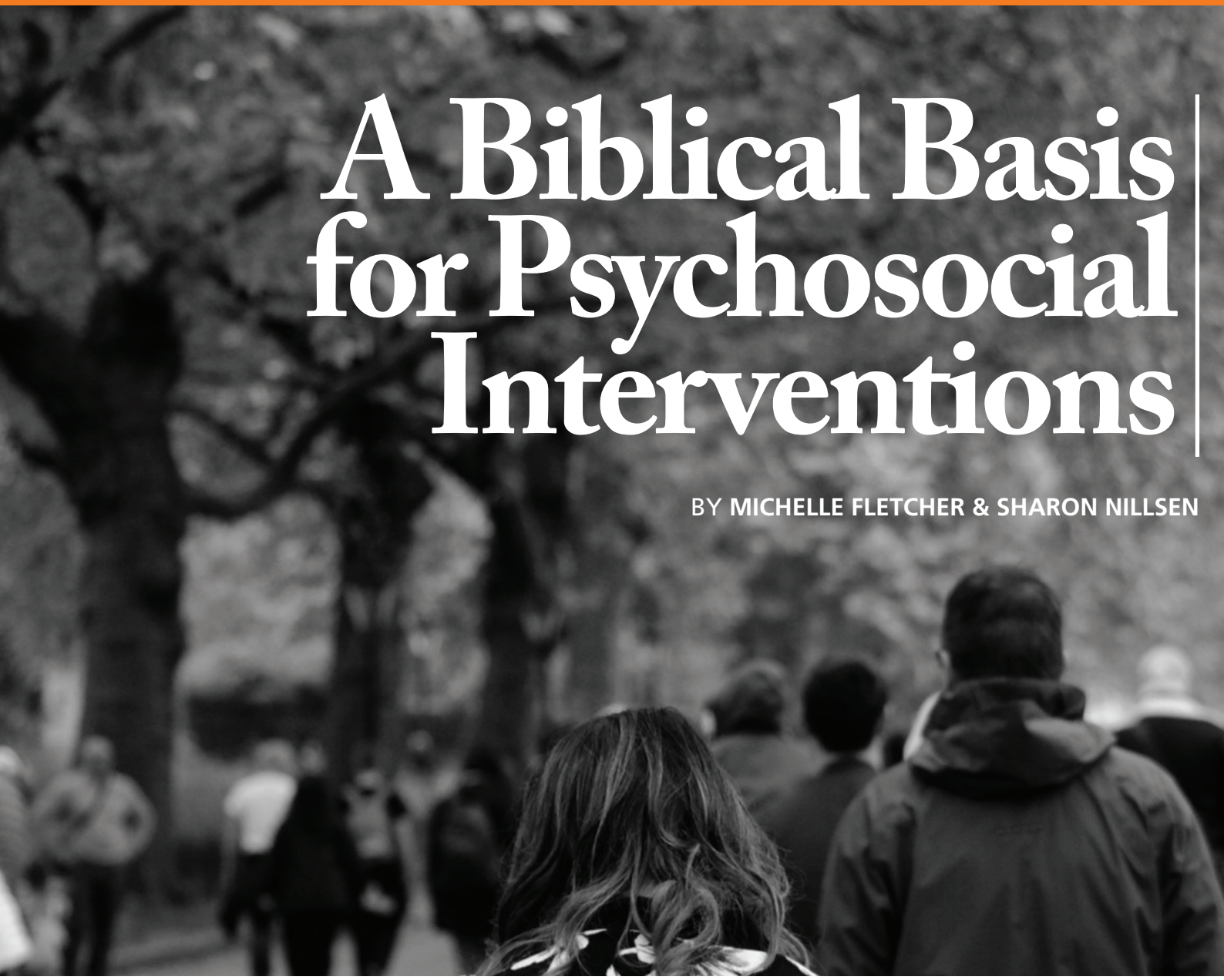


A Biblical Basis for Psychosocial Interventions

BY **MICHELLE FLETCHER & SHARON NILLSEN**

Introduction

The Pauline description of intrapsychic conflict can often be a precursor to mental illness:

> ***Although I want to do good, evil is right there with me … What a wretched man I am! Who will rescue me from this body that is subject to sin and death? (Romans 7:21, 24 NIV)***

The Bible indicates that the breakdown in mental health is a result of the fall where sin, sickness and death entered the world (Roberts, 2002) and which are described as 'infirmities' (Matthew 8:17; Romans 8:26-27). While a Christian conversion experience promises to deliver a person from this intrapsychic conflict, Seamans suggested that this does not heal completely:

