 1999:1). In trying to come to a better understanding of "thoughts" (cognitions) throughout this thesis, and the impact of these on our everyday lives, worldview and view of God, a hermeneutical element comes into play i.e. reflecting on the meaning of concepts; how one thinks about/view's God; and the effect of cognition on one's relationship with God. My hope is that after working through this thesis, the reader should be in a position to understand and reflect on their thoughts, with regards to their faith and view of God, in the context of their Christian faith and worldview. My purpose here is to provide a point of reference from which one can advance further thought and study. The aim of a hermeneutical approach to cognition is to achieve a transformed understanding of cognition/thinking through the development of wisdom and maturity in one's faith. Applying and reflecting on the Christian Scriptures to everyday problems that arise with the purpose of fostering spiritual growth. A hermeneutic approach will focus on those conditions that call for an interpretation of the meaning structures that play an important role in maintaining problematic conditions that have destructive consequences. The hermeneutical element of this thesis examines how destructive thinking, schemata, and core beliefs, influence our spirituality and worldview i.e. how we make sense of our lives and find meaning; appropriate interpretations of God (God-images) in terms of everyday and contemporary life issues. It also tries to interpret pastoral actions contextually.

As an outcome of these findings, I finally propose a holistic approach to destructive thinking in pastoral care that takes into account one's (faith and spiritual) maturity; beliefs and cognitions; and relationships (with themselves, others and God). The pastoral psycho approach I propose takes the role of cognition

seriously. Such a cognitive-psycho-pastoral approach offers an excellent, practical and manageable method to understanding and dealing with destructive thinking in a pastoral context, thereby leading to wholeness and healing through the recognition and re-programming of destructive thoughts. Future studies on the current topic are therefore recommended. Such an approach can only be liberating, both psychologically and spiritually; in helping bringing about change as well as helping others to change. Through healing individuals start to live and function from a different perspective. They develop more mature ways of thinking and interpreting giving them hope and a new vision.

This thesis then proposes an integrated approach and explanation to understanding ‘destructive thinking’ in the pastoral context. The various disciplines ought to continue to dialogue with each other. It is necessary to tap into our unique knowledge base and begin to formulate adequate responses to difficulties that arise. In many ways, pastoral care and CBT have already made inroads into this shared space. Researching this work has stimulated my outlook on ‘thinking’ and initiated new avenues of awareness about ways in which psychology and spirituality can enrich one another. In doing so, however, pastoral caregivers must still remain true to their own identity and profession. I see the notion of ‘cognition in the field of pastoral care’ as an important issue that should continually be researched. Perhaps further empirical study in this field can also be suggested.

My hope is that this current research and critical literature review will stimulate further interest and research on the topic of ‘cognition’ and ‘destructive thoughts’ in the context of pastoral care and counseling. It is also hoped that these insights will be used as a resource for further reflection with regards to the role of ‘thinking’ on one’s spiritual and psychological well-being. This research project however needs to be followed up by a more rigorous and extensive study on the subject.

5.2. Conclusion

This Thesis sought to give a broad overview of ‘destructive thinking’ within the literature of CBT, religion, spirituality and pastoral care. The aim is to inform decision making in the pastoral care context with regards to developing a Christian mind and more mature Christian thought. The proposed outcome of the study is to help individuals reform and reshape their destructive thought patterns. It is thus a quest for change, from ‘unawareness’ to ‘transformation’. Understanding these structures and practices will produce change that leads to freedom and liberation from internal bondage. Furthermore, existing evidence indicates that many areas of spirituality and religion are salient predictors of psychological functioning. Specifically, in some instances counselee’s have been encouraged to draw from personally meaningful spiritual beliefs and cognitions in the practice of cognitive restructuring and as coping statements. Knowledge of a counselee’s spiritual and religious perspectives, can work together to reduce

psychopathology, improve well-being, and promote maturity. This perspective promotes an openness and willingness to coordinate care in a spiritually sensitive manner.

Our thoughts are the center of our functioning as thinking beings. We need to embrace this connection between psychology, theology and religion. Emphasizing the role of cognition in religion and psychology is equally and theologically appropriate. If our ‘thinking’ is damaged, our power to imagine the world and act into it is destroyed or impaired. In view of this, instead of separating this discussion into an either or, that is, faith or secular dichotomy, we should rather focus on the interplay and relationship between these disciplines.

