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An Integration Approach (Chapter 4 of Counseling and Christianity, Five Approaches)

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LEARNING OBJECTIVES

- *Explain how the integration view balances psychology, theology and spirituality.*
- *Locate how the theological assertion that humans are created in God's image is applied in attending to the functional, structural and relational aspects of Jake's presenting concerns.*
- *From the session dialogue samples, describe the benefits of Recursive Schema Activation (RSA) to reveal behavioral patterns connected to core cognitive beliefs.*

I puzzle over the adage "to have your cake and eat it too." If one has cake, why wouldn't they eat it?[1] To have your cake and *not* eat it just seems silly. In the same way, if Christian counselors have the rich theoretical and scientific tradition of psychology to draw upon, why wouldn't they do so? And if the counselor has access to biblical revelation and the theological wisdom of the centuries, of course the counselor should rely on these resources also.

A substantial risk is that counselors might easily resort to haphazard means of relating psychology, theology and spirituality, drawing on Christian and

[1]The correct interpretation of this adage is that the cake is gone after one eats it. In this sense, we cannot have our cake and eat it too. But the saying is typically used to suggest we cannot have two things we want regardless of how consumable they may be, and that is what puzzles me. When it comes to integration, I want to hold psychology, theology and spirituality together at the same time.

psychological resources whenever one or the other seems most convenient, popular or pragmatic. Stanton Jones's chapter on the integration view in *Psychology & Christianity: Five Views* (Jones, 2010) is an excellent corrective to those who may practice these haphazard forms of integration. As is true of his earlier work (e.g., Jones & Butman, 1991), Jones defines and describes a thoughtful sort of integration that maintains the rightful authority of Christ and Scripture. During my 13 years at Wheaton College, Stan was first a colleague and then a supervisor (when he became provost), and always a friend and role model of Christian maturity. Like Stan, I believe integration needs to begin with a Christian understanding of the human condition, that we need a measure of humility in recognizing that we do not interpret Scripture without human error, that science is a value-laden enterprise and that psychological science can prove helpful in the work counselors do.

I appreciate how Jones (2010) considers Christianity to be bigger than Christian theology. Likewise, in my previous work I have argued that spiritual formation ought to be considered alongside theology in the context of counseling (McMinn, 2011). Like three legs of a tripod, psychology, theology and spirituality are all important to consider in formulating and providing clinical services. Most of the approaches in this book will consider these three, but one will explicitly trump the other two when providing treatment to Jake. In this chapter, I attempt to play Three No Trump.[2] That is, my approach with Jake will be influenced by all three—psychology, theology and spirituality—with all of them highly valued.

This is not to say that psychology, theology and spirituality are equally authoritative or that they are all used at every moment in counseling. Integrative counseling calls for adaptability, fluidity and sensitivity to the current moment, and for an ability to see different realms of authority in relation to the particular situation being faced. For example, I take biblical and theological wisdom to be more authoritative than psychology in understanding the deep cries of human existence. When a client is weeping in my office, confronted with the deepest pains of loss and struggle, I may occasionally ponder the psychological theories I learned in graduate school, but much more often I am thinking about a Christian view of persons. In situations such as this I sit stunned anew by the depth of brokenness that pervades the human condition. I am inwardly groaning

[2]This is a term from the card game bridge. Three No Trump is a common bid, with none of the suits trumping the others.

in harmony with my client's outward groans, yearning for all creation to be redeemed (Romans 8:22-23). Conversely, psychology is more helpful than theology when treating symptoms of panic disorder. Advances in cognitive and behavioral interventions have proven highly effective in treating symptoms of panic, and I would be quite irresponsible if I failed to provide those treatment options to clients who need help. The third leg of this tripod—spiritual formation—is a primary goal of faith communities, and can be a worthy consideration for counseling as well. The deeply personal and experiential nature of spiritual formation defies taxonomies, but I find that when I am open to hearing about my clients' spiritual journeys, they are eager to tell me.

In working with Jake, I would pray for discernment and wisdom in balancing psychology, theology and spirituality. All three are important, but the effective counselor must be discerning and wise about how these three components are emphasized at any given moment in the treatment process.

Preliminary Considerations

I once heard Dr. Larry Crabb introduce a talk by telling of a time when he was sitting with a difficult client shortly after Crabb had received his Ph.D. in psychology. As Dr. Crabb listened to the complexity of the client's life, he thought to himself, "Oh my, this person needs a professional!" I had a similar reaction when reading the case study about Jake, wondering what I had gotten myself into by agreeing to write this chapter. This is a complex case.

Who is the client? One of the early considerations from an ethical perspective is identifying the client. Is Jake being referred to another counselor in the Christian college's counseling center, or is this a counselor in the community? If the former, then it is important to clarify whether the counselor's primary commitment is to the university (as an employee) or to Jake (as a counselor). Who is the counselor's primary client, the university or Jake? This may come to bear later if Jake continues to violate behavioral standards at the college. For example, if Jake admits to using or selling drugs, or to sexual aggression, will the counselor be obligated to report this to the college? The ground rules for reporting behavioral infractions need to be specified in advance, and in writing, to minimize the chances of misunderstandings and violations of confidentiality later. If the counselor is expected to protect the college from students like Jake, then Jake needs to know this in advance, before deciding how much to disclose.

From a therapeutic perspective, the ideal situation would be a counselor who has no reporting requirement to the Christian college. This provides Jake with a greater degree of confidentiality and a sense of safety. Counselors have primary ethical and legal obligations to their clients, and if a counselor anticipates a potential conflict of interests between an employer and a client, then the counselor needs to work this out in advance by informing the client and/or renegotiating the employer's expectations. Jake will not make much progress in counseling if he does not experience it as a safe place to be open and honest.

