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A Working Model for Integrating Two Basic Christian Concepts into Trauma-Focused Cognitive Behavioral Therapy

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Running head: A WORKING MODEL

A Working Model for Integrating Two Basic Christian Concepts into Trauma-Focused Cognitive

Behavioral Therapy

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ABSTRACT

Social workers and other clinicians have an opportunity to best meet the needs of children and parents working through trauma by utilizing innovative treatment methods in the therapy process. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an evidence-based practice with research suggesting effectiveness in reducing PTSD and anxiety symptoms. My working model combines TF-CBT components as outlined in the acronym PRACTICE, and the Christian components of prayer and worship. Comprehensive descriptions of both the TF-CBT components and each Christian component are described for educational purposes. The working model suggests powerful resources to utilize with both adult and child clients in a variety of clinical circumstances. Limitations and instructions to further research are also included to provide future considerations for clinicians upon integrating this working model into their TF-CBT practice.

Keywords: Trauma-Focused Cognitive Behavioral Therapy, Prayer, Worship

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INTRODUCTION

In this paper I will explain my development of a new model of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) integrating two Christian concepts throughout the therapy method. I will start by introducing TF-CBT, explaining who can receive the treatment, how a clinician can implement it, the goals of the treatment, study results of the therapy integration, and an in-depth description of each component. The TF-CBT components explained include psychoeducation, parenting skills, relaxation skills, affective regulation skills, cognitive processing skills, trauma-narration and processing, *in vivo* mastery of trauma reminders, conjoint parent-child sessions, and enhancing safety, formulating the acronym PRACTICE. I will then explain Christianity briefly, and provide in-depth descriptions of two Christian concepts: prayer and worship. Then I will describe the working model, which incorporates Christian components into TF-CBT. This will include therapist requirements to practice the model and the purpose of integrating prayer and worship into a clinician's practice of TF-CBT. Following the introduction of the working model, I will provide a case example with instructions on how to integrate prayer and worship into each of the components of TF-CBT. I will conclude by providing a limitations section and instructions for further research.

TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY CONCEPTS

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) was established in 2006 by Judith Cohen, Anthony Mannarino, and Esther Deblinger, all doctors with specializations in psychiatry and extended experience with children and trauma. TF-CBT is a trauma-sensitive treatment utilized in therapeutic settings, applying components and several models of human development to address the needs of children who have experienced trauma, and family members who are impacted by the trauma. Components follow the acronym PRACTICE, outlined in

Treating Trauma and Traumatic Grief in Children and Adolescents: A Clinician's Guide, created by the authors of the treatment themselves. The components include psychoeducation and parenting skills, relaxation, affective modulation, cognitive coping and processing, trauma narrative, *in vivo* mastery of trauma reminders, conjoint parent-child sessions, and enhancing future safety and development (Cohen, Mannarino, & Deblinger, 2006). A logic model for TF-CBT is located in Appendix A.

TF-CBT is specifically aimed to reduce symptoms of PTSD, targeting anxiety, depression, and related issues present due to these ailments. Children and an unoffending caregiving adult can take part in TF-CBT treatment. Both individuals' therapy process has similar steps, aimed to aid in long-term healing from traumatic experiences and alleviate the effects present in both the child and subsequently the parent or close in relation adults' lives. These are integrated in separate sessions initially, then together with the parent and child at the close of the treatment. (Cohen et al., 2006).

Studies have shown TF-CBT to be effective in treating a variety of conditions. Cohen, Mannarino, and Knudsen studied the intervention's efficacy, specifically relating to youth with childhood traumatic grief (CTG), leading to the conclusion that individual treatment for children and parents is effective in reducing some PTSD and CTG symptoms (2004). In a study of girls who are both survivors of sexual abuse and living in a war-torn area, the fifteen-session treatment led to extensive decreases in both PTSD symptoms and psychosocial complications compared to the control group (O'Callaghan, McMullen, Shannon, Rafferty & Black, 2013). Another study of TF-CBT also points to improvements from affective disorders, schizophrenia symptoms, anxiety, depression, and behavioral problems, and increase in cognitive functioning (Cohen, Mannarino & Iyengar, 2011). A study in a community program environment proved TF-

CBT to be beneficial in long-term reduction of PTSD symptoms, leading to the conclusion that this treatment is helpful in community settings as well (Konanur, Muller, Cinamon, Thornback & Zorzella, 2015).

Therapists can become trained in TF-CBT by attending a training experience hosted by the developers or representative trainer, or by engaging in the web-based training. Additionally, consulting with an expert for continued guidance is highly recommended. The website for access to information on TF-CBT as well as certification requirements and opportunities is <https://tfcbt.org>.

Further descriptions of the components utilized in TF-CBT are below. All information is compiled from the original 2006 manual, *Treating Trauma and Traumatic Grief in Children and Adolescents: A Clinician's Guide*, published by the intervention's authors, Cohen, Mannarino, and Deblinger,

1. Psychoeducation
2. Relaxation Skills
3. Affective Regulation Skills
4. Cognitive Processing Skills
5. Trauma Narration & Processing
6. In Vivo Mastery of Trauma Reminders
7. Conjoint Parent-Child Sessions
8. Enhancing Safety

Psychoeducation

Psychoeducation is initially introduced in the first session, even as soon as intake, yet makes an appearance throughout the therapeutic process. The primary purpose of

psychoeducation is to normalize the responses of both children and their parent or caregiver, and to reinforce thoughts and behaviors that are true and positive. Due to the heightened emotionality that trauma often causes, this education piece is crucial to providing a level ground for the clients. Ideally psychoeducation should build trust between the clinician and clients with the comforting nature of giving more information on a situation or the effects of trauma.

Clinicians can give a brief spoken synopsis, provide children's books written by trauma survivors, and offer parents and children information sheets on specific forms of trauma, common effects, and options for treatment. The fact sheets can also include information from studies done on what causes people to perpetrate traumatic experiences, and what the consequences of these behaviors could include. Any possible misconceptions of a child or parent's behavior are likely to dissipate with the education and empirical evidence presented.

If a clinician can provide a diagnosis at this time and a regular language explanation of the condition the child is facing, then psychoeducation is a perfect component to include this piece. Viable treatment options for the disorder should be clearly laid out, and a run through of what CBT is, and why it is an appropriate method of therapy for the client. The clinician's ability to address any pressing concerns or symptoms brought up by the parent or child is crucial in this stage. Clinicians can offer brief coping strategies for specific symptoms to foster trust that although the therapy has not reached the time for specifically addressing this need, the clients are seen, heard, and cared for. For children seeking grief counselling specifically, giving resources relating explicitly to the cause of death of the loved one or parent(s), as well as offering the guidance of spiritual advisors of the family's beliefs, if relevant, is recommended. Consistent and continuing psychoeducation when necessary allows for validation and increased client cooperation in the therapeutic process.

Relaxation Skills

Relaxation skills are utilized on the front end of the treatment because they are useful to decrease the physiological expressions of PTSD and stress from a traumatic event. At the start of this component is again an education piece so the client can learn the difference between a typical stress response to one's mind and body, how a traumatic experience exacerbates these responses, and how there are skills available to reverse these effects. The specific relaxation skills introduced and taught in this component include mindfulness and focused breathing, progressive muscle relaxation, and alternate techniques for specific situations.