> ***Certain areas of our lives … are not subject to ordinary prayer, discipline, and willpower, they need … an unlearning of past wrong programming, and a relearning and reprogramming transformation by the renewal of our minds. (Seamans, 2006, p.5)***

Counsellors, social workers, psychologists and psychotherapists (hereafter referred to as practitioners) support clients to increase social connection, resilience and build social capital. From the Christian viewpoint, mental health problems are a side effect of a broken world but recovery of the soul and spirit is achieved through the psychosocial interventions of unlearning, relearning and reprogramming transformation achieved through Christian counselling. It is important then to reconcile the interventions provided by present-day professional psychotherapy and counselling with the Bible because it is the handbook of the Christian faith. So, following a description of a Christian's worldview, biblical principles will be used to evaluate societal (inter-personal) and personal (intra-personal) factors involved in mental health. Following this, there will be a discussion using the Bible as a tool to analyse approaches of Christian counselling and the various psychotherapeutic interventions.

'Mental illness does not occur in ... isolation; it evolves out of the messy reality of our lives'. It refers to the wider psychological and environmental context rather than the narrower, 'mental illness' or 'mental disorder' which refer to a diagnosable illness causing major changes in cognition, perception and behaviour.

1. A Christian Psychotherapist's Worldview

In speaking about the intersections between psychotherapeutic interventions and a biblical basis, it is important that the Christian "worldview" is explained. A worldview filters an individual's perceptions of everything they encounter and governs their behaviour (Sire, 2004). Worldviews are influenced by culture, history and religion. In our modern culture worldviews are further complicated by globalisation, technology and competing messages from science and the belief that truth is a matter of personal choice (Webber, 2003). Practitioners can use this framework to draw from the theology of their time to help articulate Christian beliefs in ways that are relevant to individuals in their local context coming from a range of different worldview collectives (Grenz, 1994):

- Objectivity: can be achieved by understanding God as the reality
- Subjectivity: is allowable through the application of God's grace
- World problems: can be understood through an understanding of the fall
- Change: transformation can be received through redemption in Christ. (Naugle, 2004; Sire, 2004)

The Christian worldview is unique in that it recognises that all truth is God's truth and that secular truths can be examined in light of God's revelation and then used by Christians. On the other hand, the Christian worldview also encompasses responses for many of the questions people grapple with in their 'messy' daily lives.

2. Biblical Principles and Inter-personal Factors in Mental Health

THE BIOMEDICAL MODEL & THE PSYCHOTHERAPEUTIC MODEL

The "biomedical explanation" of mental health disorders is a biologically-focussed approach to science, policy and practice are brain diseases emphasizes

pharmacological treatment to target the presumed biological abnormalities. This approach has dominated the healthcare system for more than thirty years (www.science.direct.com/article/pii) and offers little hope of recovery for the sufferers. While acknowledging that there are instances when pharmacological intervention is necessary and appropriate, the over-prescription of medication does not sit well with practitioners who have achieved success in non-pharmacological interventions such as counselling, skills training, behaviour modification, psycho-education and family support.

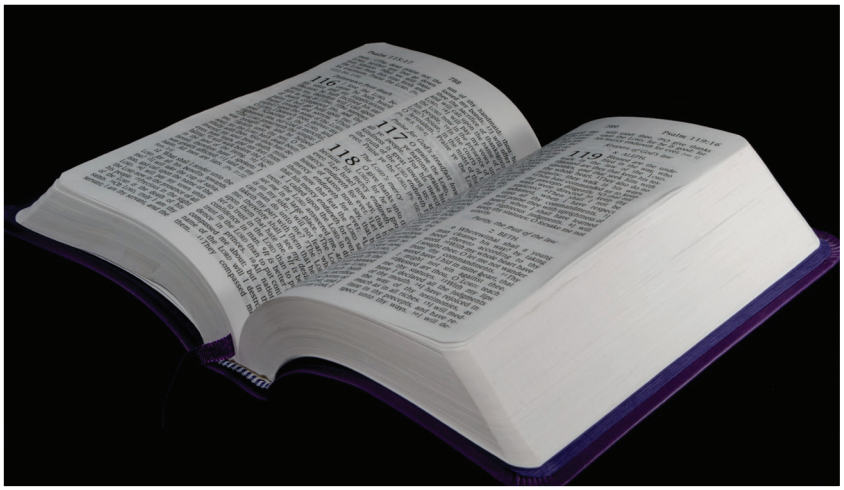
Many clients can be treated in psychotherapy to manage the psychosocial aspects of both high and low prevalence disorders including depression, anxiety, borderline personality disorder and psychosis (Government of Alberta 2014, p.1). The absence of sophisticated pharmacology in biblical times meant that the interventions were mainly going to be aimed at restoring the soul (Psalm 23: 3) through non-medical means. So, the Bible is going to have a good deal to say about a psychotherapy that is based outside of pharmacology and is going to include mental health disorders where personal, family, social, and political domains as contributing factors.