BIBLIOGRAPHY

- Abrams, David B; Niaura, Raymond; Brown, Richard A.; Emmons, Karen M.; Goldstein, Michael, G.; Monti, Peter M. 2003. The tobacco dependence treatment handbook: a guide to best practices. The Guilford Press.
- Adams, Deana. 2008. Counseling and Spiritual Formation. *Journal of Religion, Spirituality & Aging*. Vol 21:1-2. pp131-141.
- Andreeescu, Adrian. 2011. Rethinking prayer and health research: An Exploratory Inquiry on Prayer's Psychological Dimension. *The International Journal of Transpersonal Studies*. Vol 30:1-2. pp23-47.
- Arden, John B. 2009. *The Heal Your Anxiety Workbook: New Techniques for Moving from Panic to inner peace*. Fair Winds Press.
- Asquith, Glenn H Jr. 2010. *The Concise Dictionary of Pastoral Care and Counseling*. Abingdon Press.
- Aubele, Teresa; Wenck, Stan; Reynolds, Susan. 2011. *Train Your Brain to Get Happy: The Simple Program that primes your grey cells for joy, optimism and serenity*. Adams Media.
- Austin, Wendy; Boyd, Mary Ann. 2010. *Psychiatric and mental health nursing for Canadian practice*. 2nd Ed. Wolters Kluwer Health/Lippincott Williams & Wilkins.
- Ayers, Susan; Baum, Andrew; McManus, Chris; Newman, Stanton; Wallston, Kenneth; Weinman, John; West, Robert. 2007. *Cambridge handbook of psychology health and medicine*. Cambridge University Press.
- Baker, John. 2007. *Life's Healing Choices: Freedom from Your Hurts, Hang-ups, and Habits*. Howard Books.
- Beck, J. S. 1995. *Cognitive Therapy: Basics and beyond*. The Guilford Press.
- Blume, Arthur W. 2005. *Treating Drug Problems*. John Wiley & Sons.
- Boeree, C. George. <http://webspace.ship.edu/cgboer/ellis.html>.
Date accessed: 2 February 2012.
- Brandell, Jerrold R. 2011. *Theory & Practice in Clinical Social Work*. 2nd Ed. Sage Publications, Inc.
- Brenner, Hans Dieter; Roder, Volker and Tschacher, Wolfgang. 2006. Editorial: The Significance of Psychotherapy in the Age of Neuroscience. *Schizophrenia Bulletin*. Vol. 32:S1. ppS10–S11.
- Brockelman, Paul T. *The Inside Story: A Narrative Approach to Religious Understanding and Truth*. 1992. State University of New York Press.
- Burns, D. 1999. *Feeling Good. The new mood therapy*. Harper Publishers.
- Carroll, Barbara. 2001. A phenomenological exploration of the nature of spirituality and spiritual care. *Mortality: Promoting the interdisciplinary study of death and dying*. Vol 6:1. pp81-98.
- Cheston, Sharon E.; Piedmont, Ralph L.; Eanes, Beverly, and Lavin, Lynn Patrice. 2003. Changes in client's images of God over the course of outpatient therapy. *Counseling and values*. Vol 47. pp96- 108.

- Chigbo, Kenneth. 2011. *The Unheard Cry of the Igbo People. a study of meaning in life in the MetaPsychology of Abraham Joshua Heschel*. Xlibris Publications.
- Ciarrochi, Joseph; Bailey, Ann; Hayes, Steven C. 2008. *A CBT Practitioner's Guide to ACT: How to Bridge the Gap between Cognitive behavioural Therapy & Acceptance & Commitment Therapy*. New Harbinger Publications.
- Clinton, Tom & Hawkins, Ron. 2011. *The popular encyclopedia of Christian Counseling: An indispensable tool for helping people with their problems*. Harvest House Publishers.
- Cobert, Josiane. 2009. *100 Questions & Answers about Your Child's Obsessive Compulsive Disorder*. Jones & Bartlett Publishers.
- Coombs, Robert H. 2005. *Addiction counseling review: preparing for comprehensive, certification, and Licensing Examinations*. Lawrence Erlbaum Associates, Inc.
- Coon, Dennis. 2006. *Psychology: a modular approach to mind and behavior*. 10th Ed. Wadsworth Thomson Learning.
- Corsini, Raymond J.; Wedding, Danny. 2010. *Current psychotherapies*. 9th Ed. Brooks/Cole Cengage Learning.
- Cosgrove, Mark P. 2006. *Foundations of Christian Thought: Faith, Learning, and the Christian Worldview*. Kregel Publications.
- Craig, Gary. 2011. *The EFT Manual*. Energy Psychology Press.
- Curwen, Berni; Palmer, Stephen; Ruddell, Peter. 2000. *Brief Cognitive Behaviour Therapy*. Sage Publications.
- David, Daniel; Szentagotai, Aurora; Eva, Kallay; Macavei, Bianca. A Synopsis of rational-Emotive Behavior Therapy (REBT); Fundamental and Applied Research. 2005. *Journal of Rational-Emotive & Cognitive-Behavior Therapy*. Vol. 23:3. pp175-221.
- Davis, Edward B. 2009. *Authenticity, inauthenticity, attachment, and God-Image Tendencies among Adult Evangelical Protestant Christians*. Doctoral Dissertation. Regent University.
- DiGiuseppe, Raymond A.; Robin, Mitchell W.; Dryden, Windy. 1990. On the Compatibility of Rational-Emotive Therapy and Judeo-Christian Philosophy: A Focus on Clinical Strategies. *Journal of Cognitive Psychotherapy: An International Quarterly*. Vol 4:4. pp355-368.
- Dispenza, Joe. 2007. *Evolve Your Brain: The Science of Changing Your Mind*. Health Communications, Inc.
- Dobson, S. Keith. 2010. *Handbook of cognitive behavioral therapies*. The Guilford Press.
- Dockery, David S. and Thornbury, Gregory Alan. 2002. *Shaping a Christian Worldview: The Foundation of Christian Higher Education*. B & H Publishing Group.
- Dowd, Thomas E.; Nielsen, Steven Lars. 2006. *The psychologies in Religion. Working with the Religious Client*. Springer Publishing Company, Inc.
- Driskill, Joseph D. 2006. *Spirituality and the Formation of Pastoral Counselors*. *American Journal of Pastoral Counseling*. Vol 8:3-4. pp69-85.
- Dryden, Windy. 1995. *Rational Emotive Therapy: A Reader*. Sage Publications, Ltd.

