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Philadelphia College of Osteopathic Medicine

Department of Psychology

INTEGRATION OF SPIRITUALITY AND COGNITIVE-BEHAVIORAL THERAPY FOR THE TREATMENT OF DEPRESSION

By Jennifer J. Good

Submitted in Partial Fulfillment of the Requirements of the Degree of

Doctor of Psychology

July 2010

PHILADELPHIA COLLEGE OF OSTEOPATHIC MEDICINE
DEPARTMENT OF PSYCHOLOGY

Dissertation Approval

This is to certify that the thesis presented to us by Jennifer Good on the 20th day of May, 2010, in partial fulfillment of the requirements for the degree of Doctor of Psychology, has been examined and is acceptable in both scholarship and literary quality.

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possible with God, and He continues to direct my path in all areas of my life and in particular my development as a Christian Clinical Psychologist.

Abstract

Major depressive disorder (MDD) is a common mental health problem that is treated by many mental health practitioners. Cognitive-behavioral therapies have proven to be effective in helping restructure the cognitions of the client, which in turn reduces depressive symptom. Research has shown that individuals with MDD who value spirituality tend to view the world in a different way than those individuals that do not hold spirituality as an important value in their life. Spiritual individuals have religious schemas, and therefore, it would be important to incorporate spirituality into the treatment setting. This pilot study utilized a manualized treatment approach that focuses on spiritual growth and decreasing depression through a spiritually informed cognitive-behavioral approach (SICBT).

TABLE OF CONTENTS

Chapter 1……………………………………………………………………….....1

Introduction…………………………………………………………………...1

Statement of the Problem……………………………….....................................1

Purpose of the Present Study………………………………………........................2

Relevance to one or more of the goals of the Clinical PsyD program……………......3

Chapter 2. ………………………………………………………………..…………..5

Literature Review……………………………………………………………………..5

Definition…………………………………………………………………...5

Important Elements of Spirituality…………………………………………………6

Spirituality in Treatment……………………………………………………………7

Cultural differences/considerations………………………………………………...8

Assessment of Spirituality…………………………………………………………9

Clinical Issues……………………………………………………………………..11

Spirituality and Benefits…………………………………………………………..12

Spiritual Interventions……………………………………..……………………17

Major Depressive Disorder………………………………………………………..32

Spirituality and Depression………………………………………………………..51

Spirituality and Cognitive-Behavioral Treatment……………………………………52

Manualized Integrative Treatment………………………………………………...57

Chapter 3 ……………………………………………………………………………...60

Hypotheses……………………………………………………………………………..60

Research Question…………………………………………………………………...60

Statement of Hypotheses…………………………………………………………..…60

Chapter 4 …………………………………………...……………..……..70

Methods………………………………………………………………………...70

Design and Justification…………………………………………………...71

Requirements……………………………………………………………...76

Analysis of Risks/Benefits Ratio……………………………………………78

Procedure…………………………………………………………………79

Initial Evaluation…………………………………………………………..80

Diagnosis…………………………………………………………………..81

Case Formulation and Clinical Impressions………………………………………84

Chapter 5…………………………………………………..………………..88

Results……..……………………………………………………………...88

Data Sources………………………………………………………………88

Data Sources………………………………………………………………94

Data Sources……………………………………………………………..100

Data Sources……………………………………………………………..104

Objective Data…………………………………………………………...107

Chapter 6: Discussion……………………………………………………..110

Limitations…………………………………………………………………116

Future Directions……………………………………………………..…121

References……………………………………..………………………………..126

Appendices…………………………………………………………………...143

Appendix A: Ten-Week Integrative Manualized Treatment Approach Including Cognitive-Behavioral Therapy and Spirituality……………………..……..……143

Appendix B: Spiritual Assessment Tool……….……………………………..….297

Appendix C: Depression Information Sheet……….……………………………299

Appendix D: Cognitive-Behavioral Therapy Sheet…………………………......303

Appendix E: Elijah Story……………………………….…………………….....304

Appendix F: Weekly Activity Monitoring Schedule…….………………………...306

Appendix G: Weekly Check list….…………………………………………..….307

Appendix H: Cognition Log…………………………………….……………....308

Appendix I: Spiritually-Informed Dysfunctional Thought Record…………..……309

Appendix J: Biblical Passages that are Related to Various Cognitive Distortions....310

Appendix K: Cognitive Quadrant………….………………………………........326

Appendix L: Passages of God's Love……………………………….……..….327

Appendix M: Scriptures for Meditation…………….……………………….....329

Appendix N: Calendar……………………..…………………………..……335

Appendix O: Spiritual Issues for Treatment…………………..………………........336

Appendix P: Transcription of Treatment Sessions…….…………………...…350

Chapter 1

Introduction

Statement of the problem.

Spirituality is an integral and vital element in the lives of many individuals. There has been a recent explosion of studies and research in this area. Spirituality is regarded as one of the four components of overall well-being (Mohr, 2006). The four essential components of an individual, as noted by Mohr (2006), are the physical, emotional, social, and spiritual dimensions.

Spirituality may also play an important part in the identity of an individual. People often make decisions based upon their religion and may even adhere to certain rules of living founded upon their spiritual beliefs. Research has shown that spirituality is associated with values of wholeness, hope, meaning, harmony, and transcending (O' Reilly, 2004). These values help individuals cope with stressors in the world and strive toward reaching their natural potential. An important factor is ignored when the clinician fails to incorporate spirituality into the treatment of a spiritual individual.

The research and development of several approaches related to integration have evolved over time (Richards, Rector, & Tjeltveit, 1999). These methods are relatively new, receiving mixed reviews from individuals in the field of psychology. In general, some clinicians are skeptical about the integration of spirituality and therapy, as there is a general fear that this new branch of psychology may be seen as unscientific or invalid (Lindridge, 2008). Other therapists, however, embrace this new domain and continue to work towards a healthy integration of spirituality into their practice (Shafranske & Sperry, 1990).

The cognitive-behavioral approach has expanded to include spirituality. Within this approach, the therapist utilizes the basic tenets of cognitive-behavioral therapy (CBT) in combination with spiritual values and beliefs to treat the client (Beitel, Genova, Schuman-Olivier, Arnold, Avants, & Margolin, 2007). Incorporating a theory that is empirically validated with new tenets of spirituality will allow the researcher to test a hypothesis of incremental validity by synthesizing these two approaches. Once the two approaches are combined, it is feasible for the researcher to test this new approach to provide empirical validation.

Research has shown that cognitive-behavioral therapy is an effective form of treatment for individuals who are experiencing depressive symptoms (Beck, 1997). Additional studies suggest that aspects of spirituality assist in decreasing depressive symptoms (Blazer, 2007). The integration of spirituality in cognitive-behavioral therapy may assist in alleviating the depressive symptoms of a religious client. The treatment embraces the physical, emotional, social, and spiritual facets of the client through the application of a holistic approach that addresses each of these domains.

Purpose of the study.

The purpose of this study was the creation of an integrated approach to address depressive symptomatology by combining spirituality and cognitive-behavioral therapy. A case study was used to analyze the effects of a spiritually informed cognitive-behavioral approach and its effects on depression. A manualized treatment approach references the works of cognitive-behavioral therapists and spiritually oriented treatments that combine cognitive-behavioral techniques with spiritual components. Measures of depression, religiosity, therapeutic alliance, treatment adherence, and cognitive

distortions establish a baseline and assess treatment progress throughout the case study. The impact of the designed manualized treatment was examined.

Relevance to one or more goals of the clinical Psy.D. program

This research study meets all four goals established in the dissertation handbook for the Philadelphia College of Osteopathic Medicine Department of Psychology (Research Committee of the Department of Psychology, 2008). Specifically, the first goal states that the dissertation process should produce practitioner-scholars who have an appreciation and comprehension of the broad and a general knowledge base that informs the profession of psychology. This dissertation provides information related to cognitive-behavioral theory and spirituality. Both fields are relatively extensive in nature. The study examined these broad fields and created a specific and detailed approach that may assist in alleviating the symptoms of another widespread condition, depression. In doing so, this dissertation offers clinical application in the profession of psychology. This may enable psychologists to acquire new information from the research findings and utilize the techniques that are presented in the treatment manual.

The second goal states that the dissertation process will produce practitioner-scholars who effectively use empirically supported cognitive-behavioral approaches to diagnose, assess, and treat individually and culturally diverse people. One of the main features of this study is the incorporation of spirituality into the cognitive-behavioral model. By doing so, the cognitive-behavioral approach could effectively expand into other areas of treatment. This dissertation topic is also taking into account a culture, namely, the Christian community. Although some research has been compiled about this

population, there are currently limited materials with regard to the recommended treatment approach.

The third goal stipulates that the dissertation process will produce practitioner-scholars who are able to identify and understand issues of individual and cultural diversity. Through a synthesis of the research, spirituality is explored in an effort to offer more effective treatment to a culture of individuals. This study attempted to work towards an effective resolution to these concerns.

Finally, the fourth goal states that the dissertation process will produce practitioner-scholars who have adopted the attitudes and identity of professional clinical psychologists in the context of an evolving body of scientific knowledge. Advocating for the needs of our clients is an important aspect of being an effective leader in the field of psychology. This paper examines the various elements of spirituality, cognitive-behavioral therapy, and depression to create a sound integrated treatment modality for the Christian population. By advocating for a new treatment modality, it is apparent that this author is aspiring to develop and adopt the attitudes and identity of a clinical psychologist.

Chapter 2

Literature Review

Spirituality.

Spirituality has received increased attention over the course of this past decade. A variety of research has been conducted assessing spirituality and its impact upon the many components of emotional well-being (Becker, 2001; Grabovac, Clark, & McKenna, 2008; Hebert, Dang, & Schulz, 2007; Powers, Cramer, and Grubka, 2007). Spirituality has been defined in various ways and includes multiple components in these definitions.

Definition.

There is no one definition of spirituality. Becker (2001) contends that spirituality refers to the soul or the mind and different aspects of human nature that are intangible. Similarly, O'Reilly (2004) defines spirituality as an expression of the transcendent ways in which human potential is fulfilled. Synonyms such as hope, wholeness, meaning, harmony, and transcending (O'Reilly, 2004) are associated with the word spirituality. Mohr (2006) defines spirituality as an individual's search for meaning and a belief in a higher power apart from oneself.

Religion, divinity, and faith are three common words that may be misconstrued as spirituality. Worthington and Sandage (2001) define religion as a focus on the search for the sacred that is within formal institutions. Similarly, Becker (2001) states that religion is a set of beliefs that is unified by the affirmation of a higher power. Shafranske and Sperry (1990) define religion as public membership in a formal institution that contains rituals and adherence to certain denomination doctrines. These three definitions of religion differ to a degree; however, it seems that the main discrepancy between the

definition of spirituality and religion is the formal institution or membership status that is evident in religion (Mohr, 2006).

Divinity and faith are two other words with a similar connotation to spirituality. Becker (2001) characterizes divinity as the presence of a divine power, God, or deity. This definition appears more concrete. Faith has been identified as trust of things unknown and unconditional confidence in a principle (Becker, 2001). It is important to determine the different meanings that individuals associate with these various words and the ways that these connotations play out in their lives.

Important elements of spirituality.

Everyone is on a different place on the continuum of spirituality. Miller and Thoresen (1999) suggest that spirituality is a multidimensional space in which every individual can be located. These spaces may change from time to time, but individuals are working towards growth in various areas at different times in their lives.

Shafranske and Sperry (1990) propose a set of dimensions in which spirituality can be defined. These dimensions include overt behaviors, beliefs, motivations, values, goals, and subjective experiences. The overt behaviors are comprised of those practices that are viewed as sacred. These include behaviors that the individual does alone, as well as behaviors that are seen in a social context. Examples include prayer, communion, Bible study, and participation in church organizations. Beliefs are perceptions by the individual regarding personal religious convictions and the personal relationship with the worshipped deity (Shafranske & Sperry, 1990). These beliefs may vary among individuals. The third dimension encompasses motivation, values, and goals. Each of these serves to create a purpose of living for any individual (Shafranske & Sperry, 1990).

Some people may be directed toward fulfilling an aspiration of a higher power, whereas others may focus more on outreach and service to other individuals. The fourth dimension, subjective experience, is the emotional experience of an individual's spiritual journey (Shafranske & Sperry, 1990). This will wax and wane throughout time and change with development of the individual.

Some clinicians focus on the social aspect of spirituality (Kondro, 2008; Shaw, 2008). These clinicians reason that a community and sense of belonging are important in the lives of individuals. Community is defined as an atmosphere where individuals and their gifts are recognized and individuality is confirmed (Shaw, 2008). Individuals learn how to treat others in the community and develop appropriate personal behaviors through their belief system and other components of spirituality (Kondro, 2008).

Spirituality in treatment.

History.

Where are the roots of spirituality in clinical treatment? In ancient Greece, healers, otherwise known as theraputae, provided both spiritual and physical care (Becker, 2001). It was not uncommon during these times to receive both medical and spiritual advice from this one person. This did not change upon entry into the fourth century B.C., which marked the advent of the era of modern medicine (Becker, 2001). This period brought about the Hippocratic tradition of healing and health. Once again, physicians coexisted with religious leaders as caretakers of both the body and the spirit.

A major change to separate spirituality from physical health occurred during the 17th century. At that time, Rene´ Descartes profoundly influenced the importance placed on the role of religion in health by creating a philosophy that separated the mind from the

body and the physical form from the spiritual form (Becker, 2001). Thus, spirituality and medicine at that time were seen as two distinct entities. Upon the arrival of the Cartesian Age of Reason, the strong role of the church was challenged by the establishment and recognition of certain physical attributes and theories in regards to the functioning of the body (Becker, 2001). This allowed a dichotomy to emerge between the church and physicians. Physical health was the new domain of medical science, and spirituality was no longer included.

If one were to look at more modern theorists in regards to the amalgamation of spirituality and psychotherapy, Sigmund Freud's views were very influential. Freud believed that religion and spirituality comprised the roots of all mental health disturbances (Becker, 2001; Paul & Kelly, 2005). He felt that it was important to discourage individuals from seeking assistance for any spiritual concern. Freud's solution to this dilemma entailed the avoidance of religion and spirituality altogether. He maintained that the eradication of spirituality and religion from one's personal existence would result in the realization of greater emotional and psychological well-being.

Behaviorists also held antireligious points of view, contending that the incorporation of religion into mental health practice invalidated psychology as a science (Paul & Kelly, 2005). Therefore, the behavioral community did not embrace spirituality and religion and consequently did not integrate spirituality into research studies or treatment modalities.

Cultural differences/considerations.

Some countries do not hold the same stance as Freud and the behaviorists regarding the integration of spirituality in treatment. For instance, physicians in Persia

predominantly heal with the Holy Word. They are regarded as the best healers (Tillich, 1957). *Doctor* is a religious word for the Persians, to identify physicians who utilize magical healing powers during treatment. Persians believe that religion stands against all destructive powers and the highest healing power is that of faith (Tillich, 1957). Religion and spirituality are essential in the lives of Persians. Without religion or spirituality, it would be impossible to function within this culture.

Clinicians should take into account the culture of the client to ascertain whether prayer is an important part of the individual's culture and determine what should be included in treatment (Meisenhelder & Chandler, 2000). For instance, in the Native American culture, prayer and church attendance have been associated with better surgical outcomes, lower mortality, and improved immune function (Meisenhelder & Chandler, 2000). The Native American culture incorporates prayer into most every part of life. Meisenhelder and Chandler (2000) studied 71 Native American adults over the age of 65. Prayer helped these individuals reduce stress and facilitate positive health outcomes.

Assessment of spirituality.

The treatment of individuals with spiritual concerns should begin with an adequate assessment. A thorough evaluation of the spiritual dimension facilitates the development of a prognosis, or a predictive outcome, on variables of health (Gorsuch & Miller, 1999). If a clinician does not gather basic information about the spiritual domain, it is not possible to measure either obstacles or progress in this area.

A spiritual assessment is also needed in order to ascertain the client's worldviews. Upon reaching this understanding, the therapist can then work to achieve empathetic insight into the attitudes of the client (Richards & Bergin, 2005a). This worldview can be

explained through the metaphysical window of the client. The metaphysical window encompasses the personal beliefs regarding the universe and the nature of reality (Richards & Bergin, 2005a). Included in the metaphysical window are cognitions related to naturalism, idealism of freedom, and objective idealism (Richards & Bergin, 2005a).

Spiritual assessment also assists in determining whether the client's religious and spiritual beliefs and community could be used as a resource to assist in coping, helping, and growing. Richards and Bergin (2005a) assert that are three major types of religious problem solving: self-directing, deferring, and collaborative. In the self-directive approach, the individual feels the sole responsibility to solve any and all problems. The deferring approach shifts the responsibility of problem solving to God. In the collaborative approach, the individual holds the belief that there is a joint responsibility between that individual and God to effectively solve the problem.

Finally, spiritual assessment facilitates the identification of spiritual interventions that could be used in treatment and any unresolved spiritual doubts, concerns, or needs of the client that should be addressed in therapy (Richards & Bergin, 2005a). The therapist can use the spiritual doubts or concerns to establish appropriate goals for the client. Additionally, this will permit the therapist to develop an effective plan for working with the client by recognizing those interventions that are most appropriate for that individual.

The spiritual assessment requires sensitivity, creativity, and an unbiased approach on the part of the clinician (O'Reilly, 2004). In addition, mental health providers must assess their own spiritual beliefs, values, and biases to ensure that these beliefs will not cause any harm to the client (O'Reilly, 2004). Clinicians should be aware of any

countertransference that is experienced throughout the assessment process and seek supervision as needed.

Clinical Issues.

Recent research has outlined several situations where spirituality needs to be taken into consideration. Worthington and Sandage (2002) identify five clinical scenarios where spirituality or religion may be applied in therapy.

The first situation occurs when clientele request religious or spiritual therapy and question the personal beliefs of the clinician. It is essential for clinicians to be adequately prepared for these questions in order to effectively address the needs of the client. Therapists should approach any issues related to spirituality in an open, nonjudgmental, accepting, and empathetic manner (Miller & Thoresen, 1999). If this is not achieved, the client may be resistant to engaging in treatment, which would severely damage the therapeutic alliance.

The second clinical issue that is often evidenced in therapy involves those clients who are personally opposed to spiritual or religious beliefs in treatment (Worthington & Sandage, 2002). These clients may overtly express these feelings or expect the clinician to filter out any information in regards to spirituality. It is imperative for the clinician to address these attitudes during assessment in order to gain an understanding of the client and his or her feelings regarding spiritual components in treatment.

Third, spirituality issues can arise in treatment when the clinician's approach to spirituality is implicit, rather than direct (Worthington & Sandage, 2002). This can lead to friction between the client and the therapist, as the client may desire a clinician who interacts with patients in a more direct manner with regard to spirituality, while the

clinician may be unwilling or unable to do so. As a result, fundamental disagreements relating to beliefs and components of treatment may arise. The clinician should be prepared to determine an appropriate method of reacting to the situation that will best meet the needs of the client.

A fourth spirituality issue that may surface in the context of treatment transpires when religion and spirituality act as fundamental aspects of an individual's culture and interfere with the acculturation process (Worthington & Sandage, 2002). In this scenario, beliefs regarding religion or spirituality function to define one's existence. These same convictions often serve as impediments to acculturation into mainstream society.

The final issue noted by Worthington and Sandage (2002) takes place when clients are part of a relational system. In the relational system, differences could lead to additional stress and turmoil. This may occur in couples therapy when two individuals do not share the same religious or spiritual beliefs. The two individuals may be at different points in their faith development (Worthington & Sandage, 2002).

Spirituality and benefits.

It is evident throughout the research that has been conducted thus far that there is a positive association between spirituality and the benefits to individuals of spiritual beliefs. Positive outcomes have been noted in both the physical and mental health domains (Hall, Dixon, & Mauzey, 2004). Research continues to evaluate the outcomes of spirituality and its overall impact on emotional and physical well-being.

Health benefits.

Research also suggests a positive connection between spirituality and physical health. There appears to be a link between religious involvement and mortality. Some

studies have demonstrated that religious involvement helps buffer the impact of stressors on physical and mental health (McCullough, Hoyt, Larson, & Koenig, 2000). Specifically, frequent church attendees experienced a 36% lower mortality rate than those who did not attend church (Becker, 2001). Becker (2001) explained that this lower mortality rate could be attributed to the observation that those individuals who frequented church were more likely to stop smoking, exercise, and remain married.

Some studies have examined how spiritual values have assisted individuals with cancer. Hamilton, Power, Pollard, Lee, and Felton (2007) interviewed 28 African American cancer survivors recruited from the southeastern part of the United States. Results revealed that cancer patients believed that God provided types of support not available from family members or friends. These cancer survivors believed their survival was a gift from God. Romero, Kalidas, Elledge, Chang, Liscum and Freedman (2006) researched 81 women who were being treated for breast cancer and found that these cancer patients felt that both a self-forgiving attitude and spirituality were unique predictors of less mood disturbance and a better quality of life.

Quality of life studies support previous research that suggests spiritual individuals experience fewer physical and mental symptoms, less pain, fewer health concerns, less depression and anxiety than those with little or no religious convictions (Matthews, 2000). Other benefits of spirituality include enhanced physical functioning, speedier and more complete recoveries, and greater longevity (Antonovsky, 1987). Kaufman, Anaki, Binns, and Freedman (2007) studied 70 subjects ranging in age from 49 to 94 years who were recruited from the Behavioral Neurology Clinic at Baycrest. This research found

that spirituality and private religious practices, such as prayer, Bible study, and devotions, may decrease the rate of cognitive decline of Alzheimer's patients.

Blumenthal et al. (2007) studied 503 patients participating in the Enhancing Recovery In Chronic Heart Disease (ENRICHD) trial. Results from this study suggested that patients who regularly attended church tended to have lower levels of depression and more social support compared with patients who never attended church. Therefore, to the extent that spirituality encourages a healthy lifestyle, it offers protection against cardiovascular disease (Powell, Shahabi, & Thoresen, 2003). Thus, religion and spirituality could have a positive on physical health as a protective resource that prevents the development of disease in healthy people.

Mental health benefits.

Some research associates religion with emotional health and well-being. Evidence has shown that religious participation and beliefs may lead to better mental health outcomes, such as enhanced levels of psychological well-being and fewer symptoms of distress and anxiety disorders, such as depression (Ellison, Boardman, Williams, & Jackson, 2001; Grabovac, Clark, & McKenna, 2008). Affirmative religious coping styles are associated with improved positive effects (Powers et al., 2007; Hebert et al., 2007). Furthermore, individuals with strong religious convictions often utilized positive religious coping behaviors to assist with stress reduction and emotion regulation.

Prayer was noted as one of the main coping strategies utilized by spiritual individuals. Spirituality and religion provide meaning in life, which is often lacking in individuals suffering from depression (Gallagher, Wadsworth, & Stratton, 2002). Prayer was the most frequently utilized coping behavior for caregivers (Hebert et al., 2007). The

religious coping methods assisted caregivers upon experiencing loss, providing a positive adjustment to death. Prayer is also used to assist women who are coping with depression (Mirola, 1999). Presently, there is no research that provides an explanation of the physiological impact of prayer. There is a need for more research in this area to determine if there is a physiological response and connection to prayer and psychological well-being. Research has suggested that prayer elicits positive thinking, which can increase overall psychological well-being (Hagerty, 2009).

Additional research suggests that spirituality may assist in lowering depression levels (Becker, 2001). Becker (2001) found that those who regularly attended church exhibited a 0.50 relative risk for depression, which was half the rate of those people who did not attend church. She did not quantify the differences between the group with strong religious beliefs and those without.

Social support in the spiritual community has been associated with decreased levels of depression (Dew, Daniel, Goldston, & Koenig, 2008). There is both negative and positive religious support within the spiritual community. Negative religious support refers to the degree to which members of the congregation are perceived as critical or demanding. Members of congregations that are largely perceived as critical and demanding are more likely to be depressed. Positive social support occurs when individuals work with one another to provide support and guidance along their spiritual path and journey. This nurturing group support by the spiritual community may provide encouragement to those members experiencing a depressive episode. Therefore, positive social support can act to prevent or ameliorate depression.

Miller and Gur (2002) researched the relationship of religion and spirituality to depressive symptoms in adolescent girls. Results indicated that personal devotion and participation in a religious community were associated with a 19% to 26% lower likelihood of depression in girls who were not highly mature. The results of this study also indicated that these same practices accounted for a 32% to 43% lower probability of depression in highly mature girls. Additionally, personal and institutional conservatism were correlated with a 17% to 24% lower incidence of depression among girls who were not high mature, but had no link to depression in highly mature girls. All in all, the connection between religiosity and depression differed by physical maturation status in the sample of adolescent girls. Also, participation in a religious community was more strongly associated with lower risk in highly mature girls.

Several studies have evaluated the association of religiosity and spirituality to depressive symptoms in pregnant women. Mann, McKeown, Bacon, Vesslinov, and Bush (2007) found that there was a relationship between greater religiosity/spirituality and fewer depressive symptoms in pregnant women, but the association diminished as social support increased. Thus, religion/spirituality may help pregnant women with limited social support to cope with stress. The results of this study also suggest that social support significantly alleviates the symptoms of postpartum depression.

Mann, McKeown, Bacon, Vesselinov, and Bush (2008) analyzed the relationship between religious participation and postpartum depression. Results revealed that organized religious participation appeared to reduce the prevalence of postpartum depressive symptoms compared to individuals who were not involved in organized religious groups. Involvement in religious activities assisted in coping with the stress of

early motherhood. The authors did not indicate the specific components of religious participation that assisted in alleviating depression symptoms.

Koenig, George, and Peterson (1998) examined the effects of religious beliefs (intrinsic religiosity) and activities (prayer, and Bible reading, and church attendance) on the time to remission of depression in the elderly. Results indicated that intrinsic religiosity engendered a shorter time to remission. Specifically, with every 10-point increase in intrinsic religiosity score, there was a 70% increase in the speed of remission of depression. This study demonstrates that religion is an important coping factor for elderly patients.

Koenig (2007) investigated the relationship between religion, depression, and suicide. He observed that depressed patients look upon religious beliefs and practices as a source of comfort and strength. Additionally, religious activity is positively related to hope and optimism and negatively related to depression. Specific depression symptoms, such as loss of interest, feelings of worthlessness, withdrawal from social interaction, and a sense of hopelessness, were significantly less common among those using religion to cope than in those individuals who did not utilize religious coping interventions. However, somatic symptoms such as weight loss, insomnia, loss of energy, and decreased concentration, were unrelated to religious coping.

Spiritual interventions.

A variety of spiritual interventions have been utilized in psychotherapy to assist clients who have expressed a desire to incorporate spirituality into treatment. Prayer, meditation, scripture readings, biblical guidelines, and factors of surrender and control are some of the spiritual interventions employed by psychotherapists during treatment

(Richards & Bergin, 2005b). These spiritual interventions will be examined in depth to identify ways to incorporate each intervention into psychotherapy, as well as to identify its potential effects on the counseling process.

Prayer.

Prayer is a common intervention that can be used in psychotherapy. Prayer can be defined as every kind of inward communication or conversation with the power recognized as divine (Meisenhelder & Chandler, 2000; Richards & Bergin, 2005b; Richards, Hardman, & Berett, 2008). Prayer can be offered verbally or nonverbally. It is a formula of words, sighs, gestures, or even silence that contains some form of entreaty for oneself or others (La Torre, 2004). Prayer is not confined to any particular religious affiliation. Prayer is often God-centered and reality-centered (Muelder, 1957). La Torre (2004) states that prayer is a time for turning our mind and heart to the sacred. Similarly, O'Reilly (2004) notes that prayer is used to connect with inner sources of hope and solace.

A 1993 Gallup survey showed that 90% of Americans pray on at least an occasional basis (as cited in McCullough & Larson, 1999). Ninety-seven percent of the population believes that prayers are heard and that their prayers have been answered on occasion (McCullough & Larson, 1999); 87% of Americans maintain that their prayers make them better people. The survey also revealed that most people 77% are satisfied with their prayer life.

People pray for different reasons. According to McCullough and Larson (1999), individuals often turn to prayer to deal with life's problems or medical issues or to cope with natural and unnatural disasters. Older people use prayer to deal with many concerns

that become salient with aging, such as relocation to nursing facilities, fears about death and dying, widowhood, and health problems. Furthermore, prayer has served as an important resource for caregivers, such as nurses, hospice workers, parents of children with disabilities, and family members of patients with dementia and Alzheimer's disease.

Evidence gathered from research studies has shown that prayer correlates with healthy emotional and physical well-being. Muelder (1957) notes ten psychological benefits of prayer, namely: awareness of needs and realities; confession and harmonious adjustment; trust and relaxation; perspective and clarification; decision and dedication; renewal of emotional energy; social responsiveness; joy, gratitude, and relaxation; loyalty, perseverance, and integration; and personality. In addition to these ten psychological benefits, Muelder (1957) suggests that prayer helps people to discover love and forgiveness. It allows for inner peace and, as a result, can help an individual to become more self-aware and at peace with the world. Prayer also facilitates relaxation, resulting in improved mood, subjective well-being and a state of peace and calm (Christiansen, 2008; Farah, 2008; McColl, 2008; Peloquin, 2008 & Smith, 2008).

There are times when prayer has been misrepresented in society. Some individuals believe prayer to be a time to beg to God or remind God of His neglected duties and what He ought to do (Johnson, 1957). Note that there is no one specific way to pray. There exists a wide diversity of prayers, each with a different purpose and goal.

McCullough and Larson (1999) classified prayer into two distinct categories: primary and secondary prayer. Primary prayer is nonrational and emotional and expresses original, profound experiences. Secondary prayer is a derivative of spiritual

experience, but is not authentically spiritual. Secondary prayer is rational, abstract, and highly intellectualized.

Weld and Eriksen (2007) researched the degree to which clients desired audible in-session prayer: 82.0% answered sometimes but infrequently, 6.7% always, and 15.8% occasionally. Thus, the majority of clients would like to have prayer included in treatment at least some of the time. Clients who incorporate prayer into their daily lives individually and with others are more likely to desire it in psychotherapy (Weld & Eriksen, 2007).

A controversial topic in the clinical world concerns whether clinicians should pray with their clients. Some clinicians incorporate prayer into psychotherapy and others do not (Weld & Eriksen, 2007). Secular counselors may feel uncomfortable or incompetent about the expectations for prayer among Christian clients. When prayer is utilized in the therapeutic setting, it is suggested that the therapist introduce prayer as a spiritual intervention that can occur in the therapy session (Weld & Eriksen, 2007). There are a variety of ways to incorporate prayer into practice. Clinicians can pray silently with the client during and/or outside of the session. Prayer can occur vocally with the client in session. The therapist can also encourage the client to pray outside of therapy sessions (La Torre, 2004; Richards & Bergin, 2005b). The application of prayer during treatment depends on the comfort level of the therapist, the values of the client, and the specific situation that the therapist is encountering during treatment.

Prayer has also been shown to strengthen the therapeutic relationship (Farah et al., 2008). In prayer, the client and clinician are both are on equal ground, as neither one

has answers and must go to God for guidance. It is evident that prayer can have a positive effect on the therapeutic relationship (Farah, 2008).

Prayer could also evoke negative reactions that may jeopardize the therapeutic relationship (Farah, McColl, Christiansen, Peloquin & Smith, 2008). There may be a potential for role confusion when a clinician prays with the client and does not have the necessary training to participate in effective prayer with the client. In addition, employers or supervisors may not understand prayer in the therapeutic setting, which could create additional stress for the therapist (Farah, 2008; McColl, 2008; Peloquin, 2008 & Smith, 2008).

There are certain guidelines for the clinician to follow in making the decision to utilize prayer in psychotherapy. The clinician should be able to answer the following questions as posed by Farah (2008): Is there a spiritual component to the client's problem? Is the therapist equipped to offer prayer? Would the client be receptive to the prayer? Would the workplace support the use of prayer? The clinician should employ prayer in treatment with caution only when competent to exercise this skill, the client is receptive, and the workplace allows for prayer.

Mindfulness/Meditation.

Mindfulness and meditation exercises comprise an additional type of spiritual intervention that may be utilized with clients in the therapeutic setting. Mindfulness is being completely aware of the full range of experiences that exist in the here and now (Marlatt & Kristeller, 1999). This involves seeing things as they truly are. Mindful awareness is based on awareness of just what is, without any judgments. Meditation is

often identified as a relaxation technique and is developing mindfulness on a physical, psychological, or spiritual level (Marlatt & Kristeller, 1999).

Meditative processes can be performed in various ways. When attempting to enter a meditative state, one must calmly attempt to limit all thought and attention (Mohr, 2006). This may be accomplished through visualizations, devotionals, muscle relaxation, release, and focusing on one specific word. Richards and Bergin (2005b) suggest sitting and counting breaths, attending to a repeated thought, or focusing on virtually any simple external or internal stimulus in order to be fully mindful of the present moment. The individual attempts to block out all distractions through the use of these techniques and surrenders all control to the here and now (Mohr, 2006; Richards & Bergin, 2005b). A person may also be taught guided imagery in an attempt to free the mind and focus solely on the here and now moment. Regular practice is needed to induce relaxation through meditation and mindfulness.

Marlatt and Kristeller (1999) identified three different types of meditation processes: mindfulness, concentrative, and transcendental meditation. Mindfulness involves opening up, gaining insight and developing an awareness of any mental content. The mental content is known as thought stimuli occurring in the mind. Concentrative meditation occurs when one focuses on a specific object of attention, such as awareness of breath (Marlatt & Kristeller, 1999). During concentrative meditation, the individual solely focuses on this one object and works to block out all other distractions. Finally, transcendental meditation occurs when a clinician repeats a certain term as a focus of the meditation. The individual meditates on this term and enters a state of relaxation.

During the opening of the International Congress of Cognitive Psychotherapy in Goteborg, Sweden, Dr. Aaron Beck and the Dalai Lama met to discuss the theory of cognitive therapy (www.beckinstitute.org). In the meeting, Dr. Beck and the Dalai Lama discussed ways to apply analytic meditation. The Dalai Lama explained that analytic meditation is the process of analyzing what is reality and then acting accordingly (www.beckinstitute.org). He stressed that this process is most useful when a person is experiencing intense negative emotions. Analytic meditation may be utilized to have the person focus on that negative emotion and its destructive effects on physical health, family relationships, and society (www.beckinstitute.org). The individual continues to reflect and focus upon the consequences of the negative emotion until it becomes part of his or her deeper understanding. Then, when the person is in a situation that may evoke this same reaction, the individual is equipped to reflect upon the potential damages of this emotion and focus on ways to prevent the emotion from becoming destructive. The Dalai Lama stressed the next step consists of focusing on contradictions in emotions (www.beckinstitute.org).

Biblical guidelines.

The use of scriptures and biblical passages comprises an intervention that stresses the importance of spirituality. Christian psychologists proclaim that all truth is God's truth (Bobgan & Bobgan, 1989). Major theistic world religious traditions teach that God, the Supreme Being, is revealed through the words of sacred writings (Richards & Bergin, 2005b). Clinicians view these writings as a source of spiritual and moral wisdom (Richards & Bergin, 2005b). The Bible can be used to provide a scriptural foundation for

understanding and modifying the root causes and underlying spiritual deficits that may lead to unhealthy behaviors (Packer, 2004).

Richards and Bergin (2005b) observe that clinicians utilize scriptures in various ways. Christians primarily use biblical passages to help patients gain insight into feelings and behaviors and learn new ways to cope with difficult situations (Mohr, 2006). Biblical scriptures have also been applied in various ways that are similar to some cognitive interventions. For instance, clinicians may utilize biblical passages to challenge and modify dysfunctional beliefs, reframe and understand problems from an eternal spiritual perspective, clarify and enrich the understanding of the doctrines of the religious tradition, strengthen the sense of spiritual identity and life purpose, and seek God's enlightenment, comfort, and guidance (Richards & Bergin, 2005b). These clinicians work to help clients gain insight into their situations through scriptural passages and the word of God.

One of the most common sets of rules and guidelines for the Christian population are the Ten Commandments from the Bible. Each of the commandments holds a specific implication with regard to the client and his or her belief system. Psychotherapy often deals with the distinction between thoughts and actions. This differs from religious theory, as some believe that thoughts are actions and vice versa (Clemens, 2006). The Ten Commandments help to define the belief system of the individual, instruct anger management, improve the individual's state of mind, clarify the perception of self and others, and discover ways to love God (Clemens, 2006).

It is important to carefully consider the use of scriptures in a clinical setting. Sisemore (2007) emphasizes the need to use caution with biblical interventions and tread

lightly on certain scriptural passages that would not be appropriate for all clientele. Scriptural use may be contraindicated when it is not in line with the client's cultural beliefs and, as a result, may harm the client. Some biblical passages do not apply to present-day situations and consequently, clients may take some biblical stories too seriously and become misguided throughout the process. For instance, Leviticus 20:10 states: If a man commits adultery with another man's wife—with the wife of his neighbor—both the adulterer and the adulteress must be put to death. Clearly, we do not follow this guideline today. Other scriptures discuss customs that were followed in the past that are not pertinent in today's society. Clinicians should assess biblical knowledge during the intake process and determine the extent of scriptural passage usage in order to obtain accurate information for this area of spirituality. They should also be on guard for the countertransference that is often experienced in the therapeutic environment. Each of us has a set of morals and principles of right and wrong. Therapists must be aware of their own morals and values and how these may come into play during therapy (Clemens, 2006). Related to these biblical guidelines are the factors of surrender and control. It is important for the clinician to address this area in treatment in order to determine the amount of control the client feels in the situations in his or her life.

Factor of surrender and control.

Julian Rotter's theory of locus of control asserts that the likelihood of engaging in a behavior is dependent on the personal value of the goal and one's expectation to achieve that goal (Zimbardo, Weber, & Johnson, 2000). Our expectations depend on our locus of control, or our belief about our ability to control the things that happen in our lives. Certain individuals may believe that they have a certain influence on the course of

life's events, whereas others may believe that they have very little ability to control situations in life (Fournier & Jeanrie, 2003). Rotter (1966) describes locus of control as follows:

When reinforcement is perceived by the subject as following some action of his own but not being entirely contingent upon his action, then, in our culture, it is typically perceived as a result of luck, chance, fate, as under the control of powerful others, or as unpredictable because of great complexity of the forces surrounding him. When an individual interprets the event in this way, we have labeled this as a belief in external control. If the person perceives that the event is contingent upon his own behavior or his own relatively permanent characteristics, we have termed this a belief in internal control (p.1).

Another theory that is often associated with Rotter's locus of control theory is attribution theory. Attribution theorists believe that future behaviors are mostly determined by perceived cause of past events (Weiner, Nierenberg, & Goldstein, 1974). Achievements would predict future achievements in the future, and one could utilize similar reasoning to predict future failures. Attribution theorists tend to utilize reasoning built upon stable principles. It is important for the researcher to keep in mind the locus of control and the attribution theory in the context of spirituality because many individuals struggle with factors related to issues of control in their spiritual walk, and these two theories assist the clinician in formulating an accurate framework to work within.

Control and surrender of controls are important elements in the Christian faith. Cole and Pargament (1999) suggest that control is to take charge of a situation, whereas surrendering involves the act of relinquishing control. These two authors maintain that

the only way to enhance a personal control may be to give up control, which is known as the paradoxical path of surrender. The process of coping involves the initiation of a certain type of control in one's environment.

Where does spiritual surrender exist in treatment? Cole & Pargament (1999) suggest this element is incorporated in situations that are seen as uncontrollable, such as death, illnesses and accidents, and sensations of anger or anxiety. The clinician can explicitly focus on ways that clients are masking problems as spiritual surrender (Cole & Pargament, 1999). For instance, the client may defer their problems or engage in pleading behaviors and begin to adopt the attitude of learned helplessness. Therefore, it is necessary for the client to utilize some problem-solving skills and balance these skills with the notion of spiritual surrender.

Clinicians can also ask clients if there are certain issues that need to be surrendered to God (Cole & Pargament, 1999). Often, clients cling to issues that are out of their control and do not rest on the support and guidance from the higher deity or power, thereby creating additional stress in their lives.

Forgiveness is an area of focus that allows one to surrender certain emotional burdens and concerns. Sanderson and Linehan (1999) also describe forgiveness as a way to give up or give way to anger. The authors recommend forgiveness as a focus in treatment by working towards acceptance of life, processing the feelings of anger, and then moving towards feelings of love. Forgiveness can be seen in both the individual and social contexts. Individuals need to learn methods to move from past wounds that were inflicted personally or by others. Therapists should focus on the process of the patients forgiving others who have hurt, abused, and offended them, learning to forgive

themselves for their own mistakes and transgressions, and accepting forgiveness from others and from God (Richards & Bergin, 2005b).

Hope must be present in order for an individual to work towards spiritual surrender. Hope can be defined as optimism, the placebo effect, self-efficacy, and positive expectancies (Yahne & Miller, 1999). One of the clinician's first duties in treatment is to inspire hope in the client. Yahne and Miller (1999) observed a number of characteristics observed in therapists who have evoked a hopeful environment, namely, warmth, friendliness, interest, supportiveness, empathy, credibility, and a positive attitude towards the client.

Counselor roles and competencies.

There are few mental health practitioners who have received formal training to work with spiritual and religious issues in treatment (Young, Wiggins-Fram, & Cashwell, 2007). The Ethical Principles of Psychologists and Code of Conduct (APA, 2002) state that awareness and sensitivity are ethical responsibilities, as religion is regarded as an expression of diversity in different cultures. Culture is defined as the belief systems and value orientations that influence customs, norms, practices, and social institutions, including psychological processes (APA, 2002). As a component of culture, religious and spiritual training should include graduate course work, supervision, and research (Russell & Yarhouse, 2006). Walker, Gorsuch, and Tan (2005) suggest that clinical instruction is more important than course work and that it should be obtained through workshops, clinical practice using spiritual interventions, and supervision with religious clients.

A study was completed by Russell and Yarhouse (2006) on the subject of addressing religion and spirituality in internship training. A web-based survey was sent to 433 program directors of APA-accredited internship sites with active e-mail addresses; 139 surveys were returned. The results showed that 64.7% of internship sites do not offer training in spirituality or religion. Only 49 sites (35.3%) reported training in this area. Of those 49 sites, half provided training once per year, 19.7% reported training once per semester, and 6.6% offered monthly training in spirituality. Upon completion of the research, the authors made the following suggestions: facilitate discussion of spirituality and religion in supervision, add didactic sessions or training on recent trends, incorporate spirituality and religion in instruction regarding diversity, form or join an alliance of colleagues who have greater familiarity in the area, and form relationships with members of communities of faith.

Young, Wiggins-Frame, and Cashwell (2007) conducted a survey of 1,000 American Counseling Association (ACA) members. The results showed that the majority believed that specific spiritual competencies were important and that a curriculum and training guide would be helpful in the treatment setting. This would foster more awareness and provide much-needed education concerning the application of spirituality in clinical treatment.

Shafranske and Malony (1990) performed a study on 1,000 randomly selected clinical psychologists from the APA Division 12 Clinical Psychology; 409 questionnaires consisting of 65 items were completed and returned. The results showed that 40% of the clinical psychologists endorsed a personal, transcendent God orientation, meaning these individuals considered themselves religious and worked to increase their relationship

with God through prayer, worship, and Bible study. This is less than half of those who completed the survey. In addition, 53% of the participants viewed religion as valuable. This accounts for a bit more than half of the psychologists who returned the survey. Sixty-five percent viewed spirituality as personally relevant, yet 74% believed religious issues were outside the scope of psychology. It is apparent that the majority felt spirituality was relevant, but the majority also believed that spirituality should not be included in mental health treatment. With regard to spiritual interventions that certain clinicians utilize with clients, 59% stated it was improper for a psychologist to use religious scriptures or texts while conducting psychotherapy, and 68% responded that it was inappropriate for a psychologist to pray with a client. Once again, the majority of the sample felt that these religious/spiritual interventions were not suitable in the counseling session. Finally, in regard to training, 5% reported that religious and spiritual issues were presented in their training, 45% stated that spiritual issues were presented sometimes, 38% reported that these issues were presented rarely, and 35% never had it in their training. It is apparent that the psychologists in this study were split in regard to incorporating spirituality into treatment.

Some clinicians avoid discussing issues related to spirituality and religion due to lack of training, while others may not see the need to examine their personal values (Hall, Dixon, & Mauzey, 2004). T his topic is avoided in clinical health treatment centers, which may suggest to some clinicians that the application of spirituality in treatment is taboo (Miller, 1999). In order to encourage growth in this area, organizations should encourage open discussion and exploration of spiritual and religious issues during

training and supervision. In addition, clinicians should be comfortable in asking and talking about spiritual issues with clients (Miller & Thoresen, 1999).

