Biblical Counseling and Medical Illness

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March 2026

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Opening Vignette 1

In February 2026, I attended Ukrainian Week in Washington DC. The event brought together hundreds of American and Ukrainian Christians to pray, meet, and collaborate on supporting Ukraine through the present crisis and beyond. Sponsored by the American–Ukrainian Christian Alliance, Ukrainian Week covers all aspects of life, from Family and Demography to Business and the Military.

One major emphasis was the Forum on Trauma and Healing. Several experts in mental health, sociology, psychology, and the chaplaincy spoke on post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), depression, substance abuse, and other topics pertinent to a nation at war. The session was interesting, but most of the speakers made little mention of Christ. They also didn't talk about the Bible. The Diagnostic and Statistical Manual (DSM-5-TR), not the Word of God, was the primary source. One speaker said that she was a chaplain in the Ukrainian Army, but she wasn't only that. She was also trained in mental health, like psychology. The hesitation to describe the role of the Word of God struck me as odd in this overtly Christian event.

Opening Vignette 2

Saul bar Kish was the first king of Israel. A tragic figure, Saul's troubles have been variously interpreted over time.

What the Biblical Text Says About Saul's Distress

1. Several passages describe Saul experiencing a profound inner turmoil:
2. He is tormented by what the text calls "an evil spirit from the Lord" (1 Samuel 16:14).
3. His mood shifts dramatically—rage, fear, paranoia, and despair appear in cycles.
4. He becomes suspicious of David, interpreting ordinary events as threats.
5. He has episodes of violent impulsivity (throwing a spear at David and Jonathan).
6. He experiences deep depressive hopelessness, especially near the end of his life.
7. He seeks out the medium at Endor in desperation, showing spiritual disorientation.
8. The narrative paints a picture of a man whose inner world is unraveling.

How Interpreters Have Understood Saul's Condition

1. Ancient and Traditional Jewish/Christian Interpretation

Traditionally, Saul's suffering is seen as **spiritual judgment**:

1. His disobedience leads to God's favor departing.
2. The "evil spirit" is understood as a form of divine discipline or spiritual oppression.
3. His instability is tied to moral and spiritual decline.

This view focuses on covenant theology rather than psychology.

2. Modern Psychological Readings (Non-diagnostic)

Scholars and clinicians who analyze the narrative—without claiming a diagnosis—often note patterns that resemble:

1. **Severe depression:** Episodes of despair, withdrawal, hopelessness.
2. **Paranoia** Persistent belief that David is plotting against him despite lack of evidence.
3. **Mood instability:** Rapid shifts between affection, rage, fear, and remorse.
4. **Possible PTSD-like symptoms.** Saul was a wartime leader under constant threat.
5. **Spiritual distress:** Feeling abandoned by God, which intensifies his emotional collapse.

These are *literary* and *historical* observations—not clinical diagnoses – and they should be treated as such. Nonetheless, a common mistake is to try to superimpose modern categories on ancient characters. This act is as foolish as teaching that because the modern English word "dynamite" comes from the Greek "dynamos" (δυνάμις), Paul was thinking of "dynamite", when he referred to the power of God (Rom 1:16)

3. Theological-Psychological Synthesis

Some interpreters blend both perspectives:

1. Saul's spiritual disobedience and alienation from God create a context of inner fragmentation.
2. His emotional instability reflects both **moral/spiritual crisis** and **psychological suffering**.
3. David's music temporarily soothes him, suggesting emotional dysregulation rather than pure spiritual possession.

This approach sees Saul as a deeply human figure caught between divine calling and personal collapse.

Purpose

The purpose of this class is

1. To help students understand the differences in the secular and Christian paradigms for mental health and assumptions about the existence of God, characteristics of religion, and the nature of man underlying those paradigms.
2. To briefly introduce students to competing practices of healing from mental illness, including Freudian, Skinnerian, Rogerian, Mowrerian (integrity groups), and Christian.
3. To teach pastors and other leaders in the local church how to counsel their parishioners and others needing help in the context of medical illness. Medical illnesses, such as diabetes, high blood pressure, heart disease, kidney disease, liver disease, and cancer, as well as injuries, are often accompanied by mental health issues such as depression, anxiety, substance abuse, PTSD, bipolar disorder, and schizophrenia.

Day 1 – People, Principles, and Paradigms

The purpose of this lecture is to provide the theoretical and practical basis for how we think about biblical counseling. We will discuss the nature of man, paradigms for understanding man, the secular medical paradigm of health, including the DSM-5-TR, and the Christian paradigm of health, which includes and modifies some aspects of the secular but includes an overarching spiritual (Christian) perspective.

It is a common mistake for those new to biblical counseling to allow the problem or the counselee to eclipse and distract them from the truth and sufficiency of God's Word.[1] Culture encourages people who have struggles both minor and major to seek out a diagnosis. A diagnosis is believed to be helpful or necessary for people to understand their struggle. It is also believed to be foundational to recovery from the issue.

Even amid trauma and crisis, biblical counselors need to lovingly remind counselees of the fact that their relationship with God is to be the priority of their lives. Asking questions about the state of their relationship with God and providing practical homework assignments is a vital precursor to dealing with bad memories.

Anthropology

One's understanding of illness has everything to do with one's understanding of the rest of existence. What is the nature of man?[2]

Paradigm	Composition	Moral Nature of Man
Buddhist	Nothing exists, including man. Some might posit the existence of an ill-defined, Buddha-like nature	None
Hindu	Man has a perishable body and imperishable soul (atman), which transmigrates from body to body (samsara) until merging (moksha) into the universal spirit (Brahma)	Neutral, can be good or bad depending upon circumstances and one's personal choices
Secular Humanist	The body and the physical world exist, but there is no God, no human spirit, and no spiritual world. Man is essentially an animal.	Neutral, though morality itself is a societal construct
Gnostic	The spirit and spiritual world exist, but the body and the physical world are far inferior, or perhaps an illusion.	Matter is evil, and spirit is good
Islam	The material and spiritual worlds both exist, created by God and proclaimed "good".	Man is born good, submitted to Allah, but he becomes evil as he thinks and acts badly
Christian	The material and spiritual (immaterial) worlds both exist, and man has both material (body) and	Man was created perfectly good, but chose evil, and now is scarred by original sin[4]. Man is spiritually dead

[1] John Babler, PTSD, Memories, and Biblical Counseling, https://biblicalcounseling.com/resource-library/essays/ptsd-memories-and-biblical-counseling/.

[2] H Wayne House, Charts of World Religions

[4] The doctrine of original sin holds that man is corrupt (evil) in every part of his being, not that he is as bad as he could be.

	spiritual (soul/spirit) components.[3] All were created by God and proclaimed "good".	

A man's understanding of God and man, for example, will heavily impact how he feels about his actions and his circumstances. Suppose a person cheats on his taxes…

1. If he is a doctrinally observant Buddhist who believes that nothing is real, he may not feel like he has done anything wrong. Since tax cheating is frowned upon in society, he may worry that his actions brought bad karma. He may also worry about getting caught. However, this act has no bearing on his eternal destiny. It can't, as he does not exist (no self).
2. If he is a doctrinally upright Hindu, he would certainly worry about bad karma and getting caught. This infraction might delay but would not prevent his eventual moksha.
3. If he is a secular humanist, for whom nothing exists beyond this life, he may worry about getting caught.
4. If he is a doctrinally accurate Muslim, he may feel guilty about breaking Allah's rules (paying zakat) and convinced that he will be caught since Allah sees all things. He will also feel shame due to the disapproval of others. Allah may or may not forgive him, impacting his eternal destiny.
5. If a Bible-believing Christian, he will feel guilt for breaking the law and shame in the eyes of others. However, if he repents, he is guaranteed forgiveness by the work of Christ.

What is Health? The Modern Medical Paradigm

The modern medical paradigm is based on a secular humanistic anthropology. In this view of man, God and the spiritual world either do not exist at all or are unimportant. The World Health Organization defines health in its constitution as…[5]

- Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.
- The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.
- The health of all peoples is fundamental to the attainment of peace and security and is dependent on the fullest co-operation of individuals and States.
- The achievement of any State in the promotion and protection of health is of value to all.
- Unequal development in different countries in the promotion of health and control of diseases, especially communicable disease, is a common danger.
- Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.
- The extension to all peoples of the benefits of medical, psychological, and related knowledge is essential to the fullest attainment of health.
- Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people.

[3] "Soul" and "spirit" refer to the same intangible (non-material) part of man. "Soul" describes that aspect when connected to the body (Matt 16:26, Greek ψυχή (psychē)), and "spirit" describes that aspect when not connected to the body (John 19:30, Greek πνεῦμα (pneuma)).

[5] What does "Health" mean to you? https://www.emro.who.int/about-who/rc60/what-does-health-mean-to-you.html.

- Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.

The World Health Organization defines mental health as follows...[6]

1. Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and can contribute to his or her community.
2. Mental health is fundamental to our collective and individual ability as humans to think, emote, interact with each other, earn a living, and enjoy life. On this basis, the promotion, protection, and restoration of mental health can be regarded as a vital concern of individuals, communities and societies throughout the world.

What do you notice about these statements from the WHO?

1. No mention of God
2. Optimal health is a human right
3. Development of health must be equal, regardless of economic, cultural, or other factors.
4. Health includes intra- and interpersonal factors
5. No suggestion, much less acknowledgment, that some cultures and religions might be more conducive to health than others.
6. The government, not any other organization, is responsible for each person's health.
7. The goal is to think, emote, interact with each other, earn a living, and enjoy life.

The DSM-5-TR

Using this secular humanistic paradigm, mental health practitioners and researchers devised ways to categorize disease, including the International Classification for Disease (ICD), the Chinese Classification of Mental Disorders, the Psychodynamic Diagnostic Manual, and the DSM The Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR), which is the latest edition of the American Psychiatric Association's professional reference book on mental health and brain-related conditions. Written first in 1952, the DSM-5-TR is divided into the following categories:

Neurodevelopmental disorders

1. Autism spectrum disorder.
2. Attention-deficit/hyperactivity disorder (ADHD).
3. Learning disorders (dyslexia, dyscalculia, etc.).

Schizophrenia spectrum and other psychotic disorders

1. Schizophrenia.
2. Schizoaffective disorder.
3. Delusional disorder.
4. Bipolar and related disorders.
5. Bipolar I and bipolar II disorders.
6. Cyclothymic disorder.
7. Depressive disorders.
8. Major depressive disorder.
9. Persistent depressive disorder.
10. Anxiety disorders.
11. Generalized anxiety disorder.
12. Social anxiety disorder.
13. Separation anxiety disorder

[6] Health and Well-Being, https://www.who.int/data/gho/data/major-themes/health-and-well-being.

14. Panic disorder.
15. Phobias.

Obsessive-compulsive and related disorders

1. Obsessive-compulsive disorder (OCD).
2. Hoarding disorder.
3. Body dysmorphic disorder.
4. Skin-picking disorder and hair-pulling disorder.

Trauma- and stressor-related disorders

1. Post-traumatic stress disorder (PTSD).
2. Acute stress disorder.
3. Adjustment disorder.

Dissociative disorders

1. Dissociative identity disorder.
2. Dissociative amnesia.
3. Depersonalization/derealization disorder.

Somatic symptoms and related disorders

1. Somatic symptom disorder.
2. Illness anxiety disorder.
3. Functional neurological symptom disorder (conversion disorder).

Feeding and eating disorders

1. Anorexia nervosa.
2. Bulimia nervosa.
3. Binge-eating disorder.
4. Pica.

Elimination disorders

1. Enuresis (a group of disorders that includes bedwetting).
2. Sleep-wake disorders.
3. Insomnia disorder.
4. Narcolepsy.
5. Sleep apnea disorders.
6. Nightmare disorder.
7. Restless legs syndrome.

Sexual dysfunctions

Disruptive, impulse-control and conduct disorders

1. Oppositional defiant disorder.
2. Antisocial personality disorder.
3. Kleptomania.
4. Pyromania.

Substance-related and addictive disorders

1. Alcohol use disorder.
2. Inhalant use disorder.
3. Opioid use disorder.
4. Withdrawal-related symptoms.

Neurocognitive disorders

1. Delirium.
2. Alzheimer’s disease.
3. Parkinson’s disease.
4. Huntington’s disease.
5. Traumatic brain injury.

Personality disorders

1. Borderline personality disorder (BPD).
2. Narcissistic personality disorder.

Sexual behavior disorders

Other mental disorders and additional codes - Conditions that don’t match the definition of another condition, but that still significantly affect someone’s life.

Medication-induced movement disorders and other adverse effects of medication

1. Tardive dyskinesia.
2. Neuroleptic malignant syndrome.

Other conditions that may be a focus of clinical attention

These include circumstances or behaviors that aren't conditions, but that may affect or happen in relation to diagnosable conditions. Examples include self-harm and suicidal behaviors, a history of any type of abuse, unemployment, etc.

The DSM-5-TR is the most utilized classification of mental health disorders in the United States and possibly in the world. The latest revision is written with input from hundreds of experts across disciplines. The DSM-5-TR provides a standard for communicating mental health conditions to label patients, communicate with colleagues, defend oneself in court, and bill for reimbursement.

The DSM-5-TR lists symptoms, which are real, and places them under constructs, which are diagnoses. Restated, what is called a "diagnosis" is only a label for symptoms that a committee of "experts" has decided to use. These symptoms are human behaviors. For example, gaming disorder (a construct) requires the following symptoms over a specific time period.

A key point in the DSM paradigm is "personality disorders," including borderline and narcissistic, which the Bible explains is sin.

Criteria for Diagnosing Gaming Disorders (DSM-5-TR)

Internet Gaming Disorder	Gaming Disorder
1. Salience: Thinking about previous gaming activity; anticipating playing the next game 2. Gaming tolerance: Increased hours spent gaming 3. Mood modification: Use of gaming to escape or relieve negative mood (e.g., guilt, anxiety) 4. Relapse: Unsuccessful attempts to stop or reduce gaming time 5. Withdrawal symptoms: Irritability or anxiety when games are removed 6. Conflict: Loss of interest in real-life relationships, hobbies, physical activity, or other entertainment 7. Deception: Deception of gaming activities to family, therapists, others 8. Problems: Continued excessive gaming despite knowledge of negative consequences 9. Lost opportunities: Jeopardized or lost relationships, jobs, education, or career opportunities because of gaming 10. Diagnostic threshold: Patient must have at least 5 of 9 criteria for a 12-month period; gaming must cause clinically significant impairment.	1. Impaired control over gaming (e.g., onset, frequency, intensity) 2. Increased priority given to gaming so that it takes precedence over other life interests and daily activities 3. Continuation or escalation of gaming despite negative consequences 4. Diagnostic threshold: Patient must have at least 2 of 3 criteria for at least 12 months; gaming must cause clinically significant impairment.