- Dryden, Windy. 2002. Handbook of individual therapy. 4th Ed. Sage Publications.
- Dryden, Windy. 2009. Rational Emotive Behaviour Therapy. Routledge.
- Dryden, Windy. 2010. Be your own CBT Therapist: A teach yourself Guide. Mc Graw Hill Professional.
- Dryden, Windy. 2012. The “ABCs” of REBT I: A Preliminary Study of Errors and Confusions in Counselling and Psychotherapy Textbooks. Journal of Rational-Emotive & Cognitive-Behavior Therapy. Vol 30:3 pp 133-172.
- Dryden, Windy. 2012. The “ABCs” of REBT II: A Preliminary Study of Errors and Confusions Made by REBT Therapists. Journal of Rational-Emotive & Cognitive-Behavior Therapy. Vol 30:3. pp173-187.
- Dryden, Windy; and Ellis, Albert. 1997. The practice of Rational Emotive Behavior Therapy. 2nd Ed. Springer Publishing Company.
- Egan, Richard; MacLeod, Rod; Jaye, Chrystal; McGee, Rob; Baxter, Joanne & Herbison, Peter. 2011. What is spirituality? Evidence from a New Zealand hospice study. Mortality: Promoting the interdisciplinary study of death and dying. Vol 16:4. pp307-324.
- Eliason, Grafton T.; Hanley, Colleen; Leventis, Maria. 2001. The Role of Spirituality in Counseling: Four Theoretical Orientations. Pastoral Psychology. Vol. 50:2. pp77–91.
- Ellis, Albert. 1984. Rational Emotive Therapy (RET) and Pastoral Counseling: A Reply to Richard Wessler. The Personnel and Guidance Journal. Vol 62:5. pp266-267.
- Ellis, Albert. 1989. Comments on Sandra Warnock's "Rational-Emotive Therapy and The Christian Client". Journal of Rational-Emotive & Cognitive-Behavior Therapy. Vol 7:4. pp275-277.
- Ellis, Albert. 1999. How to Make Yourself Happy and Remarkably Less Disturbable. Impact Publishers.
- Ellis, Albert. 2000. Can Rational Emotive Behavior Therapy (REBT) be effectively used with people who have devout beliefs in God and Religion? Professional Psychology: Research and Practice. Vol 31:1. pp29-33.
- Ellis, Albert. 2001. Feeling better, getting better, staying better: profound self help therapy for your emotions. Impact Publishers, Inc
- Ellis, Albert. 2002. Overcoming Resistance: A Rational Emotive Behavior therapy Integrated Approach. 2002. Springer Publishing Company.
- Ellis, Albert. 2003. Ask Albert Ellis: straight answers and sound advice from America’s best-known Psychologist. Impact Publishers.
- Ellis, Albert. 2003. Helping people get better rather than merely feel better. Journal of Rational-Emotive & Cognitive-Behavior Therapy, Vol. 21:3/4. pp169-182.
- Ellis, Albert, Neenan, Michael; Gordon, Jack; Palmer, Stephen. 1997. Stress Counselling: A Rational Emotive Behaviour Approach. British Library Cataloguing in Publication.
- Ellor, James W. & McGregor, Jasmine A. 2011. Reflections on the Words “Religion,” “Spiritual Well-Being,” and “Spirituality”. Journal of Religion, Spirituality & Aging. Vol 23:4. pp275-278.

- English, Leona M.; Fenwick, Tara J. & Parsons, Jim. 2004. Fostering Spirituality in a Pastoral Care Context, *Pastoral Care in Education. An International Journal of Personal, Social and Emotional Development*. Vol 22:1. pp34-39.
- Epstein, S. 1998. *Constructive Thinking: The key to emotional intelligence*. Praeger Publisher.
- Fall, Kevin A.; Holden, Janice Miner; Marquis, Andre. 2010. *Theoretical Models of Counseling and Psychotherapy*. 2nd ed. Taylor & Francis.
- Fernandez, Alvaro; Goldberg, Elkhonon. 2009. *The Sharp Brains Guide to Brain Fitness: 18 Interviews With Scientists, practical advice, and product reviews, to keep your brain sharp*. SharpBrains, Incorporated.
- Flory, Byron M. Jr. 1983. Wholistic Ministry-Challenge to Growth and Wholeness within the Local Congregation. *Brethren Life and Thought*. Vol Xxviii. pp101-106.
- Ford, Donald Herbert; Urban, Hugh B. 1998. *Contemporary models of psychotherapy: a comparative analysis*. John Wiley & Sons.
- Freeman, Arthur & Dattilio, Frank M. 1992. *Comprehensive case book of cognitive therapy*. Plenum Press.
- Friedman, Philip H. 2009. *The Forgiveness Solution: The Whole Body RX for Finding True happiness, Abundant Love, and Inner Peace*. Red Wheel/Weiser, LLC.
- Froggatt, Wayne. 2006. A brief introduction to Cognitive – Behaviour Therapy. <http://www.rational.org.nz/prof-docs/Intro-CBT.pdf>
Date accessed: 7 November 2012.
- Gall, Terry Lynn; Malette, Judith & Guirguis-Younger, Manal. 2011. Spirituality and Religiousness: A Diversity of Definitions. *Journal of Spirituality in Mental Health*. Vol 13:3. pp158-181.
- Gallagher-Thompson, Dolores; Steffen, Ann M; Thompson, Larry W. 2008. *Handbook of Behavioral and Cognitive Therapies with Older Adults*. Springer.
- Goldapple, Kimberly; Segal, Zindel; Garson, Carol; Lau, Mark; Bieling, Peter; Kennedy, Sidney; Mayberg, Helen. 2004. Modulation of Cortical-Limbic Pathways in Major Depression. Treatment-Specific Effects of Cognitive Behavior Therapy. *Arch Gen Psychiatry*. Vol 61. pp 34-41.
- Gravitt, Wendy Jones. 2011. God's Ruthless Embrace: Religious Belief in Three Women with Borderline Personality Disorder. *Issues in Mental Health Nursing*. Vol 32. pp301–317.
- Gregas, Amanda J. 2009. *Cognitive-behavioral therapies: Efficacy of three interventions with effect sizes and confidence intervals*. The University of Wisconsin – Milwaukee. Dissertation.
- Grimes, Christopher. 2008. Chapter 2. God Image Research. *Journal of Spirituality in Mental Health*. Volume 9:3/4. pp11-32.
- Hamilton, Malcol. 2001. *The Sociology of Religion: Theoretical and Comparative Perspectives*. 2nd ed. Routledge.
- Hawkins, R.S., Tan, S., & Turk, A.A. 1999. Secular versus Christian inpatient cognitive-behavioral therapy programs: Impact on depression and spiritual well-being. *Journal of Psychology and Theology*. Vol 27:4. pp309-318.