Becker (2001) conducted a study in 1992 during the opening plenary sessions of the American Psychological Association Annual Convention. The study revealed that most of the members described themselves as atheists or agnostics and that religion was of minimal interest to them. The prevalence of belief in a divine power has been much lower among psychologists and other mental health professionals, generally only about 40%, compared with the general population, which is 83% (Becker, 2001). When treatment requires some knowledge of spirituality, it may become necessary for those psychologists unfamiliar with religion to either adapt to the new treatment needs or refer the client to someone who is more capable of providing this treatment.

There are several prerequisites for clinicians attempting to incorporate spirituality into treatment. According to Bienenfeld and Yager (2007), clinicians should be able to define terms related to spirituality, such as spirituality, religion, and faith. Additionally, clinicians should be equipped to outline a framework of spiritual development for treating clients who desire to have spirituality integrated into their treatment (Bienenfeld & Yager, 2007; Moore-Thomas & Day-Vines, 2008). Case conceptualization is important in therapeutic work. A clinician should be proficient in applying information from the spiritual development model to create a case conceptualization of the client (Persons, 1989). The case conceptualization helps the clinician understand the client by gathering information related to history, development, and current functioning (Persons, 1989). Once this information is collected, the clinician is able to plan the course of treatment and can begin to set treatment goals for the client(Persons, 1989). It is important for the

clinician to incorporate spiritual values in this process in order to treat the individual in a holistic manner.

Clinicians must also be qualified to differentiate religious beliefs and behaviors from pathological ones (Bienenfeld & Yager, 2007). Clinicians need to understand the client's personal narratives, including religious, racial, and ethnic histories (Moore-Thomas & Day-Vines, 2008). The clinician should be fully present with the client and attempt to understand the client's worldview (Butler, Koenig, Puchalski, Cohen, & Sloan, 2003). Understanding the worldview of the client can be challenging from time to time, requiring the clinician to become educated about the client's religion and cultural and spiritual beliefs to make the determination regarding pathological behaviors and the direction of treatment. In addition, these beliefs, otherwise known as cognitions, at times may or may not be adaptive or accurate.

Various emotions are evoked within the client and the therapist, making supervision a key factor when addressing issues related to spirituality. This should be a major component in training clinicians for spiritual competence (Miller, 1999; Walker, Gorsuch, & Tan, 2005). As with any modality, supervision is needed to grow in an area and to receive appropriate feedback from individuals who have more experience and knowledge than the supervisee. Unfortunately, it may be difficult to find a supervisor with knowledge in the field of spirituality as a result of the scarcity of available training in this area.

Major depressive disorder.

Spirituality and religion have been associated with better mental health outcomes (Blazer, 2007). As this study will explore the impact of integrating religion into the

treatment of depressed individuals, it is imperative to review the components that comprise depressive syndromes. Specifically, this paper will focus on four major dimensions of depression: mood, cognitive, motor, and physiological.

Depressive symptoms.

Mood. The mood symptom of depression may be the most apparent of them all. This can be described as a lowering of the mood. An individual may feel depressed, sad, “blue,” hopeless, discouraged, or “down” (Holmes, 2001; Maag & Swearer, 2005). Other symptoms of depression include sensations of isolation, rejection, and loneliness (Holmes, 2001). A person suffering from depression may also feel quite helpless. Mood symptoms may make it difficult to have the energy to start or engage in treatment.

Major depressive disorder is dissimilar from everyday sadness or sorrow (Maag & Swearer, 2005). Maag and Swearer clarify the difference between depression as a symptom and depression as a syndrome. When depression is a symptom, it tends to induce a sad affect and is a common experience of everyday life. A syndrome may include a group of symptoms that frequently appear together. Pies (2008) outlines the distinction between sorrow and depression. He states that it is still possible to feel intense social connections with others when experiencing sorrow (Pies, 2008). A depressive episode is accompanied by the perception of oneself as an outcast and being entirely alone in the world (Pies, 2008). Furthermore, when an individual is feeling the everyday type of sadness, the individual recognizes that it is only temporary and will eventually end. On the other hand, when an individual is experiencing a depressive episode, it may feel like the depressive episode does not have an end in sight and that he or she is doomed to feel that way forever (Pies, 2008). The mood symptoms experienced

in major depressive disorder overwhelm that individual and leave the person feeling stuck in the current mood.

Cognitive. Depression can have a profound impact on the cognitive states of an individual. Clark, Beck, and Brown (1989) note three types of cognitive symptoms in depression. The first cognitive symptom entails negative beliefs about the self, the world, and the future. The individual feels inadequate, inferior, and no good (Holmes, 2007). There is a prevailing sense of low self-worth. The depressed individual may look at current and past situations as a series of failures (Holmes, 2007). Any positive experiences are likely to be considered a rare stroke of luck. The individual may refuse to take any sort of credit for the successes that were achieved (Clark, Beck & Brown, 1989).

A depressed individual tends to view the world as a rotten and horrible place, often believing that he or she is unloved and/or unworthy of love. Problems appear insurmountable (Holmes, 2001). These beliefs about the world will not allow the person to move forward, but instead keep the depressed individual stuck in his or her current state (Jacobson et al., 1996). At times, the individual may continue to have these negative thoughts until they ultimately become automatic, unrealistic thoughts. Another term for these automatic thoughts is cognitive distortions.

Finally, the depressed individual holds negative views about the future. The combination of low self-worth and the negative outlook on the world will leave the person feeling that life will always be this way (Jacobsen et al., 1996). The individual perceives a negative image of self and the world, with the expectation of an arduous path of life towards a horrible and rotten future (Clark, Beck & Brown, 1989). The person

will begin to wonder if it is worth proceeding with a life such as that. These negative beliefs about self, world and the future are referred to as the negative triad of depression, a term that was initially developed by Aaron Beck (Holmes, 2001).

Another cognitive symptom of depression is low motivation. A depressed individual may feel incapable of solving problems and, as a result, lack motivation to make a change in his or her life (Holmes, 2001). As everything seems hopeless in the life of the depressed individual, it seems futile to even try. The motivation levels continue to decline, and over time, the number and intensity of unresolved problems increase (Marx, Williams, & Claridge, 1992). When the depressed individual is confronted with any sort of failure, this will feed into the negative thoughts about self, world and future and, in turn, decrease the motivation and energy to move forward from the present situation (Clark, Beck & Brown, 1989). As motivation levels continue to deteriorate, the levels of hopelessness will substantially escalate.

Impaired thinking comprises another cognitive component. A depressed individual is prone to be less effective in solving intellectual and social problems (Holmes, 2001). This impairment is not solely due to motivation levels. Particularly, a person experiencing depression may have difficulties with memory (Backman & Forsell, 1994). This often presents a hindrance while studying or solving problems. These struggles may lead to additional issues such as a negative outlook on life, a diminished sense of self-esteem, and heightened levels of sadness and depression (Holmes, 2001).

Schema. Schema is one of the main components in cognitive-behavioral treatment. A schema is a cognitive structure for screening, coding, and evaluating stimuli (Barlow, 2008) or can also be defined as unconditional core beliefs which serve as a basis

for screening, categorizing and interpreting experiences (Freeman, Pretzer, Fleming, & Simon, 2004). The information that is gained from this process is organized to categorize and interpret the experiences of the individual in meaningful ways. Developed schemas may be negative in depressed individuals. As a result, a bleak view of oneself, the world, and the future may ensue.

Young developed a list of 18 early maladaptive schemas in five hypothesized domains. The five domains are: disconnection and rejection, impaired autonomy and performance, impaired limits, other-directedness, and overviligance and inhibition. The 18 early maladaptive schemas will be described later in this paper. Young contends that a child learns to construct reality through early experiences with the environment and that the early maladaptive schemas develop when that environment does not meet the core needs of that individual (Barlow, 2008). This may lead to acceptance of beliefs by the child that is maladaptive and unhealthy in nature. These schemas generate negative interpretations of life events that lead to the engagement in depressed behaviors throughout one's lifetime (Jacobson et al., 1996).

Motor. The third domain is the motor system. There are two different types of motor symptoms evident in depression. The first common motor symptom is psychomotor retardation. Psychomotor retardation involves the reduction or slowing of motor behaviors (Holmes, 2001). This type of motor symptom would make it difficult for a depressed person to get started, perhaps even remaining in bed as a result of the slowed response. An individual who manages to get moving is likely to sit with a drooping posture and give a blank, expressionless gaze (Holmes, 2001). Difficulties may ensue regarding physical appearance and grooming, often resulting in an unkempt

appearance (Librizzi, 2006). Some people even report that they feel as if they are carrying the weight of the world on their shoulders (Holmes, 2001). A depressed individual who is experiencing psychomotor retardation may talk very little or do so in a quiet monotone voice, taking breaks midsentence from lack of energy, otherwise known as poverty of speech (Holmes, 2001). It is apparent that coping with psychomotor retardation is extremely difficult and tends to reduce levels of motivation as a result of the considerable effort that is required to do anything.

Psychomotor agitation comprises the second motor symptom of depression. Psychomotor agitation occurs when individuals are unable to sit still, are restless, or are constantly fidgeting or pacing (Holmes, 2001). These activities are random in nature, with no apparent purpose. Agitation may be accompanied by unexpected outbursts of complaining, shouting, or rapid speech (Librizzi, 2006). Persons with psychomotor agitation may experience difficulties accomplishing tasks, thereby affecting work performance, leading to lack of accomplishment. On the surface, to an outside observer, these behaviors may appear to be related to anxiety, making it difficult to differentiate between anxiety and agitation. An individual with psychomotor agitation may also experience feelings of sadness, which is a key component when differentiating psychomotor agitation from other diagnoses and symptoms (Holmes, 2001). Psychomotor agitation may provoke a decrease in goal-directed behaviors (Librizzi, 2006). The lack of direction of a person experiencing these motor symptoms produces an inverse increase in depression, which in turn creates additional problems and unfulfilled goals (Clark, Beck & Brown, 1989). Both psychomotor retardation and agitation have direct consequences for the depressed individual and his or her ability to function.

Physiological. Depression can have a profound impact on the physiological states of the individual. There are four common physical symptoms found in individuals who are experiencing depression: disturbed sleep, change in eating patterns, decreased sex drive, and an increase in physical illness.

The first symptom is disturbed sleep. Individuals who are experiencing problems in this area may either sleep too little (hyposomnia) or too much (hypersomnia). Those individuals who are sleeping too little often have trouble getting to sleep and awake prematurely in the morning (Holmes, 2001). These individuals usually sleep 3 to 4 hours per night. When they experience early morning awakenings, they are usually not able to get back to sleep. Holmes (2001) reported that early rousing appears to be associated with more severe depression, and patients tend to be melancholic. As depression begins to lift, the individual is able to remain asleep for a longer duration, and the time of awakening becomes later and later. In addition, depressed individuals may at times experience onset insomnia. During onset insomnia, the individual struggles to fall asleep. Finally, the individual may experience difficulties staying asleep, which is referred to as waking insomnia. On the other end of the spectrum, some depressed individuals may sleep too much. These individuals average 10 to 12 hours of sleep a night. This may occur in conjunction with psychomotor retardation, lacking the energy to get out of bed. These individuals utilize sleep as a primary coping intervention to avoid depression.

A second physical symptom of depression is disturbed eating patterns. As with sleeping, some individuals have an increase in their appetite, while others experience a decrease. A lack of interest in or appeal of eating will lead to weight loss (Holmes, 2001). On the other hand, depression can produce overeating. Food may offer pleasure in

the midst of depression. Thus, eating may serve as a positive reinforcer for certain individuals, which can increase eating and create weight gain. The weight gain, especially in women, may worsen the depression and yield an adverse impact on the process of recovery (Holmes, 2001).

A third physical symptom is decreased sexual drive or libido. While depression can directly lead to a decreased sex drive, it should be noted that some of the medications that are used to treat depression may also have a negative impact on sex drive (Holmes, 2001). Thus, the clinician must consider the different influences of depression and medication to accurately identify the source of the decreased sexual drive. Depressed individuals engage in isolative behaviors and avoid interpersonal interactions. Close physical contact is avoided as focus is centered on personal needs. This isolation and lack of desire for interpersonal contact further exacerbates problems with sexual desire and need.

The final physical symptom is an increase in physical illness. This is a result of the decline in functioning of the immune system when a person is experiencing depression (Herbert & Cohen, 1993). Depressed individuals produce fewer white blood cells, which are important in combating foreign substances (Glassman & Shapiro, 1999). In addition, when the individual is experiencing depression, he or she may engage in fewer health-preserving behaviors. Depression is linked to an increase in health problems ranging from colds and flu to more significant physical illnesses (Herbert & Cohen, 1993).

DSM-IV-TR diagnostic criteria.

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM IV-TR) (American Psychiatric Association, 2000) clarifies the specific requirements for an individual to be diagnosed with major depressive disorder. The individual must meet five of the nine diagnostic criteria for a minimum 2 week period (APA, 2000). Major depressive disorder is categorized into subtypes: chronic, with catatonic features, with melancholic features, with atypical features, and with postpartum onset. The levels of major depressive disorder are classified as mild, moderate, severe without psychotic features, or severe with psychotic features.

In order for an individual to qualify for major depressive disorder at least one of the symptoms must include depressed mood or loss of interest or pleasure. The nine criteria are:

1. Depressed mood most of the day, nearly every day, as indicated either by subjective account or observation of others.
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
3. Significant weight loss or weight gain when not dieting.
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observed by others, not merely subjective feelings of restlessness or of being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day.

8. Diminished ability to think or concentrate or indecisiveness, nearly every day.
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide. (American Psychiatric Association, 2000, p. 375).

Treatment for major depressive disorder.

Over the years, researchers have worked to determine the best course of treatment for major depressive disorder. The two most common treatment modalities are medication and cognitive-behavioral therapy. In fact, it has been observed that the combination of medication and cognitive-behavioral therapy is the treatment of choice when working with individuals who are experiencing depressive symptomatology (Ludman, Simon, Tutty, & Von Korff, 2007; Keller et al., 2000).

Medication.

The major cause of depression is often attributed to low levels of mood-related neurotransmitters (Holmes, 2001). Medications or drug therapies that increase the levels of those neurotransmitters may help to alleviate the symptoms of depression. The three major types of antidepressant drugs are tricyclics, selective serotonin reuptake inhibitors (SSRIs) and the monoamine oxidase inhibitors (MAOIs) (Holmes, 2001).

The tricyclic medications work to reduce the reuptake or reabsorption of serotonin or norepinephrine by the presynaptic neurons (Holmes, 2001). Once the reuptake is blocked, more of the deficient neurotransmitter is available at the synapses. When more of these neurotransmitters are available, the levels of depression are decreased.

The most commonly used antidepressant drugs are the SSRIs, also known as bicyclics. These medications block the primary reuptake of serotonin, allowing more

serotonin to be available at the synapses (Holmes, 2001). Individuals who experience depression tend to have a deficiency in their serotonin production. When there is more serotonin in the synapses, depression levels will decrease. The SSRIs are reported to have fewer side effects than the tricyclics.

Finally, there are the MAOIs that work through a complex process. A normal process destroys neurotransmitters at the synapse by other chemicals, specifically enzymes. One way to allow more neurotransmitters in the synapse is to reduce this process by restraining the enzyme that destroys them (Holmes, 2001). The MAOIs were developed to inhibit the effects of the enzymes that break down the neurotransmitters in the synapse. MAOIs should be taken with caution, as these drugs can cause serious side effects and may adversely interact with food and/or other drugs.

Cognitive-behavioral treatment.

Schema. Leahy (2003) suggests that depressed schemas are usually related to concerns about loss, failure, rejection, and depletion. It is the job of the clinician to identify these maladaptive schemas and then work with the client to modify those core schemas (Hamrin & Pachler, 2005). Cognitive-behavioral therapy helps individuals to relearn and retain more functionally effective schema, as well as to address those environmental factors that triggered the depression.

It is important to assess the religious schema of the client during treatment. The individual's religious schemata will influence the way that the individual may view the world and in turn, also influence the therapeutic process, either in a negative or positive manner (Librizzi, 2006). It is crucial for the therapist to gather information about the client's religious schemata and determine whether they are positive or negative in nature.

If the religious schema is negative, the clinician and the individual will work together to modify the negative religious schema in treatment (Parson & Wick, 1986). This will enable the client to grow in faith and approach emotional well-being.

Parsons and Wick (1986) identified two specific schemata and a variety of recommended interventions. These two schemata are the catastrophe of being alone and the unworthy sinful self. In regard to the catastrophic thinking of being alone, Parsons and Wick (1986) suggest several tools. First, the individual needs to work toward surrendering the urgency and sense of absoluteness and mustness. Moving forward from one's present situation is not possible until it is realized that it is perfectly acceptable to be alone at times. The therapist may review ways that Christ spent time alone in fellowship with the Father. Furthermore, the therapist could work to reframe the client's thinking and alone time as an opportunity to gain deeper self-acceptance. The application of these cognitive techniques may allow the client to embrace the time alone and work toward productive changes in life.

The second schema, the unworthy sinful self, can be addressed similarly through cognitive means and spiritual interventions. First, the clinician would direct the client to stop indulging in self-hate and punishment (Parsons & Wick, 1986). The therapist may utilize de-centering in order to illustrate that everyone has value. If the client continues to experience difficulties, the clinician may review the messages of the New Testament, especially in the Book of John, and the message of Christ's unconditional love. Once the client begins to see self-value and worth in the eyes of God, the levels of self-hate and punishment may begin to decline. Additionally, the therapist may review the lives of heroic Christians (saints) to assist in redefining the journey of the client as a process of

personal development (Parsons & Wick, 1986). This would make the client cognizant of similar struggles that others have endured and overcome. The client is reminded that this current place in life is not permanent in nature and that the struggle to overcome may build strength. Moreover, the clinician may attempt to create cognitive dissonance between the client's personal negative self-evaluation and theological religious beliefs (Parsons & Wick, 1986). The client may realize the disconnection between these two elements and feel the need to reshape the faulty self-perception.

Automatic thoughts. Automatic thoughts are cognitions that spontaneously flow through one's mind at the moment (Freeman, Pretzer, Fleming, & Simon, 2004). Though individuals may or may not be aware of these thoughts, they nonetheless have a huge impact on self-image and the perceptions of situations, the world, and the future. One of the goals of cognitive-behavioral therapy is to increase awareness of these automatic thoughts and the effect on mood and emotional well-being. The therapist would instruct the client to attend to personal thought processes when a shift in emotion is noted (Beck, 1995). Recognition of these automatic thoughts and the change in affect is the first step towards making change in the cognitive-behavioral approach (Bourne, 2005).

Once the automatic thoughts are identified, the individual can determine if the thought was valid in nature (Beck, 1995). If the interpretation of the event is not valid, this can be corrected, usually resulting in improved mood. Human thought is subject to many different types of thinking errors, otherwise known as cognitive distortions (Clark, Beck & Brown, 1989). Cognitive distortions can lead a person to erroneous conclusions and then misperceptions are amplified, thereby creating additional stress in the life of that individual. Treatment involves identifying the automatic thoughts and replacing them

with more functional and accurate ones (Thompson, Coon, Gallagher-Thompson, Sommer, & Koin, 2001; Hamrin & Pachler, 2005).

The clinician educates the client about the process of distorted thinking and assists in devising ways to challenge the negative thoughts. These negative thoughts or beliefs can be divided into two different categories: intermediate beliefs and core beliefs. Intermediate beliefs are composed of rules, attitudes, and assumptions that we develop, whereas core beliefs are absolute, rigid global ideas about ourselves and/or others (Beck, 1995). These different beliefs can be challenged through the utilization of a dysfunctional thought record (DTR). The DTR is usually a homework assignment to complete between sessions. The client writes down the event, the thoughts and feelings that surfaced in that situation, and then is challenged to think of a more rational and functional response. This method assists the client in taking charge of treatment and recognizing ways to implement techniques that are taught in the therapeutic setting.

Case conceptualization. Case conceptualization is an essential therapeutic component for any treatment modality. The process of case conceptualization provides an understanding of the client by classifying the client's psychological problems as occurring at two levels: the overt difficulties and the underlying psychological mechanisms (Persons, 1989). Overt difficulties may be defined as real life problems, whereas the underlying psychological mechanisms are "psychological deficits that underlie and cause the overt difficulties" (Persons, 1989, p.1). Both of these problem areas interact from time to time. The underlying psychological mechanisms tend to reveal themselves through the overt difficulties experienced by the person. Intense emotions, the underlying psychological mechanisms, are apt to be evidenced as overt

difficulties that are more noticeable (Persons, 1989). It can be difficult to clearly define these two levels.

Overt difficulties can be divided into three components: cognitions, behaviors, and moods (Persons, 1989). The cognitive component is represented as a negative automatic thought when contending with a problem. For instance, when a person is experiencing difficulties with a task, he or she may think "I will never get through this." This thought may keep the person from finishing the task at hand. The person may decide to stop what he or she is doing or become emotionally upset. The cognitive component is present in most problems (Persons, 1989). As shown in the example above, automatic thoughts and distorted thinking would be in this category. Behaviors can be subdivided into overt motor behaviors, physiological responses, and verbal behaviors (Persons, 1989). Finally, mood is comprised of the subjective feelings experienced by the person. These three overt difficulties interact and intensify the stress of an individual.

The underlying psychological mechanism is a problem of deficit that produces, or is responsible for, the individual's overt difficulties (Persons, 1989). It is impossible to directly measure the underlying psychological mechanism of an individual. Therefore, the therapist must work to determine the underlying mechanisms of the client through the therapeutic relationship and information gathered during the treatment.

The preparation of a thorough cognitive-behavioral case conceptualization requires some key steps. First, it is necessary to gather identifying information and determine the chief complaint (Persons, 1989). The identifying information assists in classifying the individual and discerning the various roles in the client's life. For instance, identifying information may include marital status, education, occupation,

interests, and children (Persons, 1989). The chief complaint embodies the main reason for seeking treatment.

The next step involves the preparation of a problem list. The problem list is a record of the current stressors and concerns in the client's life (Persons, 1989). The therapist and the client will work to make this list as detailed as possible in order to wholly identify and address the concerns. This will help to pinpoint the overt difficulties. Then the clinician can formulate a hypothesis regarding the underlying mechanisms (Persons, 1989).

The next step is to establish the relationships between the underlying mechanism, the overt difficulties, and the problem list (Persons, 1989). The underlying mechanisms relate to the core beliefs of the individual, which are expressed through the overt behaviors and concerns on the problem list (Persons, 1989). The therapist examines the various relationships between the core beliefs and the expressed problems and concerns. In doing so, the clinician takes into account the precipitants and origins of the central problem (Persons, 1989). The precipitants of the problem are comprised of those events or encounters that may trigger stressful situations (Persons, 1989). The origin of the central problem usually involves experiences that occurred in the individual's developmental stage.

Once these steps are taken, the clinician is then ready to write a treatment plan and determine appropriate interventions for the client (Persons, 1989). The clinician takes into account the problem list and also works towards addressing the overt difficulties and underlying mechanisms throughout treatment.

Cognitive triad. Cognitive-behavioral therapy incorporates interventions to focus on the three parts of the cognitive triad(Clark, Beck & Brown, 1989). The triad is reflective of the client's core beliefs in three areas: client's view of self, the world and others, and the future (Holmes, 2001). Depressed individuals often maintain negative beliefs within these three dimensions.

A client suffering from depression usually has a negative self-image. This is evidenced by feeling worthless, focusing on negative self-attributes, and filtering out positive qualities (Librizzi, 2006). A depressed individual habitually feels inadequate, and as a result, believes that all experiences will result in defeat or failure.

A depressed person may also view others and the world in a negative light (Librizzi, 2006). This is often accompanied by feelings of isolation and disengagement. A depressed individual frequently perceives that others are disinterested in his or her needs and concerns. This may even bring about a detachment from God (Librizzi, 2006). The thinking patterns could be such that "I am a worthless failure, nobody cares for me, no one can help, not even God."

A depressed person may feel worthless and undeserving of love, thereby creating a hopeless view of the future. This may heighten the depression or even eventually lead to suicide. It is apparent that the three schemata of self, others and the world, and future interact with one another.

Cognitive restructuring. Cognitive restructuring is employed to address the incorporation of irrational and dysfunctional beliefs into the individual's mental framework on all three levels of the cognitive triad (Clark, Beck & Brown, 1989). Cognitive restructuring involves challenging old distorted beliefs and developing new

healthy rational beliefs. Cognitive restructuring begins with the identification of negative, distorted, or irrational thinking (Maag & Swearer, 2005). The client learns to recognize when these negative and unhealthy thoughts occur and to start monitoring cognitions through the use of self-monitoring and the DTR (Beck, 1995). These maladaptive thoughts of the client can then be challenged and disputed through the use of Socratic questioning, examining the evidence, or through the utilization of a dysfunctional thought record. Once the thought is identified, the restructuring process can begin. The clinician works with the individual to counteract irrational beliefs with more positive or more realistic statements (Maag & Swearer, 2005). The restructuring process is done in a collaborative fashion. This process is usually introduced to the client during the session in a step-by-step fashion. When examining negative thoughts, the client may be asked questions such as: What is the evidence? What's another way of looking at it? So what if it happens? (Prochaska & Norcross, 2003). The therapist may also utilize the Socratic technique in a similar manner. Questions may be asked, such as: What did Jesus say about the worth of sinners? The lost sheep? The lost coin? What do these parables say about you? (all in Luke 15) Do you believe what Christ said, "He who is without sin among you, let him first cast a stone" (John 8:7)? Why are you so set on clobbering yourself? (Richards & Bergin, 2005c). These questions assist the individual with testing the validity of his or her statements according to God's word and the basic tenets of spirituality. This will enable the client to see how his or her thinking is distorted and, at the same time, begin to practice common themes of spirituality in ways of living. The client is guided through various phases with the therapist. This could eventually lead to a change in thinking patterns and mood. The client can then begin to practice these

techniques on his or her own with the hope of eventually completing the process in a more natural fashion as a shift in emotion is noted.

Behavioral activation. Behavioral activation is a structured approach that seeks to alleviate depression and prevent relapse by directly focusing on behavior change (Barlow, 2008). Behavioral activation aims to make rewards an inherent part of the depressed person's life. A depressed individual tends to withdraw from the world, which may actually maintain or increase the depression.

One of the first stages of behavioral activation includes self-monitoring of daily events. The individual is asked to complete a weekly schedule of engaged activities and rate the mood associated with each (Barlow, 2008). The therapist then thoroughly reviews the activity record during the next session so that the clinician and client can understand how the client's activities, routines, and life context create behavioral patterns that may prolong or exacerbate the client's depression (Barlow, 2008).

The next step is activity scheduling. This intervention instructs the client to schedule various activities throughout the week and assess the outcome of the activity, mood, pleasure, and sense of mastery. The therapist and the client then work together to distinguish those specific activities that serve as positive functions from others that illicit feelings of sadness and depression (Beck, 1995).

Relaxation. There are many different types of relaxation techniques that have proven effective in working with clients. Some of the techniques utilized in treatment include breathing training, progressive muscle relaxation, meditation, visualization, applied relaxation training, and self-hypnosis (Bourne, 2005). Typically, these relaxation methods are used with clients who are experiencing problems with anxiety. However, in

this study, these techniques were utilized to help the individual increase his or her inward spiritual growth. Spiritual interventions often tend to induce relaxation. Prayer and meditation have a positive impact on the mental and physical health of a spiritual person (Davis, Eshelman, & McKay, 2000). These spiritual interventions allow the body to relax and focus one's attention on whatever is at hand and often are effective in dealing with symptoms of depression (Davis, Eshelman, & McKay, 2000).

Spirituality and depression.

Depression is viewed as a key growth factor for spirituality (Blazer, 2007). It is a growth factor in the sense that the spiritual client relies on his or her relationship with God to overcome depression. Some clients also believe that depression may arise as a result of fatigue from continuously doing God's work, thereby feeling drained from these endeavors (Blazer, 2007).

Others view depression as a time to utilize spiritual interventions and draw closer to God (Koening, 2007). It is often during those times of greatest need, such as suffering from symptoms of depression, when it is necessary to rely on prayer, church, meditation, and scriptural references to deal with these circumstances. Some people contend that depression is derived from shame and guilt, generally caused by sin, and only alleviated by spiritual exercises, such as repentance or prayer (Blazer, 2007). However this relationship is perceived, it is evident that spirituality and depression appear to be connected in the eyes of the spiritual community (Blazer, 2007; Miller, Weissman, Gur, & Greenwald, 2002; Koenig, 2007).

Presently, there is limited research regarding ways that spirituality can be incorporated into the treatment setting. Therefore, continued refinement of existing

methods in this field as well as development of new approaches are necessary to help treat an underserved population. For those approaches utilized by clergy members, there is little guidance regarding interventions other than those previously listed. As a result, it is difficult to determine the mechanism of change for these interventions or to confirm their effectiveness.

Spirituality and cognitive-behavioral treatments.

Spiritually modified cognitive therapy.

Several individuals have worked to incorporate spirituality with the cognitive approach to psychotherapy. The goal of spiritually modified cognitive therapy is personal and spiritual growth and well-being (Sperry, 2005b). Hodge (2006) proposed that spiritually modified cognitive therapy centers on helping clients identify unproductive thoughts and underlying problems. Once these are identified, the clinician assists the individual with substituting more functional self-statements in place of the unproductive thoughts. Specifically, the clinician utilizes spiritual precepts that are derived from the client's spiritual worldview (Hodge, 2006). Spiritually modified cognitive therapy makes use of the scriptures, religious imagery, and references to Christian theology to help dispute irrational thoughts (Richards & Bergin, 2005c). In doing so, the client becomes able to recognize ways that he or she can use spirituality for support and guidance throughout the treatment process. Thus, spirituality is strengthened as the client grows in overall emotional well-being.

This approach has several advantages over traditional CBT. The most apparent advantage is the incorporation of spiritual components in treatment. CBT traditionally does not address these concerns. As a result, the individual may not feel that all of his or

her concerns are being addressed. Spiritually modified CBT embraces this area and attends to any spiritual concerns or dilemmas directly in the treatment (Hodge, 2006). A closer therapeutic relationship may be established as a result of this understanding. In addition, the spiritual identity of the client may further progress.

Behavioral approaches.

Behavioral approaches are often utilized to enhance spirituality. The focus of this treatment relies on developing or enhancing behaviors that are significant to spirituality and religiousness (Martin & Booth, 1999). Common behaviors found in many spiritual practices include prayer, fasting, meditation, the study of faith literature, volunteering for charitable work, practicing particular rituals (sacraments, holy days, and dances), and participating in compassionate sacrificial services (Martin & Booth, 1999). The three behavioral approaches to enhancing spirituality involve doing more, being more, and doing less.

Doing more involves the increase in spiritual and religious behaviors (Martin & Booth, 1999). The behaviors that usually fall under this category include meditation, prayer, and exercising forgiveness (Martin & Booth, 1999). By working to promote these types of behaviors, the client must maintain commitment over a sustained period. A variety of behavioral management techniques can be utilized for these behaviors.

One common behavior management strategy is goal setting (Martin & Booth, 1999). In goal setting, it is important that the individual creates a goal that is measurable and can be monitored or tracked over time. The clinician may need to educate the client about self-monitoring and the importance of this technique throughout the process of treatment (Martin & Booth, 1999). In addition to self-monitoring, the client may want to

establish a written agreement or contract about the specific goals that were set (Martin & Booth, 1999). The contract would specify each goal and the positive reinforcement or reward that is earned once the goal is reached (Martin & Booth, 1999). The client will have a target to work towards and may strive for the goal more seriously if it is written in a contract format.

Shaping is another behavioral technique that may assist with doing more (Martin & Booth, 1999). Specifically, the client may want to shape prayer or meditation behaviors (Martin & Booth, 1999). This is done by first establishing a baseline of the behavior through self-monitoring. Perhaps that person would like to have 1 hour of prayer or meditation each morning. The individual may start with 2 minutes a day and slowly increase this time as smaller subgoals are met. The first few steps should be simple and highly achievable (Martin & Booth, 1999). The person could also utilize a contingency management approach with these behaviors (Martin & Booth, 1999). Specifically, the person can only perform other more pleasurable activities after the completion of those behaviors that he or she is trying to increase. For instance, the person may watch TV or listen to music only after praying for 30 minutes.

Another behavioral technique that is employed in treatment is the deposit-return contract. In this contract, the client gives the therapist a monetary amount. This amount is given back to the client upon the successful completion of behavioral changes (Martin & Booth, 1999). This technique may be highly effective for those individuals who possess a strong motivation to achieve.

Finally, the spiritual practices of prayer, meditation, and study may be reinforced through stimulus control or contextual prompting techniques in which certain people,

places, or events are reliably associated with the spiritual practice (Martin & Booth, 1999). Eventually, these associations to the religious behaviors will become second nature. This is similar to chaining of stimuli, where the individual has a schedule of different activities that occur in a sequence. For instance, the person may wake, brush his or her teeth, sit in a comfortable chair, engage in a few deep breaths, and then begin prayer or meditation time (Martin & Booth, 1999). As the person continues to carry out the sequence of behaviors, it becomes more natural and functionally automatic, as the person may no longer need to attend to every step or rely on external reinforcement.

Being more is the second behavioral approach (Martin & Booth, 1999) . This is a process that works towards the enhancement of inward spirituality. Being more involves examining one's spiritual beliefs and continuing to work towards spiritual growth (Martin & Booth, 1999). Martin and Booth (1999) observed that the more spiritual ideals and values are internalized, the more that spiritual practices will become engrained into the nature of the individual. Therefore, the increase in behaviors associated with doing more may facilitate the internalization of spirituality and work towards the process of being more (Martin & Booth, 1999).

The third behavioral approach is doing less. Doing less involves decreasing spiritually inconsistent behaviors, such as overindulgence and acts of unforgiveness, condemnation and bitterness (Martin & Booth, 1999). The individual may need to remove obstacles that impede spiritual development. This may involve identifying and removing those factors that compete with the time and motivation needed for spiritual development.

Religious cognitive-behavioral therapy.

The goal of religious cognitive-behavioral therapy is to develop a spiritual identity and daily thoughts and actions consistent with core beliefs and values (Martin & Booth, 1999). Johnson, Ridley, and Nielsen (2000) suggest that clinicians seek answers to the following questions to determine if the client harbors distorted religious beliefs: Do the client's beliefs provide a way to avoid reality and responsibility? Do the client's beliefs create false expectations of God? Do the client's beliefs lead to self-destructive behaviors? If any of these answers is yes, the client may exhibit distorted religious beliefs.

Religious cognitive-behavioral techniques range from contemplative worship with religious imagery to prayer between client and therapist (Hawkins, Tan, & Turk, 1999). Other techniques include scripture memory and the participation in many different forms of Christian support groups. Scripture memory includes memorization of different Bible verses. Richards and Bergin (2005c) examined specific ways to incorporate spirituality into conventional cognitive-behavioral therapy. These authors suggest that when addressing difficulties with negative self-rating, the individual should be directed to Christ's message in Matthew 25:40, which states "If you have done it to the least…you've done it to me." This scripture portrays God's view that He considers all people to be of equal value to Him. The individual's low levels of self-worth are directly challenged by scripture such as this in the way God values that individual. Consequently, according to this belief system, denigrating the self is akin to denigrating God, something that should cause cognitive dissonance and boost the client's motivation to change (Richards & Bergin, 2005c). Richards & Bergin (2005c) recommend the utilization of

metaphors when clients begin to "awfulize." For example, the clinician may compare the client's individual situation to the death of Jesus or the flooding of the Earth and connect how these trials and awful events of that time were part of God's plan. The individual will begin to decatastrophize and see that the current situation is not really that awful. He or she may also begin to search out ways that the present situation is a part of God's plan. The therapist may also use self-disclosure to assist in this area by relating a specific personal struggle that was endured and overcome and how this experience helped to influence and shape the therapist to the present day.

Additionally, religious cognitive-behavioral therapy focuses on how problems in distorted thinking may occur as a result of feelings of depression. When distorted thinking patterns are identified, the clinician will use biblical truth to conduct cognitive restructuring and behavioral change interventions (Tan & Johnson, 2005). This will create a firm basis for the client and allow for resolution at a deeper level. The therapist may also emphasize the Holy Spirit's ministry in bringing about inner healing as well as cognitive, behavioral, and emotional change (Tan & Johnson, 2005). This can be done through the use of prayer and the affirmation of God's Word to facilitate dependence on the Lord to produce a deep and lasting personality change.

Manualized integrative approaches.

Justification for using manualized treatment approaches.

Manualized treatments have been developed over the past several years to assist therapists in working with clients. A number of clinicians support these treatments for a variety of reasons. Manualized treatment approaches are considered fundamental to systematic treatment research (Krautter & Lock, 2004). Manuals are thought to provide

clearly specific treatments that are necessary for empirically supported treatment identification. The development of manuals represents an advance for the professional practice of psychology (Scaturo, 2001). Scholars believe that manuals are helpful in defining treatment goals, developing timing interventions, and providing an overall structure for the treatment (Krautter & Lock, 2004). Manualized approaches also tend to increase validity and reliability of treatment as a result of the standardized process. The manualized approach may help the clinician remain focused on defining short-term goals, designing the treatment protocol, and staying on track with the goals that are outlined in the manual (Krautter & Lock, 2004). In addition, treatment manuals assist in focusing upon the salient and curative elements specific to certain treatment regimens and others that are common among most regimens (Scaturo, 2001). Thus, those techniques that have proven effective with certain populations or problems are already presented in an effective and productive manner.

At times, it is acceptable to divert from the manual and make use of the therapist's individual skills. The application of manualized treatment by psychotherapists requires the flexibility to allow for deviation from a given protocol when the unexpected arises (Scaturo, 2001). As the protocol may not address unforeseen clinical events and patient crises, the therapist will need to amend the treatment of the client as deemed necessary.

Objections to using manualized treatment approaches.

Even though it has been suggested that manualized treatment approaches are fundamental to systematic treatment research, many clinicians are hesitant to embrace these treatment approaches (Krautter & Lock, 2004). These individuals view treatment manuals as a "cookbook" or "paint-by-numbers" approach to treatment (Scaturo, 2001).

Some objections include that manuals are too general, are not sensitive to the unique needs of particular patients, and interfere with the development of the therapist-patient relationship (Krautter & Lock, 2004).

Scaturo (2001) contends that manuals may discourage critical thinking in students and inhibit a more sophisticated formulation of rival hypotheses. There may not be a sufficient understanding of the manual, which may also ignore essential elements related to the history and development of the individual undergoing treatment. Therefore, the student may not adequately learn the skills needed to successfully treat the client or sufficiently think through the various components that are required in a successful therapeutic environment. In addition, the essential components to treatment may not be recognized.

It is also alleged that manualized protocols may provide misleading information to governmental sources, third-party payers, and the public at large (Scaturo, 2001). Those outside sources may not see the value in the service of the highly trained professional, but instead believe that anyone is capable of following the treatment manual without additional education in counseling and clinical psychology.

Despite the noted negative aspects in utilizing a manualized treatment approach, the intent of this study was to create a new manual to direct the integration of spirituality and the cognitive-behavioral approach when working with depressed religious clients. The devised manual may assist clinicians and clergy in fulfilling the holistic needs of the client. It should be noted that the manual is geared towards Christian clients and may not be appropriate for clients with other religious beliefs.

Chapter 3

Hypotheses.

Research questions.

When spirituality and cognitive-behavioral approaches are integrated into a new treatment modality, will this new approach effectively reduce depressive symptoms, increase religiosity, decrease cognitive distortions, increase therapeutic alliance and increase treatment adherence in a Christian patient?

Statement of the hypotheses.

Hypothesis 1.

An integrative manualized treatment approach within a pilot study using spirituality and cognitive-behavioral therapy would result in an observed decrease in depressive symptoms in Christian clients, as indicated by scores on the Beck Depression Inventory-II (BDI-II; Beck, Steer & Brown, 1996) and a qualitative analysis of client responses in therapy sessions.

Justification for hypothesis. This research was designed to determine if an integrative approach cognitive-behavioral therapy and spirituality would decrease depressive symptoms in a Christian client. As previously outlined in the literature review, spirituality has served as a relevant source for helping religious individuals cope with depression (Hebert, Dang, & Schulz, 2007). In addition, many individuals have stated their desire to include spirituality in mental health treatment (Blazer, 2006). Research has found that cognitive-behavioral therapy is an empirically validated approach to working with individuals experiencing depressive symptoms, and cognitive-behavioral therapy has proven similar to spirituality in several ways (Richards & Bergin,

2005c). Therefore, it would seem obvious to incorporate tenets of spirituality with cognitive-behavioral therapy to assist in the treatment of depressed religious individuals.

Relevant work related to hypothesis. Several researchers have explored an integrative approach and the effect of such an approach on Christian clientele. Johnson and Ridley (1992) completed a study with depressed patients utilizing rational emotive behavioral therapy (REBT) and Christian-informed rational emotive behavioral therapy. The results of their study revealed no difference in depression scores with Christian-informed REBT and standard REBT. This may suggest that the Christian-informed REBT as not effective. However, may be interpreted to indicate these findings that the Christian-REBT as effective in reducing depressive symptoms as standard REBT treatment.

A study carried out by Propst and colleagues (1980) compared the effectiveness of integrating a CBT form of imagery with a similar treatment involving Christian values. Two control groups of depressed individuals were utilized, a waitlist group and a placebo group. The participants met twice weekly for 8 sessions. Results of the study revealed that the Christian therapy group and spiritual discussion group exhibited significant improvements across the 3 dependent measures (BDI, MMPI, and the MMPI-Depression Scale), while the placebo group did not. This study suggests that an integrative approach that combines CBT with Christian values is effective when working with depressed clients.

Propst and colleagues (1992) completed another similar study to the one outlined above. They assigned participants to either a waitlist or one of three treatment groups using manualized treatment. These groups consisted of cognitive-behavioral therapy,

Christian-informed cognitive-behavioral therapy, and pastoral counseling. Eighteen sessions were provided for each of the three treatment modalities. Results revealed that all three treatment groups had a significant reduction in their depression scores after treatment. The gains were maintained at the two follow-up periods across both measures (BDI and HDRS) for all three treatment modalities. Christian-informed CBT and pastoral counseling groups recorded lower levels of depression on both measures at posttreatment compared to the CBT and waitlist control group. However, only the religious cognitive therapy group reported significantly lower posttreatment BDI scores than did the wait list control group. In addition, pastoral counseling outperformed traditional cognitive-behavioral therapy at posttreatment, as indicated by scores on the BDI. Thus, those groups that incorporated spirituality into their treatment had lower ratings for depression symptoms over time.

Koenig (2007) developed a study that compared traditional cognitive-behavioral therapy with Christian cognitive-behavioral therapy in the treatment of depressed individuals. The Christian-based CBT utilized Christian rationales, religious arguments, and religious imagery to counter irrational thoughts. The results of this study showed that only Christian CBT resulted in significantly lower immediate posttreatment self-rated depression compared to regular CBT. In addition, the study revealed that Christian CBT achieved a more expedient decrease in symptoms than more traditional secular CBT.

Lastly, Hawkins and colleagues (1999) conduct that compared CBT with Christian-informed CBT. The treatment was administered in a group setting. For pretreatment and posttreatment measures, the researcher utilized the Beck Depression

Inventory (BDI) and Spiritual Well-Being scale. There were no significant differences in spiritual well-being between the two groups. However, both groups experienced significant reductions in depression and significant increases in spiritual well-being. There was a trend toward lower levels of depression was noted in the Christian CBT group.

Hypothesis 2.

An integrative manualized treatment approach within a pilot study, using spirituality and cognitive-behavioral therapy would increase religiosity, as indicated by scores on the Santa Clara Strength of Religious Faith Questionnaire (SCSORF; Plante & Boccaccini, 1997), the Religious Behaviors Inventory (RBI; Librizzi, 2006) , and a qualitative analysis of client responses in therapy sessions.

Justification for hypothesis. Positive religious coping responses are associated with positive mental health outcomes (Sperry, 2005b). At times, individuals become depressed or experience negative emotions as a result of their negative religious coping patterns. Part of the integrative approach address these coping responses and may assist the client to adopt more adaptive and positive religious coping responses(Sperry, 2005b). By focusing on spirituality and incorporating spiritual interventions in manualized protocol, the client's spirituality may strengthen and continue to grow throughout treatment.

Relevant work related to hypothesis. A few studies have examined the effectiveness of cognitive-behavioral therapy and spirituality. Hawkins, Tan, and Turk (1999) conducted a study that examined the different effects of cognitive-behavioral therapy and Christian cognitive-behavioral therapy on spiritual well-being and

depression. The results indicated that a change in depression score correlated with change in spiritual well-being. Specifically, when depression scores decreased, spiritual well being increased. Participants in both the CBT and Christian CBT groups demonstrated improvements in spiritual well-being, but greater improvement was observed for spiritual well-being in the Christian CBT program.