Treatment goals. Psychotherapists speak of client autonomy, and theologians speak of human agency; both point in the same direction when it comes to Jake. That is, Jake needs to determine what he wants to work on in the context of counseling. If it were up to me, I could come up with quite a list of behavioral changes for Jake to consider, but I don't have the sense that Jake wants to make changes in his behavior. Not yet, at least. He seems to be saying, "I want to feel better" rather than, "I want to change the destructive things I am doing."

Does this mean that a counselor should simply accept Jake's goals for treatment? Yes and no. At first, Jake's goals ought to be the primary focus of treatment. If a counselor asserts an overly directive voice at this point, Jake will simply head for the door. It is important for Jake to set his own direction for therapy, both because client autonomy is an ethical commitment for licensed counselors, and because it is how God treats us. From the earliest pages of the Bible we see God allowing human freedom, even if that freedom is ultimately self-destructive. The price of human agency is enormous, yet God chose it over predetermining how people would behave. Still, I hope that Jake's goals for treatment may deepen and grow over time. At first he may simply want to feel better and study more effectively, but as he recovers from trauma, learns more about himself, and begins to trust the process of counseling, he may also realize the need to change behaviors and take more responsibility for what lies ahead. Change takes time.

This raises a question that Christian counselors often face: is sanctification the goal of Christian counseling? This question defies simple answers. On one hand, if we answer yes, that sanctification *is* the goal of Christian counseling, then we put many licensed counselors and psychologists in an unavoidable conflict because they are accountable to state licensing bodies and insurance providers. Most counselors are trained in assessment, diagnosis, treatment planning and psychotherapy, and are responsible to provide these

services to clients. These mental health goals are not the same as the Christian notion of sanctification. On the other hand, if we answer no, that sanctification *is not* the goal of Christian counseling, then we remove virtually all spiritual formation from the counseling process, and we are left with little more than mainstream counseling practice with a few spiritual metaphors or Bible verses attached. My conclusion is that every Christian relationship has the potential of promoting sanctification because close relationships help us see things more clearly. With effective counseling, the counselor does the professional work he or she is trained to do, remaining open to discussions of faith in the process, and as this occurs the client develops a deepening awareness of self in relation to God and others. This quite naturally has a sanctifying effect. Growing in sanctification is not the goal of counseling, but it is, at least to some extent, the inevitable outcome of an effective counseling relationship between Christians.

Initial impressions. In considering Jake's situation, I have many initial impressions that will be important to consider in counseling. I will limit myself to a top-ten list.

First, he has a background of trauma that ought to be explored and understood. The immediate trauma occurred in a combat training exercise and other related military experiences, but he also experienced a childhood trauma with his father's death. Some clinicians believe substance abuse problems should be treated before any other issues are addressed in counseling. In contrast, I think the substance abuse may be a coping response to the trauma, so I would like to see the trauma addressed first, or at least simultaneously with substance abuse.

Second, he has a recent brain injury. Traumatic Brain Injury (TBI) can cause profound changes in mood, personality and cognitive abilities. This needs to be assessed, and previous medical records obtained.

Third, his views of God concern me. Jake claims some level of Christian commitment, but the nature of this is not clear. Was his conversion meaningful and sincere, or more a way to please a military chaplain or to try to win back his former girlfriend? Jake seems to hold to what Smith and Denton (2005) call Moralistic Therapeutic Deism—an increasingly common set of beliefs suggesting that God is a "Divine Butler and Cosmic Therapist" (p. 165) who should provide for his needs without making many demands on how he lives.

Fourth, I am concerned about depression and potential suicide risk. He might even be dangerous to others. What does Jake mean when he says, "I might as well get blown into oblivion"?

Fifth, I wonder about his academic ability in the context of his college experience. With his modest high school performance and his recent brain injury, does Jake have the academic ability he needs to succeed in college? His standardized test scores suggest that he does, but test scores are far from perfect predictors of college achievement. Does the college have a learning resource center where he can be assessed for a possible learning disorder and receive help if he needs it?

Sixth, it seems clear that there are substance abuse issues that ought to be considered. Jake has used and abused various substances, and he seems to deny the seriousness of this even after mandatory time in an Alcoholics Anonymous (AA) group during his medical rehabilitation. Could his substance use be an effort to cope with the trauma and depression he faces?

Seventh, there are diversity issues to consider here.[3] What sort of socioeconomic background does Jake have, and how does his background affect his experience at a Christian college, which presumably comprises middle- and upper-middle-class young adults? How does Jake perceive women? What is it like for Jake to be several years older than other new students at the college he attends? What, if anything, should be made of Jake's "strange bond" to his military bunkmate? Is Jake offering a cloaked allusion to an experience of same-sex attraction?

Eighth, I want to explore the nature of his relationships with others. He seems somewhat socially anxious, at least in the Christian college context, and he may respond by isolating himself at times. Social isolation coupled with a brain injury may compromise his social judgment when he is around others.

Ninth, I am concerned about the possibility of an emerging personality disorder. With this, I am referring to a category of disorder in the *Diagnostic and Statistical Manual*, currently in its fourth edition (DSM-IV-TR; American Psychiatric Association, 2000) and soon to be released in its fifth edition. Not all authors in this volume are comfortable using the

[3]I appreciate the input of my colleague Dr. Winston Seegobin regarding the diversity issues presented in this case example.

DSM to categorize psychological disorders, and while I concur that any taxonomy system can be misused, I find it quite a useful tool to conceptualize clients, guide treatment and communicate with other professionals. Still, I don't find the *DSM* particularly useful in describing the human condition. It is a tool—a useful one, in my opinion—but should not be mistaken for an authoritative guide to human struggle or flourishing. For these purposes, an integration approach goes to Scripture and the riches of our Christian tradition.