- Hepworth, Dean H.; Rooney, Ronald H.; Rooney, Glenda Dewberry. 2010. *Direct Social Work Practice: Theory and Skills*. Cengage Learning.
- Hodge, D., & Hodge, D. 2006. Spiritually modified cognitive therapy: A review of the literature. *Social Work*. Vol 51:2. pp157-166.
- Hodge, D. 2011. Alcohol Treatment and Cognitive-Behavioral Therapy: Enhancing Effectiveness by Incorporating Spirituality and Religion. *Social Work*. Vol 56:1. pp21-31.
- Hoffman, Louis. 2010. Working with the God Image in Therapy: An Experiential Approach. *Journal of Psychology and Christianity*. Vol. 29:3. pp268-271.
- Hollinger, Dennis P. 2005. *Head, Heart & Hands: Bringing Together Christian Thought, Passion and Action*. InterVarsity Press.
- Hood, Ralph W. Jr.; Hill, Peter C.; Spilka, Bernard. 2009. *The Psychology of Religion: An Empirical Approach*. 4th Ed. The Guilford Press.
- Hook, J. N., Worthington, E. L., Davis, D. E., Jennings, D. J., II, Gartner, A. L., & Hook, J. P. 2010. Empirically supported religious and spiritual therapies. *Journal of Clinical Psychology*. Vol 66:1. pp46–72.
- Jasper, David. 2004. *A short introduction to hermeneutics*. Westminster John Knox Press.
- Johnson, W. Brad. 2001. To dispute or not to dispute: Ethical REBT with Religious Clients. *Cognitive and Behavioural Practice*. Vol 8. pp39-47.
- Johnstone, Lucy. 2006. *Formulation in psychology and psychotherapy: making sense of people's problems*. Routledge.
- Jones, Richard Nelson. 1996. *Effective Thinking Skills*. Sage Publications.
- Jones, Stanton, L; Butman, Richard E. 2011. *Modern Psychotherapies. A Comprehensive Christian Appraisal*. 2nd Ed. InterVarsity Press.
- Jonker; Hanneke Schaap; Eurelings-Bontekoe; Elisabeth H.M.; Zock, Hetty, & Jonker, Evert. 2008. Development and validation of the Dutch Questionnaire God Image: Effects of mental health and religious culture. *Mental Health, Religion & Culture*. Vol 11:5. pp501–515.
- Joseph, Stephen & Linley, P. Alex. 2008. *Trauma, Recovery and Growth. Positive Psychological Perspectives on Posttraumatic Stress*. John Wiley & Sons, Inc.
- Kennerley, Helen; Westbrook, David; Kirk Joan. 2007. *An Introduction to Cognitive Behaviour Therapy: Skills and Applications*. Sage Publications.
- Kinsella, Philip; and Garland, Anne. 2008. *Cognitive Behavioural Therapy for Mental health workers: A beginner's guide*. Routledge.
- Klykylo, Willaim M.; Kay, Jerald L. 2005. *Clinical Child Psychiatry*. 2nd Ed. John Wiley & Sons, Ltd.
- Knaus, William J. 2006. *The Cognitive Behavioral Workbook for Depression: A Step-by-Step Program*. New Harbinger Publications.
- Koenig, Harold, G. Research on religion, Spirituality, and Mental Health: A Review. 2009. *The Canadian Journal of Psychiatry*. Vol 54:5. pp283–291.