- Personal events such as trauma; assault, accident and injury; attachment breakdown; grief and loss, homelessness; disability and chronic illness; financial stress; bullying; ageing; loneliness; sleep disturbance (Davidson et al. 2016, p. 26).

- Family stressors include housing, employment security; domestic violence; transitions including blended families or moving locations; intergenerational poverty or carer stress.

- Social and political context; gender issues, elder abuse, migration, refugees and war trauma.

These mental health issues are essentially quality-of-life issues and include far more than the pharmacological elements. Mental health symptoms compromise self-esteem, personal narrative and dispossess people of their personhood. The road to dispossession and disconnection is paved with despair, discrimination, powerlessness and stigma in a downward spiral towards diagnosis.



Once diagnosed, the path of medical and psychosocial intervention can be either positive or negative. For many, diagnosis also increases stigma, and negatively impacts their ability to access services, particularly when their disorder is seen as "untreatable, or manipulative" (Bland et al. 2009, p. 23). It is here that that a more holistic, spiritual approach such as Christian Counselling to mental health can be beneficial. This is because mental health issues are complex and seldom arise in isolation. By finding, with the client, an explanation that helps explain their current situation furnishes a starting point to explore a way forward.

WHO SUFFERS FROM MENTAL HEALTH ISSUES AND WHAT IS THE CHRISTIAN RESPONSE?

Across all social measures, structural inequities may adversely affect the mental health of some groups more than others due to access to housing, employment, services or education. This complexity leads practitioners to find reflexive ways of thinking about the person-in-environment and tailor psychosocial interventions to meet needs. Miller-McLemore reminds us that counselling is a part of 'a wide cultural, social and religious context' because in our modern western society 'public policy issues that determine the health of the human web are as important as issues of individual emotional well-being'. (1993:4). Mental health issues occur across all social groups, however, "for every … mental illness, disease or disability, poorer people are affected more ... often, more seriously and for longer." (Gomm 2009 p. 98). Kinderman (2005) argues that mental health problems are triggered by the way psychological processes assess causal factors. When trying to understand causal factors, it is necessary to contextualise environment, family, cultural background, biology, what meaning is drawn, and the impact of life events.

Christian practitioners may see the impact of the fall on the social connections and relationships with self and others and believe that it is through relationships that healing and restoration can occur (Hiltner, 2000). In particular, for Christian clients, it can be helpful to envision the person's story as part of the larger meta-narratives that surround them by reference to family, society and the Biblical story (Bartholomew & Goheen, 2014; Newbigin, 1995; Roberts, 2002). These powerful narrative elements emerge from family background, church affiliation and friendships groups that is reinforced by community singing,

worship, socialization, festivals and feasts as well as all the other things that go into Christian conversion. Within the constraints of respect for the individual's spiritual walk and religious background, the Christian practitioner can tap into the powerful response and the ready commitment to biblical narratives and events.

Furthermore, the adage "it takes a village to raise a child" (Igbo and Yoruba proverb; Isaiah 49:15-16) is very applicable here. No one person (or practitioner) can meet all of another person's needs, but God can through a team approach. This in turn helps build healthy, committed growing kingdom communities of networked practitioners workers who are less likely to burnout (Kaldor & Bullpitt, 2001; Tidball, 2008). The Bible is replete with injunctions to be involved with the ministry of reconciliation to one another and this should be central to a Christian approach to psychotherapy.