Jake may have met *DSM* criteria for conduct disorder during his teenage years, which heightens his risk of antisocial personality disorder during adulthood. Those with antisocial personality disorder seem to lack remorse for their deeds, and they seek their own pleasure at the expense of others. Jake's dismissive attitude toward the college woman who complained about his being sexually aggressive fits this possibility, though many other explanations are possible as well. A personality disorder is a serious diagnosis that may carry implications for a client's future, and I would not make it without compelling evidence.

Tenth, I am interested in Jake's experience of hope. The Christian faith calls us to hope amidst struggle (e.g., Romans 5:3-5). Though psychologists study hopelessness more than hope, in Jake's case I find hope much more interesting. At times he seems to have unrealistic hopes, such as seeing college as an automatic ticket to the middle class, but at other times he seems to lack hope: "If I can't make it here, I really have no place to go. I might as well get blown into oblivion." What is the source of Jake's hope? He tends to view God as owing him a way to escape his problems, rather than seeing a deep sense of hope in God's loving and redeeming character. This cannot be confronted directly in therapy because hope cannot be mustered by willpower. As Jake grows in self-awareness, he might also progress in the Christian journey toward trusting God's goodness in the midst of life struggles, and this will produce hope: "Not only so, but we also glory in our sufferings, because we know that suffering produces perseverance; perseverance, character; and character, hope. And hope does not put us to shame, because God's love has been poured out into our hearts through the Holy Spirit, who has been given to us" (Romans 5:3-5 NIV).

Assessment

In *Psychology, Theology, and Spirituality in Christian Counseling* (McMinn, 2011), I suggest three dimensions related to Christian mental health care. The first is a healthy sense of self. Do I know myself well? Am I aware of my thoughts, feelings, motives, inner conflicts, struggles, desires and hopes? Second is an awareness of our human brokenness. Christianity teaches us that all creation is fallen, all of us tainted by the pervasive influence of sin. With regard to health, am I humble enough to see myself as fallible, vulnerable, capable of making mistakes and hurting others? Do I accept responsibility and apologize when I hurt others? Do I try to grow and become more and more the person God wants me to be? The third dimension of health pertains to relationships. Do I fill my life with rewarding and close relationships? In all three of these dimensions, it seems that Jake has some level of health, but also has work to do.

Sense of self. We see evidence that Jake has some sense of himself. He has enough confidence and self-awareness to be quite clear and honest about his faith-related questions. He also is able to talk about his difficult military experiences—something that not every veteran is willing to do. Also, he seems forthcoming, willing to talk about matters quite directly and openly.

Even with these positives, I am concerned about Jake's self-awareness. He seems somewhat defensive and self-protective, and at times quite self-absorbed. Rather than seeing his own behavior as the obstacle to getting back together with his former girlfriend, he projects the blame on his ex-girlfriend's family, suggesting that they are not doing the Christian "thing" of forgiving and forgetting. He seems to minimize his substance abuse problems. Jake's views of God also seem quite self-serving.

Awareness of brokenness. Jake has made modest progress in the second dimension of health—awareness of his brokenness. His nominal return to faith signals some personal insight about his need for someone greater than himself. Also, he reached out and came to the counseling center for help, which suggests a measure of humility in recognizing that he has needs he cannot meet on his own.

That said, there is also ample evidence that Jake does not fully understand his complicity in his life problems. His faith seems somewhat superficial. He is not so interested in humbling himself before a majestic God

as he is in benefiting from the power that God can wield. He minimizes the degree of problem that his substance abuse is causing, and his own role in driving away his former girlfriend. The recent incident with a college woman may also reflect a high level of defense and denial on Jake's part, though the circumstances of that event are not clear.

Highly defensive clients are generally not good candidates for counseling or psychotherapy. While it is important for his counselor to offer Jake hope, I would ask the counselor to avoid making assurances that counseling will bring about dramatic changes in Jake's life. Counseling may or may not be helpful for him, depending to a great extent on whether Jake ever feels safe enough to let down his guard and begin looking honestly at himself.

Relationships. The good news is that Jake yearns for relationships. He feels isolated at school, looks back to the "good old days" when he had a tight-knit squad in the military, and desires to be reconnected with his former girlfriend. Also, he reached out for counseling. All these suggest that he sees himself as a relational being and that he wants to find meaningful connections with others.

However, we don't see much evidence that Jake is skilled at deep, meaningful relationships. From the information available at this point, it seems that his past friendships have revolved around pleasure seeking, and he appears to be quite self-focused in how he perceives God and others. He may be manipulative at times to get his way, such as when he wanted Cheryl, his counselor, to contact his former girlfriend's family, and then became morose when Cheryl hesitated. The most wholesome relationships require that both parties have developed a sense of self and are able to see themselves as flawed, broken human beings. These are areas of struggle for Jake, so it is not surprising that most of the relationships in his life seem to be fleeting and relatively superficial.

Further assessment. My views of Jake's health should, at this point, be considered musings based on a limited case study. If I were consulting in Jake's care, I would want to do a more systematic assessment, remaining open to alternative ways of viewing Jake and his circumstances. Thorough assessment would involve a sincere and sustained effort to get past medical records, referring him for a neuropsychological evaluation, personality testing, understanding diversity, and assessment of spiritual and religious identity.

The case description states, "Jake has not been cooperative with obtaining any medical or psychiatric records." These records need to be obtained, and getting them should probably not have been Jake's responsibility in the first place. The counselor needs to have Jake sign an authorization form to request the records, and then the counselor should contact former providers to get records. This is an urgent matter because it is essential to know about past test results, diagnoses and treatment outcomes for Jake.