DSM5-TR Case Study

Suppose that a man and his wife came to a primary care clinic. The wife complains that her husband has been playing internet games for ten years, but in the past two years has played a lot more, up to 20 hours per week (**tolerance**). His gaming has supplanted activities that the family used to do together, like watching favorite shows or playing board games (**conflict**). They have started arguing about his gaming, and when he tries to reduce his hours, he gets grumpy (**withdrawal**). The husband admits that he feels guilty about his gaming (**mood modification**), but work is so stressful, and he needs to unwind. He says that he doesn't know what the big deal is, and so he is inconsistent about cutting his time (**relapse**).

With 5/9 positive criteria over two years, this man clearly meets the criteria for Internet Gaming Disorder (IGD). The clinician tells him and his wife that he has the illness of IGD and prescribes treatment, including:

1. Cognitive Behavioral Therapy
2. Family Therapy and Support
3. Group Therapy – perhaps a twelve-step program.
4. Pharmacological Treatment – Bupropion or Escitalopram.

With all this therapy, the patient would likely improve. The family would believe and tell others that the husband has IGD. They would change their lives to accommodate his illness. The clinician and the therapists would

communicate with each other and bill health insurance using the same language. The pharmaceutical companies would have another stream of income for the indefinite future. Six months later, if the husband's "condition" was no better, the primary care clinician might refer him for transcranial magnetic stimulation or some other emerging treatment.

Limitations of the DSM Approach to Mental Health

Salience, mood modification, and the like are certainly characteristics that a person who games on the internet too much could have. However, each characteristic, like conflict, can apply to other conditions as well, such as antisocial personality disorder and oppositional defiant disorder. The mood changes in gaming disorder could reflect depression rather than gaming disorder. It is hard to know, in each case, where to categorize each symptom. The symptoms of a patient that one psychologist diagnoses as having gaming disorder may be diagnosed by another as depression or obsessive-compulsive disorder, who perhaps tries to drown his sorrows by playing. The diagnosis is based purely on the subjective opinions of the patient and the medical professional.

Most diseases and injuries have objective findings to make the diagnosis. Restated, most areas in medicine have hard, objective evidence of the presence or absence of a disease or injury. Rabies has the polymerase chain reaction for rabies virus, a broken leg has the X-Ray, and a stroke has the brain CT to find changes and make an objective diagnosis. Mental health diagnoses do not.

One might object that mental illnesses do have physical changes, such as insomnia occurring in patients with depression. "Clinically significant" and the time factors also need explanation.

- Insomnia is not a necessary cause for depression, and depression is not a necessary cause for insomnia.[7]
- Insomnia is not a sufficient cause for depression, and depression is not a sufficient cause for insomnia.
- Why should 5/9 criteria be required to make a diagnosis, and not 3/9 or 7/9 "yes" answers.
- What is significant about 12 months, compared to 6 or 18 months?
- What does "clinically significant" mean? Who decides?
- Why should the diagnosis only be made if the patient feels impaired, but not if they don't feel impaired? What about others who are impacted?

When one looks up physical indicators of mental illness, authors cite mood swings, behavioral changes, physical symptoms, persistent fatigue, and unexplained aches and pains. But all of these symptoms may be the result and not the cause of mental illness.

For its ubiquity, the DSM-5-TR has other major troubles

- It is dull, without powerful and memorable stories or illustrations.
- It is essentially a book of lists.

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[7] A factor is sufficient to cause a disease if the disease results every time a person is exposed to that factor. For example, cigarettes would be a sufficient cause of lung cancer if lung cancer occurred in everyone who had ever smoked a cigarette. A factor is necessary to cause a disease if the disease never occurred without that factor. For example, cigarettes would be a necessary cause of lung cancer if lung cancer never occurred except with exposure to cigarettes. In this case, cigarettes are neither a sufficient nor a necessary cause of lung cancer. Likewise, insomnia is neither a sufficient nor a necessary cause of depression, and depression is neither a sufficient nor a necessary cause of insomnia.

- It is word bound. A man can learn about God from His creation, but has to use words to understand secular psychology.
- It is weak.

Why do we prefer psychological texts like the DSM5-TR to deal with mental illness rather than the Bible?

- Because it is easier to think in categories than holistically. The DSM5-TR provides a list of symptoms, a diagnostic label encompassing those symptoms, and a duration that the symptoms must have been present to qualify for a diagnosis of each disease. The Bible provides examples of right and wrong thoughts, words, and actions.
- Because the DSM5-TR provides a modern language that we can use to communicate with patients, families, with each other, and with payers such as insurance or the government. That same language can help us defend ourselves when problems occur, such as employment, licensing, and lawsuits.
- Because therapies under the DSM5-TR paradigm can go on for a lifetime, thus providing a steady stream of income to counselors, therapists, psychiatrists, psychologists, social workers, and drug manufacturers.
- Because DSM5-TR diagnoses are guilt-free. Someone outside of us causes the problem.
- Because DSM5-TR diagnoses can be treated with a minimum of work on the patient's part. A daily pill and therapy once per week, forever, may be enough to make a person functional again.
- Because no painful reckoning with sin in our hearts, wrongs in our past, and unforgiveness is required. The Bible requires us to change our lives.
- Because we are responsible only to ourselves, and not to the Sovereign Lord of the Universe who holds our eternal destiny in His hands.

The Bible is comprehensive, meaning that it addresses the vast array of problems in human life, but it is not exhaustive, meaning that it is not an encyclopedia of diagnosis and treatment for "mental illness." The Bible is not the whole story, but it is the glasses through which we interpret the story.

What is Health? A Christian Paradigm

Unlike the secular medicine paradigm, which considers man to be no more than a sophisticated animal and morality to be no more than a social construct, the Christian understanding of reality is that man is the pinnacle of creation, made by God in His image, destined for community, ruling the world, but mortally wounded by the Fall. Christian anthropology is far richer and deeper than the secularism promoted by Marx, Engels, and Hegel.

In the Christian understanding of reality, the greatest commandments are to love the Lord your God with all your heart and with all your soul and with all your mind and with all your strength, and to love your neighbor as yourself. (Mark 12:30-31). The greatest health is to keep these commandments of the Lord most faithfully. Illness, then, is to live life in disregard of these commandments.

Biblically, illness and injury derive from the following sources:[8]

1. **Organic illness or injury** (the consequence of Adam and Eve disregarding the commandments).
    a. An identifiable cause with physical evidence
    b. Examples - Saul (1 Samuel 31:4-6), Judas (Matthew 27:1-10), Herod (Acts 12:21-23),
2. **Demonic activity** (the consequence of Satan and the demons disregarding the commandments).
    a. Examples - Saul (1 Samuel 13:1–14; 15:1–35).
3. **Sin** (the consequence of each person disregarding the commandments).
    a. Direct opposition to the commands of God
    b. Examples – adultery and murder (Psalm 51), unforgiveness (Matt 6:14-15),

What is "health" under the Christian paradigm? Jesus Christ is the perfect man, the most spiritually (and possibly physically) healthy human that ever lived. He did not sin, and he was immune from the effects of demons. Jesus had no mental illnesses, as we would call them today. The only "unhealth" that could impact Him was organic illness or disease, as He had a truly human body. Therefore, a Christian is as spiritually healthy as he is like Jesus. Likewise, all else being equal, a Christian will be more physically healthy the more he is like Christ. When you minimize sin and resist the temptations of demons (James 4:7), when you treat your body as a temple to the Lord (1 Cor 6:19-20), when you exercise in moderation (1 Tim 4:8), when you eat right (Daniel 1:12), and when you avoid intoxication (Eph 5:18), you are likely to be more physically healthy.

The Christian recognizes that the Christian paradigm is fundamental and the medical paradigm, while useful, is subsidiary. When caring for people who claim the name of Christ, Biblical counselors must examine the problem first through the spiritual paradigm, and secondarily, the medical one.

Years ago, I had a female patient in her early 40s in my primary care clinic complaining of fatigue, lack of energy, anger, depression, and a sense of hopelessness. I ordered labs, including a blood count and a thyroid test. Her symptoms had started about six years before, shortly after getting into a terrible fight with a then-friend. We explored her feelings and realized that she had never forgiven her friend, who had hurt her. I told the patient that, according to scripture, she would not get well until she forgave. I did not prescribe any medications, antidepressant or otherwise. I made no referrals for mental health care. Over time, working with

[8] Notice that Biblically, there is no recognition of non-organic mental illness

her church to help with the process, the women forgave each other, the patient's symptoms resolved, and her relationship with her friend was restored.

Twelve-Step Programs

A popular paradigm for recovery in addiction medicine is the twelve-step program. Begun with Christian underpinnings, the program has proven effective for many recovery programs. However, no twelve-step program has the power or authority of the word of God. They mention a "higher power" but say nothing of Christ. The structure of such programs may help some people, but only God the Father, Son, and Holy Spirit, working in the lives of men, can perfectly overcome sin and addiction. A Christian counselor may use such tools as twelve step programs if the format is useful, but may never downplay or undermine the surpassing authority of Scripture.

1. **Honesty**: After many years of denial, recovery can begin with one simple admission of being powerless over alcohol or any other drug a person is addicted to. Their friends and family may also use this step to admit their loved one has an addiction.
2. **Faith**: Before a higher power can begin to operate, you must first believe that it can. Someone with an addiction accepts that there is a higher power to help them heal.
3. **Surrender**: You can change your self-destructive decisions by recognizing that you alone cannot recover; with help from your higher power, you can.
4. **Soul searching**: The person in recovery must identify their problems and get a clear picture of how their behavior affected themselves and others around them.
5. **Integrity**: Step 5 provides great opportunity for growth. The person in recovery must admit their wrongs in front of their higher power and another person.
6. **Acceptance**: The key to Step 6 is acceptance—accepting character defects exactly as they are and becoming entirely willing to let them go.
7. **Humility**: The spiritual focus of Step 7 is humility, or asking a higher power to do something that cannot be done by self-will or mere determination.
8. **Willingness**: This step involves making a list of those you harmed before coming into recovery.
9. **Forgiveness**: Making amends may seem challenging, but for those serious about recovery, it can be a great way to start healing your relationships.
10. **Maintenance**: Nobody likes to admit to being wrong. But it is a necessary step in order to maintain spiritual progress in recovery.
11. **Making contact**: The purpose of Step 11 is to discover the plan your higher power has for your life.
12. **Service**: The person in recovery must carry the message to others and put the principles of the program into practice in every area of their life.

Activities of Daily Living (ADL)

ADLs are usually used in the context of geriatrics, but these activities are important for all adults. Patients with mental health issues are sometimes unable to accomplish them. A biblical counselor can use them to get an idea of how the condition is impacting the counselee's life.

TABLE 2

Assessment of Activities of Daily Living in Older Adults

Basic	Instrumental	Advanced
Self-care tasks	Tasks required to run an independent household	Ability to fulfill societal, community, and family roles
Ask patients whether they have any barriers to:		
Bathing	Driving	Community activities
Dressing	Handling finances	Hobbies and sports
Grooming and feeding	Home repair	Leisure
Toileting	Laundry	Traveling to unfamiliar areas
Transferring	Meal preparation and housework	Using technology
	Shopping for groceries	Volunteer work
	Taking medications	
	Using public transportation	
	Using the telephone	

Information from reference 16.

Discussion 1 – Struggles of the Counselor[9]

The following is a discussion for the whole class together. It comes from a case study written in an American context. The complaints are found in many cultures, though some who view them in the context of war, as in modern Ukraine, will see them as trite. Others will recognize that small matters accumulate, perhaps even more in high-stress contexts, and cause great problems. **The purpose of this discussion is to explore how everyday struggles in your home and ministry impact your function as a Christian and as a counselor.**

What is your situation? What are you facing?

1. Messy home
2. Unpacked groceries
3. unshut drawers
4. unkept used items
5. No space to work/dinner
6. Can't find things
7. Late for work
8. Trip over things strewn about the house
9. Children cry
10. Unhappy spouse
11. When I come home from work
12. When I want to rush to work

How are you reacting? What do you typically do?

1. angry/bitter "I'll do it myself."
2. threat "tidy now or else."
3. accuse "Why not train the kids?"
4. silent treatment "can't change."
5. "Don't be like them."
6. Blame "all your fault we are late."
7. Name-calling "tornado."
8. complain "unfair, I deserve my peace."
9. pride "Why can't she be like me?"

[9] Case Studies, Case Study: Kenneth, https://www.psalm88.org/case-studies/.

10. Self-interest “Don’t touch my study.”

What rules you; hijacks your heart?

1. demanding orderliness
2. comfort
3. refuge/rest
4. control
5. safety
6. work completion *(good things to desire)*

Who is God — relevant to this struggle?

1. Matthew 6:10 — Your kingdom come, your will be done
2. Romans 1:25 — They worshipped, served created things rather than the Creator
3. Ezekiel 1:21 — God’s omnipresence

Respond to God from the heart (faith)? Respond in Heat (love)?

1. Forgive me Lord *(Psalm 130)*
2. Be with me in this Lord, help me see I can’t control my life and trust the One who can *(Psalm 121)*
3. I don’t want to take things into my own hands, Lord, stop playing God, I want to trust you, love you, worship you

Case Study 1

Gather into groups of two or three. Based on your knowledge and experience, and what you have learned today, each group is to write a case study about depression in a minister who needs you to counsel him. Spend up to 15 minutes writing the case study. You have great flexibility in this case study.

As a group, present your case study to the rest of the class. Discuss how you would counsel him or her and get feedback from each group on how they would counsel this pastor.