3. Biblical Principles and Intra-Personal Factors in Mental Health

It is impossible to discuss all of these intra-personal factors in sufficient detail here. However, let us highlight adverse childhood experiences and the problems that are caused by poor childhood attachment that will lay down the tracks for a lifetime journey. Adverse Childhood Experiences and trauma are two major contributors to mental health disorders (Davidson. 2009, p. 26; Felitti et al. 1998 p. 245-256). Trauma, abuse and neglect are stored in the limbic brain as memories without language and are triggered as strong emotions without words. Therefore, people develop coping or compensatory mechanisms to keep themselves emotionally 'safe', which can be self-soothing, or self-destructive (Felitti et al.1998 p. 80). Feelings of shame, guilt, secrecy and sometimes amnesia about traumatic childhood or other traumatic events are often buried under the presenting problem (Felitti et al. 1998 p. 80). In childhood, the brain lays down the patterning of learning, resilience and coping strategies. However, a stressed brain constantly bathed in high levels of cortisol, learns to be hyper-vigilant and constantly in 'fight or flight' mode. ACE survivors have learned that the world is not a safe place and that adults around them are untrustworthy - often the only person they can rely on is themselves. The lives of many ACE survivors are forever blighted without appropriate psychosocial intervention and healing from the wounds of the past as they try to understand and manage the strong emotions driving their behaviour via the limbic system. The ACE study (Felitti et al.1998) clearly showed the 'profound' relationship between trauma and a range of psychiatric disorders and co-morbidities including chronic depression, borderline personality disorder (Bland et al. 2009, p. 123), psychosis, alcohol and substance abuse, suicidality, obesity, promiscuity and premature death.

The quality of early childhood/primary caregiver relationships are critical. Poor attachment leads to a lack of self-worth and hopelessness and influences how people believe others perceive them (Davidson et al. 2009 P. 26). Bowlby's (1979, 1982) theories on attachment and their contribution to the quality of subsequent mental health assist practitioners to understand a person's ability to form meaningful relationships with adult partners and children. Attachment can be compromised by parental mental illness, time spent in neonatal intensive care due to prematurity, illness, drug withdrawal, or Child Protection removal. Bowlby (1982) described attachment as the basis for the child's healthy psychological development of sense-of-self and relationships. It follows therefore, that any attachment break disrupts this healthy development and creates space for later psychological challenges (Henshaw, Cox and Barton 2013, p. 129). Andersen (2016) argued that the fall brought with it a problem of attachment that humans have not only with our parents and our God, but with each other.

While all of this curse of life may appear to be determined, as Christian practitioners we carry within us hope: hope which we can share with our clients. An understanding that in God all things are possible (Matt 19:26) and that God has plans for a good future for all people (Jer 29:11). Hope is defined by Schnider-Corey & Corey as 'the belief that change is possible' (1977, p. 247). This allows one to stop being a victim of the past and gives one the power to choose to be different going forward. Collins reminds Christian practitioners that counselling should seek to encourage spiritual and emotional maturity so that people can better cope with everyday problems. To do this a counsellor must understand how problems arise and how they can be resolved. (1985:14-15). Practitioners should see each individual 'as a person of worth, created by God in the divine image, marred by mankind's fall into sin, but loved by God and the object of divine redemption' (1985:31) and to present a message of hope. This hope can be communicated to a client from a practitioner through your attitude and from your belief that they can work towards restoration. Hope is discovered as you help the other(s) to make emotional connections, to realise that others do care about them and that change is possible.

4. The Intersection between the Bible and the Practice of Psychotherapy

Professional psychotherapeutic practice competency demands sufficient skills, knowledge and values to promote recovery, empowerment, restoration and well-being to individuals, families and communities. Central to this is the concept of brain plasticity which tells us it is never too late to intervene in a person's life to allow positive change to occur. Scwartz (2014) has found that if we enable a person to form a present relationship with those parts of themselves that have become stuck and listen to their story then they can be

freed to move into the present. The fact that the brain can produce new neural networks, regardless of age, means that it can be trained into new patterns of thought and behaviour at any stage of the lifespan (van der Kolk, 2014). Practitioner skills involve monitoring symptoms, assessing risk, assessment and interviewing, counselling, case planning and development, providing interventions, developing trust with clients, case work, monitoring, reporting and multidisciplinary collaboration.

- Knowledge involves understanding the theoretical underpinnings, models and tools of mental health practice and their effective application in appropriate contexts, ethics, values, policy, legal and statutory regulations and practice frameworks.

- Attitudes involve being non-judgemental, respectful, exhibiting professional integrity, communicating hope (Gormley and Quinn 2010) and valuing the lived experience (Bland et al. 2009; Miller, Duncan and Hubble, 1997).

- Recovery. Central to competency is enabling client-centred recovery. A practitioner's understanding of the contributing social context is key to developing an informed and comprehensive healing relationship (Bland at al. 2009, p. 34).

- Dialogue. Lived experience should be central to the dialogue, case planning and the relationship dynamic (Bland at al.2009, p. 22). Practitioners should respect the client's personhood and right to self-determination (AASW 2010, 12, 25). A study by Gormley and Quinn (2009) found clients appreciated empathic listening, and being shown respect, dignity and sensitivity. Munford and Sandors (2016 p. 239) reiterated that effective counselling included 'respect for persons' (AASW 2010) in the context of safe and trusted relationships when people feel listened to, have an authentic voice about service delivery and feel part of the decision-making process. Clients feel frustrated when they experience the 'ping-pong' effect of disjointed service delivery (Lawrence-Jones 2010 p.115).