Focused breathing, mindfulness & meditation.

Mindfulness and breathing techniques are closely knit, with initial instruction on how to breathe deeply, followed by instruction on how to approach thoughts from a posture of mindfulness. Opposite from traditional breathing, focused breathing directs the stomach out while inhaling and the stomach in on the exhale. This breathing pattern can be integrated in five second intervals with breaths in and out, the individual's thoughts are to remain specifically related to the exercise. This technique has evidence linking to an increase in focus and bodily awareness, and a decrease in tension. As focused breathing becomes more comfortable, clients can begin to acknowledge thoughts and choose not to respond, judge, or act upon them instead of redirecting every thought to breathing. This interrupts the thought cycle and is operating from a mindfulness approach. Mindfulness shifts to meditation when integrating a word or phrase to focus on or repeat. This word or phrase should be something that sparks peace. Clinicians can utilize a script if needed in session to integrate these. After about five minutes of practice, the clinician can ask what impact the exercise had on the client, and then suggest the client to

practice focused breathing, mindfulness, and meditation at the onset of stress outside of session as the situation permits.

Progressive muscle relaxation.

Progressive muscle relaxation can be described on the most basic level as transitioning one's body from a hard, uncooked spaghetti noodle to a becoming a limp-cooked noodle. The clinician can follow a script and suggest to the client to begin relaxation at the toes, focusing on releasing all tension in each body part while progressing up the body, ending with the head. Asking the client how their body specifically holds tension can allow for increased focus on these areas when approaching muscle relaxation. This personalizes the therapy. Listening to music can also be integrated in this technique. Children can partake in unique exercises as well such as blowing bubbles. The entire effort is to relax the muscles and shift one's focus away from the inability to sleep or from somatic symptoms or physical pain manifesting due to traumatic experiences. The clinician can again ask how the exercise impacted the client and then can suggest integrating this technique when symptoms present in their daily life, especially prior to sleeping.

Additional points.

Clinicians must be acutely aware of and prepared for potential triggers associated with each technique. For children struggling specifically with a loss of a parent, these techniques of stillness could bring up memories with the parent who is now absent due to death or abandonment. Creative changes such as instituting new bedtime patterns can be potentially more beneficial. Additionally, children with sexual abuse trauma may be triggered by laying down with closed eyes for breathing or body relaxation due to histories of abuse from a similar

position. Offering the client to have open eyes, or to sit instead could be an option; forcefulness in introducing relaxation skills is counterproductive.

In parents' therapy, clinicians can introduce the same breathing patterns, meditation, mindfulness, and muscle relaxation skills, as with the children. Parents are often exceptionally interested in the meditation piece. Clinicians can practice with the parent in-session for about five minutes. Clinicians can then suggest the parent integrate the exercise in their personal life daily, starting at ten minutes, gradually increasing time to twenty minutes. Parents also have the opportunity to do aerobic exercise which can lower depression and anxiety symptoms and decrease the physical manifestations of stress. Physical workouts can also be an opportunity to spend time the child as well. The guide for implementation also includes problem-solving points for children who may avoid pleasure.

Affective Regulation Skills

Affective expression and modulation are skills to assist children and parents in identifying and expressing their feelings. The first key is identification, which clinicians can integrate with children by implementing the trust-building exercise of discussing common daily emotions that both the clinician and client have experienced. Additionally, for younger children, compiling a list of as many emotions they can think of as possible within a few timed minutes, followed by discussion on each emotion can be helpful. Feelings wheels, coloring, and card games are all additional options for both adults and children. In this component children are reminded it is possible to have blended feelings, and some feelings that are more prominent than others. This component is especially important for parents because as parents are able to work through their emotions, they are more fit to create healthy home environments for their children. Healthy home environments allow for children to then work through their emotions. Adults are

encouraged to verbally express the emotions they are feeling. This including emotions which may cause shame or embarrassment; for example, frustration towards their child who has experienced trauma. Reflective listening is a skill clinicians often teach parents in the affective regulation session to assist them in listening and responding in a helpful manner to their child, even if they have trouble understanding or disagree with their child's declarations.

Due to this being a beginning component, it is crucial to end with a lighthearted activity at every session, so clients remain comfortable and trusting. The specific affective regulation skills clinicians can introduce include thought interruption and positive self-talk, brief safety planning, and problem solving and social skills.

Thought interruption and positive self-talk.

This technique is highly useful for slightly older children and adults. It begins the notion of being able to regulate thinking processes and prepares clients for further treatment components and sessions where the clients' trauma will be the primary focus. Thought interruption is recognizing an intrusive thought and combating it with a positive mental image such as an encouraging past experience or an imaginary image that brings hope and joy. Physical and verbal indicators can be useful to specifically show when the technique is being utilized, such as snapping a rubber band on one's wrist or saying "no" aloud.

Clinicians play a crucial role of pointing out specific positives about the client. Therefore, clinicians must listen well and pay careful attention to notice clients' strengths. Positive self-talk rearranges negative thinking patterns to positive ones about both the clients' situation, and themselves as an individual. Both children and adult clients are encouraged to identify their strengths and a selection of people who care for them to re-focus themselves away from negative thinking. For instance, instead of, "This is the worst and I should have never gotten myself into

this situation,” the client could say, “I will be stronger because of this, I cannot change my situation now, but I am already learning a lot about myself because of this.” These techniques can create a positive impact beyond the trauma-healing process and can be useful throughout the clients’ life.

Brief safety planning.

Although safety planning is an entire component near the close of the therapy process, the client is encouraged to identify how they can maximize their safety in their situation to avoid re-traumatization. Parents and clinicians should communicate about the child’s environment, so the clinician has some education before presenting the topic to the child. Clients can be reminded of people and institutions set up to provide safety in their community. Clinicians should be careful to not promise safety for the client, but rather speak to the desire for safety and how this activity it is more likely to remain without risk or harm.

Problem solving and social skills.

A brief synopsis of the seven-step problem solving process is identification, brainstorming solutions, identifying outcomes, selecting, evaluating, and acknowledging. Clinicians introduce these steps, utilizing an example problem from the client’s life, encouraging clients, if literate, to write out the responses for each stage of the problem-solving method to visually process. Social skills include both verbal and non-verbal cues, and anything clients may not understand how to respond to due to the way trauma affects the brain and ability to operate in social interactions. Group therapy is the recommended intervention to integrate social skills so clients can interact with one another and learn together, while role play between clinician and client also works if group therapy is not an option. To assist children and parents with social

interactions clinicians can work with clients in creating a list of self-soothing techniques and a list of times where symptoms or emotions may become heightened.

Cognitive Processing Skills

This is a brief component, as it is often encompassed further after the trauma narrative component. However, the primary focus is correct thoughts which will in turn affect behaviors. The cognitive triangle, as found in Appendix B, is an incredible resource to explain to clients how each of these relates to one another. This can also help to debunk the belief that an individual is unable to control their cognitions. This process begins by the clinician leading clients to expose their internal dialogue starting with thoughts during non-traumatic life experiences such as while brushing their teeth. Clients may think a behavior is a thought, or a feeling is a behavior, however clinicians can politely clarify. Clinicians can also provide brief, non-triggering, case examples for clients to pick out each piece of the triangle in the postulated illustration. Worksheets and children's books are creative ways to help children in this process of recognizing how important thought regulation is in eliminating unwanted behaviors or feelings. Due to stigmas various cultures can possibly hold relating to various traumas, clinicians must be aware and willing to reach out to religious or community leaders to address such concerns. There are three specific types of unhealthy thought patterns which are more likely to cause depression. These include thoughts relating to the world, the person specifically, and generalizing permanent negative thoughts to non-related situations.