Day 2 – Foundations of Counseling

1. Persons and Principles in Counseling
2. Reconciliation and Discipline
3. Presuppositions and Methodology
4. The Language of Counseling
5. The Language of Emotion and Action – Feeling, attitude, and behavior
6. The Problem is Sin

Persons and principles involved in counseling[10]

The Holy Spirit - The primary figure and the person of most importance. No Christian counselor should counsel anyone without everyone involved giving primacy to the Spirit

The Human Counselor

1. Biblical counseling is ministerial, a duty of ordained pastors, in the context of their ministry to people in their church.
2. The best training for Biblical counselors is Bible training
3. Pastors who counsel people in their church have the full authority given to elders as recorded in scripture
    a. Shape the congregation's understanding of scripture through routine sermons, teaching, worship, and other activities (Col 3:16).
    b. Declare the will of God (Rom 15:14)
    c. Mediate and judge between members (1 Cor 6)
    d. Exercise church discipline (1 Cor 5)
    e. Be highly esteemed in the church (1 Thess 5:12-13).
4. The non-ordained Christian counselor has none of these authorities.
5. The authorities come from God alone and must be used in accordance with His word.
6. Be directive in those areas in which the Bible is directive and non-directive in those areas in which it is not.
7. A powerful knowledge of the Word is all-important
8. Personality traits that interfere with ministry must be altered. The Spirit has the will and power to do this.

The Counselee

1. Counselors already know a lot about counselees
    a. The Scriptures
    b. His and others' counseling experience
    c. Knowledge of evil in the counselor's own heart
2. No one faces any truly unique problems, as all problems are variations on eternal themes (1 Cor 10:13).
3. Through principle or example, the Bible holds the answer to every problem man faces.
4. The counselor will need to know
    a. What is the specific problem?

[10] Jay E Adams, The Christian Counselor's Manual (Grand Rapids, MI: Zondervan Reflective, 2024).

b. What biblical principles apply to this case?
c. What must be done to bring these principles to bear on this problem?

5. The Spirit can affect a rapid, thorough change in the counselee. Radical change = new birth

Principles

1. Bible and theology, not psychology and social work, is the right training for biblical counselors.
2. Man cannot live by only day-to-day goals but also by long-term meaning. Only the long term can fuse short-term purposes into meaningful patterns.

Hope - Faith produces works and labor comes from love, but endurance is derived from hope. Hope is a confident expectation that God's purpose will be done. Which people need hope?

1. Longstanding problems
2. Especially difficult problems.
3. Have been deceived, intentionally or unintentionally, about their problems.
4. Repeated dashed hopes
5. Have tried and failed
6. Older, depressed, or suicidal
7. Suffered life-shattering experiences (loss of person, possessions, position)

How can Christian counselors provide hope? First, help them find hope in the Scriptures. Second, pay careful attention to their self-deprecating comments and illuminate them in the context of hope. Third, give concrete assignments for every session. Fourth, prepare for each session and close every session in prayer.

Reconciliation and Discipline

I read an article several months ago about ghosting. A young woman had met a man on a dating app and a few weeks later had gone out with him on a date. She texted him a day later to thank him, and hopefully he would mention future contact. He never replied. In another circumstance, two long-time friends had a falling out, and one never contacted the other again. The man on the date and the one friend had ghosted the others.

Ghosting was more difficult and often impossible in the past. When two people lived in the same small town, went to the same school, grocery store, businesses, and church, it was impossible to avoid each other entirely. Over time, the emotions would subside, and reconciliation could begin.

Christians are not allowed to ghost one another. Neither are we allowed to maintain anger, bitterness, or sin with one another. Believers in Christ will spend eternity together, even if they don't get along terribly well. God tells us to make peace with each other even before coming to worship Him (Matt 5:21-26).

Reconciliation

1. Confess your sin to God and to others that you have sinned against.

2. Receive God's forgiveness and forgive whatever you have against another. If they follow Jesus, they are required to forgive you.
3. Establish a new relationship between yourself and God and the other party.
    a. Abandon (put off) old ways – beliefs, thoughts, words, actions, activities,
    b. Adopt (put on) new ways
    c. A deliberate action like changing clothes.

Forgiveness

1. Forgiveness is a Scriptural requirement, but forgetting is not.
2. Forgiveness is an act of will, but forgetting is not directly possible through an act of will. The nervous and endocrine systems will adjust to the offense and must adjust to the new situation, the forgiveness, as well.
3. Requires that neither party to the offense dwell on the offense, the sin that was forgiven.
4. We forgive even if we are not sure of the offending party's repentance. But we can't bring it up to him, to others, or to ourselves again. A new relationship will not flower in the soil of self-pity.
5. The Bible never tells us to forgive ourselves, as all sin is not ultimately against man, any man, but against God (Psalm 51:4). Only God can forgive sins (Mark 2:5-11).
6. Forgiveness has nothing to do with feelings, but with actions.

Methods in Counseling

One's underlying view of reality, including anthropology as noted above, determines one's view of how to fix any "mental health" problems that arise.

General Approach	Specific Type	Man's Problem	Solution
Expert knowledge	Sigmund Freud (1856-1939)	Poor socialization (often blames the church and family)	Resocialization by an expert (the psychiatrist/psychologist can fix you)
	BF Skinner (1904-1990)	Environmental conditioning	Reconditioning by an expert (like training an animal, changing the total environment)
Common knowledge	Carl Rogers (1902-1987)	Failure to live up to one's potential	Resources found in oneself (the answer/power is within you)
	Integrity groups O Howbart Mowrer (1907-1982)	Bad behavior towards others	Resources in Self and group
Divine knowledge	Christian	Sin against God	Resources of the Spirit in the Word

Freudian

1. The origin of the problems that a counselee faces is external. Outside events/forces, not choices of the counselee, have caused the mental health damage that the expert now has to fix. The counselee is at the mercy of these forces.
2. Man is not responsible for anything he does. Nor is he able to individually fix whatever problem he has. He was helpless then, and he is helpless now.

3. People in the past, intentionally or not, are responsible…they harmed the counselee. Now the expert has to assume the role of key persons, typically the errant father, to undo the trauma that he caused. For example, if the actual father was stern and distant, the psychologist, assuming the role of the father, would be kind and approachable.
4. The Id (natural impulse for sex and aggression) is over-restricted by the superego (conscience), which causes guilt in the ego (conscious person). The guilt is not genuine or deserved but rather due to others' rigidity and mistreatment.
5. Dream analysis is a key feature.
6. The work is so complicated and specialized that someone with the training, such as a pastor or counselor, could not do it.

Skinnerian

1. Man is not responsible for what he does, and others are also not responsible. Rather, the total environment, including people, events, and even the weather, is responsible.
2. Man is the product of his environment. It created him, it sustains him, and if we knew every factor, we would see that he is strictly determined…he is not free in any sense.
3. With genetic manipulation and total environmental control, government technocrats can make any kind of person that they want.
4. In therapy, expert counselors help helpless counselees to modify their environment to improve their problems.

Rogerian

1. Man is morally good, not evil, and he has within him all he needs to solve his problems.
2. The therapist is a catalyst, not an expert repairman.
3. No real authoritative standards exist, and therefore none can be imposed on a counselee.
4. The therapist/counselor acts as a mirror, reflecting the counselee's ideas back on the counselee so that he can identify solutions.

Mowrer

1. Behavior that hurts others causes guilt
2. Atonement is only by suffering, confession, and restitution. Atonement must occur daily, if not continually, and there is no forgiveness or mercy.
3. The counselee's group has the answers and the resources, and must determine how each person stays in and gets out of the group.
4. The therapist speaks for the group

Divine Knowledge

1. Judging
2. Convicting
3. Changing
4. Structuring

Language of Counseling

1. Language is a gift from God. It allows us to talk, but also to think. Language shapes and brings about the reality that it describes.
2. Counselors must listen to precisely what the counselee says, noting the very words that they use. Listening to words like "I can't" and to self-deprecating statements is especially important.
3. Precision in word use "Tension" – People might say that a situation is "tense." This is false, as tension is commonly defined as being within one person, not between them. Mary might feel tense while talking with Jane, and Jane might feel tense while talking with Mary, but there is no "tension between them", only within them.

Counselor Responses and Corresponding Counselee Remarks

Counselee Remark	**Counselor Response**
"I can't"	"Do you mean each can, or want to?" or "Everything? Are you sure?"
"I could"	"Did you really try? How many ways? How consistently? What did you do?"
"I've tried that but it didn't work."	"Precisely, what did you do?"
"I did my best"	"What you did. Tell me precisely what you did."
"No one believes me, etc."	"Did you do what God seemed to direct you to do?"
"I could never do that."	"Can you think of one person who doesn't believe you?"
"If I had the time, I'd do it."	"I believe you. Really, how long do you suppose it would take if you learned to just number each day? Take, for instance, 24 hours each day. We all depend on how you slice the pie. Now schedule that to honor God."
"Don't blame me…"	"Are you saying that you are not responsible to God? Who else would know the answer?"
"Don't ask me…"	"But I am asking you. That would be my answer. I think you would know the answer. That will help you by asking some other related questions, and perhaps we can come up with it."
Counselee Remark	Counselor Response
"I guess so."	What do you really question, or what do you believe (doubt)?
"You know how it is."	Pain is more fully seen in what you do.
"But I've prayed about it."	"Fine! Have you prayed… did you do?" (Then determine responsibility, what happened, and who acted first.)
"I'm at the end of my rope."	Perhaps you see your problem as a habit, needing only desire (or to quit the need).
"I have a need to…"	I'm sure you are; but Christ gives a new person.
"I'm just one of those people who…"	God says that we can be different.
"That's just the way I am."	Of course, that is what makes it so difficult.
"That's impossible."	Surely you can do some sort of serving so that it can be measured.

Counselee Remark	Counselor Response
"There are all sorts of objections to doing that."	Objections? What will it take to answer them?
"You can't teach an old dog new tricks."	Perhaps that is true—but you are in the image and news of God in Christ. He changes and works through people who abandon their "works."
"It'll never work."	If you are a child of God, as you claim, you will be increasingly filled with Him. You will begin to get used to forgiving and begin to do so.
"I'll never forgive him!"	Are you sure? (Quit if you are not sure. What about it?)
"I don't do anything halfway, so…"	No, you can change.
"Everything is against me."	No, the Bible says the opposite. In God's eyes you are "worthless" (Romans 1:18), or may I only discuss my emotions?
"How do you feel about…?"	May I tell you what I think, or may I only discuss emotions?

Language of Emotions and Action

1. Euphemisms and misunderstood words
2. Sin triggers negative emotions by immediate conscious thought and/or action, or by unconscious habits.
3. Feeling refers to a bodily state (I feel happy, I feel sad, I feel tired, I feel sick,…). Counselees may say, "I feel inferior, I feel stupid, or I feel inadequate". These are not feelings. They are value judgments about oneself. For example, when a woman says, "I feel ugly", her judgment on her appearance may produce a genuine feeling of sadness.
4. Attitude – a combination of presuppositions, beliefs, convictions and opinions that make up one's habitual stance at any given time toward an act, person, or subject.
5. Use Biblical definitions of terms, Biblical language, and Biblical measures of value to address these mistakes.

Sin is the problem

1. Counseling is spiritual warfare
2. Love is obedience first and feelings later. Acting contrary to one's feelings is not hypocrisy. In many cases, it is a duty.
3. Christian Decision Making
    a. Commandment-oriented – What does God want? Chooses present suffering to gain long-term benefits.
    b. Desire oriented – What do I want? Chooses present benefits which will result in long-term suffering.
4. To deny personal responsibility is the jettison hope.
5. Under the power of the Spirit, circumstances and attitudes can change dramatically and quickly.

Medical Illness and "Mental Illness."

As we have seen, one of the key tenets of Biblical counseling is that mental illness is a metaphor. Labeling a set of symptoms and durations approved by experts as a disease can be useful to communicate and to bill. However, unlike influenza or automobile trauma, for which an organism and a mechanism can be identified, mental health illnesses have neither. Research done on people with "mental health" complaints nearly exclusively uses the language of the DSM5-TR as noted above.

Calling sets of symptoms "mental illnesses" comes from a naturalistic origin, meaning that they ignore God and the real moral nature of man. This "medical" paradigm is built on a godless anthropology, which makes man helpless to change. They allow everyone involved, patients, families, and caregivers, to avoid moral censure for their actions because "it is a disease, and so it's not my fault." Excluding God also denies the healing power of God to improve situations.

The following section covers common serious medical illnesses, their impact on "mental health", and "mental health's" impact on them.

Medical Illness - Cancer[11]

Cancer is a generic term for a large group of diseases that can affect any part of the body. Other terms used are malignant tumors and neoplasms. One defining feature of cancer is the rapid creation of abnormal cells that grow beyond their usual boundaries, and which can then invade adjoining parts of the body and spread to other organs; the latter process is referred to as metastasis. Widespread metastases are the primary cause of death from cancer.

Cancer is a leading cause of death worldwide, accounting for nearly 10 million deaths in 2020, or nearly one in six deaths. The most common cancers are breast, lung, colon and rectum, and prostate cancers. Around one-third of deaths from cancer are due to tobacco use, high body mass index, alcohol consumption, low fruit and vegetable intake, and lack of physical activity. In addition, air pollution is an important risk factor for lung cancer. Cancer-causing infections, such as human papillomavirus (HPV) and hepatitis, are responsible for approximately 30% of cancer cases in low- and lower-middle-income countries. Many cancers can be cured if detected early and treated effectively.

Cancer-related mental health disorders include anxiety and fear, depression, and mood disorders.[12]

Medical Illness – Cardiovascular Disease[13]

Cardiovascular diseases (CVDs) are the leading cause of death globally. An estimated 19.8 million people died from CVDs in 2022, representing approximately 32% of all global deaths. Of these deaths, 85% were due to heart attack and stroke. Over three quarters of CVD deaths take place in low- and middle-income countries.

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[11] Cancer, World Health Organization, https://www.who.int/news-room/fact-sheets/detail/cancer.
[12] The Impact of Cancer on Mental Health and the Importance of Supportive Services, https://pmc.ncbi.nlm.nih.gov/articles/PMC11368479/.
[13] Cardiovascular Disease, World Health Organization, https://www.who.int/news-room/fact-sheets/detail/cardiovascular-diseases-(cvds).

