Liberty University John W. Rawlings School of Divinity

Individual Pastoral Counseling in Combination with Celebrate Recovery Group Experience

A Thesis Project Submitted to

the Faculty of Liberty University School of Divinity

in Candidacy for the Degree of

Doctor of Ministry

By

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Lynchburg, Virginia

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THE DOCTOR OF MINISTRY THESIS PROJECT ABSTRACT

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Celebrate Recovery is a Christ-centered twelve-step program in which participants benefit from testimonies and mutual sharing of their struggles and victories. However, "cross-talk" and giving advice is not permitted in the group. Some participants may need or desire individual counseling. This thesis project focused on a Celebrate Recovery ministry in a rural setting where travel and economic obstacles create an impediment to access the services of a licensed therapist. Individual pastoral counseling was combined with the Celebrate Recovery group experience to ascertain whether the combination of these two approaches would yield enhanced and accelerated recovery as perceived by the participants. The individual therapy model employed was Cognitive-Behavioral Therapy combined with elements from Solution-Focused Brief Therapy within the context of a Christian worldview. A qualitative analysis method was used in which participants were interviewed prior to their counseling intervention and, again, upon the completion of the intervention to determine their self-perceived progress in recovery. The results indicated that participants prefer individual counseling in addition to their recovery group experience and that they experienced growth in their recovery.

Contents

Chapter 1: Introduction 1
Ministry Context 2
Problem Presented 8
Purpose Statement 8
Basic Assumptions 9
Definitions 11
Limitations 14
Delimitations 16
Thesis Statement 17
Chapter 2: Conceptual Framework 18
Literature Review 18
Introduction 18
Recovery 18
Twelve-step Programs 19
Spirituality in Recovery 22
The Social Component 24
Individual Counseling 25
Cognitive-Behavioral Therapy 25
CBT Efficacy 27
Solution-Focused Brief Therapy 29
SFBT Efficacy 32
Conclusion 32
Theological Foundations 33
Theology of Addiction 33
Disease and Desire 37
Recovery as Sanctification 39
Incarnational Presence 42
Idolatry and Recovery 43
Ultimate Recovery 44
Beyond Behavior Modification 46
Theoretical Foundations 48
Community and Individual Care 48
Christian Counseling 50
Cognitive-Behavioral Therapy 51
Solution-Focused Brief Therapy 51
Conclusion 52
Chapter 3: Methodology 55
Introduction 55
The Purpose and Objectives of the Intervention 55
Participants 56
Process 56
Counseling Intervention 59
Post-Counseling 64

Data Collection 65
Analyzing the Data 65
Chapter 4: Results 67
Participants...67
Pre-Counseling Interview..68
Question One 68
Question Two...70
Question Three 72
Question Four..74
Question Five...75
Question Six...77
Question Seven 78
Themes Related to CR Involvement..79
Wounded 79
Relationships..79
Acceptance 80
Structure 80
Spirituality...80
Hearing and Sharing Testimonies 80
Individual Attention 81
Progress in Recovery 81
Reasons for Counseling 81
The Counseling Intervention 82
Post-Counseling Interview 83
Question One 84
Question Two...85
Question Three 86
Question Four..87
Question Five...89
Question Six...90
Question Seven 92
Themes from Post-Counseling Interview Responses.................................93
Financial Cost 93
Christian Worldview...93
Personalized Attention 94
Benefits of CR Group Experience 94
Combination of Counseling and CR Group Experience..........95
Chapter 5: Conclusion 96
Interpretations..96
Applicability 97
Credibility..99
Theological and Ecclesial Significance..99
Sustainability 100
Additional Research...101

Appendix A: Serenity Prayer 102
Appendix B: Consent Form 103
Appendix C: Pre-Counseling Interview Questions 106
Appendix D: Post-Counseling Interview Questions 107
IRB Approval 108
Bibliography 110

Abbreviations

AA *Alcoholics Anonymous*

BDMA *Brain Disease Model of Addiction*

CBT *Cognitive Behavioral Therapy*

CR *Celebrate Recovery*

DMIN *Doctor of Ministry*

DSM-5 *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition*

LUSOD *Liberty University School of Divinity*

NA *Narcotics Anonymous*

SAMHSA *Substance Abuse and Mental Health Services Administration*

SFBT *Solution-Focused Brief Therapy*

TTM *Transtheoretical Model*

Chapter 1

Introduction

Twelve-step programs aid individuals in recovery from addiction and substance abuse issues.[1] Programs such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Celebrate Recovery (CR) are peer-led and offer group meetings that provide an opportunity for participants to hear testimonies from individuals who have experienced a level of success in recovery. They also provide an opportunity for individuals to share their struggles and victories in confidential settings and to connect with sponsors who offer coaching and individual support. Sponsors are peers who have completed the twelve steps and demonstrated success on the journey to sobriety or recovery from their particular “hurt, habit or hang-up.” Twelve-step programs have the added benefit of being free (no fee required) and are often readily accessible in many communities. However, in addition to the group experience, some participants may need, desire or benefit from individual counseling.

Individual therapy may benefit participants and contribute to recovery. For example, Solution-Focused Brief Therapy (SFBT) is an evidence-based therapy that shows positive results in helping those with addiction and substance abuse issues.[2] SFBT may also be cost-effective since the treatment is designed to be brief. This type of therapy allows for individualized treatment and action plans tailored to the specific needs and questions of the counselee. Some

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[1] John F. Kelly, “Is Alcoholics Anonymous Religious, Spiritual, Neither? Findings from 25 Years of Mechanisms of Behavior Change Research,” *Society for the Study of Addiction* 112 (2016), 930-934; Oliver J. Morgan and Merle Jordan, eds., *Addiction and Spirituality: A Multidisciplinary Approach* (St. Louis, MO: Chalice Press, 1999), 8.

[2] Johnny S. Kim, Jody Brook, and Becci A. Akin, “Solution-Focused Brief Therapy with Substance-Using Individuals: A Randomized Controlled Trial Study,” *Research on Social Work Practice* 28 no. 4 (2016), 452-462.

counselees may also feel more comfortable in individual therapy with an experienced counselor rather than a group setting led by peers. A participant may desire the professional training of a counselor, and they may also prefer the confidential setting.

An emphasis on spirituality is common in twelve-step programs and has evidence-based support for substance abuse and addiction recovery.[3] Spirituality is a broad term encompassing views of higher purpose, meaning, and value. The concept of spirituality differs from the practice of religion. While religion involves spirituality, it is also associated with a specific organized belief system and practices. Spirituality, on the other hand, is not limited to a specific set of religious norms, rituals, or practices. Spirituality may include a Christian worldview, but it may also include Islamic, Buddhist, or other general spiritual beliefs. For this project, spirituality is viewed from the biblical perspective of a Christian worldview.

Participants in this project live in a rural setting in the poorest county in the state. Substance abuse and addiction recovery are often more difficult for those who live in rural communities. These communities are isolated and often lack professional counseling services and rehabilitation centers. Participants may not own a vehicle, and public transportation may not be available. For those who wish to seek help, services that are available may be too expensive. The local church may be the best possible alternative for assisting individuals in rural settings. Pastors are often the first contact for those looking for help. This project examines the impact of pastoral counseling in conjunction with the group experience of CR.

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[3] Brian J. Grim and Melissa E. Grim, "Belief, Behavior, and Belonging: How Faith is Indispensable in Preventing and Recovering from Substance Abuse," *Substance Abuse Treatment, Prevention, and Policy* 13 no. 35 (2019), 1717-1723.

Ministry Context

The ministry context of this project is a Celebrate Recovery group that is a ministry program of the Naples Church of Christ in Naples, Texas. Celebrate Recovery is an international ministry founded by John Baker at the Saddleback Church in Orange County, California in 1991. The Saddleback Church is a Baptist evangelical Christian church affiliated with the Southern Baptist Convention. Celebrate Recovery is a Christ-centered, 12-step recovery program for anyone struggling with "hurts, habits, or hang-ups" of any kind. The first meeting held in 1991 had 43 in attendance. Since its inception, over 27,000 people have gone through the program at the Saddleback Church. Approximately 35,000 churches around the world have adopted the program, and over 5 million individuals have completed a Step Study. In addition to churches, Celebrate Recovery can also be found in rescue missions, recovery houses, universities, and prisons. Celebrate Recovery also has a program for teenagers called The Landing and another program for younger children called Celebration Place.[4]

In America, each state has a Celebrate Recovery representative or representatives. These representatives are responsible for promoting the program and assisting existing groups and start-up groups. Celebrate Recovery emphasizes that all groups must follow the "DNA" of the program. After a 90-day start-up period, a new group may be listed on the Celebrate Recovery internet locator site and continue to use Celebrate Recovery branding and promotional materials. The required DNA of a group is comprised of its organizational structure and meeting format.

The acrostic, TEAM, illustrates the organizational structure of a Celebrate Recovery group. Each group has a Training coach (T), an Encourager coach (E), an Assimilation coach

[4] "History of Celebrate Recovery," Celebrate Recovery, accessed March 22, 2020, https://www.celebraterecovery.com/about/history-of-cr.

(A), and a Ministry team leader (M). The Training coach conducts new leader training and orientation, provides training sessions for monthly leadership meetings, develops and oversees leadership for small groups, and develops a training coach apprentice. The Encourager coach provides and oversees the shepherding care of the groups and ministry leaders, creates fellowship events, identifies new apprentice group leaders, and develops an encourager coach apprentice. The Assimilation coach promotes the program to both the community and the church and recruits new leadership candidates. The assimilation coach also maintains group information materials and develops an apprentice coach. The Ministry leader is responsible for the entire ministry and is the primary contact for the ministry.[5]

Celebrate Recovery meetings have two sessions. Each session lasts approximately one hour. The first session is the “Large Group Meeting.” The Large Group Meeting begins with a welcome or an opening song or prayer. A few more worship songs are sung, and the Eight Recovery Principles (based on the Beatitudes and the 12 steps of AA) are read. The Eight Recovery Principles are:[6]

1. Realize I am not God. I admit that I am powerless to control my tendency to do the wrong thing and that my life is unmanageable (Matt 5:3).

2. Earnestly believe that God exists, that I matter to Him, and that He has the power to help me recover (Matt 5:4).

3. Consciously choose to commit all my life and will to Christ’s care and control (Matt 5:5).

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[5] John Baker, *Celebrate Recovery: Leader’s Guide* (Grand Rapids, MI: Zondervan, 2012), 33-36.

[6] Ibid., 9.

4. Openly examine and confess my faults to myself, to God, and to someone I trust (Matt 5:8).

5. Voluntarily submit to every change God wants to make in my life and humbly ask Him to remove my character defects (Matt 5:6).

6. Evaluate all my relationships. Offer forgiveness to those who have hurt me and make amends for harm I have done to others, except when to do so would harm them or others (Matt 5:7,9).

7. Reserve a daily time with God for self-examination, Bible reading, and prayer in order to know God and His will for my life and to gain the power to follow His will.

8. Yield myself to God to be used to bring this Good News to others, both by my example and by my words (Matt 5:10).

The Large Group meeting also includes a message based on one of the recovery principles, or a testimony from someone who has made progress in their recovery. The messages and testimonies may be either live or recorded. Recovery milestones are celebrated with special coins distributed to those who have maintained sobriety for set periods of time, and the Serenity Prayer is always recited.[7] Some CR groups also serve a meal or have a "Solid Rock Café," a place designed specifically for fellowship.

The second session involves dividing into small groups of the same gender for confidential sharing of struggles and victories. Groups may be organized according to specific issues. For example, a male group for those struggling with chemical addictions or a female

[7] Baker, 50-53. The Serenity Prayer is included in Appendix A.

group for those struggling with co-dependency may be offered. A group may also be organized for mixed issues, especially in programs with fewer participants, but they will always be gender specific. Five guidelines are read and followed in the small groups:

1. Keep your sharing focused on your own thoughts and feelings. Limit your sharing to three to five minutes.

2. There is NO cross talk. Cross talk is when two individuals engage in conversation excluding all others. Each person is free to express his or her feelings without interruptions.

3. We are here to support one another, not “fix” one another.

4. Anonymity and confidentiality are basic requirements. What is shared in the group stays in the group. The only exception is when people threaten to injure themselves or others.

5. Offensive language has no place in a Christ-centered recovery group.[8]

The format consists of individuals introducing themselves with a phrase such as “My name is (fill in the blank), and I am a grateful believer in Jesus. I struggle with (fill in the blank).” After introducing oneself, the participant shares whatever they wish without interruption or feedback from the group. When the person is finished sharing, the next person may proceed in

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[8] Baker, 54-55.

the same manner. Confidentiality is emphasized unless someone is threatening to harm themselves or someone else and offering advice to “fix” someone is prohibited.[9]

Step studies and sponsors are sometimes available for those who are interested in these aspects of the program. It depends on the availability of a sponsor or step study facilitator. A step study uses four different booklets to guide participants through the twelve steps of Alcoholics Anonymous from a biblical perspective. A step study group is comprised of participants of the same gender and is peer-led.[10] It takes approximately one year to work through the steps. These groups have a high rate of attrition due to the rigor and length of the process. A sponsor is a peer who has completed the twelve steps and made progress in their recovery. A sponsor serves as a coach to a sponsee and often has daily contact with their sponsee.[11]

The Celebrate Recovery program for this project is a ministry of a church of approximately 80-100 members. The Celebrate Recovery program has approximately nine consistent participants with a few others occasionally attending the weekly Tuesday evening meeting. The nine regular participants are comprised of six males and three females. The males range in age from 28 to 68 years old. Five are married, and one is widowed. Three are employed, two are retired, and one receives disability income. The male group is a mixed issues group. One of the male participants meets weekly with a licensed therapist. The three women range in age from 28-73 years old. Two are married, and one is divorced. Two are employed, and one receives unemployment income. The female group is also a mixed issues group.

[9] Baker, 54-56; Mac Owen and Mary Owen, “How to Develop an Effective Substance Abuse Ministry,” in *The Struggle is Real: How to Care for Mental and Emotional Health Needs in the Church*, eds. Tim Clinton and Jared Pingleton (Bloomington, IN: WestBow Press, 2019), 162-175.

[10] Baker, 57.

[11] Ibid., 125-127.

The church is in a rural setting. The county in which the church is located is the most impoverished county in the state, and drug and alcohol use rank among the highest in the state. It is a drive of approximately 45 minutes to the nearest licensed counselor, and no public transportation or taxi service is available. The Celebrate Recovery group meets in the fellowship hall and classroom building of the church. The church provides financial support for the purchase of materials such as recovery daily devotional guides, recovery Bibles, and other recovery literature and supplies.

Problem Presented

The problem is that members of the Naples Church of Christ Celebrate Recovery program do not have easy access to individual counseling with a licensed therapist but desire input from a trained counselor. Such input and guidance might enhance their progress in recovery. The reason the problem exists is Celebrate Recovery (CR) guidelines, based on Alcoholics Anonymous (AA) guidelines, explicitly prohibit “cross talk” and attempts to “fix” another person’s problem in group meetings. CR participants benefit from the support group meetings, but some participants have expressed a desire for more personalized assistance than a support group offers. Professional counseling for participants is restricted due to the rural location of the church and the financial challenges of some of the participants.

Purpose Statement

The purpose of this D.Min. action thesis is to use qualitative analysis to evaluate Celebrate Recovery participants’ self-perceived progress in recovery before experiencing short-term individual pastoral counseling and then administer a post-counseling evaluation to determine participants’ self-perceived progress. The results of the project will determine if

participants benefit from individualized pastoral counseling in combination with their Celebrate Recovery group experience.

Pastoral counseling, rather than professional counseling, will be provided since participants live in a rural setting with limited access to professional counseling services. Even if professional counseling was readily available, some of the participants are unable to afford professional counseling. The pastoral counseling provided in this project will be provided free of charge.

Basic Assumptions

Certain presuppositions are assumed as foundations for this study. A primary assumption for this project is that the Bible is the inspired message of God and is useful for teaching, correcting, and counseling one another (2 Tim 3:16-17; Heb 4:12-13). The Bible informs an individual's thinking, and the way an individual thinks about something determines how that individual feels and, subsequently, behaves (Rom 12:1-2). This conceptual framework of a change in thinking leading to a change in feelings and behavior is also the basis for Cognitive-Behavioral Therapy.[12] However, a key distinction between the renewal of the mind mentioned in Romans and Cognitive-Behavioral Therapy is the supernatural action of the Holy Spirit that brings about transformation when God's Word is involved.

Change is possible when a person chooses to collaborate with the Holy Spirit (2 Cor 3:17-18) through an encounter with the wisdom expressed by Spirit-inspired words and the Spirit's supernatural influence. Therefore, it is assumed that transformation will be accelerated

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[12] Siang-Yang Tan, *Counseling and Psychotherapy: A Christian Perspective* (Grand Rapids, MI: Baker Academic, 2011), 254.

and more sustainable when it is reinforced by Christian counseling and Christian community operating in the miraculous power of God's transformative Spirit.

In an encounter with a man who had been ill for a long time, Jesus asks the question, "Would you like to get well" (John 5:6, *NLT*)? An assumption of this project is that the participants do want to change. It is assumed that participants are either in the preparation, action, or maintenance stage, as defined by the Transtheoretical Model (TTM) of behavioral change.[13] TTM explains change as a process that occurs in six stages:

1) Precontemplation – In this stage, people do not intend to take any action either because they are unaware of the consequences of their behavior, or they may have tried to change and become demoralized by lack of progress. These individuals are in denial from a CR point of view and might be considered resistant and unmotivated.

2) Contemplation – In this stage, people intend to change their behaviors in the next six months. They are not ready to take immediate action but have become more convinced than those in the precontemplation stage that something needs to be done. They are in the process of an internal cost-benefit analysis.

3) Preparation – People in this stage intend to act within the next month. They have an idea of a plan of action and may have already taken some steps in the direction of implementing the plan.

4) Action – The action stage is characterized by specific, overt changes in lifestyle within the past six months.

[13] James O. Prochaska, Colleen A. Redding, and Kerry E. Evers, "The Transtheoretical Model and Stages of Change," in *Health Behavior: Theory, Research, and Practice,* eds. Karen Glanz, Barbara K. Rimer, and K. Viswanath (San Francisco, CA: Jossey-Bass, 2015), 125-129.

5) Maintenance – People in this stage have made concrete changes and are working to prevent relapse.

6) Termination – This stage is characterized by total self-efficacy and temptation control.[14]

The assumption that the counselees in this project are in either the preparation, action, or maintenance stage stems from their voluntary participation in Celebrate Recovery and their willingness to engage in individual therapy.