Parents are given more in-depth examples and clinicians can encourage them to walk through instances from their own life of how differing thought processes could have more positive or negative results in behavior and feeling. While working through the cognitive triangle with parents, the clinician should ask about the parents' safety.

Trauma Narration & Processing

This component should be integrated through several sessions with the client, and focuses primarily on the child, with relating aspects for parents involved in the therapeutic process. Other therapy methods often call the gradual development of explaining one's traumatic experience and relating cognitions "gradual exposure." Clinicians provide a space for children to revisit the traumatic situation because evidence reflects the greater the amount of exposure, the lesser the prevalence of symptoms and hyperarousal. Before encouraging children to share, clinicians can continue psychoeducation for both children and parents by explaining the reasoning for clients to produce their trauma narrative. The most basic way to describe this component is, for a wound to heal properly, one must address the wound by cleaning it, applying ointment, and bandaging it properly; mental trauma and the effects produced require proper care and attention as well, for proper healing to take place.

Clinicians begin introducing how to create a trauma narrative by reading a children's story relating to a similar traumatic experience with their client. Then the clinician can invite the client to create a story based on their own experience – which will then become their trauma narrative. Clients can start by talking about themselves including features of their life or personal interests unrelated to the trauma. These descriptions gradually shift to discussing the facts from the traumatic experience. Clinicians should be aware of how much to ask, to allow the process to be natural and healing, while maintaining trust and comfort, and can utilize scales as measurement instruments to gauge the effects this is having as they work through this component. Clients revisit their trauma narrative in session regularly. After establishing the facts, clients can then include thoughts and emotions from each part and if they recall more of the traumatic experience. Clinicians then invite clients to add the information as they uncover the

memory. At the conclusion the clinician has an opportunity to ensure the client has included everything necessary, asking if the most painful and hardest to articulate parts of what happened are in the 'book.' If the client reveals more, the addition should be included in the appropriate place in the book. Clinicians should also allow clients to start processing this new information. For clients with lives filled with traumatic experiences, creating a timeline or life story book where they can incorporate positive moments proves to be a positive option.

To process throughout the creation of the trauma narrative, clients and clinicians utilize the relaxation and cognition skills introduced in the previous components of the treatment. While children create their trauma narrative, the clinician asks if the parent, in their treatment, may read the narrative. The clinician can calm the nerves of both the parent and the client, tending to any relating concerns with answers and clarification. Parents must process through hearing the trauma and articulating their own history of traumatic experiences, understanding their child's trauma, and how it has been traumatic for them as a parent.

Processing the trauma narrative for children requires constant re-reading and re-visiting of the traumatic experience and strategic questions by the clinician to initiate metacognitive processing with the client. While going through the narrative, the client's goal is to try and identify inaccurate or unhelpful thoughts. Examples of these can include attempting to control the uncontrollable and placing blame. This can be an opportune time for clinicians to remind clients of the possibility for regulating their cognitions. Parents and children may have similar cognitive distortions and can be made aware of the commonality. Especially for parents, a good opportunity for at-home practice is to record daily unhelpful, inaccurate, and positive thoughts in a journal or an app in their smartphone.

By processing the trauma narrative, clients become aware of the thought progression that has led them to behaviors which then led to further emitted emotions. Clinicians can become aware of and provide psychoeducation in the case of victim-blaming. Through this process, the memory loses the power it had to elicit such a distressing and physiological response on the child and parent can transform the trauma into a monument of overcoming where courage and growth were the result.

***In Vivo* Mastery of Trauma Reminders**

Although the previous component addresses the issues specifically related to the traumatic experience in relation to the client, it is very common for lingering effects, such as generalized fears in children, which lead to avoidance. Children who have experienced trauma often interpret situations which either unknowingly or out rightly so reminds them of the trauma, creating a cue to operate in the anxiety flight response. The clinician should ensure to not eliminate any cues which are present to protect a child from current potential harm, but rather the ones negatively affecting the child's development.

The *in vivo* mastery of trauma reminders is an exposure-based method sorted into two primary parts: identification, and planning. Clinicians should create this with the child, including the parent in the formulation and any applicable institutions who may play a role in the process. To engage in this component all parties involved must be fully sold on the success of this treatment method and prove to be willing to persist through the difficulty this brings. The evidence suggests that the greater the consistency of integrating exposure in daily life, the greater the treatment's success. Gradually children will begin to face their fears utilizing the previously taught relaxation exercises, this will allow for tolerating the anxiety as it lowers over time.

Children learn from this component of the therapy process that they can have control of the parts of their life that the effects of trauma once had control of.

Conjoint Parent-Child Sessions

Allowing for parents and children to interact in a conjoint therapy session is utilized throughout many of the components, and therefore is not limited to the close of the process. However, for the conjoint sessions where clients explore deeper rooted concerns such as discussing the trauma narrative together, both the child and parent should first be equipped with and practiced in cognitive processing skills. To prepare, children will read through their trauma narrative many times, become adept in discussing the experience, and formulate a list of questions to pose to their parents in the conjoint session. Clinicians should review the trauma narrative with parents in a short individual session immediately preceding the conjoint parent-child session. In this session the clinician and child will role-play a response to each question the child will be presenting.

During the conjoint sessions both the clinician and client should encourage and praise the child for the strength and courage required to show such vulnerability. During the question discussion the clinician should be situationally aware, ensuring both the parent and child's needs are being met to work through each inquiry. Integrating psychoeducation throughout this component is key to a constructive experience, although clinicians should always prepare for hiccups and potential complications. The connection fostered through talking about the trauma directly, and conversing about connecting themes such as positive relationships, how to and why to avoid negative coping skills can carry over to the home environment and have lasting positive impacts. Due to the intense nature of these sessions, clinicians can invite both the parent and the child to express things they appreciate about each other. If the clinician makes a professional

judgment and decides with the child that sharing the trauma narrative with the parent is unhealthy or could be detrimental, on rare occasions the conjoint sessions can exclude the trauma narrative, and instead focus on the relating subject matters.

Enhancing Safety

Similar to how safety is explored in the affective regulation skills component, this component allows the client to work through ways to maintain their safety and reduce the risk for future victimization. Clinicians can incorporate the parental input and personalize this component to each child, incorporating skills that pertain to the client's traumatic experience. All clients can be introduced first to basic personal safety principles, such as protocol for riding in cars and using public transportation and walkways. After the child has completed the trauma narrative, clinicians should reinforce the skills the client utilized at the time of the trauma. This prevents the child from feeling shame over not knowing these protective skills prior to experiencing their trauma.

Once the client has processed through their experience, clinicians can utilize role play, children's books, films, and worksheets to work with the child in developing their new confidence-building skillset. First children should learn how to articulate for themselves, should a situation arise in the future. This equips children to know the vernacular and encourage boldness to verbalize their situation and engage proper assistance. This is crucial to the therapy process.