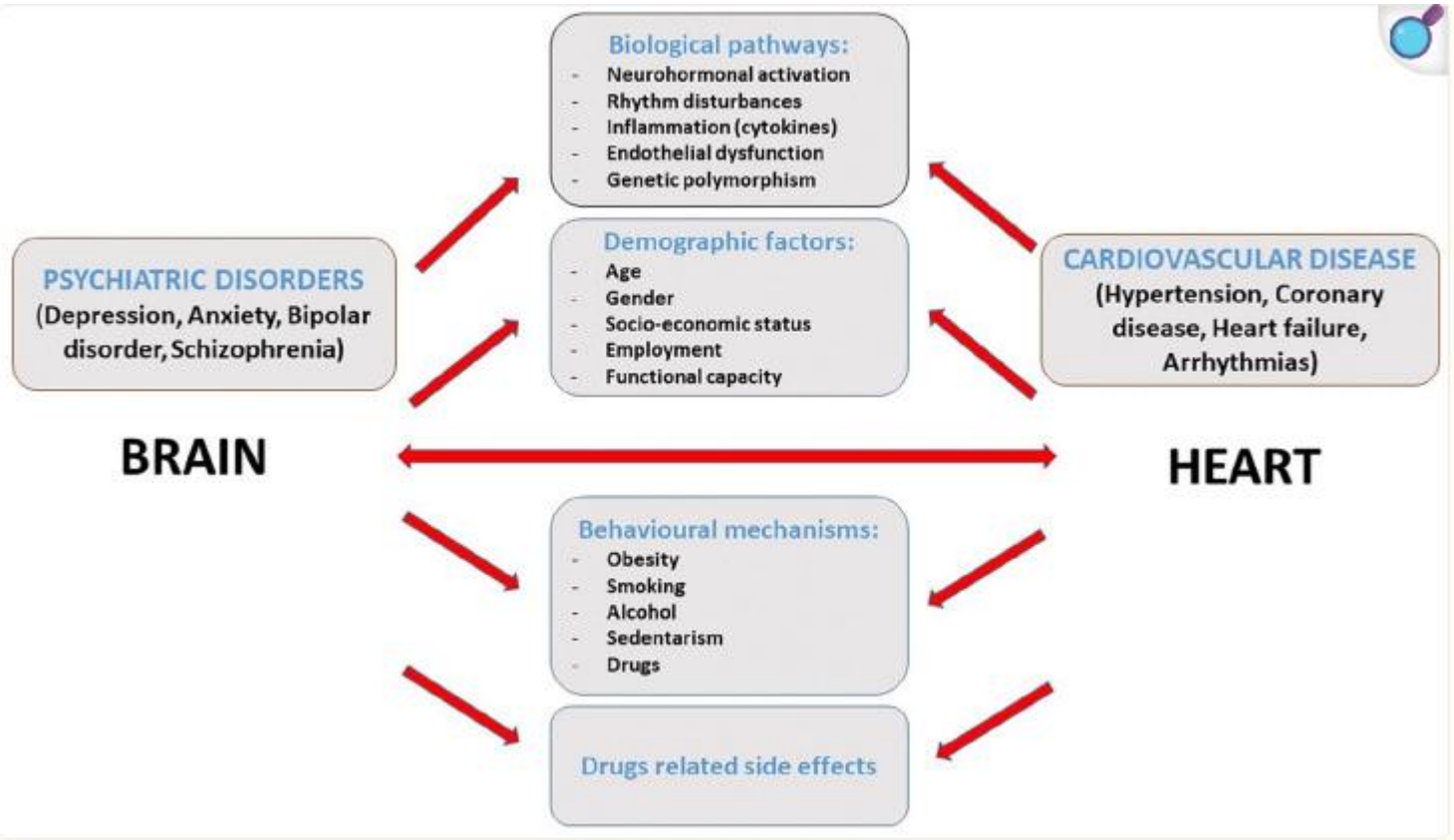
Out of the 18 million premature deaths (under the age of 70) due to noncommunicable diseases in 2021, at least 38% were caused by CVDs.

Most cardiovascular diseases can be prevented by addressing behavioral and environmental risk factors such as tobacco use, unhealthy diet (including excess salt, sugar, and fats), obesity, physical inactivity, harmful use of alcohol and air pollution. It is important to detect cardiovascular disease as early as possible so that management with counselling and medicines can begin.

Impact of Mental Health concerns on cardiovascular disease[14]

Anxiety	Depression	Bipolar disorder	Schizophrenia	Stress disorders
↑ Hospitalization for CVD ↑ Acute myocardial infarction ↑ Future IHD (in youth <20 years old)	Moderate risk for accelerated atherosclerosis ↑ Risk of early CVD ↑ Risk of CVD mortality ↑ Symptom burden and CVD events Strong association between clinical depression and future coronary disease	Moderate risk for accelerated atherosclerosis ↑ CV mortalilty ratio, greatest in young adults ↑ Symptom burden ↑ Incidence of CVD diagnosis in young age	↑ CAD and cerebrovascular disease ↑ CV mortality ↑ CV risk factors	↑ Activation of autonomic system ↑ Inflammation ↑ CV events ↑ CV mortality

Theorized mechanisms for how psychiatric disorders impact cardiovascular disease and vice versa.[15]



[14] Cardiovascular disease and psychiatric disorders: An-up-to date review, https://pmc.ncbi.nlm.nih.gov/articles/PMC11468319/.
[15] Cardiovascular disease and psychiatric disorders: An-up-to date review, https://pmc.ncbi.nlm.nih.gov/articles/PMC11468319/.

Medical Illness - Diabetes[16]

Type 1 diabetes (previously known as insulin-dependent, juvenile, or childhood-onset) is characterized by deficient insulin production and requires daily administration of insulin. In 2017, there were 9 million people with type 1 diabetes; the majority of them live in high-income countries. Neither its cause nor the means to prevent it are known.

Type 2 diabetes affects how your body uses sugar (glucose) for energy. It prevents the body from using insulin properly, which can lead to high blood sugar levels if left untreated. Over time, type 2 diabetes can cause serious damage to the body, especially nerves and blood vessels.

Type 2 diabetes is often preventable. Factors that contribute to developing type 2 diabetes include being overweight, not getting enough exercise, and genetics. Early diagnosis is important to prevent the worst effects of type 2 diabetes. The best way to detect diabetes early is to get regular check-ups and blood tests with a healthcare provider.

Symptoms of type 2 diabetes can be mild. They may take several years to be noticed. Symptoms may be similar to those of type 1 diabetes but are often less marked. As a result, the disease may be diagnosed several years after onset, after complications have already arisen.

More than 95% of people with diabetes have type 2 diabetes. Type 2 diabetes was formerly called non-insulin dependent, or adult onset. Until recently, this type of diabetes was seen only in adults but it is now also occurring increasingly frequently in children.

Gestational diabetes is hyperglycaemia with blood glucose values above normal but below those diagnostic of diabetes. Gestational diabetes occurs during pregnancy. Women with gestational diabetes are at an increased risk of complications during pregnancy and at delivery. These women and possibly their children are also at increased risk of type 2 diabetes in the future. Gestational diabetes is diagnosed through prenatal screening, rather than through reported symptoms.

Depression, anxiety, and schizophrenia are all things that are linked to the mental health of diabetics.

Medical Illness – Infectious Disease

Infectious diseases are caused by pathogenic microorganisms, such as bacteria, viruses, parasites or fungi; the diseases can be spread, directly or indirectly, from one person to another. These diseases can be grouped in three categories: diseases which cause high levels of mortality (like Ebola); diseases which place on populations heavy burdens of disability (like malaria); and diseases which owing to the rapid and unexpected nature of their spread can have serious global repercussions (like COVID). Many of the key determinants of health and the causes of infectious diseases lie outside the direct control of the health sector. Other sectors involved are those dealing with sanitation and water supply, environmental and climate change, education, agriculture, trade, tourism, transport, industrial development, and housing.

[16] Diabetes, World Health Organization, https://www.who.int/news-room/fact-sheets/detail/diabetes.

Medical Illness – Respiratory Disease (Chronic)[17]

The two most common chronic respiratory diseases are **asthma** and **chronic obstructive pulmonary disease** (COPD). These both affect the airways in the lungs. Asthma and COPD may be prevented by reducing or avoiding exposure to these risk factors.

Asthma is characterized by recurrent attacks of breathlessness and wheezing due to airway narrowing, which vary in severity and frequency from person to person. Symptoms may occur several times in a day or week in affected individuals, and for some people symptoms become worse during physical activity or at night. Asthma is the most common chronic disease among children.

In asthma, the airway obstruction is reversible with inhaled medicines, but in COPD it is mostly fixed. COPD only affects adults and usually becomes worse with time. The most common symptoms of COPD are breathlessness or a need for air, sputum production and a chronic cough. Risk factors for chronic respiratory diseases include tobacco smoking (including second-hand smoke), air pollution, allergens and occupational risks. Outdoor air pollution and indoor air pollution (often caused by cooking with solid fuels) are also common causes.

Discussion 2[18]

Please read the following story and discuss as a class how you would handle it as a counselor.

“You need to leave him!” Mary said. She was tying a bandage on her neighbor Ann's arm after Ann's husband had beaten her yet again. Ann had been married for three years. For the first year of their marriage, Ann and Joe were happy together. They were both Christians— Joe having come to Christ in recent years out of a troubled past. As a child, he saw his father beat his mother all the time. Problems erupted for Ann and Joe when two things happened at once: Ann gave birth to a baby boy who cried all the time, and Joe lost his job.

Joe chose to respond to these problems by going out and drinking with his friends. When he came home, Ann smelled perfume on his clothes. He also became angry more easily, especially as he had to face finding another job.

Ann tried to do things to please Joe, but whatever she did just seemed to irritate him more. He began to shout at her a lot. ‘There was little money coming in for food, so Ann found a part-time job and someone to care for the baby, but this only seemed to make things worse. He kept telling her that she was a bad wife and mother.

One night, Joe came home drunk and hit her so hard that she fell against a table and broke her arm. Joe was beside himself as he took her to the hospital. He said over and over, “I didn’t mean to do that! Please forgive me and don’t tell the doctor!” Ann still loved Joe and thought that maybe now he would change, so she told the doctor that she had tripped and fallen.

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[17] Chronic Respiratory Disease, World Health Organization,
[18] Every Christian Counsels, https://www.psalm88.org/case-studies/.

Then for a few weeks, Joe didn't hit Ann, but his anger came out in harsh words. He said, "You're so stupid. You can't even look after the baby properly!" She began to think she should leave him for the sake of the baby, but then she thought, "How could I live without Joe? I'm so stupid. How could I earn enough money to survive? Besides, our pastor said that wives should submit to their husbands as the head of the home!" Just then, Joe came and said he was sorry for yelling at her again, and they made up. Ann lived for those brief moments.

Before long, Joe came home drunk again. The baby was crying when he walked in the door. First he hit Ann hard, and then he said, "that stupid baby! He picked up the little boy and slapped him. The baby screamed louder. Ann grabbed the baby from his arms and ran outside. Joe followed her, yelling.

Ann banged on Mary's door. As soon as it opened, she jumped inside. "Don't let Joe in!" she gasped. Mary's husband barred the door as Joe tried to bash it in. After a few minutes, he gave up and walked back to his house, kicking the neighbor's dog as he went.

Ann had finally had enough! Mary suggested that Ann ask a kind older lady in the church if she could stay with her for the moment. Ann agreed to that, and the woman was happy to welcome her right away. Mary's husband took Ann and her baby to the woman. Mary also suggested that Ann ask her pastor's wife to come see her the next day, and Ann agreed.

Case Study 2

Gather into groups of two or three. Based on your knowledge and experience, and what you have learned today, each group is to write a case study about anxiety in a minister who needs you. Spend up to 15 minutes writing the case study. You have great flexibility in this case study.

As a group, present your case study to the rest of the class. Discuss how you would counsel him, and get feedback from each group on how they would counsel this pastor.

Day 3 – The Process

1. Love in Counseling
2. Support, Sympathy, and Empathy
3. Motivation for Change
4. Effecting Biblical Change
5. Dehabituation and Rehabituation
6. Getting Started
7. Goals and Terminal Dates
8. Two Basic Approaches
9. How to Gather Data
10. How to Ask Questions
11. Helping
12. Analyzing
13. Details on and Ways of Using Homework
14. Gifts
15. Interpreting Counselee Data

Love in Counseling

1. The overarching purpose of preaching and counseling is God's glory. Love, required for His glory, is following His commandments.
2. The Bible never calls us to love ourselves. We are only told to love God and our neighbors. One's satisfaction with himself is a by product of what he gives, under God, to others.
3. A Christian's identity is found in God alone. He wants and needs nothing else. In fact, there is nothing more than God. The key is to abandon, not affirm, oneself.
4. Repentance requires behavior change.
5. In the world, love just happens. Also, love is all about getting. In Christ, love is all about giving.
6. Love is always under control.
7. If a home has no love, it is the fault of the husband, for he is the leader of the home. He takes the initiative in love, and his wife and children respond. Even if the wife does not respond, keep loving.

Support, Sympathy, and Empathy

1. Struggling through the problems helps the counselee come to grips with it in Biblical terms. The person can then act to improve the situation with the power of God.
2. Behavioral health texts will often tell the counselor to provide support. They mean "He should listen without trying to reflect feelings or interpret them. In this listening, he can assure her of his interest and his encouragement without committing himself as to whether he believes her ideas to be accurate or even true." "Support" communicates "I know there is no answer for your need, but I love you and will try to suffer through it with you. Such support is not Biblical
    a. Christian counselors never support sinful behavior.

    b. Support is harmful in that it acknowledges and approves of the failure of the counselee to handle his problem.
    c. Scriptures provide no evidence that a minister should passively stand by a person or problem without doing or saying anything.
2. Empathy comes from entering a problem so that it becomes your own.

Motivation for Change

1. Because of our high calling in Christ, we must live differently. We must live a life consistent with Him.
2. Use reward and punishment to motivate change.
3. Rewards should be given for genuine achievements and not for doing what the person already does.
4. Modeling, encouragement by example, is a strong motivator.
5. If one method has worked in the past and it is Biblically legitimate, use it.
6. Encourage additional reasons for action as necessary.
7. Motivation that is self-oriented or humanistic must be changed.