A few measurements have been developed to measure religiosity/spirituality. One measure that has been utilized in several studies is the SCSORF, which also measures religious involvement.

Plante, Yancey, Sherman, Guertin, and Pardini completed a study to provide additional validation and support for the SCSORF. Three different populations were used: 199 undergraduate students from a West Coast private Catholic university, 91 undergraduate students from a Southern public university, and 232 people in recovery from drug and/or alcohol addiction in Northern California. The results revealed strong correlations among the SCSORF and the Intrinsic Religious Motivation Scale, the Duke Religious Index, and the Intrinsic Religious Measures Scale. These results support the validity of the instrument and confirm the relationship of strength of religious faith to established measures of religiousness and religiosity.

Lewis, Shevlin, McGuckin, and Navratil (2001) conducted a study to examine the factor structure of the SCSORF scale using confirmatory factor analytic methods in a sample of 106 Northern Irish undergraduate college students. The findings offered further evidence that the Santa Clara Strength of Religious Faith Questionnaire is psychometrically sound and therefore can be recommended for continued use by researchers to measure religious faith.

Sherman et al. (2001) completed a study that analyzed the link between religious involvement and health outcomes for cancer patients using the Santa Clara Strength of Religious Faith Questionnaire. This measure was evaluated using 95 breast cancer patients and 53 healthy young adults. Results showed the SCSORF to have strong associations with intrinsic religiosity. Additionally, religious faith moderately correlated with ratings of strength and comfort derived from religion and the perception of self as religious or spiritual. The SCSORF demonstrated high test-retest reliability and internal consistency. Convergent validity was supported in the study by high correlations with intrinsic religiousness and moderate correlations with other measures of religious involvement. Overall, results revealed reliability, convergent validity, and divergent validity of the SCSORF.

Freiheit, Sonstegard, Schmitt, and Vye (2006) also tested the reliability and validity of the SCSORF. These researchers used 124 undergraduate college students who were attending a private Catholic University. The researchers administered the SCSORF to these students and compared the results to measures of spirituality, religious behavior, religious coping, and affect. Results revealed the SCSORF to be highly correlated with spirituality, as measured by the Spiritual Exercise Index. The SCSORF was correlated with the Religious Background and Behavior self-report questionnaire, which is a self-reported measure of religious behavior. Similarly, the SCSORF was related to religious coping, but not to affect, which indicates that the scores on the SCSORF are not affect dependent. The SCSORF measures faith independent of the current mood that the individual is experiencing. All in all, their study provided additional evidence that the SCSORF is a reliable and valid measure of religious faith.

Hypothesis 3.

An integrative manualized treatment approach within a pilot study, using spirituality and cognitive-behavioral therapy would result in a clinically significant decrease in cognitive distortions, as measured by the Inventory of Cognitive Distortions (ICD; Yurica & DiTomasso, 2002).

Justification for hypothesis. It has been shown that cognitive distortions are related to depressive symptoms. Specifically, cognitive distortions cause emotional distress in individuals, which may lead to depression. Similarly, spiritual individuals may at times maintain irrational or unhealthy religious beliefs about God or their faith (Sperry, 2005b). This could intensify emotional distress and potentially lead to depression. Thus, it would be interesting to observe whether the Inventory of Cognitive distortions identifies a reduction in cognitive distortions in this new integrative manualized approach.

Relevant work related to hypothesis. There has been no research to date that incorporates the Inventory of Cognitive Distortions and an integrative manualized approach using spirituality and cognitive-behavioral therapy. The integrative manual for this study utilizes the Word of God to challenge irrational cognitions and formulate more rational cognitions. Through restructuring the thinking process and using the Word of God, the intent is the creation of a transformational process within the individual. This study seeks to identify whether there is a relationship between distorted cognitive beliefs in the Christian population and depressive symptoms, which would validate the use of the integrated treatment manual.

Yurica (2002) demonstrated in her research the significant positive correlation of the ICD scores with accepted measures of depression. The ICD has internal consistency confirmed through a comparison of outpatient psychiatric patients and a control group. Rosenfield (2004) found the ICD to be a valid and reliable measure of cognitive distortions underlying a wide range of psychological disorders across both Axis I and Axis II.

Tate (2006) completed a study that assessed a depressed patient throughout a manualized treatment, utilizing a variety of measures. One such measure was the ICD. Results of the study revealed that there was a reduction in distorted thinking, as exhibited by a reduction of the total score on the ICD. The study hypothesized that as depressive symptoms decreased, cognitive distortions would decrease accordingly. This did not occur. Overall, both measures decreased, but it appeared that the decrease in depressive symptomatology was accounted for by the therapeutic relationship and the empathetic environment, in addition to the manualized treatment modality that was used (Tate, 2006).

Hypothesis 4.

An integrative manualized treatment approach within a pilot study, using spirituality and cognitive-behavioral therapy would increase therapeutic alliance, as indicated by the Working Alliance Inventory (WAI, Horvath & Greenberg, 1989).

Justification for hypothesis. It is apparent that many individuals who value spirituality may desire to incorporate tenets of spirituality into their mental health treatment. As spirituality is essential in the lives of many people, it is particularly important to incorporate spirituality into the treatment setting for these individuals. This

addition to mental health treatment may create a stronger therapeutic bond and working alliance. The client may feel that his or her needs were being fully met. Furthermore, the inclusion of spirituality in treatment may impart great satisfaction to the client by providing an outlet to openly explore his or her spiritual beliefs with the clinician.

Relevant work related to hypothesis. There has been no research that utilizes the Working Alliance Inventory to assess therapeutic alliance in an integrative treatment approach utilizing spirituality and cognitive-behavioral therapy.

Hypothesis 5.

An integrative manualized treatment approach within a pilot study, using spirituality and cognitive-behavioral therapy would increase treatment adherence, as measured by treatment attendance, promptness for therapeutic sessions, and compliance/completion of assigned homework.

Justification for hypothesis. The integrative manualized treatment approach was designed to satisfy the holistic needs of the Christian client in the therapeutic environment. This hypothesis contends that meeting these needs of the client would result in increased treatment adherence and compliance. Treatment adherence was measured by attendance, promptness in meeting the appointment time, and compliance/completion of any homework assignments. It was believed that meeting these spiritual needs would assist the Christian client to become more vested in the integrative manualized approach. It was anticipated that the individual would feel that the treatment was of value, thereby increasing the likelihood of regular attendance, promptness, and compliance in completing given assignments.

Relevant work related to hypothesis. Presently, there is no established research that measures treatment adherence within an integrative manualized treatment approach that includes components of spirituality and cognitive-behavioral therapy. If this hypothesis were supported, this new integrative approach may be utilized in therapeutic settings to increase attendance, promptness and compliance with homework assignments. Further research could be conducted to determine those specific factors in the integrative manualized approach that lead to increases in treatment adherence.

Chapter 4

Methods

It was hypothesized that the integration of spirituality and cognitive-behavioral interventions in an integrative manualized treatment approach will result in a decrease in depressive symptoms and cognitive distortions, an increase in spirituality, a strengthening of the therapeutic alliance, and a stricter adherence to treatment. This will be established through the utilization of a 12 session therapy protocol using spiritual and cognitive-behavioral interventions. This chapter provides information about a) design and design justification, b) participant information, c) inclusion and exclusion criteria for the study, d) screening procedures for determining inclusion and exclusion criteria, e) recruitment processes, f) informed consent procedures, g) measures used to assess the above changes, h) procedure of the study, i) analysis of risk/benefit ratio and j) procedures for maintaining confidentiality. The Beck Depression Inventory - Second Edition (BDI -II) was used to measure depressive symptoms. Religiosity was assessed by the Santa Clara Strength of Religious Faith Questionnaire. The Religious Behaviors Inventory was utilized to quantify religiosity. The strength of the therapeutic alliance was measured using the Working Alliance Inventory. Finally, treatment adherence was assessed by monitoring attendance, promptness to appointments, and compliance with homework assignments. The constant was the participants, the independent variable was the treatment approach, and the dependent variables consisted of scores relating to depression, religiosity, cognitive distortions, and working alliance, in addition to observations of treatment attendance, promptness, and compliance with homework assignments.

Design and justification.

This study used a multiple person case study design. The researcher identified two individuals to evaluate the impact of the integrative manualized treatment based the five hypotheses that were previously reviewed. A multiple person case study was used to address the validity of the integrated treatment manual. The researcher gathered detailed information and qualitative reports from the participants throughout this study. This information was used in conjunction with empirically validated instruments to assess the overall effectiveness of the treatment manual.

The multiple person case study approach allowed the clinician to focus on strict manual adherence and gather multiple dependent measures to assess change. By examining only two participants, the clinician could gather more information and work to truly incorporate those tenets that are outlined in the manualized approach. This assisted in the extrication of features that could be lost in a larger group of individuals (Kazdin, 2003). The researcher believed it was necessary to examine the effectiveness through a multiple person case study and, if proven effective, then encourage future research in order to establish additional validity about the integrative manualized treatment approach.

A multiple person case study design is also advantageous as the subject in the case study serves as the sole control when comparisons are made across treatment conditions (Kazdin, 2003; Leavitt, 2001). When comparing change in scores, the investigator did not need to worry about individual differences since there was only two participants. Such control is lacking in experiments that utilize a group of individuals. The multiple person case study experiment is also useful when financial or other considerations may rule out large-scale research designs. The researcher was able to

focus on the two individuals and work to gain results that are applicable to the field of psychology. The key benefit is the time devoted to intense study of the participant (Leavitt, 2001).

The case study approach also allows for the development of new clinical innovations (Shaughnessy, Zeichmeister, & Zeichmeister, 2000). The treatment approach designed by the researcher is one of the first manualized approaches to incorporate cognitive-behavioral therapy and spirituality. This new modality may serve to assist individuals who desire spirituality in their mental health treatment and guide clinicians about how to treat clients in a holistic manner. If the hypothesized results were obtained, this would provide additional justification for incorporating CBT and spirituality in treatment when working with depressed clients of the Christian faith.

Participant.

This was a multiple person case study of two individuals in whom MDD was diagnosed (APA, 2000). The participants were drawn from a pool of individuals who requested treatment at a local outpatient treatment facility located in York County, PA. The participants had an intake evaluation that included the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I; First, Spitzer, Gibbon, & Williams, 1996), the Structured Clinical Interview for Axis II Disorders (SCID- II; First, Spitzer, Gibbon & Williams, 1997), the Beck Depression Inventory (BDI; Beck, Steer, & Brown, 1999), the Inventory of Cognitive Distortions (ICD; Yurica & DiTomasso, 2002), the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989), the Santa Clara Strength of Religious Faith Questionnaire (SCSORF; Plante & Boccaccini, 1997), the Religious Behavior Inventory (RBI; Librizzi, 2006) and the Beck Anxiety Inventory (BAI; Beck,

Epstein, Brown, & Steer, 1988) . The participants met the diagnostic criteria for major depressive disorders as indicated by the *Diagnostic Statistical Manual of Psychiatric Disorders, 4th edition, Text Revision* (*DSM-IV-TR*: APA, 2000) and as measured by intake evaluation.

Assessments.

The Structured Clinical Interview for the DSM-IV Axis I (SCID- I; First et al., 1996) is a semistructured interview for making the major DSM-IV Axis I diagnoses. The instrument is designed to be administered by a clinician or trained mental health professional. The SCID is divided into separate modules corresponding to categories of diagnoses. Most sections begin with an entry question that would allow the interviewer to skip the associated questions if not applicable. For each diagnosis, symptoms are coded as present, subthreshold, or absent.

The Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II, First et al., 1997) is a 120-item semistructured clinical interview that was constructed by the authors of the DSM-IV. It is used to assess the presence of DSM-IV diagnoses on Axis I and Axis II. A certain degree of flexibility is built into this instrument in order to tailor its administration to a wide variety of populations and contexts (Groth-Marnat, 2003). The SCID-II demonstrates good reliability and validity. SCID-I was utilized to assess clinical disorders on Axis I, whereas SCID-II was used to evaluate clinical disorders on Axis II. Both instruments were employed in this study to gauge the presence of diagnoses in these two domains.

The Beck Depression Inventory (BDI-II; Beck et al., 1996) is a 21-item inventory that measures symptoms known to be correlated with depression according to *DSM-IV-*

TR criteria. The 21 items include four different responses that the individual can choose, each rated on a 4-point scale from 0=(never) to 3=(severe). The BDI-II has been frequently utilized to assess cognitions that are often associated with depression. The inventory is self-administered and usually takes between 5 and 10 minutes to complete. In the clinical population, a score in the range of 0 to 13 would indicate no depression or mild depression, scores in the range of 14 to 19 signify mild depression, scores in the range of 20 to 28 to indicate moderate depression, and scores in the range of 29 to 63 indicate severe depression. The BDI-II has demonstrated content, concurrent, and discriminant validity, with a favorable factor analysis.

The Santa Clara Strength of Religious Faith Questionnaire (SCSORF; Plante & Boccaccini, 1997) is a 10- item measure scored on a 4-point scale that gauges the strength of religious faith, regardless of denomination. Total scores range from 10 to 40, where higher scores represent greater levels of religiosity. The SCSORF has high internal reliability and split-half reliability. Research has found the coefficient alpha to be between .94 and .95 and split-half reliability between .90 and .96 (Plante et al., 1999). The Pearson product moment correlation revealed that high scores on the SCSORF correlated positively with intrinsic religiousness on the Age Universal Religious Orientation Scale, with correlations ranging from .87 to .90 (Plante et al., 1999).

The Religious Behavior Inventory (RBI; Librizzi, 2006) is a 40-question inventory that evaluates some of the typical behaviors of highly committed religious individuals. The RBI was developed with a broad ecumenical perspective. This inventory may be used for all deeply committed individuals, regardless of their religious affiliation. Though the Religious Behavior Inventory has only been utilized in one study

thus far, its use was imperative in this study to assess any changes in religious behavior as they occurred over the course of treatment.

The Inventory of Cognitive Distortions (ICD; Yurica & DiTomasso, 2002) is a 69 item inventory of cognitive distortions composed of short sentences that reflect 11 factor-analyzed cognitive distortions. The ICD was developed and validated with an adult clinical population exhibiting symptoms of anxiety and/or depression (Yurica, 2002). Items are scored on a 5-point Likert scale used to determine the frequency of these cognitions, with 1 equal to never and 5 equal to always. The total possible ICD scores can range between 69 and 345, with lower scores reflecting lower frequencies of cognitive distortions. Factor analysis and cognitive therapy experts are in agreement that the inventory items reflect each specific distortion construct. As a result, content validity was confirmed. In addition, the initial development and validation study established high test-retest reliability with a coefficient for total ICD scores of .998 ($n = 28$, $p < .001$) (Yurica, 2002). Good concurrent validity was identified in the initial validation study, as the total ICD scores were significantly and positively correlated with other accepted measures of psychopathology. Yurica (2002) established good criterion validity as the total ICD scores successfully differentiated clinical outpatients from nonpatient controls.

The Working Alliance Inventory (WAI, Horvath & Greenberg, 1989) is a 36-item instrument used to assess the quality of the therapeutic alliance between the clinician and the client. The WAI can be applied in a variety of contexts, but has been used to study the influence of the quality of the therapeutic relationship on the process and outcome of therapy. The WAI is composed of two different forms, one for the therapist and the other for the client. Each of these forms has a full-length version (36 items) and a short version

(12 items). The WAI also includes an observer rated form. The WAI can either be scored by summing the scores and retrieving an overall measure of the alliance or by computing the separate subscale scores for goal, bond and task.

The Beck Anxiety Inventory (BAI; Beck et al., 1988) is a 21-item inventory that measures symptoms of anxiety, primarily those of the physical nature. It is rated on a 4-point scale, with 0 equal to not at all and 3 equal to severe. The maximum score is 63 points. Total scores ranging from 0 to 7 reflect a minimal level of anxiety; scores of 8 to 15 indicate mild anxiety; scores in the 16 to 25 range reflect moderate anxiety; and scores of 26-63 suggest severe anxiety. The BAI is constructed with items that are more closely representative of the diagnostic criteria for panic attacks than those associated with generalized anxiety disorder, obsessive compulsive disorder, posttraumatic stress disorder or social phobia.

Requirements.

Inclusion criteria.

Participation was voluntary and anonymity was maintained. Two participants were selected for the study. These participants received the manualized treatment at the same time. The investigator decided to select two participants in order to protect against potential dropout. The participants were required to meet a number of criteria. First, the primary diagnosis had to be major depressive disorder in the moderate to severe range. The participant's depression level was determined by self-report and through the clinical interview process. Additionally, Christian faith had to be a meaningful and important component in the participant's life. Finally, the participant had to report that he or she

was at least minimally committed towards developing a working alliance with the therapist.

The study required the participants to be between the ages of 21 and 65 years of age. The upper limit of 65 years was used in order to account for natural cognitive decline as people age (Holmes, 2001). There was no restriction on gender or race. The participants had to have a minimum of an eighth grade education.

Exclusion criteria.

One of the main purposes of this study was to examine the impact on a depressed individual of an integrated treatment containing cognitive-behavioral and spiritual components. Therefore, the researcher had to assess whether the participant has experienced any similar treatment modalities in the past. The participant could not have any prior exposure to an integrated model such as the one that was developed. This included treatment by a mental health clinician or a member of the clergy who utilized cognitive-behavioral techniques in a spiritually oriented perspective. The participants were asked to discontinue any therapeutic relationships with other providers prior to the onset of the study. In this circumstance, the clinician would have been required to obtain appropriate releases to retrieve relevant information from the previous provider.

Medication is an aspect of treatment that one must consider. Potential participants were excluded if he or she had begun a medication regimen to treat the depressive symptoms within 2 months prior to the start of this study. This exclusion criterion was established so that medication would not serve as a confounding variable to the treatment or the achieved results. Therefore, improvements in depression levels would be associated with the integrative treatment approach and not the medications.

Any potential participant outside the age range of 21 to 65 was excluded. Individuals with active psychosis or a history of psychosis were excluded. Individuals with severe personality disorders will be excluded from this study. Individuals with a history of disorders beginning in late adolescence or early adulthood that impacted social, occupational, or other important areas of functioning were excluded. In addition, individuals experiencing problems with substance abuse will be excluded from the study. The ultimate decision for participant exclusion was made through consultation between the researcher and the dissertation chair.

Analysis of risks: benefits ratio.

Potential risks to participant.

It was essential to determine the potential risks that the study may have posed for the participants as well as the potential benefits to the subjects, psychology, and society. The participants may have shared distressing information during the course of the study, which may have precipitated distressing emotions. In addition, the various assessment instruments may have caused the individuals to focus on some negative aspects of life, which could lead to anxiety, depression, and uncomfortable feelings (Librizzi, 2006). The participants were made aware of these risks before treatment begins as part of the formal informed consent process.

Potential benefit to participant.

There were benefits that may have resulted from this new manualized approach. First, the participants may have benefited if the study met its intent. This would be evidenced by the decreased depression scores of the participants. The study may have created overall emotional well-being for the subjects and help teach new ways to cope

with depressive symptoms in the future. Specifically, if treatment was successful, the participant would learn ways to combat irrational thinking by using cognitive-behavioral techniques that also incorporate various components of spirituality. The participants would be able to utilize these interventions after the study concluded to work towards decreasing levels of depression in the future.

Furthermore, the individuals received free therapy and would potentially become involved in the development of a new treatment modality. The participants may have even contributed to the development of a new treatment protocol, while being in no way indebted to the researcher.

In addition, the participants' levels of religiosity would increase should the treatment prove effective. It has been established throughout the literature that religion and spirituality have benefits for both mental and physical health. The individuals in the study would feel less depressed and may even have developed a deeper connection to God.

The subjects would also benefit from the established therapeutic relationship. The participants may have been able to apply the close connection developed during the treatment process to build other healthy and trusting relationships.

Procedure.

Requirements and selection process.

The participants were identified in a Christian outpatient setting located in Gettysburg, PA. The participants were informed of the study by the Director of Freedom Valley Counseling Services. The initial screening for this study took place over the telephone. The participants were asked several questions regarding past and present

mental health treatment. In addition, the investigator reviewed the informed consent form.

Measurement schedule.

The eight instruments (SCID, SCID-II, BDI-II, SCSORF, RBI, ICD, WAI, and BAI) were administered during the initial evaluation to determine a baseline measure prior to the start of treatment. Six instruments (BDI-II, SCSORF, RBI, ICD, WAI, and WAI) were re-administered at the beginning of the session for weeks 3, 6, 9, and 12.

Initial evaluation.

An evaluation was conducted during the first meeting after the informed consent form was reviewed and signed (Appendix Q). The clinician reviewed the informed consent document and received an oral agreement from the participant before the official document was signed. After the informed consent document was signed, assessments were administered to gather information about the individual and determine appropriate diagnosis. The clinical interview began once the inventories were completed. The evaluation included information about age, gender, ethnicity, race, culture, socioeconomic status, prior treatment experiences, spiritual background and experiences, medical history, family history, educational history, occupational history, current concerns, life stressors, and therapy goals. The participant was cooperative throughout this initial phone screening and intake process.

Reason for referral and presenting problems.

The first subject was referred by the director of the counseling program at Freedom Valley Worship Center due to the presentation of depressive symptomatology.

She complied with therapy and the expectations that were outlined from the beginning of treatment.

The subject exhibited a strong motivation to participate in the study from the onset of treatment. She viewed herself as indecisive, lacking goals, and having difficulties completing tasks in her life. Isolation and withdrawal were prevalent in her life. She also experienced low energy and fatigue. She had a negative perception of herself, the world, and her future, which are typical manifestations of the presentation of depression.

Diagnosis.

The assessment measures derived the following DSM-IV-TR Multiaxial Assessment: major depressive disorder, recurrent, severe, without psychotic features; cocaine dependence, in early remission and history of alcohol abuse (in full remission). The participant did not have any personality disorders. She suffered from asthma. In addition, the participant was experiencing a moderate amount of psychosocial stressors. The current global assessment of functioning scale for the participant at the time of intake was a 55.

Background/Relevant history.

Medical history. The subject indicated no medical problems, other than struggling with physical problems associated with her depression. These symptoms included fatigue, weakness, and body aches. The subjected reported that these symptoms usually worsened as her levels of depression increased.

Psychological history. The subject reported that she believed her period of worse depression occurred in 2006. The trial for her best friend's murder took place during this

time. The subject's best friend was murdered by her husband. After this trial, the subject proceeded to drink excessively. At the end of 2007, the subject reported to the emergency room of the local hospital. She stated that she needed someone to take control of her life, as her drinking and drug use problems were out of control. When she arrived at the hospital, she informed the hospital staff that she was going to kill herself. She reported that she did not have a plan and stayed at the hospital for 2 days. She later saw a psychiatrist for medication management. The subject was placed on medications to assist with her depression and feelings of anxiety. The subject reported that her mood stabilized to a certain degree until the middle of 2009. She began to smoke crack cocaine. She could not control her crack use and felt that her life spiraled out of control. She finally stopped smoking crack when her significant other was caught selling drugs in September of that year. She had been sober for about 4 months.

Marriage counseling was initiated about 1 year prior to the study. The subject reported that she went to about 4 or 5 sessions. Often, her husband would not attend these sessions and, as a result, the subject stopped going to counseling. She reported that she had not received any individual therapy.

She stated that her current concerns included symptoms of depression, anxiety, and low self-esteem. She reported that she had disturbances with her sleeping, eating, and energy levels and that these problems often placed a strain on her relationships. The subject denied suicidal and homicidal ideation or intent.

Social history. The subject reported that she had always maintained a close network of friends. However, she reported that she often became suspicious of others and their actions. The subject informed the therapist that she had a hard time trusting

other individuals. During her drug use periods, she developed several unhealthy relationships and, as a result, was still suspicious of other people. The subject was divorced in August 2009. She reported that the marriage included a lot of verbal fights. She stated that she was not satisfied with the marriage for some time. Her husband was unfaithful on several occasions over the course of the marriage. The subject was living with her youngest child's father at the time of the study. She reported that their relationship strengthened since she quit smoking and he stopped selling drugs.

Educational/ Occupational history. The subject reported that she earned her general education diploma. She stated that she had a hard time focusing in school and consequently worked towards earning her general education diploma. Upon obtaining this diploma, the subject reported that she received other professional credentials. She received a paralegal degree, her certified nursing assistant certification, and an IT certification, and was working towards her bachelor's degree in psychology. The subject reported that she had a string of various positions throughout her lifetime. For the majority of her work experience, the subject worked with children in some fashion.

Spiritual development/experiences. The subject did not go to church for most of her life. She stated that her parents encouraged involvement in church when she was younger, but she stopped attending for most of her adult life. She had a difficult time accepting some of the foundational tenets of Christianity because she met many individuals who claimed they were Christians, but did not exhibit the characteristics of grace and acceptance. The previous year, the subject reported that she had a special moment with her daughter during her periods of intense crack cocaine use. Her daughter prayed with her mother to help God deliver her and work towards the road to recovery.

The client noted that she felt the urge to reconnect with God at that time. She started to go to her sister's church and then desired to find her own church family. As a result, she began to attend Freedom Valley Worship Center in September 2009. She regularly attended weekly services and was involved in several small groups at the church. She helped to lead a recovery group and was involved in a women's Bible study. The subject reported that her faith helped her to heal, and she recognized that she received a lot of strength from her beliefs. The subject formed several positive relationships over the course of the preceding 4 months at the church.

Recent history. The subject was experiencing difficulties in normal functioning. She reported that she was feeling sad on most days. Difficulties in sleeping and eating, as well as irritability, fatigue, psychomotor agitation, lack of concentration, and indecisiveness ,were noted. She reported that she also experienced strong feelings of being worthlessness, undeserving of love, and guilt in regard to past behaviors.

Case formulation and clinical impressions.

Chief complaints.

The subject had not been in therapy in the past. She stated that she wanted to come to therapy to learn new ways of coping with her depression and anxiety. The subject wanted also to learn new ways to assist in increasing her levels of self-worth.

Problem list.

The participant reported the following problems: depression (feeling empty and sad, difficulties with appetite and sleep, fatigue, low energy, indecisiveness, feelings of worthlessness); anxiety (continual worry about family, feeling overwhelmed); social isolation (few friends, difficulties trusting others); financial stressors (on assistance); low

self-esteem; and stressors related to the future of her significant other (possible incarceration)

Hypothesized schema.

The participant revealed several hypothesized schema. Specifically, the participant evidenced three major schema domains. The first schema domain noted was disconnection and rejection. The subject perceived others as unreliable and did not believe that she could trust the individuals in these relationships. She reported that she had many poor relationships in the past and, as a result, tended to believe that she could trust no one (abandonment/instability). The subject believed that others were out to get her. She reported that she often thought that people were talking about her and that they could do what they can to cheat/manipulate her (mistrust/abuse). The subject reported that she did not receive the same amount of love that she often gave out. She stated that others did not appreciate her. As a result, she had difficulties sharing with and connecting to others (emotional deprivation). The subject stated that she felt defective and unworthy. She also has stated that she often felt unlovable (defectiveness/shame).

The second noted schema domain was other-directedness. The subject often placed the needs of others before herself in order to prevent abandonment. The subject frequently suppressed her own needs and emotions in order to keep others happy (subjugation). The subject would often meet the needs of others at the expense of her own. By doing so, this helps the subject to avoid feelings of guilt related to past situations of drug use (self-sacrifice).

Finally, the participant had qualities of the third domain of overvigilance and inhibition. The subject often focused on the negative events in her life. She reported that

she tended to be pessimistic about the future as a result of her past experiences (negativity/pessimism). The subject held back her feelings in order to avoid disapproval by others (emotional inhibition).

Relation of schema to problems.

The subject isolated herself and avoided close relationships as a result of her previous experiences. She had an emotionally abusive husband and several friendships that caused her a great deal of emotional pain. Consequently, she found it easier to avoid individuals and any emotional connections. As a result of many negative experiences in the subject's life, she had a difficult time moving in a new direction. She believed that she was doomed to have a miserable life and accordingly became increasingly anxious and depressed. As of result of past experiences that were negative and her lack of emotional connectedness to others, the subject felt that she had little value and turned this pain inward. She avoided reaching out to others, as she did not believe she was worthy of these kinds of connections.

Precipitants of the current problem.

Precipitants of the current problem are that the subject was criticized by her ex-husband, she is dealing with the death/murder of her close friend, she lacks coping skills/techniques to manage depression and anxiety, and she has distorted thinking patterns.

Origins of the central problem.

The origins of the central problem is the subject's drug use, detached relationships with parents, ineffective means of coping with stress, and poor previous social relationships

Treatment plan.

The overall goals for treatment were to decrease depression and anxiety. The measurable objectives for decreasing depression were: engage in one rewarding activity a day, to reduce negative automatic thoughts, sleep 7 to 8 hours a night, increase social contacts, increase self-reward for positive behaviors, modify schema of helplessness, increase religious behaviors and activities, eliminate negative religious beliefs or negative evaluation of God, eliminate all depressive symptoms, and to acquire relapse prevention skills. The measurable objective for decreasing anxiety were: reduce physical symptoms of anxiety, reduce time spent worrying (less than thirty minutes a day), reduce negative automatic thoughts, eliminate avoidance, modify schemata of helplessness/hopelessness, and acquire relapse prevention skills.

Predicted obstacles to treatment.

The predicted obstacles in treatment were the pessimistic traits of the subject and the lack of support that she had in her life.

Chapter 5

Results.

Research that utilizes a single case study often depends on non-statistical analysis. Nonstatistical analysis relies on the analysis of data through visual inspection (Librizzi, 2006). Through this visual inspection, the researcher can determine if the data has significant clinical relevance. It should be noted that although this study was a single case study, the researcher utilized two participants to account for potential drop-out. Both of these subjects completed treatment. Therefore, the results section will contain data from each of these individuals.

It was hypothesized that and integrative manualized treatment approach within a pilot study, including spirituality and cognitive-behavioral therapy, would result in an observed decrease in depressive symptoms in Christian clients, as indicated by scores on the Beck Depression Inventory-II and a qualitative analysis of client's responses in therapy sessions.

Data sources.

Objective data.

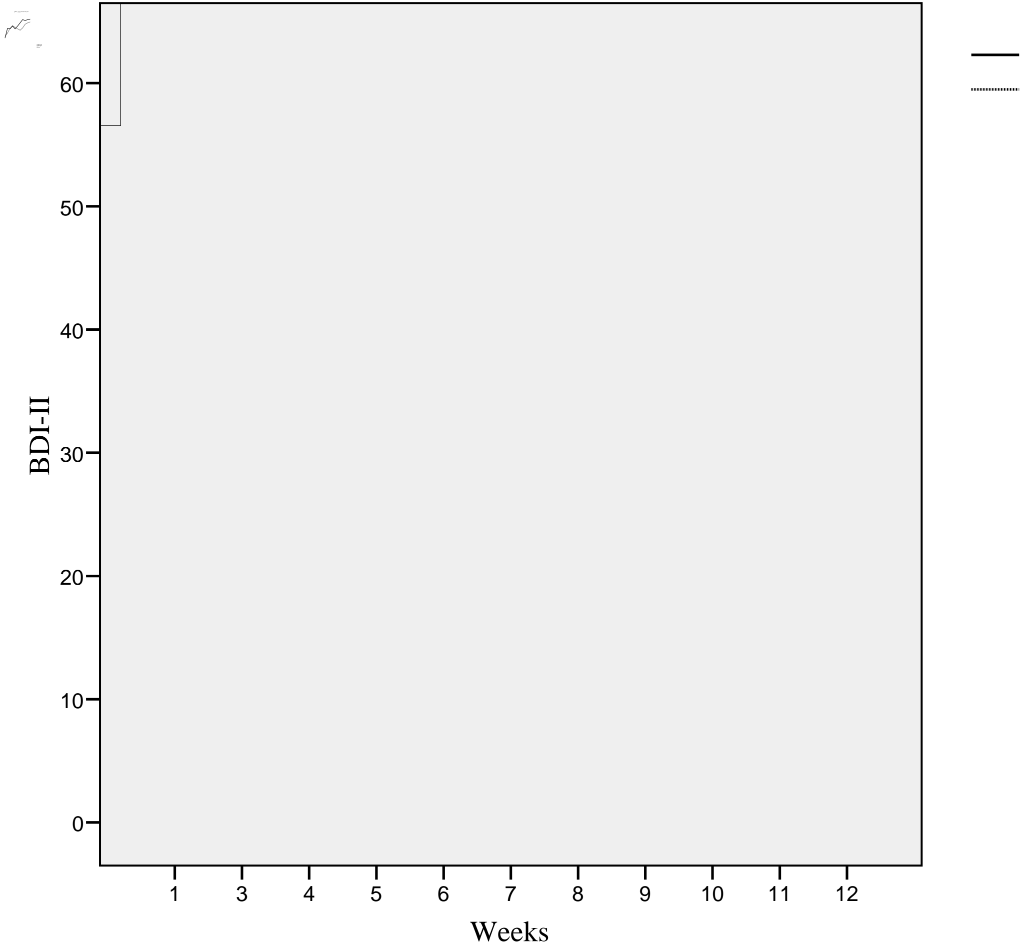
BDI-II: change in scores. Figure 1 shows the results achieved during a 12-week spiritually informed cognitive behavioral approach with religious clients who were diagnosed in the severe depression range during the intake process. The subject's progress was measured 11 times during the treatment. The measurement schedule required testing at intake and following sessions 3 through 12.

As previously noted, the BDI-II utilizes four distinct levels. In the clinical population, a score in the range of 0 to 13 would indicate no depression or minimal

depression, scores in the range of 14 to 19 signify mild depression, scores in the range of 20 to 28 indicate moderate depression and scores in the range 29 to 63 indicate severe depression. It is important to evaluate the change in the range of depressive symptoms as indicated by the BDI-II in order to determine treatment efficacy.

Both clients entered into treatment within the severe depression range. After the third session, the first subject had scores that were reflective of moderate depressive symptoms. After session 5, client one shifted from the moderate depressive symptom range to scores that were reflective of mild depressive symptoms. It should be noted that during session 6, the scores increased to the moderate depressive symptom range as the result of an extreme stressor during that week. However, the scores returned to the moderate depressive symptom range during session 7. After session 8, the first subject's depressive range scores were reduced to the minimal depressive range. The scores continued to decline through the end of the study.

The second subject also began treatment with scores in the severe depressive symptom range. After session 4, the subject's scores were reflective of the moderate depressive symptom range. Her scores declined to the mild depressive symptom range after session 5, but returned to the moderate symptom range during sessions 6 through 9. After session 10, this subject had scores within the mild symptom range. At the time of study completion, scores were within the minimal depressive symptom range.



BDI-II: change in specific items. By the end of treatment, neither client exhibited clinically significant depressive symptoms, as indicated by the BDI-II. There were several noteworthy changes in scores for items on the BDI-II. Table 3 and Table 4 reveal the changes in each of the 21 items from intake to session twelve.

Table 2

Changes in Specific Items on the Beck Depression Inventory from Intake to Termination for the first subject.

Item	Intake	Session 12
1. Sadness	1	0
2. Pessimism	1	0
3. Past failure	2	0
4. Loss of Pleasure	3	1
5. Guilty feelings	3	0
6. Punishment feelings	3	0
7. Self-dislike	3	0
8. Self-criticism	3	0
9. Suicidal thoughts or wishes	1	0
10. Crying	3	0
11. Agitation	3	0
12. Loss of interest	2	1
13. Indecisiveness	2	1
14. Worthlessness	2	0
15. Loss of energy	1	1
16. Changes in sleeping patterns	2	0
17. Irritability	2	0
18. Changes in appetite	3	0
19. Concentration difficulty	2	0
20. Tiredness or fatigue	3	0
21. Loss of interest in sex	1	0

Table 3

Changes in Specific Items on the Beck Depression Inventory from Intake to Termination for the second subject.

Item	Intake	Session 12
1. Sadness	1	0
2. Pessimism	1	0
3. Past failure	2	0
4. Loss of Pleasure	2	1
5. Guilty feelings	2	0
6. Punishment feelings	3	0
7. Self-dislike	3	0
8. Self-criticism	2	0
9. Suicidal thoughts or wishes	1	0
10. Crying	2	0
11. Agitation	1	0
12. Loss of interest	3	1
13. Indecisiveness	3	1
14. Worthlessness	2	0
15. Loss of energy	2	1
16. Changes in sleeping patterns	2	1
17. Irritability	2	1
18. Changes in appetite	1	1
19. Concentration difficulty	2	1
20. Tiredness or fatigue	3	1
21. Loss of interest in sex	2	1

Subjective data.

Subject self-report. The results of the study reveal that both clients experienced a significant decline in their depressive symptoms. This included changes in mood, behaviors, and cognitions. Both subjects made statements that were reflective of these changes during the treatment sessions. Both clients also attributed the decline in depressive symptoms directly to cognitive, behavioral, and spiritual skills they had acquired from the spiritually informed cognitive behavioral treatment interventions. For full session transcripts, see Appendix P.

Client one made several remarks about how the spiritually informed cognitive behavioral treatment assisted in decreasing her depression. "I am not depressed. I feel like I can handle a lot more and have better coping skills." "To read the Bible and put them with what I am going through, knowing that God is stronger and everything. The coping cards, breathing, the relaxation techniques." "Know that what I think affects how I behave and all comes from a choice I make or how I think. There are some things that I have to take the way they are." "I sleep better. I feel like I am not depressed. I feel more - I can't explain it. I have more energy. I have more everything." "I can endure anything, I think, and because what I have already done there can't be too much more of anything else that I can't do."

Client two also felt that the spiritually informed cognitive behavioral model help to decrease her depression as noted by the following statements. "Well, obviously for the first time in forever, if not in a long time, I am slowly starting to believe that I do have worth and value and the good things that other people have said to me, I can see some truth in them. I think I am able to think things through a little different instead of just letting my emotions take over and run rampant and just go wild and make me crazy. I feel like I have learned a good bit about myself and that I do have some good special qualities." "I actually feel like, not completely yet, I actually feel like I am starting to like life again. I actually found myself thinking the other day and it really shocked me because for the longest time I just wanted God to take me when I was feeling bad, because I didn't want to feel that way anymore. When I started to learn more about Him I would say, yeah, I am ready to die because I know what is waiting for me is way better than what is here. I found myself saying the other day that I am not ready and I have so

many things that I want to do. I just want to have the time to do them." "I felt really good about the things that she said about me, but looking back, it made me realize that I think I have finally shaken off a lot of the pain." "I didn't do it at all for myself, but I still felt good. I really like to compliment people and make people feel good about themselves because I know how hard it is to feel good about yourself, but I really like to do that. To give encouragement and to try to build others up. It made me feel really good to do that for him." "Other people can see it too. They make comments. Especially Wendy, she comments on that all the time. She will send me a text message and say I love to see what God is doing is doing in you. I see you smile. When I first came here I just cried and cried. I am sure that I looked miserable and for other people to notice it and tell you that. I feel it myself but that just confirms it."

The second hypothesis stated that an integrative manualized treatment approach within a pilot study, including spirituality and cognitive-behavioral therapy, would increase religiosity, as indicated by scores on the Santa Clara Strength of Religious Faith Questionnaire and a qualitative analysis of subject's responses in therapy sessions.

Data sources.

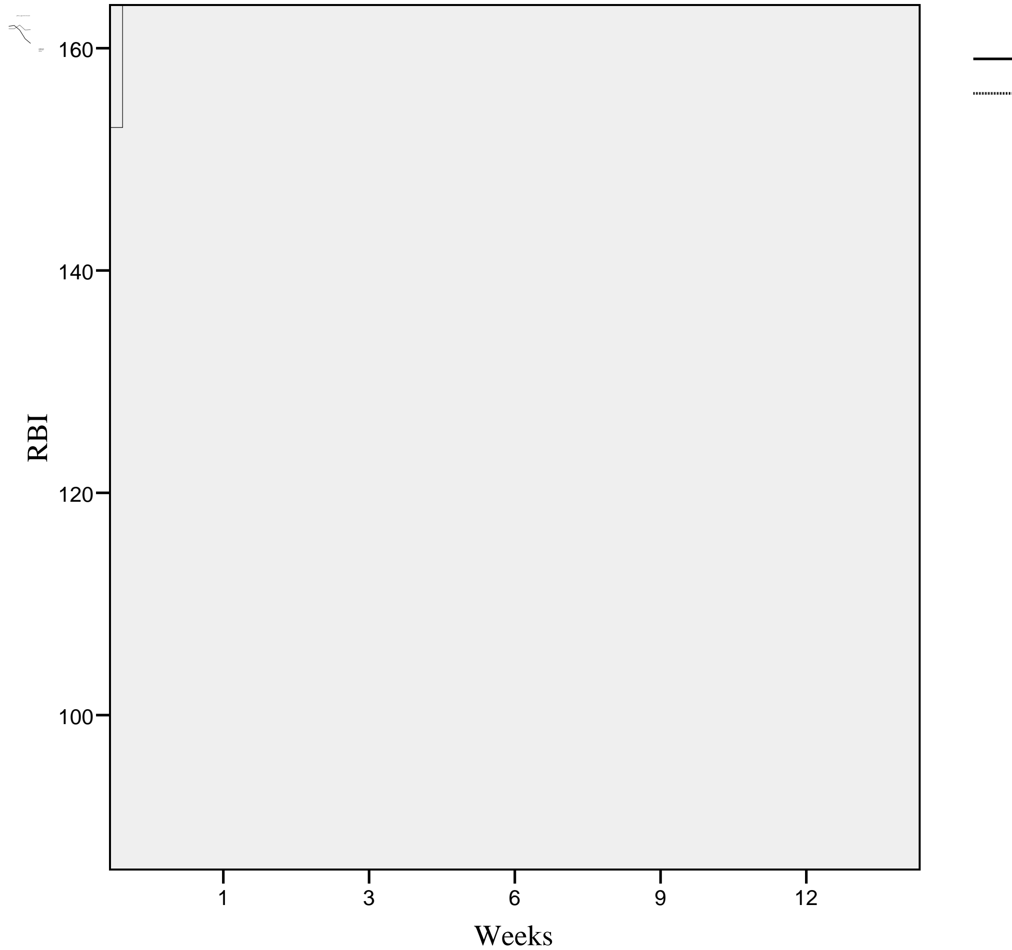
Objective data.

RBI: change in scores. The Religious Behavior Inventory (RBI; Librizzi, 2006) is a 40-question inventory that measures some of the typical behaviors exhibited by highly committed religious individuals. This study hypothesized that the integrative treatment approach would increase the client's religious behaviors. Both clients were administered the RBI five times during the 12 week case study. The RBI was designed to categorize individuals into one of three different ranges. The first range typifies a person with a

limited range of religious exercises. This includes scores between 0 and 60. The second range is described as a growing range of religious exercises. This category includes scores between 61 and 119. The third range identifies those individuals with a robust and vital range of religious exercises. This range includes scores within the range of 120 to 160.

The scores from the intake session to the final session for the first subject were: 102, 100, 111, 132, and 143. The difference in RBI scores from intake to discharge reflects a 40% increase as a consequence of the integrative treatment approach. This subject entered treatment in the middle growing range and ended treatment in the robust and vital range. Thus, as a result of the integrative treatment approach, the first subject was able to grow in her faith, as evidenced in the change of levels.

