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Restoration or Transformation? A Proposal for Integrating CBT Techniques into Biblical Counseling

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A B S T R A C T

Christian counseling faces the challenge of integrating faith with psychological science responsibly. This paper explores combining Cognitive Behavioral Therapy (CBT) with biblical counseling for anxiety disorders. CBT is an effective, evidence-based method for reshaping harmful thought patterns. However, its use in faith-based counseling raises theological concerns about Scripture's authority, sin, and the Holy Spirit's role in healing. The author reviews Beck's CBT theory alongside biblical views on anxiety, proposing an approach that respects Scripture's sufficiency. Through literature review and pastoral reflection, the paper highlights the importance of addressing anxiety's biological, psychological, and spiritual roots. It also stresses that Christian counselors should act as companions, not saviors, ensuring counseling is both sound and theologically grounded.

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INTRODUCTION

According to a survey conducted by the **World Health Organization (WHO)**, 1 in 10 people experience mental health issues. **Anxiety disorders** are among the most common mental health problems globally and continue to rise across various regions (Yang et al., 2021). It is estimated that **33.7% of the world's population** experience anxiety disorders at some point in their lives (Bandelow & Michaelis, 2015). In **Indonesia**, anxiety disorders are also notably prevalent. In 2018, **9.8%** of individuals aged 15 years and older were reported to experience emotional mental disorders marked by symptoms of anxiety and depression an increase from **6%** in 2013 (Ministry of Health, Republic of Indonesia, 2018).

Current therapeutic approaches are built upon various hypotheses explaining the etiology of anxiety disorders. Based on the biopsychosocial model, therapeutic interventions generally include both psychotherapy and psychotropic medication. Although pharmacological treatment is not always necessary, cognitive-based psychotherapeutic interventions such as **Cognitive** Behavioral Therapy (CBT)—have proven to be effective and are considered the gold standard for treating anxiety disorders (Ströhle et al., 2018). In fact, Mayo-Wilson and colleagues (2014) found that for certain types of anxiety disorders, such as social anxiety disorder (formerly known as social phobia), CBT outperforms other psychological therapies and pharmacological treatments.

CBT itself is a combination of two previously distinct schools of psychotherapy: cognitive therapy and behavioral therapy. Cognitive therapy operates on the assumption that psychological disorders arise from maladaptive thought patterns, and its primary goal is to restructure those patterns. Meanwhile, behavioral therapy is grounded in the view that behavior is learned, and therefore aims to help individuals acquire adaptive behaviors and eliminate dysfunctional ones (Gellman, 2020).

In the development of Christian counseling, some biblical counselors have begun adopting CBT to address psychological issues such as anxiety. CBT is regarded as a practical and structured method for altering negative thought patterns. However, this adoption has sparked controversy. Critics argue that CBT risks replacing the authority of Scripture with secular psychological principles, creating tension between modern clinical approaches and the values of Christian faith. Biblical counseling is rooted in the conviction that God's Word is sufficient and fully authoritative for human restoration—not through psychological theory, but through repentance, application of biblical truth, and the work of the Holy Spirit.

Thus, integrating methods like CBT is seen by some as a shift from spiritual restoration to naturalistic technical solutions. Some critics claim that CBT undermines doctrinal clarity and marginalizes spiritual aspects such as sin and heart renewal. Although CBT incorporates positive elements, such as personal responsibility, it is still considered insufficient in directing individuals toward Christ as the true center of healing. The article "*Biblical Counseling is not Cognitive Behavioral Therapy (CBT): A Biblical Critique*" highlights the fundamental difference between the two: CBT focuses on cognitive restructuring for the sake

of well-being, whereas biblical counseling emphasizes spiritual transformation through the Word of God.

Even so, Jay Adams, a key figure in Nouthetic Counseling, recognized the importance of interdisciplinary dialogue and opened the possibility for integration, provided it is approached cautiously. Therefore, an integrative framework is needed one that allows for the utilization of CBT techniques without compromising the authority of Scripture. This paper aims to explore the application of CBT principles within biblical counseling for addressing anxiety, and to evaluate the extent to which these methods can be aligned with Christian faith, remaining faithful to the Word of God while also being open to empirically supported techniques.

LITERATURE REVIEW

The integration of Cognitive Behavioral Therapy (CBT) with faith-based counseling has been one of the approaches that has received significant attention in the psychotherapy literature of the last decade. Religiously Integrated Cognitive Behavioral Therapy (RCBT) is a CBT development that adapts religious values into the cognitive-behavioral therapy framework. Pearce et al. (2014) formulated a manual of RCBT across religions, including Christianity, Islam, Judaism, Hinduism, and Buddhism, which emphasizes strengthening the meaning of life, managing negative thoughts, and adjusting behavior within the framework of spiritual values. This approach allows the therapeutic process to become more culturally and religiously relevant to the faith counselor. Koenig et al. (2015) showed that RCBT has equal effectiveness, even superior in increasing optimism in patients with major depressive disorder (MDD) who hold religious values compared to conventional CBT. In line with that, Ogorek and Isaacson (2020) emphasized that RCBT can be an evidence-based alternative for depressed people who are open to spiritual intervention.

This study views the integration of CBT techniques in biblical counseling as a form of adjustment that maintains harmony between modern psychotherapeutic strategies and Christian faith principles. From a practical perspective, the application of Biblical Counseling that utilizes the CBT framework includes cognitive restructuring interventions and behavioral skills training tied to biblical teachings. This model is in line with the integrative approach described in the modern Christian counseling literature, where the renewal of the mind is positioned as the core of psychological and spiritual change (Integrity Seminary, 2023).