Effecting Biblical Change

1. Repentance includes a sorrow over past sins and a turn away from them.
2. Personality includes nature and nurture.
3. The change of an activity is not the same as the change of a person. Someone who has stolen something is a thief. Unless he has a change of heart and becomes a new person, he will still be a thief ten years from now, even if he steals nothing in the interval. If his heart changes, including a change in his way of life, he will stop being a thief at the time of his change.

Dehabituation and Rehabituation

1. The way to become a godly person is to stop bad habits and develop good habits in every area of life.
2. Counseling is not a solo endeavor.
3. Christians may give up because they want change too soon…change without the struggle.
4. Psychoactive medications provide the illusion of change, deadening a person without any real lifestyle change.
5. Prayerful, willing, and persistent obedience to God becomes part of us.
6. Elements involved in Biblical change
    a. Discovering the Biblical alternatives – a comprehensive knowledge of the Bible
    b. Structuring the whole situation for change – putting off people, places, and things.
    c. Breaking links in the chain of sin.
    d. Getting help from others
    e. Stressing her whole relationship with Christ.
    f. Practicing the new pattern.
7. Big fights over small problems
    a. The underlying problem is likely bigger than the small infraction the people are fighting about. Spilling milk on the counter is likely not the reason that a couple is considering divorce.

    b. The disputants are probably not seeking solutions. They are probably trying to prove themselves right and the other person wrong.
    c. People don't seek solutions to conflicts with others if they have not repented for their sins with others. Repentance for unforgiveness precedes reconciliation.
8. Getting help from others - Be honest about what help is needed, who should provide it, and when and how it should be given.
9. Rapid, radical change is possible when a counselee becomes aware of his sin, repents, and commits to change.
10. A new, good activity that is substituted for an old, bad activity accelerates the change and makes it permanent.
11. Successful counselees act differently towards the problem and only then begin to feel differently for the problem.
12. Change requires discipline.

Getting Started

1. Let parishioners know that you, as the pastor, are willing and able to counsel them.
2. Sermons directed to the whole congregation can build the foundation for counseling success. For example, a sermon on Proverbs 31:1-10, given to the whole congregation, may especially motivate someone to seek help for alcohol use.
3. The pastor's study at the church, with others around, during business hours, is the right place to counsel. The counselee's home is not the right place.
4. A counseling center
    a. Lacks the sacred space of a church
    b. Lacks the disciplinary role of a church
    c. Lacks the congregation, which can influence the counselee towards godliness.
    d. Lacks the chance to see the whole person, like the pastor can do at church.
5. Counseling cements and does not unglue relationships.

The First Session

1. Establish leadership and gain commitment.
2. The counselor should set the tone and direction of the counseling relationship.
3. Center the process on Christ and Scripture.
4. The session should begin with a clear grounding in biblical authority.
5. Discern whether the counselee is a Christian.
6. Encourage regular Bible reading and prayer if these habits are not already present.
7. Give hope.
8. The counselor should communicate that change is possible.
9. Address some initial problems or at least take first steps toward solutions.
10. Focus on solutions rather than only gathering information.
11. Assign homework that leads to early, biblically grounded success.
12. Enlist help from others when appropriate and begin involving additional parties if needed.

13. Identify the main problem(s) as early as possible.

Goals and Terminal Dates

1. All problems can be solved if done God's way. Improvement will come quickly and may even begin day one.
2. Timing
    a. The major issues should be defined by the sixth visit.
    b. By eight or ten weeks of counseling, solutions should be in place.
    c. Wrapping up no later than week twelve.
3. Objectives
    a. General – salvation, honor God, build up the Church, benefit the counselee
    b. Specific – what do I want for the counselee today, tomorrow, and next week…
    c. Common problems include the failure to complete homework and complications that have arisen from doing what is required.
    d. If assigning a homework task that will be hard, assign one or two alongside that should be easier to provide motivation.
    e. "Today I wanted you to do this, but your failure to accomplish your assignment for last week will hold us back." A statement like this can help motivate, explain slow or no progress, give hope, and place responsibility where it belongs.
    f. At the end of every session, reread all assignments before offering the final prayer.
    g. Talk, by itself, is rarely therapeutic. It must be combined with biblically responsible action.

Basic Approaches

1. Intensive Approach – The counselor focuses on one problem, typically a large and sensitive one.
2. Extensive Approach – The counselor tries to address the whole gamut of life.
    a. Make a list of any problem areas in your life that we failed to touch on today.
    b. What are the most important facts in these areas – sex, parenteral problems, and budget?

How to gather data

1. Core data
    a. Data given directly by the counselee
    b. Can be collected during the interview and also as homework.
    c. Ask specific questions that require answers beyond yes or no.
    d. Take notes. Rereading notes from past sessions can demonstrate trends.
    e. Counselors should not talk about others behind their backs, and should not allow counselees to do so.
    f. Talk to as many people involved as possible to get the full story.
2. Halo data

a. Visual and auditory cues, tactile (such as a clammy handshake demonstrating anxiety or fear), and olfactory (the smell of alcohol or marijuana).
b. Most accessible when the counselees are listening to others speak or thinking about a question.

Spiritual Gifts

1. Every believer has at least one spiritual gift. No one is useless.
2. There is a niche in the church for each person's gift.
3. The Church, the body of Christ, needs the particular gift and combination of gifts possessed by each person.
4. God made as you are

Asking Questions

1. What is your problem? What brought you here?
2. What have you done about it?
3. What do you want us to do?

Counselors and counselees must reach similar goals in order to make progress. Counselors must be sympathetic but also systematic.

Reasons people seek counseling

1. Advice on making simple decisions
2. Answers to troublesome questions
3. Anxiety, worry, and fear
4. Bizarre behavior
5. Conflicts with others
6. Crises, Failures, and Grief
7. Depression and guilt
8. Deteriorating interpersonal relationships
9. Drug and alcohol struggles
10. Family and marital trouble
11. Guidance in career planning
12. Nervous breakdown
13. Other unpleasant feelings
14. Perceptual distortions (like hallucinations)
15. Psychosomatic issues
16. Sexual problems
17. Thoughts and actions related to suicide
18. Troubles in school or work

Types of questions to ask

1. Avoid questions that can be answered with a single yes or no.
2. Ask questions that will eliminate extraneous material
3. Ask questions about specifics.

"What" is the standard question to acquire data. "How" asks for the mechanics behind what happened. "What for" tests motive, and "when" reveals contingencies. Counselors must watch for rambling responses and keep control of the session at all times.

Helping through homework

1. Desire-oriented life
2. Command-oriented life

3. Regular homework assignments set a pattern for the expectation of change
    a. Homework clarifies expectations
    b. Homework allows the counselor to do more counseling more rapidly.
    c. Homework keeps counselees from becoming dependent on the counselors.
    d. Homework provides the counselors and the counselee to gauge progress.

Interpreting Counselee Data

First the counselor must make sense of the data for himself or herself. Second, the counselor must determine what he or she will say to the counselee.

The process of interpreting data

1. Gather data
2. Interpret the data
3. Formulate a working interpretation of the data
4. Test the validity of the interpretation

Categories of data to collect

1. Physical – symptoms, organic disease or injury, lack of sleep, etc.
2. Resources – is this person a Christian (Holy Spirit, fellow Christians, church, other spiritual and social resources).
3. Emotions – What emotions does this person have? How much power does he or she feel that he or she has over those emotions?
4. Actions – what has the counselee tried to get better?
5. Concepts – what key things does the counselee believe? How do they square with truth?
6. History – how long has this person had these troubles?

What Biblical Category best describes this person? Is he or she saved or unsaved? Is this person spiritually mature or immature? Is he or she unruly, fainthearted, or weak?

What biblical language best describes the problems this person is experiencing?

What insights does the Bible say about proximate causes of this counselee's problems?

1. Conflict – James 4:1-2
2. Instability – James 1:8
3. Lying – Gen 18:1-15
4. Confusion – James 3:16
5. Fear – John 4:18
6. Insecurity – Prov 28:1
7. Bizarre behavior – 1 Sam 21:10-15, Dan 4:28-33
8. Worry or anxiety – Luke 10:38-42
9. Hypercritical – 3 Jan 9-10

What is the relationship of problems to each other?

1. What hindrances to biblical change exist in the counselee's life?

2. Why has this person failed to resolve their difficulties on their own?
3. What is their understanding of the problem(s)?
4. Have they failed to change because they don't want to or don't know how?
5. What environmental factors may worsen the problem?
6. What false ideas are exacerbating the problem?
7. What rewards are they receiving for their current behavior?

What does the person expect and desires from counseling? Are there any possible organic or physiological factors? Why does the person want to change? Have I (the counselor) experienced a similar situation? Have I (the counselor) counseled someone previously with a similar problem? Determine plausible reasons for the problem and consider the counselee's heart.

Test the validity of your interpretation

1. Review mental and written notes to confirm the information received
2. Imagine and consider other alternatives
3. Solicit additional information
4. Discuss the case with other experienced biblical counselors
5. Carefully explain your interpretation with the counselee and ask for their feedback

The Nature of Biblical Counseling

Biblically based

1. Practical
2. Comprehensive
3. Trustworthy – the finiteness and fallenness of man
4. Adequate

Biblically accurate

1. Know the meaning of Biblical words
2. Determine the meaning of a passage in its context
3. Interpret every passage in the context of its book, section, testament, and all of Scripture
4. Christocentric and evangelical
5. Action-oriented
6. Emphasize positive and negative – what to do and what not to do
7. Distinguish between divine directives and human suggestions

Biblically appropriate

1. The content should include addressing the counselee's immediate concerns
2. Using an appropriate method of instruction – lecture, observation, interviews, role-playing, experience, research, questions, discussion, assignments, evaluation, testimony, and illustration.
3. The counselor must have a deep knowledge of Scripture.

Inducement and Commitment

Defining commitment

1. Acknowledge personal responsibility for desires, motivations, thoughts, attitudes, words, feelings, and actions
2. Choose to look at circumstances (past and present) from a biblical view
3. Commit to eliminate whatever hinders biblical change – this will involve personal choice
4. Exert energy towards the goal
5. Persevere in obedience
6. Trust God for the strength and resources to change.

How to motivate counselees toward commitment

1. Teach people about their exalted position in Christ and how to live out their position
2. Recount God's promises
3. Give them specific, measurable, attainable, realistic, and time-determined goals
4. Provide specific instructions on how to attain these goals.
5. Show evidences of divine power.
6. Redirect their focus to God
7. Describe God's character and plan.

Evidence of resistance

1. Absenteeism
2. Failure to do homework
3. Distancing from the counselor
4. Threats
5. Intimidation
6. Manipulation – flattery, side-tracking the conversation (irrelevant arguments, trivial stories)

Church discipline for unrepentance in sin may be used.

Discussion 3

Please read the following story and discuss as a class how you would handle it as a counselor.

Pastor Jay has been working hard since two of the big factories in the town shut down. Many people lost their jobs and are losing their housing. Crime is increasing. People from his church are coming to him, and he has heard one heartbreaking story after another. He thinks that, as a pastor, he should always be ready to listen, to attend to their requests, and to try to help them find work and housing.

One of Pastor Jay's best friends, Manuel, also lost his job. Pastor Jay does all he can to help out, but with no income and no savings, sometimes Manuel's family has had to go to bed without dinner. One night while Manuel and his family were sleeping, two armed men broke in through their bedroom window. They put a gun to Manuel's head and warned the family members that if they moved, they would kill them. The family stayed completely still while they watched the men take all their food and valuables. Since then, they all sleep in one room at night. Manuel often wakes up afraid, and then realizes that it was only a dream. Manuel came to Pastor Jay and told him about the attack in great detail.

Since Manuel's visit, Pastor Jay cannot stop thinking about what his friend told him. He is not sleeping well. He wakes at the slightest sound. He has lost his energy and gets up very tired. Last week, he woke up three times with terrifying nightmares of robbers breaking into his home and holding him up at gunpoint. He feels like a failure as a pastor and doesn't like preaching anymore. He is thinking of resigning.

Pastor Jay's wife is concerned because he rarely speaks to her. Yesterday, he was distracted by his thoughts and had an accident. He broke his leg, and his car was totally wrecked.

Case Study 3

Gather into groups of two or three. Based on your knowledge and experience, and what you have learned today, each group is to write a case study about PTSD in a minister who needs you. Spend up to 15 minutes writing the case study. You have great flexibility in this case study.

As a group, present your case study to the rest of the class. Discuss how you would counsel him, and get feedback from each group on how they would counsel this pastor.

Day 4 – Specific Conditions

Modern psychology and psychiatry see the human being as purely material, a highly evolved animal, with no non-material existence. A 19th-century incident demonstrates the idea that material incidents determine, not only influence, personality and other aspects of life previously understood as the “soul.”

The case of Phineas Gage[19]

Phineas Gage survived a severe brain injury in 1848 when an iron rod pierced his skull, profoundly influencing the study of brain function and personality.

Early Life and Career

Phineas P. Gage was born in July 1823 in New Hampshire and grew up on a family farm. He was described as healthy, strong, and energetic, with a well-developed muscular system and an "iron will" by his physician, John Martyn Harlow. Gage worked with explosives from a young age and became a railroad construction foreman, known for his skill and reliability in handling blasting operations.

The Accident

On September 13, 1848, while preparing explosives for the Hudson River Railroad near Cavendish, Vermont, Gage tamped down gunpowder with a 43-inch, 13-pound iron rod. The powder detonated unexpectedly, propelling the rod through his left cheek, behind his eye, and out the top of his skull, destroying much of his left frontal lobe. Remarkably, Gage remained conscious, spoke immediately after the accident, and walked to a cart that transported him to a local doctor. Some accounts suggest small amounts of brain tissue were expelled, though the extent is uncertain. By October, he was walking and talking again. Physically, he appeared to regain his strength. Mentally and emotionally, however, something had changed.

Personality and Behavioral Changes

Following the injury, Gage reportedly underwent significant personality changes. Previously responsible and well-liked, he became impulsive, irreverent, and exhibited poor judgment, leading friends to remark that he was "no longer Gage". These changes were linked to damage in the prefrontal cortex, highlighting the role of the frontal lobe in decision-making, social behavior, and personality. Modern research suggests that while early reports exaggerated his behavioral changes, Gage eventually regained social and occupational functionality, working later as a stagecoach driver in Chile.