One reason for obtaining records is to determine which tests have already been conducted since the time of his head injury. Has he already had a careful medical workup? Has he had a neuropsychological evaluation to determine the functional deficits of his injury? If not, he should be referred for a neuropsychological evaluation now to determine his current intellectual abilities as well as lasting effects his injury may be having on the skills required to succeed in school and in social relationships.

Throughout the centuries Christians have sometimes been guilty of gnostic views of the world. That is, we elevate immaterial spiritual knowledge above the material nature of our existence. Recently I passed by a church that had this sign out front: "We are not human beings on a spiritual journey; we are spirits on a human journey." Inwardly, I muttered about the heresy inherent in such a message. We are indeed human beings, embodied souls whose physicality matters, looking forward to a day when we have new bodies and live in a new heaven and new earth. The incarnation—and indeed, all of Scripture—argues against gnostic views. Materiality matters. Jake's brain function is important to understand.

I would also like to see some personality testing with Jake. If he has not had a personality evaluation in the recent past, I would administer the Minnesota Multiphasic Personality Inventory, second edition, restructured format (MMPI-2-RF); the Rotter Incomplete Sentence Blank (RISB); the Young Schema Questionnaire, third edition (YSQ-3); the Beck Depression Inventory, second edition (BDI-II); and the Beck Anxiety Inventory (BAI). I would also conduct a careful diagnostic interview.

Regarding diversity, I wonder what it feels like for Jake to be "different" in the context of a Christian college. As rapport develops in counseling, I would ask his counselor to pursue this. What does it feel like for Jake to be older than other students? What sort of socioeconomic

background does Jake have, and how does that feel to him in relation to students who presumably come from relative affluence? If Jake's counselor is a person of color, it would also be good to explore how the ethnic differences between counselor and client might feel to Jake as he grows to trust the counseling process.

In addition to personality testing and understanding diversity, I would like to know about his religious and spiritual perspectives on life. He expresses some faith commitment, but it appears to be nominal and relatively superficial. It would be useful to administer the Religious Commitment Inventory (Worthington et al., 2003) and the Spiritual Assessment Inventory (Hall & Edwards, 2002) in order to determine the depth of his faith commitments and the way he views God.

Case Conceptualization

In *Integrative Psychotherapy* (McMinn & Campbell, 2007), Clark Campbell and I discuss the relationship between assessment and case conceptualization, as illustrated in figure 4.1. Assessment is a set of activities designed to learn more about the client, and is less theoretically bound than case conceptualization. The counselor views the information gleaned from the assessment through his or her theoretical lens, and then conceptualizes the case. Notice also the backward arrow in figure 4.1, which indicates that no counselor can be completely objective in assessing clients. Our theoretical assumptions influence the questions we ask and the assessment methods we use. Still, it is safe to say that assessment is less theory-bound than case conceptualization.

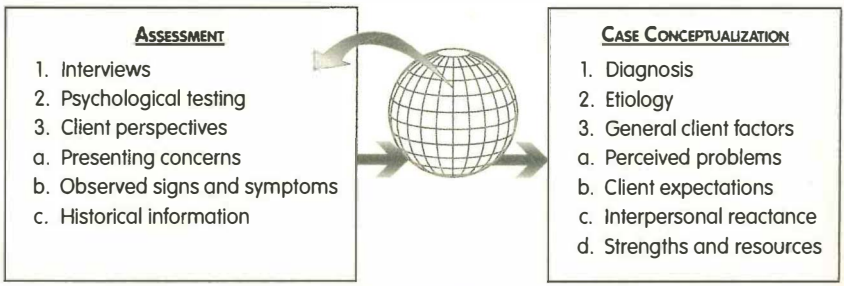

Figure 4.1. Assessment, Theory and Case Conceptualization.
Adapted from McMinn & Campbell (2007). Used by permission.

Because case conceptualization is theory-bound, the next portion of this chapter introduces my theoretical perspective on counseling and psychotherapy. In doing this, I am offering only one theoretical perspective on how integration looks. Others in the integration tradition may have very different ways of conceptualizing Jake.

Integrative Psychotherapy

Integrative Psychotherapy (McMinn & Campbell, 2007) begins with the theological assertion that humans are created in God's image (Genesis 1:26-28), the imago Dei. Philosophers, biblical scholars and theologians have typically understood the imago Dei in one or more of three ways (Erickson, 1985). Jones (2010) refers to these in his *Five Views* chapter, correctly noting that these are not mutually exclusive and that all have merit.

Functional. Functional perspectives on the image of God emphasize that humans are given certain responsibilities that the rest of the animal kingdom does not share. After creating humans, "God blessed them and told them, 'Multiply and fill the earth and subdue it. Be masters over the fish and birds and all the animals'" (Genesis 1:28 NLT). Humans do a better job managing the world around them than dogs would do, or chimpanzees or any other living creature. This managerial capacity that humans have reflects—however faintly—the image of God.

Jake, created in God's image, manages tasks in his daily life. He needs to function in particular ways, and as one created in God's image he is capable of doing so. For example, he needs to figure out how to manage the demands of school, how to cope with his feelings of anxiety and depression, how to deal with urges for alcohol and illegal substances, how to form cooperative relationships with others. Jake is not merely a victim to his impulses; he is an image bearer, one who is capable of functioning in a more effective way than he is currently functioning.