- Koenig, Harold George. 1998. *Handbook of Religion and Mental Health*. Academic Press.
- Koenig, Harold George. 2005. *Faith and Mental Health. Religious Resources for Healing*. Templeton Foundation Press.
- Kumari, Veena; Fannon, Dominic, Peters, Emmanuelle R.; Ffytche, Dominic H.; Sumich, Alexander L.; Premkumar, Preethi; Anilkumar, Anantha P.; Andrew, Christopher; Phillips, Maty L.; Williams, Steven C.R; Kuipers, Elizabeth. 2011. Neural changes following cognitive behaviour therapy for psychosis: a longitudinal study. *Brain*. Vol 134. pp2396-2407.
- Ladd, Kevin L. 2007. Religiosity, the need for structure, death attitudes, and funeral preferences. *Mental Health, Religion & Culture*. Vol 10:5. pp451-472.
- Lawrence, Constance and Huber, Charles, H. 1982. Strange Bedfellows? Rational-Emotive Therapy and Pastoral Counseling. *The Personnel and Guidance Journal*. Vol 61:4. pp210-212.
- Lehmann, Peter & Coady, Nick. 2001. *Theoretical perspectives for direct social work: a generalist eclectic approach*. Springer Publishing Company, Inc.
- Lizardi, Dana; Worchel, Dana; Gearing Robin E. 2010. *Suicide Assessment and Treatment: Empirical and Evidence-Based Practices*. Springer Publishing Company, LLC.
- Loiselle, Kristin A.; Devine, Katie A. Reed-Knight, Bonney; Blount, Ronald L. 2011. Posttraumatic Growth Associated with a Relative's Serious Illness. *Families, Systems & Health*. Vol.29:1. pp64-72.
- Louw, D.J. 1998. *A Pastoral Hermeneutics of Care and Encounter. A Theological Design for a Basic Theory, Anthropology, Method, and Therapy*. Wellington: Lux Verbi.
- Louw, D.J. 1999. *A Mature Faith Spiritual Direction and Anthropology in a Theology of Pastoral care and counseling*. Peeters Publishers.
- Louw, Daniel J. 2000. *Meaning in Suffering*. Peter Lang.
- Louw, D.J. 2001. Creative Hope and imagination in a Practical Theology of Aesthetic (Artistic) Reason. *Religion and Theology*. Vol 8:3/4. pp327-344.
- Louw, D.J. 1998. "God as Friend:" Metaphoric Theology in Pastoral Care. *Pastoral Psychology*. Vol 46:4. pp233-242.
- Louw, D.J. 2008. *Cura Vitae. Illness and the healing of Life*. Lux Verbi.
- Lowinson, Joyce H.; Ruiz, Pedro; Millman, Robert B.; Langrod, John G. 2005. *Substance Abuse. A Comprehensive Textbook*. 4th Ed. Lppincott Williams & Wilkins.
- Lucado, Max. 2011. *The Lucado Life Lessons Study Bible, NKJV: Inspirational Applications for Living Your Faith*. Thomas Nelson Publishers.
- MacKinlay, Elizabeth. 2003. Mental Health and Spirituality in Later Life: Pastoral Approaches. *Journal of Religious Gerontology*. Vol 13:3-4. pp129-147.
- MacKinlay, Elizabeth. 2008. A Perspective on the Development of Knowledge of Spirituality and Aging in Nursing and Pastoral Care: An Australian Context. *Journal of Religion, Spirituality & Aging*. Vol 20:1-2. pp135-152.

- Magaldi-Dopman, Danielle, Park-Taylor, Jennie & Ponterotto, Joseph G. 2011: Psychotherapists' spiritual, religious, atheist or agnostic identity and their practice of psychotherapy: A grounded theory study. *Psychotherapy Research*. Vol 21:3. pp286-303.
- Majerus, Brian D. and Sandage, Steven J. 2010. Differentiation of Self and Christian spiritual maturity: social science and theological integration. *Journal of Psychology and Theology*. Vol 38:1. pp41-51.
- Mary L., Williams, Steven C.R. and Kuipers, Elizabeth. 2011. Neural changes following cognitive behaviour therapy for psychosis: a longitudinal study. *Brain*. Vol 134. pp2396–2407.
- Matson, Johnny, L.; Andrasik, Frank; Matson, Michael, L. 2009. *Treating childhood psychopathology and developmental disabilities*. Springer.
- McConnell, Kelly M.; Pargament, Kenneth I.; Ellison, Christopher G.; Flannelly, Kevin J. 2006. Examining the Links between Spiritual Struggles and Symptoms of Psychopathology in a National Sample. *Journal of Clinical Psychology*. Vol.62:1. pp1469–1484.
- McDaniel, Thomas R. 1998. Thinking The ““Ultimate Basic””? The Clearing House: A Journal of Educational Strategies, Issues and Ideas. Vol 71:5. pp260-261.
- McKay, Matthew; Davis, Martha; Fanning, Patrick. 2007. *Thoughts and Feelings*. New Harbinger Publications.
- McKay, Matthew. 2009. *Self-esteem: A proven program of cognitive techniques for assessing, improving, and maintaining your self esteem*. 3rd Ed. ReadHowYouWant
- McMinn, Mark R. and Phillips, Timothy R. 2001. *Care for the Soul: Exploring the Intersection of Psychology & Theology*. InterVarsity Press. (Essay by Robert C. Roberts 2001:134)
- McMinn, Mark and Campbell, Clark D. 2007. *Integrative Psychotherapy. Towards a Comprehensive Christian Approach*. InterVarsity Press.
- McNamara, Patrick. 2006. *Where God and Science Meet: The psychology of religious experience*. Praeger Publishers.
- Milkman, Harvey B.; Sunderwirth, Stanley G.; 2010. *Craving for Ecstasy and Natural Highs: A positive Approach to Mood Alteration*. Sage Publications, Inc.
- Natale, Samuel M. 1986. *Psychotherapy and the Lonely Patient*. The Haworth Press.
- Neenan, Michael and Dryden, Windy 2004. *Cognitive Therapy: 100 key points and techniques*. Brunner-Routledge.
- Neenan, Michael and Dryden, Windy. *Cognitive Therapy in a nutshell*. 2005. Sage Publications.
- Neenan, Michael; and Dryden, Windy. 2011. *Rational Emotive Behaviour Therapy in a Nutshell*. 2nd Ed. Sage Publications, Ltd.
- Neukrug, Edward. 2011. *Counseling Theory and Practice*. Brooks/Cole, Cengage Learning.
- Newman, Barbara M. and Newman, Philip R. 2007. *Theories of human development*. Lawrence Erlbaum Associates, Inc.
- Nielsen, Stevan L.; Johnson, W. Brad; Ellis, Albert. 2001. *Counseling and Psychotherapy with Religious Persons. A Rational Emotive Behavior Therapy approach*. Taylor & Francis.