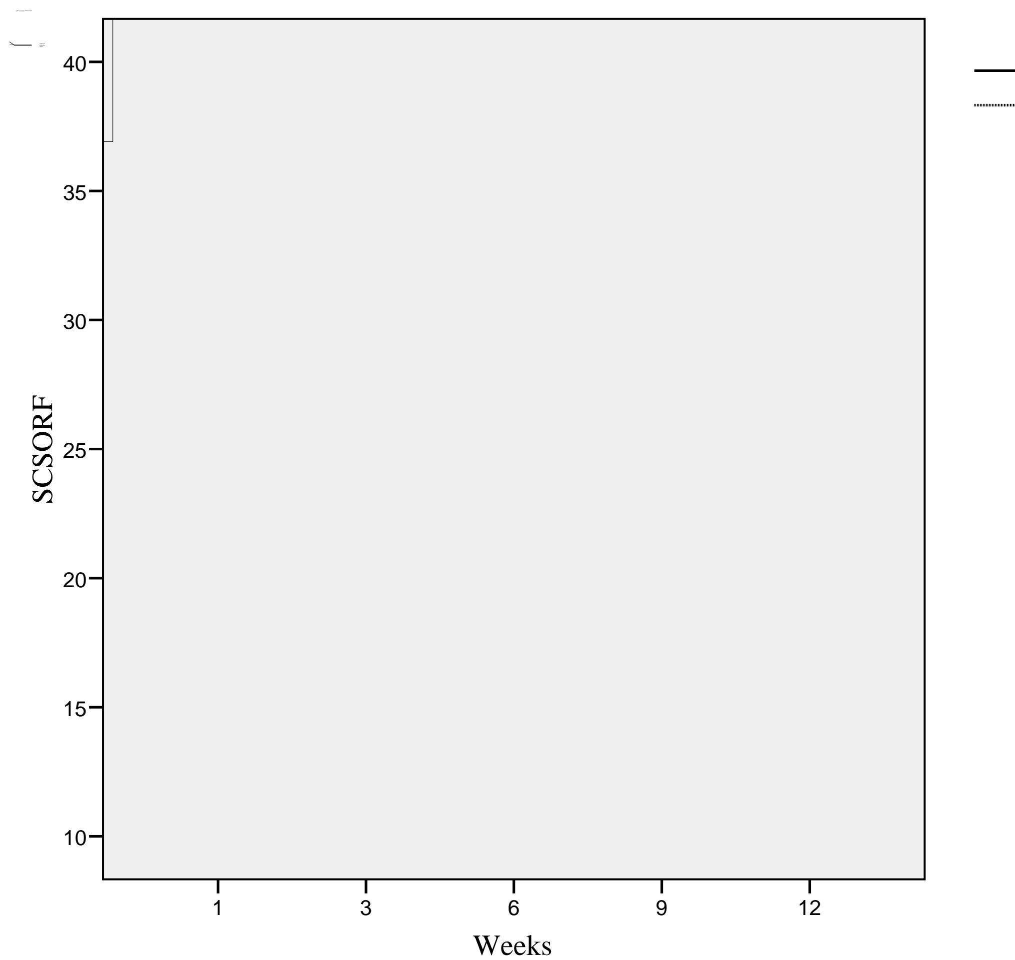
Scores from the intake session to the final session for the second subject were: 108, 108, 99, 111, and 110. The difference in score from intake to discharge indicates a 2% increase in religious exercises as a consequence of the integrative treatment approach. This subject entered treatment in the growing range and concluded treatment in this same range. The subject's score increased minimally and did not shift to another level.



SCSORF: change in scores. The Santa Clara Strength of Religious Faith Questionnaire (SCSORF; Plante & Boccaccini, 1997) is a 10- item self-report measure scored on a 4-point Likert scale that gauges the strength of religious faith, regardless of denomination. Total scores range from 10 to 40, where higher scores represent greater levels of religiosity. This study hypothesized that the integrative treatment approach would increase the subject's religious faith scores. Both subjects were administered the SCSORF five times during the 12 -week study. Scores from the intake session to the final session for the first subject were: 36, 40, 40, 40, and 40 as a consequence of the integrative treatment approach .

Scores from the intake session to the final session for the second subject were: 39, 39, 39, 39,

and 39. It is evident that this subject's scores were consistent over the course of treatment. While this subject did not have an increase in religiosity, it should be noted that a score of 39 is very high and indicative of great faith.



Subjective data.

Subject self-report. The following section documents statements that were taken from the transcripts of sessions that reflect personal spiritual growth. Subject one made the following statements. "I am learning more, I know more and I am trying to believe more and I guess it is a lot more trusting in God then I used to." "Yes, God is going to provide for me. Or a lot of times it will be, I focus on fellowship. I have fellowship, I have people." "I believe that if it wasn't for God that I wouldn't even be sitting here right now. He has kept me alive. I believe He has a plan for me. I believe that He has given me strength and endurance, the endurance that He has made me have for some significant reason. I believe that I am one of His chosen ones. I believe that He loves me so much and has made me go through so much that I have gone through because He wants me to have so much more. I think that I believe I know if it wouldn't be for my faith and accepting, I would probably be still doing drugs, still depressed, probably be near in prison myself. I believe that is just what He is here for. I believe that He is going to be forever."

Subject two made the following statements regarding her growth in her spiritual life. "It has just gotten stronger and stronger and better and better and that is the road that I want to continue on. I think back to when I first started to come here, I am not where I want to be but I think it is good to want to continue that forward process. I just feel like a sponge. I just want to learn everything about God and Jesus and what is in the Bible. I feel like the more that I know, the better person I will be, the better I will feel, the kinder I will be to other people."

"I love hearing and saying to myself that I am a child of God. I can't tell you what it makes me feel inside. Just saying it, hearing it, it makes me feel special or worth something." "Dear God, I feel so extremely blessed to have a personal relationship with you. This relationship is my rock, my foundation, and my strength. Over the past week, I have felt it grow in leaps and bounds, and I am so excited. I actually think I felt butterflies. I look forward in the coming months and years to strengthening my relationship with you by studying your word, meditating on it and applying it directly to my daily life." "I also desire to fully understand and grasp and understand your unconditional and unwavering love for me. In doing so I hope to strengthen our personal relationship into a more intimate one. I also humbly ask you to give me the strength to release all my burdens to you. Burdens of doubt, especially self-doubt, worry, and fear. I ask for the courage to release the control of these things over to you so you can carry them for me."

These statements demonstrate the growth of each client over the course of treatment. Even though it was not always reflected in the scores, both clients strove to continue to develop in their faith and sought God in their daily lives. They reported feeling closer to God and desiring to grow in their relationship with God.

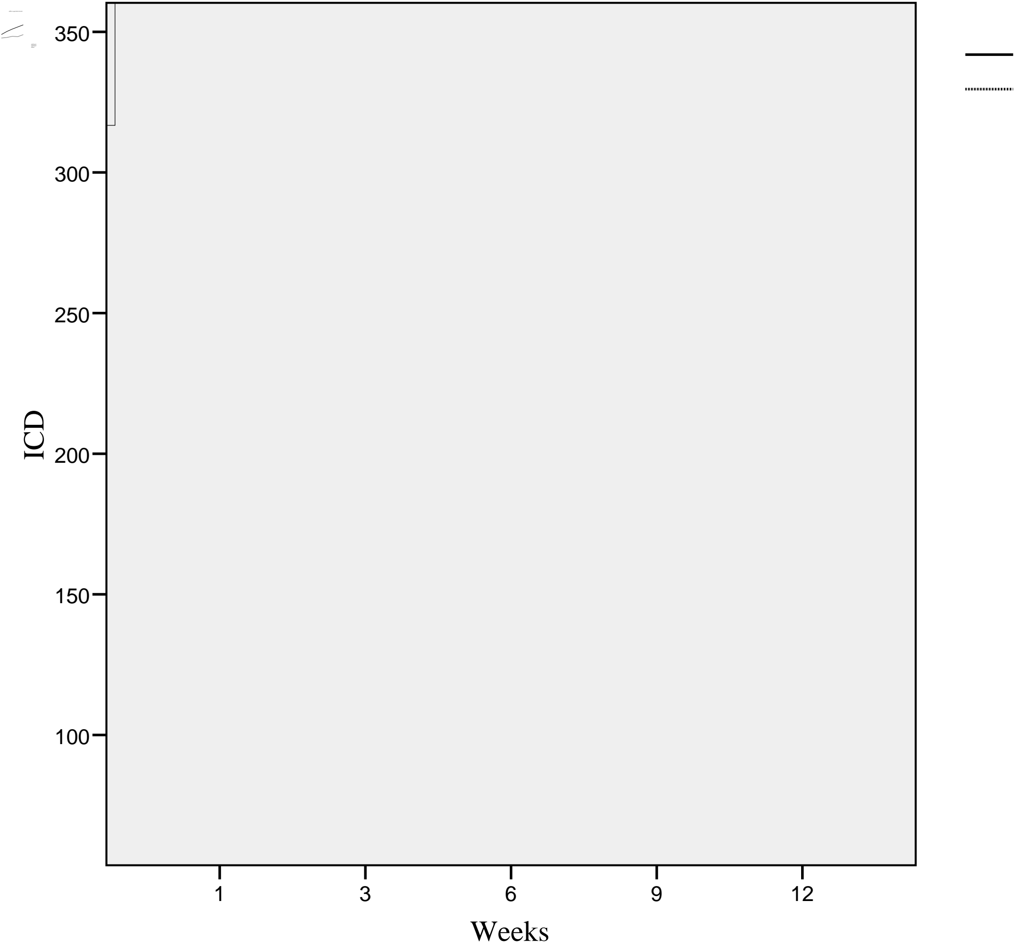
The third hypothesis stated that an integrative manualized treatment approach within a pilot study, including spirituality and cognitive-behavioral therapy, would result in a clinically significant decrease in cognitive distortions, as measured by the Inventory of Cognitive Distortions.

Data sources.

Objective data.

ICD: change in scores. The Inventory of Cognitive Distortions (ICD; Yurica & DiTomasso, 2002) is a 69 -item inventory of cognitive distortions composed of short sentences that reflect 11 factor-analyzed cognitive distortions. Items are scored on a five-point Likert scale to determine the frequency ranging from 1 for never to 5 for always. The total possible ICD scores range between 69 and 345, with lower scores reflecting lower frequencies of cognitive distortions. Both subjects were administered the ICD five times during the 12-week study.

Scores from the intake session to the final session for the first subject were: 235, 206, 183, 163, and 143. The changes in ICD scores from intake to completion indicate a decrease of 39% as a consequence of the integrative treatment approach. Scores from the intake session to the final session for the second subject two were: 268, 263, 252, 255, and 236. Thus, there was a 12% decrease in distorted cognitions, as indicated by the ICD, as a direct consequence of the spiritually informed cognitive-behavioral treatment approach.


350
300
250
200
150
100
ICD
1
3
6
9
12
Weeks

ICD: specific items. The ICD consists of 11 subscales that assesses the individual's particular pattern of thinking and the ways in which dysfunctional thoughts maintain depression. The subscales include: a) Externalization of Self-Worth, b) Fortune-Telling, c) Magnification, d) Labeling, e) Perfectionism, f) Comparison to Others, g) Emotional Reasoning, h) Arbitrary Inference/Jumping to Conclusions, i) Emotional Reasoning and Decision Making, j) Minimization, and k) Mind Reading.

The first subscale, Externalization of Self-Worth, assesses the s need for approval. Of a possible 75, the first subject scored a 49 at intake and a 24 at session 12. The second subject scored a 63 at intake and a 52 after session twelve. Fortune-Telling measures the subject's tendency to predict negative outcomes for the future. The first subject scored a 40 at intake and a 20 after session 12, with the highest possible score being 55. The second subject scored a 44 at intake and a 37 after session 12. Magnification quantifies the tendency to exaggerate both negatives and positives in a circumstance or personal trait. Of a possible 35, the first subject scored a 26 at intake and a 17 after session 12. The second subject scored a 28 at intake and a 22 after session 12. Labeling gauges the tendency to direct derogatory terms towards oneself. The first subject scored a 16 at intake and a 10 after session 12 of a possible high score of 25. The second subject scored a 19 at intake and a 16 after session 12. Perfectionism assesses the tendency to live up to some internal or external representation of perfection. The first subject scored a 13 at intake and a 10 after session 12. The second subject scored a 16 at intake and a 15 at the end of session 12. The highest possible score for this distortion is a 20. Comparison to Others measures the tendency to compare oneself to others and reach negative conclusions about oneself. Of a possible score of 20, the first subject scored a 12 at

intake and an 8 after session 12. The second subject scored a 16 at intake and a 16 after session 12. Emotional Reasoning is used to evaluate the tendency to form conclusions about oneself based on emotional states. The highest possible score is a 20. The first subject scored a 13 at intake and an 11 after session 12. The second subject scored a 13 at intake and a 12 after session 12. Arbitrary Inference/Jumping to Conclusions gauges the tendency to draw negative conclusions in the absence of evidence for those conclusions. Of a possible score of 15, the first subject scored a 10 at intake and a 6 after session 12. The second subject scored an 8 both at intake and at session 12. Emotional Reasoning and Decision Making assesses the tendency to rely on emotions to make decisions. The highest possible score is 10. The first subject scored an 8 at intake and a 5 after the end of session 12. The second subject scored an 8 at intake and a 7 after session 12. Minimization measures the tendency to discount the importance of a trait, circumstance or event. Of a possible high score of 10, the first subject scored a 4 at intake and a 3 after session12. The second subject scored a 6 at intake and a 4 after session 12. Mind Reading assesses the tendency of an individual to believe that he or she knows what others are thinking. The highest score for this subscale is 10. The first subject scored a 7 at intake and a 5 after session 12. The second subject scored an 8 at intake and after session 12.

All 11 subscale scores decreased from intake to the final session for the first subject. Eight of 11 subscales decreased from intake to the final session for the second subject. The other three subscales (Comparison to Others, and Jumping to Conclusions, and Minding Reading) had the same score at intake and after the final session for the second subject.

The fourth hypothesis was that an integrative manualized treatment approach within a pilot study, including spirituality and cognitive-behavioral therapy, would increase therapeutic alliance, as indicated by the Working Alliance Inventory.

Data sources.

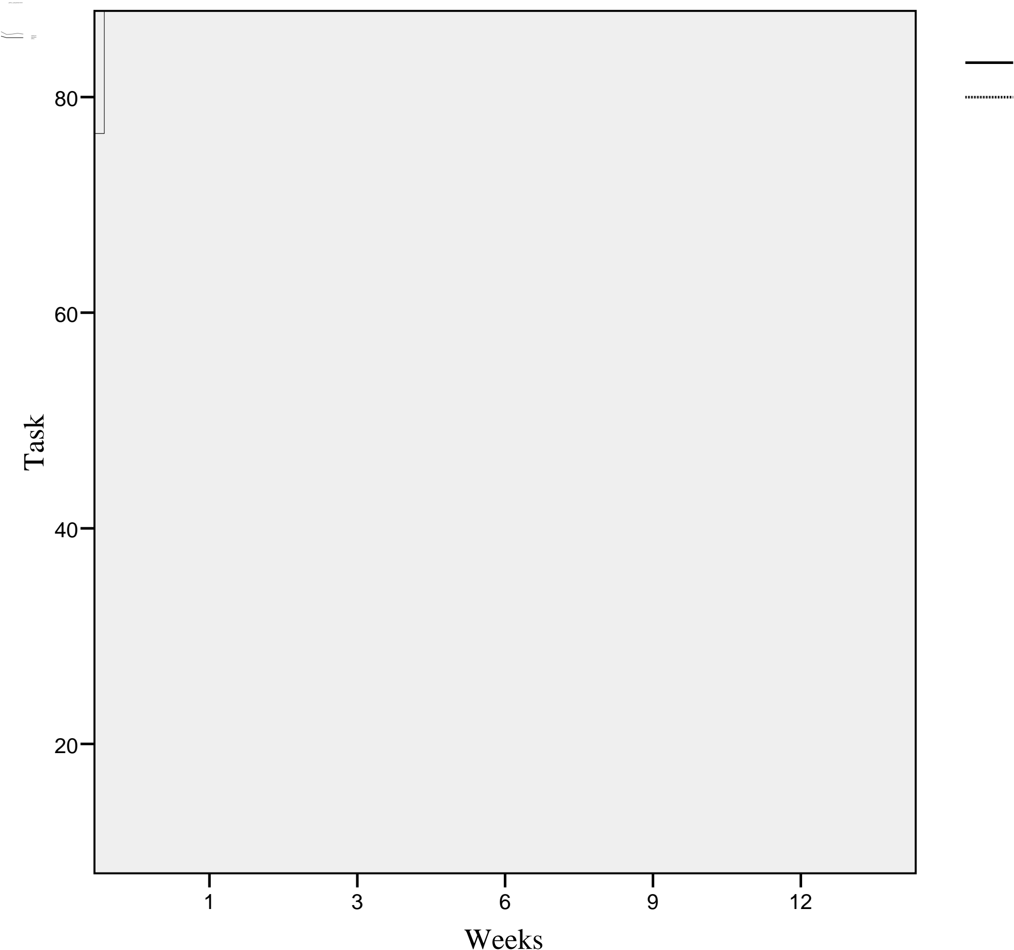
***Objective data*.**

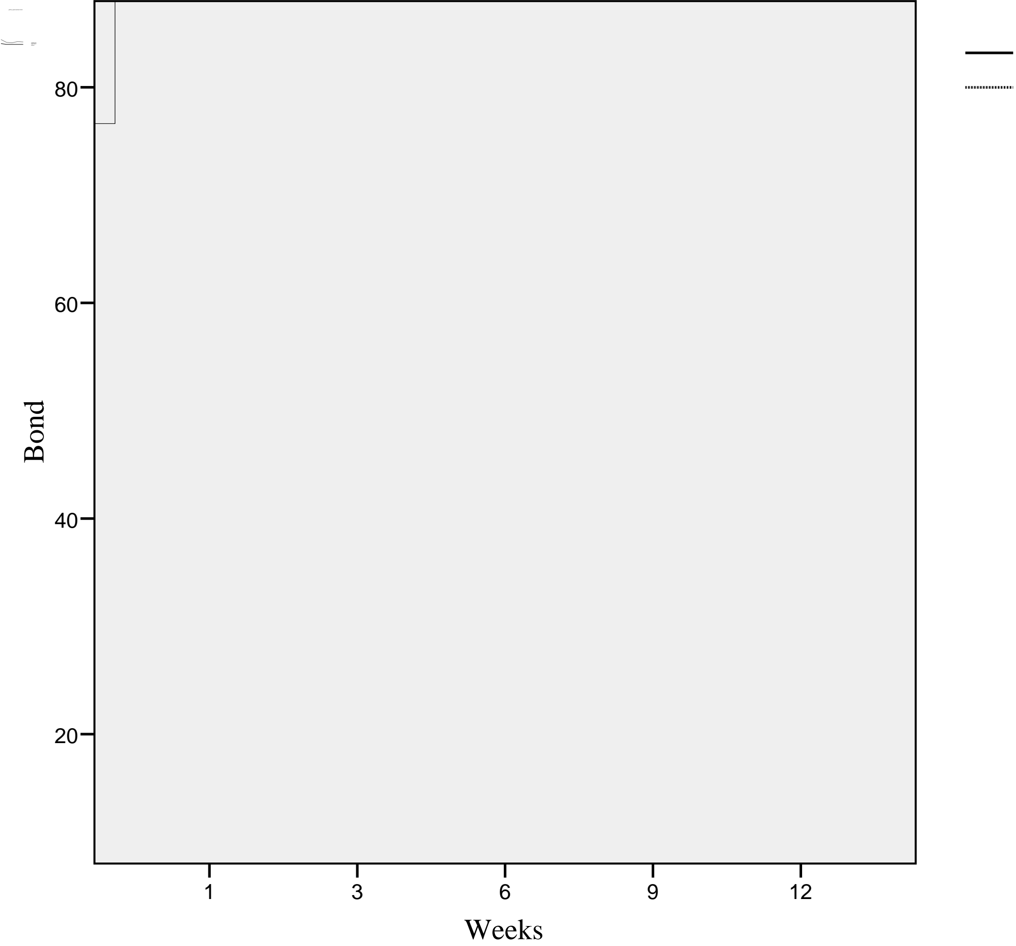
WAI: change in scores. The Working Alliance Inventory (WAI, Horvath & Greenberg, 1989) is a 36-item instrument used to assess the quality of the therapeutic alliance between the clinician and the client. The WAI can either be scored by adding up all the scores and deriving an overall measure of the alliance or by computing the separate subscale scores. These subscales are: goal, bond, and task. The WAI was administered to both subjects on five occasions, at intake, and after sessions 3, 6, 9 and 12.

The following were the task subscale scores for the first subject: 80, 84, 84, 84, and 84. This subject's bond subscale scores of 82, 84, 84, 84, and 84. Finally, this subject had the following goal subscale scores: 71, 82, 84, 84, and 84. For the task subscale, this represented a 4.8% increase, the bond subscale had a 2.4% increase, and the goal subscale demonstrated a 15.5% increase. The subscale score of 84 is the highest possible.

The second subject had the following task subscale scores: 69, 76, 75, 73, and 75. The bond subscales for this subject were 72, 79, 80, 77, and 78. Finally, this subject had following goal subscale scores: 69, 77, 75, 79 and 77. Over the course of the study, the second subject had an 8% increase for the task subscale

scores, the bond subscale exhibited a 7.7% increase, and the goal subscale revealed a 10.4% increase. During administration of this test, the client reported that she was hesitant to choose a score of 7 (which was coded as always) or a 1 (which was coded as never), as she felt that these terms were too absolute. Thus, from time to time, she changed scoring in certain areas.




80
60
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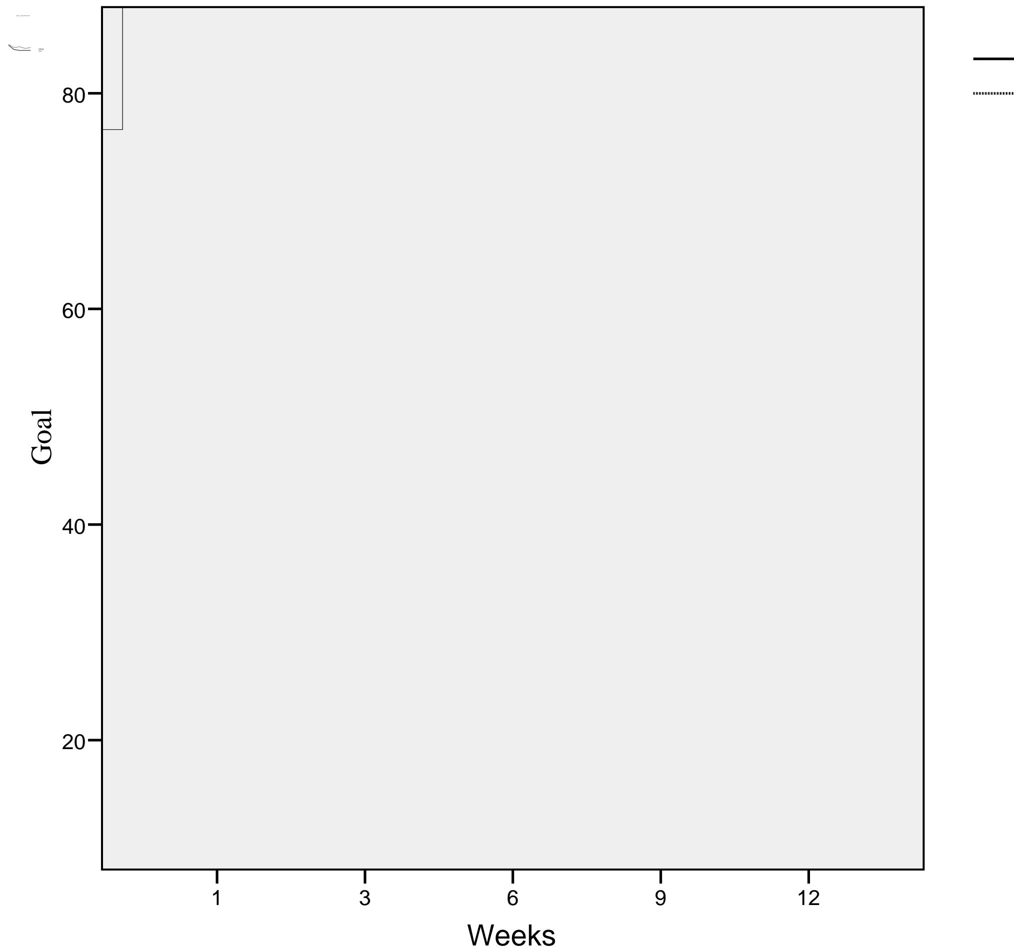

It was hypothesized that an integrative manualized treatment approach within a pilot study, including spirituality and cognitive-behavioral therapy, would increase treatment adherence, as measured by treatment attendance, promptness for therapeutic sessions, and compliance/completion of assigned homework.

Objective data.

Treatment attendance. Both subjects attended all 12 treatment sessions. The first subject rescheduled two sessions. One session was rescheduled a few days prior to the appointment because of a forecasted blizzard. She rescheduled another session as she

was not feeling well. Both of these sessions were made up during the same week that they were scheduled, and the client gave the therapist at least 24 hour's notice.

The second subject attended all 12 sessions. She contacted the therapist on one occasion to reschedule a session for later in the same week because she had volunteered to watch her sick niece for her sister. The client contacted the therapist several hours before the appointment and was available to schedule an appointment at any time later that week. Both subjects continued to report over the course of treatment how much they valued the sessions.

Promptness for therapeutic sessions. The first subject was only late for one session. She called into the church, attempted to contact the therapist, and also sent an e-mail to notify the therapist about her late arrival due to bad traffic coming to her appointment from work. She was 10 minutes late for the session and apologized profusely. For all other sessions, she was on time or a few minutes early.

The second subject experienced difficulties arriving on time for 9 of the 12 sessions. She informed the therapist during the intake session that she had difficulties arriving at almost any event on time. She was about 5 minutes late for 6 sessions and about 10 minutes late for three other sessions. She was very apologetic about her tardiness, and this issue was addressed and discussed in treatment. She reported that it did not have anything to do with her motivation to engage in treatment and was often worried about the impact her lateness may have upon the therapeutic relationship.

Completion of/adherence to assigned homework. The first subject completed all of the collaboratively created homework assignments during the 12weeks of treatment. She reported that the assignments were beneficial, as she was able to practice those skills

that were taught in the therapy session. The second subject completed all of the homework assignments except for one (the assignment that was given after session 10). When the therapist discussed the need for review of the homework assignment during session 11, the client was taken surprised, as she did not remember that she had an assignment. She completed the assignment with the therapist in the session and was an active and willing participant.

Chapter 6

Discussion

Based on the objective and subjective data that was gathered, the research results suggest with a certain degree of confidence that an integrative treatment approach will decrease depressive symptoms in Christian clients. The noted symptom reductions were validated through the use of several measurements.

First, there were changes in the overall BDI-II score, the range of the depressive levels, and other specific items. The BDI-II also reflected a decrease in the range of depressive levels for both subjects. Both started treatment at the severe level of depression and ended treatment with a score in the minimal range. Finally, specific items on the BDI-II reflected changes that were consistent with the reduction of depressive symptoms.

Subjective data was also utilized to assess modifications in depressive symptoms. The subjects reported changes in depressive symptoms over the course of treatment during individual sessions. The therapist recorded and transcribed all sessions in order to identify comments that were suggestive of symptom reduction. Those remarks by the subjects that signified symptom reduction were detailed in the Results section and can also be found in Appendix P. These comments help to demonstrate the overall treatment effect and reduction of depressive symptoms.

Based on the objective and subjective data findings, it is realistic to conclude that the first hypothesis was supported. The spiritually informed cognitive-behavioral manualized approach was effective in the reduction of

depressive symptoms in these two Christian subjects. This conclusion supports, supplements, and in other instances contradicts some of the research in this area (Koenig, 2007; Propst et al., 1980; Propst et al., 1988; Propst et al., 1992).

The second hypothesis concerned the impact of an integrative approach upon the spiritual development of the subject. This hypothesis proposed that a client who considered faith an important component of his or her life would experience spiritual growth in treatment as a result of the integrative approach. Based on the objective and subjective measures, it can be concluded that the integrative treatment approach increased spirituality in Christian subjects. The level of spirituality was quantified through the use of various measures. The researcher utilized the Religious Behavior Inventory (RBI) and the Santa Clara Strength of Religious Faith Questionnaire (SCSORF) over the course of the 12 weeks. The researcher analyzed the total scores, changes in the range of scores, and specific items. Both subjects had demonstrated an increase in their overall RBI score. The first subject started in the growing range and progressed to the robust and vital range of religious exercises by the completion of treatment. However, the second subject stayed within the growing range of religious exercises throughout the entire study. Therefore, mixed results were obtained for these participants. Finally, both subjects had changes noted on specific items on the RBI, with the first subject exhibiting significantly more changes.

It is apparent that the RBI served as a good measure for the first subject's religious behaviors. She was involved in multiple groups in the church and attends several services per week. The second subject was also involved in a

variety of church-related activities, yet she did not score as highly. Part of this difference can be attributed to the second subject's feelings of worthlessness that were explored throughout treatment. This client was highly motivated to grow in her faith, but most likely would not score herself in the higher ranges for fear that she would be presenting herself in a self-inflated manner. Therefore, it was easier for the second subject to report in the middle ranges in order to allow for growth and reflect that she is indeed a work in progress.

The Santa Clara Strength of Religious Faith Questionnaire was also employed to measure the subjects' level of spirituality. The overall score, change in range, and specific items were reviewed in the analysis. The statements on this questionnaire reflect feelings about God, the spiritual community, and the desire to grow in faith. The first subject felt strongly on all of the testing items, and this was evident in her responses. The second subject maintained the same score throughout the entire process. It should be noted that subject two's score was a 39 throughout the process and the highest score one can receive is a 40. Therefore, the subject's self-rating of her faith was in the high faith range throughout treatment. Thus, the SCSORF may not have measured spiritual growth, but it served as a good indicator of the subject's level of faith throughout the course of treatment.

Subjective reporting by both subjects revealed a desired increase to grow in their spiritual walk. The first subject specifically remarked that she was now able to trust in God and His plan as a result of the sessions. She prayed more often and relied on the strength and support of God and her Christian community

during times of struggle. The transcripts of these sessions can be found in Appendix P. These transcripts include a more detailed account of the first subject's growth in her spirituality and faith over the course of treatment. The second subject also voiced a strong desire to grow in her faith. These statements were especially critical to take into account for this subject, as her RBI and SCSRF scores did not noticeably reflect her spiritual development. She expressed her desire to "want to learn everything about God and Jesus and what is in the Bible."

The results of the study are consistent with existing research that suggests the integrative approach assists in increasing spirituality during treatment (Hawkins, Tan, & Turk, 1999). The integrative approach helps to promote religious well-being through believing in a loving and caring God. Furthermore, it plays a role in the reduction of symptoms for depressed individuals (Murphy & Fitchett, 2009). The participants utilized their religious convictions to foster positive religious coping behaviors. Affirmative religious coping styles are associated with enhanced positive effects (Powers et al., 2007; Hebert et al., 2007).

The third hypothesis predicted decreases in cognitive distortions would occur when using an integrative treatment approach. This hypothesis proposed that a subject in whom depression has been diagnosed and who considers faith an important component of his or her life would demonstrate a decrease in cognitive distortions as a result of the integrative approach. Based on the objective measures, it can be concluded that an integrative treatment approach reduced

cognitive distortions in these Christian subjects. Cognitive distortions were measured by the Inventory of Cognitive Distortions (ICD). Both subjects exhibited decreases in the ICD scores over the course of treatment, reflecting significant reductions in distorted cognitions. Finally, both subjects demonstrated positive changes on specific items of the ICD.

The fourth hypothesis predicted increases in the therapeutic alliance when using an integrative treatment approach. This hypothesis proposed that a subject with depression who considered faith as an important component of his or her life would show an increase in the therapeutic alliance as a result of the integrative approach. Based on the objective measures, it can be concluded that an integrative treatment approach increased the therapeutic alliance in these Christian subjects. The therapeutic alliance was measured through the use of the Working Alliance Inventory (WAI, Horvath & Greenberg, 1989). The WAI does not quantify specific ranges for the scores obtained in the assessment. Therefore the magnitude of the difference in the scores cannot be assessed.

The working alliance may have been strengthened through the use of prayer during sessions. Each session was ended by prayer. Both subjects seemed very appreciative of this gesture and at times were deeply moved, as indicated by crying during and after the prayer. Rakel and Weil (2007) state that one goal of holistic health care is to integrate the patient's spirituality in clinical encounters. Wernik (2009) suggests that prayer beads help to increase the therapeutic alliance and create an opportunity for playful and creative interaction between client and

therapist. It is believed that the use of prayer in the present study benefited the therapeutic alliance.

However, research also indicates that prayer could evoke negative reactions that may jeopardize the therapeutic relationship (Farah, 2008). There may be a potential for role confusion when a clinician prays with the client and does not have the necessary training to participate in effective prayer. The clinician should work to recognize his or her personal emotions and take measures to avoid expressing those in prayer that could be disruptive to the client.

The fifth predicted increases in treatment adherence when using an integrative treatment approach. The measures used to assess treatment adherence were treatment attendance, promptness for therapeutic sessions, and completion of assigned homework. This hypothesis proposed that a client with depression who considers faith an important component of his or her life would exhibit an increase in treatment adherence as a result of the integrative approach. Based on the objective measures, it can be concluded that an integrative treatment approach increased the treatment adherence in these Christian subjects. Both subjects attended all 12 therapy sessions. For the majority of the sessions, both subjects were prompt for their appointments and completed the homework assignments, with the exception of one missed assignment from the second subject because she forgot about the assignment over the course of the week.

Stern et al. (2008) conducted research on treatment adherence. It was discovered that the rates of nonadherence with psychiatric treatment ranged from 24% to 90%. In a large meta-analysis, with a pooled sample of over 23,000

patients, the mean rate of nonadherence was 26%. Stern and coworkers noted that rates of treatment adherence vary with population, diagnosis, and the intervention. Their study also revealed that 45% of patients referred for psychotherapy from a general hospital psychiatric outpatient department came to one or more appointments. Overall, the research revealed that a collaborative approach, with both patients and clinicians involved in the decision making, is most effective. In the present study, the researcher attempted to establish a collaborative therapeutic process throughout treatment. As a result, the subjects complied with treatment through regular attendance, promptness to sessions, and completion of homework assignments.

There is presently very little research about treatment adherence with the integrative model. Therefore, little evidence is available to support or negate this hypothesis. The main body of research usually addresses treatment adherence for children, parental treatment adherence, and treatment adherence within the medical realm.

Limitations.

Design and internal validity limitations.

The design of this study posed had benefits and limitations. One researcher was solely responsible for the development of the manual, completing the course of treatment, and collecting and scoring data. Definite limitations are created by having one individual accountable for the creation and collection of the data. The researcher utilized a specific manual and set of interventions throughout the process. At times, this may have narrowed the researcher's

approach during therapy. However, it should be noted that a licensed psychologist was consulted on a weekly basis for clinical supervision. This promoted flexibility and allowed for adjustments in the treatment regimen, when clinically indicated. Moreover, supervision was also provided to reduce potential bias and further weave CBT interventions into the treatment manual. A recurrent issue in supervision in the middle and latter sessions was the identification and modification of maladaptive schema. In the interest of providing the most effective and enduring CBT, the final treatment manual reflects additional attention to schema modification as provided to the participants in this study.

Although the treatment manual was developed from extensive research reviewed solely by the clinician, the final content of the manual was determined with assistance from her dissertation committee. The researcher was the only individual who worked with each of the participants in the study. The study did not include a double blind or single blind element and, as a result, experimenter bias could have entered into the sessions and data analysis. Furthermore, the manual was tailored for the Christian community. The manual worked well with the two clients who were selected, as they held similar beliefs to the researcher.

It is difficult to determine the specific treatment methods that were responsible for the positive results in the study. Was it the components from the cognitive-behavioral model, the spiritual interventions, or the combined integrative approach? Perhaps use of a control group or various treatment groups could have assisted in determining the most effective treatment modality to reduce depressive symptoms. It should be noted that both subjects valued the

spiritual interventions and the cognitive-behavioral interventions, as evidenced by their subjective reports during the sessions.

This research did not utilize a control group to eliminate any confounding variables that could occur. The researcher was unable to control for those external, intervening variables that could possibly influence the religious behaviors of the clients. A control group would help to determine the reasons for the changes in the treatment setting. Also, additional data and assessment measurements could have been used to control for and assess these variables.

Limitations to external validity. One of the main questions for external validity is: How do these two clients compare to the general population? Perhaps they represent the Christian community well, but it would be rather presumptuous to make such a statement. The study only used two participants, which makes it very difficult to generalize to any sort of population. Overall, one cannot make any sort of generalizations from the limited amount of data collected from this study. Additional evaluation is needed to determine whether it is possible to replicate the results of this study in order to increase power and determine the external validity of the treatment manual and the collected data. Thus, the results of the study should be interpreted with caution.

Individuals from different faith backgrounds and ethnic backgrounds, with different demographics and from various settings should be studied in future integrative research. In addition, clinicians from different faiths, settings, and clinical backgrounds should work with this manual to ascertain whether these diversities have an impact on the generalizability of the results. All in all,

continued research is necessary with a larger and more diverse population to determine if the results of this study are generalizable.

Measurements. The treatment results were primarily measured through the use of the BDI-II. The BDI-II is often the standard measurement tool used in research studies to evaluate depression. Additional measures could be utilized to assess depression in future studies. In addition, it would be beneficial to conduct a follow-up evaluation of the subjects in order to determine if the treatment promoted the reduction of depressive symptoms over the course of time.

The two instruments that were utilized to measure spirituality in this study were the Religious Behavior Inventory and the Santa Clara Strength of Religious Faith Questionnaire. Both measures were limited in their reliability and validity. As detailed in Librizzi's research (2006), the Religious Behavior Inventory offers face validity but lacks construct validity. Librizzi attempted to validate this measure in his research, but was ultimately not able to do so. Thus, the results obtained from this measure may be questionable. Further research is needed on this instrument in order to determine the overall construct validity. Librizzi (2006) also noted that the instrument was designed for a more traditional, religious client and that it would not be as useful for clients from a nonreligious environment.

The Santa Clara Strength of Religious Faith Questionnaire also offers limited value to research applications. Research has identified coefficient alphas between .94 and .95 and split-half reliability between .90 and .96 (Plante et al., 1999). The Pearson correlation coefficient revealed that high scores on the

SCSORF correlated positively with intrinsic religiousness on the Age Universal Religious Orientation Scale, with scores ranging from .87 to .90 (Plante et al., 1999). It appears that the SCSORF is a valid tool to determine religious faith, yet it may not effectively measure religious growth. Both subjects in the present study demonstrated high religious faith, but exhibited little change in their scores.

The researcher employed the Inventory of Cognitive Distortions (ICD) to measure cognitive distortions over the course of treatment. Factor analysis and cognitive therapy experts agree that the ICD items reflect each specific distortion construct. The current research suggests content validity and concurrent validity of the ICD. However, the ICD is a relatively new tool, and continued research should be established to document its continued validity.

The WAI has been frequently used to measure the strength of the therapeutic alliance in clinical settings. It appeared to be a useful tool for this research to measure the changes in the therapeutic relationship. However, it was difficult at times to determine whether these changes were significant. There were instances in the study when the second subject did not want to mark a score of 1 or 7, as these were extremes and she did not consider some responses as either an always or a never. She was working to avoid thinking in black and white terms, making it difficult to choose values in the therapeutic relationship that were absolute. Therefore, the scores may not have been reflective of the true therapeutic relationship. Perhaps the researcher could have used another tool that would have more accurately assessed the different levels of the therapeutic relationship.

The collection and interpretation of subjective data may also be questionable. The researcher recorded statements from the subjects during sessions and identified those that alluded to spiritual growth. The researcher may not have effectively chosen statements that reflected change in spiritual development. It is difficult to select those specific statements that are indicative of change in this area, as the researcher relied solely on clinical judgment to make this determination. Future studies should incorporate another party to analyze the sessions and create a rating or coding system when reviewing the session transcriptions. This would eliminate possible personal bias in the data analysis.

Future directions.

The manualized approach of this treatment requires further study. The researcher used the manual as a guide throughout treatment, and it proved effective in reducing the depressive symptoms of both subjects in only 12 sessions. Further research is needed to evaluate and identify those specific factors that helped to alleviate the depression and increase spirituality using this manualized approach. The manualized approach may also assist clinicians in creating a guide for treatment. It provides a session-by-session outline, which is useful for clinicians new to the field of integration or for those clinicians who are seeking guidance to grow in this area. The manualized approach will be helpful in training clinicians and also provide a model for a brief therapy.

It is also imperative to develop additional integrative approaches for clients with other mental health disorders. This manual focused upon depression, but the manual could be used to treat individuals with other mental health problems, such as anxiety, social phobia, and adjustment issues. Additional studies could utilize the manual to

identify those treatments that produce positive results for individuals with different diagnoses. However, further analysis is required to determine ways to alter the treatment methods presented in the manual to accommodate clients with other mental health issues.

This study could also serve as a basic guide for participants who are not Christian. Additional research should be conducted with individuals from a variety of religions, faiths and spiritual beliefs. Evaluations of these different populations could assist in determining similar themes and also assess how differences can be addressed in treatment. While this study was designed to be used with a Christian population, it provides a basic framework that could be adapted to other religions and faiths. Further studies could assess the effectiveness of this manualized approach on individuals from different spiritual walks as well as individuals who do not practice a particular religious faith.

More research is also needed regarding clinicians. Specifically, it would be beneficial to determine those characteristics that are important to effectively deliver integrative therapy. Is it necessary for the therapist to share similar beliefs to the client in order to achieve effective treatment? What is the main factor in resistance for those clinicians who oppose integration in the clinical setting? It is imperative to determine the specific qualities and proficiencies of the clinician when working within this field to facilitate effectiveness and competency in this area.

In addition, research should be performed to evaluate the importance of intrinsic beliefs and overt religious behaviors. An analysis of each of these areas was included in the treatment protocol for this study. It is uncertain what behaviors precipitated the greatest change in the reduction of depressive symptoms and increase in spiritual ratings.

Additional studies could identify and evaluate the most successful techniques in enhancing overall well-being and spiritual growth.

The incorporation of spirituality into treatment is received with mixed reactions by professionals in the mental health field. This study offers support for the integration of spirituality and cognitive-behavioral therapy. Educational programs should provide training in integrative treatment in an effort to provide potential benefits to specific patient populations in the clinical setting. Clinicians who do not consider the client's belief system or identity when designing a treatment protocol are doing a disservice to the client. It would be beneficial to clients for professionals in the mental health field to become knowledgeable about ways to effectively treat a client in this integrated holistic approach. The overall impact could produce significant positive changes in the mental health field.

Clinicians and researchers alike should become familiar with the additional tools presented in this study to embrace the spiritual dimension in the therapeutic environment. Some of these treatment tools include the cognitive quadrant, the spiritually informed cognitive-behavioral thought record, religious imagery, Christian meditation, and coping scripture cards. All of these interventions are various techniques that help to combat the cognitive distortions and negative beliefs of the client. Of course, clinicians must be willing to adopt these interventions and have an open mind about including spirituality in treatment. As the current study has demonstrated, spiritual interventions serve as supplemental tools to existing methods, such as the cognitive-behavioral approach, that have received empirical support and validation.

Clergy members and pastoral counselors can also gain additional skills from this integrative approach. They may benefit by learning new ways to understand individuals through the cognitive-behavioral model. Religious leaders could apply tools from the integrative approach to help others understand their thought processes and schemas. Clergy members could utilize spiritual interventions to assist their parishioners in devising healthy and adaptive beliefs to work towards growth and overall well-being. While religious leaders may feel confident regarding their own spiritual beliefs, they may be lacking the necessary clinical skills that an integrative approach, such as the one used in this manual, provides.

Additional research should be conducted in the field of therapeutic adherence. Specifically, in relation to this study, there should be further studies regarding integration and treatment adherence. It is important for clinicians to recognize those factors that promote treatment adherence. Once these factors are identified, clinicians can incorporate these components into treatment and therefore achieve better results in therapy.

Integration continues to be an area of continued research for many different areas in both the mental health and medical field. It is evident that spirituality has a positive impact on the lives of many individuals, both mentally and physically. Individuals have reported their desire to have this area included in treatment. Therefore, clinicians need to recognize the importance of integration and take the necessary steps to evaluate their own thoughts on this matter and proceed accordingly. The world continues to embrace spirituality in many different areas, and the mental health field is beginning to do so, as well. The current study was developed to explore the integration of spirituality into

treatment with Christian subjects who were experiencing depressive symptoms. Continued research is essential in order to abreast of the growing need in this area. Further studies are needed to advance the field of integration by creating a more detailed step-by-step integrative approach that can be used by mental health clinicians and clergy alike.

This research project sheds light on the importance of incorporating components of spirituality into clinical treatment. It is evident that through the use of spiritual interventions and cognitive-behavioral interventions, the two subjects in the study experienced a significant reduction in their depressive symptoms. It is believed by the researcher that the integrative approach was helpful in achieving these results. The integrative approach treated the subjects in a holistic manner and included all elements of the individuals' identity. Spirituality should continue to be embraced and incorporated into clinical treatment in order to address all dimensions of well-being and identity.

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Appendix A

Twelve-Week Manualized Spiritually-Informed Cognitive-Behavioral Treatment

The emphasis of the 12-week, Spiritually-informed Cognitive-Behavioral protocol was designed to teach individuals new skills to manage their levels of depression. The treatment focuses on the beliefs of the client and utilizes various spiritual interventions to challenge faulty thinking. Research has shown individuals requesting clinical treatment desire the integration of spirituality into their treatment (Margolese, 1998; Belaire, Young & Elder, 2005; Guinee & Tracy, 1995). This manual was developed to address that issue and to assist clinicians throughout this integrative process. It will also facilitate clergy members in their efforts to introduce cognitive-behavioral interventions into their spiritual framework.