In *Integrative Psychotherapy* (McMinn & Campbell, 2007), functional interventions are typically aimed at changing symptoms, and are therefore called *symptom-focused strategies.* Behavioral and cognitive-behavioral strategies in psychology are often valuable tools in helping people function more effectively and responsibly. I discuss symptom-focused strategies for working with Jake later in the chapter.

Structural or substantive. Another tradition emphasizes the ontological nature of the imago Dei. There is something about being human that is fundamentally different from being a cat or a gopher or a deer. Most often philosophers and theologians emphasize our human capacity to be rational and to make moral choices. It would do little good for a cat to become convicted about eating food from the dog's food bowl and try to make a change in behavior, because cats lack the rational and moral capacity to do such a thing. But Jake, made in God's image, can make deliberate changes in his life if he chooses to do so.

More than just having rational and moral capacity, we humans actively make meaning of our lives. We each tell our story even as we live it. Only humans reminisce about childhood days, set goals for the future, place their faith in a divine being and anticipate their own death. How we make meaning in life has both spiritual and psychological implications.

Jake is living out a particular story, no doubt influenced by past trauma. In counseling, it will be important to explore how he tells the story of his life, with the goal of helping him restructure his story into one with deeper faith experiences, more hope for the future and healthier relationships. Because structural interventions in integrative psychotherapy (McMinn & Campbell, 2007) consider the schemas (i.e., meaning-making structures) used by the client, they are called *schema-focused strategies.*

Relational. A relational view of the imago Dei is strikingly different from either the functional or structural view. With functional and structural views, a human individual carries the image of God—the image is contained within a person. But the relational view, which emerges out of the work of twentieth-century Swiss theologian Karl Barth (1958) and others in the neo-orthodox movement, suggests that the image is not contained in an individual, but in relationship. It's not so much that Jake carries the image, or that his counselor carries the image, but rather when Jake and his counselor interact, they reflect God's relational image.

The relational view of the imago Dei has clear implications for counseling. The intimate, caring, genuine, confiding, accepting nature of a counseling relationship reveals something of God's abiding, steady, loving presence with humanity. From this perspective, Jake will change not because of therapeutic techniques or strategies but because of his relationship with his counselor.

A theological view of health. One might ask why I, a psychologist, suggest the theological notion of the imago Dei for understanding psychological health. Every theory in psychology asserts some state of health and unhealth, and it seems reasonable for Christians to look to biblical and theological wisdom for this. If brilliant Christian philosophers and theologians have mused over the imago Dei for all these centuries, then we ought to pay attention to what they have to offer. My assumption is that God is bigger than every human system, including functional, structural and relational views of the imago Dei, but that these formulations of God's image reflect our best Christian efforts to know what a fully functioning human looks like. So in the counseling office, as I attempt to help people come to a place of well-being, I ought to pay attention to what our Christian tradition has to offer in defining health. Many of the treatment methods I use come from psychology, and I find the *DSM* a useful way to communicate with other professionals who may not share my faith beliefs, but I believe the essence of health is best understood from this theological vantage point.

It is interesting to see that psychology also has functional, structural and relational perspectives on treatment. This does not surprise me because one does not need to profess Christianity to discover parts of God's truth.

The process of addressing functional, structural and relational issues. Initial efforts in counseling with Jake should be functional, symptom-focused strategies. Like most clients, Jake came with particular problems he wants to have addressed. He is concerned about his class performance, fitting in at college and perhaps about feelings of depression. I am concerned about trauma and patterns of substance use, though it is not clear if Jake is concerned about this or not. These are all functional concerns, and will be the primary focus early in treatment.

Beyond these functional issues, pressing structural issues call for schema-focused methods if Jake persists long enough. How does he tell his story—where he has been, and where he is going? Although we do not yet know much about Jake's schemas (his ways of understanding and making meaning of life), it seems likely that he feels quite alone and isolated. Imagine a 10-year-old wandering through the house after a day at school, looking for his father, and then seeing the horrifying sight of his father dead on the bathroom floor, blood streaming from his mouth and nose. At that moment, Jake must have felt profoundly alone, left to survive in a

complex world without substantial connection with other family members. It is telling that his mother left Jake alone and let him make his own decisions after his father's death. She was probably traumatized herself and didn't know how to handle a rambunctious 10-year-old son, but her aloofness no doubt contributed to Jake's feeling isolated in a complicated and unpredictable world. In high school he made connections through partying, and he had at least one meaningful relationship with his girlfriend, Missy, but that relationship has now disappeared, and Jake has not even met the child that he may have fathered. Even his understanding of God seems to presume that God is distant and uncaring, evidenced in his mind by God's not giving Jake the life he wants.

Jake may not want to talk about his schemas in the early parts of counseling, both because it requires a good deal of trust to be this vulnerable with his counselor, and because he may not be fully aware of his underlying schemas. It will take time, trust and an effective counselor for Jake to open up to these structural issues in counseling. Sometimes clients start feeling better after the functional issues are addressed, and then they stop coming to sessions. Jake will be prone to do this because he is quite alone in the world, and it will be hard for him to trust another person with the experiences and perceptions that make him feel most vulnerable. If the counselor is able to engage Jake beyond the first few sessions of counseling, then they are likely to move into this structural realm of intervention.

The relational domain of intervention needs to be considered throughout the entire treatment process. Jake is likely to participate in relational patterns that occur time and time again, known as Cyclical Maladaptive Patterns (Levenson, 1995). These patterns may occur without Jake's conscious awareness. As with the structural domain, this will require some good clinical perception on the part of the counselor to figure out what these relational patterns are, and then to engage in a relationship that forces Jake out of his typical cycle. We do not know enough to be certain about his relational patterns, but I suspect that he has a knack for disengaging, or even pushing people away, when he starts to feel vulnerably close. Jake's father was gone or emotionally absent at first, and then dead. His mother was aloof, especially after Jake's father died. Jake longed for intimacy, but ended up feeling abandoned. However painful this felt, it became familiar for Jake, and now he may avoid the fear of abandonment by keeping people at a distance.