- Nielsen, Johnson and Ridley. 2000. Religiously Sensitive Rational Emotive Behavior Therapy Theory, Techniques, and Brief Excerpts from a Case. *Professional Psychology: Research and Practice* Vol.31:1. pp21-28.
- Norcross, John C. 2002. *Psychotherapy Relationships that Work: Therapist Contributions and Responsiveness to Patients*. Oxford University Press.
- Oberholster, Frederick R.; Taylor V, John Wesley; & Cruise, Robert J. 2000: Spiritual Well-being, Faith Maturity, and the Organizational Commitment of Faculty in Christian Colleges and Universities. *Journal of Research on Christian Education*. Vol 9:1. pp31-60.
- O'Donohue, William T.; Kitchener, Richard F. 1996. *The Philosophy of Psychology*. Sage Publications, Ltd.
- Oman, D; Hedberg, J; Thoresen, Carl E. 2006. Passage Meditation Reduces Perceived Stress in Health Professionals: A Randomized, Controlled Trial. *Journal of Consulting and Clinical Psychology*. Vol 74:4. pp714-719.
- Paloutzian Raymond, F., Park, Crystal L. 2005. *Handbook of the Psychology of Religion and Spirituality*. The Guilford Press.
- Paquette, Vincent; Le ´vesque, Johanne; Mensour, Boualem; Leroux, Jean-Maxime; Beaudoin, Gilles; Bourgouin, Pierre; and Beauregard, Mario. (2003). "Change the mind and you change the brain": effects of cognitive- behavioral therapy on the neural correlates of spider phobia. *Neuroimage*. Vol 18. pp401–409.
- Paukert, Amber L.; Phillips, Laura; Cully, Jeffrey A.; Loboprabhu, Sheila M; Lomax, James W.; Stanley, Melinda A. 2009. Integration of Religion into Cognitive-behavioral Therapy for Geriatric Anxiety and Depression. *Journal of Psychiatric Practice*. Vol 15:2. pp103-112.
- Peale, Norman Vincent. 2003. *A Guide to Confident Living*. Fireside.
- Peloso, Jeanne M. Adult images of God: Implications for Pastoral Counseling. 2008. *Journal of Pastoral Counseling*. Vol 43. pp15-31.
- Pembroke, Neil. 2007. *Moving Toward Spiritual Maturity: Psychological, Contemplative, and Moral Challenges in Christian Living*. The Haworth Press.
- Phillipy, David A. 1983. Hearing and Doing the Word: An integrated approach to Bible study in a maximum security prison. *Journal of Pastoral Care*. Vol xxxvii:1. pp13-21.
- Porto, Patricia Ribiero; Oliveira, Leticia; Mari, Jair; Volchan, Eliane; Figueira, Ivan; Ventura, Paula. Does cognitive behavioral therapy change the brain? A systematic review of Neuroimaging in anxiety disorders. 2009. *The Journal of Neuropsychiatry and Clinical Neurosciences*. pp114-125.
- Propst L R; Ostrom R, Watkins P, Dean T, Mashburn D. 1992. Comparative efficacy of religious and nonreligious cognitive-behavioral therapy for the treatment of clinical depression in religious individuals. Vol 60:1. pp94-103.
- Rabe, Sirko; Zoellner, Tanja, Beauducel, Andr ; Maercker, Andreas; and Karl, Anke. 2008. Changes in Brain Electrical Activity After Cognitive Behavioral Therapy for Posttraumatic Stress Disorder in Patients Injured in Motor Vehicle Accidents. *Psychosomatic Medicine* Vol 70. pp13–19.
- Rasmussen, Paul R. 2010. *The Quest to Feel Good*. Routledge. Taylor & Francis.

- Reich, K. Helmut. 2000. What Characterizes Spirituality? A Comment on Pargament, Emmons and Crumpler, and Stifoss-Hansen. *International Journal for the Psychology of Religion*. Vol 10:2. pp125-128.
- Reinecke, Mark A.; Davidson, Michael R. 2002. *Depression: A Practitioner's Guide to Comparative Treatments*. Springer Publishing Company.
- Rhoads, Jacqueline. 2011. *Clinical Consult for Psychiatric Mental Health Care*. Springer Publishing Company.
- Richards, Thomas A. <http://www.socialanxietyinstitute.org/chemical.html>.
Date accessed: 16 November 2011.
- Robb, Hank. 2002. Practicing Rational Emotive Behavior Therapy and Religious Clients. *Journal of Rational-Emotive & Cognitive-Behavior Therapy*. Vol. 20:3/4. pp 169-200.
- Robb, Harold B. 2001. Can Rational Emotive Behavior Therapy Lead To Spiritual Transformation? Yes, Sometimes! *Journal of Rational-Emotive & Cognitive-Behavior Therapy*. Vol 19:3. pp153-161.
- Robb, Harold B. 2001. Facilitating Rational Emotive Behavior Therapy by Including Religious Beliefs. *Cognitive and Behavioral Practice*. Vol 8. pp29-34.
- Ronen, T; Freeman, A. 2007. *Cognitive behaviour therapy in clinical social work practice*. Springer Publishing Company, LLC.
- Rosmarin, David H.; Krumrei, Elizabeth J.; and Andersson, Gerhard. 2009. Religion as a Predictor of Psychological Distress in Two Religious Communities. *Cognitive Behavior Therapy*. Vol. 38:1. pp 54-64.
- Rosmarin, David H., Pargament, Kenneth I.; Pirutinsky, Steven; Mahoney, Annette. 2010. A randomized controlled evaluation of a spiritually integrated treatment for subclinical anxiety in the Jewish community, delivered via the Internet. *Journal of Anxiety Disorders*. Vol 24:7. pp799–808.
- Rosmarin, David H.; Pirutinsky, Steven; Auerbach, Randy P., Bjorgvinsson, Throstur, Bigda-Peyton, Joseph; Andersson, Gerhard; Pargament, Kenneth I.; and Krumrei, Elizabeth J. 2011. Incorporating Spiritual Beliefs into a Cognitive Model of Worry. *Journal of Clinical Psychology*. Vol. 67. pp1-10.
- Rosmarin, David H.; Auerbach, Randy P.; Bigda-Peyton, Joseph S.; Björgvinsson, Thröstur; Levendusky, Philip G. 2011. Integrating Spirituality into Cognitive Behavioral Therapy in an Acute Psychiatric Setting: A Pilot Study. *Journal of Cognitive Psychotherapy: An International Quarterly*. Vol 25:4. pp287–303.
- Salsman, John M. And Carlson, Charles R. 2005. Religious Orientation, Mature Faith, and Psychological Distress: Elements of Positive and Negative Associations. *Journal for the Scientific Study of Religion* 44:2. pp201–209.
- Salkovskis, Paul M. 1996. *Trends in cognitive and behavioural therapies*. John Wiley & Sons.
- Sandage, Steven J. and Jankowski, Peter J. 2010. Forgiveness, Spiritual Instability, Mental Health Symptoms, and Well-Being: Mediator Effects of Differentiation of Self. *Psychology of Religion and Spirituality*. Vol. 2:3. pp168-180.
- Saxena, S; Gorbis, E; O'Neill, J; Baker, SK; Mandelkern, MA; Maidment, KM; Chang, S; Salamon, N; Brody, AL; Schwartz, JM; and London, ED. 2009. Rapid effects of brief intensive cognitive-