Utilizing "I" statements and appropriate assertive body language for bullying or verbal abuse situations can be beneficial. Identifying what a "gut" reaction is and how to properly respond in situations where these are elicited can help children learn when a situation has potential to be traumatic and teach them to leave unsafe environments. For instances of physical

abuse or witnessing domestic violence, children are encouraged to identify a safe place to run to, identify courses of action to call authorities, and practice a conversation with the operator. For sexual abuse situations children should understand how surprises and secrets are different to understand. Clinicians can share that surprises are positive and inevitably will be revealed, while secrets are negative and must be carefully discerned. Children can practice yelling “NO!” and can clearly define their body’s physical boundaries and what areas are not for others to touch.

CHRISTIAN CONCEPTS

One who holds a personal relationship with Jesus Christ, believing in the triune God, Father, Son, and Holy Spirit, is a Christian. Christian beliefs reflect the doctrine of the Bible as described in Appendix C. The teachings are comprised of the words of the prophets, accounts of people who walked with Jesus, and point to several practices key to living as a Christian, including various forms of prayer and worship. These concepts enhance one’s relationship with God and promote a lifestyle of communion with God and with others. A person often learns more about Christianity by attending church, an event such as a conference, or through interaction and discipleship from another believer. Children and adults have potential to be Christians and integrate Christian concepts in their life, however it is likely for adults to have a deeper understanding of God than children. As one integrates their Christian beliefs in their life, and progress in their faith they are more likely to take part in activities such as prayer and worship. Often the two intersect with one another, and more in-depth descriptions are located below. For the sake of this paper, all Bible citations are to be taken from the New International Version (NIV).

Prayer

In the Christian faith, prayer is best described as communication with God. Jesus, Father, Holy Spirit, Abba, and Lord are all common names people refer to God, each name pointing to a different piece of who scripture explains God to be. Scripture contains a format for prayer (Matthew 6:9-13), provides many examples throughout the chapters, and explains that no situation on Earth can cut off the potential for this dialogue (Romans 8:39). There are numerous options to approaching prayer although they can be grouped. Brian Brennt, a missionary who created a helpful book for new Christians, explains the types of prayer in the acronym TACIS. The letters stand for thanksgiving, adoration, confession, intercession, and supplication (2011, p.18).

Thanksgiving and adoration prayer can be done in a group prayer environment or individually by addressing what God has done, and promises through scripture to do, and thanking God for it. Thanksgiving can be offered for simple things such as holding off the rain for a big outdoor event or about Jesus' death and resurrection and all of the benefits this brings to believers. Brennt describes this type of prayer as "like keys to open the door to the courts of the almighty, allowing ... enter[ance] into [God's] presence," which "prepare[s] ... hearts to receive from [God]," and shifts attitudes by washing away negativity and "opening the door for great intimacy with Jesus" (2011, p.18). Thanksgiving quickly shifts to adoration. The way this prayer is formulated is generally based on how much one has spent time seeking God and reading scripture. The more an individual receives revelation of God in the seeking and pursuing intimacy, these are the attributes they will speak to in adoration or praise prayer.

Confession is "praying to God and acknowledging [one's] sin" (Brennt, 2011, p.18). A prayer of confession stems from an inner recognition of needing a savior which leads to

admitting sin, asking and receiving forgiveness. Repentance is included in confession prayers. Preacher John Bevere states, “repentance means changing our mind so deeply that it changes our personality from the core of our being” (“Killing Kryptonite ..”, n.d.). This means one is deciding to turn from the sin they have committed. Christians believe a prayer of confession leads to salvation (Romans 10:9-10 & 2 Corinthians 7:9-10). This prayer is for restoration of purpose, the inner person, and relationship with God (Brennt, 2016).

Scriptures suggest God’s will is good, perfect, and for everyone (1 Timothy 2:3-4 & Romans 12:2). In both intercessory and supplicatory prayer individuals are partnering with God to ask for God’s will to be done (Kolenda, 2016). Intercessory prayer means to stand in the gap and pray for others whether this be for a softened heart, or health in their mind and body (Brennt, 2011, p.18). Praying for oneself is supplicatory prayer (Brennt, 2011). This is asking God for something whether it be a job, a spouse, a change in attitude, or healing in the body or mind.

All Prayer is meant to be offered in faith (Mark 11:22-25). Prayer can be silent, vocalized, or written and either in groups or individually. Christians are invited to pray with other Christians because the Bible says where two or more are gathered and praying in the name of Jesus, God is with them there (Matthew 18:19-20). This is called corporate prayer. Personal communication with God is never meant to stop, an individual can talk to the Holy Spirit throughout the day (1 Thessalonians 5:16-18 & Ephesians 6:18). Prayer is also about listening for God’s voice (John 10:27). One can hear God’s voice in prayer in the same mental space where they would have a song stuck in their head. is often in the same space where one would count in their head, envisioned as thought. Kenneth Copeland’s article on hearing God’s voice suggests aligning the thought with the Bible to check the compatibility and determine if it is God speaking (2018).

Worship

“An entire life set apart for Christ” is how Brian Brennt describes worship (2011, p.57). Worship is intentionally placing God as one’s primary focus. A person can worship in silence, by singing, raising their hands, playing instruments, dancing, and living with their life as a sacrifice to God (Linton, 2017 & Brennt, 2011). Worship can be on an individual basis or in a corporate setting at church services, conferences, or in a small group.

Most commonly recognized is worshipping God with music through singing, dancing, clapping, playing instruments, and dancing. The Bible instructs Christians to do this throughout the entirety of scripture (Psalm 47:1, Psalm 63:4 & Psalm 95:1). In the Bible King David did this with the psalms he wrote, and people pray through and worship with the psalms to this day. There is a myriad of Christian artists with music dedicated to God. These can provide as a sing-along or a listening option for Christians. The Bible says when Christians worship with song they are inviting in the presence of God (Psalm 100) and are ministering to God (Acts 13:2) (Linton, 2017).

One-way people worship can be by performing actions specifically for the purpose of bringing glory to God (1 Corinthians 10:21 & Acts 2:42-47). Ephesians 6 talks about how being entirely devoted to God protects believers from the devil’s schemes, fighting against oppression. Generosity such as giving money to the church or someone facing socioeconomic difficulties, or even by purchasing someone’s meal is considered worship when it is for God’s glory. When worshipping with giving, the Bible says the giver and the remainder of your money will be blessed (Philippians 4:19 & Malachi 3:10).

Another way to worship God and publicly declare to follow Jesus is by participating in water baptism. Full submersion in the water is a physical symbol of the already internal act of

denying one's old self including sinful patterns, behaviors, and beliefs (Ephesians 4:22-24 & "What is the," 2015). When choosing to be baptized, the individual acknowledges the potential for patterns to remain present but declares a decision live separate from sin and trust in God that they can overcome temptation through Jesus.