Recent research also underscores a transformational model, which is a counseling strategy that not only restores behavioral functions (restoration), but also results in deeper changes in identity and values (transformation). However, this integrative approach cannot be separated from theological criticism. An article from the Transform Conference (2024) warns that CBT has basic assumptions that are secular and symptom-oriented, so its application in biblical counseling requires modifications so as not to conflict with the principles of faith. Effective integration therefore demands clarity of theological framework,

sensitivity to cultural differences of faith, and adequate support of empirical evidence.

METHODOLOGY

This study employs a literature review approach, as its primary focus is a conceptual examination of the use of Cognitive Behavioral Therapy (CBT) within biblical counseling, particularly in addressing anxiety disorders. The review is also aimed at critically evaluating how anxiety is understood—whether as a clinical disorder requiring psychological intervention, or as a spiritual struggle necessitating faith-based responses. A literature review enables the researcher to explore sources from various disciplines, including Christian theology, clinical psychology, and pastoral counseling. The analyzed materials include peer-reviewed journals, major reference books, and digital articles that discuss anxiety disorders, CBT approaches, and Bible-based counseling. Sources were selected based on academic criteria such as credibility, recency, and topical relevance. The author critically reflects on how the integration of CBT and Christian faith can be carried out without compromising the authority of Scripture, while also discerning appropriate contexts in which anxiety should be addressed clinically or spiritually within a holistic Christian counseling framework.

RESEARCH RESULT AND DISCUSSION

Definition of Anxiety Disorders

This study discusses a range of **anxiety disorders** characterized by **excessive fear, anxiety**, and associated behavioral disturbances (American Psychiatric Association, 2022). It is important to distinguish anxiety disorders from **everyday anxiety**, which is a common experience for all individuals. Both fear and anxiety are **normal adaptive responses** to potentially dangerous environments, playing a crucial role in helping individuals remain alert and survive threats. However, this article focuses on **pathological anxiety disorders**, in which responses become **maladaptive** and significantly **disrupt daily functioning**.

According to the **American Psychological Association**, anxiety disorders are part of a group of disorders primarily characterized by emotional states involving **excessive fear, worry**, or anxiety (VandenBos & American Psychological Association, 2007). Fear refers to a **conscious emotional reaction** to an imminent threat or danger, whereas anxiety involves the **anticipation of future threats**, whether real or imagined. Although fear and anxiety are often adaptive and facilitate survival, they become **disorders** when they are **disproportionate to actual threats**, persist over time, and impair **normal functioning** (Penninx et al., 2021). Thus, fear and anxiety in anxiety disorders are not typical human experiences; rather, they are **intense and chronic**, severely disrupting everyday activities and quality of life.

In a clinical context, pathological fear and anxiety are not merely momentary emotional reactions but **deep psychological conditions** that affect how individuals think, feel, and behave. Symptoms may include **obsessive thoughts about threats**, **avoidance of certain situations**, **sleep disturbances**, **difficulty concentrating**, as well as **physical manifestations** such as heart

palpitations, shortness of breath, and muscle tension. Therefore, anxiety in this context is no longer adaptive, but becomes a **source of chronic psychological distress**, significantly diminishing one's well-being. Recognizing these dynamics is vital not only in **psychological care** but also in **pastoral and theological approaches**, since the suffering caused by anxiety disorders touches on deeply **existential dimensions** such as safety, relationships, meaning, and faith.

The **pathophysiology of anxiety disorders** is the result of complex interactions between **neurobiological, genetic, and environmental factors** that affect brain circuitry and neurotransmitter systems. Central to this process is the **dysregulation of the fear-anxiety circuit and extinction circuit**, involving key brain areas such as the **amygdala**, **prefrontal cortex**, and **hippocampus**. These circuits are influenced by **neurotransmitters** including **GABA, serotonin, and norepinephrine**, and are further modulated by **genetic and epigenetic** factors (Rubin & Walth, 2025).

Clinical Presentation

Although anxiety disorders comprise several distinct diagnoses, they often share similar **clinical features**. **Stahl (2021)** categorizes the core symptoms into two domains: **fear-related symptoms** and **worry-related symptoms**. Fear-related symptoms are commonly associated with **autonomic arousal** necessary for the **fight-or-flight** response, thoughts about **immediate danger**, and **escape behaviors**. Worry-related symptoms are more often associated with **muscle tension**, **heightened vigilance** in preparation for future threats, and **avoidant or cautious behavior** (American Psychiatric Association, 2022, p. 215). Autonomic symptoms are especially prominent and give anxiety disorders their characteristic presentation. Common physiological sensations include **headaches**, **gastrointestinal discomfort**, **chest tightness**, **palpitations**, and **sweating**, while motor symptoms may manifest as **restlessness** (Boland et al., 2022). The **type and severity** of these symptoms can vary depending on the **specific diagnosis** within the anxiety disorder spectrum. For example, in **panic disorder**, severe anxiety symptoms are typically more pronounced than in other anxiety conditions.

An illustration in Figure 2.1 (not included here) provides a broad comparison among various types of disorders that fall within the anxiety disorder category.