Accounts tend to polish Gage’s pre-accident image as an upstanding citizen while presenting an almost cartoonishly perturbed version post-injury – neither in keeping with Harlow’s more nuanced clinical descriptions. This likely reflects enthusiasm for fitting Gage’s case to localization theories.

Scientific and Historical Significance

Gage’s case became a landmark in neuroscience and psychology, providing early evidence that specific brain regions influence personality and behavior. It challenged 19th-century views of the brain as a uniform organ

[19] Phineas Gage: His Accident and Impact on Psychology, Olivia Guy-Evans, MSc, Updated on May 19, 2025, https://www.simplypsychology.org/phineas-gage.html.

and contributed to the understanding of cerebral localization. His skull and the tamping iron are preserved at Harvard's Warren Anatomical Museum, symbolizing the enduring impact of his case on medical and psychological studies.

Modern Studies

In the 1990s and 2000s, researchers used neuroimaging and CT scans to reconstruct Gage's skull and estimate the trajectory of the rod. Damasio et al. (1994) suggested that the damage extended to both the left and right prefrontal cortices, which are involved in emotional regulation and rational decision-making. Ratiu et al. (2004) generated three-dimensional reconstructions of the skull using computed tomography scans (CAT) and found that the extent of the brain injury was limited to the left frontal lobe only and did not extend to the right lobe. Van Horn et al. (2012) supported Ratiu et al. (2004), who concluded that the rod only damaged the left frontal lobe and not the right. Van Horn's team also found that Gage likely lost 11% of his white matter and 4% of his grey matter—enough to affect thinking and behavior, but not to prevent functional recovery.

Legacy

Phineas Gage remains a central figure in neurology, psychology, and neuroscience education. His story illustrates the brain's role in personality, the effects of frontal lobe damage, and the potential for recovery after severe injury. Despite myths and embellishments, his case continues to inform research on brain-behavior relationships and the resilience of human cognition.

The Example of Psalm 19

Verses 1-6 – General revelation

- God's Handiwork declares His Glory
- People in every land and culture can see God through His creation.

Verse 7-14 – Special revelation

The Word of God refreshes life, grants depth of insight, renders joy to the heart, opens the eyes of understanding, and never gets stale.

Secular Psychology, a Review

The process by which secular psychology, counseling, and other mental health disciplines practice is as follows:

- A person develops a certain set of symptoms or observable behaviors.
- These symptoms are displeasing to the individual and most likely interfere with social, educational, or occupational functioning. If there is no displeasure, there is no problem.
- The person goes to see a mental health practitioner.
- The practitioner listens to all the symptoms that the person has and the duration of time that he or she has had these symptoms (and/or) observable behaviors.

- The practitioner compares this patient's concerns with a reference guide, typically in the US, the DSM-5-TR. He or she determines which diagnosis (label) best matches the patient's symptoms, observable behaviors, and duration. Then the practitioner assigns that label to that person.
- For example, a person who enters a counseling office complaining of feeling sad, poor sleep, loss of interest in activities, impaired function, and other similar symptoms, for a period of two months, in the absence of major personal trauma, may be labeled (diagnosed) as having major depression. There is no physical exam finding, lab test, imaging, or other objective study that can prove the diagnosis (label) of major depression. Even less, no physical exam finding, lab test, imaging, or other objective study can identify the cause of major depression. The opinions of a panel of "experts" assign the labels (diagnoses).
- The practitioner then tells the patient what the diagnosis is and recommends treatment.
- Finally, the practitioner notes all of this in the patient's medical record. The medical record is used for follow-up care, to communicate with other healthcare professionals, to bill insurance, and to defend the practitioner and the facility in case of complaints, civil liability, or criminal charges.
- The patient leaves with a diagnosis that promises to explain his or her condition. He or she likely has a prescription for an antidepressant and a referral to a psychologist or counselor. The patient will likely use the medication for years, if not for his or her entire life, thus ensuring another long-term income stream for the pharmaceutical company. The counseling typically lasts several weeks.
- The patient feels that he or she has a "condition" or a "disease" and therefore whatever troubles are not his or her fault.

There are significant problems with this from a Biblical counseling standpoint.

- Such a system ignores the Lordship of Christ and the power of the Word. Instead, it looks to secular psychology and drugs.
- Patients think of God as a cosmic psychologist.
- They lose hope and descend into despair.
- They become discouraged because unbiblical labels encourage people to think that solutions are humanistic.

Plan for Counseling[20]

Biblical counselors will encounter counselees (patients) with common conditions such as depression, anxiety, and PTSD. Specifics on how to care for people with these conditions is as follows.

Five-Step Biblical Counseling Plan	Notes	**Four-Step Secular (Medical) Counseling Plan**	Notes
What is the counselee's relationship with God?		What are the counselee's feelings/beliefs on spirituality?	May or may not ask
What is the problem (multiple sources)?	Judgment required according to the Word of God	What is the problem (multiple sources)?	Non-judgmental, no strict moral standards
What resources are available to solve the problem?	The Almighty and His creation	What resources are available to solve the problem?	Secular or spiritual, but nothing about God
How can these resources be used to solve the problem?		How can these resources be used to solve the problem?	
What will life look like once the problem is solved?	Godliness	What will life look like once the problem is solved?	Self-fulfillment

[20] This plan can be used to analyze historical, including Biblical, characters as well.

Anger

What is it?

Anger is a strong feeling of displeasure and belligerence aroused by a wrong, wrath, and ire. Like fear, anger is not always wrong and may be productive. Sinful anger is prominent in perhaps 90% of all counseling problems. Righteous anger can become unrighteous anger if the person ventilates it (unloads on others) or internalizes it (blows up and clams up).

The Bible

1. Ventilation – Prov 14:17, 14:29, 15:18, 19:11,19:19, 22:24-25, 25:28, 29:11, 29:20, and 29:22
2. Internalization- Eph 4:27

The World – Symptoms of problematic anger

1. Difficulties managing and expressing emotion in healthy ways
2. Problems in social, romantic, or work relationships because of behaviors stemming from anger
3. Substance misuse and/or addiction
4. Turning anger toward the self through self-harm or social withdrawal
5. The ability to work or study is impacted by anger or related behavior
6. Difficulty negotiating or coming to an agreement with others calmly
7. Anger is intense and/or occurs very often
8. Being very quick to rise to anger
9. Angry feelings continue for a long time
10. Getting very angry or violent when drinking alcohol
11. Violent, antisocial, or aggressive behavior
12. Encountering issues with law enforcement due to anger-related behaviors (Lench, 2004; Priory, 2020; Thomas, 2001)

DSM-5-TR has many conditions associated with anger

1. Intermittent Explosive Disorder
2. Attention-deficit/hyperactivity disorder
3. Conduct disorder
4. Oppositional defiant disorder
5. Autism spectrum disorder

What do we do about it?

The Bible

1. Look for a root cause in each case of anger
2. The angry person must repent and ask forgiveness from the Lord and from those he has harmed.
3. He or she must change his or her lifestyle to minimize anger recidivism. Something new and better must be erected on the ground just cleared.
4. If a relationship is involved, such as a husband and wife, identify each person's responsibilities before God. Begin with each partner pointing at themselves, not at the other partner. End with mutual understanding, repentance, and forgiveness.

5. Reconciliation takes precedence over worship
6. A counseling session is not the place to vent ones spleen against another. Doing so is in direct violation of God's law (Eph 4:29)
7. Direct comments towards the problem, not the person.
8. There are two problems in any relational conflict. The first is the issue about which the parties differ. The second is the attitudes and relationship towards one another.

The World

1. Medications – SSRI, SNRI
2. Non medication therapy
    a. Cognitive Behavioral Therapy
    b. Anger management
        i. Relaxation
        ii. Stress inoculation – role play an internal dialogue of a potentially anger-inducing situation, but figure out how to avoid anger
        iii. Cognitive restructuring - recognize dysfunctional or biased beliefs and thinking processes that lead to anger
        iv. Social skills training

Envy, Brooding, Fretting, and Self-Pity

What are they?

1. Envy - a feeling of discontented or resentful longing aroused by someone else's possessions, qualities, or luck
2. Brooding - preoccupied with depressing, morbid, or painful memories or thoughts. Brooding is thought without action.
3. Fretting - to feel or express worry, annoyance, discontent, or the like. See the section on anxiety.
4. Self-pity - a self-indulgent dwelling on one's own sorrows or misfortunes

The Bible addresses the danger (John 14:1-6). The DSM-5-TR diagnostic possibilities include brooding (rumination disorder, depression, anxiety), envy (narcissism), fretting (worry, anxiety), self-pity (depression)

What do we do about it?

Provide the counselee a biblical overview of these issues (Psalm 37, 73)

Envy

1. Pray for the welfare of those we envy
2. Looking for whatever good one can find in others
3. Encourage other people in their abilities

Brooding and Self-Pity

1. A concentration on self and one’s supposed rights
2. Usually a protest against God’s providence
3. It is typically part of a chain from self-pity to anger to bitterness to depression

The story of Elijah is a good example. After his great victory at Mount Carmel, Jezebel threatened Elijah’s life, and he ran. The prophet was physically exhausted and more discouraged than ever. God gave him sleep. Then He fed and watered him (1 Kings 19:5-8). Once Elijah’s physical needs were met, God gave him an assignment. Once Elijah arrived at Mount Horeb, thus completing the assignment, God met him, spoke to him, encouraged him, and gave him another assignment (1 Kings 19:9-18).

Whenever you start thinking useless thoughts

1. Take two minutes to think about it.
2. Conclude the two-minute prayer with thanks for what God will do about it.
3. Get up and get to work on a present responsibility.

Depression and Bipolar Disorder

Depression comes from a cyclical process in which the initial problem, like guilt, sin, self-pity, jealousy, or a turn in circumstances, is mishandled, leading to a downward spiral into despair. This downward cycle leads from a problem to a sinful response to persistent, enslaving sin. The Biblical story of Cain is a good example.

1. Cain gave a lesser sacrifice
2. Cain grew angry
3. Cain let his anger fester and grow, despite being warned by God
4. Cain committed a much greater sin.
5. Cain never repented, but lived his life in disaster

Depression is a result of sin on the part of the counselee, but herein lies hope, because God forgives sin.

1. Check out complicating problems
2. Discover the initial problem and the sinful reaction to it.
3. Explain the dynamics of depression to the counselee and family.

Bipolar

There is no proof that bipolar disorder ever has an organic cause. There are various possibilities as to the origin of the corresponding bizarre behavior in each individual.

1. Camouflage – Bizarre behavior is simulated to gain something for oneself from others.
2. Sinful solutions to depression – an attempt to overcome depression
    a. Elation as overcorrection – highly emotional events are common
    b. Elation as a solution – a “laugh when you are down” attitude. While this sounds good, it lacks the power to overcome the hard times in life.
    c. Elation as denial – things are not so bad after all. This also lacks power in the toughest times.
    d. Elation as frantic straw grasping – attempt anything to feel better, even for a moment. Excessive risk-taking, spending money, and other acts are examples.
    e. Elation as one part of a way of life – a habit of pendulum emotions and pendulum living.

Offering help

1. Use the Word of God to bring counselees to repentance.
2. Reach the counselee while he or she is in a state of despair.
3. Teach the counselee how to handle problems biblically.
4. Do not minimize their hostility and guilt

Secular Treatment

Medication - serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), norepinephrine-dopamine reuptake inhibitors, and mirtazapine, an alpha-2 and 5-HT2 antagonist. Bupropion, escitalopram, mirtazapine, paroxetine, sertraline, and extended-release venlafaxine

Non-medication

1. Light therapy
2. Cognitive behavioral therapy – often includes as solutions the elation factors above.
3. Exercise

Schizophrenia

What is it?

Some patients with "schizophrenia" may only have a severe fear of a situation mixed with guilt for their part in it. For example, one patient who had a history of selling illegal drugs and gang membership, years afterward, had hallucinations of law enforcement agents and rival gang members stalking and eventually harming him. Hence, the lifestyle that he adopted early in his adult life intruded on his functioning years later.

Poor sleep is a common cause of hallucinations, which is a common finding in schizophrenia. A lack of sleep for 72 hours causes hallucinations similar to using the hallucinogen LSD. Chronic sleep loss is a plausible cause for many patient diagnoses of schizophrenia. Problems include:

1. Bad scheduling
2. Worry about unsolved problems
3. Bad habits – too much screen time just before bed
4. Failure to finish chores at the right time.
5. Late dating

Substance abuse is another reasonable cause.

What to do?

1. Get a good medical evaluation to rule out organic disease
2. Improve sleep hygiene and improve sleep.
3. Prayer for God's blessing on sleep
4. Hard exercise before retiring.
5. Relaxation exercises
6. Use night notes to capture thoughts
7. Address substance abuse

Secular treatments

Medications

1. First-generation antipsychotics - (chlorpromazine), thioxanthenes (e.g., thiothixene), and butyrophenones (e.g., haloperidol)
2. Second-generation antipsychotics - aripiprazole (Abilify), olanzapine (Zyprexa), paliperidone (Invega), quetiapine (Seroquel), risperidone (Risperdal)

Non-medication - cognitive behavior therapy for psychosis, psychoeducation, supported employment services, assertive community care, and family interventions

Sexual Dysfunction

Sexual dysfunction is a condition that prevents a person from experiencing satisfaction from sexual activity, affecting desire, arousal, orgasm, or causing pain during sex. Organic causes, such as abnormal anatomy, are uncommon and relatively straightforward to diagnose. Sexual dysfunction is usually the result of relationship difficulties between the partners. Worry, guilt, suspicion, jealousy, and fatigue are common.

Biblical teachings on sexuality

1. Within marriage, sexual relations are holy and good.
2. Pleasure in sexual relations is not sinful but assumed, as the bodies of each partner belong to each other (Prov 5:18-19, Song of Solomon)
3. One's sexuality is not self-oriented but other-oriented. The hope is to give to the other rather than take for oneself.
4. Sexual relations are regular and often enough to avoid sexual sin.
5. Each partner provides sexual satisfaction as often as the other partner desires.
6. Bargaining and withholding sexual opportunities within marriage is a sin.
7. Sexual partners are equal, and relations are reciprocal.