DEVELOPMENT OF A WORKING MODEL

Generally, individuals seeking a therapeutic treatment integrating religion must ascribe to the belief system which supports the components incorporated. In this case, clients must sign an informed consent form to participate in treatment including and agreeing on the beliefs surrounding the Christian components of worship and prayer. Clinicians practicing in this model are to offer the Biblical approach to incorporating prayer and worship in TF-CBT sessions and treatment homework. Clinicians can maintain a list of local churches to recommend should clients inquire. These churches should further teach Christian concepts and reflect the beliefs expressed in this model. Through additional involvement in a church, clients have an opportunity to be disciplined, grow in knowledge, be granted opportunities for practicing techniques incorporated in sessions, and to fellowship with people of similar beliefs.

Purpose

This model is meant to integrate the two basic Christian concepts of prayer and worship into the existing evidence-based intervention TF-CBT for youth and parents working through trauma. This therapy is not designed for initial teaching of Christian principles, but rather a method of treatment with values and methods to compliment clients ascribing to Christianity. Clinicians are not meant to be pastors; their expertise should remain as a clinician. To assist in keeping professional boundaries, clinicians must refer clients to local churches and outside resources for theological information. The incorporation of Christian components is for

consenting clients and at the clinician's discretion for the level of integration. The clinician can ask questions about the involvement a client has in Christianity and use this to gauge the level of integration.

Requirements

The primary requirement to utilize the working model is for social workers themselves to profess a belief in the Gospel message, identifying with Biblical beliefs, and holding a Christian worldview. Adding this requirement as well as the requirements above eliminates potential for bias, persuasion, and conflict of interest. Clients remain with the right of self-determination, able to set their own goals, discontinue the services at any time, and remove the use of Christian concepts.

Social workers must follow and prioritize adherence to the *National Association of Social Workers Code of Ethics*, the framework to an ethical and legitimate practice. This is especially important when merging Christianity and social work. A primary value for social workers is competence. The ethical principle surrounding this is, "Social workers practice within their areas of competence and develop and enhance their professional expertise" (National Association of Social Workers [NASW], 2017). Therefore, social workers must operate ethically by remaining within the standards for competence and only practicing TF-CBT with integrated Christian concepts if they have received proper training, studied, and have supervision. Social workers must also have a high regard for cultural awareness to uphold the social work professions' value of respecting the "Dignity and Worth of the Person" (NASW, 2017). This encompasses sensitivity to differences in culture, and to act in adherence to this value would mean to engage in this Christian-specific therapy with clients who believe the Bible and identify

as Christian. Clients must be explicitly seeking Christian counselling for clinicians to offer this model as a potential treatment option.

CASE EXAMPLE

This is a model I have created to integrate the Christian components of prayer and worship into TF-CBT, beginning with generalized instructions followed by integration into the PRACTICE components. For general integration of the Christian components, prayer and worship throughout the TF-CBT components, the clinician should discuss in the first session how much the client desires this integration, with follow-ups throughout the therapy process to ensure comfort. For minimal integration the clinicians can offer to open and close each session in prayer and play up-beat worship music at the close of sessions where TF-CBT recommends creating a fun atmosphere at the session's close. Clinicians can offer for the client, or themselves to pray in the name of Jesus. These prayers can praise God for His nature, kindness, and love. The individual can invite the comfort of the Holy Spirit and the peace of the Lord to fall on the client in a prayer of supplication. These prayers can also thank God for the Biblical promise "Therefore, there is now no condemnation for those who are in Christ Jesus" (Romans 8:1, NIV). There is a fluid nature to prayers at open and close of sessions. There is no standard for perfection and no time requirement, however a one- or two-minute prayer is suggested. Upbeat worship music to integrate with young children at the close of a heavy session is VeggieTales (<https://www.veggietales.com>), and for older children and adults Hillsong Young & Free (<https://hillsong.com/youngandfree/>) music.

Psychoeducation

In the initial psychoeducation component, clinicians can invite children and parents pray a prayer of supplication asking God to bring clarity to what they are learning about the trauma,

and how it can affect their mind and body. They can ask for the peace of God to fall in the room and ask for God to give them discernment on how to follow through with treatment. to say what they believe God's original intent was for their life is.

Relaxation Skills

Integrating the Christian components in the relaxation skills component of TF-CBT offers the opportunity for an additional relaxation skill and an adaptation to the recommended mindfulness meditation skill. While practicing bodily awareness, clients are directed to focus on a word or phrase from the Bible. Adults with deep Biblical understanding who find it comforting to meditate directly on the person of God can also do this. For children I recommend these verses: "The Lord gives strength to his people; the Lord blesses his people with peace" (Psalm 29:11, NIV), "Peace I leave with you; my peace I give you. I do not give to you as the world gives. Do not let your hearts be troubled and do not be afraid." (John 14:27, NIV), "Cast all your anxiety on [God] because he cares for you." (1 Peter 5:7, NIV), "The God of peace be with you all. Amen." (Romans 15:33, NIV), and "[God] says, "Be still, and know that I am God; I will be exalted among the nations, I will be exalted in the earth." (Psalm 46:10, NIV).

The new relaxation skill for clinicians to introduce is listening to worship music or worship by reading a book. For instance, at home where a longer break to practice relaxation skills is possible, "The Father's Song" by UPPERROOM and Elyssa Smith (<https://upperroom.co>) offers a tune from the perspective of God. For shorter options, "Comforter" by Amanda Lindsey Cook (<https://bethelmusic.com/artists/amanda-lindsey-cook/>), "Lean Back (feat. Dion Davis)" by Capital City Music and Dion Davis (<https://www.gracecapitalcity.com/capitalcitymusic#>), and "Defender" by Rita Springer (<http://www.ritaspringer.com/music>) are recommended when PTSD symptoms arise, or anxiety prevails. Songs can be introduced in session with the clinician and

client and a CD, or link to online listening can be provided for at-home utilization. Reading a book such as *Good Good Father* by Chris Tomlin and Pat Barrett

(<https://www.amazon.com/Good-Father-Chris-Tomlin/dp/0718086953>) , or *When God Made*

You by Matthew Paul Turner (<https://www.penguinrandomhouse.com/books/537389/when-god-made-you-by-matthew-paul-turner-illustrated-by-david-catrow/9781601429186/>) can calm

children clients by reminding them of the nature of God.

Affective Regulation

Integration throughout the affective regulation skills component includes modifications to the positive self-talk skill and additional recommendations to foster social skills. As a Christian one believes many benefits are offered because of this belief, and these are often interpreted in “I am” statements from the Bible as located in Appendix D. This allows the client to shift from focusing on themselves to worshipping God in their speech by focusing on who God made them to be. Clients can keep a printed list of the declarations or young children can memorize their favorite for recitation. The clinician and client can then pray a prayer of thanksgiving for who the Bible says the client to be. This can be followed by a prayer of supplication asking God to reveal these truths to the client through the spirit of wisdom and revelation (Ephesians 1:17).

Additionally, to practice social skills outside of the session, the clinician can encourage the client to go to a church service, youth group, or an adult community group. Clinicians can express to clients that these gathering are more likely to be positive environments because Christians are instructed to refrain from judgment, love everyone, and live in harmony (Romans 12:16-18, Matthew 7:1-5 & Luke 6:31-36).