Davidson et al. (2016 p. 163) argue that a biopsychosocial-environmental and person-centred approach to safety planning and casework is key to understanding how a client's mental illness impacts their life (Bland at al. 2009 p. 6,160). Listening to peoples' 'stories' gives insight into their experiences, behaviour and emotions and often identifies problem situations, missed opportunities or unused potential (Egan 2002 p. 77). Egan, in quoting Carl Rogers, cites 'unconditional positive regard, accurate empathy, and genuineness' within the therapeutic alliance to progress therapy. These are the basic skills which support clients to understand themselves, 'liberate their resources, and manage their lives more effectively' (Egan 2002, p. 42). Without a working therapeutic alliance, the work is difficult, if not impossible.

All approaches involve counselling and advocacy. Whether a practitioner is utilising a narrative approach of changing the story and externalising the problem; interpersonal therapy focusing on grief; role transitions; or mechanisms of interpersonal relationships while working on improving mood and functioning, the goal is always psychosocial functioning towards better quality of life rather than the alleviation of symptoms (MacPherson, Evans and Richardson, 2009). This holistic approach is as valid for depression and anxiety as for psychotic disorders.

The criticism of many evidence-based 'recovery' approaches is the focus on alleviation of symptoms rather than quality of life and hope for the future (McPherson, Evans and Richardson 2009). Miller, Duncan and Hubble (1997) found that the factors which contributed to positive outcomes in any approach included focusing on strengths and building hope (Munford and Sanders 2016, p. 237), the quality of the therapeutic alliance, the choice of models chosen and psycho-education of the client and carers (Hay 2012; Morawetz, 2002). Duncan and Miller (2000, p. 89) promote 'enlisting the client's resources, courting participation and wooing a favourable impression, and honouring the client's theory of change' a process which can be accomplished through understanding and accommodating the clients worldview. Patrick (2004) concurs with this and reminds us that mental health practitioners grapple with diversity continuously, with race and culture and all the other differences that may affect our work with clients, such as age, disability, gender and class.

Counselling research has shown that the matching of client preferences is one of the key predictors of therapeutic change (Morawetz, 2002, p. 1). One way practitioners can do this is by seeking to understand how clients make sense of their world and how these worldviews can be honoured and matched in counselling. Sire (1988, p. 17) states that a world view is a set of presuppositions (assumptions that may be true, partially true or entirely false) which we hold (consciously or subconsciously, consistently or inconsistently) about the basic makeup of our world'. To be of value to others we need to not only know our own worldview and understand why we hold it but also to be able to detect the worldview of others (Sire, 1988, p. 11). Sire reminds us that world views develop under different conditions such as race, nationality, history and political climate so there is a multiplicity of worldviews (Sire, 2004, p. 25). Griggs (1998, p. 1) defines counselling as an interactive learning process, between a practitioner and a client, which facilitates the client's understanding of self, others and the environment and results in positive changes. Therefore for an individual to maintain their psychological health they must be capable of altering their world view in light of new experiences and understandings (Peck, 1978, p. 148). Effective practitioners can assist clients to adjust their world view to accommodate their current circumstances.

Fowler (1999a:1) suggests that Christian

practitioners reconcile what we observe to be true with what the Bible reveals in the Christian counselling central context as follows:

1. The spirit of Christ is the 'real' counsellor (Isa. 9:6; John 14:16,26)
2. The Bible reveals God's will and ways (II Tim. 3:16)
3. That sin underlies all human problems (Rom 3:23)
4. That we are all affected by past patterning of sin (Gal 5:17)
5. Human behaviour is derivative in spirit, soul and body (I Thes. 5:23)
6. Christians are enabled to behave differently though dependent on Christ (Col 1:27)
7. We are called to encourage each other to love, growth (Heb. 10:25)
8. Evangelism can accompany counselling (Matt. 28:19-20)

These overtly biblical principles require Christian Counsellors to ensure that the therapeutic alliance is based on unconditional positive regard, accurate empathy, and genuineness.

5. Biblical Principles and the Treatment of Mental Health Issues

As practitioners, envisioning the client through a Christian worldview can enable us to meet them with Christ's compassion and to believe that there is a hope of restoration in their lives (Whitfield & Johnson no date: 1-3).