When he had an intimate relationship in high school, he risked his relationship with Missy—and eventually sabotaged it—by leading a duplicitous life. His relationship with his bunkmate in the Army is not clear, but it will be important to see what sort of relational dynamics occurred there. Do his inaccurate flashbacks of his buddy being in the helicopter have something to do with fears of his friend abandoning him too? Even his relationship with Cheryl, his first counselor, seems to fit this same pattern. Cheryl seemed happy providing counseling for him when she thought Jake would just be another case of the college blues, but soon Jake started making unrealistic requests (e.g., his request for Cheryl to contact Missy's family) and revealing what a difficult client he could be (e.g., substance abuse, a thinly veiled suicidal threat, allegations of sexual inappropriateness with a college woman). Shortly thereafter, Cheryl had a shift in responsibilities, abandoning Jake again. Jake's next counselor needs to recognize the relational dynamics at play and remain available to Jake throughout the entire course of counseling.

Treatment Plan and Techniques

Treatment relationship. Whatever treatment plan is used with Jake, it is important in working with him to first emphasize the role of empathy, genuineness and positive regard. Most psychotherapists and counselors no longer perceive these to be sufficient for effective counseling, as Carl Rogers (1957) did, but they are necessary. Jake has some behavioral and cognitive patterns that might easily annoy a counselor, such as downplaying his substance abuse problems, not taking full responsibility for his moral shortcomings, making derogatory and unfair comments about God, and so on. Is the counselor able to overcome these annoyances and genuinely like and care about Jake? If not, counseling is not likely to be successful. Romans 15:7 reads, "So accept each other just as Christ has accepted you; then God will be glorified" (NLT). This is our mandate as Christians, and even if none of us is fully able to accept another as thoroughly as Christ has accepted us, counseling is not effective if we do not aspire toward this goal.

Functional perspectives. As mentioned earlier, the treatment plan should begin with Jake's functional concerns. He initially came for help because of troubles completing his class assignments. Some combination of behavioral

and cognitive-behavioral strategies may be helpful to Jake. Before introducing these strategies, though, his counselor should receive and review his medical records. It is possible that neurological impairment is affecting his classroom performance, in which case he will benefit from cognitive rehabilitation as well as psychotherapy. He should also be referred to a psychiatrist for a consultation because he has been prescribed medications that he is not taking regularly. This irregular use of medications might be affecting his mood, thoughts and behavior. The counselor should have a direct conversation with the psychiatrist, after getting Jake's authorization to do so.

Several functional strategies emerging from scientific psychology may be useful for Jake. The Premack Principle holds that low-probability behaviors (studying, in Jake's case) can be paired with high-probability behaviors (computer games, for example) to increase the likelihood of low-probability behaviors (Premack, 1959). So, for example, he might try studying for an hour before giving himself permission to play an online game. Over time, the study time might be increased to two hours. This will require compliance and motivation on Jake's part, which could be a challenge.

He might also try writing down a summary of his activities throughout a typical week, with the goal of monitoring how much he studies. Even the act of monitoring tends to increase the target behavior (studying, in this case). Once he has monitored for a week or two, he might then set goals for increasing study time in future weeks.

At this point, it is not clear how much motivation Jake has to make changes in his life. Motivational interviewing might be used to help prepare him for change (Miller & Rollnick, 2002). In motivational interviewing, the counselor helps Jake confront his ambivalence for change, perhaps by thinking through the consequences of how he is currently living, and then to consider how a different set of choices might impact his life.

Jake's trauma also needs to be treated. Though addressing trauma was not his explicit goal when coming for counseling, Jake talked a fair amount about trauma and the implications of trauma in his five sessions with Cheryl. His difficulty sleeping, for example, seems clearly related to efforts to avoid traumatic memories. It is also possible that much of his substance abuse might be related to trauma—both recently and in the distant past. Sometimes people turn to substances to escape from the pain of past memories, making it especially difficult to change the substance abuse

behaviors if the trauma is untreated. There are several effective ways to treat trauma, with two of the best being Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT) (Resick, Monson & Rizvi, 2008). In PE, just as the name implies, the client is asked to recount the details of past events in great detail after first learning systematic breathing and relaxation skills. The idea is to relive the experiences as if they are currently happening. Rather than pushing back the images and memories, as Jake is now doing, he would be encouraged to let them come forward in his consciousness, to remember them as fully as possible. Though this deliberate exposure to trauma can be difficult for clients, it can also help free them from the frantic efforts to push back the memories. CPT also involves exposure, but by writing about the trauma more than speaking about it. The client and counselor then consider how the trauma may have affected the client's way of looking at the world. Does Jake blame himself for his father's death? Does he experience guilt that he was not on that helicopter? The point of CPT is to make cognitive and emotional connections as the client reevaluates traumatic experiences.

An additional functional concern is his suicide risk. This needs to be assessed early and often in the treatment relationship. One tool used to assess risk is an acronym known as SAD PERSONS (Patterson, Dohn, Bird & Patterson, 1983).

S = Sex (males are at more risk than females). Jake is, of course, male.

A = Age (some age groups are at more risk than others). At age 22, Jake is in an age group with elevated risk.

D = Depression (depressed individuals are at a much higher risk than others). We do not know if Jake has been diagnosed with depression because we have not seen his medical records, but this seems likely in terms of his current symptom patterns.

P = Prior History (most suicides are preceded by an unsuccessful attempt). We do not know if Jake has attempted suicide, but this should be assessed.