General Counseling Procedure

1. Discover the areas of conflict, both central and peripheral, that are impacting the sexual relationship.
2. Once the underlying conflict improves, sexual dysfunction also improves.
3. Work to improve the relationship in every area.
4. Determine what was wrong, how it was made better, and how to establish these fixes in the future.

Masturbation

1. Masturbation is a sin.
    a. It can achieve mastery over those who practice it (c.f. 1 Cor 6:12)
    b. It involves lust, which is similar to adultery in the eyes of God (Matt 5:27-28)
    c. It is not presented as a biblical option (1 Cor 7:9)
    d. It is self-pleasing and not focused on the pleasure of others (1 Cor 7:3-4)
2. Treatment involves explaining the biblical basis of sex to the counselee. The counselor should also talk through the problem from a biblical perspective. Include specific lifestyle changes that will help him or her eliminate masturbation in life.

Homosexuality

1. Homosexuality is a sin (Leviticus 18, Romans 1).
2. The desire as well as the act are sinful.
3. Like all sins, homosexuality grows from part of life to all of life in people who are enslaved to it.
4. It is not determined by genetic or social factors. Therefore, it has been covered by Jesus' sacrifice and dealt with like other sins.

What to do? The counselor will reassure the person that Christ handles all sin, even homosexuality. The counselee will respond with…

1. Christian conversion
2. Acknowledgment and confession of the sin of homosexuality leading to forgiveness.
3. Fruits appropriate to repentance.
    a. Break off all past associations or friendships made with other homosexuals.
    b. Restructure the course of life to avoid places in which homosexual contacts have been made.
    c. Restructuring all of life according to Biblical principles by the power of the Holy Spirit
    d. Less emphasis on sexual experience.
4. Lifelong celibacy or a heterosexual marriage.

Secular treatments

1. Medications – Bupropion, testosterone, estrogen
2. Non-medication - Cognitive behavioral therapy, directed masturbation
3. No treatment needed for homosexuality, as it is not considered a disease or a problem. In fact, treatment to change homosexuality is illegal and punishable in many US jurisdictions.

Fear and Anxiety

Fear can be defined as “an unpleasant emotion caused by the threat of danger, pain, or harm.” Fear is not necessarily wrong, as it serves as a warning and a defense mechanism against hazards. The fear that one feels when driving too fast is an adaptation, not a sin. However, a lot of fear is unreasoned and unreasonable (Prov 28:1, Leviticus 26:36). Restated, is the fear Biblically legitimate (fear of a lion) or illegitimate (fear of a test that a student has not studied for)?

As John says, fear involves punishment (1 John 4:17-18). Love is self-giving, while fear is self-protecting. Love moves towards others, and fear shrinks from others. Fear and love are inverse, as more of one produces less of the other. The ultimate fear is the fear of death.

A Christian might realize that his fear stems from a lack of love. For example, a talented musician may refuse to use his God-given gifts in church because of a lack of love for the people there. The same may be said for a powerful teacher. Using their spiritual gifts to serve the Body would build love and decrease fear.

In the Christian faith, the fear of the Lord refers to the awe that a creature shows to his Creator, and the terror that a criminal shows before his Judge. The Christian substitutes the gratitude of the forgiven for the guilt of the condemned.

There is no reference to phobias in the Bible. In some cases, a bad experience in a certain environment or being (person, animal, etc.) contributes to a fear of that environment or being. Other times, people use a fear of something (phobia) as a way to manipulate others, gaining attention and/or sympathy. A woman with bacteriophobia may refuse to change the diapers of her debilitated mother, thereby escaping an unpleasant but critical duty for her care.

To diminish a fear, the counselor must correctly identify the fear

1. Does the fear arise from an object that is legitimately fear-inducing?
2. Is the experience of fear associated with what should be a non-fearful object?
3. Does the presence of certain persons, places, or things remind the counselee of possible fearful consequences of his or her sin?
4. Has a way of life developed under truly fearful conditions that has persisted, although these conditions are no longer present?
5. Was the way of responding originally a manipulation that has now become reality?

Evaluate the following stories by these criteria.

Story 1 - An elderly woman was treated for obstructive sleep apnea for several years. She refused to wear her CPAP mask because she found it uncomfortable. She tried many masks. For years, family members tried to get her to wear any CPAP mask, but despite the health benefits, the elderly woman refused. Recently, she was admitted to the intensive care unit for influenza A pneumonia. On discharge, she was given another CPAP mask for her breathing. Finding it unpleasant, she again refused.

Story 2 – A child was detonating firecrackers in his backyard. Hearing the explosions, the police responded with pistols drawn. Police with pistols are legitimately fear-inducing. Years later, the young man was arrested

and briefly jailed for possession of drugs. Again, he faced police with pistols. The young man developed a way of life to avoid the police at all costs, even decades later, when he could have used the help of law enforcement. His life is completely clean, and his environment dramatically altered. Even today, he rarely talks to a police officer, even in church, and would never share Christ with one.

Treatments for fear, or specifically, the anxiety often associated with it

In the secular world, in which religion or spirituality play little or no role, and practitioners don't know what to do with it, anxiety diagnosis and treatment involves:

Generalized Anxiety Disorder

1. Duration and Breadth of Worry

The worry must:

1. Occur more days than not
2. Persist for at least six months
3. Cover multiple domains (e.g., work, school, health, finances, relationships)

The duration prevents diagnosing GAD based on short-term stress or a single focused concern.

2. Difficulty Controlling the Worry

The person feels the worry is **intrusive**, **persistent**, and **not easily dismissed**. This distinguishes GAD from personality style or normal conscientiousness.

3. Physical and Cognitive Symptoms

At least **three out of six** symptoms must be present (only one for children):

1. Restlessness or feeling keyed up — the body is on alert.
2. Fatigue — chronic worry drains energy.
3. Concentration problems or blanking out — cognitive load from anxiety.
4. Irritability — emotional tension spills over.
5. Muscle tension — often neck, shoulders, jaw.
6. Sleep disturbance — trouble falling asleep, staying asleep, or feeling rested.

These symptoms show how anxiety affects both mind and body.

4. Functional Impairment

The anxiety must cause **meaningful disruption** in work, school, relationships, or daily functioning. This ensures the diagnosis reflects real-world impact.

5. Not Due to Substances or Medical Conditions

Examples: stimulant use, hyperthyroidism. This avoids misdiagnosis when anxiety is a symptom of something else.

6. Not Better Explained by Another Mental Disorder

The worry must not be primarily about:

1. Panic attacks
2. Social judgment
3. Contamination or compulsions
4. Separation
5. Trauma reminders
6. Body image
7. Health fears
8. Delusional beliefs

This ensures the diagnosis fits the *pattern* of GAD rather than another condition.

First-line treatment includes

1. Medication - (SSRIs and SNRIs), escitalopram (Lexapro), duloxetine (Cymbalta), venlafaxine, and pregabalin (Lyrica).
2. Psychotherapy - relaxation techniques; cognitive restructuring, including CBT; and exposure therapy

Post-Traumatic Stress Disorder

Here near the end, the question in this class remains, in this case in a PTSD context. While the DSM diagnostic criteria do present descriptive data, does the person who meets the criteria for the diagnosis actually have a mental disorder? Is there a better biblical description or label? Finally, is it possible that someone who meets the diagnostic criteria might not be impaired, but exhibiting normal responses to trauma?

What is it?

Post-traumatic stress disorder (PTSD) is a mental health condition that's caused by an extremely stressful or terrifying event — either being part of it or witnessing it. Symptoms may include flashbacks, nightmares, severe anxiety and uncontrollable thoughts about the event.

The Bible teaches that believers can take every thought captive (2 Cor. 10:5b), and this has been both surprising and encouraging for counselees in the context of .

1. Showing compassion - Matthew 4:14, Matthew 9:36, John 1:14, Romans 12:15, 2 Corinthians 1:3-4
2. Listening - Proverbs 18:13, Luke 24:15-19, James 1:19
3. Serving - Luke 10:33-34, John 13:13-14.1 Pet 4:9-10
4. Ministering scripture
5. Prayer - Matthew 14:23, Luke 22:31-32a, 1 Thessalonians 5:25, James 5:16

The World - PTSD Diagnostic Criteria (DSM-5-TR)

A. Trauma Exposure

The person must have experienced or been exposed to a traumatic event in at least one of these ways:

1. Directly experiencing it
2. Witnessing it happen to others
3. Learning it happened to a close family member or friend (must be violent or accidental)
4. Repeated/extreme exposure to details of trauma (e.g., first responders)[21]

B. Intrusion Symptoms (need 1+)

These begin after the trauma:

1. Intrusive, distressing memories[22]
2. Trauma-related nightmares[23]
3. Dissociative reactions (flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)[24]

[21] Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work-related.
[22] Note: in children older than six years repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
[23] Note: in children, there may be frightening dreams without recognizable content.
[24] Note: in children, trauma specific reenactment may occur in play.

4. Intense psychological distress when reminded of the trauma
5. Physical reactions to reminders

C. Avoidance (need 1+)

1. Avoiding thoughts, feelings, or memories of the trauma
2. Avoiding external reminders (people, places, conversations, activities)

D. Negative Changes in Thoughts & Mood (need 2+)

Examples include:

1. Memory gaps about the trauma
2. Persistent negative beliefs ("I'm bad," "The world is dangerous")
3. Distorted blame of self or others
4. Persistent negative emotions (fear, anger, guilt, shame)
5. Loss of interest in activities
6. Feeling detached from others
7. Inability to feel positive emotions

E. Arousal & Reactivity Changes (need 2+)

1. Irritability or angry outbursts
2. Reckless or self-destructive behavior
3. Hypervigilance
4. Exaggerated startle response
5. Difficulty concentrating
6. Sleep problems

F. Duration - Symptoms from B–E last more than 1 month.

G. Functional Impact - Symptoms cause significant distress or impairment in daily life.

H. Not Due to Substances or Medical Conditions - Symptoms cannot be explained by drugs, medication, or another medical issue.

Specifiers

With dissociative symptoms

1. **Depersonalization** (feeling detached from oneself)
2. **Derealization** (feeling the world is unreal)

With delayed expression

- Full criteria are not met until 6+ months after the trauma.

What do we do about it?

1. The Bible
2. The World
    a. Medications – SSRI, SNRI, tricyclic antidepressants, amytriptyline
    b. Therapy – trauma-focused CBT psychotherapy, stress inoculation training,

When present, also treat traumatic brain injury, sleep disturbance (sedative hypnotics), nightmares (prazosin), obstructive sleep apnea (CPAP), and behavioral health comorbidities such as alcohol use.

Discussion and Case Study

The focus of this discussion is PTSD. Rather than providing a case study, I would like each of you who has counseled a patient with PTSD to describe the case and what you did or are doing about it.

Conclusion

The Bible, the Word of God given to man, is sufficient for every need of man. The Holy Spirit indwells Christians to affect the work of the Bible and make each person more like Jesus Christ. The life purpose of each Christian is to glorify God and enjoy Him forever. Therefore, the goal of biblical counseling is not the whole health of the individual but individual transformation into the image of Christ.

Biblical counseling is built on the Bible. It rests on a scripturally sound anthropology rather than a specious, secular, materialistic one. While cooperating with physicians to ensure that physical maladies are addressed, and while open to using effective techniques, whatever the origin, the biblical counselor uses the Bible as primary authority and source.

Biblical counseling is for Christians. The natural man does not have the indwelling Holy Spirit and cannot understand the things of the Spirit (1 Cor 2:14). For non-Christians coming for care, the first step is to introduce them to Christ.

A summary of the findings of the studies and articles included in this systematic review.[25]

PPE, personal protective equipment; HCV, hepatitis C virus; NCDs, non-communicable diseases

Author names	Study title	Publication year	Summary of findings
McGinty E, Baller J, Azrin S, Juliano-Bult D, Daumit G	Quality of medical care for persons with serious mental illness: A comprehensive review.	2015	The study disclosed that persons with severe mental illnesses often receive poor quality healthcare services in comparison to the general population. This also includes lower rates of preventive care, screenings, and chronic condition management.
DeKock JH, Latham HA, Leslie SJ, et al.	A rapid review of the impact of COVID-19 on the mental health of healthcare workers: Implications for supporting psychological well-being.	2021	The study disclosed that increased levels of anxiety, depression, distress, and insomnia existed among healthcare workers, with the various risk factors contributing to such psychological health issues including closer contact with COVID-19 patients, concerns regarding the safety of one's family, underlying health conditions, and lack of PPE.
Thornton C, Chaisson LH, Bleasdale SC	Characteristics of pregnant women with syphilis and factors associated with congenital syphilis at a Chicago hospital.	2022	The study disclosed that a substantial proportion of the women diagnosed with syphilis were either inadequately treated or did not receive timely treatment. The major risk factors for congenital syphilis included insufficient and late prenatal care, substance abuse, and a sexually transmitted infections history. The study stressed the significance of early screening and treatment to prevent congenital syphilis, in addition to emphasizing the need for targeted interventions to tackle identified risk factors.

[25] The Impact of Infectious Diseases on Psychiatric Disorders: A Systematic Review, https://pmc.ncbi.nlm.nih.gov/articles/PMC11377121/.

Bransfield R, Cook M, Bransfield D	Proposed Lyme disease guidelines and psychiatric illnesses.	2019	The study disclosed the probable consequences of not recognizing the psychiatric manifestations of Lyme disease, including an increased risk of suicide, substance abuse, and violence. The study also highlighted the need for significant revisions to the guidelines, stressing the need for increasingly accurate diagnostic criteria and recognition of the severe mental health implications of Lyme disease
Bransfield R	Neuropsychiatric Lyme borreliosis: An overview with a focus on a specialty psychiatrist's clinical practice.	2018	The study disclosed that Lyme disease may result in a wider range of mental health issues, including anxiety, depression, bipolar disorder, and cognitive impairments. Such symptoms normally present alongside other physical complaints that may be exacerbated by different co-infections.
Abo-Al-Ela HG	Toxoplasmosis and psychiatric and neurological disorders: A step toward understanding parasite pathogenesis.	2020	The research disclosed how the *Toxoplasma gondii* parasite contributes to the pathogenesis of conditions that include schizophrenia, bipolar disorder, and neurodegenerative diseases. The study has further disclosed that *T. gondii* can alter neurotransmitter systems, immune responses, and brain function, potentially leading to behavioral and cognitive changes.
Adinolfi LE	Chronic hepatitis C virus infection and neurological and psychiatric disorders: An overview.	2015	The study explored the existing correlations between chronic HCV infection and an array of psychiatric and neurological disorders. It disclosed that a substantial percentage of individuals with chronic HCV tend to experience neuropsychiatric symptoms that include cognitive impairment, anxiety, depression, and fatigue. The conditions have been noted to result from the virus' neurotoxic effects, immune-mediated mechanisms, and metabolic disturbances.