- behavioral therapy on brain glucose metabolism in obsessive-compulsive disorder. *Molecular Psychiatry*. Vol 14. pp197–205.
- Sentowski, H. C. 2007. *Cognitive Disorders Research Trends*. Nova Science Publishers.
- Shafranske, Edward P. 2009. Spiritually oriented Psychodynamic Psychotherapy. *Journal of Clinical Psychology: In Session*. Vol 65:2. pp147-157.
- Smeets, Wim. 2012. Identity and Spiritual care. *Journal of Empirical Theology*. Vol 25. pp22-56.
- Smith, T. B., Bartz, J., & Richards, P. S. 2007. Outcomes of religious and spiritual adaptations to psychotherapy: A meta-analytic review. *Psychotherapy Research*. Vol 17:6. pp643–655.
- Southwick, Steven M.; Charney, Dennis.; Friedman, Matthew J. 2011. *Resilience and Mental Health: Challenges across the Lifespan*. Cambridge University Press.
- Spilka, B & McIntosh, D. N. 1997. *The Psychology of Religion: Theoretical Approaches*. Westview Press.
- Steenwyk, Sherry A.M.; Atkins, David C.; Bedics, Jamie D.; Whitley, Bernard E., Jr. 2010. Images of God as They Relate to Life Satisfaction and Hopelessness. *The International Journal for the Psychology of Religion*. Vol 20:85–96.
- Stone, C. 2005. Liberating Images of God. *American Journal of Pastoral Counseling*. Vol 7:2. pp1-11.
- Straube, Thomas; Glauer, Madlen; Dilger, Stefan; Mentzel, Hans-Joachim; and Miltner, Wolfgang H.R. 2006. Effects of cognitive-behavioral therapy on brain activation in specific phobia. *Neuroimage*. Vol 29. pp125–135.
- Stroebe, Margaret S.; Stroebe, Wolfgang. 1993. *Handbook of bereavement: theory, research, and intervention*. Cambridge University Press.
- Strelan, Peter; Acton, Collin; and Patrick, Kent. 2009. Disappointment with God and Well-Being: The Mediating Influence of Relationship Quality and Dispositional Forgiveness. *Counseling and Values*. Vol 53. pp202-213.
- Summerall, Henry, Jr. 2009. *Such a Great Salvation: An Overview of the Christian Faith*. Tate Publishing & Enterprises, LLC.
- Taliaferro, Lindsay A.; Rienzo, Barbara A., Pigg, Morgan Jr.; Miller, David M.; Dodd, Virginia J. 2009. Spiritual Well-Being and Suicidal Ideation Among College Students. *Journal of American College Health*. Vol. 58:1. pp83-90.
- Tedeschi, Richard G. and Calhoun, Lawrence G. 1996. The Posttraumatic Growth Inventory: Measuring the Positive Legacy of Trauma. *Journal of Traumatic Stress*. Vol. 9:3. pp455-471.
- Testerman, John K. 1997. Spirituality vs. Religion: Implications for Healthcare. http://circle.adventist.org/files/CD2008/CD1/ict/vol_19/19cc_283-297.htm
- Thomas, Michael J. 2009. *The Effect of a Manualized Group Treatment Protocol on God Image and Attachment to God*. Doctoral Dissertation. Regent University.
- Towl, Graham, J.; Brighton, David. A. 2010. *Forensic Psychology*. Blackwell Publishing, Ltd.