In the protocol, individuals will learn about depression, the impact of depression on the body and the mind, and new ways to cope with depression. These methods include behavioral interventions that assist in alleviating depressive symptoms. The components to create a successful behavioral plan, decrease certain problematic excess behaviors and increase those positive behavioral deficits will be presented to the participant. Cognitive interventions are reviewed that are designed to replace unhealthy cognitive patterns or beliefs with those healthy spiritual beliefs of the client. This is accomplished through utilization of both cognitive and spiritual techniques. The belief systems of the client will be reviewed and analyzed to determine the impact of certain beliefs on depression. The individual will examine his or her view of God and fully explore this relationship through guided imagery, meditation and other relaxation exercises. The model that is created in

this approach is Christ-centered and works with the cross as the central component in treatment.

The treatment consists of 12 sessions that are outlined below. Each session will run approximately one hour in length. The client will be expected to do homework assignments between sessions to practice and apply the presented techniques.

The Therapeutic Relationship

As with most therapeutic modes, the therapeutic relationship is imperative in the creation of an effective environment for treatment. An alliance between the therapist and the client must be established to enable the success of the treatment modality.

Key requirements for the therapist include the ability to show empathy, warmth, genuineness, and establish rapport with the client. The therapeutic relationship must also be collaborative in nature (Rogers, 1951). The therapist and the client will work together to set the agenda, test cognitions, and implement homework assignments. The therapist should work to reflect and model Christ’s love to provide an atmosphere of acceptance and to model the roots of Christian practices. The client should be able to sense God’s love and feel safe within the presence of the therapist. The therapist should seek God’s support and guidance throughout the process and recognize the importance of imparting acceptance and understanding throughout the therapeutic process.

The therapist in this setting must be sensitive to the client’s religious and spiritual beliefs, working to gain competencies in this area through experience and supervision. It is also advised to institute or join an alliance of colleagues whom have familiarity in the area of spirituality or religion and to also establish relationships with members of the

communities of faith. The clinician should exude an aura of comfort and self-confidence with this treatment scope.

Prayer

Prayer comprises an important element in this spiritually-informed CBT model. The notion of prayer in treatment has been met with mixed emotions and at times is considered controversial. The author believes that prayer can be a vital part of the therapeutic process. Several research articles have even suggested that prayer serves as a coping mechanism for individuals (Ellison et al., 2001; Hettler & Cohen, 1998; Mirola, 1999; Pargament et al., 2000; Stuckey, 2001). Individuals turn to religion and prayer in times of crisis or when dealing with various stressful events (Ellison et al., 2001; Hettler et al., 1998; Stuckey, 2001). For these reasons, it is imperative for the researcher to incorporate prayer in the sessions. By doing so, the research will also model religious coping interventions that the individual can utilize outside of the session to continue personal growth in the relationship with God. At the end of each of the sessions is an optional prayer the clinician can use with the client. The clinician may also devise prayers that are personalized to the client.

Confidentiality

Confidentiality is a matter that requires consideration in any treatment setting. The therapist is not permitted to share information obtained in the session with the exception of a few circumstances. The therapist must advise the necessary persons if the client is believed to be a danger to either self or another individual. Confidentiality must be broken in this circumstance in order to protect the patient and/or the person that he or she is threatening to harm. Furthermore, the therapist is mandated by law to report

suspected child abuse and at times, the therapist may be asked to testify about what was discussed in therapy. Information may also be shared with the therapist's supervisor during supervision. Any other information that will be released to other parties must be done through informed consent by the client.

Model of Depression

The following includes a brief description of depression. A more thorough description of depression can be found in Appendix C.

1. Depression is a disorder that affects mood, cognitions, physiological states and motor abilities.
2. Depression differs from "everyday sadness" and the "blues" because it is associated with certain symptoms and usually occurs over a prolonged period of time.
3. Depression has many potential causes. The cause may be social or psychological, such as negative events in childhood, negative social relationships, etc. As a result of these experiences, individuals may develop negative thoughts about themselves, others and their future. Another cause of depression is biology. Individuals are at a greater risk of experiencing depression if their parents or close relatives have experienced depression.
4. The depressed person has learned negative ways to cope with stress as a result of personal life experiences and biology. An individual may isolate from others and avoid doing pleasurable activities when faced with certain dilemmas.
5. The depressed person does not have a positive self-image. The individual may perceive a worthless self-image and selectively attend to the negative self-attributes while neglecting or filtering out the positive ones (Librizzi, 2006). With this negative

view of self, the person begins to feel defective or inadequate and as a result, believes that all experiences will result in defeat or failures.

6. The depressed individual views others and the world in a negative light, creating a tendency to feel isolated and disconnected from others and the world. The depressed person may perceive that others are disinterested in his or her needs and concerns.
7. The depressed individual may even experience a disconnection from God when experiencing feelings of depression with thinking patterns such as "I am a worthless failure, nobody cares for me, no one can help, not even God."
8. The depressed individual does not believe things will get better, but instead holds a negative view of the future. The person may truly feel uncared and unloved by others due to this negative self-image and foresees an utterly bleak future. This may lead to a greater severity in the depression or eventually suicide. It is apparent that all three schemas (self, others/world, and future) interact with one another.
9. The common treatments for depression are: medication and cognitive-behavioral therapy.

Spiritually informed cognitive-behavioral therapy

Spiritually informed cognitive-behavioral therapy may be an effective treatment modality for depression. These are the basic characteristics of this method:

1. The main focus of the treatment is the individual's thoughts, feelings and behaviors. These three parts work together in most activities.

2. Individuals often have different thoughts, feelings and behaviors in their spiritual practices. These three elements may present a positive or negative impact on emotional well-being.
3. Thoughts have an impact on feelings and behavior, behaviors have an impact on thoughts and feelings, and feelings have an impact on thoughts and behaviors.
4. Positive thoughts lead to positive behaviors and feelings. Negative thoughts lead to negative behaviors and feelings. At times, individuals may have negative outlooks on their religion or spiritual beliefs. As a result, they may feel unsupported and begin to isolate from others, which could lead to symptoms associated with depression.
5. Spiritually informed cognitive-behavioral therapy works at changing our negative thoughts. This is done through the use of scripture, prayer, meditation, relaxation and guided imagery.
6. One must work to change the downward spiral to an upward one. When an individual becomes depressed, the individual will begin to view various aspects of the world in a negative light. Everything seems to be going wrong, and the cycle continues creating a downward spiral. To address this problem, the individual needs to become aware of the downward spiral and learn new skills to work towards seeing life through a different perspective.
7. Spiritually informed cognitive-behavioral therapy also requires the individual to look at the cognitive quadrant. This is the way the individual views self, others and the world, the future, and God. If these beliefs are irrational or negative, treatment will focus on providing biblical truths and spiritual knowledge to challenge these beliefs and replace them with new adaptive beliefs.

8. Change in spiritually-informed cognitive behavioral treatment requires work both in and out of sessions. Homework is assigned to assist in the transfer of learned material and to test out the concepts learned in treatment.

General Session Structure

The approach outlined in this manual is moderately structured. The goal of the therapist is to balance those essential skills that are proven to promote a positive working alliance with the application of the interventions illustrated in this manual. At times, the therapist may need to tailor specific elements of the treatment to the client. While the structure in this manual serves as a guideline, it should be noted that the skills and interventions outlined there are necessary for a reduction in depressive symptoms. Sessions are usually one hour in length (60 minutes). The sessions are divided into three major sections:

1. During the first third of the hour, the therapist will set the agenda with the individual, analyze mood, review any significant events that occurred throughout the week and discuss homework assignments.
2. The middle third of the session involves psychoeducation and the learning of new skills. The clinician will link the problems that the client is experiencing with the skill that is presented.
3. The final third of the session is used to complete other items on the session agenda and to plan the homework assignments. The rationale for the homework assignments must be explained so the individual can see the relevance of this task in treatment. The therapist should work with the client to plan how the homework should be completed and to problem-solve any barriers that may be present.

Recommended Sequence of Spiritually-Informed Cognitive Behavioral Treatment

Week	Topic	Time
1	Explanation and Education about Depression	60 minutes
2	Education about the SCBT Approach	60 minutes
3	Behavioral Strategies	60 minutes
4	Behavioral Strategies	60 minutes
5	Cognitive Strategies	60 minutes
6	Cognitive Strategies	60 minutes
7	Cognitive Strategies	60 minutes
8	Cognitive Quadrant	60 minutes
9	Surrender and Control	60 minutes
10	Christian Meditation and Guided Imagery	60 minutes
11	Relaxation and Music	60 minutes
12	Review and Overview of Treatment	60 minutes

The Beck Depression Inventory, the Santa Clara Strength of Religious Faith Questionnaire, Religious Behavior Inventory, Inventory of Cognitive Distortions, the Working Alliance Inventory and the Beck Anxiety Inventory should be administered at intake, week 3, week 6, week 9 and the final session.

Initial Case Conceptualization

An accurate case conceptualization is needed before the clinician begins treatment with the client. The case conceptualization is used to help the clinician bring together different aspects about the person (their history, current status, etc.) to formulate the course of treatment. If an adequate case conceptualization is performed, the goals that will be focused upon in treatments should be obvious. The model presented in this manual is the cognitive model developed by Jacqueline Persons, in conjunction with Jeffrey Young's schema theory. These two models are integrated to explain the theory behind Spiritually informed cognitive-behavioral therapy. There are nine steps for the clinician to complete in order to develop an accurate case conceptualization according to Persons' model:

1. Collect identifying information regarding the client, which is most often gathered during the clinical interview. This will include information related to the client's history (family, development, schooling, medical conditions, relationships, schooling, interests, religion, etc.), past treatment, and current levels of functioning.
2. Derive the chief complaint, that is, the primary reason why the client is seeking treatment. This usually can be drawn from the client by asking him or her: What brought you here today?
3. Compose a list of the problems that are evidenced in the life of the client. This could include emotional states, stressors, relationship problems, communication difficulties, and health concerns.

4. Determine the hypothesized mechanisms for treatment of the client. Persons references Young's schemas in this area, which falls into two different categories: early maladaptive schemas and schema domains. Early maladaptive schema consist of themes regarding oneself and one's relationship with others (Young, Klosko & Weishaar,2003). These schemas are developed in one's childhood and continue to be adapted throughout one's life. These early maladaptive schemas may at times be self-defeating patterns that we continue to repeat throughout our lives. The schema domains usually relate to the basic emotional needs of a child. When these needs are not met in childhood, schemas develop that lead to unhealthy life patterns (Young, Klosko & Weishaar, 2003). There are a total of 18 early maladaptive schemas which fall under five schema domains. These are shown below, with the five schema domains in bold followed by the related early maladaptive schemas in italics. The clinician can address the spiritual beliefs of the client through identification of the hypothesized mechanism, otherwise known as the schema domains. In the list below, the author included scriptures and various ways spiritual beliefs may be impacted with each schema domain and early maladaptive schema. The therapist should identify the early maladaptive schemas and schema domains that seem to best fit the client.

DISCONNECTION & REJECTION- LOVE FROM GOD

This schema domain has the expectation that one's needs for security, safety, stability, nurturance, empathy, compassion, acceptance, and respect will not be met in a predictable manner. The typical family origin for depressed individuals is detached, cold, rejecting, withholding, lonely, explosive, unpredictable, and/or abusive. As a result, the

client may not feel love from God. He may perceive God as punishing or feel undeserving of a close relationship, as no sense of love and connection was sensed from the client's biological family. The clinician should focus on the unconditional love that God provides. The following early maladaptive schemas are associated with this schema domain.

1. *ABANDONMENT / INSTABILITY (AB)*

The individual perceives others as instable or unreliable in regards to providing support and connection. This early maladaptive schema involves the perception by the client that significant others will not be able to continue providing emotional support, connection, strength, or practical protection because they are emotionally unstable and unpredictable (e.g., angry outbursts), unreliable, erratically present, facing imminent death, or likely to abandon in favor of someone better. The clinician should redirect the focus on the unrelenting and unending love of God. Specific biblical passages or stories that profess God's unconditional love may also be related to the client.

For God so loved the world, that he gave his only begotten Son, that whosoever believeth in him should not perish, but have everlasting life. For God sent not his Son into the world to condemn the world; but that the world through him might be saved.

(John 3:16-17)

In this was manifested the love of God toward us, because that God sent his only begotten Son into the world, that we might live through him. Herein is love, not that we loved God, but that he loved us, and sent his Son to be the propitiation for our sins

(1 John 4:9-10)

2. *MISTRUST / ABUSE (MA)*

This early maladaptive schema comprises the expectations that others will harm, abuse, humiliate, cheat, lie, manipulate, and/or take advantage of the individual. It usually involves the perception that the harm is intentional or the result of unjustified and extreme negligence. This may include the sense that one always ends up being cheated relative to others or "getting the short end of the stick." Once again, the clinician should focus on the love that God provides for all of His people. The individual may feel that he or she does not deserve the love of God as a result of past abuse or hurts. The therapist should focus on the supportive and loving role of God and discuss the role of God in the life of the client. The therapist might also focus on ways that God can protect us and heal us from our past wounds. Even though individuals may have experienced hurts in the past, God will help to heal those wounds and provide everlasting love and protection to the client.

The LORD hear thee in the day of trouble; the name of the God of Jacob defend thee; Send thee help from the sanctuary, and strengthen thee out of Zion; Remember all thy offerings, and accept thy burnt sacrifice; Selah

(Psalm 20:1-3)

There shall not any man be able to stand before thee all the days of thy life: as I was with Moses, so I will be with thee: I will not fail thee, nor forsake thee.

(Joshua 1:5)

3. *EMOTIONAL DEPRIVATION (ED)*

Emotional deprivation concerns the expectation that one's desire for a normal degree of emotional support will not be adequately met by others. The three major forms of deprivation are: deprivation of nurturance (absence of attention, affection, warmth, or

companionship), deprivation of empathy (absence of understanding, listening, self-disclosure, or mutual sharing of feelings from others) and deprivation of protection (absence of strength, direction, or guidance from others). The clinician should assess the extent of God's love as perceived by the client. The individual may incorrectly assume that God will provide the limited love that others give to the individual.

The LORD loves righteousness and justice; the earth is full of his unfailing love.

(Psalm 33:5)

O Israel, put your hope in the LORD, for with the LORD is unfailing love and with him is full redemption.

(Psalm 130:7)

4. *DEFECTIVENESS / SHAME (DS)*

This early maladaptive schema involves the feeling that one is defective, bad, unwanted, inferior, or invalid in important respects; or that one would be unlovable to significant others if exposed. It may entail hypersensitivity to criticism, rejection, and blame; self-consciousness; comparisons to others; insecurity around others; or a sense of shame regarding one's perceived flaws. These flaws may be private (e.g., selfishness, angry impulses, unacceptable sexual desires) or public (e.g., undesirable physical appearance, social awkwardness). The clinician will focus on the view of the individual through the eyes of God. God views all of his creations as beautiful. God accepts each individual as they are and loves the individual despite all of his or her imperfections and sin.

So God created man in his own image, in the image of God he created him; male and female he created them.

(Genesis 1:27)

5. *SOCIAL ISOLATION / ALIENATION (SI)*

Social isolation or alienation involves the feeling that one is isolated from the rest of the world, different from other people, and/or not part of any group or community. As a result of these perceptions, the individual will sense very little support from environment and may feel very alone and distant from the rest of the world. The therapist will focus on the beautiful and extraordinary qualities that make the individual unique and special in the eyes of God. The clinician should also focus on acceptance the person may receive from the church community or from others in any social event. Additionally, the therapist may focus on testing some of the client's cognitions regarding being different and encourage the client to become actively involved in a group in which he or she can feel welcomed and comfortable.

Do not let your hearts be troubled. Trust in God, trust also in Me. In My Father's house are many rooms; if it were not so, I would have told you. I am going there to prepare a place for you. And if I go and prepare a place for you, I will come back and take you to be with Me
that you also may be where I am.

(John 14:1-3)

IMPAIRED AUTONOMY & PERFORMANCE-

VALUE OF SELF/INDEPENDENCE- LOVE OF SELF

This schema domain includes expectations about oneself and the environment that interfere with one's perceived ability to separate, survive, function independently, or perform successfully. The typical family origin of a depressed individual may be enmeshed (does not have clear boundaries), undermining of the child's confidence, overprotective, or failing to reinforce the child for performing competently outside the family. The client may have difficulties separating from the family and as a result, experience difficulties when expected to independently move forward in life. The patient

may exhibit low self-esteem and self-worth and may rely on family of origin to define self identity. The clinician should help the client find ways to foster self-love and assertiveness. The therapist should stress the value and importance of the person in the eyes of God and help the client develop a healthy relationship with God that combines love for God and self.

6. *DEPENDENCE / INCOMPETENCE (DI)*

This early maladaptive schema involves the belief that one is personally unable to handle one's everyday responsibilities (e.g., take care of oneself, solve daily problems, exercise good judgment, tackle new tasks, make good decisions) in a competent manner, and thereby requires considerable help from others to do so. It is often presented as a sense of helplessness. The clinician may focus on ways to empower the client and recognize the inherent character strengths of the client. The depressed individual may at times feel profoundly insecure and inadequate. The client will begin to recognize different times in his or her life when God provided support. When the patient is able to recognize these times, it will become evident that through God all things are possible.

But Jesus looked at them and said to them, "With men this is impossible, but with God all things are possible."

(Matthew 19:26)

7. VULNERABILITY TO HARM OR ILLNESS (VH)

The client may experience an exaggerated fear that imminent catastrophe will strike at any time and feel unable to prevent it. Fears focus on one or more of the following: (A) medical catastrophes (e.g., heart attacks, AIDS) (B) emotional catastrophes (e.g., going crazy) (C): external catastrophes (e.g., elevators collapsing, victimized by criminals, airplane crashes, earthquakes). The client may react in a vigilant manner and be on guard

most of the time. The therapist should work to have the client develop a strong trust in God's plan and provision for the individual's future. When the client is able to release his or her concerns and worries to God, a sense of freedom and release will ensue.

Therefore take no thought, saying, What shall we eat? or, What shall we drink? or, Wherewithal shall we be clothed? For your heavenly Father knoweth that ye have need of all these things. But seek ye first the kingdom of God, and his righteousness; and all these things shall be added unto you

(Matthew 6:31-33)

8. *ENMESHMENT / UNDEVELOPED SELF (EM)*

This early maladaptive schema involves excessive emotional involvement and closeness with one or more significant others (often parents) at the expense of full individuation or normal social development. In addition, this often includes the belief that at least one of the enmeshed individuals cannot survive or be happy without the constant support of the other. This may also entail feeling smothered or overly attached to others. It could very well result in insufficient development of individual identity. The schema is often experienced as a feeling of emptiness and floundering, having no direction, or in extreme cases, questioning one's existence. The client may need to focus on the personal relationship with God and the sufficient and healthy boundaries of that relationship. The clinician may consider ways for the patient to develop a healthy give and take relationship with others.

Trust in the Lord with all your heart, and lean not on your own understanding; In all your ways acknowledge Him, and He shall direct your paths.

(Proverbs 3:5-6)

9. *FAILURE (FA*)

This early maladaptive schema concerns the belief that one has failed, will inevitably fail, or is fundamentally inadequate in areas of achievement (school, career, sports, etc.) relative to one's peers. The client may perceive oneself as stupid, inept, untalented, ignorant, lower in status, and less successful than others. The clinician will focus on the value that is inherent in the patient's life. The therapist may also concentrate on the client's successes and accomplishments throughout his or her lifetime

A Call from Macedonia

Next Paul and Silas traveled through the area of Phrygia and Galatia, because the Holy Spirit had prevented them from preaching the word in the province of Asia at that time. Then coming to the borders of Mysia, they headed north for the province of Bithynia,[a] but again the Spirit of Jesus did not allow them to go there. So instead, they went on through Mysia to the seaport of Troas. That night Paul had a vision: A man from Macedonia in northern Greece was standing there, pleading with him, "Come over to Macedonia and help us!" So we[b] decided to leave for Macedonia at once, having concluded that God was calling us to preach the Good News there.

(Act 16:6-10)

IMPAIRED LIMITS- LOVE OTHERS

This schema domain focuses on deficiency in internal limits, responsibility to others, and long-term goal-orientation. This may result in difficulty respecting the rights of others, cooperating with others, making commitments, or setting and meeting realistic personal goals. Typical family origin for individuals who are experiencing difficulties with mental health problems are characterized by permissiveness, overindulgence, lack of direction, and/or a sense of superiority, as opposed to attributes of appropriate confrontation, discipline, limits in relation to taking responsibility, cooperating in a reciprocal manner, and setting goals. In some cases, the child in this family of origin may

not have been pushed to tolerate normal levels of discomfort, or may not have been given adequate supervision, direction, or guidance. In treatment, the clinician will focus on considerate, compassionate and responsible ways to love others. Biblical passages that underscore the need to love thy neighbors as we love ourselves could also be presented to the client.

10. *ENTITLEMENT / GRANDIOSITY (ET)*

This early maladaptive schema includes the belief that one is superior to other people, entitled to special rights and privileges, and/or not bound by the rules of reciprocity that guide normal social interaction. This often involves insistence that one should be able to do or have whatever one wants, regardless of what is realistic, what others consider reasonable, and/or the cost to others. This may also include an exaggerated focus on superiority (e.g., being among the most successful, famous, wealthy) in order to achieve power or control (not primarily for attention or approval). Another element of this schema may be an excessive competitiveness or domination in interactions with other. This is demonstrated by asserting power, one's point of view or controlling the behavior of others in line with one's own desires without empathy or concern for others' needs or feelings. This schema is not in accordance with Scripture and Christian guidelines. The clinician should focus on the importance of developing respectful and loving relationships with others, as depicted in the Bible.

And the second is like, namely this, Thou shalt love thy neighbour as thyself. There is none
other commandment greater than these.

(Mark 12:31)

11. INSUFFICIENT SELF-CONTROL / SELF-DISCIPLINE (IS)

This early maladaptive schema is reflected by pervasive difficulty or refusal to exercise sufficient self-control, frustration and intolerance in the effort to achieve personal goals, and/or excessive expression of emotions and impulses. In its milder form, the patient presents with an exaggerated emphasis on discomfort-avoidance as evidenced by measures to avoid pain, conflict, confrontation, responsibility, or overexertion, all at the expense of personal fulfillment, commitment, or integrity. The client will need to focus on developing appropriate emotional regulation and control. The clinician should discuss emotional processes and the importance of healthy emotional expression.

bearing with one another, and forgiving one another, if anyone has a complaint against another; even as Christ forgave you, so you also must do.

(Colossians 3:13)

OTHER-DIRECTEDNESS- SELF RESPECT/ADVOCACY/ ASSERTIVENESS

This schema domain concerns an excessive focus on the desires, feelings, and responses of others, even at the expense of one's own needs, in order to gain love and approval, maintain one's sense of connection, or avoid retaliation. As a result, the individual may suppress emotions and experience a lack of awareness regarding one's own anger and natural inclinations. The typical family origin is based on conditional acceptance: children must suppress important aspects of themselves in order to gain love, attention, and approval. In many such families, the parents' emotional needs and desires for social acceptance and status are valued more than the unique needs and feelings of each child. The clinician may need to look at assertiveness skills training and explore ways to enhance self-respect and develop a voice of empowerment. Once again, it is

apparent that continuously placing the needs of others above one’s own precipitates a significant amount of stress upon the individual.

The therapist may also focus on ways that the church is God’s family. Anyone is able to be a member of the church body and the goal is to work together in the spiritual walk. By focusing on the church family, the person will be able to pursue a personal relationship with God and also work towards incorporating healthy relationships into his or her own life.

12. SUBJUGATION (SB)

This early maladaptive schema involves excessive surrendering of control to others in an effort to avoid anger, retaliation, or abandonment. The two major forms of subjugation are: subjugation of needs (suppression of one's preferences, decisions, and desires) and subjugation of emotions (suppression of emotional expression, especially anger). The schema usually involves the perception that one's own desires, opinions, and feelings are not valid or important to others. Frequently, the individual may act with excessive compliance combined with hypersensitivity to feeling trapped. This generally leads to a build up of anger, manifested in maladaptive symptoms (e.g., passive-aggressive behavior, uncontrolled outbursts of temper, psychosomatic symptoms, withdrawal of affection, "acting out,” and substance abuse). The client will need to focus on personal needs and expectations in life.

And as you wish that others would do to you, do so to them.

(Luke 6:31)

13. SELF-SACRIFICE (SS)

Self-sacrifice is expressed by an excessive focus on voluntarily meeting the needs of others in daily situations at the expense of one's own gratification. The most common justifications for this include the prevention of causing pain to others, avoidance of guilt from feeling selfish, or the maintenance of social connections with others who are perceived as needy. It is often accompanied by an acute sensitivity to the pain of others. These repeated acts of self-sacrifice sometimes lead to a sense that one's own needs are not being adequately met and the resentment of others under his or her care. It should be noted that this schema overlaps with the concept of co-dependency. In this situation, the clinician should focus on self-love and ways to values one's own needs and life. The therapist should also concentrate on the client's love for Jesus and God. Self-sacrifice in an effort to obtain God's love is justified. The individual would be striving towards reaching his or her religious potential and continuing to draw closer to God.

"Therefore My Father loves Me, because I lay down My life that I may take it again. No one takes it from Me, but I lay it down of Myself. I have power to lay it down, and I have power to take it again. This command I have received from My Father."

(John 10:17-18)

14. APPROVAL-SEEKING / RECOGNITION-SEEKING (AS)

In this early maladaptive schema, there is an excessive emphasis on gaining approval, recognition, or attention from other people, or fitting in, at the expense of developing a secure and true sense of self. One's sense of esteem is dependent primarily on the reactions of others rather than on one's own natural inclinations. This sometimes includes an overemphasis on status, appearance, social acceptance, money, or achievement as a means of gaining approval, admiration, or attention (not primarily for

power or control). It frequently results in major life decisions that are inauthentic or unsatisfying; or in hypersensitivity to rejection. The clinician may focus on ways to enhance the self-esteem, self-worth and self-love of the client.

In addition, the clinician may stress to the client that God loves the individual as he or she is, with no need to be "perfect" or a "super Christian" in order to earn God's love. God's love is given freely to those that accept Him and believe in Him. Once the client recognizes that he or she does not have to impress God, a great amount of stress will be relieved from the individual.

But now a righteousness from God, apart from law, has been made known, to which the Law and the Prophets testify. This righteousness from God comes through faith in Jesus Christ to all who believe. There is no difference, for all have sinned and fall short of the glory of God, and are justified freely by his grace through the redemption that came by Christ Jesus. God presented him as a sacrifice of atonement,[a] through faith in his blood. He did this to demonstrate his justice, because in his forbearance he had left the sins committed beforehand unpunished— he did it to demonstrate his justice at the present time, so as to be just and the one who justifies those who have faith in Jesus.

(Romans 3:21-26)

OVERVIGILANCE & INHIBITION- LOVE & ENJOY LIFE/ACCEPTANCE

Overvigilance and inhibition relates to an excessive emphasis on suppressing one's spontaneous feelings, impulses, and choices or adhering to rigid, internalized rules and expectations about performance and ethical behavior. This is often at the expense of happiness, self-expression, relaxation, the formation of close relationships, or personal health. Typical family origin for the depressed individual is typically grim, demanding, and sometimes punitive. Performance, duty, perfectionism, adherence to rules, masking emotions, and avoiding mistakes takes precedence over pleasure, joy, and relaxation. There is usually an undercurrent of pessimism and worry that things could fall apart if

one fails to be vigilant and careful at all times. The individual may not experience much joy or enjoyment in life. The therapist should focus on relaxation, optimism and finding hope in the client's spirituality and religious preferences. The client should also be assisted to abandon the need to cling to the worries and concerns of life and hand them over to God. The individual may struggle in this area, wanting to cling to problems and not surrender control. However, this is essential in productive treatment.

15. NEGATIVITY / PESSIMISM (NP)

In this early maladaptive schema, there is a pervasive, lifelong focus on the negative aspects of life (pain, death, loss, disappointment, conflict, guilt, resentment, unsolved problems, potential mistakes, betrayal, things that could go wrong, etc.) while minimizing or neglecting the positive or optimistic aspects. This usually includes an exaggerated expectation in a wide range of work, financial, or interpersonal situations that things will eventually go seriously wrong, or that aspects of one's life that seem to be going well will ultimately fall apart. The individual usually has an inordinate fear of making mistakes that might lead to financial collapse, loss, humiliation, or being trapped in a bad situation. The prospect of potential negative outcomes is exaggerated and is frequently characterized by chronic worry, vigilance, complaining, or indecision. The clinician may focus on providing hope and encouragement during treatment. As the client begins to feel optimistic about his or her life, motivation may increase and perhaps the individual can start to rely on God and faith instead of counting on the worse possible scenario to occur.

Do not be anxious about anything, but in everything, by prayer and petition, with thanksgiving, present your requests to God.

(Philippians 4:6)

16. EMOTIONAL INHIBITION (EI)

This early maladaptive schema is characterized by an excessive inhibition of spontaneous action, feeling, or communication usually to avoid disapproval by others, feelings of shame, or losing control of one's impulses. The most common areas of inhibition involve: (a) inhibition of anger & aggression; (b) inhibition of positive impulses (e.g., joy, affection, sexual excitement, play); (c) difficulty expressing vulnerability or communicating freely about one's feelings, needs, etc.; or (d) excessive emphasis on rationality while disregarding emotions. The individual should learn effective methods of self-expression and realize that emotions are acceptable and are part of the joys of life. The therapist will stress the importance of the individual living for God and His purpose. In order to work towards one’s spiritual journey, he or she must feel various emotions and recognize that these feelings are a natural part of the process. The therapist may review the various emotions that Jesus experienced in His life on earth and stress that Jesus understands any emotion the client could be enduring. The individual should embrace the positive emotions and work through the rough times.

Finally, brethren, whatever things are true, whatever things are noble, whatever things are just, whatever things are pure, whatever things are lovely, whatever things are of good report, if there is any virtue and if there is anything praiseworthy—meditate on these things

(Philippians 4:8).

17. *UNRELENTING STANDARDS / HYPERCRITICALNESS (US)*

This early maladaptive schema maintains the underlying belief that one must strive to meet very high internalized standards of behavior and performance, usually to avoid criticism. This typically results in feelings of pressure or difficulty slowing down and in being overly critical towards oneself and others. It is also accompanied by a significant impairment in pleasure, relaxation, health, self-esteem, sense of accomplishment, or the formation of satisfying relationships. The unrelenting standards typically present as: (a) perfectionism, inordinate attention to detail, or an underestimation of one's own performance as related to the norm; (b) rigid rules and "shoulds" in many areas of life, including unrealistically high moral, ethical, cultural, or religious precepts; or (c) preoccupation with time and efficiency, so that more can be accomplished. The clinician may focus on aspects of perfectionism and ways that the individual will never reach this goal. In addition, the therapist may focus on God's grace, understanding and forgiveness to assist the person in recognizing the ability to make mistakes and learn from these mistakes.

God will not fail nor forsake us. Men may fail, mistreat, or disappoint us. Not God. He always remains faithful to us, provided that we remain faithful to Him.

(Hebrews 13:5-6)

18. PUNITIVENESS (PU)

In this early maladaptive schema, there is the belief that people should be harshly punished for making mistakes. This involves the tendency to be angry, intolerant, punitive, and impatient with oneself and others, for not meeting certain expectations or standards. In addition, this usually includes difficulty forgiving mistakes in oneself or others because of a reluctance to consider extenuating circumstances, allow for human

imperfection, or empathize with feelings. In regards to this specific early maladaptive schema, the clinician should focus on acceptance and allowing for imperfections in life. God accepts individuals for their flaws and forgives their sin. It is important for the individual to take on the accepting nature of God and work towards loving others as God does.

God values us more than He does birds and flowers, yet He feeds and clothes them. Surely He will care for us, if we will serve Him.

(Matthew 6:25-33)

And be kind to one another, tenderhearted, forgiving one another, even as God in Christ forgave you.

(Ephesians 4:32)

5. Formulate relationships of the presenting problems, chief complaints and the problem list to those hypothesized mechanisms in the previous step. The clinician will attempt to link the schemas will the presenting problems and problem list.
6. Identify the precipitants of the current problem. The client identifies different events that trigger stressors in current and/or past situations.
7. Determine the origins of the central problem. The therapist pinpoints the client's past events from childhood or development that may have originally created the roots of the problem.
8. Devise a treatment plan. The clinician works with the client to develop treatment goals that address the chief complaint, problem list, and the hypothesized mechanism/schema domain.
9. Recognize the potential obstacles to treatment. The therapist identifies any potential obstacles to effective treatment.

SESSION ONE

This is the first session for the therapist and client upon completion of the assessment period and case conceptualization process. At this point, the therapist should have a working treatment plan and goals that have been mutually agreed upon with the client. Included in Appendix B is a spirituality assessment tool that was created by this researcher. The clinician may opt to utilize this tool when collecting valuable data relevant to the client's spiritual history or the clinician may utilize other available tools.

Capsulation:

1. Set the agenda
2. Overview of the individual session structure and treatment schedule
3. What is depression
    - A. Symptoms
        - I. Mood
        - II. Biological
        - III. Cognitions
        - IV. Behavior
        - V. Motor
    - B. Identify symptoms of depression client is experiencing
4. Assessment of suicidality/self-harm
5. Assign homework

1. Set the agenda

At the beginning of the session, the therapist and the client will review the items to cover during the session. The therapist will make suggestions based on the different

elements of this protocol. It is essential for the client to work with the therapist in setting the agenda in order to make treatment a collaborative process from the beginning. The client is given the opportunity to propose additional items that may be included on the agenda that are in agreement with the therapeutic goals for the session.

2. Overview of the individual session structure and treatment schedule

The therapist should provide a clear overview of the individual session structure and treatment schedule. This includes educating the client about the three parts of each session that was previously reviewed in this manual: 1) setting the agenda, assessing the client's mood, and reviewing any significant events, 2) psychoeducation and learning of new skills and 3) completing other items on the session agenda and planning the homework assignments. The therapist should also relay the number of sessions included in this treatment, what is expected during each session and the duration of each meeting. Confidentiality will be discussed, although this should also be reviewed in the initial intake evaluation. The therapist will also allow time for the client to ask any questions regarding any of these matters.

3. What is depression?

It is important to review the symptoms of depression in the first session, as suggested by Beck, Rush, Shaw and Emery (1979) in *Cognitive Therapy of Depression.* Depression is not the everyday blues that one may experience on an occasional basis. Depression occurs when an individual feels poorly for an extended period of time. This period of time usually lasts at least two weeks or more. When an individual is experiencing depression, it is not possible to simply "bounce back" or "just snap out of it." Depression is described as a mood disorder in the Diagnostic Statistical Manual of

Mental Disorders. Depression has an impact on the way that we feel, think, behave and relate to others. At times when individuals are experiencing depression, there may be a loss of interest in certain things, activities, interests and even relationships. The future seems hopeless and one may believe that things will always be this way. Depression may also have an impact on our physical condition. One may experience problems sleeping (either too much or too little) and difficulties with appetite and sexual drive. In addition, energy levels may be low for individuals who are experiencing symptoms of depression. The causes of depression vary from person to person. Sometimes depression may be a result of a past experience, occurring anytime from early childhood to the present. Other times there could be a biological cause to the problem. Depression could also occur as a result of distorted thinking patterns which will be explained further in this manual.

A. Symptoms

As previously stated, depression impacts the life and well-being of the individual in many different areas. The four main areas are: mood, biology, cognitions, behavior and the motor system.

I. Mood

Sad or irritable

Bored and not enjoying things

Guilty

II. Biology

Sleeping too little or too much

Loss of appetite or weight or eating too much and gaining weight

Fatigue and little or no energy

Limited or loss of sex drive

Physical Illness

III. Cognitions

Difficulties concentrating or making decisions

Loss of interest in activities or interests (anhedonia)

Criticism of self

Thoughts of death, dying or suicide

Negative views about future

Thinks the world is a horrible, rotten place

May see themselves as inadequate with little self-worth

VI. Behavior

Isolating oneself

Crying

Avoiding others

Possible self-harm

V. Motor

Psychomotor agitation- unable to sit still, restless, constantly fidgeting or pacing

Psychomotor retardation- the reduction or slowing of motor behaviors

B. Identify symptoms the client is experiencing

As depression and its symptoms are explained, the therapist should also inquire and assess the client's particular symptoms of depression. It is important to record these symptoms, as they will be evaluated throughout treatment with the goal of reducing those symptoms that are causing additional distress and thereby facilitate the onset of a

healthier way of life for the client. The therapist will also gain this information through use of the Beck Depression Inventory.

The therapist may fill out the following form with the client:

Depression Symptoms Questionnaire

Mood Assessment

Most of the time I would say that I am feeling ___________________________________

The times of the day when I am feeling the worse are______________________________

I believe that I feel sad/depressed _______% of my day.

Other feelings that come over me throughout the day are____________________________

____

I am feeling my best when____

____

Biological Assessment

I sleep ____ hours a night.

The quality of my sleep is ____

____

____

Any difficulties with sleep (i.e. Getting to sleep, interrupted sleep, waking up too early)

____

____

____

____

____

Describe your appetite and eating patterns____________________________________

____

____

____

____

Describe your energy levels____

____

____

____

Describe your sex drive (if applicable)_______________________________________

____

____

____

How is your overall physical health?____

____

____

____

Cognitive Assessment:

Describe a situation in which you feel sad or depressed__________________________

____

____

____

Complete the following sentence: "I feel sad because I am thinking…"_______________

____

____

____

"This would be not be good, because it would mean…"____________________________

____

____

____

My depression would go away if…____

____

____

____

The future looks____

____

____

Behavioral Assessment

List examples from your life, including duration, frequency, and intensity for the following items:

Isolation:

Withdrawal from others:

Lack of concentration:

Difficulties making decisions:

Loss of previously rewarding activities:

Not enough motivation to engage in activity:

Arguments:

Loss of relationship:

Few contact with others:

Motor Assessment

Have you experienced any problems with the following areas:

Inability to sit still:

Restlessness:

Constantly fidgeting:

Pacing:

Reduction or slowing of motor behaviors:

Grooming difficulties:

Feeling as if a huge weight was being pulled behind you:

4. Assessment of suicidality and self-harm

The therapist should ask the client about the current emotional status, including the presence of any suicidal tendencies. If suicidal thoughts are expressed, the therapist and the client should work together to develop a safety plan to ensure the safety of the client’s well-being. This process is called contracting for safety. If the client cannot create the safety plan with the therapist, the clinician should discuss the option of hospitalization and work with the client to pursue this option. Should the suicidal client have a plan and agrees to contract for safety, the therapist may proceed with the treatment but will need to continue to assess for safety throughout the session. In addition, the client will be expected to include others in the safety plan who guarantee to hold the

individual accountable to this agreement. If the suicidal patient has no plan, the therapist should continue to assess the client's suicidality throughout treatment and also communicate to the client the need to be open and honest about this particular area.

During the initial intake assessment, the clinician should have gained information about self-harmful behaviors. The therapist should continue to monitor these behaviors throughout treatment. This manual does not include any specific interventions related to self-harm. Additional material may need to be supplemented with this manual if the client engages in self-harmful behaviors. The clinician may utilize the following questions to assess for this domain or Beck's Scale for Suicidal Ideation (SSI, Beck et. al 1979) or Beck's Suicidal Intent Scale (SIS, Beck et. al, 1974).

The following are questions that may be used to assess suicidality in the client (Leahy & Holland, 2000):

Do you have thoughts of harming yourself? (If yes) Describe.

Have you ever threatened to hurt yourself (If yes) Who do you say this to and why?

Have you ever tried to hurt yourself on purpose? (If yes) What did you do?

How many times did you do the above behavior?

Did you tell anyone afterwards?

Did you plan to hurt yourself?

What were you feeling when you hurt yourself?

Did you go to the doctor or hospital?

How do you feel about this afterwards? (glad you were alive, embarrassed, guilty, upset you were alive?)

Was there anything that triggered the event? (If yes) Describe.

If something like the event above happened again, how would you handle this now?

Has anyone else you are close with inflicted self-harmful behaviors in the past?

How would you describe your present desire to live?

Could you describe the reason for your current or past desire to die?

Do you have any reasons not to harm yourself?

Are there more reasons to live than to die?

What would have to change in your life so you would want to live?

Do you own any weapons?

Do you live on a high floor or near a bridge?

Are there any medications in your home for a future attempt to hurt yourself?

How fast do you normally drive? Excessively fast?

How much alcohol do you normally consume?

Do you use medication or other drugs?

Have you ever written a suicide note?

Why would things seem hopeless?

What things give you hope in your life?

Would you be willing to promise me that you would not do anything to harm yourself until you have called me and spoken to me?

Can I speak with your loved ones to be sure we have extra support?

5. Assign homework

The therapist will ask the client to read the handout on depression included in Appendix C as well as the handout in Appendix D that describes the process of cognitive-behavioral therapy. The patient should be ready to discuss the handout on cognitive-behavioral therapy and prepared to ask the therapist any additional questions related to depression and symptomatology. The therapist will also instruct the client to read 1 Kings 19:1-18. This biblical story details the spiritual and vegetative depression that Elijah experiences. This story is also located in Appendix E.

SESSION TWO

The main focus of this second session is to educate the client about the approach that will be utilized in this treatment manual. The therapist will review the content from the previous session and then proceed with the new material.

Capsulation

1. Set the agenda and review homework
2. Psychoeducation about spiritually-informed cognitive-behavioral therapy
   A. One's faith has the potential to positively impact treatment
   B. Thoughts influence feelings
   C. Diagram of beliefs/thoughts directly influencing feeling and behaviors
   D. Negative spiritual coping can lead to negative beliefs in life
   E. Interventions to alter the cycle
3. Assign homework and optional prayer

1. Set the agenda and review homework

At the beginning of the session, the therapist and the client will review the items that will be included in the session. The therapist will make suggestions based on the different elements of this protocol. It is essential for the client to work with the therapist in setting the agenda in order to make treatment a collaborative process from the beginning. The client is given the opportunity to propose additional items that may be included on the agenda that are in agreement with the therapeutic goals for the session.

The therapist will review the homework assignment from the previous session and answer any questions from the client regarding the handout on depression or cognitive-behavioral therapy. Before the therapist moves on to the next section of the session, the

client will be informed that it is not necessary to understand all of the components of cognitive-behavioral therapy at this time. The theory will be explained in greater detail as it is incorporated with spiritually informed cognitive-behavioral therapy. When the client is ready to move forward with the next step in the session, the therapist will do so.

2. Psychoeducation about spiritually-informed cognitive-behavioral therapy

Spiritually-informed cognitive-behavioral is an educational and explorative approach. It requires collaboration between the therapist and the client throughout the treatment process. It is essential for the client to understand the main tenets of the theory behind this new therapy before utilizing the interventions in this manual.

A. One's faith has the potential to positively impact treatment

The therapist may cite recent literature to relay to the client the importance of faith in mental health treatment. The following include some relevant examples in the research community:

Benefits of Spirituality on Mental Health:

- Grabovac, Clark & McKenna (2008)
    - enhanced psychological states
    - reported a sense of inner peace, hope, and mystical experience
    - utilized positive religious coping behaviors assists with stress reduction and emotion regulation
- Powers, Cramer and Grubka (2007)
    - positive religious coping styles associated with improved positive effects

  - spiritually based motives to help others associated with positive feelings
- Hebert, Dang and Schulz (2007)
  - prayer, religious attendance and beliefs all associated with a decreased level of depression
  - prayer was the most frequently utilized coping behavior for caregivers
- Becker (2001)
  - church attendees more often had a 0.50 relative risk for depression, which were half those of people who were not religious
  - recovery from depression significantly faster in individuals with strong religious beliefs
  - study of 850 persons hospitalized for acute physical illness showed that those with religious coping skills were significantly less depressed.
- Gallagher, Wadsworth and Stratton (2002)
  - spirituality and religion provide meaning in life, often lacking in depressed individuals
  - spirituality helps the person to gain hope and allow depression to subside
- Ferraro and Koch (1994)
  - evidence for the social support hypothesis is found. The social support hypothesis states that religious groups may provide emotional,

cognitive, and material support, fostering the individual's perception of being cared for esteemed.