Another assumption is that Jesus wants people to live full and satisfying lives (John 10:10). The ministry of helping individuals manage or be free from their enslaving thoughts and addictions brings glory to God by connecting them to the life-changing power of Jesus. This type of ministry helps bring peace and health to suffering individuals and to their friends and family who may be suffering along with them. It restores the true identity of the individual as a beloved child of God. The individual begins to understand their identity is not rooted in their hurt, habit, or hang-up. Their identity is rooted in God.

Definitions

"Addiction" may refer to substance abuse or behavioral issues. Addictions are typically categorized four ways: (1) addictions that stimulate, (2) addictions that tranquilize, (3) addictions that serve some psychological need, and (4) addictions that satisfy "unique appetites" such as pornography and some fetishes.[15] "The essential feature of a substance use disorder is a cluster of

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[14] Prochaska, Redding, and Evers, 125-129.

[15] Eric Scalise, "Addiction," in *The Popular Encyclopedia of Christian Counseling: An Indispensable Tool for Helping People with their Problems,* eds. Tim Clinton and Ron Hawkins (Eugene, OR: Harvest House Publishers, 2011), 376-377.

cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems."[16]

Debate exists as to whether addiction is disease-based or choice-based. The National Institute on Drug Abuse (NIDA), characterizes addiction as

> … a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. It is considered a brain disease because drugs change the brain – they change its structure and how it works. These brain changes can be long lasting, and can lead to the harmful behaviors seen in people who abuse drugs.[17]

Others assert that addiction is choice-based claim:

> People who suffer from an addiction often refrain from engaging in addictive behavior for periods; and further, their addiction often requires an elaborate series of actions, which cannot all be compelled. Some therefore argue that addiction is voluntary, a "disorder of choice." Addiction, like many basic choices that people make, is influenced by preferences and goals. The relief, if not pleasure, that is derived from satisfying one's addiction could be understood as a rational choice . . . Large-scale epidemiological studies show high percentages of spontaneous recovery, even without specific treatment.[18]

For the purpose of this project, addiction is understood as "an ongoing affliction that affects the brain's reward system, motivation, learning and memory. Altered brain function in these areas, due to prolonged use of substances [or behaviors] leads to biological, psychological, social and spiritual consequences."[19] As a result, treatment for addiction may require a combined

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[16] *Diagnostic and Statistical Manual of Mental Disorders: DSM-5* (Arlington, VA: American Psychiatric Association, 2013), 483.

[17] National Institute on Drug Abuse, National Institutes of Health. 2007. Drugs, Brains, and Behavior: The Science of Addiction. https://www. drugabuse.gov/publications/drugs-brains-behavior-scienceaddiction/drug-abuse-addiction.

[18] Lily E. Frank & Saskia K. Nagel, "Addiction and Moralization: the Role of the Underlying Model of Addiction," *Neuroethics* 10 (2017) 129–139. PAGE 130.

[19]Charles Robinson, III, *Loving the Addict in Your Pew: A Roadmap for Building a Church-based Recovery Ministry* (Long Beach, CA: Elements Behavioral Health, 2016), 34.

biological, psychological, social, and spiritual approach depending on the severity of the addiction.

"Christian counseling," as used in this research project, refers to "a form of discipleship designed to help free people to experience God's pardon, purpose, and power so they become fully devoted followers of Jesus Christ."[20] It is "an explicit integration" of spiritual resources "such as prayer, Scripture, referrals to church or other support groups or lay counselors, and other religious practices."[21] "It views the spirituality of both the therapist and the client to be foundational for effective therapy as well as for growth and wholeness."[22]

"Cross-talk is when two individuals engage in conversation, excluding all others."[23] Cross-talk is prohibited in Celebrate Recovery meetings. During the small group sharing time, each person is free to share without interruption. It is not permitted to offer advice, make comments, or ask questions.

"Brain disease model of addiction (BDMA)" describes an addiction as a disease with biological, neurological, and genetic sources of origin.[24] Studies indicate that neurobiological processes occur in individuals who engage in substance abuse[25] and some studies indicate that behaviors such as viewing internet pornography "share similar basic mechanisms with substance

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[20] Ron Hawkins and Tim Clinton, *The New Christian Counselor: A Fresh Biblical & Transformational Approach* (Eugene, OR: Harvest House Publishers, 2015), 31.

[21] Tan, 342.

[22] Ibid.

[23] Baker, 55.

[24] Wayne Hall, Adrian Carter, and Cynthia Forlini, "The Brain Disease Model of Addiction: Is it Supported by the Evidence and has it Delivered on its Promises?," *The Lancet Psychiatry* 2, 1 (2015), 105-110.

[25] Nora D. Volkow and George Koob, "Brain Disease Model of Addiction: Why is it so Controversial?," *The Lancet Psychiatry* 2, 8 (2015), 677-679.

addiction."[26]

However, this model is not without controversy. Freedom of choice is also involved. Some addicted individuals can and do recover without the assistance of medical or pharmaceutical intervention. The capacity for choice allows the person with an addiction to experience recovery even after physiological processes have been affected. "Addiction can be viewed as a form of self-medication that works against psychological suffering." [27] While experiences that are repeated enough times lead to changes in synaptic networks, this change does not necessarily qualify as a disease.[28] A danger of the BDMA is that it may foster a victim mentality that relieves the individual of personal accountability.

"Pastoral counseling," for the purpose of this project, refers to counseling conducted by a Christian pastor who has training in counseling theory, practice, and techniques. The term "pastoral" carries with it the idea of shepherding. The pastoral counselor actively shepherds his or her counselee. Shepherding implies guidance and care. The pastoral counselor uses psychological interventions consistent with a Christian worldview to assist the counselee in a sensitive but directive manner.

"Recovery," for this project, is a non-linear process of change through which individuals improve their health and wellness and strive to maintain a trajectory of spiritual growth and Christ-centered living through the power of the Holy Spirit and the encouragement of a Christian community. This definition differs from the Alcoholics Anonymous concept of recovery as total

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[26] Todd Love, Christian Laier, Matthias Brand, Linda Hatch, and Raju Hajela, "Neuroscience of Internet Pornography Addiction: A Review and Update," *Behavioral Sciences* 5, 3 (2015), 388.

[27] Marc Lewis, "Addiction and the Brain: Development, Not Disease," *Neuroethics* 10 (2017), 8.

[28] Maia Szalavitz, "Squaring the Circle: Addiction, Disease and Learning," *Neuroethics* 10 (2017), 83-86.

abstinence.[29] Recovery is understood as a journey more than a destination. In theological terms, recovery may be described as sanctification. It is an ongoing process of being transformed into the likeness of Jesus Christ through the power of the Holy Spirit (2 Cor 3:18) and the instruction and counsel of other Christians.

"Relapse" is the return to maladaptive behavior and abandonment of the recovery trajectory. "Lapse" differs from "relapse." A lapse is a temporary slip and return to maladaptive behavior that results a in a renewed effort to sustain recovery.

"Spiritual" and "spirituality" are general terms and may be defined as broadly as "that which gives meaning and purpose in life," [30]but for this project, the terms refer to Christian beliefs and worldview.

Limitations

This project is limited by sample size and age-range. A convenient sample is used rather than a random sample. The sample size is limited due to the number of Celebrate Recovery participants in the program hosted by the Naples Church of Christ. Also, the age-range is limited to individuals between 28-73 years old. Results might differ in a younger population.

Another limitation is the rural nature of the population. An urban or suburban setting might yield different perspectives from participants due to cultural and educational variants. Also, individuals in urban and suburban settings typically have more resources and support available for recovery that might lead to different outcomes.

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[29] Annette Mendola and Richard L. Gibson, "Addiction, 12-Step Programs, and Evidentiary Standards for Ethically and Clinically Sound Treatment Recommendations: What Should Clinicians Do?" *AMA Journal of Ethics* 18, no. 6 (2016), 647.

[30] Anthony E. Brown, J. Scott Tonigan, Valory N. Pavlick, Thomas R. Kosten, and Robert J. Volk, "Spirituality and Confidence to Resist Substance Use Among Celebrate Recovery Participants*," Journal of Religion and Health* 52 (2013), 108.

The methodology of self-reporting via pre-counseling and post-counseling interviews is a qualitative methodology that has inherent limitations, and "Ethnographic interviewing requires practice to acquire the necessary skills."[31] Potential drawbacks of qualitative interviews includes poor question formation, a failure to properly understand or plumb the depths of a participant's response, and reliance on the accuracy of a participant's response. The researcher's reflective thoughts will be recorded in the counseling case notes in an effort to maintain sufficient self-awareness so as to not unwittingly bias the trustworthiness of conclusions.

The relationship between the researcher and the participants may create a limitation. According to Sensing, "A story, an explanation, or response told to a researcher differs from what is told to friends."[32] The researcher for this project thesis is a friend, pastor, CR ministry leader, and pastoral counselor for the participants. The close relationship between the researcher and participants may influence interview responses. It is conceivable that participants may tend to report recovery progress in a more favorable light out of consideration for the researcher despite instructions otherwise. The researcher will emphasize the need for honest responses even if the participants believe their responses might reflect negatively on the process.

Another limitation is the gap in precedent literature related to Celebrate Recovery, pastoral counseling with Celebrate Recovery participants, and evidence-based Christian therapeutic models. Additionally, the pastoral counselor for this project is not a licensed therapist. The therapeutic model that will be used is an integration of Cognitive-Behavioral

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[31] James P. Spradley, *The Ethnographic Interview* (Long Grove, IL: Waveland Press, Inc., 2016), 68.

[32] Tim Sensing, *Qualitative Research: A Multi-Methods Approach to Projects for Doctor of Ministry Theses* (Eugene, OR: Wipf & Stock, 2011), 21.

Therapy (CBT) and Solution-Focused Brief Therapy (SFBT) with a Christian counseling worldview and interventions. The pastoral counselor for this project has had graduate level training in counseling techniques but does not have extensive supervised training in either CBT or SFBT.

Finally, a potential limitation is the availability of the participants to meet for individual therapy. Participants must be willing to meet, and they must have the time to meet. Work schedules and family obligations may have a detrimental impact on participant availability for individual counseling.

Delimitations

The scope of the project is deliberately narrowed to include only a range of subjects from CR participants of the Naples Church of Christ since these individuals form the immediate context of the researcher's pastoral and recovery ministry. Furthermore, the therapeutic model is delimited to Christian pastoral counseling that utilizes elements of Cognitive-Behavioral Therapy and Solution-Focused Brief Therapy. Other therapy modalities might yield different results. Caution should be exercised in attempting to make broader applications to other contexts.

Another delimitation is the nature of the participants' respective recovery issues. For example, a different CR group might have participants who are in recovery for issues not represented within the target group for this study. Counselees experiencing different issues might respond differently to the course of therapy used in this project. The skill level and training of the counselor is also a delimitation. Treatment is not manualized or scripted identically for each counselee. General principles coupled with some specific techniques derived from CBT and SFBT will be employed.

These delimitations should be considered so that conclusions from this study are not over generalized. Precise reproduction of the therapeutic approach and corresponding results may not find broader application in other ministry contexts.

Thesis Statement

Celebrate Recovery group meetings provide support for recovery via a Christ-centered Twelve-Step (TS) approach adapted from AA, but if participants engage in individual pastoral counseling in conjunction with group meetings, then it is theorized that progress in recovery will be accelerated and more satisfying for the participants.

Celebrate Recovery group meetings provide a community context that has a positive effect on recovery, but studies of twelve-step programs exist that indicate relapse rates continue to be high. Most relapses related to substance abuse occur within the first year. Most relapses that occur in the first year occur within the first 90 days.[33] Individual pastoral counseling can supplement and reinforce the CR community experience by providing personalized guidance, support, and direction that is consistent with a Christ-centered CR approach.

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[33] Dennis C. Daley and Antione Douaihy, *Relapse Prevention Counseling: Clinical Strategies to Guide Addiction Recovery and Reduce Relapse* (Eau Claire, WI: PESI Publishing & Media, 2015), 1-8.

Chapter 2

Conceptual Framework

Literature Review

Introduction

This chapter is a review of literature pertaining to the twelve-step recovery model, Cognitive-Behavioral Therapy, and Solution-Focused Brief Therapy with an emphasis on spirituality as a key component in recovery. Theological underpinnings are explicated, and the theoretical models applicable to this project are addressed. This chapter lays the foundation for the methodology of the project.

Recovery

There is no one-size-fits-all approach to recovery. Mendola and Gibson assert that evidence is lacking regarding the efficacy of addiction recovery modalities.[34] Mendola and Gibson, along with Lund,[35] believe the challenge lies, at least partly, in the use of quantitative measurements for qualitative experiences. Recovery means different things to different individuals, and no single authoritative definition of recovery has been established.

For example, the American Society of Addiction Medicine holds that total abstinence constitutes recovery.[36] If their definition is understood as the standard, then sobriety and recovery rates might be somewhat easier to track. However, the Substance Abuse and Mental Health Services Administration (SAMHSA) considers recovery to be more of a trajectory than a

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[34] Mendola and Gibson, 651.

[35] Ibid.; Pekka Lund, "Christianity in Narratives of Recovery from Substance Abuse," *Pastoral Psychology* 65 (2016), 353.

[36] Mandy Stokes, Peter Schultz, and Assim Alpaslan, "Narrating the Journey of Sustained Recovery from Substance Use Disorder," *Substance Abuse Treatment, Prevention, and Policy* 13, no. 35 (2018), 2.

destination.[37] SAMSHA defines recovery as consisting more in the process of addiction management that leads to health and wellness rather than addiction abstinence. In other words, if an individual is struggling with alcoholism but has been able to manage their drinking to a set number of drinks and their lifestyle and relationships are not suffering, then it might be said that the individual has experienced recovery from the control of alcohol. Hendershot et al.[38] and Pichot and Smock[39] also adhere to this concept.

Post takes a more esoteric view as opposed to behavioral definitions. He believes recovery occurs when the individual "abides in the ontological generality of triadic love."[40] In other words, recovery happens when one finds oneself in the right relationship with God, others, and self. Total sobriety is easier to quantify but evaluating the trajectory of recovery and abiding in the "ontological generality of triadic love" is a qualitative analysis.

Twelve-Step Programs

Among differing definitions of recovery, twelve-step programs, such as AA and CR, define recovery as complete abstinence.[41] Based on this definition of recovery, twelve-step programs, including CR, give indications of efficacious results.[42] Even though evidence exists to support

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[37] Daley and Douaihy, 2.

[38] Christian S. Hendershot, Katie Witkiewitz, William H. George, and G. Alan Marlatt, "Relapse Prevention for Addictive Behavior," *Substance Abuse Treatment, Prevention, and Policy* 6, no. 17 (2011), 2-3.

[39] Teri Pichot and Sandra A. Smock, *Solution-Focused Substance Abuse Treatment* (New York, NY: Routledge, 2009), 36.

[40] Stephen G. Post, "The Ontological Generality: Recovery in Triadic Community with a Higher Power, Neighbor, and Self," *Alcoholism Treatment Quarterly* 32 (2014), 121.

[41] Kevin T. Nieman, "Cohesiveness and its Effects on Recovery Among a Celebrate Recovery Group: A Hermeneutic Interpretation" (PhD Diss., University of Louisiana, 2007), 30; Pichot and Smock, 10.

[42] Helen Dermatis and Marc Galanter, "The Role of Twelve-Step-Related Spirituality in Addiction Recovery," *Journal of Religion and Health* 55 (2016), 510-517; Grim and Grim, 1717-1723; Kelly, 930-934; Morgan and Jordan, 8.

twelve-step groups as efficacious, addiction relapse rates remain high if abstinence is used as the definition of recovery. Relapse rates are estimated to be at least 40-60% within the first six months of addiction treatment.[43] Hendershot et al. cite studies that indicate tobacco and alcohol relapse rates range from 80-95% at the twelve-month mark.[44] A gap exists in the literature regarding analyses pertaining to CR, and more studies are needed to track CR participant recovery rates. However, one study conducted by Brown et al., revealed that 74% of the 91 participants in the study considered Narcotics Anonymous (NA) and AA to be helpful while 76% found CR to be more helpful.[45] Ninety-three percent of all the participants indicated their higher power was either God or Jesus.

Peele represents a different view. He believes that twelve-step groups are not only ineffective but are counter-productive to recovery.[46] His stance is based on the belief that the brain disease model of addiction (BDMA) contributes to a mindset of helplessness and keeps an individual stuck in their addiction. Debate continues to exist regarding the concept that addiction is a disease of the brain.[47] Peele believes it fosters a victim mentality that keeps a person locked into feeling trapped by their addiction. His theory is logical but more philosophical than evidentiary, and his viewpoint represents a minority of researchers in the field. According to

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[43] Daley and Douaihy, 1; Mendola and Gibson, 650.

[44] Hendershot et al., 1.

[45] Brown et al., 108.

[46] Stanton Peele, "AA is Ruining the World," *HuffPost,* October 3, 2011, https://www.huffpost.com/entry/problems-with-aa_b_989832.

[47] Nora D. Volkow, George F. Koob, and A. Thomas McLellan, "Neurobiologic Advances from the Brain Disease Model of Addiction," *The New England Journal of Medicine* 4:374 (2016), 363-371.

Volkow, et al., "In the past two decades, research has increasingly supported the view that addiction is a disease of the brain."[48]

A corollary of the BDMA is that an individual is powerless over their addiction since the addiction is a disease. It is not the fault of the individual. "The core of the brain disease model of addiction is the 'brain-hijack theory.' It posits that addiction is a brain disease caused by a dysfunction of brain systems involved in reward and pleasure seeking. According to this view, a greater emphasis on the biological aspects of addiction is a gateway to greater social acceptance of people with an addiction."[49] It is claimed that that the BDMA reduces the stigma attached to addiction and, thereby, provides an advantage for recovery. It relieves one of shame and self-blame.

Even though CR is based on a twelve-step approach (and twelve-step models have their roots in BDMA), the program attempts to circumvent a rigid disease model approach by focusing on the externalization of a participant's hurt, habit, or hang-up. CR stresses that one's identity is found in God, not in their addiction. For example, in AA, a participant introduces themself as an addict: "Hello, my name is John, and I am an alcoholic." In CR, a participant introduces themself differently: "Hello, my name is Jane, and I am a grateful child of God who struggles with alcohol." The person is not the problem; the problem is the problem.

Even though powerlessness is a foundational concept in CR, the belief is that an individual has the power to choose to submit to Jesus as their higher power. A person has free will. The result of this submission is that God will bring about healing or, at least, the strength to endure

[48] Volkow, Koob, and McLellan, 363.