- Tu, Jingyi. 2005. Interpretation and intellectual change: Chinese hermeneutics in historical perspective. Transaction Publishers.
- Underwood, Ralph L. 2006. Enlarging Hope for Wholeness: Ministry with Persons in Pain. *The Journal of Pastoral Care & Counseling*. Vol. 60:1-2. pp3-12.
- Underwood, Ralph E. 2009. Hope in the Face of Chronic Pain and Mortality. *Pastoral Psychology*. Vol 58: 5-6. pp655-665.
- Unterrainer, Human-Friedrich; Ladenhauf, Karl Heinz; Wallner-Liebmann, Sandra Johanna; Fink, Andreas. 2011. Different Types of Religious/Spiritual Well-Being in Relation to Personality and Subjective Well-Being. *The International Journal for the Psychology of Religion*. Vol 21. pp115–126.
- Uys, L. R. and Middleton, Lyn. 2010. *Mental health nursing: a South African perspective*. 5th Ed. Juta and Company Ltd.
- Van Arkel, Jan T de Jongh. 2000. *Religion & Theology*. Vol 7/2. pp142-168.
- Van Beek, Aart M. 2010. A Cross-Cultural Case for Convergence in Pastoral Thinking and Training. *Pastoral Psychol*. Vol 59. pp471–481.
- Van Bilsen, Henck; Thomson, Brian. 2011. *CBT for Personality Disorders*. Sage Publications.
- Van Deusen Hunsinger, Deborah. 1995. *Theology and Pastoral Counseling: A New Interdisciplinary Approach*. Eerdmans Publishing Co.
- VanKatwyk, Peter L. 1997. Healing Through Differentiation: A Pastoral Care and Counseling Perspective. *The Journal of Pastoral Care*. Vol. 51:3. pp283-292.
- VanKatwyk, Peter L. 2002. Pastoral Counseling as a Spiritual Practice: An Exercise in a Theology of Spirituality. *The Journal of Pastoral Care & Counseling*. Vol. 56:2. pp109-119.
- Vasegh, Sasan. 2011. Cognitive Therapy of Religious Depressed Patients: Common concepts between Christianity and Islam. *Journal of Cognitive Psychotherapy: An International Quarterly*. Vol 25:3. pp177-188.
- Ventrella, Scott. 2001. *The Power of Positive Thinking: 10 Traits for Maximum Results*. The Free Press.
- Verhagen, Peter J.; van Prag, Herman M.; Lopez-Ibor, Juan J. (Jr); Cox, John L.; Moussaoui, Driss. 2010. *Religion and Psychiatry. Beyond Boundaries*. John Wiley & Sons.
- Wal, S. 2006. *Education & Child Development*. Sarup & Sons.
- Wanberg, Kenneth W.; Milkman, Harvey B. Timken, David, S. 2005. *Driving with care: education and treatment of the impaired driving offender- strategies for responsible living and change: The provider's guide*. Sage Publications.
- Warnock, Sandra D.M. 1989. Rational-Emotive Therapy and the Christian Client. *Journal of Rational-Emotive & Cognitive-Behavior Therapy*. Vol 7:4. pp263- 274.
- Weiten, Wayne; Dunn, Dana S; Hammer, Elizabeth Yost. 2012. *Psychology Applied to Modern Life: Adjustment in the 21st Century*. Wadsworth Cengage Learning. Tenth Ed.
- Wessler, Richard. 1984. A Bridge Too Far: Incompatibilities of Rational – Emotive Therapy and Pastoral Counseling. *The Personnel and Guidance Journal*. Vol. 62. pp264-267.

- Williams, Clifford. 2002. *The Life of the Mind. A Christian Perspective*. Baker Academic.
- Wilson, R and Branch, R. 2006. *Cognitive Behaviour Therapy for Dummies*. John Wiley & Sons, Ltd.
- Winterowd, Carrie; Beck, Aaron T.; Gruener, Daniel.2003. *Cognitive Therapy with Chronic Pain Patients*. Springer Publishing.
- Winzeler, Robert L. 2008. *Anthropology and Religion: What We Know, Think, and Question*. AltaMira Press.
- Worthington, M Everett L. Jr. and Aten, Jamie D. 2009. *Psychotherapy with Religious and Spiritual Clients: An Introduction*. *Journal of Clinical Psychology: In Session*. Vol. 65:2. pp123 -130.
- Wright, Jesse H.; Basco, Monica Ramirez; Thase, Michael E. 2006. *Learning cognitive behaviour therapy: an illustrated guide*. American Psychiatric Publishing, Inc.
- Young, Courtenay. 2010. *Help Yourself Towards Mental Health*. Karnac Books, Ltd.
- <http://www.beckinstituteblog.org/2007/01/what-cognitive-therapy-does-to-your-brain/>
Date accessed 16 Nov 2011.
- <http://www.socialanxietyinstitute.org/biography.htm>
Date accessed 16 Nov 2011.
- http://thebrain.mcgill.ca/flash/d/d_07/d_07_cl/d_07_cl_tra/d_07_cl_tra.html
Date accessed 17 Nov 2011
- <http://iveronicawalsh.wordpress.com/2011/04/24/brain-plasticity-you-can-actually-rewire-your-brain-with-cbt/>
Date accessed: 17 Nov 2011.
- <http://www.bahaistudies.net/asma/hermeneutics-wiki.pdf>
Date accessed 30 Nov 2011.
- <http://www.rlwclarke.net/Theory/Notes/Hermeneutics.pdf> Date accessed 30 Nov 2011
- <http://voices.yahoo.com/spiritually-modified-cognitive-behavioral-therapys-2040052.html>
Date accessed: 9 April 2012
- Using spiritual interventions in practice: developing some guidelines from evidence-based practice by David R. Hodge *Social Work* / April 2011 http://findarticles.com/p/articles/mi_hb6467/is_2_56/ai_n57319684/pg_3/
Date accessed: 15 May 2012.