	Selective mutism	Separation anxiety	Specific phobia	Social anxiety disorder	Agoraphobia	Panic disorder	Generalised anxiety disorder
Core emotions or cognitions	Consistent failure to speak in situations for which there is an expectation to speak, despite language competence	Unrealistic, persistent fear or anxiety about separation from, or loss of, attachment figure, or adverse events occurring to them	Marked, excessive, and unreasonable fear or anxiety of circumscribed objects or situations (eg, animals, natural forces, blood injection, or places)	Marked, excessive, and unreasonable fear or anxiety of scrutiny or negative judgement by other people	Marked, excessive, and concerning fear of leaving home, entering closed or open public places, crowds, or transportation	Recurrent, unexpected panic attacks with sustained mental (eg, fear, fear of losing control, or feeling of alienation) manifestations	Marked, uncontrollable, and anxious worry and fears about everyday events and problems
Physical symptoms	No physical symptoms	Nightmares and symptoms of distress	No physical symptoms	Blushing, fear of vomiting, urgency or fear of micturition or defaecation	No physical symptoms	Multiple symptoms (eg, palpitations, dyspnoea, diaphoresis, chest pain, dizziness, paraesthesia, or nausea)	Restlessness, fatigue, irritability, difficulty concentrating, muscle tension, sleep disturbance, or autonomic arousal
Behaviour	Disturbance interferes with (educational) achievement or social communication	Reluctance to leave attachment figure; disturbance impairs social, school, or other functioning	Avoidance of circumscribed objects or situations; disturbance impairs social, school, work, or other functioning	Avoidance of social interactions and situations; disturbance impairs social, school, work, or other functioning	Avoidance of fear-inducing situations; disturbance impairs social, school, work, or other functioning	Changed behaviour in maladaptive ways related to the attacks; disturbance impairs social, school, work or other functioning	Disturbance impairs social, school, work, or other functioning
Required symptom duration	>1 month (beyond first school month)	>1 month (childhood; 4–18 years); >6 months (adulthood; 18 years or older)	>6 months	>6 months	>6 months	>1 month	>6 months
Median age of onset	Childhood (<5 years)	Childhood (around 6 years)	Childhood (around 8 years)	Early adolescence (around 13 years)	Late adolescence (around 20 years)	Adulthood (around 25 years)	Adulthood (around 30 years)

Characteristics and features for anxiety disorders were based on criteria from the Diagnostic and Statistical Manual of Mental Disorders (fifth edition) and International Classification of Diseases (11th edition).

Table 1: **Core diagnostic features and characteristics for anxiety disorders**

Figure 1. Clinical Symptom Differences
Source: Penninx, 2021

This table presents the core diagnostic characteristics of various types of anxiety disorders based on the criteria from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) and the International Classification of Diseases, Eleventh Revision (ICD-11). In general, anxiety disorders involve intense emotional or cognitive responses, such as fear and anxiety, that are disproportionate to the actual situation. The table compares seven types of anxiety disorders: selective mutism, separation anxiety disorder, specific phobia, social anxiety disorder, agoraphobia, panic disorder, and generalized anxiety disorder (GAD). Each disorder has distinctive core symptoms. For example, selective mutism is marked by the inability to speak in specific social settings, despite having normal language ability, while separation anxiety involves excessive distress related to separation from attachment figures.

Specific phobia and social anxiety disorder are characterized by intense fear of specific objects or situations and fear of negative evaluation by others, respectively. In contrast, agoraphobia centers on the fear of public places or situations where escape might be difficult, panic disorder is marked by recurrent and unexpected panic attacks, and GAD involves persistent and uncontrollable worry about various aspects of daily life.

Some disorders do not prominently feature physical symptoms, but disorders such as panic disorder present many somatic symptoms, including palpitations, shortness of breath, or chest pain. Behaviorally, all these disorders exhibit avoidance patterns or significant dysfunction in social, educational, or occupational life. The minimum duration for diagnosis varies, though most require symptoms to persist for more than six months, except for selective mutism and separation anxiety, which can be diagnosed after one month of symptoms. Age of onset also differs: most disorders first appear in childhood or adolescence, such as specific phobia (around age 8) and social anxiety disorder

(around age 13), whereas panic disorder and GAD typically emerge in adulthood. Understanding these diverse characteristics is essential for distinguishing between anxiety disorders and for developing contextually appropriate interventions clinically and pastorally.

Diagnostic Basis of Anxiety Disorders

Categorical diagnostic criteria are clinically useful, yet the boundaries between disordered anxiety and normative anxiety are often blurred. Differentiating between disorders requires clinical judgment regarding severity, duration, and, importantly, the level of distress and impairment (Penninx et al., 2021). The key distinction between general anxiety disorders and normal anxiety lies in the excessiveness, uncontrollability, and disruptive impact of the worry (Boland et al., 2022). For instance, while public speaking may be nerve-wracking for many, in individuals with social phobia, it can trigger severe anxiety symptoms, even panic attacks.

Anxiety is a natural emotional response to threat or uncertainty. However, in a clinical context, anxiety disorders are psychological conditions marked by persistent, excessive, and difficult-to-control anxiety that impairs daily functioning. These include generalized anxiety disorder (GAD), panic disorder, social anxiety disorder, and phobias. The causes are complex and multifactorial, involving biological factors (e.g., neurotransmitter imbalances), psychological factors (e.g., trauma, maladaptive thought patterns), and sociocultural-environmental factors (e.g., life stress, occupational strain, interpersonal difficulties). In this context, anxiety should not always be viewed as a spiritual weakness or disobedience to God, but rather as a medical condition that may require psychotherapy and/or pharmacological treatment.