[49] Eric Racine, Sebastian Sattler and Alice Escande, "Free Will and the Brain Disease Model of Addiction: The Not So Seductive Allure of Neuroscience and its Modest Impact on the Attribution of Free Will to People with an Addiction," *Frontiers in Psychology* 8:1850 (2017), 2.

temptations. CR explores the motivations for the addictive behavior rather than focusing on brain chemistry. Regaining one's true identity as a child of God is considered crucial to recovery. The addiction is externalized as the sinful nature of the individual, not the true or redeemed nature of the individual. A cornerstone passage of scripture supporting this view is found in Romans 7:15-20: "I don't really understand myself, for I want to do what is right, but I don't do it. Instead, I do what I hate . . . I am not the one doing wrong; it is sin living in me that does it . . . But if I do what I don't want to do, I am not really the one doing wrong; it is sin living in me that does it" (*NLT*). It is believed that the sinful nature is the culprit or "disease," but this sinful nature can gradually be overcome by the power of Jesus Christ. Stigma should not be attached to this "disease" of sin because the entire population of the world is "infected" (Isaiah 53:6; Proverbs 20:9; Romans 3:23) even though they may not realize or accept it.

Spirituality in Recovery

Spirituality, as part of recovery, is a cornerstone concept for twelve-step participants.[50] In a study conducted by Grim et al., it was discovered that approximately 73% of addiction treatment programs include spirituality as an element.[51] Lyons et al. found in one study that 82% of recovery participants who claimed a spiritual awakening during recovery maintained complete sobriety after one year, while only 55% of those who did not maintain strong spiritual beliefs remained abstinent.[52] The 45% relapse rate for individuals in the general population aligns with

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[50] Brown et al., 107; Dermatis and Galanter, 510-512; Grim and Grim, 1713-1717; David R. Hodge, "Alcohol Treatment and Cognitive-Behavioral Therapy: Enhancing Effectiveness by Incorporating Spirituality and Religion," *Social Work* 56 no. 1 (2011), 21; Kelly, 930; Lund, 351-366; Nieman, v.; Post, 120-126; Stokes, Schultz, and Alpaslan, 9.

[51] Grim and Grim, 1713.

[52] Ibid., 1717.

the 40-60% relapse rates previously cited by Mendola and Gibson,[53] and Daley and Douaihy.[54] The concept or experience of spirituality surfaces as a critical variable in the difference between relapse and sobriety rates. However, as with the definition of recovery and relapse, the definition of spirituality can be quite broad.

Spirituality may be defined as broadly as "that which gives meaning and purpose in life."[55] Spirituality is typically differentiated from being religious, although the two concepts may be conjoined. "Spirituality [is] that dimension of personal experience related to the sacred, ultimate, or transcendent. Religion, by contrast, carries an organizational dimension, involving a community of believers with a shared set of doctrines or beliefs and ritual activities."[56] The broad definition of spirituality does not necessarily include religious beliefs, associations, or practices, but those who maintain religious beliefs, associations, and practices would understand them to be part of their spirituality.

The concept of a higher power in the process of a spiritual awakening is a consistent theme in twelve-step groups,[57] but the spirituality may be Christian, Muslim, Buddhist, or even non-theistic.[58] Wilson, one of the founders of AA, refers to the "God idea" as a tool in recovery.[59] It is unclear if he placed more emphasis on the mere idea of a higher power or the

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[53] Mendola and Gibson, 650.

[54] Daley and Douaihy, 1.

[55] Brown et al., 108; Dermatis and Galanter, 510.

[56] Roger D. Fallot, "Spirituality and Religion in Recovery: Some Current Issues," *Psychiatric Rehabilitation Journal* 30, 4 (2007), 262.

[57] Brown et al., 107-108; Dermatis and Galanter, 511; Kelly, 930; Lund, 351-352; Nieman, v.; Post,120-126; Stokes, Schultz, and Alpaslan, 9.

[58] Grim and Grim, 1720; Lund, 351-366; Mendola and Gibson, 648.

[59] Kelly, 933.

actual reality of a higher power. CR participants believe that God is more than an idea or tool. In CR, Jesus (God) is believed to be the only higher power and surrendering to Jesus is the only way to experience freedom from addiction,[60] but recovery rates among CR participants and AA members are not vastly different.

Whether or not one believes God is merely a concept or a real being, the evidence indicates it makes a difference toward more positive outcomes when spirituality is a component of the recovery process. One study of 40 participants conducted by Jarusiewicz discovered that twelve-step group members with more than two years of sobriety expressed greater emphasis on spirituality than those who had recently experienced a relapse.[61] In a logistic regression analysis conducted by Brown et al. of CR members, it was also demonstrated that spirituality was connected to greater resistance against relapse.[62] Based on their study results, Brown et al. conclude that increasing levels of spirituality among CR members could lead to increased self-efficacy and recovery.[63] In general, "In first-person reports, in qualitative summaries and in structured surveys yielding quantitative data, consumers have consistently indicated that religion and spirituality can serve as major resources in recovery."[64]

The Social Component

"Spirituality or religion may be connected to important sources of social support and community."[65] Nieman concludes from his study that "Cohesion among Celebrate Recovery

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[60] Nieman, 31.

[61] Brown et al., 108.

[62] Ibid., 110-111.

[63] Ibid., 111-112.

[64] Fallot, 262.

[65] Ibid, 263.

participants is paramount to the recovery process."[66] The social component provides participants with a feeling they are not alone in their struggles, and individuals gain insights from those who share about their own progress in recovery.[67] The spiritual component helps mitigate potential expressions of hostility, and potential racial, ethnic, and socio-demographic divisions are lessened due to common beliefs in God and the biblical imperative to love one's neighbor.[68]

Individual Counseling

Twelve-step groups, including CR, provide a viable resource for assisting addicts in recovery, but individualized treatment offers another approach. Each person who is struggling with addiction is different. While some commonalities exist, it is generally accepted that the unique bio-psycho-social context of each individual needs to be considered.[69] It is not within the scope of this review to examine all existing individual therapies for substance abuse and addictions, but two evidence-based modalities are considered: Cognitive-Behavioral Therapy (CBT) and Solution-Focused Brief Therapy (SFBT).

Cognitive-Behavioral Therapy

Jordan, Froer, and Bavelas identify the primary dichotomy of CBT and SFBT as problem-solving versus solution-building.[70] CBT places the therapist in the position of "expert,"

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[66] Nieman, iv.

[67] Charles Allen Kollar, *Solution-Focused Pastoral Counseling: An Effective Short-Term Approach for Getting People Back on Track*, (Grand Rapids, MI: Zondervan, 2011), 206-207.

[68] Ibid., 95-97.

[69] Daley and Douaihy, 19; Paula Hall, "A Biopsychosocial View of Sex Addiction," *Sexual and Relationship Therapy* 26 no. 3 (2011), 218; Pichot and Smock, 3; Stokes, Schultz, and Alpaslan, 2.

[70] Sara Smock Jordan, Adam S. Froer, and Janet Beavin Bavelas, "Microanalysis of Positive and Negative Content in Solution-Focused Brief Therapy and Cognitive Behavioral Therapy Expert Sessions*," Journal of Systemic Therapies* 32 no. 3 (2013), 48.

and an attempt is made to help the client uncover the underlying causes of their problem and how maladaptive thoughts about the problem keep them stuck. New ways of thinking about the problem are explored together, and the therapist typically provides homework to aid the client in acquiring coping skills.[71]

Albert Ellis and Aaron Beck are recognized as the founders of Cognitive Behavioral Therapy. CBT combines principles originating from B. F. Skinner and Albert Bandura (behavioral therapy) with Aaron Beck's cognitive therapy and Albert Ellis' rational emotive therapy.[72] Behavior therapy is referred to as the "First Wave" of CBT and focuses on classical conditioning and operant learning. "Second Wave" CBT focuses on information processing. For example, Ellis developed a variation known as Rational Emotive Behavioral Therapy (REBT). While both Beck's cognitive therapy and Ellis' REBT use similar techniques, REBT is a more "persuasive and confrontational style."[73] "Third Wave" CBT emphasizes contextual and experiential change strategies. Examples of third wave CBT include Schema Therapy (ST), Acceptance and Commitment Therapy (ACT), Mindfulness Based Cognitive Therapy (MBCT), Compassion Focused Therapy (CFT), Emotion Based Therapy (EFT), and Dialectical Behavior Therapy (DBT).[74]

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[71] Hall, 223; Jordan, Froer, and Bavelas, 46-48; Tan, 254-270.

[72] Jeanne Brooks, "Cognitive-Behavioral Therapy," in *The Popular Encyclopedia of Christian Counseling: An Indispensable Tool for Helping People with their Problems,* eds. Tim Clinton and Ron Hawkins (Eugene, OR: Harvest House Publishers, 2011), 455-458.

[73]W. Brad Johnson, and William L. Johnson, *The Minister's Guide to Psychological Disorders and Treatments*, (New York, NY: Routledge, 2014), 23-24.

[74] S. Carvalho, S., C. Martins, H. Almeida, and F. Silva, "The Evolution of Cognitive Behavioral Therapy – the Third Generation and its Effectiveness," *European Psychiatry* 41 (2017), S773-S774.

Despite variations within the CBT approach, the underlying assumption of all CBT is that distorted thinking and faulty beliefs are responsible for the client's distress. The role of the counselor is to work with the client in a collaborative process to restructure irrational beliefs. The focus is not so much on the presenting problem as it is on the clients' perception of the problem. A change in thinking leads to a change in feeling, and a change in feeling leads to a change in behavior.

CBT Efficacy

CBT has been demonstrated to be an effective treatment approach for a wide range of mental illnesses and disorders including, but not limited to, alcoholism,[75] eating disorders[76] depression,[77] anxiety,[78] PTSD and trauma,[79] marital discord,[80] schizophrenia,[81] and grief.[82]

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[75] Hodge, 21-31.

[76] Sandra Mulkens, Chloe de Vos, Anastacia de Graff, and Glenn Waller, "To Deliver or not to Deliver Cognitive Behavioral Therapy for Eating Disorders: Replication and Extension of Our Understanding of Why Therapists Fail to Do What They Should Do," *Behaviour Research and Therapy* 106 (2018), 57-63.

[77] N. Hundt, J. Mignogna, C. Underhill, and J. Cully, "The Relationship Between use of CBT Skills and Depression Treatment Outcome: A Theoretical and Methodological Review of the Literature," *Behavior Therapy,* 44 (2013), 12-26.

[78] Tian Po Oei and Niamh May McAlinden, "Changes in Quality of Life Following Group CBT for Anxiety and Depression in a Psychiatric Outpatient Clinic," *Psychiatry Research,* 220 (2014), 1012-1018.

[79]Patricia Gaspar Mello, Gustavo Ramos Silva, Julia Candia Donat and Christian Haag Kristensen, "An Update on the Efficacy of Cognitive-Behavioral Therapy, Cognitive Therapy, and Exposure Therapy for Posttraumatic Stress Disorder," *International Journal of Psychiatry in Medicine,* 46, 4 (2013), 339-357; Glenn Schiraldi, *The Post-Traumatic Stress Disorder Sourcebook: A Guide to Healing, Recovery, and Growth*. New York, NY: McGraw Hill, 2016.

[80]Melanie S. Fischer, Donald H. Baucom, and Matthew J. Cohen, "Cognitive-Behavioral Couple Therapies: Review of the Evidence for the Treatment of Relationship Distress, Psychopathology, and Chronic Health Conditions," *Family Process* 55 (2016), 423-442.

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[81]Stefan G. Hofmann, Anu Asnaani, Imke J. J. Vonk, Alice T. Sawyer, and Angela Fang, "The Efficacy of Cognitive Behavioral Therapy: A Review of Meta-analyses," *Cognitive Therapy Research* 36 (2012), 427-440.

[82] Phyllis S. Kominsky, "CBT for Grief: Clearing Cognitive Obstacles to Healing from Loss," *Journal of Rational-Emotive & Cognitive-Behavior Therapy* 35 (2017), 26-37.

Evidence exists that CBT is effective in both individual and group settings[83] and even via internet applications.[84] However, no therapeutic model is perfect, and CBT does have critics. For example, some critics assert that CBT meta-analyses have been too limited.[85] Another criticism is that CBT may not be effective with children or those with limited reasoning capabilities. Some critics assert that cognitive behavioral therapists tend to overlook the importance of the therapeutic relationship and focus more on method.[86] Some express concern over the lack of standardization and the multiplicity of variants within cognitive behavioral therapies. However, as Tai et al. point out, "CBT is better understood in terms of a set of core principles that rely on a personalized conceptualization of an individual's problems to guide the application of techniques and strategies."[87] Despite these and other criticisms, CBT is the most researched, empirical, evidence-based psychotherapy, and while other therapies may produce comparable results, no other psychotherapy has been demonstrated to be systematically superior to CBT. CBT is considered the "gold standard" of psychological treatment.[88]

Basic principles of modern CBT include gaining an understanding of the dysfunctional or maladaptive thoughts connected to the client's presenting problem, providing psychoeducation

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[83] Oei, 1012-1018.

[84] Gerhard Andersson and Per Calbring, "Internet-Assisted Cognitive Behavioral Therapy," *Psychiatric Clinics of North America* 40, (2017), 689-700.

[85] Fischer et al., 423-442.

[86] Jonathan W. Kanter, Laura C. Rusch, Sara J. Landes, Gareth I. Holman, Ursula Whiteside, and Sonja K. Sedivy, "The Use and Nature of Present-Focused Interventions in Cognitive and Behavioral Therapies for Depression, *Psychotherapy (Chicago),* 46, 2, (2009), 220-232.

[87] Sara Tai and Douglas Turkington, "The Evolution of Cognitive Behavior Therapy for Schizophrenia: Current Practice and Recent Developments," *Schizophrenia Bulletin,* 35, 5 (2009), 865.

[88] Daniel David, I. Cristea, and S. Hofmann, "Why Cognitive Behavioral Therapy is the Current Gold Standard of Psychotherapy," *Frontiers in Psychiatry,* 9, 4 (2018), 1-3.

regarding the CBT approach, encouraging a working collaboration between therapist and client, focusing on the present, equipping the client to become more self-aware of their thoughts and reactions, and using structured, goal-oriented sessions with "homework" to help move the client to a more healthy cognitive, emotional, and behavioral state independent of the therapy sessions. The goal is to help the client become aware of the dysfunctional thinking and automatic thoughts that are causing them distress and then help them restructure their thinking to ease or eliminate the distress.

Solution-Focused Brief Therapy

SFBT emphasizes the need to focus on solutions rather than being problem centered. "It evolved from practice rather than theory,"[89] and was developed by Insoo Kim Berg and Steve de Shazer in the 1970s.[90] "The insight that clients most frequently gain during a solution-focused session is about the solution and what they will be doing differently to create the desired solution, rather than insight about the problem and its etiology."[91] Some basic assumptions of SFBT include:[92]

1) If it's not broken, don't fix it.

2) If something is working, do more of it.

3) If it is not working, do something different.

4) Small steps can lead to large changes.

5) The solution is not necessarily directly related to the problem.

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[89] Sean Foy, *Solution Focused Harm Reduction: Working Effectively with People Who Misuse Substances*, (Cham, Switzerland: Palgrave MacMillan, 2017), 7.

[90] Pichot and Smock, 17.

[91] Ibid., 19.

[92] Ibid., 22-23.

6) The language requirements for solution development are different from those needed to describe a problem.

7) No problem happens all the time. There are always exceptions that can be utilized.

8) The future is both created and negotiable.

SFBT techniques will almost always involve establishing the goal of the counselee for seeking counseling, the use of the miracle question, scaling, and exceptions.

A counselor utilizing an SFBT approach attempts to identify the goal of the counselee by asking questions. Typically, counselees will begin by describing problems. The counselor will attempt to reframe the conversation in order to elicit a solution building focus through which the counselor and the counselee can co-create the future the counselee desires. For example, if a counselee expresses concerns about being anxious, the counselor might ask what the counselee will be doing when they are no longer anxious. It is a shift toward forward thinking that can help the counselee get unstuck and begin visualizing a better future.[93]

The miracle question is used to help the counselee begin to clarify his or her vision for the future when the problem is no longer a problem. The miracle question has variations but will usually follow this basic form:

> Imagine after our session that you go home and do whatever you need to do and then you go to bed and drift off to sleep. While you are sleeping a miracle happens and the problem which brought you here today is completely resolved. However, this miracle has taken place while you were sleeping so you don't know the problem is resolved. When you wake up tomorrow morning, what would be the first thing you would notice which would let you know that the problem has been resolved?[94]

The counselor will attempt to get the counselee to describe actions rather than feelings. Using the anxiety example, the counselee might say they would be feeling happier. The

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[93] Kollar,105-11.

[94] Foy, 13.

counselor would respond by asking the counselee what they would be doing when they feel happier. The counselor will continue to ask the client to identify what else they will be doing in order to identify possible exceptions to the problem that may be consolidated. The language used by the counselor assumes the counselee will be doing these things. This approach plants seeds of hope. The counselor guides the counselee with well-phrased questions and techniques to help them recognize and move forward toward their desired future outcome.[95]

As the counselee identifies behaviors they will be engaging in after their "miracle" happens, the counselor is listening for exceptions to the problem. It is assumed that no problem happens all the time; there are exceptions when the problem is not occurring. As the counselor identifies these exceptions, the question is asked, "When is this exception happening even a little right now?" The concept is to get the counselee to begin to recognize that exceptions exist, and this recognition will provide them with hope that these times of victory can be expanded.[96]

Scaling is another technique of SFBT. An example of a scaling question might be, " On a scale of 1-10, with one being 'I am so anxious I cannot get out of bed in the morning,' and ten being 'My anxiety is no longer out of control,' where are you now?" The counselor keeps track of the number and can use it as a baseline in future sessions to see if the number has changed as a result of implementing solution-based behaviors. The counselor can also use the scale to ask the client what it would take to move up just one point. The assumption is that small changes lead to larger changes.[97]

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[95] Thomas V. Frederick, "Solution-Focused Brief Therapy and the Kingdom of God: A Cosmological Integration," *Pastoral Psychology* 56 (2008), 414; Jordan, Froer, and Bavelas, 48; Pichot and Smock, 19; Gary J. Oliver, "Solution-Focused Counseling," in *The Popular Encyclopedia of Christian Counseling: An Indispensable Tool for Helping People with their Problems*, eds. Tim Clinton and Ron Hawkins (Eugene, OR: Harvest House Publishers, 2011), 491-492.

[96] Kollar, 188.

[97] Ibid., 185-187; Foy, 16-17; Pichot and Smock, 33-37.

SFBT Efficacy

Meta-analytic studies indicate that SFBT is an efficacious therapeutic model.[98] Despite some of the differences between CBT and SFBT, some of the elements may be integrated since they both focus on cognition and behaviors. Both CBT and SFBT can be conducted as brief therapy, and both therapies may use similar techniques such as scaling questions and the "miracle question." [99]

Conclusion

The literature review reveals that recovery may be defined in different ways. When abstinence is the definition of recovery, twelve-step groups demonstrate efficacy on par with other treatment models but still experience high rates of relapse. When spirituality is a component of recovery, the relapse rates decrease. Solution-Focused Brief Therapy and Cognitive-Behavioral Therapy for substance abuse demonstrate rates of recovery similar to other modalities. Gaps in the literature are present pertaining to research on Celebrate Recovery and recovery rates.