E = Ethanol Abuse (those who use alcohol in excess are at an elevated risk). This is clearly a warning sign for Jake.

R = Rational Thinking Loss (psychotic individuals are at high risk for suicide). Jake does not appear to have any signs of psychosis.

S = Support System Loss (a loss of a significant relationship can precipitate suicide attempts). Jake seems quite alone and feels a poignant sense of loss in his relationship with Missy.

O = Organized Plan (those with a plan are at higher risk than others). This is not clear in Jake's case, but it is important to ask what he meant when he said that he "might as well get blown into oblivion." Does he have access to explosives? Has he considered a plan for how he might kill himself or others?

N = No Significant Other (those who feel all alone are at greater risk for suicide). It is difficult to know what sort of connections Jake has maintained with Army buddies, but otherwise it appears that he is quite isolated from others. His relationship with his counselor might be essential for him to maintain some sense of hope.

S = Sickness (those with chronic illness are much more likely to commit suicide than others). Jake's head injury is a sort of chronic illness that may hinder his sense of hope for the future.

Based on the SAD PERSONS test, Jake appears to be at risk for suicide. This should be discussed explicitly in counseling and assessed routinely. It is possible that Jake will need to be hospitalized if the risk of suicide seems imminent.

Structural perspectives. If Jake and his counselor are able to establish rapport, and if the functional interventions help to relieve some of Jake's immediate symptoms, then it is likely the treatment focus will shift toward the ways Jake interprets and makes meaning of the world. We cannot know exactly how this might look in therapy, of course, but for the sake of illustration I will proceed with the assumption that he feels quite isolated and alone in the world, expecting to be abandoned by those closest to him.

It is beyond the scope of this chapter to describe schema-focused therapy in detail, but the general strategy used in *Integrative Psychotherapy* (McMinn & Campbell, 2007) is called Recursive Schema Activation (RSA). Whereas the earlier generations of behavioral and cognitive-behavioral therapy tended to assume that faulty schemas could be identified and replaced with more adaptive schemas, the so-called third wave of cognitive-behavior therapy calls for greater acceptance and understanding of the schemas that are most persistent and troubling (McMinn, Jones,

Vogel & Butman, 2011). Rather than trying to utterly obliterate a troubling schema, perhaps it is better to learn from it. With time, the client gains some critical distance from the old schema and learns to view life through a different set of lenses.

Jake seems to have a belief that he is alone and bound to be abandoned. Rather than trying to convince Jake that this is not the case—that people really do love and care about him, after all—perhaps it is better to listen and learn from Jake's life. How did he come to view life in this way? What was it like for him to grow up in a home with marital strife, and then his father's premature death? How did his mother's zeal for faith affect Jake and his way of understanding himself in relation to a complex world? How did his military experience feel to him with regard to social connections and isolation? To what extent has his socioeconomic background influenced his connections with others at the Christian college? What sort of relational future does Jake anticipate? What does he hope for? Rather than simply trying to rid Jake of his schema, the notion of RSA is to help Jake understand and evaluate the schemas that influence how he makes meaning of the world.

RSA is recursive in that the counselor repeatedly brings the client back to the same schema to explore and discover its meaning. Schemas are resistant to change, and they operate both consciously and unconsciously, making it important for the counselor and client to return to the schemas over and over again. This requires a degree of creativity so that it does not seem that every session is the same. Rather, the counselor helps Jake take the material from the present moment and connect it with the underlying schemas that are being considered. For example:

SESSION 1 (EARLY IN THE SESSION)

Jake: I don't know why, but Cheryl said she couldn't see me anymore. She sent me to talk to you instead.

Counselor: That must have felt disappointing.

Here the counselor offers a statement sometimes referred to as "advanced accurate empathy," while also hinting at Jake's underlying schema—that he will be abandoned.

SESSION 1 (LATER IN THE SESSION)

Jake: There is so much religion in this school, which is cool, I guess, but I don't understand why everyone acts like God will hold their hands and take care of everything. These guys haven't seen how awful the world can be.

Counselor: It feels like God has left you to figure everything out on your own.

This is a simple reflection, but it points toward Jake's underlying schema. Rather than trying to engage in a theological conversation here, it is better to simply place Jake's schema in front of him so he can see how it operates in his life.

SESSION 2

Counselor: How is dorm life going?

Jake: About the same. Mostly I keep to myself, you know, play video games and stuff.

Counselor: I wonder if keeping to yourself feels safer than relationships feel.

This is a more direct reference to Jake's schema, but again one to keep him thinking about how he interprets the world.

SESSION 6

Jake: You seem to think that I like being alone.

Counselor: That's an interesting observation. Tell me more.

Jake: Well, you keep saying that I'm scared of relationships and stuff.

Counselor: How would that relate to being alone?

Jake: You know, like I keep to myself because others will hurt me or something.

Counselor: Let's sit with that a minute. How does it feel when you say it?

Jake: I don't know. I've been thinking about it though. Sometimes I wish I had better friends, or like a close relationship with a parent or something. Missy means so much to me, but she won't even return my calls. No one on my floor even cares if I'm alive or dead.

Counselor: This feeling you're having right now—feeling alone—is that new or old? Is that a feeling that you remember having years ago?

Jake: I guess.

Counselor: [Sits silently.]

Jake: [Tears in eyes.] I've been alone for a long time.

Counselor: [Nods. Continues sitting silently.]

Again, the counselor is returning to the schema. Rather than chasing the suicide threat, which will need to be discussed in a few moments, the counselor brings Jake back to his schema. Jake's tears indicate the schema is fully activated.