To make a clinical diagnosis, practitioners generally refer to the DSM-5 as the standard diagnostic manual. The DSM-5 categorizes anxiety disorders based on characteristic features, including separation anxiety disorder and selective mutism (primarily childhood-onset; between ages 4–18), specific phobias, social anxiety disorder, generalized anxiety disorder, panic disorder, and agoraphobia (typically adult-onset; age 18 and older). Additional categories include substance/medication-induced anxiety disorder and anxiety disorder due to another medical condition (American Psychiatric Association, 2022).

Cognitive Theory of Anxiety Disorders

Next, the paper explores cognitive theories that explain the development and maintenance of anxiety disorders. These theories emerge from the biopsychosocial model of mental disorders and emphasize the role of cognition in anxiety. Various frameworks within the cognitive tradition aim to conceptualize anxiety from this perspective. In general, cognitive theory posits that thoughts influence emotions (Clark & Beck, 2011, p. 31). One widely accepted model is the Beck cognitive model, which outlines how maladaptive thought patterns underlie anxiety symptoms. According to Beck's cognitive theory, anxiety disorders are sustained by distorted cognitions about the self, the world, and the future. These distorted thoughts lead to biased interpretations of

threat, heightened vigilance, and avoidant behaviors. Figure 2.2 (not included here) illustrates the formulation of anxiety disorders based on Beck's cognitive model.

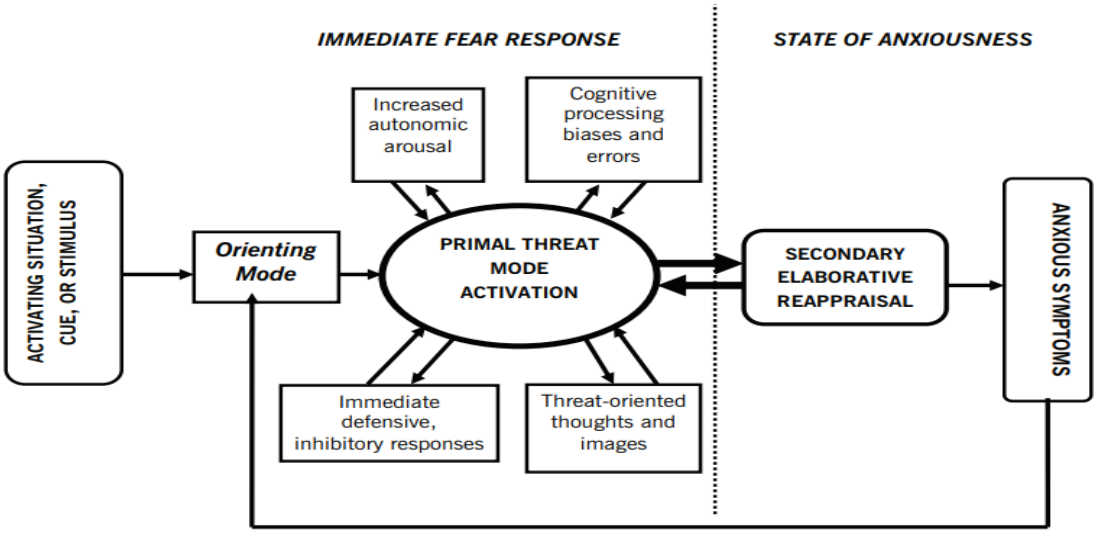

Figure 2. Conceptual Model of Anxiety Disorders
Source: Beck, 2011

Cognitive Distortions in Anxiety Disorders

Cognitive distortions refer to inaccurate, unrealistic, and typically negative patterns of thinking characteristic of individuals with anxiety disorders. These distortions play a central role in the development and maintenance of anxiety symptoms, whether through exaggerated threat appraisals, misinterpretation of situations, or negative beliefs about the self (Clark & Beck, 2011).

According to Beck, several common forms of cognitive distortions found in anxiety disorders include:

1. Exaggerated Threat Appraisals
   Anxious individuals exhibit excessive selective attention to risks or dangers and perceive threats as highly serious and threatening to their vital interests and well-being.
2. Heightened Helplessness
   Anxiety often involves an underestimation of personal ability to handle difficult situations. Consequently, individuals feel powerless even though they have the capacity to cope with challenges.
3. Inhibitory Processing of Safety Information
   In individuals with anxiety disorders, information or cues indicating that a situation is actually safe tend to be ignored or poorly processed, so the perception of threat remains dominant.
4. Impaired Constructive or Reflective Thinking
   When anxious, a person struggles to access logical, realistic, and reflective thinking. As a result, the ability to rationalize fears or solve problems is impaired.
5. Automatic and Strategic Processing

Anxiety disorders involve a mix of negative automatic thoughts and ineffective cognitive strategies, causing anxiety to persist unintentionally and uncontrollably.

6. Self-Perpetuating Process
   The anxiety cycle repeats and reinforces itself. Individuals become increasingly focused on their anxiety symptoms (such as rapid heartbeat or shortness of breath), which further intensifies the anxiety.
7. Cognitive Primacy
   Primary cognitive evaluations of danger and personal vulnerability can lead to threat generalization, causing individuals to interpret various neutral situations as threatening and respond defensively.
8. Cognitive Vulnerability to Anxiety
   The tendency to experience anxiety is influenced by core schemas or beliefs about helplessness, personal weakness, and a dangerous world. These schemas form the basis for excessive anxious reactions to certain situations.