Existing theories and methods are used to create a framework that addresses the Problem, Purpose, and Thesis statements for the D.Min. Project. Information from the project will add to the body of research, especially as it relates to the integration of individualized therapy and Celebrate Recovery participants.

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[98] Wallace J. Gingerich, and Lance T. Peterson, "Effectiveness of Solution-Focused Brief Therapy: A Systematic Qualitative Review of Controlled Outcome Studies," *Research on Social Work Practice* 23 no. 3 (2013), 266-283; Johnny Kim, Sara Smock Jordan, Cynthia Franklin, and Adam Froerer, "Is Solution-Focused Brief Therapy Evidence-Based? An Update 10 Years Later," *Families in Society: The Journal of Contemporary Social Services* 100, 2 (2019), 127-138.

[99] Jordan, Froer, and Bavelas, 47.

Theological Foundations

The theological foundation for this project is the compassionate desire of God to heal and redeem humanity from compulsive idolatry that stems from a sinful nature and leads to enslavement and death. "He forgives all my sins and heals all my diseases. He redeems me from death and crowns me with love and tender mercies" (Ps 103:3-4, *NLT*). God desires to heal humanity's brokenness. One way by which God describes himself is, "I am the LORD who heals you" (Ex 15:26, *NLT*). The Bible reveals God's compassionate and healing character throughout both Old and New Testaments.[100] For example, "The metaphor of sickness and healing is one of the more powerful and more radical in the tradition of Jeremiah."[101] The healing character of God and his desire to restore his people are evident in physical and spiritual situations throughout the Bible (e.g., Ex 23:25; Psa 30:2; Psa 34:17-18; Psa 103:2-4; Ps 147:3; Prov 4:20-22; Isa 40:29-31; Jer 30:17; Mal 4:2; Matt 8:1-3; Matt 11:28; Lu 6:19; Phil 4:6-7; Jas 5:16; 1 Pet 2:24).

Theology of Addiction

Many, though not all, of the participants in a twelve-step group are struggling with what might be termed an addiction. An addiction may be related to either substance abuse (e.g., alcohol or cocaine) or to a behavior (e.g., gambling or over-eating). How one understands and approaches addiction counseling depends on the presuppositional model of addiction held by the counselor. If a strict BDMA model is the orientation, then the focus may be on pharmacological and biological solutions. This model views addiction as the result of a biological predisposition

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[100] Philip G. Monroe and George M. Schwab, "God as Healer: A Closer Look at Biblical Images of Inner Healing with Guiding Questions for Counselors," *Journal of Psychology and Christianity* 28, 2 (2009), 121-129; D.F. O'Kennedy, "God as Healer in the Prophetic Books of the Hebrew Bible," *Horizons in Biblical Theology* 27, 1 (2005), 87-113.

[101] Walter Brueggemann, "'The Uncared for' Now Cared for (Jer 30:12-17): A Methodological Consideration," *Journal of Biblical Literature* 104, 3 (1985), 420.

or genetic disorder over which the counselee has no control. Psychotherapy may be conjoined with a pharmacological-solution oriented approach.[102]

Another framework for understanding addiction is the psychosocial model. "This model is based on the assumption that there exists an addictive personality."[103] Psychosocial models examine the impact of psychological and social factors on a person's addiction. A primary focus of this model is helping the counselee to discover new ways to manage stress and new social environments to support healthy behaviors.

A third paradigm for understanding addiction is the moral or spiritual model. Although these two models are similar, there are some differences. [104] "The moral model of addiction assumes that we all have the ability to freely choose the behaviors we participate in."[105] One may consider themselves moral without attributing it to a spiritual connection. The spiritual model moves beyond moral choices alone. The spiritual model, as with the moral model, stresses the free will of the individual but draws a connection to a relationship with God.

For a Christian counselor, the development of a counseling approach for addiction begins with a theology of addiction. A theology of addiction is rooted in a biblical worldview. This means that "God's revealed Word - not science or the DSM-5 – is the final authority on truth."[106]

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[102] Steve Baker, "Addictions Counseling," in *The Popular Encyclopedia of Christian Counseling: An Indispensable Tool for Helping People with their Problems*, eds. Tim Clinton and Ron Hawkins (Eugene, OR: Harvest House Publishers, 2011), 378.

[103] Ibid., 378.

[104] Ibid.; Robinson, 26-28.

[105] Robinson, 26.

[106] Matthew S. Stanford, *Grace for the Afflicted: A Clinical and Biblical Perspective on Mental Illness* (Downers Grove, IL: InterVarsity Press, 2017), 39.

The word, “addiction,” does not appear in the biblical text, but descriptions of behaviors and attitudes associated with the concept of addiction are evident. An addiction is a persistent behavior “that affects the brain’s reward system, motivation, learning and memory.” [107] Addictions typically fit into one or more of four categories: 1) addictions that stimulate, 2) addictions that tranquilize, 3) addictions that serve some psychological need (e.g., codependency or workaholism), and 4) addictions that satisfy unique appetites (e.g., pornography and some fetishes).[108]

Descriptions of these types of behaviors are found throughout the Bible. For example, Romans 1:24-32, 1 Corinthians 6:9-11, Galatians 5:19-21, and Ephesians 4:17- 5:5 provide descriptions of behaviors that might be termed addictions. Some of the behaviors mentioned include such things as drunkenness (alcoholism), sexually deviant activities, and greed. Those who persist in these types of behaviors are called idolaters or are said to be worshipping created things rather than the Creator. These behaviors affect the brain’s reward system: “they have given themselves over to sensuality” (Eph 4:19, *NIV*). The behaviors also affect their motivation: “they have closed their minds and hardened their hearts against him [God]” (Eph 4:18, *NLT*). Their learning has been affected: “that isn’t what you learned about Christ” (Eph 4:20, *NLT*), and so has their memory: “forgetting that they have been cleansed from their old sins” (2 Pet 1:9, *NLT*).

Behaviors described by the modern term, “addiction,” are referred to in scripture by terms such as “sin,” “slavery,” and “idolatry.” The apostle Paul refers to the “sinful nature” being

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[107] Robinson, 34.

[108] Scalise, 376-377.

the root cause of his addictive behaviors:

> So the trouble is not with the law, for it is spiritual and good. The trouble is with me, for I am all too human, a slave to sin. I don't really understand myself, for I want to do what is right, but I don't do it. Instead, I do what I hate. But if I know that what I am doing is wrong, this shows that I agree that the law is good. So I am not the one doing wrong; it is sin living in me that does it.
>
> And I know that nothing good lives in me, that is, in my sinful nature. I want to do what is right, but I can't. I want to do what is good, but I don't. I don't want to do what is wrong, but I do it anyway. But if I do what I don't want to do, I am not really the one doing wrong; it is sin living in me that does it. I have discovered this principle of life—that when I want to do what is right, I inevitably do what is wrong. I love God's law with all my heart. But there is another power within me that is at war with my mind. This power makes me a slave to the sin that is still within me. Oh, what a miserable person I am! Who will free me from this life that is dominated by sin and death? Thank God! The answer is in Jesus Christ our Lord. So you see how it is: In my mind I really want to obey God's law, but because of my sinful nature I am a slave to sin. (Rom 7:14-25, *NLT*)

"The biblical narrative portrays the human person in the bondage of sin, with an inner struggle that he cannot overcome on his own."[109] Paul describes himself as a slave to sin. In Romans 6:19 (*NLT*), he writes, "Because of the weakness of your human nature, I am using the illustration of slavery to help you understand all this. Previously, you let yourselves be slaves to impurity and lawlessness, which led ever deeper into sin. Now you must give yourselves to be slaves to righteous living so that you will become holy."

"Idolatry" is another term for the addictive condition. "In turning to idols, we are saying that we desire something in creation more than we desire the Creator."[110] Idols include more than physical objects of worship. Idolatry is primarily about the heart (Ezek 14:3). The apostle John

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[109] Elahe Hessamfar, *In the Fellowship of His Suffering: A Theological Interpretation of Mental Illness – A Focus on "Schizophrenia"* (Eugene, OR: Cascade Books, 2014), 45.

[110] Edward T. Welch, "Addictions: New Ways of Seeing, New Ways of Walking Free," *The Journal of Biblical Counseling* 19, 3 (2001), 20.

urges his readers to “keep away from anything that might take God’s place in your hearts” (1 John 5:21, *NLT*).

Disease and Desire

The BDMA and the spiritual model of addiction are often viewed as mutually exclusive, but as Mercadante points out, sin and addiction are not so much “conceptual enemies” as they are “fellow travelers.”[111] Welch notes that “sin has many things in common with a disease,” and the Bible “*does* use illness as a metaphor for our spiritual condition.”[112] The compassion of God is active in Jesus’ physical healings. Some examples from just two chapters in Luke include Jesus casting out a demon (Luke 4:31-36), Jesus healing Simon’s mother-in-law of fever and many others who were sick (Luke 4: 38-41), healing a man with leprosy (Luke 5:12-15), and healing a paralytic (Luke 5:17-25). Jesus is not only concerned with physical healing. He goes on to say that “healthy people don’t need a doctor – sick people do. I have come to call not those who think they are righteous, but those who know they are sinners and need to repent” (Luke 5:31, *NLT*). This statement, in which Jesus uses disease terminology, was not made directly in reference to those with physical afflictions, but to those with spiritual afflictions.

“The dichotomous thinking about addiction (disease and choice models) emerged from different assumptions about the origins of behaviors; namely, whether behavior is determined by physical mechanism or willed by an emergent force that transcends direct physical

[111] Linda Mercadante, “Sin and Addiction: Conceptual Enemies of Fellow Travelers?,” *Religions* 6 (2015), 614-625.

[112] Welch, 24.

mechanism."[113] Rather than seeing these models as dichotomous, they may be understood as intersectional. Madueme states,

> The relationship between sin and addiction is like the overlapping circles of a Venn diagram. In the smaller, nonoverlapping areas of the circles, we have addictions that involve no sin (e.g., a baby affected by intrauterine cocaine addiction) and sins that have no addictive component (e.g., cheating on my yearly income tax). In most other instances, sin and addiction are coextensive.[114]

From a theological perspective, sin and addiction affect both body and soul (Gen 2:15-17; Psa 32:1; Matt 10:28; Rom 1:27; 6:23). "An understanding of sin can provide a better understanding of addiction, where the addicted person at some stage has chosen to sin and then the sin (addiction) has chosen and enslaved him/her."[115] This enslavement may include changes in brain chemistry that make it difficult to find freedom from the addiction.[116] A point exists at which a person may not recover (Gen 6:5; Prov 28:13-14; Jer 17:9; Mark 4:12; John 12:40; Eph 4:18; 1 Tim 4:2; 2 Tim 3:1-4; Heb 3:12). Since addiction affects the whole person, a bio-psycho-social-spiritual approach is preferred.[117]

- Biological health includes sobriety but also physical health and sound lifestyle habits

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[113] Petar Valkov, "Is Addiction a Disease or Choice? Disease Model on Trial," *Trakia Journal of Sciences* 13, 1 (2015), 541.

[114] Hans Madueme, "Addiction and Sin: Recovery and Redemption," *American Medical Association Journal of Ethics* 10, 1 (2008), 56.

[115] Valkov, 543.

[116] W. Hall, A. Carter, and C. Forlini, "The Brain Disease Model of Addiction: Is it Supported by the Evidence and has it Delivered on its Promises?," *Lancet Psychiatry* 2 (2015), 105-110.

[117] Robinson, 34-35.

- Psychological and emotional health is where the person learns how to manage their emotions and urges without masking them or numbing themselves with substances or other addictive behaviors
- Social health is choosing to be in relationship with people who support their recovery and who are seeking to be healthy individuals themselves
- Spiritual health requires that a person come into a real relationship with Jesus Christ and discover purpose and meaning in their life

Recovery as Sanctification

In AA and CR, the concept of recovery is often associated with total abstinence regarding alcohol, drugs, pornography, gambling, and other issues. If someone who is struggling with alcoholism has a drink after being sober for 6 months, then it is termed a relapse. This is the terminology used even if it is only one drink and sobriety resumes following the one drink. However, a theology of recovery is more about sanctification than perfection. In this view, having a drink is a lapse or a slip but not necessarily a relapse.

Paul writes, “This means that anyone who belongs to Christ has become a new person. The old life is gone; a new life has begun” (2 Cor 5:17, *NLT*)! This new life includes the indwelling presence and power of the Holy Spirit (Acts 2:38; Rom 8:1-17; 1 Cor 12:13; 2 Cor 3:16-18; Gal 5:22-26; Eph 5:15-20; Phil 1:19; 2 Tim 1:7; Titus 3:5; Heb 10:29; 1 Pet 1:2). Jesus uses the phrase “born again” when referring to this new life (John 3:3-5). Peter writes, “It is by his great mercy that we have been born again” (1 Pet 1:3, *NLT*). Paul also writes that God has given a “new birth and a new life through the Holy Spirit” (Titus 3:5, *NLT*). This indwelling Spirit who brings new birth and new life was prophesied by Ezekiel:

> Then I will sprinkle clean water on you, and you will be clean. Your filth will be washed away, and you will no longer worship idols. And I will give you a new heart, and I will put a new spirit in you. I will take out your stony, stubborn heart and give you a tender, responsive heart. And I will put my Spirit in you so that you will follow my decrees and be careful to obey my regulations. (Ezek 36:25-27, *NLT*).

Gratitude for this new birth through God's life-giving Spirit motivates the Christian to worship God (Heb 9:14) and to live in alignment with the holiness with which God has gifted his children. Peter writes, "God the Father knew you and chose you long ago, and his Spirit has made you holy. As a result, you have obeyed him and have been cleansed by the blood of Jesus Christ" (1 Pet 1:2, *NLT*). After beginning his letter by stating that God has made the recipients of the letter holy, he adds,

> So think clearly and exercise self-control. Look forward to the gracious salvation that will come to you when Jesus Christ is revealed to the world. So you must live as God's obedient children. Don't slip back into your old ways of living to satisfy your own desires. You didn't know any better then. But now you must be holy in everything you do, just as God who chose you is holy. (1 Pet 1:13-15, *NLT*).

Peter urges his audience to live up to what has already been accomplished through the blood of Jesus. Paul writes something similar, "Only let us live up to what we have already attained" (Phil 3:16, *NIV*). Sanctification involves spiritual growth and transformation (Rom 8:1-17; 1 Cor 6:9-11; 2 Cor 13:11; Gal 5:25; Eph 4:23-24; Phil 2:12-13; Col 3:1-17; Heb 3:12-15; 1 Pet 2:1-3; 2 Pet 1:5-11). Sanctification is recovery from sin and its effects. It is both now and not yet. It is now in the sense that Jesus has accomplished it for the world (John 3:16; 2 Cor 5:21). It is not yet because no one lives a sinless life even after accepting the gift of grace.

Recovery as sanctification is a trajectory more than a destination. Speaking to Christians, John says, "If we claim we have no sin, we are only fooling ourselves and not living in the truth. But if we confess our sins to him, he is faithful and just to forgive us our sins and to cleanse us

from all wickedness" (1 John 1:8-9, *NLT*). He adds, "I am writing this to you so that you will not sin. But if anyone does sin, we have an advocate who pleads our case before the Father. He is Jesus Christ, the one who is truly righteous" (1 John 2:1, *NLT*). John echoes what is written in Proverbs 20:9, "Who can say, 'I have cleansed my heart; I am pure and free from sin?'" Paul writes about doing what he does not want to do (Rom 7:14-25) and confesses that he has not reached perfection:

> I don't mean to say that I have already achieved these things or that I have already reached perfection. But I press on to possess that perfection for which Christ Jesus first possessed me. No, dear brothers and sisters, I have not achieved it, but I focus on this one thing: Forgetting the past and looking forward to what lies ahead, I press on to reach the end of the race and receive the heavenly prize for which God, through Christ Jesus, is calling us. (Phil 3:12-14)

To the church in Ephesus, Jesus says, "Look how far you have fallen! Turn back to me and do the works you did at first. If you don't repent, I will come and remove your lampstand from its place among the churches" (Rev 2:5, *NLT*). Sanctification (recovery) is an ongoing process, and even though Christians will continue to trip on the path of sanctification, the journey can continue.

The distinction of recognizing recovery as ongoing sanctification is important because an individual may lose hope if they slip and believe they are unable to change. A person's identity is defined by their position in Christ and not the sin with which they are struggling. While perfection is the goal, it should be understood that "the Lord – who is the Spirit – makes us more and more like him as we are changed into his glorious image" (2 Cor 3:18, *NLT*). We are changed more and more. Peter calls it a growth experience: "Like newborn babies, you must crave pure spiritual milk so that you will grow into a full experience of salvation" (1 Pet 2:2, *NLT*).

Incarnational Presence

Ultimately, it is the Spirit of the Lord that brings about transformation and recovery, but the pastoral counselor may be used as a tool of the Holy Spirit.

> Providing incarnational pastoral care necessitates being a faithful presence who is actively attuned to one's own spirit, to the spirit of recipient of care, and, of course, to the Spirit of God. This type of listening—spirit-to-spirit-to-Spirit listening—allows the pastor to hear the messages embedded within the stories of the person they are caring for and to be aware of the state of the other's spirit.[118]

As a Christian, the pastoral counselor is an incarnational presence of the body of Christ (Rom 8:10, 12:4; 1 Cor 12:12-31; 2 Cor 13:5; Gal 2:20; Col 1:27). The counselor is an ambassador of God (2 Cor 5:20) and seeks to follow the example of Jesus (1 John 2:6) in being a counselor (Isa 9:2,6-7) and physician of the soul (Mark 2:17). Through calling, training, and wisdom, the pastoral counselor serves as adviser and guide for the counselee. "The purposes of a person's heart are deep waters, but one who has insight draws them out" (Prov 20:5, *NIV*).

The CR community also serves as an incarnational presence. It is another manifestation of a local congregation of the church. It is "church" under a different name. As such, participants are encouraged to follow the admonition of the writer of Hebrews,

> Let us hold tightly without wavering to the hope we affirm, for God can be trusted to keep his promise. Let us think of ways to motivate one another to acts of love and good works. And let us not neglect our meeting together, as some people do, but encourage one another, especially now that the day of his return is drawing near. (Heb 10:23-25, *NLT*).