- Blumenthal, Babyak, Ironson, Thoresen, Powel and Czajkowski et al. (2007)
    - patients who attended church regularly tended to have lower depression and more social support, compared with patients who never went to church
- Romero, Kalidas, Elledge, Chang, Liscum and Friedman (2006)
    - forgiveness decreases negative thoughts, feelings and behaviors towards an offender following an interpersonal transgression
- Parker et al. (2003)
    - spirituality and religious practices promote psychological well-being in the general public and in medical populations
- Oman, Shapiro, Thoresen, Plante and Flinders (2008)
    - meditation-based stress-management practices reduced stress and enhance forgiveness among college undergraduates
- McColl et al. (2000)
    - Spiritual practices and beliefs frequently were used as a means of coping with loss. Participants who were more spiritual reported enhanced awareness of self, increased perception of independence, a sense of purpose in life, and greater awareness of personal mortality and vulnerability

- Riley et al. (1998)
    - individuals that were classified as religiously spiritual reported deriving the greatest degree of comfort and strength from their faith

Benefits of Spirituality on Physical Health:

- Becker, 2001
    - frequent church attendees had a 36% lower mortality rate when compared with those that did not attend church
    - church attendees more likely to stop smoking, exercise, and remain married
- Hamilton, Power, Pollard, Lee & Felton (2007)
    - Cancer survivors regarded their survival as gift from God.
    - believed that God healed their cancer and kept it from spreading, sent others to provide needed help, took away their worries, and lessened their burden from the cancer experience
- Kaufman, Anaki, Binns & Freedman (2007)
    - higher levels of spirituality and private religious practices, but not quality of life, are associated with slower progression of Alzheimer's disease
- Chen and Koenig (2006)
    - organizational and private religiousness could be a protective factor in the lives of the elderly
- Rippentrop (2005)
    - many persons with chronic pain use religious and spiritual beliefs and activities to cope with pain

- Cronan, Kaplan, Posner, Blumberg and Kozin (1989)
    - Prayer was the nonconventional pain management remedy used most often in the previous 6 months for those 382 participants
- Bill-Harvey, et al. (1989)
    - 92% African Americans in the study and 50% of Hispanics reported using prayer as a way of coping with their pain
- Abraido-Lanza, Vasquez and Echeverria (2004)
    - second most common coping strategy for Latina women with arthritic was prayer and religious beliefs or activities
- Matheis, Tulsky and Matheis (2006)
    - quality of life was highest among participants who use existential spiritual as opposed to religious spiritual coping
- Matthews (2000)
    - spiritual individuals report decreased physical and mental symptoms, pain, health concerns, depression and anxiety
- Antonovsky (1987)
    - Individuals tend to also experience enhanced physical functioning, recovering more quickly and completely from surgery and enjoying greater longevity when spirituality is vital in their life
- Powell, Shahabi and Thoresen (2003)
    - church/service attendance protects healthy people against death

The clinician may ask the client the following questions to review ways that spirituality has positively impacted his or her life.

Describe your experience when you first became a Christian:________________________

What was it about the Christian faith that interested you? __________________________

What impact do prayer, the Christian community and the Bible have in your life? ______

____

____

Can you think of specific times in your life in which your faith helped you to get by? ___

____

____

The therapist may utilize stories from the site to below to relay how faith helped one woman conquer different battles in her life. (http://www.raysdupministry.com/intro.asp). Other stories such as the ones above can be found on the website and through various media sources. Two of these stories are provided below. The previous stories were included to provide the clinician several resources as references immediately in the session.

These Stories of Hope were taken from the following website:

http://www.raysdupministry.com/intro.asp

Be Still

"Be Still and Know I am God" (Psalm 46:10)

One beautiful sunny day I was working out in my garden. Life had changed completely for me in the past few months. My entire family, totaling eleven, had moved three hundred miles away from the city to a ranch. Instead of gardeners and a big beautiful house, we were starting over with run down property and a manufactured home. Even though many would think, "What a dream come true!" Living with my husband, son and daughter and their spouses and five grandchildren was an adjustment.

Eight years prior, my family and I had a horrible accident that left my husband and me severely burned. At that time we all realized how fast our lives could change, and we began working toward living together on a ranch.

During the past eight years, I had jumped feet first into a new life as a burn survivor. As soon as I was physically able, I started working with other burn survivors to help them to be able to adjust to their new lives. I ran our local support group and spoke at burn retreats and conferences. I wrote our story, "Out of the Fire" that was published in "Today's Christian Woman" Magazine. All of these experiences have been rewarding.

I realize that whatever circumstance in which I find myself, I bloom where I am planted. That is not a bad thing to do. However, I know now, I had kept myself so busy that I did not take time to think and heal from my own loss.

That season was a piece of the puzzle of my life. As I quietly pulled the weeds in my garden, I thought back and wondered what God had in store for me now. I felt His voice ringing in my ears, saying, "Be Still, just Be and not Do." My entire life I had kept myself busy for all kinds of reasons. Do any of you relate? I loved to be productive and have accomplishments, but it also kept me from thinking about my sad past, the loneliness I felt, the rejection I experienced and the pain I had from being different with my burn scars. Keeping busy helped me avoid dealing with the unbearable times in my life.

Now, in the quiet surroundings of hundreds of acres, it was just God and me, and I was able to hear that I had to now face my past. This has been a time to be quiet and write my story to seek and see how God has used my complete life as an opportunity to glorify Him. I believe, sometimes we get stuck in certain seasons, and are reluctant to go on with the next, mainly because we do not know what is ahead of us.

We all have a story! It took moving from the busyness of my former life to this quiet valley to be still enough to hear His voice. I had been so busy helping others through their burn injuries that I did not face my own fears. I realized this one evening when I ended up in the hospital, because I could not breathe. As I laid on the gurney waiting to be seen, looking up at the lights on the ceiling brought back horrible memories. My biggest fear

was to be out of control of what was to happen to me. Tears streamed from my eyes and I begged my family not to leave me.

Thinking back of my 60 years, I know with each circumstance God has carried me, and given me opportunities to share Him with others. During many turbulent times, I have called upon Him and relied on His help. He has always been faithful. I have not always been able to thank Him for all circumstances. I now look at each one of them as another part of the puzzle that made me who I am today. I am a strong woman with confidence in my Lord, and feel honored to have been chosen to be His instrument. In Jeremiah 1:5, it says, "God knew me, God consecrated me, and God appointed me before I was even born." I never really understood that verse until now.

This year of being still has given me an opportunity to see and realize in a positive way every incident in my life has worked together for God's glory and good. As long as I walked the trials and journey hand in hand with Him, He revealed His appointed assignment for me.

My garden flourishes now and our family has settled into a wonderful life style. I have the privilege of being part of my grandchildren's lives each day watching them grow along with my flowers. We are all blooming into God's perfect plan and the lesson I have learned is to "Be Still" and listen.

You are no longer our son, and you are not welcome in our home anymore." I heard those words come out of my husband's mouth early one morning. I felt like someone had taken a knife and stabbed me in the heart. One side of me wanted to protect my youngest child, and the other was angry with my husband for saying such harsh words. I was not ready to let go of my only son. I had always made my children my life, and had tried to prepare for the empty nest when the time arrived. No one could have prepared me for this time in our lives.

We had been in this incredibly painful process for the past two years. The three of us had gone through an eight week outpatient drug therapy. At least my husband and I had. We began the program all together; but our son had dropped out, and we agreed that we would finish it no matter what he chose to do. During those sessions, we learned some tools to help us through this never-ending hell. Al-anon came next and then finally a sixty day in-patient program. We seemed to be taking one step at a time to try to help him and ourselves. The one thing parents always need to remember is a substance has taken over their child; and no matter how hard you try, you can't control it. Most of the time, your children cannot control it either. They have to want this horrible journey to end as much as you do.

On this fateful rainy morning, he had only been out of the drug center two days. After his release, we put him in a halfway house where they said, "If you use or don't follow the rules you are kicked out; no second chances!" We had received a call from the house in the wee hours of the morning letting us know he had used once again and was out. I recall both of us crying and lying in our bed. We were each in our own quiet hell not

knowing what to do next. We were grateful for all the counseling we had received during both programs. The main thing we learned was that we had to stick together in whatever decision we had made. Once more we had to do something.

Now, as my husband opened the door to our son, I heard those awful words come out of his mouth. He said them quietly and with much disappointment. I wanted to scream, “Wait we haven’t talked about this yet.” But in my soul I knew he was right. For all of our sakes, this hell had to end. We had tried everything; and the Lord had guided us to the help we had received, but now we had to turn our son completely over to the grace of God. I kissed him goodbye and watched him walk away wondering if I would ever see him again.

This energetic little boy that I spent so much time raising with his curly hair and happy smile was gone. I was grateful he was over eighteen, but the pain was like losing a child to death. Each time I went down the picture hallway of our house, I was reminded of much happier times in our lives. I mourned over his loss when I studied his face in the pictures.

Drug addiction affects each family member differently. Our older daughter was angry with him. He was ADHD and had always demanded all our attention time and energy. She had been the forgotten child; and, now, once again, she could see the pain he was creating. Being away at school, she worried for our safety, horrified with what could happen. The drug dealers knew where we lived. Many of our possessions were stolen to support his habit. This was a world of the unknown to us, and we had only heard or read about it. Now we were living in it.

Days and months passed without any contact. We prayed and prayed, and went through the motions of daily life. I went over and over in my head what we had learned through the process of treatments and attended Al-anon meeting for support. I will name a few of the important things we remembered:

1. Do not allow the “If only” to take over your thinking. I know we did the best we could for our son while raising him. NO GUILT TRIPS, it doesn’t help anyone. You did the best you knew how.
2. Make a decision and stick by it! If you say no living in this house while you are using, MEAN IT.
3. Parents need to support each other. Don’t be slipping the kid a twenty in his pocket while he’s walking out the door. You might worry about him not eating, but he won’t use it for food anyway.
4. This is not the child you raised. The words out of his or her mouth and their actions are the DRUGS talking. Be angry with that.
5. Know you cannot control this DRUG, it is too big.
6. If what you have tried does not work, do the opposite.
7. PRAY and turn them over. Something has stolen your child and you cannot stop it.

We had such good advice and I will never forget it. I will always remember the example of the pillow story. You have this adorable baby and you meet its needs and protect it from harm. While it is learning to walk, you throw a pillow down in front of him so he doesn't get hurt. They learn to ride a bike, and you still have that pillow. The question is when do we stop wanting to help our children not feel the pain of the fall? This story made so much sense to me. It is all about teaching our kids to take responsibility for their own actions and not wanting to numb the pain of their lives with drugs.

Not all stories have a happy ending but our does. God has blessed our family with keeping our son alive. He protected him when I could not. We had a very long five years of drug abuse. By the grace of God, He totally took our son and turned him around. I feel a drug-addicted person is living in a journey of hell, and our son yelled out for God to save him from that hell. God answered him and delivered him from the addiction. He gave him a heart to serve the Lord, and he is now a Pastor and works with young people in all walks of life. He has a beautiful wife and four adorable children. I had always hung on to the verse, "Raise up a child in the way of the Lord and he shall not depart from it." I claimed this verse, but now I say to others, it does not say he might not leave for a little while.

But he will return!

God's Answers to Prayers

I've been driven many times to my knees by the overwhelming conviction that I had nowhere else to go. My own wisdom, and that of all about me, seemed insufficient for the day. - Abraham Lincoln

Within a matter of minutes our lives were transferred from happy and healthy to sad and hopeless. My husband and I barely survived a horrendous motor home accident that would change our lives forever. The first week I was in a drug-induced fog, on the live or die list with a shattered back and 48% of my body burned. My husband was 68% burned, and in a coma two rooms from my own with a nine-percent chance of living.

During my two-month stay I had many skin grafts and a surgery to fuse my back. I would lie in the hospital wondering how I was ever going to be able to care for myself again, let alone care for him. I prayed for God to send someone to help me when I was released.

He sent my niece, Vikki, a home health aide, to be with me twenty-four hours a day for the next five months while my husband remained in the hospital. When she first came to live with me, we were not close, but because of her expertise in nursing and my need for her help, our relationship created an everlasting bond.

In the beginning, I was learning to do the simplest of human chores, like walking and eating, so there were many other caregivers in and out of our home too. Each morning, a nurse came to change my bandages, which took two hours. In the afternoon, a physical therapist arrived. There were usually five or six people in the house to help out. There

was heaps of laundry each day and good meals, which were usually provided by the neighbors. There were appointments to make and keep; and a lot of therapy and exercise to do on our own.

In the midst of it all, Vikki was my protector, mentor, and healer.

I had weekly burn doctor appointments and weekly back doctor visits that usually took two to three hours because of full doctors' offices. Vikki taught me how to solve this problem. She put me in the wheel chair, puffed a little powder on my face and told me to drool, as if I didn't look pathetic enough already! It seemed to work, because they started taking me right in. Through it all, we laughed a lot, and Vikki kept everything going, thank God.

Every fear I had in my life reoccurred with the trauma of this accident, so she not only had to deal with my physical injuries but also my psychological needs. I was such a mess. She taught me to be strong and wouldn't allow others around me to baby me. She taught me to do things for myself again and many times had to say, "JUST DO IT". I couldn't believe her persistence and perseverance. She taught me well that love must be tough, and I remember not liking her many times because she made me do things that hurt. At times, other family members seemed jealous of our relationship. We shared the pain, tears, and sense of humor that it took for me to recover. I trusted the Lord to send me the right person to help me through this experience, and He definitely did.

While all of this was going on at home, my husband was still in the hospital.

It took two months for him to wake up from the coma, and more months to be in recovery. He had fifteen fractures of his head and lost four fingers of his left hand, his left eye and the left side of his face. I knew how hard and painful it was learning to take care of myself, and I knew he would have to go through the same process. I longed for the day I could help him. It took nine months for me to be able to be his caregiver. Thanks to my niece, I was able to take care of myself, so we no longer needed a caregiver living with us when he came home from the hospital. He was declared legally blind and at first I was very frightened to be on our own. Vikki had taught me how to help him by making him realize that he is a survivor, not a victim. It was so difficult to watch him struggle learning to dress himself and putting on his shoes with one hand. At times, I felt more like his mother than his wife, and I had little patience. Every movement seemed to be in slow motion. When I felt like giving up I would tap into all the kindness but firmness my Vikki had taught me. He had to learn to do things for himself again, and many times I had to say, "JUST DO IT." I couldn't believe MY persistence and perseverance.

By the grace of God we made it through those challenging eight years of healing and rebuilding and we are closer than ever before. We wear our scars as badges of courage and are proud to tell our success story.

My husband often shares how he, too, had laid in the hospital praying that God would send the right person to help him. Then he kisses my cheek and says, "He did, He sent me you."

B. Thoughts influence feelings

In the cognitive-behavioral model, focus is geared towards thoughts, feelings and behaviors (Beck et al., 1979). The model states that an event happens which causes the person to have a particular thought, the thought then leads to an emotion, which ultimately leads to a behavior. For instance, suppose a student is anxious about giving a presentation in class. The presentation starts and the student subsequently observes someone laughing quietly during the presentation (the event). The individual may think to self "I am such an idiot and I knew I was going to sound stupid" (the thought). The resulting emotions from this thought may include sadness, frustration, and/or embarrassment, which could potentially lead to the person retreating to another room after class and crying (behavior). It is evident in this situation how the thought produced a feeling. In this example, the individual developed a negative thought and feel cycle. The same can happen in a positive direction. For instance, an individual might be driving to work and receive a text message from a friend who states "just thinking about you" (event). As a result, the person may have a thought such as, "wow she is a great friend and I really matter to her" (thought). After this thought, the person may experience feelings of happiness or joy. This is an example of the positive cycle of thinking and feeling.

Ask the client to identify ways that thoughts have influenced feelings in his or her life.

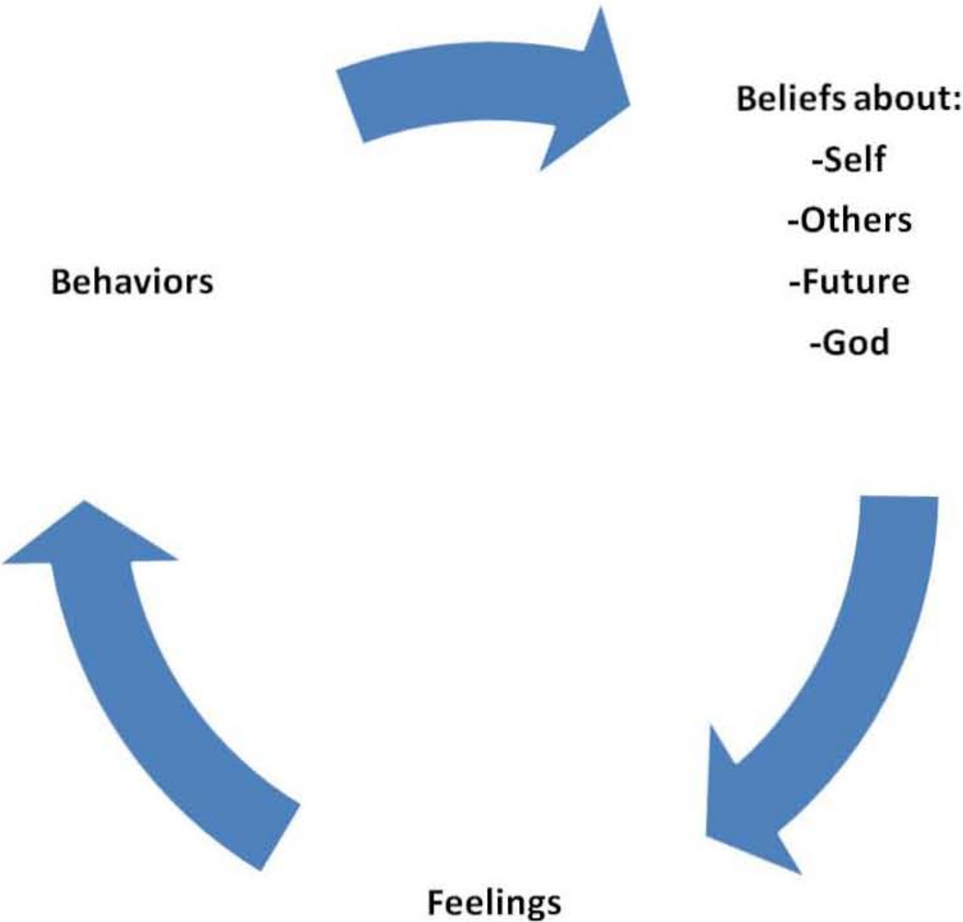
Negative cycle:

Positive cycle:

C. Diagram of beliefs/thoughts directly influencing feelings and behaviors

At times it is helpful for individuals to review a visual representation of the theory and concepts at work. The clinician may show this diagram while explaining the cycles in part B or wait to present the diagram afterwards. The therapist should ensure that the client is able to understand the nature of the diagram and ways that the cycle can be both positive and negative in nature. This diagram can be referred throughout treatment to make certain that the client has gained a thorough understanding of the impact of thoughts on feelings and behaviors. The therapist should have the client fill in parts of the diagram that are applicable to his or her personal life in order to achieve an understanding of the cycle.

Diagram of ways that thoughts directly influence feelings and behaviors



D. Negative spiritual coping can lead to negative beliefs in life

Just as negative thoughts about one's daily life can lead to negative feelings, negative spiritual coping can lead to negative beliefs that carry over in one's life and may result in negative feelings. Examples of negative spiritual coping include: having a negative view of God, being selective when looking at the Bible, holding oneself to impossible standards, experiencing difficulties with forgiveness of self and others, and engaging in other spiritual practices that may place additional stress and demands on one's life. Throughout treatment, the therapist will assess the spiritual coping styles and beliefs of the individual and work to modify any negative coping strategies or beliefs. The therapist should gain an understanding of ways the client utilizes his or her faith to help cope with situations.

The clinician may ask the following questions to gain a better understanding of the client in this particular area:

Spiritual Coping Strategies:

How often do you pray and what are your prayers usually about? ____________________

Do you have certain rules about how you should pray or how often?__________________

Do you read the Bible, and if so, are you presently focusing on certain books or themes?____

Are there any scripture passages or parables that help you in your daily living?

____

____

Are there any biblical passages that place additional demands, stress, or worry in your life? ____

Do you place rules on how often you should read the Bible?______________________

____

____

How does God feel about you? ____

____

____

How do you think God views your life?_______________________________________

____

____

E. Interventions to alter the cycle

The main interventions from this manual that will be employed to alter this cycle are behavioral, cognitive, factors of surrender and control, meditation, guided imagery, relaxation and musical selections.

Behavioral strategies: The therapist and the client will focus on the behaviors that are related to depression (sleeping, eating, sex, and physical illness). Then the therapist and the client will create an individualized behavioral plan that focuses on doing more (increasing spiritual and religious behaviors), being more (enhancing inward spirituality) and doing less (decreasing spiritually inconsistent behaviors). This will be established through goal setting, self-monitoring, a rewards system, shaping and stimulus control. These strategies will be explained and explored in session three.

Cognitive strategies: The therapist and the client will discuss the beliefs of the client in various areas of life. If it is evident that the client holds certain negative beliefs or cognitions about various facets of his or her life, the therapist and client will further examine these convictions. Spiritually-informed cognitive-behavioral strategies will be applied to challenge and confront the client's beliefs through Socratic questioning and the study of biblical passages that challenge the unhealthy cognitions. Biblical passages will also be utilized to help the client restructure thinking and incorporate new counterstatements upon the occurrence of negative thoughts. The therapist and client will also look at the cognitive quadrant, which encompasses beliefs regarding self, others, the future and God. These areas will be explored and challenged through the same process that was described above. These cognitive interventions will be explored in sessions five through eight.

Surrender and Control/Guided Imagery: The therapist and the client will review the cognitive quadrant and the client's view of God. The therapist and the client will discuss references in the Bible that profess the loving nature of God. The serenity prayer will be evaluated in conjunction with a discussion of surrender and control regarding the problems in the client's life. Collaboratively, the therapist and the client will review ways to adopt these strategies in personal life situations and examine the impact that these changes may present on the client's emotional well being. A guided imagery exercise will be administered by the therapist to focus on releasing the burdens of the client into God's hands. These interventions will be explored in greater detail during session seven.

Christian meditation/Guided Imagery: The therapist and client will continue to explore the images of God as held by the client. This will be followed by a discussion of

Christian meditation processes and ways they allow the client to focus on the moment. The therapist will impart the different forms of meditation, including breathing exercises, visualizations and visual meditation. A review of the guided imagery interventions which were introduced during session nine will also be presented by the clinician. The process of meditation will be further explored in session ten.

Relaxation and Music: Relaxation and music are additional techniques that may help the client focus on the important and positive messages in life. The therapist will teach the client relaxation exercises (breathing, progressive muscle relaxation) in the session while stressing the release of control during these exercises and giving any concerns to God. During the exercises, the therapist will review religious coping statements and focus on biblical verses that promote relaxation within the client. The therapist and client will also explore the ways that music may impart a positive impact on treatment. These elements will be explored in greater detail during session eleven.

3. Assign homework and optional prayer

The therapist will ask the client to complete the activity monitoring schedule that is found in Appendix F. Beck et al. (1979) recommends for the client to engage in activity scheduling as a homework assignment at the beginning of treatment and over the course treatment. Activity scheduling allows for the client to obtain "objective data about his/her present level of functioning" (Beck et el., p.106, 1979). The client will write down the engaged activities every hour during the following week. In addition, the client will be asked to rank both the levels of enjoyment and depression during the activity on a 0 to 5 Likert scale. The specifications regarding this scale are listed on the form in Appendix F. The therapist will allow the client to ask questions about this form and explain that it

will be explored in greater detail during the following session. The therapist will also express that it is important to track the events of the client to determine those activities which lead to enjoyment during the week and to assess which activities may account for higher levels of depression.

The clinician may incorporate prayer into the session. For each session until termination, this manual will include an optional prayer at the end of the session. The therapist does not have to use this optional prayer, or may utilize the prayer at another point in the session if it is more appropriate. Prayer is an important element of spirituality and faith. By including prayer in treatment, the clinician will model an effective spiritual intervention that will assist the individual in his or her spiritual walk as well as facilitate the regulation of emotions.

<u>Prayer for Session Two:</u>

"Heavenly Father, thank you for bringing _________ to this place. Lord, I pray that you are present throughout these sessions and throughout the work that we will be embarking on together. Help guide ____ and may he/she seek you and feel your love and guidance. Lord, help ____ to turn to you in his/her times of need and to recognize your promise, that if we call on You, You would answer and show us great and mighty things that we did not know. Lord thank you for all the things you continue to bless us with in our lives and help us to continue to reflect on your abundant love throughout the week. All these things I pray in Jesus' name. Amen."

SESSION THREE

The main focus of session three centers on the behavioral strategies that were briefly reviewed in session two. The client was assigned to complete an activity sheet for homework during the previous session. This activity sheet will help to establish baseline data regarding the daily activities of the client. In addition, it should reveal to the client that symptoms of depression are not experienced throughout the entire day. The activity sheet will highlight and permit further evaluation of those behaviors that seem to make the depression increase as opposed to others that help to alleviate feelings of depression from time to time (Beck et al.,1979). The therapist will work with the client to create a behavioral plan that focuses on doing more.

Capsulation

1. Set the agenda and review homework
2. Discuss behaviors related to depression
3. Create a behavioral plan
    A. Doing more
        I. Goal setting
        II. Self-monitoring
        III. Rewards
4. Assign homework and optional prayer

1. Set the agenda and review homework

At the beginning of the session, the therapist and the client will review the items that will be included in the session. The therapist will make suggestions based on the different elements of this protocol. It is essential for the client to work with the therapist

in setting the agenda in order to make treatment a collaborative process from the beginning. The client is given the opportunity to propose additional items that may be included on the agenda that are in agreement with the therapeutic goals for the session.

The therapist will review the homework assignment from the previous session and answer any questions from that the client regarding treatment. The therapist will explain the reasons behind completing the activity schedule. The activity schedule gives the therapist a baseline of the weekly behaviors of the client throughout the week. In addition, the activity schedule helps the client and the therapist to see that the client is not feeling depressed throughout the entire day. There are certain times of the day in which the client engages in enjoyable activities. On the other hand, there are other times throughout the day where the client partakes in behaviors that are not pleasurable and may subsequently increase the depressive levels. The goal of this session is to look at these behaviors and increase those behaviors that promote pleasure in the client's life and decrease or eliminate those behaviors that may feed into the depression.

2. Discuss behaviors related to depression

During the initial session, the therapist educated the client about various behaviors related to depression (Beck et al., 1979). The therapist will review these behaviors once again, as behavioral strategies are the focus of the session. The therapist will also revisit the answers to the depression symptoms inventory that was completed in session one and also review those questions listed in the following sections in order to gain an accurate assessment of the behavioral symptoms.

Depressed individuals usually experience the following behavioral symptoms:

- Problems with sleep
  - Too little
  - Too much
  - Early rising
  - Difficulties getting to sleep
  - Difficulties staying asleep

  Do you have any of these problems?

  How do these problems have an impact on your mood/depression levels?

  How was your sleep pre-depression?

  How would you like this to change?

- Problems with appetite
  - Eating too little
  - Eating too much
  - Not eating healthy foods
  - Eating out of boredom
  - May result in weight gain or weight loss

  Are you experiencing any of these problems?

What ways are these problems related to your mood/depression levels?

How was your appetite pre-depression?

How would you like this to change?

- Problems with social patterns
  - Isolation
  - Avoiding friends/spending time alone
  - Not going out
  - Experiencing less enjoyment with these friendships

  Are any of these problems apparent in your life?

  What ways are these problems related to your mood/depression levels?

  What did your social life look like pre-depression?

  How would you like this to change?

- Physical illness
  - Immune system lower than usual
  - Increased sickness/illness
  - Fatigue/lack of energy

  - Difficulties getting started

Do you experience difficulties with any of these problems listed?

What ways are these problems related to your mood/depression levels?

How healthy were you pre-depression?

How would you like this to change?

- Problems with sex drive (if applicable)
  - Decreased sex drive
  - Does not appear to be important in your relationship
  - Loss of interest in sexual activities
  - Absence of sexual activity

Are you experiencing any of these problems?

What ways are these problems related to you mood/depression levels?

How was your sex drive pre-depression?

How would you like this to change?

- Problems in spiritual life
    - Decrease in prayer time
    - Decrease in devotions
    - Decrease in bible study
    - Decrease in church attendance

    Are there any problems in these areas in your life?

    What ways are these problems related to your mood/depression levels?

    How was your spiritual life pre-depression?

    How would you like this to change?

3. Behavioral plan to address depressive behavioral symptoms

After the depressive behavioral symptoms are gathered, the therapist and the client can work together to create a behavioral plan that will focus on increasing pleasurable activities and decreasing activities that contribute to the depression. This can be established by focusing on three different themes: doing more, being more and doing less.

A. Doing more- This involves increasing those behaviors that provide fulfillment and enjoyment to one's life. This may also include enhancement of the spiritual and religious behaviors of the individual. As this manual was specifically addressed to incorporate spirituality in treatment, it is necessary to assess this domain throughout every process of

the treatment protocol. Most likely, the client would like to see behavioral changes in this area of life. These spiritual behaviors include prayer, devotional time, bible study, and social events. The therapist has already gathered data concerning the client's current baseline behaviors. Now is the time to collect information regarding new areas of interest to the client, as opposed to those currently engaged activities. This may be accomplished by asking the following questions:

Doing More Questions

What activities do you enjoy?____

Do you have any special interests or hobbies?_________________________________

____

What activities would you like to be doing more of?____________________________

In regards to your spiritual activities, are there any areas that you would like to be doing more? (Prayer, devotion, bible study, church attendance, social events, etc.)___________

____

____

Any other areas you would like to explore?___________________________________

____

____

I. Goal setting

The therapist and the client can now evaluate the client's response to the above questions and work towards setting specific measurable goals for doing more. The client has been stuck in a way of living for some time and it may take additional time to move

forward. Thus, it is important that the goals are mutually agreed upon, measurable and allow room for the client to grow.

Goals for Doing More

Goal #1:

Goal #2:

Goal #3:

Goal #4:

II. Self-monitoring

To measure one's progress and work towards the established goals, it is necessary to create a self-monitoring procedure. The type of self-monitoring procedure is dependent upon the mutually agreed upon goals that were established between the clinician and the client. For instance, if the client has decided to increase prayer time, this could be monitored on a checklist or in a journal. The therapist and the client will collaborate and determine the best way to track the various behaviors and goals that were set for the individual. Appendix F includes the activity monitoring sheet that can be used. Appendix G provides a weekly checklist that the client may complete to track the progress of behaviors towards the goal.

The goal may be modified, if need be, as the individual works towards reaching it. Also, if the individual experiences difficulties reaching the goal, the clinician may revise

the goal in an effort to make it more achievable. It is important to move in a graded or stepwise fashion. This allows the client to set smaller goals that are more readily attainable, facilitating a sense of accomplishment while striving towards the goal.

III. Rewards

Establishing rewards is an important component of the behavioral plan. Rewards keep motivation levels high and remind the client that progress is being made with the completion of each small achievement. These rewards may vary per individual. They should be chosen from a those items or activities of personal value which also provide pleasure to the client. The rewards should enable easy, quick and immediate self-administration by the individual undergoing treatment upon successful completion of the assigned behavior. For instance, if the client wishes to engage in a daily prayer time, a reward that may be implemented for completing this behavior might be a cup of coffee once prayer time has completed. The individual is able to self-administer this reward immediately after the behavior is achieved.

Potential Rewards

____ Reading	____ Playing a game	____ Exercise
____ Writing	____ Talking to a friend	____ Take a walk
____ Music	____ The Internet	____ Enjoy nature
____ Coffee/Hot Drink	____ Knitting	____ Baking
____ Bath	____ Gardening	____ Enjoy a snack
____ Watch a movie	____ TV	____ Any fun activity

4. Homework and optional prayer

The therapist will ask the client to implement the behavioral strategy that was created in this session. This will include self-monitoring the progress towards the goals and following through with the rewards when earned. Appendix G includes a daily checklist that the client can utilize. The client can mark whether he or she completed those behavioral goals that were established. The therapist will explain that it is important to follow the behavioral plan to increase those enjoyable behaviors and to decrease those behaviors that do not assist in the reduction of depression. The goal in the behavioral plan will be working towards a decline in depressive symptoms.

The clinician may incorporate prayer into the session. The therapist does not have to use this optional prayer or may utilize the prayer at another point in the session if it is more appropriate. Prayer is an important element of spirituality and faith. By including prayer in treatment, the clinician will model an effective spiritual intervention that will assist the individual in his or her spiritual walk and help to regulate emotions.

Session Three Prayer:

"Father, we know that You know the stressors, pains and hurts that we face every day in our lives. We ask this week that you help us to focus on our behaviors. Help us to look at those things that we need to do less of, those things that we want to do more of, and help us lastly and not least to be more. Help ______to keep his/her eyes not on the problems or the stressful situations, but upon You and Your mercy and grace. Father, we cannot change the situations that cause stress in our lives but we know that You can. Lord help our hearts to be humble and open to you throughout all the struggles and rocky times in our lives. I ask that you give ___________ Your strength to stand and face these

struggles, for we know that at times we need to be held and loved by you. Guide ______ throughout the week and keep him/her in your care. In the name of Jesus, Amen."

SESSION FOUR

This session will discuss two other techniques for doing more: shaping and stimulus control. In addition, the session will focus on the concepts of being more and doing less. The therapist will begin the session by reviewing the homework that was assigned the previous week. The therapist will devise ways the client can work towards incorporating various strategies to adapt these new behavioral patterns in the client's life.

Capsulation

1. Set the agenda and review homework.
2. Review behavioral concepts
    - A. Doing more
        - I. Shaping
        - II. Stimulus control
    - B. Being more
    - C. Doing less
        - I. Bitterness and problems with forgiveness
        - II. Overindulgence
3. Homework and optional prayer

1. Set the agenda and review homework

At the beginning of the session, the therapist and the client will review the items that will be included in the session. The therapist will make suggestions based on the different elements of this protocol. It is essential for the client to work with the therapist in setting the agenda in order to make treatment a collaborative process from the

beginning. The client is given the opportunity to propose additional items that may be included on the agenda that are in agreement with the therapeutic goals for the session.

The therapist will review the homework assignment from the previous session and answer any questions from the client regarding treatment. The behavioral plan created at the last session will be reviewed followed by a discussion with the client regarding any noted progress or problems. The behavioral plan will be modified as needed. The client will also share any successes with the therapist in an effort to reinforce the gains that the client has achieved and encourage the client to continue to implement the procedures throughout treatment.

2. Review behavioral concepts

The concept of doing more was explained in session three. In this session, the therapist will teach the client two other techniques, shaping and stimulus control. The session will also explore two other concepts: being more and doing less.

A. Doing more

I. Shaping

The process of shaping involves creating a series of steps to follow to carry out a certain behavior. Shaping may include rewards upon the successful completion of each step or successive approximations of the behavior. In this section, the sole focus is on breaking down a behavior into several small parts. Here is an example of a shaping procedure which can be applied for an individual who is working towards increasing current levels of activity. A shaping procedure might involve a step-wise approach to establishing a daily walk regimen. This first step involves packing suitable walking clothes the night before. Next, the individual changes into these walking clothes before

returning home. Once home, the individual drops off the work items. The actual walk activity on a pre-established route comes next. Finally, upon returning from the walk, the individual will sit in a chair and drink a glass of water. At first, the individual will mindfully attend to each step in the behavioral chain. Eventually the steps will become natural, as the individual will no longer need to think about each step and is able to carry out the desired behaviors without any prompting.

Shaping Procedure

Desired Behavior:

Steps to complete behavior:

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

II. Stimulus control

Stimulus control deals with the environment where one is trying to carry out the behavior. It involves decreasing any sort of distractions and creating an environment that is conducive to the successful completion of the desired behavior. For instance, an individual who wishes to increase devotional time and has a family with young children may need to utilize stimulus control for achieving this goal. This individual may decide to work towards establishing a time for bible study when the children are not present or sleeping. The individual may decide to conduct bible study in the morning before anyone else has awakened. This will provide a peaceful environment. Additionally, the individual may choose a chair that is comfortable and lighting that will facilitate the successful performance of the behavior. By eliminating any distractions and increasing the comfort levels, the person is creating a peaceful and relaxing environment for executing the behavior.

Potential distractions to remove/account for:

Ways to increase likelihood of performing the behavior:

B. Being more

The notion of being more involves more than the eye can see. Being more implies that one is working towards enhancing inward spirituality. It requires that the individual enters a state of inner reflection by contemplating the desired outcome of the spiritual walk. Being more also entails working towards the incorporation of scriptural messages and passages into the client's daily living. This is a process that should be utilized throughout the life of the person. The person should strive to continually reflect upon the personal spiritual walk, acknowledge growth, and identify other areas that require further development and growth.

Inward Spiritual Growth

How have I seen myself grow in my spiritual walk?_______________________________

____

____

Is spiritual growth important in my life?____

____

____

In what ways am I working towards inward spiritual growth? _______________________

____

____

What supports do I have in my life to help in this area?_____________________________

____

C. Doing less

Doing less focuses on decreasing behaviors that feed into the depression, as well as decreasing behaviors that are spiritually inconsistent. It may be difficult for individuals to identify the behaviors that are spiritually inconsistent. Three major themes are bitterness, problems with forgiveness and overindulgence. These factors impede spiritual growth and development and reinforces the negativity of the individual.

Doing Less Questions:

Can you identify certain behavioral excesses that may contribute to your depression? ___

____

____

Is bitterness a problem area in your life?__________________________________

____

____

Do you feel unforgiveness is a problem in your life?_________________________

____

____

Is overindulgence a problem for you?______________________________________

____

____

I. Bitterness and problems with unforgiveness

Bitterness and difficulties with forgiveness are two elements that may impede spiritual growth. One cannot be spiritually fulfilled and emotionally free when holding onto these two emotions. Bitterness and difficulties with unforgiveness can be addressed by exploring the sources of these emotions. Upon assisting the individual to get these feelings out into the open, the therapist can then examine how they are controlling the individual. It should be stressed to the client the need to release bitterness and any barriers to forgiveness by handing over these emotions and situations to God. The individual will review ways that bitterness and unforgiveness run contrary to the objective of the spiritual walk. The therapist should stress that maintaining an unforgiving demeanor may hinder the spiritual growth of the individual. The person will gradually begin to decrease the levels of bitterness and learn ways of forgiveness, which will allow for continued spiritual development. The therapist may share the following scriptural passages with the individual to attach biblical truth to this concept.

In the Lord's prayer it states "And forgive us our trespasses, as we forgive those who trespass against us."

Do not let any unwholesome talk come out of your mouths, but only what is helpful for building others up according to their needs, that it may benefit those who listen. And do not grieve the Holy Spirit of God, with whom you were sealed for the day of redemption. Get rid of all bitterness, rage and anger, brawling and slander, along with every form of malice. Be kind and compassionate to one another, forgiving each other, just as in Christ God forgave you. (Ephesians 4:29-32)

In addition, it is important to note the physiological responses and effects of unforgiveness. The clinician may share this impact with the client. There are two hypotheses that are relevant to the notion of forgiveness and unforgiveness that may be related to physical health and disease. The hypotheses are as follows:

1. Unforgiveness is associated with health risks
2. Positive states that are characteristic of forgiveness have benefits beyond those associated with the reduction of unforgiveness (Harris & Thoresen, 2005).

Hypothesis 1: There are physiological, psychological, behavioral and social areas in which unforgiveness may impact health (Harris & Thoresen, 2005). Unforgiveness causes health problems that are similar to other chronic stress responses. In addition, unforgiveness is the experience of emotions that are already linked to health risks. For instance, anger, hostility, fear and blame have been associated with health and disease outcomes (Harris & Thoresen, 2005). Also, behaviors associated with unforgiveness may cause health problems. The intense and chronic experience of emotions may lead to hyperarousal in the autonomic nervous system and wear and tear associated with increased allostatic load (Harris & Thoresen, 2005). Unforgiveness could also initiate aggressive acts of isolation which are linked to additional health risks.

Hypothesis 2: There is research that suggests the positive effects of forgiveness on health. A forgiving attitude creates a direct positive impact on the immune system, the value of emotional experiences, psychological well-being, mood, and the elicitation of social support (Harris & Thoresen, 2005).

The therapist may utilize the following prompts to assess the client's levels of bitterness/unforgiveness and the impact these factors may have in the client's life.

Describe your source of bitterness or unforgiveness:

What ways have these feelings impacted or taken control of your life?

How do these feelings have an impact on your spiritual growth?

II. Overindulgence

Overindulgence occurs when an individual is focused on behaviors that are inconsistent with spiritual growth. These behaviors are usually addictive in nature. These behaviors may include drinking, impulsive spending, drugs, and pornography. Individuals must displace addictive behaviors while enhancing and replacing it with spirituality (Martin & Booth, 1999). By refocusing on spirituality, the individual will work towards strengthening religious faith and reducing the addictive behaviors.

Are there any overindulgent behaviors/addictive behaviors in your life?______________

____

____

What spiritual behaviors might replace these unhealthy behaviors?__________________

____

____

<u>3. Assign homework and optional prayer</u>

The therapist and the client will work to add components as needed to the behavioral plan created in session three. The client will also focus on being more and the development of spiritual identity. The individual will continue to work towards doing less regarding behaviors that are spiritually inconsistent and feed into the depressive state. The therapist will stress the importance of following this behavioral plan to increase those behaviors that are enjoyable and decrease behaviors that aggravate the depressive state.

The clinician may incorporate prayer into the session. The therapist may choose to use this optional prayer following at the conclusion of this session or may utilize the prayer at another point in treatment if it is more appropriate. Prayer is an important element of spirituality and faith. By including prayer in treatment, the clinician will model an effective spiritual intervention that will assist the individual in his or her spiritual walk and also assist with the regulation of emotions.

<u>Session Four Prayer:</u>

"Lord be with _________ as he/she continues to battle with feelings of sadness from time to time. We ask that you look after ______________ and help him/her to recognize those behaviors that cause his/her depression to grow and replace these behaviors with ones that will allow __________________ to move forward in a positive direction in his/her life. We recognize the care and provision that you give to all of us and I ask that you help

_______________ to develop new ways to cope and to focus on doing more, being more and doing less. Help ____________ to do those things that will lift his/her mind, to seek internal spiritual growth and to eliminate those behaviors that may draw focus off of You. We thank you for your continued love and guidance and praise You for all the wondrous things you have provided us day in and day out. All these things I pray in Jesus' name, Amen."

SESSION FIVE

Session five is the first of four sessions with a focus upon the cognitive interventions. The therapist will begin to educate the client about the impact of cognitions on depression. A review of the cognitive-behavioral model will also be presented to the client. This session will examine ways that different spiritual interventions can be utilized in conjunction with the cognitive-behavioral model.

Capsulation

1. Set the agenda and review homework
2. Review cognitions that are related to depression
3. Explanation of the cognitive-behavioral model
    A. Connection to thoughts and feelings
    B. Ways spirituality can be incorporated to challenge cognitions
    C. Develop an awareness of the thinking pattern
    D. Connecting current beliefs to the past
4. Assign homework and optional prayer

1. Set the agenda and review homework

At the beginning of the session, the therapist and the client will review the items that will be included in the session. The therapist will make suggestions based upon the different elements of this protocol. It is essential for the client to work with the therapist in setting the agenda in order to make treatment a collaborative process from the beginning. The client is given the opportunity to propose additional items that may be included on the agenda that are in agreement with the therapeutic goals for the session.

The therapist will review the homework assignment from the previous session and answer any questions from the client regarding treatment. The behavioral plan that was created during the last session will be examined followed by a discussion with the client concerning any noted progress or problems. The behavioral plan will be modified as needed. The client will also share any successes with the therapist to reinforce the gains that the client has made and to encourage the client to continue to implement the procedures throughout treatment.

2. Review cognitions related to depression

The therapist will review with the client those cognitions previously discussed in session one during the depression symptom questionnaire. The therapist will briefly explain that these cognitions are automatic in nature and help to maintain the depression (Beck et al.,1979). It is essential for the client to understand the importance of examining these thoughts and how this process is an important step in the process of therapy. The clinician will explain that the next four sessions will be devoted to looking at the thought processes of the individual and examining ways that these thoughts are related to depression. The following four sessions will also utilize interventions to challenge these thoughts and derive new counterstatements to help the individual to appropriately deal with them as they occur.

3. Explanation of the cognitive-behavioral model

The main focus of the treatment is the individual's thoughts, feelings and behaviors. These three parts work together in most activities. Refer to the chart that was shown in session two to help explain the process to the client. The individual often has different thoughts, feelings and behaviors regarding life and spiritual practices. These

three elements may pose a positive or negative factor for the emotional well-being of the individual.

Positive thoughts lead to positive behaviors and feelings. Negative thoughts lead to negative behaviors and emotions. The therapist may provide examples of the client's thought processes from information gathered during the first four sessions. This will help the client see the cognitive-behavioral theory from the perspective of the client's life.

A. Connection to thoughts and feelings

Individuals typically do not reflect upon their thought processes. They tend to come to therapy for many different reasons, but most do not state that it is related to their thoughts. Many individuals may discuss their feelings or behaviors immediately, but not their thought processes. The therapist will explain that thoughts bring about many emotions. The inward messages told by the client to oneself in times of deep despair should be identified and explored. The therapist will show the client ways that thought processes are related to feelings and how these feelings are also related to behaviors (Beck et al., 1979). The client should begin to see how cognitions play a big role in current levels of depression.