Biblical Perspective on Anxiety

In Jesus' teaching in Matthew 6, anxiety is highlighted not only as an emotional issue but as a matter of faith. Four times Jesus emphasizes, "Do not worry" about life (v.25), age (v.27), basic needs (v.31), and the future (v.34). This repeated emphasis shows that anxiety is not trivial but a symptom of something deeper. The root of anxiety is explicitly explained in Matthew 6:30, when Jesus rebukes, "O you of little faith!" Here, anxiety is directly linked to a lack of faith in the Father in heaven. When disbelief or doubt about God's provision dominates the heart, anxiety arises as a result. In this context, anxiety is seen as a form of spiritual unbelief—a response of a heart that does not fully trust in God's goodness and power. The author of Hebrews also warns against the danger of a "hard unbelieving heart," which in application may mean a heart filled with anxiety. Thus, some anxiety indeed arises not merely from psychological disturbances but from weak faith and fractured trust in the sustaining God.

One may also experience anxiety rooted in struggles of faith, such as feelings of guilt over sin, fear of God's judgment, or uncertainty about salvation. This anxiety emerges from an inner conflict between theological beliefs and one's personal spiritual condition. For example, a person with a legalistic view of salvation may live in constant fear of God's wrath, even though doctrinally they have been justified by faith. Theologically, anxiety can be viewed as part of the human condition stemming from separation, alienation from God, existential uncertainty, or loss of life's meaning. Thus, anxiety in its deepest form can be understood as an existential consequence of humanity's separation from God. In Genesis 3, humanity's first response to sin was fear and hiding (Gen. 3:10). This shows that anxiety is a post-fall experience accompanying shame, guilt, and alienation from God. Therefore, in a theological framework, anxiety is not simply healed through psychological function improvement but through reconciliation only possible in Christ.

Besides being a general condition due to the fall, anxiety can also arise from awareness of personal sin that has not been confessed or dealt with before

God. In Psalm 32:3–4, David describes his struggle before confessing sin, "My bones wasted away through my groaning all day long." In this context, anxiety is a spiritual warning that something is wrong spiritually. Such experiences are often found in pastoral counseling practice: someone feels restless, depressed, or afraid of punishment, while the primary source is guilt unaddressed by the gospel. In many cases, anxiety is also triggered by erroneous theological views. For instance, a person with a legalistic view of salvation tends to live in constant fear of God's wrath. This contradicts the truth that justification by faith (Rom. 5:1) brings peace with God. In Christian faith, emphasis on God's unconditional grace and his eternal care is the primary foundation for overcoming the fear of divine rejection. Thus, correcting false doctrine is an important part of spiritual restoration and reducing anxiety in the context of faith.

However, it is important to acknowledge that even when someone doctrinally believes biblical truths, this does not automatically eliminate emotional anxiety. Here lies the importance of distinguishing between rational confession of faith and true heart union with Christ. The Apostle Paul, for example, was no stranger to "inner struggles" (2 Cor. 1:8–9) that even led him to despair, yet he still trusted in God who raises the dead. This shows that faith does not mean absence of anxiety but the ability to bring anxiety to God in prayer and steadfast hope (Phil. 4:6–7). In the Reformed tradition, pastoral care for anxiety includes heart and mind formation through the Word, as well as spiritual disciplines like prayer, confession of sin, and holy fellowship. Nonetheless, the recognition of creation as "already fallen but not yet fully restored" opens space for understanding the complexity of anxiety, which also involves biological and psychological factors. In this context, medical approaches and therapies like Cognitive Behavioral Therapy (CBT) can be common grace tools used by God to support His people, as long as they remain under the supremacy of the Gospel and biblical authority.

Christian counselors are called not to replace the work of the Holy Spirit but to be instruments in God's hands to lead souls to truth and restoration. This requires counselors to have deep theological understanding and sensitive pastoral wisdom. In dealing with anxiety, counselors need to help counselees identify the root of their anxiety—whether trauma, hidden sin, or distorted faith—and lead them to Christ as the One who understands human weakness (Heb. 4:15) and gives peace that surpasses all understanding (Phil. 4:7). Here, Christian counseling is not merely soul therapy but ministry of the Word and shepherding that leads to repentance and relief in Christ. Ultimately, Christian faith views anxiety experienced by believers as to be addressed in the light of eschatological hope. In a world full of suffering and uncertainty, we await perfect restoration at Christ's second coming. Revelation 21:4 promises that God will "wipe away every tear" and there will be no more "mourning or crying or pain." This hope is not escapism but an acknowledgment that this world is not the final destination. Thus, in facing anxiety, believers are called to fix their hearts on "the city that has foundations, whose architect and builder is God" (Heb. 11:10), and thereby find true rest in His grace and eternal promises.

The Cognitive Behavioral Theory Perspective on Anxiety

According to the cognitive theory proposed by Beck (2011), anxiety disorders can arise when individuals hold erroneous or negative thinking patterns. Beck and Knapp (2008) explained that individuals experiencing anxiety tend to develop cognitive distortions as well as maladaptive behaviors. These distortions are a form of cognitive bias known in Beck's terminology as automatic thoughts. Beck emphasized that psychological disorders such as anxiety are not merely caused by specific events or experiences but rather by inaccurate or distorted ways of interpreting those events. Psychologically, cognitive behavioral therapy (CBT) understands anxiety as a result of learned cognitive distortions and behaviors that reinforce fear and maladaptive responses.