During CR meetings, participants are encouraged to recognize and admit that God's supernatural power is necessary to overcome their hurts, habits, and hang-ups (Rom 7:18; Phil 2:13). Participants are encouraged to surrender their lives to the Lord (Rom 12:1) and to perform

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[118] Joel A. Juestock and Kyle J. Vlach, "Claiming a Substantive View of Presence: The Significance of the Pastor's Self," *The Covenant Quarterly* 73, 3/4 (2015), 32.

a confessional self-inventory (Prov 28:13; Lam 3:40; Jas 5:16) and repent (Jas 4:10). Participants are also encouraged to seek and offer forgiveness to others (Matt 5:23-24; Luke 6:31), to engage in spiritual disciplines (Col 3:16), and to reach out to bring the message of healing to others (Gal 6:1).

Idolatry and Recovery

The Old Testament describes the repetitious relapse of the Israelites (Judg 2:10-17). The people of God deviate from his commands and worship idols. God punishes them, and the people repent but eventually relapse into idol worship again. The cycle is repeated throughout the Old Testament and is prophesied by God in 2 Chronicles 7:11-22. Israel looks to substitutes for God to meet their needs and desires, and they also look to alliances with other nations to solve their problems (Isa 30:1-5). Despite Israel's repeated failures, God is always willing to restore them (Ps 103:1-18). Restoration and redemption are only achieved by turning to God (Isa 30:15-18) after receiving messages from his prophets.

Israel's cycle of flourishing, sinning, suffering, repenting, restoration, and redemption form a theological framework for recovery ministry. Individuals, as dependent beings seeking independence, are, ironically, enslaved by the idols (alliances) to which they turn for freedom. Idols may take the form of substances, behaviors, or attitudes that gain control over individuals and place them in bondage.

> The real human predicament, as Scripture reveals, is that inexplicably, irrationally, we all keep living our lives against what's good for us . . . an addict, for example, partakes of a substance or practice that he knows might kill him. For a time he does so freely. He has a choice. He freely starts a "conversion unto death," and, for reasons he can't fully explain, he doesn't stop until he crashes. He starts out with a choice. He ends up with a habit. And

> the habit slowly converts to a kind of slavery that can be broken only by God or, as they say in the twelve-step literature, "a higher power." [119]

It is not often that people in a Western culture create physical idols. Welch points out, "To detect our idols, we must begin by realizing that Old Testament idols were concrete, physical expressions of new loyalties and commitments that were established in the human heart."[120] Idolatry begins in the heart. Jesus says, "It is what comes from inside that defiles you. For from within, out of a person's heart, come evil thoughts, sexual immorality, theft, murder, adultery, greed, wickedness, deceit, lustful desires, envy, slander, pride, and foolishness. All these vile things come from within; they are what defile you" (Mark 7:20-23, *NLT*).

This condition continues to exist in the modern world where individuals search for satisfaction, security, and significance in devotion to something or someone other than God. As a result, they become enslaved and in need of rescue, redemption, and recovery. After "hitting rock bottom," individuals are sometimes more open to hearing words from God that guide them back to their true identity and purpose.

Ultimate Recovery

God's ultimate act of healing and redemption occurs in the incarnation, death, burial, and resurrection of Jesus Christ. God takes the form of a human and experiences suffering and testing. He demonstrates a compassionate understanding of the suffering of all humans and forms, what might be called in counseling terms, a therapeutic alliance (Heb 3:14-18). Jesus is not detached from an intimate understanding of the human condition and the temptation to

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[119] Cornelius Plantinga, *Engaging God's World: A Christian Vision of Faith, Learning, and Living* (Grand Rapids, MI: Eerdmans, 2002).

[120] Welch, 20.

worship something or someone other than God, the Father (Matt 4:1-11). He knows the pain of endurance.

During his time on earth, Jesus also embodies compassion as he heals both physical and spiritual maladies and as he teaches people how to find fulfillment and peace by finding their purpose in him (Matt 8:14-17; 9:35-36; 11:28; John 10:10; 14:27). His ultimate act of compassion is the redemption of humanity through his absorption of the sins of all people and the transference of his holiness via his Spirit to those who are willing to receive this gift (John 3:16; Rom 5:6-11; 8:1-11; 2 Cor 5:21; 1 Pet 2:24; 1 John 2:1-2). His ultimate act of healing on the cross is foreshadowed in Numbers 21:6-9 when the Israelites who were bitten by snakes were told to look upon the bronze serpent on the pole to be "healed" (Num 21:8-9; John 3:14-15). God is a healer.

Jesus announces he has come to proclaim the release of captives and set the oppressed free (Luke 4:18-19). He sends out his apostles and others with the same mission (Matthew 10:1; Luke 10:1-20). Those whom the apostles baptize are taught to continue to pass on this mission (Matt 28:18-20). Since Jesus came to help those who suffer, his followers also help those who suffer (1 John 3:16). "Some people make cutting remarks, but the words of the wise bring healing" (Prov 12:18, *NLT*).

Helping those with addictions find freedom in Christ is one way this mandate is accomplished. Addictions are a manifestation of the same issue the Israelites exhibit by turning to idols and alliances to fulfill their needs. Pastoral counseling, while not the only means of treatment, helps those who are captivated by their idols of addiction to find freedom and redemption.

Beyond Behavior Modification

From a theological perspective, the goal of recovery ministry is more than behavior modification. The goal of recovery ministry is heart and mind transformation. Overcoming an addiction, for a Christian, is the result of "letting go, and letting God." Although this phrase has become cliché, it captures the essence of recovery. Recovery happens as an individual surrenders to God. Jesus says, "If any of you wants to be my follower, you must turn from your selfish ways, take up your cross daily, and follow me. If you try to hang on to your life, you will lose it. But if you give up your life for my sake, you will save it" (Luke 9:23-24, *NLT*). In other words, do not hang on; let go. It is not about tying harder; it is about trying softer. It takes more than sheer willpower to overcome enslaving hurts, habits, and hang-ups. It takes surrender (trying softer) to the supernatural power of God.

Paul uses the metaphor of dying to communicate the nature of the total surrender that leads to a changed life: "My old self has been crucified with Christ. It is no longer I who live, but Christ lives in me" (Gal 2:20, *NLT*). "Or have you forgotten that when we were joined with Christ Jesus in baptism, we joined him in his death? For we died and were buried with Christ by baptism. And just as Christ was raised from the dead by the glorious power of the Father, we now also may live new lives" (Rom 6:3, *NLT*). One must die before one can be reborn. This death includes the nailing of sinful passions and desires to the cross (Gal 5:24).

Simply resisting the old way of life is not enough. It must be replaced with something new. Jesus tells a story about a person who has an evil spirit leave them, but the spirit later returns to the person to find that nothing has replaced it during its absence. The evil spirit moves back into the person and brings more evil spirits with it. The person's condition is worse in the

end than it was in the beginning (Luke 11:24-26). Recovery involves not just removing the old life but putting on the new life (Gal 5:16-26; Eph 4:17-6:17; Col 3:5-17).

Putting on the new life requires thought transformation. Paul says, "Since you have been raised to new life with Christ, set your sights on the realities of heaven [a solution focused approach] . . . Think about the things of heaven, not the things of earth. For you died to this life, and your real life [true identity] is hidden with Christ in God" (Col 3:1-3, *NLT*). He exhorts the Roman church to "let God transform you into a new person by changing the way you think" (Rom 12:2, *NLT*), and he tells the Philippians to "Fix your thoughts on what is true, and honorable, and right, and pure, and lovely, and admirable. Think about things that are excellent and worthy of praise" (Phil 4:8, *NLT*).

The role of the pastoral counselor in recovery is the same as every Christian's role. It is to "tell others about Christ, warning everyone and teaching everyone with all the wisdom God has given us. We want to present them to God, perfect in their relationship to Christ" (Col 1:28, *NLT*). The difference between the pastoral counselor and other Christians is a difference in spiritual gifts, experience, and training.

While a disease-like stage may exist during which an individual becomes "powerless" to break the control of the addiction, the individual "can overcome this stage by developing new techniques of self-control." [121] For a Christian, this self-control comes as a fruit of the Holy Spirit (Gal 5: 22-26). Paul writes, "Let the Holy Spirit guide your lives. Then you won't be doing what your sinful nature craves" (Gal 5:16, *NLT*).

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[121] Anke Snoek, "How to Recover from a Brain Disease: Is Addiction a Disease, or is There a Disease-like Stage in Addiction?," *Neuroethics* 10 (2017), 185.

The pastoral counselor's role is to be an incarnational presence of Jesus and to come alongside suffering individuals to offer them hope and guidance (Gal 6:1). The guidance offered by the pastoral counselor derives primarily from the Bible (2 Tim 3:16-17) and prayer (Jas 5:16), and, secondarily, from evidence-based therapeutic practices. Neither the client nor the counselor is the expert. God is the expert (Isa 48:17-18). The counselor and the counselee collaborate in a triadic relationship with the Holy Spirit of God to experience transformation (2 Cor 3:17-18).

Theoretical Foundations

The theological foundation of compassionate restoration of individuals who experience addiction may find expression in a variety of forms. The theoretical framework and form for this project thesis is pastoral counseling utilizing an integrated approach of Christian counseling with elements of Cognitive-Behavioral Therapy and Solution-Focused Brief Therapy. This pastoral therapeutic approach is applied in combination with Celebrate Recovery group meetings because these meetings comprise the ministry context of the researcher.

Community and Individual Care

Celebrate Recovery is an effective addiction intervention program and offers a community network of individuals who experience similar struggles with "hurts, habits, and hang-ups."[122] The program is a practice that already exists within the theological framework of community care, encouragement, and accountability (Heb 4:12-13; 10:24-25) and is based on biblical principles. Twelve-step programs, such as CR, provide a social network that supports recovery.[123]

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[122] Brown et al., 107-113.

[123] Mendola and Gibson, 647.

However, some individuals may not benefit as much from group meetings as they would from individualized treatment. In one study, Nieman discovered that some participants were concerned about the level of confidentiality in group meetings, and others came hoping to engage with a counselor.[124] While CR provides a support group that helps participants understand they are not alone and that many others share similar struggles, long-term recovery may require an individualized approach.[125] A combination of peer group support combined with individual Christian counseling provides more resources than either group or individual care alone:

> Two people are better off than one, for they can help each other succeed. If one person falls, the other can reach out and help. But someone who falls alone is in real trouble. Likewise, two people lying close together can keep each other warm. But how can one be warm alone? A person standing alone can be attacked and defeated, but two can stand back-to-back and conquer. Three are even better, for a triple-braided cord is not easily broken. (Eccl 4:9-12, *NLT*)

Kwee offers three guidelines that will be used as part of the theoretical framework for this project:[126]

1) Treat each client as a unique bio-psycho-social phenomenon, with his or her own unique constructed reality, rather than as a sufferer of a disease that is independent from other contextual forces.

2) Help the client to develop cognitive, social, and emotional skills for relating, communicating, and problem solving. Allow the client to consolidate these skills in the group setting and through conjoint therapy.

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[124] Nieman, 52-90.

[125] Pichot and Smock, 5-7.

[126] Alex Kwee, "Constructing Addiction from Experience and Context: Peele and Brodsky's Love and Addiction Revisited," *Sexual Addiction & Compulsivity* 14, 3 (2007), 234.

3) Help clients to "buy into" their treatment by giving them a personal stake in the process. Kwee believes this is the reason twelve-step intervention appears to work for committed, faith-oriented individuals who view their recovery within a vastly bigger and intensely personal frame of spiritual salvation.

Christian Counseling

Christian counseling in combination with CR group meetings is preferred in this project because the participants profess a Christian worldview, and spirituality is a cornerstone of twelve-step recovery programs, including CR.[127] The incorporation of spirituality into Cognitive-Behavioral protocols may enhance outcomes for CR participants but is rarely used by professional counselors.[128] However, pastoral counseling lends itself to this approach since it incorporates the participant's spiritual worldview into evidence-based Cognitive-Behavioral interventions.[129] The ability to achieve therapeutic progress is also integrally connected to the therapeutic alliance between the counselor and the counselee.[130] Shared worldview enhances trust.

Christian counseling integrates theology and pastoral identity with behavioral sciences to create a transformative relationship with the counselee.[131] An explicit integration of Christian faith will be used in the counseling approach. As Tan points out, "The Christian therapist who practices explicit integration in Christian therapy will more verbally, directly, and systematically

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[127] Grim and Grim, 1713-1717.

[128] Hodge, 21-31.

[129] Ibid.

[130] Clinton, 414-416.

[131] Loren Townsend, *Introduction to Pastoral Counseling* (Nashville, TN: Abingdon Press, 2009), 75-133.

deal with spiritual issues in therapy and use spiritual resources such as prayer, Scripture, referrals to church or other support groups or lay counselors, and other religious practices."[132]

Cognitive-Behavioral Therapy

Cognitive-Behavioral Therapy will be combined with an explicit Christian counseling approach. CBT has solid evidentiary support and is considered the "gold standard" of psychological treatment.[133] Aspects of CBT may be integrated into Christian counseling since they share some common foundational concepts and do not present inherently antithetical methods. CBT presupposes that maladaptive thoughts and faulty beliefs are at the root of a client's issues. When the client changes how they think about their situation, then they will experience a change in emotions that leads to an alteration of behavior. This concept of change is also found in the Bible. For example, "You will keep in perfect peace all who trust in you, all whose thoughts are fixed on you" (Isa 26:3, *NLT*), and "let God transform you into a new person by changing the way you think" (Rom 12:2, *NLT*). Transformation occurs as cognition is modified. An individual's cognition may be modified with or without a Christ-centered intervention, but, according to Scripture, it is a method that God uses in a supernatural fashion to create change.

Solution-Focused Brief Therapy

Solution-Focused Brief Therapy has also demonstrated effectiveness in a variety of

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[132] Tan, 342.

[133] Andersson et al., 689-700; Fischer et al., 423-442; Hodge, 21-31; Hofmann et al., 427-440; Hundt et al.,12-26; Kominsky, 26-37; A. Marchand, P. Roberge, S. Primiano, and V. Germain, "A Randomized Controlled Clinical Trial of Standard, Group and Brief Cognitive-Behavioral Therapy for Panic Disorder with Agoraphobia: A Two-year Follow-up," *Journal of Anxiety Disorders* 23 (2009), 1139-1147; Mulkens et al., 57-63.

contexts, including addictive behaviors.[134] SFBT springs from the Positive Psychology movement of Martin Seligman. Positive Psychology emphasizes positive goals, virtues, and character strengths.[135] The positive emphasis aligns well with a biblical worldview. "Fix your thoughts on what is true, and honorable, and right, and pure, and lovely, and admirable. Think about things that are excellent and worthy of praise" (Phil 4:8, *NLT*). However, Christian accommodation of SFBT requires some revision. For example, a foundational concept of SFBT is that the client is the expert, and the goal of the therapist is to assist the client in the realization of the client's desired outcome without any moral correction or valuation. This approach runs counter to biblical admonitions (Luke 9:23; 2 Tim 3:16-17). Nevertheless, certain aspects of SFBT may be adopted for use in pastoral counseling. For example, the concept of focusing on positive things, the use of scaling questions, exceptions, and the miracle question may all find accommodation.

Conclusion

None of the practices described in the planned intervention are novel. Christ-centered support groups, Christian counseling, CBT, and SFBT have all been used effectively in different settings. The unique aspect of this project thesis is the combination of the approaches and their

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[134] C. Bond, K. Woods, N. Humphrey, W. Symes, and L. Green, "Practitioner Review: The Effectiveness of Solution Focused Brief Therapy with Children and Families: A Systematic and Critical Evaluation of the Literature from 1990-2010," *The Journal of Child Psychology and Psychiatry,* 54, 7 (2013), 707-723; Gingerich and Peterson, 266-283; Kim et al., 452-462; Pichot and Smock, 19; E. Schmit, M. Schmit, and A. Lenz, "Meta-analysis of Solution-Focused Brief Therapy for Treating Symptoms of Internalizing Disorder," *Counseling Outcome Research and Evaluation,* 7, 1 (2016), 21-39; G. Spilsbury, "Solution-Focused Brief Therapy for Depression and Alcohol Dependence: A Case Study," *Clinical Case Studies,* 11, 4 (2012), 263-275; M. Stark, J. Kim, and P. Lehmann, "Solution-Focused Brief Therapy Training: What's Useful When Training is Brief?," *Journal of Systemic Therapies,* 37, 2 (2018), 44-63.

[135] C. Titus, "Aquinas, Seligman, and Positive Psychology: A Christian Approach to the Use of the Virtues in Psychology," *The Journal of Positive Psychology,* 12, 5 (2017), 447-458.

application with participants of the Naples Church of Christ CR ministry by a pastoral counselor. Application in this specific ministry context is what makes the approach unique, but it might be found to be applicable in other contexts of a similar nature.

Chapter 3

Methodology

Introduction

This chapter explains the intervention design and the individual methods that will be used in the action research project. The theoretical context of the intervention is set within the framework of qualitative research and practical theology. "Practical Theology seeks to examine the theories and assumptions that underlie current forms of practice as well as to contribute to the development and reshaping of new theories which are then fed back into practices of church and world."[136] According to Swinton and Mowat, "the task of qualitative research is to *describe* the lived realities of individuals and groups in particular settings and to give the reader theoretical comparisons and explanations that can be used elsewhere."[137]

The Purpose and Objectives of the Intervention

Purpose defines the reason for the intervention and the intended or desired result. The immediate purpose of the project intervention is to determine the effects of individual pastoral counseling on recovery when combined with the Celebrate Recovery group experience. The immediate purpose is derived from an overarching purpose to please God and "obey the law of Christ" by identifying and implementing better ways to help participants of the Naples Church of Christ Celebrate Recovery ministry carry their burdens (2 Cor 5:9; Gal 6:1-3). A secondary purpose is to provide research that leads to replicable application and beneficial results in other

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[136] John Swinton and Harriet Mowat, *Practical Theology and Qualitative Research* (London: SCM Press, 2016), 25.

[137] Ibid., 43-44.

ministry contexts of a similar nature. The objectives are the project tasks and clearly defined steps that lead to the fulfillment of the purpose and are discussed in the remainder of this chapter.

Participants

After applying for and securing project approval from the Institutional Review Board, a convenient sample of participants will be selected for inclusion in the project. Participants will be selected from the Celebrate Recovery program of the Naples Church of Christ. The program currently has nine consistent attendees comprised of six men and three women ranging in age from 28 to 68 years old. Seven of the participants are married, one is divorced, and one is widowed. Five of the participants are employed, two are retired, and two are unemployed and receive government benefits. Participants' stated reasons for participation in CR include issues with substance abuse, co-dependency, anger, grief, loneliness, marital discord, sexual abuse, and physical abuse.

Process

Participants will be approached individually before or after CR meetings by the researcher and informed of the project and its purpose. If an individual agrees to participate in the study, then they will be provided with a consent form[138] that explains the following:

1) The purpose of the study

2) What will happen if they take part in the study

3) How they or others could benefit from the study

[138] A copy of the consent form is included in Appendix B.