In working with clients in this way it is important that we remember:

'our task is not to force some theological agenda on the people who seek our help but to be informed, knowledgeable followers of Jesus Christ who are available to be guided by the Holy Spirit and used as His instruments in changing lives.' (Collins 2001:251)

As Seamans (2006, p.5) pointed out earlier, the biblically-based psychotherapeutic of unlearning of past wrong programming, and a relearning and reprogramming transformation by the renewal of our minds. The following treatment therapies have much in common with the biblical injunction to renew the mind (intrapsychic) and reconciliation (interpsychic):

a. Cognitive Behavioural Therapy (CBT). The objective of cognitive behaviour therapy (CBT) is to change unhelpful cognitive and behavioural patterns and emotional regulation by challenging thought processes, particularly automatic thoughts and maladaptive beliefs, self-talk, emotional responses, behaviours and coping strategies. CBT also includes psycho-education and relaxation techniques (Bland at al. 2009, p. 101-110; Davidson at al. 2016, p. 31-32). Depression occurs in approximately ten percent of Australians (Davies 2003). It has a high co-occurrence with anxiety, substance abuse, and pregnancy (Bland et al. 2009, p. 104). Depression and anxiety can be treated pharmacologically or with CBT. CBT is often used alongside medication to address the cognitive and behavioural aspects of psychotic disorders such as schizophrenia, schizoaffective, delusional and substance-induced disorders. Dual diagnosis of psychotic and co-occurring substance use disorders is common. It is postulated that substance use is an attempt to self-medicate and ameliorate unpleasant experiences of mental illness (Horsfall et al. 2009, p. 24). Psychotic clients may experience poor problem-solving and coping skills, low self-esteem, have unstable housing, relationships, employment and experience stigma and discrimination (Horsfall et al. 2009, p 24-27). The psychosocial approaches cited by Horsfall et al. (2009, p. 27-28) available for dual diagnosis clients include motivational interviewing, CBT, family support and group interventions.

b. Motivational interviewing (MI) is designed to facilitate and engage intrinsic motivation within dual-diagnosis clients to change long-standing problematic and risky behaviours. MI acknowledges and challenges client ambivalence around the harm their substance use is causing and develops strategies for change and harm minimisation. Clients identify strengths and aspirations, and link them to substance use problems (Rollnick et al. 2010, p. 750; Horsfall et al. 2009). MI is increasingly effectively used with adolescents and adults to address substance abuse, schizophrenia, smoking, risky sexual behaviour and medication adherence (Hall et al. 2012, p. 660-667).

c. Problem solving is linked to CBT through psychological function, coping ability and resilience. Its roots are in social casework (Healy, 2005) which is strengths-based and

incorporates resilience, possibility and change. This approach teaches clients to solve problems systematically, but practically, through utilising their skills to alleviate life's negative effects on psychological functioning, rather than focussing on pathology.

d. Family-based treatment (FBT) is particularly important for mental health disorders as they recognise and support not only the person-in-their-environment but also the impact and burden of mental illness on the family. Practitioners facilitate communication and problem-solving and support crisis management through psycho-education (Bland at al. 2009, p. 200-202). Effective family-sensitive and inclusive practice is provided to mental health clients and dual diagnoses clients, in all stages, but it requires skilful management by practitioners to develop open and honest relationships while maintaining professional boundaries, and client and family confidentiality (Bouverie Centre 2009).

e. Dialectical behaviour therapy (DBT) (Linehan 1993) uses group and individual sessions to target the mood instability and impulsivity of borderline personality disorder. DBT also provides consistent boundaries within a long-term therapeutic alliance to manage suicidal risk. Central to DBT is family support to help manage the regular crises, risky behaviours, suicidality, emotional reactivity and relationship challenges experienced by sufferers and families.

f. Group interventions. The major advantages of group interventions are their ability to change attitudes and behaviours, and their cost effectiveness. Groups utilise skills training, problem-solving, rehabilitation and peer support. Recognition of high-risk situations, social skills training and relapse prevention are taught in staged approaches in accordance with the client's motivation level. The benefit of these groups comes from the social support of being with others who fully understand the difficulties of maintaining sobriety. Addressing lifestyle and social issues are important demands on dual-diagnosis clients and research shows that consistent, long-term psychosocial intervention is most effective for significant change (Horsfall 2009, p. 28-29). Through learning about the illness, delusions and root causes, clients build a toolbox of coping strategies to modify delusions, moderate stress, strengthen resilience, prevent relapse and ameliorate negative social and personal consequences. Early intervention is critical to prevent 'impairment, disability and handicap' (Davies 2003).