Cognitive Processing Skills

Since the purpose of introducing cognitive processing skills is to expose the inner dialogue the client has in their thought life, the clinician can suggest introducing communicating with God throughout the day through constant communication with the Holy Spirit. The clinician can ask questions exploring how often the client prays and how they typically pray. Then the clinician can provide a brief description of what it means to communicate with the Holy Spirit. For parents, I recommend the book *The Practice of the Presence of God* by Brother Lawrence (<https://www.amazon.com/Practice-Presence-God-Brother-Lawrence/dp/0883681056>). For children, I recommend clinicians suggest prayers at every meal and daily pattern moments such as brushing one's teeth or putting on lip balm. These prayers serve as a check-in, inviting God into every moment, and to readjust thoughts with God's truth. In regard to clinicians connecting clients with cultural leaders in the case of misunderstanding, clinicians can create a standard email for this contact and a potential list of these churches. In this component the clinician can also introduce prayers clients can use to take captive their thoughts as spoken of in 2 Corinthians 10:5, "We demolish arguments and every pretension that sets itself up against the knowledge of God, and we take captive every thought to make it obedient to Christ." This is done by acknowledging verses in the Bible to combat discouragement, shame, and intrusive thoughts.

Trauma Narration and Processing

Similar to an already established model, *Christian-Accommodative Trauma-Focused Cognitive-Behavioral Therapy*, approaches the trauma narration and processing component, clinicians can encourage to children to process through their thoughts about God throughout the traumatic experience, even incorporating this in the trauma narrative (Walker, Quagliana, Wilkinson & Frederick, 2013). This serves as a written prayer and begins to expose internal

thoughts and notions about God, which the above skills of prayer and worship can address to bring comfort and clarity to these thoughts. Additionally, adult and child clients can create a prayer journal to process through emotions and write down thoughts that arise relating to the trauma narrative, while they are not with the clinician. Clinicians can suggest that upon using the prayer journal, clients pray a prayer of thanksgiving and adoration. Following these prayers, clients can pray a prayer of supplication to ask God to give them peace of mind to move forward with their day. Further prayers of supplication can include asking if the Lord would give them peace and remove any anxiety the situation could have sparked.

***In Vivo* Mastery of Trauma Reminders**

To integrate prayer into the *in vivo* mastery of trauma reminders component of TF-CBT we suggest clinicians teach clients how to pray through Philippians 3:10-12, “I want to know Christ—yes, to know the power of his resurrection and participation in his sufferings, becoming like him in his death, and so, somehow, attaining to the resurrection from the dead. Not that I have already obtained all this, or have already arrived at my goal, but I press on to take hold of that for which Christ Jesus took hold of me” (NIV). Due to the goal of this section centering around feeling in control of one’s self and the physiological and mental reminders of the traumatic experience, this verse emphasizes the ability to “take hold” of what Jesus told hold of, whether it be anxiety, fear, anger, despair, etc. This is another way to pray and invite God to bring further inner-healing. Additionally, this is an opportune component for clinicians to present the option of baptism for clients who are fully invested in integrating Christianity in their therapy process. As mentioned previously, baptism is symbolic of letting go of everything hindering an individual from being a Christian and following Jesus. This could be a helpful option for clients to start new and move forward from their traumatic experience. This

paves the way spiritually for clients to approach life with their new coping skills and all they have learned from the therapy experience.

Conjoint Parent-Child Sessions

Integrating prayer and worship in conjoint parent-child sessions is quite simple. I recommend clinicians invite both the parent and child to pray for one another at the close of the session. Additionally, clinicians can invite parents and children to select a worship song they enjoy singing together at the start of the session. This can be used outside of the session in the car or at home to increase trust and positive memories with one another. Parents of young children can sing Christian lullabies to their child at bedtime to foster an environment of worship in the home. Parents with children of all ages can read Bible stories with their child as an act of worship, utilizing a Children's Bible such as *The Jesus Storybook Bible: Every Story Whispers His Name* by Sally Lloyd-Jones (<https://www.sallylloyd-jones.com/books/jesus-storybook-bible/>), when necessary.

Enhancing Safety

We recommend clinicians invite clients to pray a prayer of supplication asking the Lord for wisdom and safety, should any situation arise risking the client's safety. Additionally, clients can pray a prayer asking the Holy Spirit for creative ideas of how to maintain safety. The clinician can ask the if the client desires prayer for this area. If the client does, but does not want to pray for themselves, the clinician can pray a prayer of intercession for the client during the session.

FURTHER RESEARCH

Some clients begin treatment with a Christian worldview closely knit to their identity. This religious and spiritual affiliation can be utilized as a resource in the healing process.

Integrating Christian concepts in the therapeutic treatment is a long-standing exercise, however many of these practices lack substantial empirical evidence of producing more positive impacts than other, secular interventions (Worthington, Johnson, Hook & Aten, 2013). To evaluate if this treatment is effective in reducing the persisting effects of trauma such as PTSD symptoms (such as anxiety, depression, flashbacks, and night terrors) and to determine how the integration differs in results from traditional TF-CBT, substantial research must be implemented.

Before researching the model, it is crucial to standardize the model's design with exact instructions for integration to elicit viable results. Research should include scales to measure items such as PTSD symptoms, anxiety, and depression, at both the start and end of the therapeutic process, as well as several years after the treatment. Scales to measure the amount of integration of Christian concepts in an individual's life prior to the research could serve as an interesting demographic point to see how the outcomes differ with varying amounts of prior integration. Researchers can select which measuring instrument to use. Researchers will need to create a research design, recruit participants, gain consent, complete the treatment on both the control and intervention groups, then collect and analyze data. I recommend creating an experimental design from a population of individuals fitting "Christian" criteria, and a quasi-experimental design from a general population. Once research is implemented, further studies should utilize the same research model to see if results are replicable, which would lead to strengthening empirical evidence. In some instances, parents and children may operate from different belief systems. Specifically researching the dynamic of integrating the Christian components with only either the parent or child, should also be investigated.

LIMITATIONS

The working model will have limitations, the primary limitation being both the clinician and client must ascribe to the Christian belief system as described in the model design and must consent to the integration in treatment. This could limit the number of clients who can receive this treatment and significantly affect the number of participants for studies assessing the model's efficacy. Due to the requirements of the ascribed beliefs, this excludes many types of potential participants in the treatment. Additionally, clinicians have some freedom in the amount of integration, which could skew research results because some clients' therapy has further integration of the Christian components than others. Clients could also have varying levels of experience with the Christian faith and differing outside information on Christianity than other research subjects. Finally, clinicians must go through special training to become qualified in implementing the working model in their practice, which adds a cost to formulate such training, and cost to the clinician to attend the training.