4) Risks they might experience from being in the study

5) How personal information will be protected

6) The voluntary nature of the study

7) How to withdraw from the study

8) Whom to contact with questions or concerns

9) A statement of consent to be signed and dated

Consent forms may be completed and signed during the invitation or may be taken home by the individual and brought back to the initial pre-counseling interview. During the invitation, individuals will be informed that participation in the study is voluntary. They will be informed that their decision regarding participation will not affect their current or future relations with the researcher, the CR ministry, the Naples Church of Christ, or Liberty University. It will be explained that they are free to decline to answer any question during the project and may choose to withdraw at any time without affecting the aforementioned relationships. If individuals have questions or concerns about the project at any time and would like to talk to someone other than the researcher, they will be encouraged to contact either the researcher's faculty mentor or the Institutional Review Board.

Each participant will be informed that the project poses minimal risk to them. Minimal risk is defined as risk equal to the risk they would encounter in everyday life. Potential benefits will also be explained to participants. A potential benefit for the participant is an enhanced and accelerated recovery derived from counseling. Benefits to society include a better understanding of the benefits of combining individual pastoral counseling with the recovery group experience.

If a participant chooses to withdraw, they will be asked to inform the researcher. The researcher will promptly destroy any data collected from the participant, and it will not be included in the study.

The process for the participant includes a pre-counseling interview with the researcher to obtain a baseline set of responses to questions about the participant's CR experience prior to individual counseling.[139] The duration of the interview will be approximately one hour and responses will be audio recorded on the researcher's I-phone. The device has a lock screen and may only be accessed by the researcher. Recording will begin as participants become comfortably settled. The researcher will then ask for permission to begin recording. Recording will terminate at the end of the session. These interviews will then be transcribed by the researcher and stored in a locked filing cabinet in the researcher's home office and on a password-locked laptop computer. Pseudonyms will be assigned to the files to assist in the maintenance of confidentiality. The pre-counseling interview will be held in the home office of the researcher.

After the completion of the pre-counseling interview, the researcher will set a day and time with the participant for a weekly one-hour counseling session. Counseling sessions will be held at the home office of the researcher. This location provides a higher degree of privacy than the church office and is the location typically used by the researcher for counseling. All counseling sessions will be audio recorded in the same manner as the pre-counseling interviews, but no transcriptions will be made. Written case notes will be taken by the researcher and kept in the participant's file in the locked cabinet in the home office of the researcher and on a

[139] Pre-counseling interview questions are included in Appendix C.

password-locked laptop computer belonging to the researcher. Case notes will provide a record of counselees' responses and the counselor's observations. Counseling sessions will last from four to eight weeks depending on the needs, desires, and progress of the participant in counseling.

Counseling Intervention

The counseling intervention will take place in the home office of the researcher. Counselees will be seated on a sofa, and the researcher will be seated in a chair opposite the counselee in casual attire with a coffee table between them. A tissue box will be located on the coffee table, and the iPhone used for recording will also be placed on the coffee table. The researcher will use a clipboard for making written notes. Counselees will be offered bottled water when they arrive.

The researcher (counselor) will ask the counselee if they are comfortable if the counselor begins with prayer. The counselor will assure the counselee that it is not required if they are uncomfortable with the idea of prayer. If the counselee answers affirmatively, then the counselor will begin the session with a brief prayer asking God for wisdom and his blessings on the counselee. Each subsequent session will begin with prayer. It is not anticipated that any of the counselees will be uncomfortable with prayer since they are all from a Christian background and experience prayer regularly in the Celebrate Recovery meetings. However, if a counselee expresses discomfort with the practice, then the counselor will forego praying aloud but will be silently praying throughout each session for wisdom, understanding, and guidance.

Next, the counselor will begin the first session by thanking the counselee for their willingness to participate in the project and for their desire to grow spiritually through Celebrate

Recovery and counseling. Supportive compliments "help to reduce any fears the counselee may have about the counseling process, which in turn may prepare the counselee to act on the goal and task" of recovery.[140] A statement such as, "I am impressed by your willingness to participate in counseling. It demonstrates spiritual maturity, and I think that is great!" encourages the counselee and assists in building rapport and helps the counselee feel at ease. Some general rapport-building questions about the counselee's week, work, or family will be asked to help the counselee settle in and feel comfortable. The therapeutic alliance between the counselor and the counselee is a critical component in healing and recovery. It is a relational bond formed between counselor and counselee.

> Clinically, cultivation of alliance should be prioritized at the earliest stages of treatment. In addition to being broadly associated with optimal treatment outcomes, a stronger alliance appears to also itself reflect an independent contributor to symptom reduction and likely be one of the many processes driving change across therapy types, patient characteristics, and treatment settings.[141]

Duff and Bedi[142] have identified eleven key behaviors useful for fostering therapeutic alliance:

1) Asking questions

2) Making encouraging comments

3) Identifying and reflecting the client's feelings

4) Making positive comments about the client

5) Validating the client's experience

6) Making eye contact

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[140] Kollar, 142-143.

[141] Allison L. Baier, Alexander C. Kline, Norah C. Feeny, "Therapeutic Alliance as a Mediator of Change: A Systematic Review and Evaluation of Research," *Clinical Psychology Review* 82 (2020), 11.

[142] Carlton T. Duff and Robinder P. Bedi, "Counsellor Behaviours that Predict Therapeutic Alliance: From the Client's Perspective," *Counselling Psychology Quarterly* 23, 1 (2010), 91-110.

7) Greeting the client with a smile

8) Referring to details discussed in previous sessions

9) Being honest

10) Sitting still without fidgeting

11) Facing the client

Next, the counselee will be asked, "What is your goal in coming to see me today?" After the presenting problem is expressed and the desired goal of the counselee is determined, the counselor will assist the counselee in creating a detailed description of their goals and evaluating where they are in relation to the goals. A scaling technique will be used to ascertain a baseline of where the counselee sees himself or herself in relation to his or her desired outcome. An example of a scaling question is, "On a scale of 1-10, where do you see yourself in relation to your desired goal?"[143] In each subsequent session, the same scaling question will be used to determine if the client perceives progress in their recovery.

Next, the counselor will help the counselee identify "exceptions." Exceptions are times when the problem is not occurring or when the counselee is moving toward the desired goals.[144] These exceptions will be explored to see how the counselee can expand them. The concept is to help the counselee identify when things are going well and do more of what they are doing during those times. Focusing on exceptions and the desired outcome creates a solution-focused approach rather than a problem-centered approach. It is forward-looking at the solution rather than backward-looking at the problem. This approach has theological underpinnings in Pauline literature. For example, Paul writes, "but I focus on this one thing: forgetting the past and looking

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[143] Pichot and Smock, 33-37.

[144] Ibid., 40-41.

forward to what lies ahead, I press on to reach the end of the race and receive the heavenly prize for which God, through Christ Jesus, is calling us" (Phil 3:13b-14, *NLT*). In Colossians, he writes, "Think about the things of heaven, not the things of earth" (Col 3:2, *NLT*). These statements reflect a solution-focused mentality that is forward-thinking rather than dwelling on the past and its problems.

After identifying exceptions, the next step in the counseling intervention will be to ask the "miracle question." The miracle question may take various forms. For this project, the counselor will begin by having the counselee read Matthew 11:28: "Then Jesus said, 'Come to me, all of you are weary and carry heavy burdens, and I will give you rest'." The counselor will ask, "What if tonight, while you were sleeping, this passage of Scripture came true for you? During the night, a miracle occurred, and the problems that brought you here to speak with me are solved. But you were sleeping, so you are not aware that this miracle occurred. Tomorrow morning, when you wake up, what will you notice that will tell you that this miracle has happened?" [145] The counselor will then assist the counselee in clarifying his or her responses. "The emphasis is on doing. What actions or things will the counselee be doing differently?"[146] The counselor will then aid the counselee in identifying times when some of these things are already happening (exceptions) and guide the counselee in exploring ways to expand these exceptions. "The goal of the miracle day is to help the client to methodically discover these specific elements and to identify possible things that he or she could actually do tomorrow (if not sooner) to begin the change process." [147]

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[145] Kollar, 107.

[146] Ibid., 107-108.

[147] Pichot and Smock, 55.

A scaling question will be incorporated into the use of the miracle question. If the counselee indicates, for example, that they are currently at a four on a scale of one to ten, then the counselor will ask the counselee what it would look like to go from a four to a five. A follow-up question will be, "What will be the first sign that you are on track to moving from a four to a five? Is that something you think you can do between now and our next meeting? How will you do that?" The counselor will end the session by summarizing the goals and tasks that have been set and by asking the counselee for permission to pray for them before they leave. After the counselor has prayed, he will turn off the recording device and escort the counselee to the door as they exit the office. After the counselee has departed, the counselor will reflect on the session and make final notes in the case file.

Subsequent sessions will begin in the same manner as the first session: welcome, recording, and prayer. The counselor will then ask the counselee the same scaling question used in the first session to ascertain if the client has regressed, stayed the same, or progressed in their recovery. If the counselee has regressed, then the counselor will explore the reason for the regression and attempt to work with the counselee to identify steps to prevent this from happening again. The counselee may be encouraged to retry the original tasks to move up on their scale, or it may be necessary to rethink the tasks and define new ones that are more attainable.

If the counselee has stayed the same or progressed on their scale, then the counselor will compliment them. For example, if the counselee has stayed the same, the counselor will say, "Wow! That is encouraging! You are holding steady. How were you able to do that?" Compliments of this nature encourage the counselee and help to identify what is working for them. If the client has made progress and moved up on their scale, then the counselor will express excitement that the client was able to make progress and ask them how they did it. The answer given by the

counselee will be positively reinforced by the counselor and used to demonstrate there is a reason to be hopeful for further positive change. Additional exceptions will be explored, and pertinent scriptures will be shared. The successful tasks will be reassigned, or additional tasks will be co-constructed and assigned. The session will end in the same manner as the first session.

Following the fourth session, the counselor will ask the counselee how they feel about their progress. If the counselee feels positive, then the counselor will suggest terminating the counseling sessions. The counselee will be assured that they are welcome to continue counseling sessions if they are not ready to terminate and that if they do terminate the sessions, they are welcome to resume them at any time. If a counselee feels they are not making progress, then sessions may continue until the counselor and counselee feel sufficient progress has been made or a referral needs to be made.

Post-Counseling

Following the conclusion of the counseling series, a post-counseling interview[148] will be completed with each individual. Post-counseling responses will be compared with pre-counseling responses to ascertain whether improved and accelerated recovery has occurred and to gain insights from the participants regarding individual counseling in conjunction with the CR group experience. The interview will be held in the home office of the researcher. The duration of the interview will be approximately one hour, and the interview will be audio recorded in the same fashion as the pre-counseling interview using the same secure audio device. The researcher will transcribe the recordings and store the transcriptions in the same locked filing cabinet and on

[148] Post-interview counseling questions are included in Appendix D.

the same password-locked laptop computer as the pre-counseling interview transcriptions and counseling case notes.

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Records will be stored securely, and only the researcher will have access to the records. Data collected from the study may be shared for use in future research studies or with other researchers. If data is shared, any information that could identify a participant will be removed.

Data Collection

The type of data collected from this study is qualitative. Data is derived from pre-counseling and post-counseling interviews. Interviews are the most widely used method for collecting information in qualitative studies.[149] The interviews for this study are semi-structured with questions written ahead of time by the researcher. Each interview has the same structured questions but may utilize limited ad hoc follow-up questions. The goal is to maintain a comparable interview format and style with each participant.

Analyzing the Data

The pre-interview and post-interview process is a form of narrative inquiry that involves paradigmatic cognition. "In paradigmatic work, researchers analyse narrative data, including interviews, in order to generate [or recognize] themes that represent patterns observable across a data set."[150] Since a standardized interviewing format will be used, responses to interviews will

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[149] Ali Alsaawi, "A Critical Review of Qualitative Interviews, "*European Journal of Business and Social Sciences* 3, 4 (2014), 149.

[150] Kathryn Roulston, "Analysing Interviews," in *The SAGE Handbook of Qualitative Data Analysis,* ed. Uwe Flick (London: SAGE Publications Ltd., 2014), 303.

be organized question by question. Next, themes from each interview will be compared with one another and categorized (coded).

One potential pitfall of qualitative analysis is forcing data to fit preconceived hypotheses. A useful strategy to offset this danger is "to review the data to search for negative cases and discrepant data that would disprove or complicate findings."[151] This strategy will be utilized to foster more rigorous reflexivity on the part of the researcher and identify slippages. Such an approach does not eliminate but may substantially reduce the tendency toward a hermeneutic of self-serving confirmation bias by the researcher. Silences will also be considered. Silences represent realities known by the researcher that may not be addressed in participants' responses.[152] Results of the data analysis will be reported in chapter four of this project thesis.

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[151] Roulston, 306.

[152] Sensing, 197-202.

Chapter 4

Results

This chapter is an examination of the results of the project thesis counseling intervention. It is theorized that individual pastoral counseling combined with the Celebrate Recovery group experience will enhance and accelerate the recovery process for CR participants. Information is categorized from the counseling sessions, the pre-counseling interviews, and the post-counseling interviews. The interviews used standardized questions, and these questions form some of the categories.

Participants

Nine Celebrate Recovery members were invited to participate in the project thesis intervention. One individual declined. No reason was offered by the member regarding his decision to abstain from participation. The researcher did not inquire about the reason for the abstention because he did not want to create an uncomfortable situation for the member that might lead to the member dropping out of CR. The member has continued his participation in the CR group experience.

The remaining eight CR members agreed to participate in the intervention. These participants included five men and three women. The methodology described in the previous chapter was followed, and each participant completed four individual counseling sessions with the researcher. Some members were unable to meet consistently each week due to work or health restraints, but each completed a total of four sessions (not including the pre-counseling interview and the post-counseling interview). Four of the participants (three men and one woman) expressed a desire to continue counseling at the completion of the project.

Pre-Counseling Interview

The pre-counseling interview consisted of seven standardized questions combined with ad hoc follow-up questions. The seven standardized questions included:

1) Why did you choose to participate in Celebrate Recovery?

2) What were your expectations of what you would experience from your participation in CR?

3) Were your expectations met? If so, how?

4) Did you have any unmet expectations? If so, what were they?

5) How would describe your recovery progress so far?

6) Why did you accept the invitation to participate in this action research project (individual brief therapy)?

7) What are your expectations of what you will experience as a result of your participation in this project?

Direct quotations are included from the answers given by the participants. The quotations are not exhaustive, but they are substantive and provide "enough detail and evidence to illuminate and make the case."[153] Responses are organized question by question. Participants' answers are provided using an identifier of male or female and a numeral. After providing participants' responses to the pre-counseling questions, themes are identified.

Question One

"Why did you choose to participate in CR?"

Female 1: "I was molested when I was younger, and I had a lot of resentments. I needed to deal with pain from past relationships. Had a lot of hurts. And I needed help with my

[153] Sensing, 209.

marriage. I had been in NA but dropped out after a disagreement with some of the leaders. I was starting to swerve and needed to get back into a twelve-step group."

Female 2: "I had to. It was a condition of CPS [Child Protective Services] in order to keep my kids. I had to be in a recovery group or twelve-step program of some sort. I'd been to NA and AA, but I knew I needed God in my life."

Female 3: "Everybody has stuff inside them that needs to get out. It was important for me to share my feelings with others. I needed to be with people like me in a place where I wouldn't be judged."

Male 1: "I started coming to CR to support 'Adam' (pseudonym). I wanted to see him get some help. After coming, though, I realized that I had things I needed help with, too."

Male 2: "I was feeling shame over a porn addiction. My church youth leader was a member of CR, and he introduced me to it. I thought it would be a good idea because I didn't have any money to pay for counseling, and CR is free. I also wanted my fiancée to know I was trying to get help. I had told her about my struggle with porn, and I didn't want to lose her. I also wanted a group that was Christian. I was a little intimidated by the idea of a non-Christian group."

Male 3: “To be honest, I just wanted to help support it because we used to have one here years ago, and I saw the way it helped people. I was impressed and thought it would be a beneficial ministry.”

Male 4: “Well, the first time I joined CR was several years ago when we used to have one here. I went just to see what it was like. I hadn’t been to any twelve-step programs before. I liked that it was spiritually based, and it felt safe. It was good to see I wasn’t the only one with problems. After they stopped having it here, I went to NA for a while, but nobody there believed in God. We had things in common because of our addictions, but they worshiped NA instead of Jesus Christ. Your higher power could be a chair for all they cared. So, I was really excited when they decided to start up a new CR because my goal is not just to stay clean from drugs; my goal is God. I knew I needed to be around other Christians and we just don’t talk about these kinds of things with each other in church on Sunday morning.”

Male 5: “I started coming to support ‘Jill’ [pseudonym]. I also knew I needed to get sober. I didn’t really want to come the first time, but I knew I needed to help her.”

Question Two

“What were your expectations of what you would experience from your participation in CR?”

Female 1: “I thought it would help me get over my issues. I thought it would give me the structure I needed.”

Female 2: “I knew it would be helpful. I cried like a baby at the first meeting. I was ready to burst. I had so much stuff inside of me that just needed to get out. I knew I’d be able to do that at CR.”

Female 3: “I thought I’d have a place to get stuff off my chest. I really needed to feel better about myself. You can’t talk about these things in church, and you never know who you can trust.”

Male 1: “I thought I might get some support and encouragement, but, like I said, I was really trying to help somebody else out that I knew was going to be there.”

Male 2: “My expectations? Some hope. I felt like I was drowning, and I needed a lifeline. I thought I could get some tools that would help me.”

Male 3: “I didn’t know what to expect. I guess I thought I’d build some relationships. Maybe it would be a place where we could kind of hold each other accountable. You know, get some support. Yeah, I reckon I was expecting it to be, you know, encouraging.”

Male 4: “Well, the first CR I attended – I just wanted to see what it was like. The one I’m in now? I expected to be uplifted. I was hungry for the Word of God and expected I’d hear it at CR. I think just being around the group uplifts you because we all got the same

goal. I wanted, I mean I really needed to be around Christians. I was hoping it would be like a little taste of heaven."

Male 5: "I wasn't keen on sharing my feelings. I didn't think I'd be opening up. It was just something I was going to endure. I didn't think I really needed it, so I didn't have a lot of expectations."

Question Three

"In what ways were your expectations met?"

Female 1: "I get encouragement from being there. Something I didn't realize was how helpful the songs would be. The worship time is where I really feel blessed. Those songs – they just get to you, you know."

Female 2: "They were exceeded. I love it. I especially like the songs and the testimonies. The testimonies are just like me. I mean, they are telling their story, but it's also my story. It gives me hope."

Female 3: "I'm able to express the things that I know are wrong in my life or where I really need help. That sort of stuff just eats you up. It's hard for me to share that kind of stuff with people I know, like my friends or family – not that CR isn't family, but I mean people you just see on a regular basis during the week. I don't want to burden them or scare them off. I don't think they'd be able to relate. Oh, and the testimonies. They're probably the best part because you hear people sharing stuff that sounds like you."