Conclusion

Psychosocial interventions coupled with the Christian practitioners' worldview are effective with mental illnesses because they consider the biopsychosocial context of the person and allow practitioners to work reflexively but within well integrated evidence-based frameworks of practice. This requires the sometimes difficult process of reconciling modern professional psychotherapeutic interventions with the Bible as the handbook of the Christian faith. This reconciliation between faith and psychotherapy allows Christians to use modern research such as investigations that have indicated that brain plasticity allows for clients to unlearn past wrong programming, and a relearn and reprogram transformation by the renewal of our minds – all central to the act of repentance and entrance into the Christian life. This gives Christian practitioners' hope that a mental health client can successfully work towards change at any time across their lifespan in both societal (inter-personal) and personal (intra-personal) areas of our 'messy lives".

References

Andersen, J. 2016, Attachment and the Snake in the Garden. Counselling Connections Across Australia.Vol.7.

Australian Association of Social Workers 2010, Code of Ethics, https://www.aasw.asn.au/document/item/1201

American Psychiatric Association 2013, Diagnostic and statistical manual of mental disorders (5th ed.) American Psychiatric Publishing, Arlington, VA

Bartholomew, C. G., & Goheen, M. W. 2014, The drama of scripture: Finding our place in the biblical story. (2nd ed.). Baker Academic, Grand Rapids

Bland, R., Renouf, N. and Tullegren, A. 2009, Social Work Practice in Mental Health. 1st ed. Allen and Unwin, Sydney

Bouverie Centre 2009, Seven Principles of Family Sensitive Practice.

Bowby, J, 1979, The Making and Breaking of Affectional Bonds, Psychology Press, New York.

Bowlby, J, 1982, Attachment, 2nd Ed. Basic Books, USA.

Collins, G. 2001, The Biblical Basis of Christian Counselling for People Helpers. Navpress, USA

Collins, G. R, 1985, Christian Counselling. Word Publishing, England.

Davidson, G, Campbell, J, Shannon, C & Mulholland, C, 2016, Models of Mental Health, Palgrave Macmillan, New York

Davies, J, 2003, A Manual of Mental Health Care in General Practice. Commonwealth Department of Health and Ageing, Canberra.

Duncan, B & Miller. S, 2000, The Shift to Client-Directed Change. The Heroic Client – Doing Client Directed, Outcome Informed Therapy, 63-89. Jossey-Bass, San Francisco.

Egan, G, 2002, 'The Skilled Helper; a Problem Management and Opportunity-Development Approach to Helping' (7th ed), Wadsworth Group, Brooks/Cole, Pacific Grove CA.

Felitti, V., Anda, R., Nordenberg, D., Williamson, D., Spitz, A., Edwards, V., Koss, M. and Marks, J. 1998, 'Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults', American Journal of Preventive

Medicine, vol.14, no.4, pp.245-258.

Fowler, J., Counselling, Christ in you Ministries (1999a) http://www.christinyou.net/pages/counseling.html retrieved 8/11/2006

Gomm, R, 2009, 'Mental Health and Inequality', in J. Reynolds, R. Muston, T. Heller, J. Leach, M. McCormick, J. Walcraft and M. Walsh (eds) Mental health still matters. Macmillan, Bassingstoke.

Gormley, D. and Quinn, N. 2009, 'Mental Health Stigma and Discrimination: Social Work', Practice, vol. 21, no. 4, pp.259-272.

Government of Alberta 2014, Psychosocial Interventions: An Interpretive Guide to the Restricted Activity Alberta Health, Strategy Workforce. p.1. http://www.health.alberta.ca/documents/Psychosocial-Intervention-Guideline.pdf

Grenz, S. J, 1994, Theology for the Community of God. Eerdmans Publishing Company, Grand Rapids, MI.

Griggs, Shirley A. 1998, Counselling Students through Their Individual Learning Styles. Eric Counseling and Personnel Services Clearing House, Michigan.

Hall, K, Gibbie, T & Lubman, D, 2017, RACGP - Motivational interviewing techniques – facilitating behaviour change in the general practice setting. [Online] Racgp.org.au. http://www.racgp.org.au/afp/2012/september/motivational-interviewing-techniques/ [Accessed 1 Jun. 2017].

Hay, P, 2012, Avoid being 'tyrannised' by the evidence: Reflections on family-based treatment in adolescent anorexia nervosa', Australian & New Zealand Journal of Psychiatry, vol. 46, no. 11, p. 1102-1103.

Healy, K. 2005, and Social work theories in context: Focusing on task centred practice. 1st ed. Palgrave McMillan, Houndmills, Basingstoke, pp.108-131.