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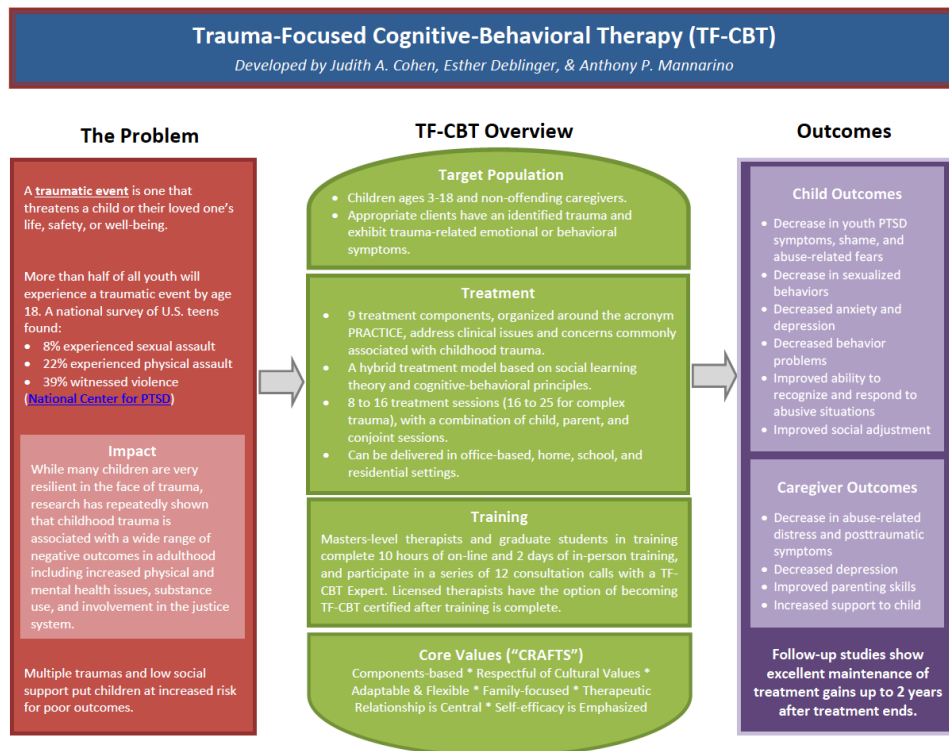
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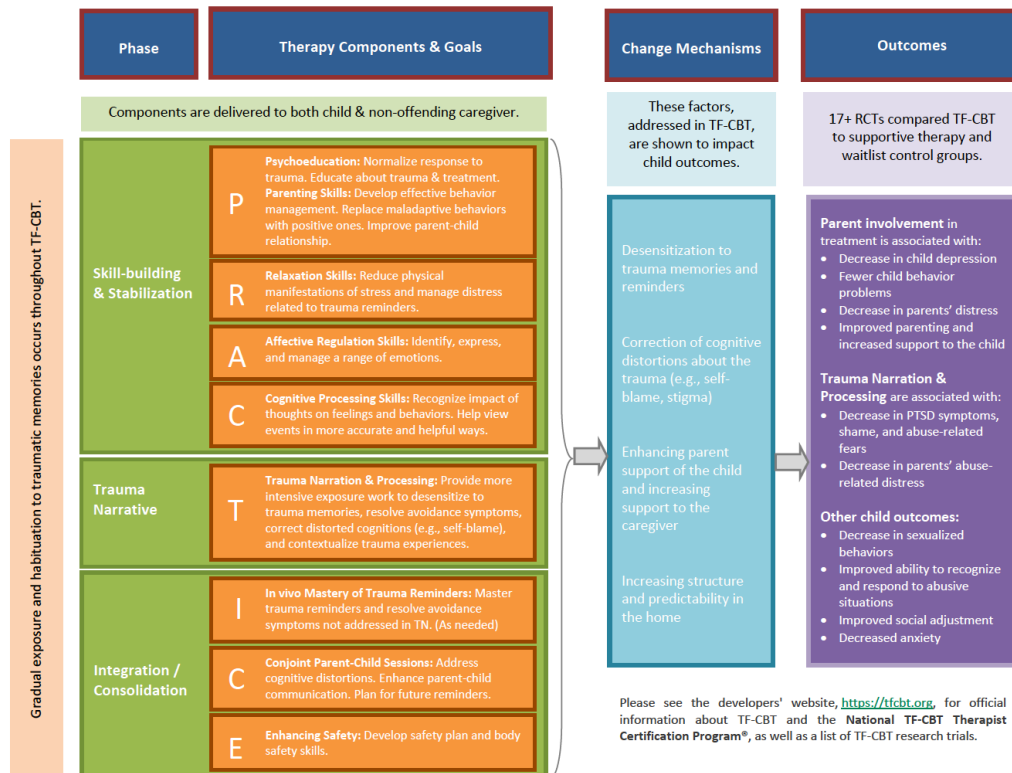
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APPENDIX A: TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY LOGIC MODEL

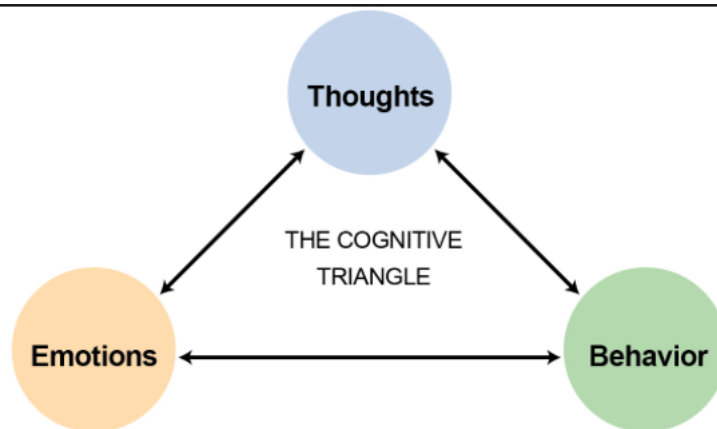


Logic Model created by the Evidence-based Prevention and Intervention Support Center (EPISCenter) at Penn State University



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APPENDIX B: THE COGNITIVE TRIANGLE



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APPENDIX C: GENERAL OVERVIEW OF BIBLICAL BELIEFS

The Bible is the core instrument to understanding Christian beliefs and how to operate as a Christian. Below is a general overview of the Bible with the purpose of clarifying the basics of the belief system employed throughout this project. This is meant to assist in understanding the Bible and in no way serve as a replacement to All Bible references cited refer to the New International Version of the Holy Bible.

The doctrine starts with God creating the heavens and the earth and all creation including humankind, made in the image of God, for the purpose of ruling and communing with God (Genesis 1:26-27, New International Version). However, man has free-will and when confronted with temptation, disobeyed God (Genesis 3:13), therefore separating themselves from Him (Isaiah 59:2). Sin leads to death (James 1:15), therefore God gave Moses ten commandments to keep people from falling to sin, and people would sacrifice burnt offerings as a reparation for sin (Leviticus 5:14-16) to invest in and restore right standing with God. The people subsequently dismissed their relationship with God due to their inability to follow the law (Daniel 9:10-11).

God then sent his son Jesus to be born of a woman to live perfectly within these laws (Matthew 1:23). Jesus spent his adult life practicing miracles such as multiplying food, raising the dead (John 11:43-44), and healing the blind and the sick (John 9:11-12 & Matthew 15:30-31). He challenged the views many religious people had of God, from condemning and shaming to loving and gracious (Matthew 23). The religious leaders of the day set out to kill Jesus for his claims to be the Son of God (John 10:30), deeming Him blasphemous of which the penalty is death (Leviticus 24:16). He is crucified, nailed to a cross where he died (John 19:16-18). The death of Jesus is symbolic of the blood sacrifices used in the Jewish law of atonement (Leviticus 4:32-35 & Revelation 5:6-9). After Jesus' death, he resurrected (Matthew 28:5-7), revealing

Himself to his disciples (Matthew 28:16-20). The death of Jesus was the final atoning sacrifice to give mankind opportunity to enter into eternal relationship with God the Father (1 John 2:2).