One way to overcome cognitive distortions is through cognitive behavioral therapy (CBT). CBT is a combination of two psychotherapy approaches—cognitive therapy and behavioral therapy—that originally developed separately. Cognitive therapy is based on the assumption that psychological disorders stem from maladaptive thinking patterns. Therefore, this approach focuses on restructuring or changing the thought patterns that underlie the emergence of such disorders. Meanwhile, behavioral therapy is grounded in the view that behavior is a result of learning processes. Thus, behavioral interventions aim to help individuals learn adaptive behaviors and abandon dysfunctional ones.

Pastoral Reflections on Integrating Cbt in Anxiety Disorder Care

Cognitive Behavioral Therapy (CBT)

CBT and similar psychotherapies have been recommended as the gold standard for treating anxiety disorders (Carpenter et al., 2018). CBT is a short-term therapy (consisting of eight to twenty sessions) that incorporates principles from behavioral and cognitive psychology. Besides non-pharmacological therapy, pharmacotherapy also serves as a first-line treatment for anxiety disorders, especially in cases resistant to psychotherapy, chronic or complex conditions, and comorbidities (Penninx et al., 2021). The cognitive approach emphasizes human cognitive abilities—that is, the intellectual capacity to think, remember, and anticipate. Cognitive theorists argue that cognitive processes are at the core of behavior, thoughts, and emotions, and that abnormal psychological functioning is best understood through the cognitive perspective known as the cognitive model. This model states that cognitive processes influence human behavior as an intermediary variable between stimulus and response. Cognitive therapists believe that psychological disorders arise due to inaccurate or maladaptive thinking patterns (Mohamed Arip, 2024). Therefore, the primary goal of therapy is to change or reconstruct the client's way of thinking by developing more functional thought patterns (Beck, 1986; Eysenck & Keane, 2015).

In Beck's cognitive therapy approach, therapists help clients recognize negative thoughts, biased interpretations, and logical errors in their thinking. Beck's theory assumes that anxiety is caused by distorted views of reality. These cognitive distortions cause individuals to have negative views of themselves,

others around them, and ultimately, the world as a whole. Beck found that individuals with anxiety and depression often have automatic thoughts—irrational ideas that dominate their lives, described as "words or images that suddenly come to mind." Behind these automatic thoughts usually lie core beliefs, which are fundamental beliefs considered absolute truths about oneself and the world, applicable across various situations (Beck et al., 2024).

Between core beliefs and automatic thoughts lie intermediary beliefs, consisting of attitudes, rules, and assumptions. When someone is in a certain situation, these core and intermediary beliefs influence the emergence of automatic thoughts, which in turn affect the individual's mood and behavior. The goal of therapy is to help clients stop negative automatic thinking patterns and modify core beliefs, enabling them to develop a more realistic perspective toward the situations they face (Beck et al., 2024).

The behavioral approach, a product of behaviorism, states that scientific psychology should only study observable behavior. This approach emphasizes a person's response to the environment rather than internal mental events. American psychologist John Watson, known as a behaviorism pioneer, stated that all behavior and its changes can be explained through classical conditioning—a process in which a stimulus acquires the ability to evoke a response previously elicited by another stimulus. Through his famous experiment with the subject "Little Albert," Watson found that loud noises, such as a gong strike, could induce fear in the child subject. This finding is considered an early explanation for the etiology of fear in humans. Behaviorists believe that the stimulus-response relationship is key to understanding human behavior and that even complex behaviors can be formed or eliminated through learning processes involving classical conditioning (Ledley et al., 2018).

Biblical Counseling

The biblical counseling movement emerged in the late 1960s as a critical response to the increasing influence of secular psychiatry and psychotherapy. This movement aimed to restore the church's role in addressing personal and spiritual issues through a distinctive theological framework. Key figures such as Jay Adams and David Powlison played vital roles in shaping this movement, promoting a counseling paradigm that acknowledges the complexity of human struggles while remaining firmly rooted in a biblical worldview (Davis, 2023).
Biblical counseling aims to help individuals experience personal change and spiritual growth by guiding them to live lives reflecting Christian principles and teachings. Counseling emphasizes the power of the Holy Spirit to transform hearts and minds (Campbell-Lane & Lotter, 2005).

Despite the clear foundational differences between Biblical Counseling and CBT, some views hold that these two approaches can be integrated. Some Christian counselors combine contemporary psychological methods with biblical principles to meet both the psychological and spiritual needs of individuals. The goal of this integration is to provide a holistic counseling approach that recognizes the value of empirical techniques while maintaining a focus on spiritual growth and the teachings of God's Word (Falaye, 2013).

The ideology of biblical counseling is rooted in the sufficiency of Scriptures as the authoritative source for understanding human nature, sin, and restoration. Adams states that non-organic mental problems are purely caused by sin; therefore, change is needed to live according to biblical standards through various forms of counsel as an expression of loving care (Utomo, 2018).
The methodology used in counseling includes: first, addressing transitional issues clients face in various life phases; second, discovering and discussing new data or dynamics emerging during the counseling process; and third, client commitment to accept beliefs, make decisions, and adopt new behaviors aligned with biblical principles. Thus, biblical counseling also employs analytical methods that promote holistic life transformation through repentance and spiritual growth (Adams & Adams, 1986).