Depression Cognitions

Lately, when I am feeling sad I find myself saying________________________________

At times, when I am feeling sad I think ____

Other times I find myself saying I am____

When I have these thoughts about myself or my life I start to feel___________________

When I begin to feel this way I____

B. Ways spirituality can be incorporated to challenge cognitions

Spiritually-informed cognitive-behavioral therapy works to change negative thoughts. One must work to change the downward spiral to an upward one. This is achieved through the use of scripture, prayer, biblical meditation, and spiritually directed relaxation. The clinician will utilize these spiritual interventions to help the client through emotional difficulties. This spiritual focus will allow the client to see Christ as the healer. A variety of interventions will be employed to assist the client in feeling the presence of Christ during times of need.

Spiritually-informed cognitive-behavioral therapy also requires the individual to look at the cognitive quadrant. This cognitive quadrant is to very similar to Beck's cognitive triad with one additional component; God. The cognitive quadrant involves the way the individual views self, others and the world, the future, and God. If these beliefs are irrational or negative, treatment will focus on providing biblical truths and spiritual knowledge to challenge these beliefs and create new adaptive beliefs for the individual. The clinician will inform the client that these specific interventions will be covered in detail throughout the remaining sessions. The therapist should indicate that the focus of this session is to explain the process of spiritually-informed cognitive-behavioral therapy and have the client begin to recognize the necessary components of change.

C. Develop an awareness of the thinking pattern

Becoming aware of one's cognitions and thought processes can be a difficult process. Some theorists refer to our thoughts as automatic, as we have thoughts continuously throughout the day and do not actively attend to these thoughts. Awareness of one's cognitions is the first step in spiritually-informed cognitive-behavioral therapy.

In an effort to recognize thoughts, the client will be instructed to stop at the moment when a change in affect is noted and immediately attend to the cognitions (Beck et al., 1979). The individual may adopt a certain statement to ask at that moment, such as “what was I just thinking?”

D. Connecting current beliefs to the past

Most of the thoughts that we have today are a result of our life experiences and the different messages that we received growing up. These messages and the rules that were passed along during our development are referred to as schema. Schema are the “related set of beliefs serving as a framework” for one’s life (Gilson & Freeman, 1999). As with automatic thoughts, individuals are usually not aware of their personal schemas. Schemas are mostly permanent in nature, but can be modified if the schema is no longer valid for the individual. It is difficult to modify schemas as the individual may have lived with a particular schema for the entirety of his or her lifetime.

The therapist will work to establish a connection between the client’s current beliefs and ways that they are related to past events. The clinician may begin this process by focusing on past events or by asking the individual to identify when these beliefs and feelings were initiated. It may take the individual some time to recognize the event of significance. When discussing these past events, different emotional patterns will be noted and strong feelings may be elicited as a result. The therapist will work with the client to identify these past emotional targets. While these events will be addressed as therapy progresses, it is imperative for the individual to first identify the source in order to recognize ways that the past is related to the current personal beliefs and convictions.

List family rules of behavior or messages that you received as you were growing up:

1.
2.
3.
4.

Do these same rules still apply to your life?

Have you adopted any other rules for your life or ways you "should" behave?

4. Assign homework and optional prayer

The therapist will instruct the client to fill out the cognition log that is included in Appendix H. Specifically, the client will be asked to notice when a change in affect, whether positive to negative or negative to positive, is encountered. During that moment, the client will be instructed to attend to that cognition and ask "What was I just thinking?" and then record the thought on the cognition log (Beck et al., 1979). The therapist will explain the importance of noting these cognitions and becoming aware of

the thinking process. This is the first component of the cognitive process in spiritually-informed cognitive-behavioral therapy.

The clinician may incorporate prayer into the session. The therapist may use this optional prayer at the conclusion of this session or at another time during treatment if it is more appropriate. Prayer is an important element of spirituality and faith. By including prayer in treatment, the clinician will model an effective spiritual intervention that will assist the individual in his or her spiritual walk and also help to regulate emotions.

<u>Prayer for Session Five:</u>

"Lord, we ask throughout the week that you will be with ______ and guide him/her throughout the week. Help him/her to see and hear those messages and rules that play out in their lives. Sometimes, Lord, it's so hard to see and hear these rules. We squint and struggle to make sense of what you're showing us, but at times are not able to focus on You and Your message. Help us know when you are guiding us, Lord, and when we are turning down the wrong pathway. Help us to recognize times when we are harming ourselves with destructive messages and allow us to remember your kind and loving words. Thank you for supporting us throughout this process and for your unending love and care. In Jesus' name. Amen."

SESSION SIX

Session six will continue to focus on the cognitive strategies of spiritually-informed cognitive-behavioral therapy. The therapist will review the cognition log from the client's homework for the previous session. This will be followed by an examination of the various cognitive distortions that have been identified, followed by a discussion to determine whether they are evident in the client's thinking processes. The therapist will look at ways to combat these cognitive distortions through spiritual interventions using biblical passages, surrendering to God and prayer. The client's spiritually-informed dysfunctional thought record will then be discussed. In addition, the therapist will review the spiritual interventions in the session to help the client recognize ways these interventions can be utilized outside of the therapy session.

Capsulation

1. Set the agenda and review homework
2. Review cognitive distortions
3. Spiritual interventions that challenge cognitive distortions
    - A. Biblical passages
    - B. Surrendering to God
    - C. Prayer
4. Review the spiritually-informed cognitive-behavioral dysfunctional thought record
5. Assign homework and optional prayer

1. Set the agenda and review homework

At the beginning of the session, the therapist and the client will review the items that will be included in the session. The therapist will make suggestions based on the different elements of this protocol. It is essential for the client to work with the therapist in setting the agenda in order to make treatment a collaborative process from the beginning. The client is given the opportunity to propose additional items that may be included on the agenda that are in agreement with the therapeutic goals for the session.

The therapist will review the homework assignment from the previous session and answer any questions from the client regarding treatment. This will be followed by an examination of the cognition log that was completed by the client. The therapist will inform the client that these cognitions will be further explored in the course of the session and the client will learn several spiritually-informed cognitive-behavioral interventions to challenge these negative cognitions. The client will be provided with time to ask any questions related to this matter.

2. Review cognitive distortions

The therapist will inform the client about cognitive distortions, pointing out that everyone has them to some extent. Cognitive distortions are faulty or inaccurate thoughts that individuals have about themselves, others, and the world (Beck, 1995). When explaining the cognitive distortions, the client should be asked if any of these cognitive distortions are present in his or her own thinking patterns. The following list of cognitive distortion categories, which was compiled by theorists and taken from David Burns' book *Feeling Good*, will then be presented to the client.

1. All-or-nothing thinking*:* You see things in black and white categories. If your performance falls short of perfect, you see yourself as a total failure.

2. Overgeneralization: You see a single negative event as a never-ending pattern of defeat.

3. Mental filter*:* You pick out a single negative detail and dwell on it exclusively so that your vision of all reality becomes darkened, like the drop of ink that discolors the entire beaker of water.

4. Disqualifying the positive*:* You reject positive experiences by insisting they "don't count" for some reason or other. You maintain a negative belief that is contradicted by your everyday experiences.

5. Jumping to conclusions*:* You make a negative interpretation even though there are no definite facts that convincingly support your conclusion.

a. Mind reading. You arbitrarily conclude that someone is reacting negatively to you and don't bother to check it out.

b. The Fortune Teller Error. You anticipate that things will turn out badly and feel convinced that your prediction is an already-established fact.

6. Magnification (catastrophizing) or minimization*:* You exaggerate the importance of things (such as your goof-up or someone else's achievement), or you inappropriately shrink things until they appear tiny (your own desirable qualities or the other fellow's imperfections). This is also called the "binocular trick."

7. Emotional reasoning*:* You assume that your negative emotions necessarily reflect the way things really are: "I feel it, therefore it must be true."

8. Should statements*:* You try to motivate yourself with shoulds and shouldn'ts, as if you had to be whipped and punished before you could be expected to do anything. "Musts" and "oughts" are also offenders. The emotional consequence is guilt. When you direct should statements toward others, you feel anger, frustration, and resentment.

9. Labeling and mislabeling*:* This is an extreme form of overgeneralization. Instead of describing your error, you attach a negative label to yourself: "I'm a loser." When someone else's behavior rubs you the wrong way, you attach a negative label to him, "He's a damn louse." Mislabeling involves describing an event with language that is highly colored and emotionally loaded.

10. Personalization*:* You see yourself as the cause of some negative external event for which, in fact, you were not primarily responsible.

Do any see any of these ten cognitive distortions in your own thinking patterns?

Provide examples of cognitive distortions in your thinking patterns.

3. Spiritual interventions that challenge cognitive distortions

Throughout the course of this treatment protocol, a variety of spiritual interventions will be learned to alleviate the depressive symptoms of the client. Three of these techniques consists of using biblical passages or scripture to challenge and come up with counterstatements for cognitive distortions or irrational thoughts, surrendering control to God and prayer. The main focus of this session will be learning ways to utilize biblical passages, scriptures and parables to challenge negative cognitions and develop new counterstatements for coping with these irrational cognitions.

A. Biblical passages

In traditional cognitive-behavioral therapy, a series of questions may be administered to help examine the evidence behind the individual's cognitive distortions. Cognitive-behavioral therapy utilizes a very scientific approach in looking at the reasoning behind the way people think and feel. Spiritually-informed cognitive-behavioral therapy takes this same approach but also focuses on the Word of God and the biblical truths. Often the irrational thoughts of an individual are not in line with the Word of God. Thus, the Bible, scripture and different parables can be used in treatment to challenge any distorted cognitions of the individual. References to biblical passages can also help the individual contrive a healthy adaptive counterstatement to irrational thoughts as they arise.

The therapist should explain to the client about the different types of biblical passages and effective interventions according to these biblical passages. The three types of biblical passages are declarative, descriptive and directive.

The declarative biblical passages concern the promises of God. Clinicians may utilize these kinds of passages when a client feels hopeless and does not have the motivation to move forward from his or her present condition. The therapist will help the client reflect upon these promises and realize hope in his or her life. John 14:1- 7 is a good example of a declarative biblical passage:

Let not your heart be troubled: ye believe in God, believe also in me.

In my Father's house are many mansions: if it were not so, I would have told you. I go to prepare a place for you.

And if I go and prepare a place for you, I will come again, and receive you unto myself; that where I am, there ye may be also.

And whither I go ye know, and the way ye know.

Thomas saith unto him, Lord, we know not whither thou goest; and how can we know the way?

Jesus saith unto him, I am the way, the truth, and the life: no man cometh unto the Father, but by me.

If ye had known me, ye should have known my Father also: and from henceforth ye know him, and have seen him.

(John 14: 1-7)

Descriptive biblical passages are stories. These passages use stories from the Bible to help the client learn about God's faithfulness. These stories may be reviewed in treatment and used to help the client battle through a difficult time. The client may relate

to the descriptive biblical passages and recognize that his or her current state of unhappiness is not permanent and that it is possible to overcome.

Finally, directive biblical passages are the commands of God. These passages deal with how individuals should act in life. The directive passages are straight forward and proclaim the basic rules of life.

*Looking back to those distorted cognitions that were listed previously in this session, can you think of any biblical truths, scripture references or parables that may combat the cognitive distortion?*____

*What ways are the messages that you are telling yourself that is counteractive to the messages of God's word?*____

B. Surrendering to God

The therapist will introduce explain the act of surrendering to God in this session, but it will be further explained in session nine. In session nine, the main content of the session will focus on ways the client can surrender concerns, worries, depression and any other burden to God. As humans, we tend to cling to the worries of the world and thereby add a great deal of stress into our lives. This stress is unnecessary as we can receive assistance with these burdens from our Heavenly Father. By releasing these burdens into God's hands, the individual will feel relieved as this stress is taken away. The individual will learn to utilize appropriate coping skills to deal with the depression and the worry and also learn that the concern is most secure when placed into the hands of God.

John 17 serves as a good example in the Bible about the notion of surrendering to God.

C. Prayer

The importance and impact of prayer will be discussed throughout the entire treatment protocol. Prayer may have been emphasized during session four if the individual decided at that point to increase the amount of prayer time in the daily schedule. Prayer has been noted to have a beneficial impact on emotional and physical well-being. Several research articles have even suggested that prayer serves as a coping mechanism for individuals (Ellison et al., 2001; Hettler & Cohen, 1998; Mirola, 1999; Pargament et al., 2000; Stuckey, 2001). Individuals turn to religion and prayer in times of crisis or when dealing with various stressful events (Ellison et al., 2001; Hettler et al., 1998; Stuckey, 2001). Thus, prayer helps people deal with issues which in turn assists to lower stress levels and keeps physical and mental health in at equilibrium.

It is apparent that prayer is an important factor in mental health and spiritual well-being. Prayer can also help the individual freely communicate with God about his or her concerns. The client should be reminded that communication with God is open and available at all times. From time to time, an individual may have faulty or irrational beliefs about prayer and impose certain rules regarding the proper procedure of prayer. This should be revealed when the clinician is gathering information concerning spiritual cognitive distortions. The therapist will begin to review these distorted cognitions and continue to elaborate on irrational cognitions in session six. The therapist should briefly review the responses from the spiritual coping questionnaire in session two to assess this area and determine if further treatment is necessary.

4. Review the spiritually-informed cognitive-behavioral dysfunctional thought record

The clinician will explain the importance of monitoring negative cognitions as they occur and to evaluate the impact of the cognitions (Beck et al., 1979). The client should be somewhat familiar with the need to monitor these cognitions as a result of the homework assignment. At this point in the session, the therapist will ask the client to pull out the cognition log to move onto the next step in treatment, the spiritually-informed cognitive-behavioral dysfunctional thought record. A copy of this form can be found in Appendix I. The therapist will help the client learn the process, explaining that at times it is difficult to fill out the form. Some of the problems that may occur in learning this process are:

- Difficulties identifying the irrational cognition
- Confusing thoughts and feelings
- Not immediately following through with the assignment

The therapist will conduct a step-by-step review with the client to demonstrate how to fill out the form. In the first column located on the left, the client will fill out the date and the time of the event. The next column will be used to briefly note what happened. After this, the client will write down the cognition. When doing this, the client will rank how much thought was believed to be true at the time of the incident through the use of percentages. The client may also identify the specific cognitive distortions present in that moment. The client will record the feelings from this situation as a result of the cognition. The intensity of the emotion will be expressed in terms of a percentile.

The client should be able to complete the above described steps without much assistance from the therapist. While it may require some lengthy discussion with the therapist to identify the cognition related to the experience, the client should be able to fill out these columns. In the next step, the client will respond to a series of questions about the cognition. These questions are listed at the bottom of the spiritually-informed cognitive-behavioral dysfunctional thought record and are as follows:

1) What is the evidence that my automatic thought is true? Not true?

2) If my cognition is true, what's the worst that could happen? Could I live through it? How would my life be different 3 months (6 months, 1 year) from now?

3) What's the best that could happen?

4) What will probably happen?

5) Is there an alternative explanation--Another way of looking at the situation?

6) If a friend was in the same situation experiencing the same automatic thoughts, what would I tell him or her?

7) What are the advantages of my believing the automatic thoughts?

8) What are the costs to thinking this way? The benefits?

9) What is in my best interest, to continue accepting the automatic thoughts as true, or to challenge this kind of thinking?

10) What would God say about this situation?

11) What does the Bible say about the thoughts I am having?

12) Would Jesus agree with my thoughts?

Once the client is able to go through those questions, it will begin to become clear that the thought was not entirely true. At times, the client may even smile or laugh upon realizing the faulty ways of his or her thinking. The therapist should also instruct the client to refer to several biblical passages. Appendix J includes a list of the cognitive distortions and biblical passages that challenge these cognitive distortions. This will help to clarify that the cognition was not in line with the Word of God. With the assistance from the therapist, the client will work to create an alternative response to the cognition that emerged in the situation (Beck et al., 1979). The client will complete at least two dysfunctional thought records with the therapist to help with this process. The spiritually-informed cognitive-behavioral dysfunctional thought record will help the client to learn new ways to cope with irrational thoughts and devise alternative responses to irrational cognitions and situations that usually trigger these irrational cognitions. The therapist should make sure that the client has a complete understanding of the process to complete the form and the rationale behind the form. It is expected that the client will eventually learn how to utilize these methods without the use of the form, being able to do so intuitively and essentially become his or her own therapist.

5. Assign homework and optional prayer

The client will be asked to fill out several spiritually-informed cognitive-behavioral dysfunctional thought records. The therapist will advise the client to do his or her best when feeling stuck. The client will be warned that it takes time to learn the thought record and not to worry or allow the thought record to create additional stress. The clinician will give the client the two thought records that were completed in the session as a guide on how to complete the thought record. The therapist will notify the

client that this thought record will be reviewed in the next session. The thought record form is located in Appendix I of this manual.

The clinician may incorporate prayer into the session. The therapist may use this optional prayer at the completion of this session or at another point in therapy when it may be more appropriate. Prayer is an important element of spirituality and faith. By including prayer in treatment, the clinician will model an effective spiritual intervention that will assist the individual in his or her spiritual walk and also help to regulate emotions.

Prayer for Session six:

"Lord, we come before you with heavy hearts and a desire to control our thoughts. We recognize that at times our thoughts are faulty and not reflective of how you view us. As a result, we may view ourselves, others, the world, our future and even You in a negative and tainted manner. In our quest to move beyond these misconceptions we ask for your help, guidance and support. Help _______________ to utilize the cognitive and behavioral skills to decrease his/her levels of depression. Guide ____________ to welcome these new skills and become an active member of his/her treatment. Help _____________ to reflect on Your word and work towards examining these beliefs and the negative impact the belief has on his/her life. We thank you for Your unending and unwavering love. Thanks for being with us throughout this process and guiding ______________ in his/her treatment. In Jesus' name, Amen."

SESSION SEVEN

This session will focus on verbal and visual beliefs and how they play out in the life of the individual. The session will focus on ways that biblical passages or stories can be used to challenge irrational cognitions. In addition, the therapist will explore ways that healthy counterstatements are reflective of God's love and supervision.

Capsulation

1. Set the agenda and review homework
2. Review verbal and visual beliefs
3. Relate how biblical stories or passages challenge irrational cognitions
4. Review healthy counterstatements that are reflective of God's love and supervision
5. Assign homework and optional prayer

1. Set the agenda and review homework

At the beginning of the session, the therapist and the client will review the items that will be included in the session. The therapist will make suggestions based on the different elements of this protocol. It is essential for the client to work with the therapist in setting the agenda in order to make treatment a collaborative process from the beginning. The client is given the opportunity to propose additional items that may be included on the agenda that are in agreement with the therapeutic goals for the session.

The therapist will review the homework assignment from the previous session and answer any questions from the client regarding treatment. The therapist will review the spiritually-informed dysfunctional thought record that was completed by the client. The

therapist will go over any difficulties the client may have faced during the week. Time will be provided for the client to ask any questions related to this matter.

2. Review verbal and visual beliefs

Barlow's work reviews two different kinds of beliefs: verbal and visual beliefs (Barlow, 1999). The therapist will work with the client to explain and identify these two different types of beliefs.

Verbal beliefs are things that clients say to themselves on a daily basis. These voices may be referred to as self-talk that occurs within the client's mind. The origins of the verbal beliefs tend to be messages that were received from one's family or other institutions in the individual's life. The verbal beliefs are very similar to Beck's cognitive triad that was previously discussed (Beck et al., 1979). The verbal beliefs usually have the format of "I am," "they are," or "it will be" statements. Those "I am" statements that are negative in nature may be upsetting for the client and lead to emotional distress and unhealthy behaviors. The client may also have verbal beliefs about God. These usually are characterized by "He" statements and are based upon the scriptures.

Visual beliefs constitute the second category of beliefs observed by Barlow. Visual beliefs are often the images that are formed in the mind and imagination of the individual (Librizzi, 2006). As time progresses, the individual may eventually believe that the situation will occur without any proof for this impending occurrence. The clinician may utilize visualization to challenge the visual beliefs of the individual. In addition, the clinician could use declarative biblical passages and descriptive stories from the Bible to challenge any distorted visual belief.

One descriptive story that could be used with the client comes from Genesis 15:1: *After these things the word of the LORD came unto Abram in a vision, saying, Fear not, Abram: I am thy shield, and thy exceeding great reward.* The therapist and the client could utilize this passage in a variety of ways. It could be used to launch a discussion about God's protection and provision in the hard times. The therapist may also utilize this passage as a tool for visualization. The client could envision God's shield providing protection from the troubles and worries of the world.

Verbal Beliefs:

I am:

They are:

It will be:

He: (scripture-oriented)

Visual Beliefs: (situations or scenarios that play out in your mind)

3. Relate how biblical stories or passages challenge irrational cognitions

The therapist will review Appendix J, explaining to the client that the list is not exhaustive in any means and that it may be supplemented with other biblical stories or passages of special meaning to the client. The client may find certain verses suitable to use as a motto throughout treatment. The therapist may explore a specific biblical passage with the client and relate ways the individual in the story dealt with the situation at hand. The therapist should confirm that the client has an accurate understanding regarding how to utilize the Bible to challenge negative distortions and warn that the Bible should not be used to reinforce any distortion.

4. Review healthy counterstatements that are reflective of God's love and supervision

The therapist and client will have a brief discussion about creating counterstatements or alternative responses that are reflective of God's love and supervision. The therapist may review several verses from the Bible about God's love to reinforce this point. These verses should be used to help the client formulate ways to battle cognitive distortions. The client's view of God and on his or her spiritual beliefs will be reviewed in session eight.

> "The Lord shall enlighten my darkness," (2 Samuel 22:29).
>
> "Come to Me, all you who are weary and burdened, and I will give you rest" (Matthew 11:28, New International Version).
>
> "Therefore do not be anxious for tomorrow; for tomorrow will care for itself. Each day has enough trouble of its own" (Matthew 6:34, NIV).
>
> "In the world you will have tribulation," Jesus said; "but be of good cheer, I have overcome the world" (John 16:33).
>
> "I can do all things through Christ who strengthens me" (Philippians 4:13).

What are two or three things that are particularly upsetting to you right now?

Are any of these verses meaningful for those situations?

Do you believe that God does love you and wants the best for your life?

5. Assign homework and optional prayer

The client will be asked to fill out index cards for the homework assignment. On one side of the index card the client will answer the following question: What am I particularly struggling with right now? On the other side of the index card the client will find a scripture that challenges the statement that was described on the front of the index card. This will help the client begin the process of converting his or her negative cognitive thought processes to a healthy, Christian belief system. Appendix J includes biblical stories and scriptures to assist in challenging these beliefs.

The clinician may incorporate prayer into the session. The therapist may use this optional prayer at the end of this session or may utilize it during another time in treatment when it is more appropriate. Prayer is an important element of spirituality and faith. By including prayer in treatment, the clinician will model an effective spiritual intervention that will assist the individual in his or her spiritual walk and foster the regulation of emotions

Prayer for Session Seven:

"Lord, we ask that you continue to be with _____ as he/she looks at ways that his faith can continue to help him/her with his/her depression. Help ____ to see you as a loving God and reflect upon all the good that you provide in his/her life. Have_____ take a deeper look at the Bible and utilize Your word to challenge faulty cognitions that bring him/her down and farther away from you. Draw _____ closer to You and have _____feel your love and support throughout these struggles. Thank you God for everything that you provide us with day in and day out in our lives. All these things I pray in Jesus' name. Amen."

SESSION EIGHT

Session eight is the last one that focuses solely on the cognitive interventions. This session addresses any previous questions of the client concerning those interventions that were taught and delves into aspects of the cognitive quadrant. The cognitive quadrant encompasses beliefs about self, others, the future, and God or spirituality. The therapist will focus on each of these areas and ways they play out in the life of the client. The therapist will work with the client to identify the roots of these belief systems and strive to modify beliefs in a manner that is spiritually consistent with the client's way of living.

Capsulation

1. Set the agenda and review homework
2. Explain the cognitive quadrant
    A. Beliefs about self
    B. Beliefs about others
    C. Beliefs about the future
    D. Beliefs about God and spirituality
3. Examine the beliefs of the client in regards to the cognitive quadrant
4. Discuss ways these beliefs impact life and ways to create healthier beliefs according to the spiritual doctrine
5. Assign homework and optional prayer

1. Set the agenda and review homework

At the beginning of the session, the therapist and the client will review the items that will be included in the session. The therapist will make suggestions based on the different elements of this protocol. It is essential for the client to work with the therapist in setting the agenda in order to make treatment a collaborative process from the beginning. The client is given the opportunity to propose additional items that may be included on the agenda that are in agreement with the therapeutic goals for the session.

The therapist will review the homework assignment from the previous session and answer any questions from the client regarding treatment. The therapist will review the spiritually-informed cognitive-behavioral dysfunctional thought record that was completed by the client. The forms and process of the dysfunctional thought record will be examined, addressing any related questions or concerns of the client. The therapist will discuss the effectiveness of the dysfunctional thought record and its usefulness as the client proceeds in treatment. Finally, the therapist will ask for feedback from the client in regards to the dysfunctional thought record.

2. Explain the cognitive quadrant

Beck introduced the cognitive triad in his writings. He observed that individuals who are depressed tend to view themselves, their current experiences, and their future in an extremely negative manner. Beck labeled these set of perceptions as the cognitive triad. The cognitive triad has three components: beliefs about self, beliefs about others and the world, and beliefs about the future. Dr. William Librizzi added a fourth component to Beck's cognitive triad, namely, beliefs about God and spirituality, which completes the final dimension of the cognitive quadrant. The beliefs in each quadrant are

independent and separate from one another, yet maintain a certain connection on a subtle level.

A. Beliefs about Self

Individuals experiencing symptoms of depression usually experience a negative self-image and may even feel inferior to others (Beck et al., 1979). They experience sensations of worthlessness and focus upon the negative self-attributes while filtering out the positive ones (Librizzi, 2006). Persons suffering from depression feel defective or inadequate and as a result, believe that all experiences will result in defeat or failures.

B. Beliefs about others and the world

Individuals who are depressed tend to develop a negative view of the world and their relationships with others (Beck et al., 1979; Gilson & Freeman, 1999). These individuals see the world as a never-ending battle of struggles and view others as critical, unsupportive or rejecting in nature. Since these individuals feel that they are of little value, they also believe that they are not worthy to have the support of others and anticipate rejection. Depressed individuals tend to feel isolated, disconnected and feel that others are disinterested in their personal needs and concerns. This belief may actually come true as the client may eventually become rejected and lose the support from others as a result of previous behaviors.

C. Beliefs about the future

The third component of the cognitive quadrant is comprised of the negative outlook on the future (Beck et al., 1979). Individuals who are depressed may foresee continued hardships and little opportunities for success in the future. They do not believe things will get better, but instead view the future as worsening. This may lead to a greater

severity in the level of depression or eventually suicide. The notion of suicide may be an opportunity for individuals to escape these feelings of hopelessness and desperation.

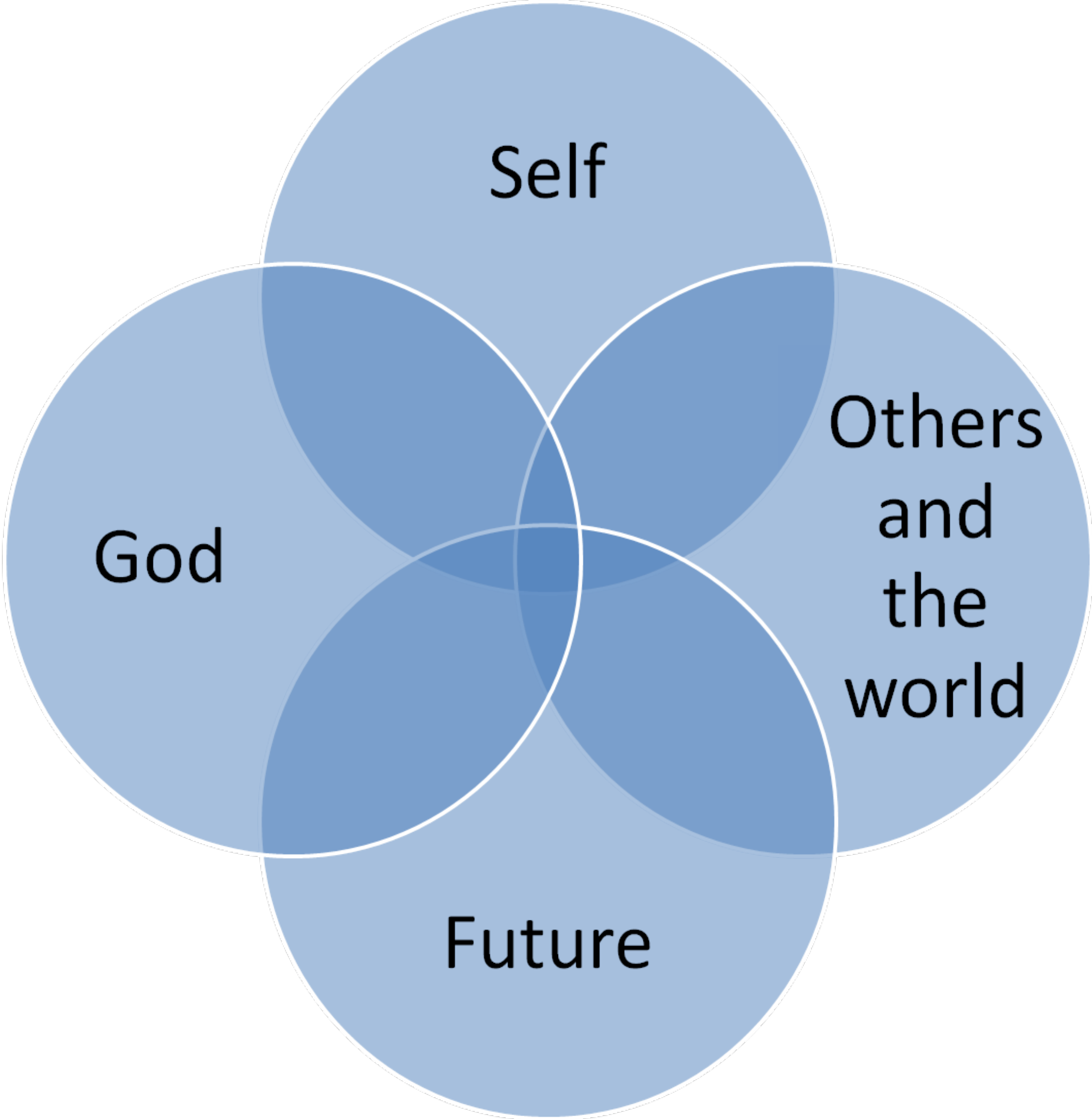
<u>D. Beliefs about God and spirituality</u>

The final component of the cognitive quadrant encompasses the beliefs of the individual concerning God and spirituality. Beliefs about God may have an impact on the other three components of the cognitive quadrant. It is essential that the clinician examines ways that the beliefs about God and spirituality impact the other components of the cognitive quadrant. In addition, the client's beliefs regarding God and spirituality should be evaluated to determine if they are healthy or need to be modified. If it is apparent that an individual holds beliefs that are spiritually inconsistent with the scriptures and the Christian doctrine, the therapist should point out these inconsistencies to the client. Then the therapist and client may work together to create new beliefs that adhere to the foundational principles as written by the Word of God.

This final component can also be used to assess the beliefs in the other three areas of the cognitive quadrant. For instance, a depressed individual may feel disconnected from God. The thinking patterns could be such that "I am a worthless failure, nobody cares for me, no one can help not even God." This thought reflects both a belief about self and a belief about God. Reviewing the scriptures that discuss God's unending love would help to make it apparent that those statements are false and unfounded.

<u>3. Examine the beliefs of the client in regard to the cognitive quadrant</u>

The therapist will instruct the client to complete the following diagram:


Self
Others and the world
God
Future

The therapist may present the following questions/statements to elicit responses from the client:

Beliefs about self:

1. I am a ____________ person
2. What are several words that you would use to describe yourself?

Beliefs about others and the world:

1. The world is a ________________ place.
2. Other people __________________________.
3. My friends are _________________ individuals.

Beliefs about the future:

1. The future looks ____________________.
2. I feel ______________ when thinking about the future.

Beliefs about God:

6. God is _______________________.
7. God is _________ with my life.

4. Discuss ways these beliefs impact life and ways to create healthier beliefs according to the spiritual doctrine

Those beliefs that were filled out in the preceding cognitive quadrant diagram may have a negative impact on the life of the individual. The therapist and the client should work to understand the source of these beliefs. There may have been messages received in childhood or rules that were carried out over the course of the client's lifetime. It is imperative to find the roots of these beliefs in order to work through the healing process during later sessions.

The therapist should help the client recognize the negative impact of these beliefs and work to modify the beliefs through utilization of biblical passages, scripture and parables. Appendix J lists some of these biblical passages that are aimed at providing hope and encouragement for the individual.

Beliefs about self:

When did I start believing this message? Where did it originate?____________________

____

____

What impact do these negative beliefs have on my life?___________________________

____

____

What biblical passages or scriptures challenge these beliefs?______________________

____

____

What verses can help to challenge this belief?__________________________________

____

____

Beliefs about others and the world:

When did I start believing this message? Where did it originate?____________________

____

____

What impact do these negative beliefs have on my life?___________________________

What biblical passages or scriptures challenge these beliefs?________________________

____

What verses can help to challenge this belief?_____________________________________

____

____

<u>Beliefs about the future:</u>

When did I start believing in this message? Where did it originate?__________________

____

____

____

What impact do these negative beliefs have on my life?____________________________

____

____

What biblical passages or scriptures challenge these beliefs?________________________

____

What verses can help to challenge this belief?_____________________________________

____

____

<u>Beliefs about God:</u>

When did I start believing in this message? Where did it originate?__________________

____

____

What impact do these negative beliefs have on my life?____________________________

____

____

What biblical passages or scriptures challenge these beliefs?________________________

____

What verses can help to challenge this belief?____________________________________

____

____

5. Assign homework and optional prayer

For homework, the client will be asked to continue to evaluate his or her cognitive triad. The client will research various biblical passages or truths to negate those irrational beliefs and work towards restructuring personal beliefs according to spiritual doctrine. If the client is able to achieve this, then healthier working beliefs can be developed regarding self, others, the world, the future and God. The individual will complete this assignment by filling out another Cognitive Quadrant form found in Appendix K. On this new form, the client will record biblical verses that challenge old beliefs and incorporate new ones in each component of the cognitive quadrant.

The clinician may incorporate prayer into the session. The therapist may use this optional prayer at the completion of the session or may do so at another point in treatment when it is more appropriate. Prayer is an important element of spirituality and faith. By including prayer in treatment, the clinician will model an effective spiritual intervention that will assist the individual in his or her spiritual walk and facilitate the regulation of emotions.

Prayer for Session Eight:

"Heavenly father we come before you with all of our concerns. We recognize that at times we hold onto these concerns and try to control our own lives. This often makes us tired, worn out and frustrated. Lord, I ask that you help ____ from holding onto the worry and concern. Help _____ to give these concerns to You. Help ____ to recognize that you have a plan for his/her life and that there is no need to carry these burdens and that You will gladly do this for him/her. In all these things I pray in Jesus' name. Amen."

SESSION NINE

Session nine focuses on the elements of surrender and control. This session will explore this further. The session will begin by reviewing the Cognitive Quadrant that was completed for homework since the previous session. The therapist will pay special attention to the client's beliefs about God and spirituality. The therapist will explain that the focus of this session is to begin the process of surrendering to God and allowing Him to have complete control over the client's life. A review of the client's religious beliefs will be conducted to ensure an environment that encapsulates a warm and loving God. If the individual has a misconception about God, significant time will be permitted in this session to discuss God's love and specifically God's role as God, the Father. The will review the Serenity Prayer with the client and also share a musical piece that expresses God's love and provision. The therapist will direct the client in a guided imagery exercise which will help the client release concerns into the care of God's loving hands.

Capsulation

1. Set the agenda and review homework
2. Review the cognitive quadrant and client's view of God
3. Unconfessed sin/Spiritual incongruence
4. Discuss biblical references as a loving God
5. Guided imagery exercise
6. Assign homework and optional prayer

1. Set the agenda and review homework

At the beginning of the session, the therapist and the client will review the items that will be included in the session. The therapist will make suggestions based on the

different elements of this protocol. It is essential for the client to work with the therapist in setting the agenda in order to make treatment a collaborative process from the beginning. The client is given the opportunity to propose additional items that may be included on the agenda that are in agreement with the therapeutic goals for the session.

The therapist will review the homework assignment from the previous session and answer any questions from the client regarding treatment. This will be followed by an examination of the new cognitive quadrant created by the client. The therapist will examine ways the client can begin to work towards challenging previous beliefs and incorporating these new adaptive beliefs into life situations. The therapist will answer any questions from the client concerning the restructuring of these new beliefs.

2. Review the cognitive quadrant of the client's view of God

The therapist will thoroughly explore the client's view of God. This will be achieved by reviewing the responses from the chart completed by the client in session eight and the beliefs composed by the client for homework in the previous session. The therapist and client will discuss the differences between these two belief systems. These two belief systems include the current cognitive quadrant beliefs and the cognitive quadrant beliefs the client is working towards in treatment. The client and therapist will assess the possible reasons behind these differences. The client will be asked to identify, if possible, where these messages about God were learned. The client will describe these events or messages and distinguish whether they were determined by human reason or based upon biblical truth.

In addition, the therapist may ask the client to complete a list of positive attributes of God. This may aid the client in taking the first steps to challenge any negativity and

clear any confusion concerning the personal beliefs of God. Depressed individuals tend to focus on negative elements and experience difficulties when requested to reflect on anything positive. This will help the client start to bridge the gap between the present belief of God and the desired belief of God.

Current belief in God:

Events that formed this belief:

Messages received from others that formed this belief:

Do these beliefs align with the biblical view of God?

Positive attributes of God:

3. Unconfessed sin/Spiritual incongruence

It is imperative to provide an opportunity to voice any unconfessed sin at this time. When discussing beliefs about God, difficult emotions may arise from unconfessed sin. Unconfessed sin may have an emotional impact on the individual, as it creates a feeling of spiritual incongruence within the person. Unconfessed sin can create spiritual incongruence due to differences in the external and internal presentation of one's faith. The individual may believe that he or she is doing all that is possible in regards to the faith journey, but secretly harbor unconfessed sin, which will instill emotional distress and conflict within the individual. The therapist will allow the client to communicate any unconfessed sin at this time. The therapist will determine if this unconfessed sin is based on reality or perception. If the unconfessed sin is based on reality, the clinician should work with the client to acknowledge this sin and move forward accordingly. On the other hand, if the client is harboring unconfessed sin that is based on perception only, the clinician will review God's mercy and instruct the client is ask for God's forgiveness.

In addition, the therapist may review the story of David. David realized the consequences of unconfessed sin. He wrote about these experiences in Psalm 32. David

emphasized that unconfessed sin can make you hurt physically, emotionally and spiritually. Psalm 32:3 states that “when I kept silent, my bones wasted away through my groaning all day long.” David reflected ways that ~~it~~ his unconfessed sins harmed him physically when he stated, “For day and night your hand was heavy upon me; my vitality was turned into the drought of summer.”(Psalm 32:4).Later David revealed these unconfessed sins to God and felt a sense of liberty and release as evidenced in Psalm 32:2: “Blessed is the man to whom the Lord does not impute iniquity and in whose spirit there is no deceit.” The client should be informed that all sin distances us from God. Small sins grieve God just as much as David’s sins.

4. Discuss references in the Bible of a loving God

Once the client responds to the questions from the previous section, the therapist and the client will reflect on passages of God’s love and review those Scriptures that discuss the role of God. Passages that reflect God’s love are included in Appendix L. The client will explore these passages and discuss the differences between the present belief of God and the biblical view of God. The therapist and client will work to develop new ways to move towards the adoption of the desired belief in God. For clients who are experiencing negative emotions towards God, the Bible can serve as an effective means to decrease levels of anger or frustration towards God. These individuals may begin to see God through a different light as God is revealed to be a loving, caring and compassionate God. It may be helpful for individuals to begin to understand God in terms of God the Father.

Desired belief of God:

Ways this desired belief differs from the present belief of God:

5. Guided imagery exercise

The therapist will utilize the guided imagery exercise to provide a visual means for the release of the client's burden to God. The therapist will go through the following script with the client to carry out this process. Before the therapist directs the client to engage in this exercise, the client will be instructed to first complete a breathing exercise. This breathing exercise was taken from Edmund Bourne's workbook on anxiety and phobias.

<u>Calming Breath Exercise</u>

1. Breathe from your abdomen, inhale through your nose slowly to a count of five (count slowly "one…two…three…four…five" as you inhale)
2. Pause and hold your breath to a count of five.
3. Exhale slowly, throughout nose or mouth, to a count of five (or more if it takes you longer). Be sure to exhale fully.
4. When you've exhaled completely, take two breaths in your normal rhythm, then repeat steps 1 through 3 in the cycle above.
5. Keep up this exercise for at least 3 to 5 minutes.
6. Throughout the exercise, keep your breathing smooth and regular, without gulping in breaths or breathing out suddenly.
7. Each time you exhale, you may wish to say, "Relax," "Calm," "Let go," or any other relaxing word or phrase silently to yourself. Allow the whole body to let go as you do this. Eventually this word may illicit the relaxation process if you continue to utilize this word with your breathing exercises.

Once the therapist has completed the steps above with the client, the following guided imagery exercise may be administered.

Guided Imagery Exercise

Instruct the client to get into a comfortable position with the head supported. Inform the client that you are about to engage in a guided imagery exercise.

Then begin the exercise:

Guided imagery involves visualization and relaxation. As the therapist, I will be depicting a certain scene for you. I will try to use words that will evoke your senses and promote as realistic of an experience as possible. This specific exercise will be related to the topic that we have discussed today, surrendering control of your concerns into the loving hands of our Heavenly Father. When we begin the activity, I would like for you to focus on your breathing and the scene that I am describing. If you find other words or thoughts coming to mind throughout the exercise, do you best to attend to your breathing and my voice. Do you have any questions before we begin?

First I would like you to close your eyes and focus on your breathing. Take three deep breaths in and out. Focus on your breathing and the sensations in your body. Now I want you to picture your life… (Add stressors the client is experiencing). Think about these stressors and the feelings that these stressors cause in your life. The frustration, the anger, the stress, exhaustion and so on…As you are focusing on these stressors you begin to experience a feeling of a warm gentle breeze that instantly provides comfort to your body. You notice freshness in the air. The warmness that you feel begins in your stomach and slowly begins to extend throughout your body, to your legs, your chest, your arms and your feet. The warmness provides a sense of comfort and you realize that you are in the presence of God. Relief, comfort and love begin to envelop your body. Your Heavenly Father is before you and you feel loved. As you look into His adoring eyes, he reaches

out His strong, broad hands. You realize in this moment that God is providing you the opportunity to give up all of those burdens that you have been carrying for so long. As you reach to grab these burdens, you continue to feel the warm love of God. These burdens are incredibly heavy and seem insurmountable. You struggle to lift these burdens into God's strong caring hands. Somehow, when you release the burdens into God's hands, they appear small and weak. God smiles down on you and says, "I love you my child. You no longer need to hold onto these concerns. I will keep them safe. Trust in me and know that I am Your God and have all things under control." God places his hand on your back and you immediately experience his loving embrace and warmth. I want you to continue to experience God's loving presence. Focus on the feeling and stay in the moment. In a moment you can begin to come back to an alert, wakeful state of mind. Pay attention as I count from one to five. When I get to five, I want you to slowly open your eyes and feel awake, alert, refreshed and rejuvenated. One- you gradually begin to feel more alert coming to a wakeful state. Two- you are becoming more awake and alert. Three- you may want to adjust your posture or move some of your extremities as you are becoming more alert. Four-you are almost back to your most alert state. And five- open your eyes now fully and you will find yourself awake, alert and rejuvenated. When you are finished this exercise with the client, reflect on the experience. Allow the client time to process any experienced emotions.

<u>6. Assign homework and optional prayer</u>

The client will be asked to write a letter to God for homework. The letter will include burdens the client is working to release into the hands of God. The letter will also include the present relationship with God and the client's desired relationship with God.

The client should communicate to God the personal efforts to start to bridge this gap. Various emotions will be evoked as a result of the letter. The therapist should explain to the client that while this may be a difficult assignment, the struggle is part of the process of treatment. The therapist will instruct the client to bring in the letter to review at the beginning of the next section.