Male 1: “It’s more than what I thought it would be. I look forward to it every week. It’s an opportunity to be around people who are supportive and don’t judge. I can see they struggle with things just like me. I’ve heard people say things that are the same things I struggle with. It helps me to know I’m not alone. It’s deeper than a typical group, you know, like a Bible study group.”

Male 2: “I did find some hope. I found acceptance, too. I realized you can make mistakes and still be a child of God. I’ve gotten some tools, too. I think one of the most helpful things was learning to live one day at a time. When I thought about never looking at porn again, it seemed impossible, but when I learned to just take one day at a time, I could do it.”

Male 3: “I didn’t have no real expectations, so I can’t say none were met strictly speaking. It’s been a blessing, though.”

Male 4: “In the first CR, I wasn’t close to people. I didn’t hang out and talk afterwards. I could see people were holding back in group, too. They weren’t really sharing everything, or they’d just pass. This time, I just share all my thoughts. I mean, if I’m going to go, I might as well go all the way with it. Ain’t no point in going if you don’t. I’ve learned to share things. I realized I’m pretty judgmental sometimes. But I got stuff off my chest and God got me off the pills. God is real. I know that, now.”

Male 5: “I don’t know how to answer because I didn’t really have any great expectations coming in. I wasn’t expecting that I would end up sharing my life story, but I have, and it helps.”

Question Four

“In what ways were your expectations unmet?”

Female 1: “I can’t think of anything. It’s all been good.”

Female 2: “The only thing I can think of is that I was expecting more people. I thought the group would be bigger.”

Female 3: “I wish there was someone older. Somebody more mature who could be a mentor for me. I feel like I’m the one who does all the mentoring. Some weeks I feel like I’m not really making a ton of progress with my own issues because I’m the one who is giving, but I’m not receiving.”

Male 1: “Well, I didn’t really have any expectations going in, so I’m not sure any were met or unmet. I mean, I’ve gotten a lot out of it though. I learned more about myself – that I’m a people pleaser. I guess you could say I’m co-dependent in that way. I don’t like to upset anybody.”

Male 2: “It hasn’t been immediate deliverance. I didn’t get fixed overnight. That’d been nice. I wish I had a single mentor. The group is good but having some personal attention would be better. There’s no real long-term accountability or contract.”

Male 3: “Can’t think of anything. The sharing helps me put thoughts and feelings into words.”

Male 4: “I feel the hurt when guys are sharing, and you want to comfort them, but you can’t because there’s no cross-talk. You just have to sit there quietly. It’s like trying not to be human. If I poured out my heart to God and he just sat there and stared at me, I’d feel unloved. It’s hard for me to keep my mouth shut. I know they’re afraid you might give wrong advice or something, but it just doesn’t feel right.”

Male 5: “I guess you could say that I was expecting it wouldn’t mean much to me, but I actually like it. I like the guys who are there.”

Question Five

“How would you describe your recovery progress so far?”

Female 1: “I feel better. My job was knocking me down. I was just exhausted and stressed out all the time. I got some health problems, but I feel like I’m doing better now. I still feel pretty tired most of the time, but I don’t feel as anxious and my marriage is better.”

Female 2: “I’ve surprised myself. I mean I’ve never been more proud of myself. That might sound bad, but this is the longest I’ve been sober. It’s been four months now, and I like it.”

Female 3: “I feel like I’ve made progress. It comes and goes. Some days are better than others, but, in general, I feel like I’m getting better. I feel like I’m accepting some things and growing.”

Male 1: “I think the biggest thing is that I recognized some hurt that I didn’t know was there before. That self-awareness has helped me kind of understand why I feel the way I do sometimes – why I say and do some of the things I do.”

Male 2: “CR has taught me that my problem wasn’t about what I thought it was. I thought it was porn, but now I know it’s selfishness, sin, and the desire to be in control. I guess that was kind of like a light bulb moment for me. Porn was just the symptom. I guess that’s pretty obvious when you think about it, but it just became really clear to me. The porn is gone, but I still struggle with wanting to control things.”

Male 3: “I’m more confident now. I have a better idea of what direction I need to go with things. You could say it’s a little like thinking out loud. It just forces you to do that when you wouldn’t have done it on your own.”

Male 4: “It’s opened my eyes to where I can hear God. I guess that would be my ears, not my eyes. Anyway, I recognize him. I know he’s real. God knew I needed an intervention. I’ve been able to vent and dissect myself. I’m not drinking or drugging. Still smoking cigarettes though. I guess you could say I feel more normal. I care now. I care about God. I care about my family. I just care.”

Male 5: "It's been good. It helps me at work. It makes me more understanding of people. I don't get angry as quick. The testimonies have helped me open up and know I'm not alone."

Question Six

"Why did you accept the invitation to participate in this action research project (individual therapy)?"

Female 1: "I think one-on-one counseling might help me even more. I want to reboot."

Female 2: "I love my husband, and I don't want to lose him. I know I need to change if I want to keep him. I think counseling will help."

Female 3: "I think it will help me. I need a place to be able to talk outside the group."

Male 1: "I think it will help me to learn how to help myself."

Male 2: "I've had some counseling experiences in the past. I think it will help me with some underlying issues -- some spiritual issues. I'm also interested to know how your [the researcher] topic turns out, but I really think it will help me and support me right now."

Male 3: "I think it will help me become more intentional about things I need to do."

Male 4: “I trust you [the researcher]. I need help. I asked. I connect with you, and I think you can help me grow.”

Male 5: “I want to keep my marriage and family together. My kids are too young to see their parents splitting up.”

Question Seven

“What are your expectations of what you will experience as a result of your participation in this project?”

Female 1: “I think it will help my marriage.”

Female 2: “I think it will help me stay sober and save my marriage.”

Female 3: “I’m not sure I have any strong expectations. I just want to see where it takes me.”

Male 1: “I think I’ll get some good advice and encouragement.”

Male 2: “I hope it helps me with my parenting. I think my relationship with my dad might be a symptom of a core issue. I want to see if I can get some perspective. I don’t want to turn out like my dad.”

Male 3: “I guess I don’t rightly know. I haven’t really put a lot of thought to it.”

Male 4: “To be stronger. To grow more. To be better prepared for whatever comes my way. I need input from a more mature Christian.”

Male 5: “I hope it will help me to learn to forgive. I don’t want to be so angry.”

Themes Related to CR Involvement

An analysis of the participants’ responses reveals themes. Some of the themes overlap or intersect with each other. These themes are identified here, and conclusions regarding these themes are included in the final chapter of this thesis.

Wounded

None of the participants used the word “wounded,” but it surfaces as a theme in statements like “had a lot of hurts,” “stuff inside that needs to get out,” “get stuff off my chest,” “my issues,” “hurt that I didn’t know was there.” Participants recognized that something inside of them needed to change. They were looking for healing for their hurts.

Relationships

Five (slightly over half) of the participants indicated that they were looking for help with relationship issues. Relationship issues involved marital relationships, a relationship with a fiancée, work relationships, and concerns about their children. Two of the participants mentioned that their initial reason for attending CR was to support someone else. Six of the participants mentioned they have benefited from the relationships they have established in CR.

Acceptance

Participants felt that CR provided a safe and accepting environment. Some of the statements that highlight this theme include, “I needed to be with people like me in a place where I wouldn’t be judged,” “It was good to see I wasn’t the only one with problems,” “we’ve all got the same goal,” “it’s an opportunity to be around people who are supportive and don’t judge,” “I found acceptance.”

Structure

A desire for structure emerged as a theme in comments such as “I needed to get back in a twelve-step group,” “I had to be in a twelve-step group,” “I thought it would give me the structure I needed,” “I thought I could get some tools that would help me,” “I’ve gotten some tools, too.” The need for structure via tools and steps is a significant theme.

Spirituality

Spirituality emerged as a theme from participants. Five of the participants (slightly more than half) mentioned God, Christianity, worship, or something similar. Some examples include, “I knew I needed God in my life,” “I also wanted a group that was Christian,” “My goal is God,” “I needed to be around other Christians,” “I was hungry for the Word of God,” “The worship time is where I feel really blessed,” “God got me off the pills,” “God is real,” “It’s opened my eyes to where I can hear God.”

Hearing and Sharing Testimonies

Hearing and sharing testimonies surfaces as a major theme. Six of the participants made comments indicative of this theme. Some of the comments include, “It was important for me to share my feelings with others,” “It was good to see I wasn’t the only one with problems,” “I had so much stuff inside me that just needed to get out,” “I especially like the songs and

testimonies," "[The testimonies are] probably the best part because you hear people sharing stuff that sounds like you," "I've heard people say things that are the same things I struggle with," "I've learned to share things," "The sharing helps me put my thoughts and feelings into words," "The testimonies have helped me open up and know I'm not alone."

Individual Attention

Three participants (almost half) mentioned a desire for more individual attention. A lack of one-on-one mentorship and long-term accountability was expressed. Male 2 stated, "The group is good but having some personal attention would be better," and Male 4 expressed, "I feel the hurt when guys are sharing, and you want to comfort them but can't because there's no cross-talk."

Progress in Recovery

One hundred percent of the participants indicated progress in their recovery resulting from participation in Celebrate Recovery. Progress not only included such things as sobriety from drugs and alcohol, but also increased confidence, more self-awareness, reduced anxiety, better relationships, a better understanding of others, less anger, and better relationship with God.

Reasons for Counseling

All eight participants explicitly stated they thought individual counseling would be "helpful." Different reasons were given regarding how it would be helpful. Two participants believed it would be helpful for their marriage relationship. One indicated it would be helpful for parenting. Another individual thought it would be helpful for becoming more intentional in his steps to recovery. Another respondent thought it would be helpful in learning how to help himself, and one other said he thought it would help him to control his anger and be more

forgiving. Only one individual mentioned that they thought it would be helpful for the researcher in completing his project.

The Counseling Intervention

The counseling intervention proceeded as described in detail in the methodology section of this thesis. In general, a counseling approach that utilized a combination of CBT, SFBT, and Christian counseling was used. Individual sessions were typically one hour long but occasionally lasted ninety minutes. Most of the participants were able to meet weekly over four weeks, but some were less consistent due to illness or work situations. Those who were unable to meet weekly still engaged in a total of four counseling sessions. The inconsistency on the part of two of the participants caused a delay of several weeks in the compilation and analysis of the data.

Each counselee was asked to identify the goal for their counseling. Female 1 focused on anxiety and marriage issues brought on by drug abuse. Female 2 chose to address marriage issues that were created by alcohol abuse. Female 3 wanted help with grief management from the loss of relationships. Male 1 was concerned with co-dependent behavior. Male 2 wanted help with parenting issues and self-esteem. Male 3 was experiencing anxiety and grief resulting from an adverse medical diagnosis. Male 4 was concerned primarily with substance abuse and anger problems. Male 5 was concerned with substance abuse and marital conflict.

The use of scaling questions on a scale of 1-10 enabled the researcher to determine the degree of progress for each counselee. Female 1 began at eight on a scale of anxiety and was able to reduce her anxiety to a scale of five after four weeks of individual counseling. Female 2 began marital counseling at seven on marital satisfaction and improved to a scale of ten by the conclusion of counseling. Female 3 was at eight on a level of grief scale at the beginning of

counseling and, after four sessions, was down to a scale of four. The females in the study improved 3-4 points on their respective scales.

Male 1 began at nine on a co-dependent scale and finished at seven. Male 2 indicated he was a two on a scale of successful parenting, and after four sessions, had advanced to a four. Male 3 identified as level six on anxiety and finished at level four. Both Male 4 and Male 5 were at level ten on substance abuse, and both finished at level 1 (complete sobriety) after four sessions. Each male indicated progress in their recovery resulting from individual counseling.

Post-Counseling Interview

The post-counseling interview consisted of seven standardized questions combined with ad hoc follow-up questions. The seven standardized questions included:

1) Why did you accept the invitation to participate in this action research project (individual brief therapy)?

2) In what ways were your expectations met?

3) In what ways were your expectations unmet?

4) Describe your therapy experience.

5) What difference, if any, has your therapy experience made with your CR experience?

6) Describe any changes in your thoughts, feelings, or behaviors as a result of your therapy experience.

7) In your opinion, is it beneficial to combine individual pastoral counseling with the CR group experience? Why or why not?

Direct quotations are included from the answers given by the participants. Responses are organized question by question. Participants' answers are provided using an identifier of male or

female and a numeral. After providing participants' responses to the post-counseling questions, themes are identified.

Question One

"Why did you accept the invitation to participate in this action research project (individual brief therapy)?

Female 1: "I just knew counseling would help me. I couldn't afford it anywhere else, and I could walk to get here."

Female 2: "I wanted to stay sober and keep my marriage together."

Female 3: "I needed someone I could open my heart to without being judged. There are some things I feel like I can't share with just anyone. I thought you would have the professional ability to help me from a Christian way of thinking."

Male 1: "I wanted to do this to get some help working through some struggles. Having someone to talk to has been encouraging. I get encouragement from the group, but I didn't know if I could share as much with all of them as I can with you. Sometimes, I want to say some things, but then I hold back. In the group, we don't get a lot of guidance. It's more listening. I was looking for some more input."

Male 2: “I wanted help. I wanted an outside voice. A second opinion. I think anybody can benefit from counseling – especially if it’s free. And I wanted to help you with your project.”

Male 3: “I wanted to see what would surface in me. I thought it would do some good.”
Male 4: “I wanted to grow spiritually. CR taught me I had some character defects that I needed to work on.”

Male 5: “I knew I needed some help, and I couldn’t do it on my own. I want to stay sober and learn to forgive.”

Question Two

“In what ways were your expectations met?”
Female 1: “It’s helped. I don’t feel as overwhelmed and anxious as I did before. I mean, I still have days, but I put the scriptures you gave me up all over the house and it helps me think about them instead of worrying about everything else.”

Female 2: “I got some good advice. I’ve stayed sober. My marriage is better. I can think more clearly now that I’m not using drugs.”

Female 3: “It’s done me a world of good. I’ve unloaded a lot. I got a lot off my mind and gave them to you. It’s made me feel different and helped me heal myself in a spiritual way.”
Male 1: “The one-on-one helped me get some good advice.”

Male 2: “I didn’t have a lot of expectations. It helped me clarify some things and take some specific steps in getting things in order. I was able to put some action into my intentions. I haven’t done all of them yet, but I’m headed in a good direction.”

Male 3: “I was able to talk about issues from my past. I was able to identify some contributing factors from childhood. I was able to see some practical things I could do to change. It helped me with accountability. I’ve gotten closer to my goals. It’s been safe and confidential. It’s been free.”

Male 4: “I got a program set up that helped me stay focused. It’s helped me spiritually, and I’m learning to eat an elephant one bite at a time.”

Male 5: “I was nervous, but it helped me be more aware of my wife’s feelings. It made me understand her more.”

Question Three

“In what ways were your expectations unmet?”

Female 1: “I wish we could have met every week, but my job and stuff kept getting in the way. I’d like to keep coming if that’s okay with you. I think now that I’m not so anxious, I can try and make things better in my marriage. I want my husband to come, too.”

Female 2: “I can’t think of anything. I know I keep saying it, but it exceeded my expectations.”

Female 3: “I can’t think of anything.”

Male 1: “I really can’t think of anything. Like I said, I didn’t really have any, you know, major expectations.”

Male 2: “Well, I haven’t been transformed overnight [said jokingly]. We didn’t focus on the past as much as I thought we would, but I think that’s okay because it can just turn into a pity party.”

Male 3: “None I can think of. It’s helped me take some steps I needed to.”

Male 4: “I didn’t have any other expectations. I just wanted to grow spiritually.”

Male 5: “It was more friendly than I expected. I went to a psychiatrist a couple of years ago and it was more . . . clinical. It wasn’t as warm. It was more like doctor and patient. This was more like friends.”

Question Four

“Describe your therapy experience.”

Female 1: “It was good. It helped me calm down and get everything out. I needed somebody to talk to who could give me good advice. I just wish I didn’t have to miss so many times.”

Female 2: “We met every week and talked about staying sober and working on my marriage. You gave me homework every time, and that helped a lot. It made me think about the things I needed to do. I’ve stayed sober and things are better.”

Female 3: “I had to make up my mind to be truthful and honest no matter how much it hurt. After you say it out loud, it’s wonderful. I didn’t have a person I could confide in before. I got things off my chest and emptied my sack of burdens. I think it’s important you make sure you go to the right person. That’s why I wanted Christian counseling.”

Male 1: “It was good to have somebody else to bounce things off of. I like one-on-one better. It’s harder for me to share everything in a group. I share some things, but I don’t go as deep as I could in the group.”

Male 2: “I was safe. I felt open and comfortable to talk about my issues. I got feedback, some clarification, and coaching. It’s more specific and action-oriented. It was biblically-focused.”

Male 3: “It was a positive experience. It helped me face my mortality, and I was able to talk more openly about it with others.”

Male 4: “It was actually relaxing. I enjoyed it because it gave me a place to vent and get some positive feedback. It was more objective than if I was just talking to my wife or some of the guys in CR. I like to get spiritual answers. It was good for that.”

Male 5: “I feel closer to you [the researcher]. I trust you. You helped me get more focused. And you helped me get closer to God. You gave me stuff I could take and apply immediately.”

Question Five

"What difference, if any, has your therapy experience made with your CR experience?"

Female 1: "It helps to have someone who knows how to do counseling. The group is good, too, but you can't always get what you need there because you're not supposed to cross-talk."

Female 2: "Talking here makes me more comfortable than talking in group. Maybe it's because I've already said it out loud or something, I don't know. But it helps."

Female 3: "CR is good. It makes you realize you're not alone. You're not the only one who has made mistakes. It puts things into perspective. I think the difference between CR and counseling is that CR opens you up to do more in-depth counseling."

Male 1: "Couldn't say for sure. They're both good for growth and change."

Male 2: "Counseling is more direct and moves more quickly. There's no cross-talk in CR, so you're limited. In CR you kind of have to find your own way. Counseling is more specific, more directive. To me, you could compare CR to physical therapy and counseling is more like surgery."

Male 3: "For me, it [counseling] makes what we're doing [in CR] more real. It keeps everything in your mind during the week. Counseling is more nitty-gritty. If I have a

question, I can clarify it. I learn a lot in CR, and the counseling helped me to take it in and make it my own."

Male 4: "There's no cross-talk in CR, but there's times when you want feedback. I have to wait until counseling to talk about the deeper stuff because it's stuff I want input on. CR helps, too. Being able to share helps me spiritually, and I think it lets people know they're not alone."

Male 5: "I think CR is good for breaking the ice, but counseling gets down to the details. I probably wouldn't have done counseling if I hadn't gone to CR first."