Integrative Perspective

Gary R. Collins is a prominent figure in the Christian counseling movement who emphasizes the importance of an integrative approach between modern psychology and biblical principles. In his monumental work *Christian Counseling*, Collins asserts that truth can be found both in general revelation (psychology, science) and special revelation (the Bible), and both should be seen as complementary, not contradictory. He rejects dualism that completely separates faith and science and encourages open dialogue that respects biblical authority while appreciating empirical findings in psychology (Collins, 2019).

Collins believes that effective Christian counseling not only focuses on symptom reduction but directs individuals toward spiritual growth, relational restoration, and character transformation into Christlikeness. Integration, therefore, is not merely mixing two approaches but filtering psychological principles through the lens of Christian faith. He emphasizes that all psychological approaches must be evaluated based on biblical truth (Collins, 2019). Collins states that combining both helps us understand humans better and assist those needing psychological-spiritual help more effectively (Johnson & Collins, 2009).

Additionally, Collins notes that Christian counselors engaging in cross-disciplinary integration need competence in two fields: psychology and theology (Johnson & Collins, 2009). True integration happens when counselors not only apply techniques but also guide clients toward faith growth and awareness of God's work in their lives. This requires counselors to be spiritually non-neutral but agents of transformation led by the Holy Spirit, using the Bible as the primary foundation for assessing the meaning of suffering, change, and hope. Finally, Collins stresses that integration is dynamic, not a fixed formula. The client's context, background, and spiritual maturity level are important factors determining the depth of integration possible. Thus, integration according to Collins is not theological compromise but an effort to empower counseling with the riches of both general and special grace simultaneously, aiming for the holistic restoration of humans—psychologically, socially, and spiritually (Collins, 2019).

Space for Integration of CBT in Biblical Counseling:

1. Helping clients recognize thought patterns that do not align with the truth.
   CBT methods facilitate counselors in helping clients identify cognitive distortions (e.g., negative assumptions, irrational thoughts) which often lie at the root of anxiety. In an integrative approach, this can be paired with spiritual disciplines such as biblical reflection or renewing the mind (Romans 12:2).
2. Aligned with the principle of repentance and changing perspectives
   CBT encourages clients to replace faulty thinking with more realistic and adaptive thoughts— a process spiritually comparable to *metanoia* (repentance), which means a change of mind and life direction. However, it is important to remember that the humanistic approach of CBT should be paired with biblical counseling that objectively upholds God's Word and spiritual guidance in the form of biblical truth advice.
3. Developing self-control skills and self-awareness
   CBT focuses not only on cognition but also on managing behavior and emotions, such as through relaxation techniques, journaling, and exposure. This is relevant to developing spiritual disciplines like self-discipline and perseverance in the Christian faith.
4. Open to integration of faith values
   CBT can be methodological rather than ideological; thus, it is open to being combined with Christian values such as hope, grace, and trust in God. Several studies even support religiously integrated CBT (e.g., Christian CBT) as an effective form (de Abreu Costa & Moreira-Almeida, 2022). However, integration is not merely adding methods without reviewing the philosophy behind CBT. Responsible integration goes beyond mental recovery to spiritual transformation.
5. Encouraging active involvement and personal responsibility
   CBT emphasizes the client's active role in the healing process, which aligns with the Christian view that humans cooperate with God's grace in growth and restoration (Philippians 2:12-13).

The Use of Cognitive Behavioral Therapy (CBT) in Biblical Counseling Raises Theological Risks

Particularly when used without filtering through Christian faith values. One main weakness of CBT is its tendency to view anxiety only as a disorder of thought patterns and behaviors, neglecting that sometimes anxiety stems from spiritual issues such as lack of trust in God, guilt from sin, or spiritual emptiness. However, not all anxiety originates from spiritual problems. Often, anxiety is a complex psychological condition influenced by biological factors, trauma, or intense life stress. Therefore, counselors need theological and clinical sensitivity to discern when spiritual intervention is needed and when professional psychological approaches are necessary. CBT's emphasis on human effort to restructure thoughts risks shifting the meaning of healing from the work of the Holy Spirit to mere human cognitive power. This can obscure God's grace and power in transformation. Moreover, since CBT lacks concepts of sin, forgiveness, or grace, it often misses the deeper heart conflicts related to the human-God

relationship. Its technical approach may exclude divine interventions like prayer, spiritual comfort, and God's presence—core to Christian counseling. Without theological critique, overuse of CBT can shift authority from Scripture to human methods and weaken confidence in the sufficiency of Scripture. Therefore, CBT should only be used as a limited tool, not as the main foundation in Gospel-centered counseling.