Schema activation in RSA means that the client is engaged affectively and relationally as well as cognitively. The goal of schema-oriented counseling, then, is to identify and activate schemas over and over until the client can begin to construct a new way of understanding life.

It is important to recognize that schemas exist because they once worked well. They now cause problems because they are no longer working well. In Jake's situation, his self-protective schema of anticipating abandonment may have been a useful way to cope after finding his dead father, but now in his early 20s, faced with the developmental task of forming lasting, intimate relationships, his schema is not working well. It will be helpful for him to discover this in counseling, recognizing that his old schema is not foolish or stupid, but that the time of its usefulness has passed.

I find the Pauline notion of an old self and a new self a useful metaphor when thinking of RSA (e.g., Ephesians 4; 6; Colossians 3). The idea is for Jake to develop a new vantage point for looking at his life: the new self views the old self. The old self may never be entirely removed, but as the new self grows in strength and confidence, Jake will be able to make better decisions and grow toward psychological and spiritual health.

Relational perspectives. The relational dimension of integrative psychotherapy (McMinn & Campbell, 2007) informs the way the counselor interacts with Jake. This is closely related to the notion of schemas because the counselor should treat Jake in ways that cause him to reevaluate old schemas. If Jake fears abandonment, it will be important for the counselor to communicate stability in the counseling relationship. In order to move

forward, Jake needs to feel safe, to know that he can come to counseling as long as he desires.

Jake's past and current relationships with others are also considered in the relational domain. As Jake starts to make improvements and develop friendships with his peers and mentors, to what extent do these relationships replay his roles in prior relationships, and with what effect? Ideally, Jake will learn to be a student of how he relates to others, and to find ways of establishing healthy, mutually satisfying relationships. In the process, he may also come to see God differently. Rather than God being distant and aloof, Jake may eventually come to see God as loving and present amid the messy and difficult parts of life. If so, this could become an enormous source of hope and resilience for Jake while also helping him understand God better.

Evaluation and Follow-Up Care

There are three potential exit points in integrative psychotherapy (McMinn & Campbell, 2007). Some clients decide to stop counseling after functional concerns are addressed. This is a legitimate endpoint in counseling, even if deeper issues of schemas and spiritual matters are never addressed explicitly. Just as Christ devoted a good deal of his ministry to the physical and health needs of individuals, health care providers can legitimately treat the emotional and psychological needs of clients. Jake may choose to stop counseling once he feels less depressed and is doing better in school.

Perhaps in the process of addressing functional concerns, Jake will become engaged enough in counseling that he persists through a schema-focused phase of treatment. If so, it may well have positive implications for how he understands himself and others. Beyond treating his present symptoms, a schema-based intervention will help him gain insight into his areas of vulnerability and be more intentional about his life choices. This, in turn, may help him live a life more pleasing to God, and one that brings greater hope for his future. Once this schema-focused work has proven effective, Jake and his counselor may elect to stop counseling.

If symptom-focused work takes weeks, and schema-focused work takes months, some clients decide to engage in longer-term relational work that may take many months or several years. This involves a more intensive look at past and present relationships in the client's life as the client builds

bridges between past and present relational patterns and works toward enhanced self-understanding in the process. Long-term therapy is unusual in a college counseling center context, and at least at first glance Jake does not appear to be introspective and insightful enough to be interested in long-term therapy. Still, it may be therapeutic for Jake to know up front that long-term counseling is available to him, because knowing this might help him relax his fears of abandonment from the counselor. It seems unlikely he will engage in long-term counseling, but just knowing it is available may help him do better in short- or moderate-term counseling.

It is wise to enter a maintenance phase in counseling before termination. If Jake is being seen weekly for most of the counseling, then he might be scheduled for every second or third week during the maintenance phase. After several maintenance sessions, it would be good to schedule a follow-up appointment in two or three months to see how he is doing.

It should also be noted that counseling is not the only option for Jake. Becoming involved in a church-based support group, a campus ministry or a mentoring relationship may be alternatives and/or adjuncts to counseling. There are various ways to grow emotionally and spiritually, with counseling being only one of them.

Conclusion

This approach to counseling and psychotherapy is described more fully in *Integrative Psychotherapy* (McMinn & Campbell, 2007) and demonstrated in a DVD published by the American Psychological Association (Carlson, 2006). As with any approach to counseling or psychotherapy, it requires graduate-level training and advanced supervision before a counselor should be considered qualified. Counseling can bring great hope and healing to a person's life, but it can also do substantial damage; therefore, it is important to receive excellent education and supervision prior to launching a counseling career.

I appreciate the case-oriented nature of this book, in part because it offers a practical glimpse into the work of Christian counselors and psychotherapists. Jake would be a challenging client, but his is a good case for this book because of the multifaceted nature of his presenting problems. Readers have opportunity to see different counseling approaches applied to clinical issues such as substance abuse, trauma, perceptions of God,

depression, suicide, childhood relationships and so on.

That said, I also find it difficult to describe my approach to counseling with any particular case, especially in a single chapter of a book. Counseling is art as well as science, and as art it takes many years to master. Several months ago I spent 10 minutes in silence with a client because words simply seemed cheap amid the depth of pain he was experiencing. Those 10 minutes became pivotal in therapy, as he settled into a place of safety with me, knowing that I wasn't going to trivialize his pain or imply that I could fix him with five new principles for living. Even as an experienced writer, I'm not sure such a counseling experience could be captured in a book chapter or a book or even a series of books. Some things that happen in the counseling office defy theoretical description. They come from the movement of the Holy Spirit, stirring in the lives of counselor and client. May all our theories and book chapters and musings about what makes counseling work always leave room for the work of the Spirit.

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