Question Six

"Describe any changes in thoughts, feelings, or behaviors as a result of your therapy experience."

Female 1: "I'm just a happier person now. I can control my emotions better."

Female 2: "I'm finally convinced I'm saved. I used to wonder why God would want me. I'm flawed. I realize now, that's not the way he wants us to feel. I've wanted to be perfect since I was born. When I fall short, it eats at me. I recognize now that I'm always going to come up short of my expectations – and maybe some other people's expectations, too. But it doesn't matter as much to me now. I can accept it because I know how God looks at me and I've found people who don't judge at CR."

Female 3: “I’m more comfortable in my own skin. I can think more clearly now. I didn’t like myself before. I felt stuck. I was doing things I didn’t really want to do, but I couldn’t stop. I can honestly say I’ve never felt better.”

Male 1: “My Quiet Times are better. My communication with my wife is better. And my attitude toward others has changed. I’m not as judgmental. I realize I’ve got my own problems just like everybody else. I’m not the only one dealing with issues. I think being more aware of other people’s problems has helped me reach out more to others to encourage them.”

Male 2: “I think the bottom line is that I’ve improved on my goals.”

Male 3: “I think I value CR more than I did before, and the counseling has given me some hands-on stuff to work on.”

Male 4: “I’m more open to listening to my wife and trying to understand where she’s coming from. I know every time I point my finger at her, I’ve got three more pointing back at me.”

Male 5: “It’s pretty much what I’ve already said. I’m sober, I’m closer to God. I open up more, and my marriage is totally better.”

Question Seven

"In your opinion, is it beneficial to combine individual pastoral counseling with the CR group experience? Why or why not?"

Female 1: "Oh, yeah. For sure. It's more personal. CR is good for sharing and seeing you're not the only one screwed up, but counseling gives you specifics to work on."

Female 2: "Absolutely. One makes you more comfortable with the other. And I think they kind of go together. You know what I mean? CR gets some stuff out, and counseling gives you something to do with the stuff. I think it helped because you're [the researcher] in CR and you're also the one doing the counseling."

Female 3: "Counseling is great but not with just anybody. It needs to be faith-based. God needs to be at the center. And it needs to be someone who knows where you're coming from and appreciates your background. You're just not going to get that deep in CR by itself."

Male 1: "Yes, especially if you're dealing with something that's heavy. Then you definitely need more one-on-one. More direction and input. You can't do that in CR."

Male 2: "Yes, the counseling helps because it's more personal."

Male 3: "Yes, it gives you an opportunity for one-on-one input. It gives the counselor the opportunity to speak into your life."

Male 4: "Yes. In CR, you hear similar stories and how they deal with it. It sets the tone for new people to find freedom. The counseling helps because it's free. You know the pastor is meeting with you because he cares, not because he's making money on you by the hour. I don't want to be just another dollar bill, just another client. It's also closer. It's hard just to take one step, but it'd be even harder if I had to take a 40-mile step."

Male 5: "Sure. Like I said, CR breaks the ice, but the counseling gets down to more specifics. Plus, you have more time to share in counseling than you do in CR."

Themes from Post-Counseling Interview Responses

Financial Cost

Four of the eight participants indicated finances were an issue in choosing to participate in pastoral counseling rather than seeking out a licensed therapist. Of the four who mentioned the cost factor, two also mentioned distance as a contributing factor. The proximity of pastoral counseling was more favorable than attempting to arrange transportation and take the time to travel a longer distance for a licensed therapist.

Christian Worldview

Seven out of eight participants mentioned the importance of Christian counseling and biblical input as an influence on their choice of pastoral counseling. Some representative statements include, "I thought you would have the professional ability to help me from a Christian way of thinking," "I wanted Christian counseling," and "It needs to be faith-based."

When reflecting on their experience in the counseling intervention, such statements as, "You helped me get closer to God," "I like to get spiritual answers," "My quiet times are better,"

and “It helped me spiritually” are indicative of the underlying goals of the counselees and the results of their therapeutic experience.

Personalized Attention

Another theme that emerges from the post-counseling interview responses is the desire and helpfulness of personalized attention from the counselor. Every participant made some reference to this aspect. For some, it was the personal connection (therapeutic alliance) that had an impact. This is witnessed in statements such as, “I didn’t know if I could share as much with [the group] as I can with you,” “I think it’s important to make sure you go to the right person,” “I feel closer to you. I trust you.”

The need for one-on-one interaction also surfaced from the responses. This desire for more direct and personalized interaction is represented in such statements as “ I was looking for some more input,” “The one-on-one helped me get some advice,” “I needed somebody to talk to who could give me some advice,” and “I got feedback.” The lack of cross-talk in the CR group experience was noted as a weakness or drawback: “The group is good, too, but you can’t always get what you need there because you’re not supposed to cross-talk,” “There’s no cross-talk in CR, so you’re limited,” “There’s no cross-talk in CR, but there’s’ times when you want feedback.”

Benefits of CR Group Experience

Half of the participants made direct mention of the CR group experience, especially when it comes to knowing they were not alone or abnormal: “CR is good. It makes you realize you are not alone,” “I think it lets people know they’re not alone,” “I think CR is good for breaking the ice,” “I’m not the only one dealing with issues,” “CR is good for sharing and seeing you’re not the only one screwed up,” “In CR, you hear similar stories and how they deal with it.” Neither

individual pastoral counseling nor CR were considered exclusive of each other. Benefits were identified from both experiences.

Combination of Counseling and CR Group Experience

All eight participants stated they believed that it was beneficial to combine individual counseling with the CR group experience. The counseling intervention provided more personalized input and feedback than CR, but CR provided a platform for sharing and hearing others' stories. Hearing others' stories was considered valuable because it normalized the hurts, habits, and hang-ups of the participant. Hearing common experiences helps the participant feel understood, and normalization brings enhanced self-awareness and hope for change. Counseling takes the recovery experience deeper because the counselor can tailor interventions specific to the counselee's situation and provide feedback and input.

The next and final chapter of this thesis project provides conclusions based on the identified themes. The results are interpreted, and applicability is discussed. The credibility of the study is also considered. Ecclesial and theological significance is identified, and areas for future research are noted.

Chapter 5

Conclusion

The purpose of this D.Min. action thesis was to use qualitative analysis to evaluate Celebrate Recovery participants' self-perceived progress in recovery before experiencing short-term individual pastoral counseling and then administer a post-counseling evaluation to determine participants' self-perceived progress. The results of the project indicate participants benefit from individualized pastoral counseling in combination with their Celebrate Recovery group experience. This chapter interprets the results of the study and answers the question of the significance of the study.

Interpretations

"Interpretation means attaching significance to what was found, making sense of findings, offering explanations, drawing conclusions, extrapolating lessons, making inferences, considering meanings."[154] The primary significance ascertained from the responses of the participants to the interview questions and the self-perceived progress of the participants noted in the individual counseling sessions leads to the conclusion that participants benefit from individualized pastoral counseling in combination with their Celebrate Recovery group experience. Each counselee improved on their scaling questions.

CR and individual pastoral counseling are complimentary. CR forms a welcoming, non-judgmental group where participants are exposed to recovery principles in both a didactic and testimonial form. The educative element is provided through lessons and the repetition of the recovery principles. Motivation and inspiration come from hearing stories shared. Newcomers begin to identify with others in the group who have had similar life experiences. Members of the

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[154] Michael Quinn Patton, *Qualitative Research & Evaluation Methods*, 3rd ed. (Thousand Oaks, CA: Sage, 2002), 480.

group are at different stages in their recovery journey, and this is helpful for newcomers because they not only hear stories of the same hurts, habits, and hang-ups they are experiencing, but they also hear stories of victory and recovery. The former helps them feel they are in a safe place, and they are not the only ones who have such problems. The latter gives them hope they can make progress in their respective areas of struggle. The group sharing time makes participants feel more comfortable in beginning to tell their stories. This, in turn, makes sharing their issues with a pastoral counselor somewhat easier.

Individual counseling allows for a deeper exploration of specific issues. A therapeutic alliance is formed that allows the counselee to share openly and enables the counselor to speak into the life of the counselee from a Christian perspective. CR participants are interested in biblical advice. Counseling allows for feedback and input that the CR cross-talk rule prohibits. The nature of CBT also allows for a more directive approach than the group CR experience.

Applicability

Twelve-step groups, such as CR, have demonstrated efficacy in the recovery process, but they do not all offer an individual counseling option. A Twelve-Step group participant may seek out a sponsor who has already completed the steps and demonstrated progress in their recovery, but the level of assistance from the sponsor may not be comparable to a trained counselor. More research is needed to compare self-perceived recovery progress when using a sponsor rather than using a trained counselor.

"The very nature of qualitative research looks at the depth of a particular context more than the breadth of multiple contexts."[155] Nevertheless, this study suggests that similar results might be replicated in settings of proximal similarity. Variables that might limit transferability

[155] Sensing, 214.

include the relationship between the counselor and counselees, the nature of the struggle a counselee is experiencing, and the skill level of the counselor. The context for this study was one in which the counselor and counselees already had a warm relationship through church and CR connections. The counselor was also the CR ministry leader and the senior pastor.

While the nature of the struggles addressed with the counselees was serious, none of them were using anti-psychotic medication or experiencing, for example, anything on the level of dissociative identity disorder, suicidal ideation, or other mental disorders that might require immediate attention by a psychiatrist or admittance to a mental health or rehabilitation facility. It is not suggested that the model employed in this project context would transfer to a context where more severe disorders or trauma are involved.

Even though the pastoral counselor for this project has graduate and post-graduate training and education in counseling, he is not a licensed therapist and is not employed as a full-time therapist. The counselor is employed as a senior pastor, and counseling is only one of many other ministry roles in which he is engaged. A full-time licensed therapist might be more proficient in assisting counselees. On the other hand, one of the participants mentioned that he did not want to be just "another dollar bill" for a professional therapist and valued the pastoral connection. The importance of spirituality and a biblical worldview expressed by participants suggests that the counselor needs to maintain these values and approach.

The degree of homogeneity in participant responses despite age, gender, marital, educational, and economic differences suggests heterogeneity of irrelevancies. These differences appear to be irrelevant and support the concept of replicability. More research is required to verify whether the principle of discriminate validity is applicable.

Credibility

Only one participant (Male 2) explicitly stated that one of his motivations for participating in the project was to aid the researcher. However, it is possible that participants' desire to aid the researcher may have influenced them to respond more positively than they would have if the researcher were not already associated with them. This rival explanation should be taken into consideration when analyzing the participants' responses and could have an adverse impact on transferability. To offset this potential contamination of data, participants were repeatedly assured that the tenor of their responses would not have a negative impact on the project or the relationship with the researcher. However, these reassurances do not guarantee the responses were not skewed in a more positive direction. When utilizing qualitative research, it is difficult, if not impossible, to completely exclude confirmation bias.

Theological and Ecclesial Significance

Celebrate Recovery functions as an independent parachurch program. CR groups may be found in a variety of settings but are most frequently hosted in a local church setting. The setting for this action research project was the Naples Church of Christ. CR is considered one of several ministries sponsored and led by this church. The church maintains a strong focus on community service and outreach and believes the CR program is an asset for helping its members and the community. The results of this study confirm the program is making a positive difference in the lives of its participants and, therefore, fulfilling the desire of the church to bless its members and the community. The CR program is an expression of the church's desire to embody the compassionate desire of God to heal and redeem humanity from compulsive idolatry that stems from a sinful nature and leads to enslavement and death.

Individual pastoral counseling is an adjunct to the CR program. Pastoral counseling is not an essential element for a successful CR program, but, in the case of the Naples Church of Christ ministry, it is an effective element when combined with the CR group experience. It provides enhanced and accelerated recovery for participants. It is an approach that fosters spiritual growth and sanctification. The pastoral counselor and the CR community serve as an incarnational presence (the body of Christ) for those who seek healing.

Sustainability

The intervention employed for this project was intended to address a specific problem in the ministry of Celebrate Recovery at the Naples Church of Christ. The problem was that members of the CR program did not have easy access to individual counseling with a licensed therapist. Professional counseling for participants is restricted due to the rural location of the ministry and the financial cost of using a licensed therapist. Pastoral counseling was offered as a partial solution to the problem. Pastoral counseling eliminated the financial cost and travel distance, but the pastoral counselor is not a licensed therapist. Nevertheless, pastoral counseling did provide enhanced recovery for the participants based on their responses to self-perceived progress. More significant recovery might be possible with a more skilled therapist.

The project intervention is sustainable if a pastoral counselor remains available and the number of counselees does not interfere with the pastoral counselor's other ministry responsibilities. The counseling intervention can be integrated into the existing program by making newcomers to CR aware of the opportunity for individual counseling. An announcement and welcome brochure can be provided for newcomers each week that informs them of the available resources.

Additional Research

Additional research is needed to ascertain the transferability of the counseling intervention with other CR groups. The need may not exist for this intervention in groups that have easy access to licensed therapists, or groups where the church will pay for professional counseling for individuals. Groups that have a greater number of participants than the ministry context under consideration in this study might overwhelm the caseload of a pastoral counselor or a licensed therapist on staff at a church.

The counseling models that formed the foundation of this intervention were CBT and SFBT set within a Christian worldview. The individual interventions were not manualized, so a counselor who has more expertise or less expertise with these models might see different results. A counseling approach other than CBT and SFBT might also yield different results. The therapeutic alliance between the counselor and counselees was already established in this study since the counselor had an existing relationship with the participants as their CR ministry leader and pastor. All these factors could either limit or improve the transferability of the intervention. However, the results of the study indicate a benefit is derived by the person in recovery when their recovery group experience is combined with personalized counseling.

Appendix A: Serenity Prayer

God, grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference. Living one day at a time, enjoying one moment at a time; accepting hardship as a pathway to peace; taking, as Jesus did, this sinful world as it is, not as I would have it; trusting that you will make all things right if I surrender to your will; so that I may be reasonably happy in this life and supremely happy with you forever in the next. Amen.[156]

[156] John Baker, 277.

Appendix B: Consent Form

Consent

Title of the Project: Individualized Pastoral Counseling in Combination with Celebrate Recovery Group Experience
Principal Investigator: Stephen F. Curtis, Graduate Student in Rawlings School of Divinity, Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. In order to participate, you must be 18 years of age or older and a participant in the Naples Church of Christ Celebrate Recovery program. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research project.

What is the study about and why is it being done?

The purpose of the study is to determine the effects of individual pastoral counseling on recovery when combined with the Celebrate Recovery group experience.

What will happen if you take part in this study?

If you agree to be in this study, I would ask you to do the following things:

1. Complete a pre-counseling interview with the researcher (approximately one hour). The interview will be audio recorded.
2. Complete 4-8 individual regularly scheduled counseling sessions with the researcher (approximately one hour each). All sessions will be audio recorded and transcribed as part of the counseling's normal practice but none of the information discussed in the sessions or transcribed will be included in the research.
3. Complete a post-counseling interview with the researcher (approximately one hour). The interview will be audio recorded.

How could you or others benefit from this study?

Participants should not expect to receive a direct benefit from taking part in this study. Benefits to society include a better understanding of the benefits of combining individual pastoral counseling with the recovery group experience.

What risks might you experience from being in this study?

The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life.

How will personal information be protected?

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records. Data collected from you may be shared for use in future research studies or with other researchers. If data collected from you is shared, any information that could identify you, if applicable, will be removed before the data is shared.

- Participant responses will be kept confidential through the use of pseudonyms. Interviews and counseling sessions will be conducted in a location where others will not easily overhear the conversation.
- Data will be stored on a password-locked computer and a locked filing cabinet and may be used in future presentations.
- Interviews and counseling sessions will be audio recorded and transcribed. Recordings will be stored on a password locked computer for three years and then erased. Only the researcher will have access to these recordings. None of the recorded counseling sessions' information will be used in the research.

Does the researcher have any conflicts of interest?

The researcher serves as a pastor at Naples Church of Christ. This disclosure is made so that you can decide if this relationship will affect your willingness to participate in this study. No action will be taken against an individual based on his or her decision to participate in this study.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether to participate will not affect your current or future relations with Liberty University, the Naples Church of Christ, or the Naples Church of Christ Celebrate Recovery program or the researcher. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please contact the researcher at the email address or phone number included in the next paragraph. Should you choose to withdraw, data collected from you will be destroyed immediately and will not be included in this study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Stephen F. Curtis. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact him at 720-371-1269 or curtis.sf@gmail.com. You may also contact the researcher's faculty sponsor, Dr. J. Steven Davis, at jsdavis2@liberty.edu.

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu.

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the researcher using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to audio-record me as part of my participation in this study.

____

Printed Subject Name

____

Signature & Date

Appendix C: Pre-Counseling Interview Questions

1. Why did you choose to participate in Celebrate Recovery (CR)?

2. What were your expectations of what you would experience from your participation in CR?

3. In what ways were your expectations met?

4. In what ways were your expectations unmet?

5. How would you describe your recovery progress so far?

6. Why did you accept the invitation to participate in this action research project (individual brief therapy)?

7. What are your expectations of what you will experience as a result of your participation in this project?

Appendix D: Post-Counseling Interview Questions

1. Why did you accept the invitation to participate in this action research project (individual brief therapy)?

2. In what ways were your expectations met?

3. In what ways were your expectations unmet?

4. Describe your therapy experience.

5. What difference, if any, has your therapy experience made with your CR experience?

6. Describe any changes in thoughts, feelings, or behaviors as a result of your therapy experience.

7. In your opinion, is it beneficial to combine individual pastoral counseling with the CR group experience? Why or why not?

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

July 24, 2020

Steve Curtis
Jack Davis

Re: IRB Exemption - IRB-FY19-20-403 Individual Pastoral Counseling in Combination with Celebrate Recovery Group Experience

Dear Steve Curtis, Jack Davis:

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your studyto be exempt from further IRB review. This means you may begin your research with the data safeguarding methodsmentioned in your approved application, and no further IRB oversight is required.

Your study falls under the following exemption category, which identifies specific situations in which humanparticipants research is exempt from the policy set forth in 45 CFR 46:
101(b):

Category 2.(iii). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met: The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §46.111(a)(7).

Your stamped consent form can be found under the Attachments tab within the Submission Details section of your study on Cayuse IRB. This form should be copied and used to gain the consent of your research participants. If youplan to provide your consent information electronically, the contents of the attached consent document should be made available without alteration.

Please note that this exemption only applies to your current research application, and any modifications to yourprotocol must be reported to the Liberty University IRB for verification of continued exemption status. You may report these changes by completing a modification submission through your Cayuse IRB account.

If you have any questions about this exemption or need assistance in determining whether possible modifications to your protocol would change your exemption status, please email us at

irb@liberty.edu.

Sincerely,
G. Michele Baker, MA, CIP
Administrative Chair of Institutional Research

Research Ethics Office

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