One is saved and receives salvation by grace, through faith (Ephesians 2:8) and is given eternal life with God (Romans 6:23). Acknowledging one's need for a savior and repenting (Acts 3:19), believing in the heart and professing the mouth that Jesus is Lord (Romans 10:9-10), will lead to an infilling of the Holy Spirit (John 3:3-8, Romans 8:9). In this, those who were once dead to sin are made alive in Christ (Ephesians 2:1-5). No one is excluded from the opportunity for salvation (Romans 10:13). The Spirit, which now resides in the hearts of those who believe (1 Corinthians 3:16), produces fruit such as love, joy, peace, goodness, and self-control (Galatians 5:22-23). The entire Gospel is centered on God's love for mankind (John 3:16 & 1 John 4:9).

Members of the early and modern church respond to the Gospel of Jesus by baptism in the Holy Spirit, receiving an impartation of spiritual gifts from God such as faith, wisdom, healing, and prophesy (1 Corinthians 12:4-11). These gifts are for the Church, which is the body of Christ (1 Corinthians 12:27), for building up individuals and the Church as a whole (1 Corinthians 12:7 & 14:12).

APPENDIX D: BIBLICAL “I AM” STATEMENTS

Biblical “I am” statements can be used when teaching positive self-talk skills in the affective regulation component of the therapeutic process. Below is a list of general positive affirmation statements adapted from Bible verses meant to speak over one’s self. This has been created by Christian speaker and writer Joyce Meyer. Clinicians can print the list and give it to the client, giving credit to Christian speaker and writer Joyce Meyer, who created it. The client can then look through the list (if literate) and select the statements that best identify or combat the negative thoughts they’re having about themselves.

“I am complete in Him Who is the head over all rule and authority—of every angelic and earthly power ([Colossians 2:10](#)).

I am alive with Christ ([Ephesians 2:5](#)).

I am free from the law of sin and death ([Romans 8:2](#)).

I am far from oppression, and will not live in fear ([Isaiah 54:14](#)).

I am born of God, and the evil one does not touch me ([1 John 5:18](#)).

I am holy and without blame before Him in love ([Ephesians 1:4](#); [1 Peter 1:16](#)).

I have the mind of Christ ([1 Corinthians 2:16](#); [Philippians 2:5](#)).

I have the peace of God that surpasses all understanding ([Philippians 4:7](#)).

The Spirit of God, who is greater than the enemy in the world, lives in me ([1 John 4:4](#)).

I have received abundant grace and the gift of righteousness and reign in life through Jesus Christ ([Romans 5:17](#)).

I have received the Spirit of wisdom and revelation in the knowledge of Jesus, the eyes of my heart enlightened, so that I know the hope of having life in Christ ([Ephesians 1:17-18](#)).

I have received the power of the Holy Spirit and He can do miraculous things through me. I have authority and power over the enemy in this world ([Mark 16:17-18](#); [Luke 10:17-19](#)).

I am renewed in the knowledge of God and no longer want to live in my old ways or nature before I accepted Christ ([Colossians 3:9-10](#)).

I am merciful, I do not judge others, and I forgive quickly. As I do this by God’s grace, He blesses my life ([Luke 6:36-38](#)).

God supplies all of my needs according to His riches in glory in Christ Jesus ([Philippians 4:19](#)).

In all circumstances I live by faith in God and extinguish all the flaming darts (attacks) of the enemy ([Ephesians 6:16](#)).

I can do whatever I need to do in life through Christ Jesus who gives me strength ([Philippians 4:13](#)).

I am chosen by God who called me out of the darkness of sin and into the light and life of Christ so I can proclaim the excellence and greatness of who He is ([1 Peter 2:9](#)).

I am born again—spiritually transformed, renewed and set apart for God’s purpose—through the living and everlasting word of God ([1 Peter 1:23](#)).

I am God’s workmanship, created in Christ to do good works that He has prepared for me to do ([Ephesians 2:10](#)).

I am a new creation in Christ ([2 Corinthians 5:17](#)).

In Christ, I am dead to sin—my relationship to it is broken—and alive to God—living in unbroken fellowship with Him ([Romans 6:11](#)).

The light of God’s truth has shone in my heart and given me knowledge of salvation through Christ ([2 Corinthians 4:6](#)).

As I hear God’s Word, I do what it says and I am blessed in my actions ([James 1:22, 25](#)).

I am a joint-heir with Christ ([Romans 8:17](#)). I am more than a conqueror through Him who loves me ([Romans 8:37](#)).

I overcome the enemy of my soul by the blood of the Lamb and the word of my testimony ([Revelation 12:11](#)).

I have everything I need to live a godly life and am equipped to live in His divine nature ([2 Peter 1:3-4](#)).

I am an ambassador for Christ ([2 Corinthians 5:20](#)). I am part of a chosen generation, a royal priesthood, a holy nation, a purchased people ([1 Peter 2:9](#)).

I am the righteousness of God—I have right standing with Him—in Jesus Christ ([2 Corinthians 5:21](#)).

My body is a temple of the Holy Spirit; I belong to Him ([1 Corinthians 6:19](#)).

I am the head and not the tail, and I only go up and not down in life as I trust and obey God ([Deuteronomy 28:13](#)).

I am the light of the world ([Matthew 5:14](#)).

I am chosen by God, forgiven and justified through Christ. I have a compassionate heart, kindness, humility, meekness and patience ([Romans 8:33](#); [Colossians 3:12](#)).

I am redeemed—forgiven of all my sins and made clean—through the blood of Christ ([Ephesians 1:7](#)).

I have been rescued from the domain and the power of darkness and brought into God’s kingdom ([Colossians 1:13](#)).

I am redeemed from the curse of sin, sickness, and poverty ([Deuteronomy 28:15-68](#); [Galatians 3:13](#)).

My life is rooted in my faith in Christ and I overflow with thanksgiving for all He has done for me ([Colossians 2:7](#)).

I am called to live a holy life by the grace of God and to declare His praise in the world ([Psalm 66:8](#); [2 Timothy 1:9](#)).

I am healed and whole in Jesus ([Isaiah 53:5](#); [1 Peter 2:24](#)).

I am saved by God's grace, raised up with Christ and seated with Him in heavenly places ([Ephesians 2:5-6](#); [Colossians 2:12](#)).

I am greatly loved by God ([John 3:16](#); [Ephesians 2:4](#); [Colossians 3:12](#); [1 Thessalonians 1:4](#)).

I am strengthened with all power according to His glorious might ([Colossians 1:11](#)).

I humbly submit myself to God, and the devil flees from me because I resist him in the Name of Jesus ([James 4:7](#)).

I press on each day to fulfill God's plan for my life because I live to please Him ([Philippians 3:14](#)).

I am not ruled by fear because the Holy Spirit lives in me and gives me His power, love and self-control ([2 Timothy 1:7](#)).

Christ lives in me, and I live by faith in Him and His love for me ([Galatians 2:20](#))."

By Joyce Meyer

Retrieved from <https://joycemeyer.org/everydayanswers/ea-teachings/knowing-who-i-am-in-christ>