Henshaw, C., Cox, J & Barton, J, 2013, Modern Management of Perinatal Psychiatric Disorders, 1st Ed, RCPsyche Publications, London, p.129.

Hiltner, S. 2000, "The Meaning and Importance of Pastoral Theology." In The Blackwell Reader in Pastoral and Practical Theology, edited by J. Woodward and S. Pattinson, 27-48. Wiley-Blackwell Oxford.

Horsfall, J, Cleary, M, Hunt, G, & Walter, G, 2009, 'Psychosocial Treatments for People with Co-occurring Severe Mental Illnesses and Substance Use Disorders (Dual Diagnosis): A Review of Empirical Evidence', Harvard Review of Psychiatry, vol. 17, no. 1, p.24-34.

Kaldor, P & Bullpitt, I, 2001, Burnout in Church Leaders. (pp. 109-134). Openbook, NSW.

Kinderman, P, 2005, 'A Psychological Model of Mental Disorder'. Harvard Review of Psychiatry, vol. 13, no. 4, pp.206-217.

Kitchener, B. & Jorm, A, 2007, Mental Health First Aid Manual. 1st ed. University of Melbourne, Melbourne

Lawrence-Jones, J, 2010, 'Dual Diagnosis (Drug/ Alcohol and Mental Health): Service User Experiences', British Association of Social Workers, Vol 22. No. 2, p.115-117.

Linehan, M, 1997, Skills training manual for treating borderline personality disorder. 1st ed., Guilford Press, New York

McPherson, S, Evans, C & Richardson, P& 2009, 'The NICE Depression Guidelines and the recovery model: Is there an evidence base for IAPT?' Journal of Mental Health, vol. 18, no. 5, pp.405-414.

Miller, S, Duncan, B & Hubble, M, 1997, Escape from Babel, 1st Ed, Norton, New York

Miller-McLemore, B, 1993, 'the human web: reflections on the state of pastoral theology', The Christian Century, http://www.findarticles.com/p/articles/mi_m1058/is_n11_v110/ai_13651530/pg_5 Retrieved 8/11/2006

Morawetz, D, 2002, "What Works in Therapy: What Australian Clients Say". Psychotherapy in Australia 9, no. 1 p. 66-70.

Munford, R. and Sanders, J. 2016, 'Finding Meaningful Support: Young People's Experiences of "Risky" Environments.' Australian Social Work, vol. 69, no. 2, pp.229-240.

Naugle, D. K, 2004, Worldview: History, Theology, Implications. Cornerstone University.

Newbigin, L. 1999, Judges, Kings and Prophets, A walk through the Bible. Regent College Publishing, London, p. 25-32.

Patrick, E, 2004, "It's Ok to Be Different." Counselling & Psychotherapy Journal 15, no. 8 p. 15-17.

Peck, M. S, 1978, The Road Less Travelled. Touchstone, New York.

Roberts, V, 2002, God's big picture; tracing the storyline of the Bible. Inter-Varsity Press Nottingham.

Rollnick, S, Butler, C, Kinnersley, Gregory, J & Mash, B. 2010, 'Motivational Interviewing', Child: care, health and development, vol. 36, no. 5

Schnider-Corey, M & Corey, G, 1977, Groups: Process and Practice, Brooks/Cole, USA.

Scwartz, R, 2014, Working with a Client's Inner Systems to Heal Trauma and Develop Greater Calm and Compassion/ Interviewer: R. Buczynski. Rethinking Trauma Webinar, The National Institute for the Clinical Application of Behavioral Medicine, www.nicabm.com.

Seamands, D, 2006, Healing for Damaged Emotions. Authentic Media, USA.

Sire, J, 1988, The Universe Next Door: A basic world view catalog. InterVarsity Press, Illinois.

Sire, J. W, 2004, Naming The Elephant; Worldview As A Concept. InterVarsity Press Illinois.

Tidball, D, 2008, Ministry by the Book. InterVarsity Press, Illinois, p. 234-246.

van der Kolk, B, 2014, How to Help Patients Rewire a Traumatized Brain - Applying the Latest Strategies to Speed Healing and Reduce Symptoms for Even the Most Traumatized Clients/ Interviewer: R. Buczynski. Rethinking Trauma Webinar, The National Institute for the Clinical Application of Behavioral Medicine, www.nicabm.com.

Webber, R. E., 2003, The World We Evangelize Ancient-Future Evangelism: Making Your Church a Faith-Forming Community. Baker Books, Michigan. p. 123-136.

Whitfield, K & Johnson, E, (date unknown) A History of Recent Christian Psychology http://www.christianpsych.org/Articles/History.pdf