Model of CBT and Biblical Counseling Integration for Anxiety Disorders

1. Initial Assessment and Problem Conceptualization
   At the first meeting, the counselor maps anxiety symptoms and the client's spiritual context. The counselor can use CBT techniques such as Socratic questioning and the downward arrow technique to explore automatic thoughts and intermediate beliefs related to anxiety. It is crucial to distinguish whether the issue is spiritual or not by observing the situations or stimuli triggering the anxiety. At this stage, the counselor may conduct a spiritual interview to assess the client's spiritual maturity and views on God, sin, and hope. This step helps identify potential sin roots or conflicts with faith principles (e.g., excessive control, distrust in God's providence). Counselors must understand anxiety broadly, especially concerning stimuli and responses that are not spiritual problems. Counselors should also clarify that the integrative approach leads to transformation, not just mental improvement. The client's spiritual maturity is essential; clients must be spiritually ready to explore and obey biblical truth. Without a strong faith foundation or new birth, transformational approaches centered on repentance and Christlikeness may be hard to accept or fully internalize. Spiritual sensitivity and pastoral care are key in determining intervention depth so counseling is effective psychologically and has eternal spiritual impact.
2. Biblical Education and Psychoeducation
   At this stage, the counselor helps the client understand anxiety conceptually that anxiety can stem from faulty perceptions but is not always sin. Explain how anxiety can form cognitively and biologically. The client learns emotional responses are not always sinful but can open doors for spiritual reflection.
3. Correcting Cognitive Distortions with Biblical Reframing
   The counselor helps the client replace irrational thoughts with liberating spiritual and cognitive truth using cognitive restructuring. The counselor repeatedly asks what Scripture says that conflicts with the client's cognitive distortions or maladaptive thoughts. However, this should not be one-way advice but involve active discovery of values within the truth. Beyond changing concepts, the counselor encourages repentance when spiritual elements like pride or lack of faith underlie distortions.
4. Surrender of Control and Spiritual Practice
   The counselor builds faith responses to uncertainty and fear by modifying behaviors. Replace safety behaviors with spiritual grounding such as singing, giving thanks, or reading Psalms during anxiety.

5. Behavioral Activation and Spiritual Discipline
   The counselor trains courage to face anxiety triggers with God's strength. Gradual exposure to triggers combined with spiritual activities: reading verses, faith journaling, or singing praises. Behavioral activation is not merely functional activity but spiritual discipline to strengthen faith and identity.
6. Evaluation, Growth, and Discipleship
   Each therapy session evaluates progress, encourages growth, and involves the client in faith community. Assess cognitive, spiritual, and behavioral changes. Sessions may end with the client summarizing insights and counselor accompanying if the mental issues are healthy. Sessions conclude with prayer as dependence on God the healer. If anxiety is not primarily spiritual, the counselor can collaborate with other professionals for complementary care but maintain integrative accompaniment believing anxiety is part of spiritual growth

CONCLUSION AND RECOMMENDATIONS

This paper emphasizes that although CBT has been empirically proven effective in addressing anxiety disorders, its application in Biblical counseling cannot be done pragmatically without deep theological considerations. In the practice of Biblical counseling, the use of CBT is only justified if it remains subject to the authority of God's Word as the highest source of truth. Christian counselors must place the Bible as the primary foundation in evaluating, filtering, and directing every technique used, including CBT. The integration between CBT and Christian counseling must be rooted in the paradigm of the sufficiency of Scripture, so that CBT functions only as an aid tool, not the main foundation of restoration.

The ultimate goal of counseling is not merely mental function recovery or symptom reduction, but true heart transformation by the work of the Holy Spirit. Therefore, cognitive change in CBT is insufficient if it remains only rational; cognitive distortions must be connected to and submitted under biblical truth. Although there is a technical intersection between cognitive restructuring in CBT and the principle of renewing the mind in the Christian faith (Romans 12:2), CBT still has limitations in touching the deepest dimensions of humans that include sin, relationship with God, and the need for transformation by the Holy Spirit, because not all anxiety originates from spiritual issues; in some cases, the symptoms may be more biological or situational in nature. Here lies the importance of professional awareness: counselors need to recognize their competency boundaries and be willing to refer to medical professionals when functional recovery is needed rather than just spiritual transformation. Therefore, Christian counselors are called to develop a holistic approach rooted in God's Word, open to valid scientific methods, and sensitive to the psycho-spiritual reality of the counselee, recognizing that they are not substitutes for Christ but pastoral partners in the true restoration process.

Above all, Christian counselors must realize that faith is not the result of human effort through therapy or cognitive techniques but is a gift from God. Thus, the counselor's role is not as a savior or changer but as a faithful companion who helps the counselee walk in the light of the Gospel toward deeper

knowledge and dependence on Christ. Counselors also need to be competent integrators who understand both psychological and theological fields and apply them with a God-fearing heart for the restoration of the counselee. This effort is to develop an approach in serving God's church. Finally, Christian counseling is challenged to integrate restoration and reformation of the mind in the light of the Gospel, making it not merely a means of mental recovery but also a vehicle of grace to shape a Christ-like character.

ADVANCED RESEARCH

Future advanced research on the integration of CBT techniques into Biblical counseling should focus on developing empirically tested models that maintain theological fidelity while leveraging evidence-based psychological methods. Such studies could explore the differential impact of integration approaches—restorative (symptom-focused) versus transformational (character and spiritual formation-focused)—on both psychological outcomes and spiritual growth indicators, such as increased Scripture engagement, Christ-centered identity, and behavioral sanctification. Mixed-method longitudinal designs may capture both the measurable clinical improvements (e.g., reduction in anxiety scores) and qualitative spiritual changes (e.g., testimonies of renewed dependence on God) over time. Further, research should examine competency frameworks for Christian counselors, identifying the theological literacy, clinical skills, and ethical discernment required for effective integration, as well as guidelines for interdisciplinary collaboration with medical professionals in cases where anxiety has biological or situational roots. This work would contribute to building a biblically grounded, psycho-spiritually holistic counseling paradigm that aligns with the sufficiency of Scripture while responsibly engaging contemporary mental health practices.

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