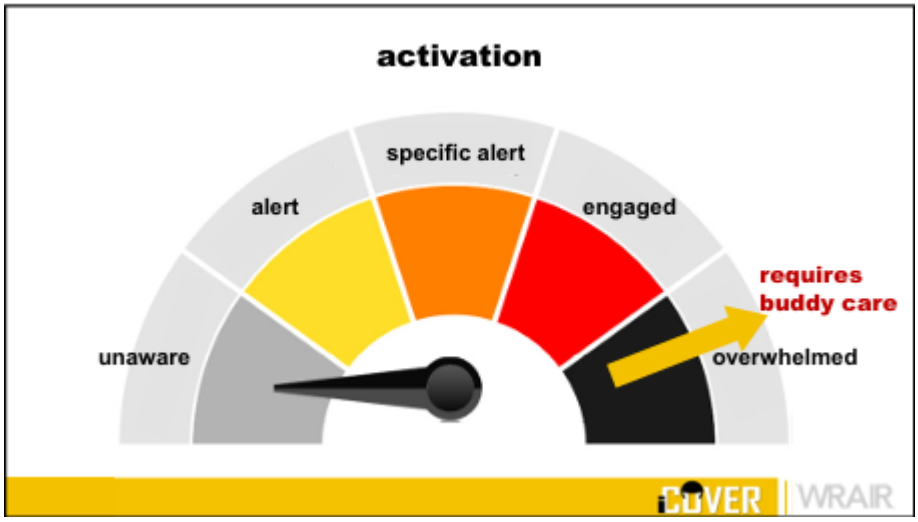
Serrano-Castro PJ, Estivill-Torrús G, Cabezudo-García P, et al.	Impact of SARS-CoV-2 infection on neurodegenerative and neuropsychiatric diseases: A delayed pandemic?	2020	The study disclosed that SARS-CoV-2 was a neuroinvasive virus capable of inducing a cytokine storm, which can have lasting effects on the central nervous system. Therefore, the researchers proposed that the virus may exacerbate or trigger the onset of neuro-inflammatory conditions, potentially leading to a delayed pandemic of neurodegenerative and neuropsychiatric disorders.
Klein RS, Garber C, Howard N	Infectious immunity in the central nervous system and brain function.	2017	The study has revealed how immune responses to infections may influence the CNS processes, potentially impacting brain function and behavior. The study also focused on the dual role of the immune system with regard to the protection of the brain from pathogens and contributing to neurological disorders when dysregulated.
De Picker LJ	The future of immunopsychiatry: Three milestones to clinical innovation.	2021	In outlining the emergence of the immune-psychiatry field, this study has highlighted three critical milestones required for the advancement of the field, including the definition of patient populations in the immune-psychiatric continuum, demonstration of clear clinical benefits, and integration of the findings with other biological psychiatry paradigms.
Bhaskar S, Bradley S, Israeli-Korn S, et al.	Chronic neurology in COVID-19 era: Clinical considerations and recommendations from the REPROGRAM consortium.	2020	In offering insights into the neurological complications linked to COVID-19, both chronic and acute, the study has disclosed that COVID-19 may result in various neurological issues, including Guillain-Barré syndrome, strokes, and encephalitis, among others.
Menzies RE, Menzies RG	Death anxiety in the time of COVID-19: Theoretical	2020	The study explored the effects of the COVID-19 pandemic on death anxiety, which is a type of existential distress regarding the fear

	explanations and clinical implications.		of death. The study disclosed that the pandemic intensified this anxiety as a result of increased exposure to death-linked cues, including the daily mortality statistics and various public health interventions such as mask-wearing.
Palmer K, Monaco A, Kivipelto M, et al.	The potential long-term impact of the COVID-19 outbreak on patients with non-communicable diseases in Europe: Consequences for healthy aging.	2020	The study explored the potential long-term impacts of the COVID-19 disease on patients with NCDs in Europe in relation to the outcomes for healthy aging. The study has disclosed that disruptions in healthcare services, delays in diagnoses, and reduction in management of chronic conditions during the pandemic were linked to the exacerbation of NCDs, resulting in poorer health outcomes and increased mortality rates.
Frontera JA, Simon NM:	Bridging knowledge gaps in the diagnosis and management of neuropsychiatric sequelae of COVID-19.	2022	The study disclosed that there was a significant association between neuropsychiatric sequelae and COVID-19, resulting in cognitive impairment, anxiety, and mood disorders. The study has emphasized the need for the performance of comprehensive research to enable the understanding of mechanisms driving such conditions in addition to advocating for standardized diagnostic criteria and treatment protocols.

Appendix 2 - ICover (US Army Acute Stress Reaction Training)[26]

Ukraine is a nation at war. Pastors, chaplains, counselors, and other leaders may find themselves ministering to others in highly stressful situations. A small number of these people, soldiers and civilians alike, will develop acute stress reactions that make it impossible to cope. iCover is intended to help these people retain their ability to act.

Stress levels (levels of activation) in human physiology



The protocol covers six steps which must be accomplished in less than sixty seconds for the purpose of restoring meaningful action in the person.

Step 1 - Identify a buddy in need.

First, assess the Soldier and confirm that they aren't physically injured. • It is important to check whether the Soldier has a serious physical injury. [NOTE: In that case, the priority would be Tactical Combat Casualty Care (TCCC). It is also possible that a Soldier may be physically injured and have an acute stress reaction at the same time. After TCCC, the Soldier may still benefit from iCOVER.]

Second, look for indicators that they are in the black and experiencing a functional collapse. He or she may be frozen (unable to move), dissociated (dazed, disoriented, or unable to connect), or agitated (hyperactive, panicky, behaving recklessly). If so, intervene.

Step 2 – Connect with the impaired person

1. Speak, make eye contact, or touch. This will help break the chaos of their interior experiences and transfer attention to external experiences.
2. Avoid using emotional or calming language. Instead, use a calm and composed tone. Be authoritative, clear, and mission-oriented.

Step 3 – Offer commitment

[26] iCover Protocol for Acute Stress Reaction, https://media.defense.gov/2023/Jun/02/2003234523/-1/-1/1/ICOVER-STAND-ALONE-TRAINING-WRAIR-V2%2028SEP22-FOR-DISTRO.PDF.

Assure them that you will stay with them. He or she is not alone.

Step 4- Verify facts

Ask two or three short, fact-based, specific questions about the situation. Ask easy questions that do not require a lot of cognitive effort for them.

Step 5 – Establish order of events

Explain in a few short sentences what happened, what is happening now, and what will happen. It's a kind of like a rapid SITREP to help get them reoriented

Step 6 – Request action

Give your buddy a specific, mission-related task that they can immediately accomplish. This serves two functions: it restores their sense of control and gets them back to mission effectiveness and the capability of your team

Resources (iCover)

1. US Army iCover Training Video https://www.bing.com/videos/riverview/relatedvideo?q=acute+stress+reaction+in+combat&&mid=032B738F2C75D5172774032B738F2C75D5172774&churl=https%3a%2f%2fwww.youtube.com%2fchannel%2fUCS02RtQk1lRgsOXg-XaDaLQ&FORM=VRDGAR.
2. Shapiro, E. (2012). EMDR and early psychological intervention following trauma. European Review of Applied Psychology, 62, 241-251. https://doi.org/10.1016/j.erap.2012.09.003
3. Adler, A. B., & Gutierrez, I. A. (2022). Acute stress reaction in combat: Emerging evidence and peer-based interventions. Current Psychiatry Reports, 24, 277– 284. https://doi.org/10.1007/s11920-022-01335-2
4. Adler, A. B., Svetlitzky, V., & Gutierrez, I. A. (2020). Post-traumatic stress disorder risk and witnessing team members in acute psychological stress during combat. BJPsych open, 6(5), e98. https://doi.org/10.1192/bjo.2020.81
5. Adler, A. B., & Gutierrez, I. A. (2022). Preparing soldiers to manage acute stress in combat: Acceptability, knowledge, and attitudes. Psychiatry, 85(1), 30-37. https://doi.org/10.1080/00332747.2021.2021598.

Appendix 3 - Phobias[27]

A

Ablutophobia: Fear of bathing

Achluophobia: Fear of darkness

Acrophobia: Fear of heights

Aerophobia: Fear of flying

Algophobia: Fear of pain

Agoraphobia: Fear of open spaces or crowds

Aichmophobia: Fear of needles or pointed objects

Amaxophobia: Fear of riding in a car

Androphobia: Fear of men

Anemophobia: Fear of air

Anginophobia: Fear of angina or choking

Angrophobia: Fear of anger

Anthrophobia: Fear of flowers

Anthropophobia: Fear of people or society

Aphenphosmphobia: Fear of being touched

Aquaphobia: Fear of water

Arachibutyrophobia: Fear of peanut butter

Arachnophobia: Fear of spiders

Arithmophobia: Fear of numbers

Astraphobia: Fear of thunder and lightning

Astrophobia: Fear of outer space

Ataxophobia: Fear of disorder or untidiness

Atelophobia: Fear of imperfection

Atychiphobia: Fear of failure

Automatonophobia: Fear of human-like figures

Autophobia: Fear of being alone

B

Bacteriophobia: Fear of bacteria

Barophobia: Fear of gravity

Bathmophobia: Fear of stairs or steep slopes

Batrachophobia: Fear of amphibians

Belonephobia: Fear of pins and needles

Bibliophobia: Fear of books

Botanophobia: Fear of plants

Bromidrophobia: Fear of smelling bad

C

Cacophobia: Fear of ugliness

Catagelophobia: Fear of being ridiculed

Catoptrophobia: Fear of mirrors

Chionophobia: Fear of snow

Chrometophobia: Fear of spending money

Chromophobia: Fear of colors

Chronomentrophobia: Fear of clocks

Chronophobia: Fear of time

Cibophobia: Fear of food

Claustrophobia: Fear of confined spaces

Cleithrophobia: Fear of being trapped

Climacophobia: Fear of climbing

Coulrophobia: Fear of clowns

Cyberphobia: Fear of computers

Cynophobia: Fear of dogs

D

Daemonophobia: Fear of demons

Decidophobia: Fear of making decisions

[27] List of Phobias: Common Phobias From A to Z, https://www.verywellmind.com/list-of-phobias-2795453.

Dementophobia: Fear of madness or insanity

Dendrophobia: Fear of trees

Dentophobia: Fear of dentists

Domatophobia: Fear of houses

Dysmorphophobia: Fear of deformity

Dystychiphobia: Fear of accidents

E

Ecophobia: Fear of the home

Elurophobia: Fear of cats

Emetophobia: Fear of vomiting

Enochlophobia: Fear of crowds

Entomophobia: Fear of insects

Ephebiphobia: Fear of teenagers

Erotophobia: Fear of sex

Equinophobia: Fear of horses

G

Gamophobia: Fear of marriage

Genophobia: Fear of sexual intercourse

Genuphobia: Fear of knees

Glossophobia: Fear of speaking in public

Gynophobia: Fear of women

H

Haphephobia: Fear of touch

Heliophobia: Fear of the sun

Hemophobia: Fear of blood

Herpetophobia: Fear of reptiles

Hexakosioihexekontahexaphobia: Fear of the number 666

Hippopotomonstrosesquipedaliophobia: Fear of long words

Hydrophobia: Fear of water

Hypochondria: Fear of illness

I

Iatrophobia: Fear of doctors

Insectophobia: Fear of insects

K

Koinoniphobia: Fear of rooms

Koumpounophobia: Fear of buttons

L

Leukophobia: Fear of the color white

Lilapsophobia: Fear of tornadoes and hurricanes

Lockiophobia: Fear of childbirth

M

Mageirocophobia: Fear of cooking

Megalophobia: Fear of large things

Melanophobia: Fear of the color black

Microphobia: Fear of small things

Mysophobia: Fear of dirt and germs

N

Necrophobia: Fear of death or dead things

Noctiphobia: Fear of the night

Nomophobia: Fear of being without your mobile phone

Nosocomephobia: Fear of hospitals

Nosophobia: Fear of disease

Nyctophobia: Fear of the dark

O

Obesophobia: Fear of gaining weight

Octophobia: Fear of the figure 8

Ombrophobia: Fear of rain

Ommetaphobia: Fear of eyes

Ophidiophobia: Fear of snakes

Ornithophobia: Fear of birds

Osmophobia: Fear of smells

Ostraconophobia: Fear of shellfish

P

Papyrophobia: Fear of paper

Paraphobia: Fear of sexual perversion

Pathophobia: Fear of disease

Pedophobia: Fear of children

Philematophobia: Fear of kissing

Philophobia: Fear of love

Phobophobia: Fear of phobias

Podophobia: Fear of feet

Porphyrophobia: Fear of the color purple

Pteridophobia: Fear of ferns

Pteromerhanophobia: Fear of flying

Pyrophobia: Fear of fire

S

Samhainophobia: Fear of Halloween

Scolionophobia: Fear of school

Scoptophobia: Fear of being stared at

Selenophobia: Fear of the moon

Siderodromophobia: Fear of trains

Sociophobia: Fear of social evaluation

Somniphobia: Fear of sleep

T

Tachophobia: Fear of speed

Technophobia: Fear of technology

Teraphobia: Fear of monsters

Thalassophobia: Fear of the ocean

Trichophobia: Fear of hair

Tonitrophobia: Fear of thunder

Trypanophobia: Fear of needles/injections

Trypophobia: Fear of holes

V-Z

Venustraphobia: Fear of beautiful women

Verminophobia: Fear of germs

Wiccaphobia: Fear of witches and witchcraft

Xanthophobia: Fear of the color yellow

Xenophobia: Fear of strangers or foreigners

Zoophobia: Fear of animals

Zuigerphobia: Fear of vacuum cleaners