The clinician may incorporate prayer into the session. The therapist may use this optional prayer at the completion of the session or do so at another time when it is more appropriate. Prayer is an important element of spirituality and faith. By including prayer in treatment, the clinician will model an effective spiritual intervention that will assist the individual in his or her spiritual walk and help to regulate emotions.

Prayer for Session Nine:

"Father, You know at times we question events in our life and in turn question You for these events. We have even resented some of the unchangeable things in our lives that have caused us pain. Sometimes we ask for explanations for these times, but it never seems to come. Today, we ask for you to help us to stop fighting You over these things that we don't understand. Help _______ to be at peace. Today, we pray the prayer of surrender. Your kingdom come, Your will be done in our lives. Help _____ to say this every day. Help _____ to change those things that he/she can but to accept the things that cannot be changed. Help _____ to accept the plan that you have for his/her life and continue to help _____surrender to Your control and trust Your care. In Jesus' name. Amen."

SESSION TEN

Session ten will focus on teaching the client meditation processes and reviewing the guided imagery exercise. The client will be educated about meditation processes that incorporate breathing, visualizations and visual meditation. The therapist will explain that the meditation process will help to gain perspective in the client's spiritual walk and also to work towards establishing a time for quiet reflection and inner peace. It is important to focus on learning ways to self-soothe. The client has learned cognitive and behavioral interventions,-interventions to help combat stress and now with the incorporation of meditation and relaxation, the client will be able to channel stress in a healthy manner. The client will also be instructed through a guided imagery process to allow for time of reflection.

<u>Capsulation</u>

1. Set the agenda and review homework
2. Discuss images of God and surrender/control from last session
3. Serenity Prayer and musical selection
4. Ways to maintain the message in the biblical passages, Serenity Prayer and musical selection in the life of the client.
5. Introduction to Christian meditation practices
    A. Counting breathing
    B. Mantra meditation
    C. Christian meditation
    D. Visualization/Guided imagery
    E. Visual meditation

6. Review any questions related to each technique
7. Assign homework and optional prayer

1. Set the Agenda and Review Homework

At the beginning of the session, the therapist and the client will review the items that will be included in the session. The therapist will make suggestions based on the different elements of this protocol. It is essential for the client to work with the therapist in setting the agenda in order to make treatment a collaborative process from the beginning. The client is given the opportunity to propose additional items that may be included on the agenda that are in agreement with the therapeutic goals for the session.

The therapist will review the homework assignment from the previous session and answer any questions from the client regarding treatment. The therapist will read the letter that the client completed for homework. The therapist will instruct the client to read the letter out loud in the session and then to reflect on its content. This will lead to the next part of the session in which the client will continue to reflect on the personal images of God.

2. Discuss images of God and surrender/control from last session

The therapist will continue with the discussion of God by focusing on the theme from the last two sessions. This will be followed by a discussion of the client's present belief in God and ways that the client is striving to develop and feed this relationship. The therapist will instruct the client to reflect on this relationship throughout life. The therapist will also explain that worrying about the relationship is a part of growth. It is more of a concern when an individual becomes complacent with the status of the personal

relationship with God. This usually means that the person feels that all has been done that is within the client's power and as a result, the quest in this relationship is halted.

3. The Serenity Prayer and musical selection

The therapist will read the Serenity Prayer with the client. It will be explained that this prayer is used to help individuals surrender control of their problems. Individuals tend to place a significant amount of weight and emphasis on their ability to handle their own problems and stressors in life. This stress is not necessary, as their concerns can be placed in the hands of God. The clinician may refer to scriptural examples of patience and acceptance in order to motivate the client and allow the client to begin to release problems into the loving hands of God (Librizzi, 2006).

God grant me the serenity

To accept the things that I cannot change;

Courage to change the things I can;

And wisdom to know the difference.

Living one day at a time;

Enjoying one moment at a time;

Accepting hardships as the pathway of peace;

Taking, as He did, this sinful world;

As it is, not as I would have it;

Trusting that He will make all things right

If I surrender to His Will;

That I may be reasonably happy in this life

And supremely happy with Him

Forever in the next.

Amen.

Do you have the tendency to hold onto your burdens and worries?___________________

Is it difficult to give your concerns and worries to God?___________________________

What is the impact of holding onto your concerns?_______________________________

____

____

What would be the impact of giving God your concerns?__________________________

____

____

The therapist may also share a musical selection with the client. These selections may focus on God's love, God's provision, surrendering control to God or other examples of ways that God has a powerful impact on one's life. Examples of musical selections that may reflect these important values are:

Held- Natalie Grant

Redeemer – Nicole C. Mullen

Amazing God

I Can Only Imagine- Mercy Me

Blessed Be Your Name- Tree 63

Holy – Nichole Nordeman

In Christ Alone- Brian Littrell

One of these Days- FFH

Testify to Love- Avalon

On My Knees – Jaci Velasque

He Reigns – Newsboy

God Of Wonders – City On A Hill

Open The Eyes Of My Heart – Sonic Flood

What does this musical selection say to your heart?________________________________

____

____

4. Ways to maintain the message in the biblical passages, Serenity Prayer and musical selection in the life of the client.

Now that various messages have been shared with the client, the therapist and the client will reflect on developing and devising ways to integrate the belief of God into daily living. This may include utilizing resources already available to the client. Some activities include reading a self-enhancement book, joining a Bible study, and continuing to work on developing ways to challenge those previous negative beliefs by reflecting on God's love. The therapist will review the list below and help the client choose some ways to apply and cultivate these new messages in his or her life.

Maintaining this Belief in Daily Living:

____ Bible Study ____ Spiritual outreach ____ Meditation

____ Self-enhancement books ____ Music ____ Prayer

____ Devotionals ____ Providing time to reflect on God

5. Introduce client to Christian meditation practices

Meditation is often identified as a relaxation technique to develop mindfulness on a physical, psychological or spiritual level (Marlatt & Kristeller, 1999). This involves seeing things as they truly are. The individual is presenting the here and now and focused on being in the present moment. This may be difficult with the lives that most people lead. Individuals usually do not allow time in their schedules for things to "just be." People are always on the go and simply "do not have time" to attend to their inner peace and emotional processes.

There are various medical benefits to meditation. The following health benefits were taken from Edmund Bournes's book, *The Anxiety and Phobia Workbook.* These include:

- A decrease in heart rate
- A decrease in blood pressure
- A decrease in oxygen consumption
- A decrease in metabolic rate
- A decrease in the concentration of lactic acid in the blood
- An increase in forearm blood flow and hand temperature
- An increase in electrical resistance of the skin
- An increase in alpha brain wave activity

To enter a meditative state, one must attempt to calmly limit all thought and attention (Mohr, 2006). This may be accomplished through visualizations, devotionals, muscle relaxation, release, and focusing on one specific word. Regular practice is needed

to induce relaxation through meditation and mindfulness. Meditation is a process and one cannot be expected to learn the process without continued practice and work.

Bourne suggests four essential components to effective meditation: right attitude, right technique, developing concentration and cultivating mindfulness.

Right Attitude: It is imperative to bring in a positive attitude for the process of meditation. This is a part of the practice. The overall impact of meditation will depend on the way that the individual approaches the process.

Right Technique: The proper technique first involves getting into the proper position. These positions include the individual lying on the floor on the back in a cross-legged position or sitting upright with back straight and feet flat on the floor. Before engaging in meditation, the individual should do the following:

1. Find a quiet environment
2. Reduce muscle tension- this will be further explored in session eleven with the progressive muscle relaxation technique that will be taught.
3. Sit properly
4. Set aside time for meditation
5. Make meditation part of your daily routine
6. Don’t meditate after you have just eaten
7. Choose a specific focus for your attention

Developing concentration: In order to meditate, one must have a specific area to focus upon throughout the process. This may include a mantra (word or phrase to focus on), breathing or a visualization.

Cultivating Mindfulness: One of the easiest and most utilized definitions of mindfulness is moment-to-moment awareness. This is accomplished by purposefully paying attention to those things that we commonly ignore in our everyday lives. It involves paying attention to things as they occur and living in that moment.

A. Breathing

Counting breaths is one of the main focuses that one can utilize when beginning the meditation process. Breathing becomes the focus of the meditation process. Breathing exercises are useful when one is first learning the meditation process, as it will help the individual develop concentration and focus. The therapist can direct the client through the following steps to instruct how meditation can be cultivated using breathing as the focus:

Counting Breaths

1. Sitting quietly, focus on your breath as it comes in and out of your body. Allow yourself to breathe slowly and evenly. Every time that you exhale, slowly and silently count the breath. You can count up to ten, and start over again, or keep counting as high as you would like.
2. When you notice your focus wandering, bring it back to your breathing and counting. If you get caught in your own internal monologue, don't worry about it. Just relax and return to your counting again.
3. If you lose track of your counting, start over at 1 or at a round number like 50 or 100.
4. When you have practiced breath-counting for a while, you may want to stop the counting and just focus on your breaths as they enter and leave the body.
5. Continue the process for a minimum of 10 minutes or up to 30 minutes.

B. Using a Mantra

Another basic form of meditation involves using a mantra. This allows the individual to focus on a single word or phrase. This word or phrase becomes the focus of the meditation process. This process is outlined below.

Mantra Meditation

1. Select a word or phrase to focus on. These words may be spiritual or biblical in nature. Common phrases used may be “Jesus,” “peace,” “let go,” “Messiah,” “God is with me,” “now,” and “relax.”
2. Silently repeat this word or phrase. This should ideally occur when the client is exhaling.
3. If any thoughts or reactions come to mind, allow them to pass over and through you and bring your attention back to your mantra.
4. Continue this process for at least 10 minutes or up to 30 minutes.

C. Christian Meditation

The practice of Christian meditation entails engaging in thought, contemplation, and reflection about our relationship with Christ and/or the Word of God. There is nothing that is abnormal about this process. We all meditate every day and are not aware of ways that we become single-mindedly focused on a task at hand. The goal of Christian meditation is to create a more fruitful walk with the Lord. Listed below are several Scripture verses in support of regular meditation. The therapist may recommend for the client to meditate in a certain location. As detailed below Psalm 4:4 suggests that we should meditate while in bed. The therapist will review different locations and times with

the client. If the client is able to agree to a set location and time, the likelihood of the meditation occurring will increase

Psalms chapter 46:10 tells us to be still and know that I am God.

Joshua chapter 1 verse 8, admonishes us to meditate on God's word day and night.

Psalms chapter 4: 4 persuades us, "When you are in your beds, search your hearts and be silent."

David desired in Psalms 104: 34, that his meditations be pleasing to the Lord.

Isaiah declared in Chapter 50:4, "He wakens me morning by morning, wakens my ear to listen like one being taught."

Moses spent 40 days on the mountain abiding and learning from God (Exodus 34-35).

Paul received revelation and saw visions from heaven (2 Corinthians 12).

John wrote visions that are recorded in the book of Revelations. The Bible says even Jesus spent hours alone with God (Luke 5:16; Mark 1:35).

The necessity of Christian meditation is apparent from these scriptures. The method this treatment protocol will address for Christian meditation is meditation on verses in the Bible. The outline below gives a step-by-step description in regards to engaging in this process:

Scriptural Meditation

Psalm 145:9, "The LORD is good to all: and his tender mercies are over all his works."

1. Read the above meditation aloud 3 times.
   Each time you read it, place emphasize on a different word.
2. Take a deep breath in….exhale. Repeat.
3. Close your eyes and silently repeat the meditation 3 times in alignment with your breathing.
4. Take in another deep cleansing breath and exhale.
5. Spend a few more moments enjoying the silence.

6. Open your eyes.
7. Ask God to make these words alive in you today.
8. Ponder the meditation throughout the day.

Appendix M provides additional verses for scriptural meditation.

D. Visualization/Guided imagery

The therapist will explain the visualization process. This process is very similar to the guided imagery exercise that was employed in session nine. Visualization uses imagery to modify behaviors, feelings and physiological states (Bourne, 2005). The main function of the visualization process for this treatment protocol is to assist with emotional processing and reduce tension in the physiological states. Specially, visualization is used to help the client focus on the personal relationship with God and establish an outlet to deepen this relationship. There are a few key components one must take into account before beginning the visualization process:

1. Get into a comfortable position with your head supported.
2. Be sure that you are in an environment that is quiet and free from distractions.
3. You may want to utilize the breathing technique that was described in session nine or other techniques to be presented in session nine to evoke a relaxed state in the client.
4. At times individuals like to accompany their visualization with affirmations such as “I am letting go,” or “God is with me.” This may help the individual release excess tension and fully focus on the visualization process.

Two different visualizations are provided below that the therapist may use with the client. The therapist may also create different visualizations that are more tailored to the client’s specific concerns and needs.

Spiritual Journey

We are going to take a spiritual journey. I would like for you to get into a comfortable position and close your eyes. We are going to start this process by allowing all the tension from your body to be released. Feel the tension leave your body through your arms, your legs, your fingertips and your toes. Allow all the stress and tension to wash away. I want you to imagine that there is this brilliant ball of light inside of you. The light is glowing strongly radiantly and is powerful. The light feels warm and comfortable and you recognize that this light is the center of your being and your spiritual core. Imagine God's strong hands coming in and holding that ball of light. The ball is not connected to any human characteristics or earthly possessions. It is who we are in the eyes of God. You realize as God is holding the ball of light the freedom the ball has and you become this ball of light sitting in the hands of God. You are safe in his hands and free from any burdens in your life. Love envelops your body as God protects you from all the demons and stressors of the world. You feel relaxed, at peace and one with God. You no longer need to worry about concerns at work, relationships, and family problems for you are in God's care. In God's hands none of these matters can affect you, for God is the solution to all of these concerns. As you are in God's hands you recognize that this is where the ball of light belongs, this is where you belong and all along where you have been. The hands of God will continue to comfort you, provide for you and hold your concerns. The ball of light burns brighter and will continue to burn as the love of God in your heart burns and desires this close, caring relationship with your heavenly Father. You feel ready to face the world, ready to confront your challenges, for you realize that God has been holding onto you and you are in His care. You say to God, "Thanks for allowing my

light to shine, thank you for taking on my burdens, I know that I am loved and taken care of, and because of that I continue to shine and my love for you burns in my heart." Bring your awareness back to your body. This light of God continues to glow inside of you and you know that God is in control. Pay attention as I count from one to five. When I get to five, I want you to slowly open your eyes and feel awake, alert, refreshed and rejuvenated. One- you gradually begin to feel more alert coming to a wakeful state. Two- you are becoming more awake and alert. Three- you may want to adjust your posture or move some of your extremities as you are becoming more alert. Four-you are almost back to your most alert state. And five- open your eyes now fully and you will find yourself awake, alert and rejuvenated.

A Child

I want to imagine you as a child. You recognize a feeling of fear or concerns that starts to spread throughout your body. This fear begins in your heart and nervousness surrounds you. Now, I want to separate you from this child. You are the adult- you. Look at this child and the amount of fear, anxiety and worry that he or she is experiencing. You do not feel these feelings but you can see them in the child as he or she is sitting there. You recognize again that the feelings of the child are not your own, but you feel sorry for the child. A sense of caring and warmth spreads through the air. This feeling of caring and warmth is noticed by the child. You recognize that you are providing this caring without an expectation for anything back from the child. You are giving this concern unconditionally and willingly. As this caring spreads, you go over to the child and wrap your arms around him or her. You tell the child that it will be ok...that things will get better because you are here. As you hug the child you begin to feel the atmosphere or

love and warmth surround you. The same love that you showed the child-you is God's love that is flowing down upon you. You feel God's love flow through your body and into the presence of your inner child. You recognize that this love is always present and you feel reassured. You hear a message as you continue to feel embraced by God, "My child, I am with you always, I will love you always and this will never change." The child disappears, but you know that he or she is still with you. The fear of the child has faded as love fills your heart and surrounds your life. You whisper "Thank you Lord for protecting and loving me. Help me to remember this in my times of need and surround me with your love." Continue to rest in this moment and feel God's love around you and inside you. Pay attention as I count from one to five. When I get to five, I want you to slowly open your eyes and feel awake, alert, refreshed and rejuvenated. One- you gradually begin to feel more alert coming to a wakeful state. Two- you are becoming more awake and alert. Three- you may want to adjust your posture or move some of your extremities as you are becoming more alert. Four-you are almost back to your most alert state. And five- open your eyes now fully and you will find yourself awake, alert and rejuvenated.

E. Visual Meditation

Several websites have been recently created by clinicians and clergy members that offer visual meditation. The visual meditation referenced by this author consists of videos that include inspirational music and phrases. The videos are usually only 4 to 5 minutes in length. The client may find this form of meditation to be particularly useful. Music can be an extremely powerful tool and when utilized with meditation, can help to serve the client quite well.

Several websites that offer visual meditation tools are:

www.thechristianmeditator.com

www.godtube.com

6. Review any questions with the techniques described

Once the therapist has reviewed the different meditation techniques, it will be confirmed that the client has an accurate understanding about each technique. The therapist will provide time for the client to ask questions in order to gain a better understanding about the meditation process or any specific technique. The variety of presented meditation techniques will be discussed to determine those that would be most effective to implement in the client's life.

7. Assign homework and optional prayer

The client will practice whatever techniques were decided would work in his or her life. The client will be prepared to share with the therapist those techniques that helped to gain control over emotions and provided a time for focus and attention. The client will also come into the next session with any particular questions concerning these techniques. In addition, the therapist will ask the client to track these daily practices on a calendar. The therapist will instruct the client to place a check mark on the calendar when he or she has accomplished the task. The client can create a color key for each task that is being tracked. For example, a pink check mark could represent prayer on the calendar. A calendar is located in Appendix N.

The clinician may incorporate prayer into the session. The therapist may use this optional prayer at the completion of the session or do so at another point in therapy when it is more appropriate. Prayer is an important element of spirituality and faith. By

including prayer in treatment, the clinician will model an effective spiritual intervention that will assist the individual in his or her spiritual walk and facilitate the regulation of emotions.

Prayer for Session ten:

"Lord help us to seek You in all the things that we do. Help ______ throughout the week recognize ways that his/her beliefs about himself/herself, others, the world and You impact his/her life. Reveal yourself to _____ when he/she is seeking you and teach him/her about your loving and caring nature. Allow _____ to focus and mediate on Your love and guidance and to allow __________ time this week to focus on his/her relationship with You. Lord, continue to be with _______ in his/her treatment and help us to continue to work through any struggles that might come our way."

SESSION ELEVEN

Session eleven will focus on learning relaxation techniques. The therapist will review those meditation exercises that were taught in the previous session. Once the therapist is certain the client has gained an accurate understanding, the therapist will begin to describe relaxation techniques. The therapist will teach the client some progressive muscle exercises and also discuss the value of music in the relaxation process. The therapist will allow time for the client to reflect upon these new exercises and to develop a relaxation plan to implement over the course of the week.

Capsulation

1. Set the agenda and review homework
2. Introduce relaxation techniques
3. Progressive muscle relaxation
4. Importance of music
5. Assign homework and optional prayer

1.Set the agenda and review homework

At the beginning of the session, the therapist and client will review the items that will be included in the session. The therapist will make suggestions based on the different elements of this protocol. It is essential for the client to work with the therapist in setting the agenda in order to make treatment a collaborative process from the beginning. The client is given the opportunity to propose additional items that may be included on the agenda that are in agreement with the therapeutic goals for the session.

The therapist will review the homework assignment from the previous session and answer any questions from the client regarding treatment. This will be followed by a

discussion of the meditation processes that the client tried throughout the week. The client will report on the meditation exercises that were practiced and the impact on his or her emotional well-being and spiritual growth. An opportunity will then be to ask questions about any of the meditation exercises. The therapist will respond to the questions and elaborate on any specific area of concern.

2. Introduce relaxation techniques

The most common relaxation techniques used in treatment are breathing exercises, muscle relaxation, imagery/visualization, meditation, yoga, and music. In this manual, we have already reviewed breathing exercises in session nine, imagery/visualization in sessions nine and ten, and meditation in session ten. The promotion of relaxation through the use of muscle relaxation and music will be presented in this session.

3. Progressive Muscle Relaxation

Progressive Muscle Relaxation (PMR) is a systematic relaxation technique that is used to induce deep relaxation. This technique involves tensing and relaxing, in succession, sixteen different muscle groups of the body. The individual is instructed to tense each muscle hard (but not too hard, to avoid muscle strain) for about ten seconds, and then to allow the muscle to relax. The muscle will remain in this relaxed state for about 15-20 seconds. The individual will be instructed to note the difference between the tense muscle and the relaxed muscle. The individual will also continue to focus on the feelings in the muscle and be instructed to bring the mind back to the individual muscle if the mind starts to wander. Below are the general guidelines for PMR:

1. Go to a setting that is quiet and peaceful. You want to make sure to eliminate any distractions before the exercise begins.
2. Only tense the muscle for 7 to 10 seconds and make sure that you are not straining any muscles.
3. Concentrate on the muscles throughout the activity. Focus on the build up of the tension as you tense the muscles. You may want to visualize the muscle groups as they are tensing.
4. When you relax the muscles, do so abruptly and immediately. Enjoy the sensations of relaxation and allow the relaxation process to fully develop for 15 to 20 seconds.
5. Other muscles in your body should stay relaxed.

Parts of the PMR exercise below were pulled from Edmund Bourne's book, *The Anxiety and Phobia Workbook.* This author utilized his method as a basic framework, but included other elements and suggestions throughout the exercise.

Progressive Muscle Relaxation

Now, settle back, close your eyes, and let yourself become very, very comfortable. If you feel any tension or tightness in your body, just let the tension or tightness fade, and let yourself become very, very relaxed.

Begin by concentrating on the feelings in your fingers and in your hands. Clench your fists. Feel the tension in your hand. We are going to hold this for 10 seconds. Hold…hold…hold…hold…and release. Concentrate on these feelings, and as you concentrate let any tension, tightness, or constricted feelings—just let those feelings gradually fade—and let yourself feel the relaxation very gradually, very slowly take over.

Let those muscles lose any tense or anxious feelings, and let them become very, very relaxed, very calm, very quiet. Just let yourself go. Keep your attention focused on these feelings, and let those muscles become longer and smoother, free of tension and tightness. Just let yourself go. Relaxation produces very loose, very long, and very calm muscles. Just let yourself go.

Now, concentrate on the muscles in your arms, your forearms and upper arms. Put your attention on the muscles in your arms. Tighten your biceps by drawing your forearms up toward your shoulders and "making a muscle" with both arms. Hold this position. Hold…tense…feeling the tightness…hold.…and relax. Concentrate and let these muscles become very, very relaxed, very quiet, very calm, and let the tension and tightness fade. Just let it go. Let those muscles go deeper and deeper into relaxation. Focus all your attention on those feelings there. If you feel your mind wandering, just bring it back and continue to concentrate on the muscles in the arms and in your hands.

Now we are going to focus on your triceps, these are the muscles on the undersides of your upper arms. I want you to extend your arms straight out and lock your elbows. Now hold.…hold…hold…feel the tension…hold…and relax. Feel the difference between relaxation and tension. Let those muscles become longer, calmer, smoother, and warmer. Let them remain very, very still…very, very tranquil. Just let yourself go. Let your shoulders just hang there very, very heavily. Very heavy. Let them continue to get heavier and heavier and heavier. As your shoulders become more and more relaxed, also let your upper arms, your forearms, your hands, and your fingers become even more relaxed. Deeper and deeper into a state of relaxation.

Now concentrate on the muscles in your forehead. You will tense these muscles by raising your eyebrows as far as you can. Hold….hold…hold…keep them up there and relax...Allow the muscle in your forehead to smooth out. Picture your forehead and the smoothness that you now feel. Your body is becoming more relaxed and you can feel sensations of those muscles also lose any tense or tight feelings they may have; let them become very tranquil, very smooth, very calm. Just let yourself go. Let yourself go.

Tense the muscles in your eyes by clenching your eyelids tightly shut. Hold…hold…notice the feeling of tension…hold…and relax. Allowing the tension to leave your body and relaxation following through your mind. Your body is becoming more relaxed and you are allowing all the stress and tension to freely flow from your body.

Now we are going to focus on the muscles around your jaw. Tighten the muscles in your jaw by opening your mouth so widely that you stretch the muscles around the hinges of your jaw. Hold…hold...hold…continue holding…and relax. Let your lips part and your jaw hang loose. Just let your jaw open to a place that's very comfortable, very quiet and calm, so you don't feel any pulling or contraction of muscles. There shouldn't be any tension there at all. Let that feeling of relaxation take over those muscles and let it become very, very relaxed, free of tension and free of tightness. Just let yourself go. Concentrate on the feelings on the muscles in your jaw. Just let your jaw find that place where it's very calm, very quiet, so it feeling like there's no tension or tightness.

Focus your attention on these feelings in the back of your neck. Pull your head way back, as if you were going to touch your head to your back. And hold…hold…hold... hold…and relax. If you feel any tension or tightness remaining in those muscles, let me

know and we will do this cycle twice. Allow yourself to focus on relaxation and allowing your muscles to remain smooth and relaxed. Just let yourself go. Let the muscles in the back of your neck become relaxed, and as they become relaxed let your entire body go deeper and deeper and deeper into relaxation. Let yourself go. Tune into the weight of your head singing into the surface that it is resting on and allow it to relax.

Tighten the muscles in your shoulders by raising them up as if you were going to touch your ears. Hold….hold…keep them up…and relax. Allow your shoulders to drop and rest naturally. Experience the feeling of releasing the tension from your body and welcome the feelings of relaxation.

Now, concentrate on the muscles around your shoulder blades. Push your shoulder blades back as if you were going to touch them together. Hold the tension in your shoulder blades…keep holding…holding…holding…and relax. Let those muscles also become very calm, very smooth, quiet and tranquil. Just let them become very, very relaxed, free of any tensions or any tightness. If you feel any tension or tightness at all let me know by raising your finger and we will do this area again. Just let yourself go; let it happen to you. Let the relaxation sweep over your body.

Focus on the muscles in your chest by taking in a deep breath. We are going to hold this for up to ten seconds. Ready…hold…one…two…three. Holding…five…six…seven Hold…eight…nine and breathe. Imagine any excess tension from your chest to flow away as you breathe out the air.

Now, focus on the muscles in your stomach. Tighten your muscles in your stomach by sucking your stomach in and hold….hold…hold…and release. Let those muscles also become very limp and very heavy, very calm, very peaceful. Let the feelings

of relaxation replace any constricted or tight feelings you may have. If you feel any tension or tightness at all, concentrate on those feelings, and let those muscles become more and more relaxed. Let them become more and more relaxed. Just let yourself go…Let yourself go. Relaxation spreading all around you. As your stomach becomes more relaxed, let your entire body just sink deeper and deeper and deeper into relaxation…your entire body

Tighten your lower back by arching it up. And hold…hold…hold. Keep holding, and relax. Allowing the muscles to smooth out in your lower back, feeling the tension leave your body and a sense of relaxation taking over.

Tighten your buttocks by pulling them together. Hold…hold…hold…and relax. Imagine the muscles in your hips going lose and the sensations of calm and peace moving over your body. Your entire body continues to release any tension and you are experiencing a deeper and deeper sense of relaxation.

Now, concentrate on the muscles around your legs. Squeeze the muscles in your thighs all the way down to your knees. You will probably have to tighten your hips along with your thighs since your thigh muscles attach at the pelvis. Hold.…hold…hold…and relax. Feel your muscles smoothing out and relaxing completely.

Tighten the muscles in your calves by pulling your toes downward and hold. Keeping holding.…feel that tightness…hold…and relax. Just let all the parts of your legs go very, very deeply into relaxation. Let those muscles become totally calm, totally quiet, and very, very relaxed. Just let yourself go. Let yourself go. Concentrate on the muscles in your legs. If there's any residual tension or tightness or feelings of anxiety, let those

feelings just fade away and be replaced by feelings of tranquility, peace and calmness…feel them become longer and smoother, calmer and quieter.

Tighten your feet by curling your toes downward and hold…hold…hold…and relax. Keep your attention focused on relaxation. If your mind wanders, just bring it back, and continue focusing on those feelings. Let yourself become very, very relaxed, very quiet, very calm. Let your feet, your legs, your stomach, the muscles in your face, your neck—just let all those muscles become very, very tranquil; very, very loose. Mentally scan your body for any residual tension and allow the tension to flow from your body. Let your breathing become very free and very even. Let your whole body just sink down very passively. Let your arms and your legs and your back and your head become very, very limp. Allow a wave of relaxation to spread throughout your body. I want you to continue to experience the state of relaxation and when you are ready you can open your eyes.

The therapist should review the experience with the client upon completion of the exercise and address any questions or concerns of the client at that time.

4. Importance of music

The use of music is another technique that can assist with both relaxation and stress management. Music has often been referred to as the language of the soul. Music may be relaxing in nature or uplifting. Music can have a powerful impact on the client. A musical selection was shared by the therapist in the previous session. During this session, the therapist will discuss ways that music can communicate powerful messages to the client. The therapist will present another selection to the client and disclose ways that the particular song helped the therapist in time of struggles or provided encouragement to

progress towards certain goals in life. The therapist should also review ways that singing and listening to positive music can have an impact on our mood and thinking. As one listens to the music and sings the positive lyrics he or she may begin to believe those lyrics to be true. The therapist will instruct the client to pick out a song over the course of the week to share in the last session.

5. Assign homework and optional prayer

The client will be instructed to independently complete the PMR exercise throughout the week. The therapist will have the client write down notes to enable completion of the activity on his or her own. The therapist may also provide the client with the script that was used in the session to help the client through the process. There are various online resources as well if the client would like to look into them. The client will also be asked to bring a musical selection to share at the closing of the final session. The therapist will inform the client that this last session will include an evaluation of the progress in treatment, a review of skills learned in treatment and the establishment of goals for the future.

The clinician may incorporate prayer into the session. The therapist may use this optional prayer at the completion of the session or may do so at another time during treatment when it is more appropriate. Prayer is an important element of spirituality and faith. By including prayer in treatment, the clinician will model an effective spiritual intervention that will assist the individual in his or her spiritual walk and help to regulate emotions.

Prayer for Session Eleven:

"Heavenly Father we come to You today and praise You for the work that you have been doing with ______ and in his/her life. We thank You for guiding us along this journey and helping ______ every step along the way. Lord, today I would like to ask you to help _____ develop his/her inner peace. Help him/her to utilize the techniques taught today throughout the week in order to work towards solace and rest. Help ____ to rest from his/her labors and find the peace and quietness that is within his/her soul. Continue to fill ______ with your love and fill him/her with your abundant joy so he/she can be a ray of light to the entire world. All these things we ask in Jesus' name. Amen."

SESSION TWELVE

Session twelve is the final session in this treatment protocol. The therapist will begin the session by reviewing any concerns or comments of the client concerning any of the materials that were covered in the last session. This will be followed by a discussion of several areas to provide closure for the treatment and the therapeutic relationship. The therapist and client will review ways the client changed throughout treatment. The therapist and client will examine the goals that were initially established and how the client has advanced towards these goals during the course of treatment. Then the session will proceed to a discussion of the client's depressive symptoms from the onset of treatment, the tools that were learned during treatment, and those that appeared to be most effective in the reduction of these symptoms. The client will impart the personal views of spirituality and note if any changes occurred in this area as a result of the treatment. Finally, the client will set goals for the future and discuss relapse prevention with the therapist.

<u>Capsulation</u>

1. Set the agenda and review homework
2. Closure
    A. Review areas of change
    B. Identify previously reported symptoms of depression and present status
    C. Discuss spirituality and changes noted
    D. Review skills/strategies that were learned and how, when, why one would use those strategies
    E. Set goals for continued change

F. Relapse prevention

3. Share musical selection and say good-bye

1. Set the agenda and review homework

At the beginning of the session, the therapist and the client will review the items that will be included in the session. The therapist will make suggestions based on the different elements of this protocol. It is essential for the client to work with the therapist in setting the agenda in order to make treatment a collaborative process from the beginning. The client is given the opportunity to propose additional items that may be included on the agenda that are in agreement with the therapeutic goals for the session.

The therapist will review the homework assignment from the previous session and answer any questions from the client regarding treatment. This will be followed by a discussion of the PMR exercise that the client was to complete throughout the week. Any struggles or questions of the client concerning this procedure will be resolved. The therapist will explain that the musical selection that was chosen for homework will be reviewed at the end of the session. This selection will serve as a symbol for the work completed by the client during treatment and will also provide time to reflect upon the client's new direction in life.

2. Closure

The therapist will discuss areas of change, symptoms of depression, spirituality, coping strategies, goals for the future and relapse prevention with the client. These areas will be discussed to review what has transpired during treatment. This will provide the client an opportunity to reflect upon the last eleven sessions and also re-evaluate his or her work and efforts. The discussion will also help to identify new goals that the client

would like to work towards and provide a time for the client to recognize tools that can be used in the future to work towards these goals while preventing relapse.

A. Review areas of change

The therapist will allow the client time to reflect upon the changes that he or she feels were made throughout treatment. This will be done in an open format. The therapist will specifically address changes in depressive symptoms and spirituality during the remainder of the session.

What changes have you noted as a result of these sessions?________________________

____

____

B. Identify symptoms of depression and changes that have occurred

The therapist will look through the notes and questionnaires to reveal changes that occurred throughout the treatment process. The therapist and the client will then discuss these noted alterations in the client's depressive symptoms. Each area of depression will be addressed in detail. In addition, the therapist may opt to share the Beck Depression Inventory scores with the client and explain any modifications that occurred on this scale since this administration of this assessment.

C. Discuss spirituality and any changes noted

The therapist and the client will review the spiritual life of the client. The therapist can discuss the various activities that were completed during treatment and ways the client exhibited growth throughout treatment. This will be followed by a reflection of the client's current beliefs systems and spiritual walk.

D. Review coping strategies and how, when, where and why one would use these strategies

The therapist instructed the client in a variety of behavioral, cognitive and spiritual interventions over the course of treatment. Each of these skills will be reviewed, including a discussion regarding how and when to use them. The therapist will then answer any final questions from the client relating related to these skills. Finally, the importance of the continued use of these skills will be underscored.

Behavioral Interventions: This comprises doing more (goal setting, self-monitoring, rewards, shaping, stimulus control), being more (inward spirituality), doing less.

Cognitive Skills: This includes identifying cognitive distortions, challenging distortions with biblical passages, the DTR, developing counterstatements that reflect God's love, the cognitive quadrant.

Relaxation Skills: This encompasses the Serenity Prayer, musical selection, imagery/visualization, progressive muscle relaxation, meditation, and breathing techniques.

E. Set goals for continued change

After a discussion about what the client has learned and when to use these skills, the client and the therapist will set goals for continued change. It was important for the client to have ongoing direction during treatment and a plan to work towards these new goals. At this point, the client should realize that treatment is a lifelong process, requiring both goal-setting in order to move forward and monitoring of one's present status along the way. The client should write goals that address his or her depression levels and also goals for spiritual growth.

Goals for the Future

1.

2.

3.

4.

5.

6.

7.

8.

F. Relapse prevention

The therapist and the client will discuss potential problems and indicators of relapse. These obstacles will be reviewed in detail with a determination of skills and supports for the client to use when confronted with these situations. The therapist will explain the importance of a relapse prevention plan and the need for the client to continue to monitor his depressive symptoms in order to note immediately when a change occurs. When an adverse change is observed, the client should evaluate what happened and utilize those skills learned in treatment.

3. Share musical selection and say good-bye

Once the treatment process has been reviewed, the therapist will ask the client to share the musical selection. The therapist and the client will listen to the selection. When the piece is over, the client will explain why the selection was chosen. The client will discuss the importance of the song and the main message the client receives from the song. The session will end with reflections regarding the therapeutic relationship and the work that was accomplished during treatment as a result of the therapeutic alliance.

Appendix B

Spiritual Assessment Tool

What type of religious problem solving do you use?

Self-directing: it is your sole responsibility to solve any and all problems.

Deferring: defers the responsibility of problem solving to God

Collaborative: belief that there is a joint responsibility between that individual and God to effectively solve the problem.

How important is religion or spirituality in your life?

Do you practice religion currently?

Do you believe in God or a Higher Power?

Are there spiritual practices that you follow regularly?

What things are most important to you?

What gives your life purpose or meaning?

How can spiritual beliefs help you cope, and what beliefs give your life meaning?

How much do faith and belief influence your life and important decisions?

Are you part of a spiritual community, and how is it supportive?

How can these issues of belief be addressed in the therapeutic setting?

Appendix C

Depression Information

Depression is much more than simple unhappiness. Clinical depression, sometimes called major depression, is a "mood disorder" that is a significant mental health problem. Everyone feels blue at one time or another. A death in the family, a disappointment in your career, a romance gone awry–all can cause most people to feel down for a period of time. Grief and sadness are normal reactions to life's stressful events. After a time, however, most people will heal and return to a normal life.

Depression is more than the normal ups and downs of life that we all have. When sadness just won't go away and it begins to interfere with daily life we recognize this as a mood disorder called depression.

Sometimes depression goes unrecognized because it may manifest itself in more ways than just a sad mood. A depressed person may feel any or all of the following emotions: anger, irritability, hopelessness, fear, anxiety, fatigue, numbness, confusion, worthlessness, or shame. A depressed person may also feel physically ill, weak, or in some cases, experience hallucinations.

Depression can affect every aspect of your life: your physical health, your sleep, your eating habits, your job, and your relationships with friends and family. It affects your thoughts, feelings and behaviors.

People with untreated depression may choose to self-medicate with drugs or alcohol. They may also relieve their emotional pain by overeating, physically harming themselves (cutting, burning), being sexually promiscuous, or other self-destructive behaviors.

Depression may come on suddenly as result of a stressful event or it may grow slowly over months and years. It may have an apparent cause or it may not seem to have any rhyme or reason. Depressed people suffer from an imbalance in their brain chemistry that makes them especially prone to stress. What may seem a small setback to someone else may be the proverbial straw that broke the camel's back for a person prone to depression.

It is very important for those who love a depressed person–as well as the depressed person to understand that a depressed person suffers from a very real illness. A depressed person cannot just "snap out of it" or "cheer up". They are not weak, lazy, defective, or seeking attention. They are ill and need your help.

Symptoms

The main symptom of depression is a sad, despairing mood that:

- is present most days and lasts most of the day
- lasts for more than two weeks

- impairs the person's performance at work, at school or in social relationships.

Other symptoms of depression may include:

- changes in appetite and weight
- sleep problems
- loss of interest in work, hobbies, people or sex
- withdrawal from family members and friends
- feeling useless, hopeless, excessively guilty, pessimistic or low self-esteem
- agitation or feeling slowed down
- irritability
- fatigue
- trouble concentrating, remembering and making decisions
- crying easily, or feeling like crying but being not able to
- thoughts of suicide (which should always be taken seriously)
- a loss of touch with reality, hearing voices (hallucinations) or having strange ideas (delusions).

Depression in women

Major depression can occur in 10 to 25 percent of women – almost twice as many as men. Many hormonal factors may contribute to the increased rate of depression in women – particularly during times such as menstrual cycle changes, pregnancy and postpartum, miscarriage, pre-menopause, and menopause.

Depression in men

Men with depression typically have a higher rate of feeling irritable, angry and discouraged. This can make it harder to recognize depression in men. The rate of completed suicide in men is four times that of women, though more women attempt it.

Depression in older adults

Some people have the mistaken idea that it is normal for older adults to feel depressed. Older adults often don't want to discuss feeling hopeless, sad, a loss of interest in normally pleasurable activities, or prolonged grief after a loss.

Depression in children

A child who is depressed may pretend to be sick, refuse to go to school, cling to a parent or worry that the parent may die. Older children may sulk, get into trouble at school, be negative or grouchy, and feel misunderstood. Because normal behaviors vary from one childhood stage to another, it can be difficult to tell whether a child is just going through a temporary "phase" or has depression.

Types of depression

Different types of depression have different symptoms. These include:

- Seasonal affective disorder
  This type of depression is usually affected by the weather and time of the year.
- Postpartum depression
  This occurs in women, following the birth of a child. About 13 per cent of women will experience this type of depression.
- Depression with psychosis
  In some cases, depression may become so severe that a person loses touch with reality and experiences hallucinations (hearing voices or seeing people or objects that are not really there) or delusions (beliefs that have no basis in reality).
- Dysthymia
  This is a chronically low mood with moderate symptoms of depression.

Causes

Several factors may play a part in the onset of depression. These include a genetic or family history of depression, psychological or emotional vulnerability to depression, biological factors such as imbalances in brain chemistry and in the endocrine/immune systems, or a major stress in the person's life.

Depressive symptoms may be the result of another illness that shares the same symptoms, such as lupus or hypothyroidism. Depression may be a reaction to another illness, such as cancer or a heart attack. Finally, depression may be caused by an illness itself, such as a stroke, where neurological changes have occurred.

Treatments

The most commonly used treatments are pharmacotherapy (medications), psychoeducation, psychotherapy and electroconvulsive therapy. These treatments may be used individually or in combination.

Self-help organizations, run by clients of the mental health system and their families, can be an important part of treatment and recovery for people with depression and their families.

Recovery

Clinical depression needs to be managed over a person's lifetime. Depression, like disorders such as diabetes, can be effectively managed and controlled by combining a healthy lifestyle and treatments. Watching for early warnings of a relapse can possibly prevent a full depressive episode.

Misconceptions

- People should just get over “the blues” and get on with their lives.
  Clinical depression is not just unhappiness – it is a complex mood disorder caused by a variety of factors, including genetic predisposition, personality, stress and brain chemistry. While it can suddenly go into remission, depression is not something that people can “get over” by their own effort.
- My life will never be normal again.
  Most people can and do return to function at the level they did before they became depressed.

1 King 19:1-18 details spiritual depression that was experience by Elijah. In this passage, Elijah became physically and emotionally exhaustive. Eventually, God takes initiative to seek Elijah out (Psalm 103: 13-14). He then addresses Elijah’s most basic and immediate needs-rest and sleep. Once Elijah is recovered, God instructs Elijah to reflect on his perspective and then corrects this perspective later with His truth.

Adapted from Depressive Illness: A Guide for People with Depression and their Families

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Appendix D

Cognitive-Behavioral Therapy

Cognitive-behavioral therapy is a form of psychotherapy that emphasizes the important role of thinking in how we feel and what we do.

Most cognitive-behavioral therapies have the following characteristics:

1. CBT is based on the cognitive model of emotional response.
Cognitive-behavioral therapy is based on the idea that our *thoughts* cause our feelings and behaviors. We are able to look at our thoughts and change the way we think.

2. CBT is Brief and Time-Limited.

3. A sound therapeutic relationship is necessary for effective therapy, but not the focus.

4. CBT is a collaborative effort between the therapist and the client.

5. CBT uses the Socratic method.
Cognitive-behavioral therapists want to gain a very good understanding of their clients' concerns. That's why they often ask *questions.* They also encourage their clients to ask questions of themselves.

6. CBT is structured and directive.
Cognitive-behavioral therapists have a specific agenda for each session. Specific techniques / concepts are taught during each session. CBT focuses on the client's goals.

7. CBT is based on an educational model.
CBT is based on the scientifically supported assumption that most emotional and behavioral reactions are learned. Therefore, the goal of therapy is to help clients *unlearn* their unwanted reactions and to learn a new way of reacting.

8. CBT theory and techniques rely on the inductive method.
The inductive method encourages us to look at our thoughts as being hypotheses or guesses that can be questioned and tested. .

9. Homework is a central feature of CBT.

Appendix E

1 Kings 19:1-18 (King James Version)

1 Kings 19

[1]And Ahab told Jezebel all that Elijah had done, and withal how he had slain all the prophets with the sword.

[2]Then Jezebel sent a messenger unto Elijah, saying, So let the gods do to me, and more also, if I make not thy life as the life of one of them by tomorrow about this time.

[3]And when he saw that, he arose, and went for his life, and came to Beersheba, which belongeth to Judah, and left his servant there.

[4]But he himself went a day's journey into the wilderness, and came and sat down under a juniper tree: and he requested for himself that he might die; and said, It is enough; now, O LORD, take away my life; for I am not better than my fathers.

[5]And as he lay and slept under a juniper tree, behold, then an angel touched him, and said unto him, Arise and eat.

[6]And he looked, and, behold, there was a cake baken on the coals, and a cruse of water at his head. And he did eat and drink, and laid him down again.

[7]And the angel of the LORD came again the second time, and touched him, and said, Arise and eat; because the journey is too great for thee.

[8]And he arose, and did eat and drink, and went in the strength of that meat forty days and forty nights unto Horeb the mount of God.

[9]And he came thither unto a cave, and lodged there; and, behold, the word of the LORD came to him, and he said unto him, What doest thou here, Elijah?

[10]And he said, I have been very jealous for the LORD God of hosts: for the children of Israel have forsaken thy covenant, thrown down thine altars, and slain thy prophets with the sword; and I, even I only, am left; and they seek my life, to take it away.

[11]And he said, Go forth, and stand upon the mount before the LORD. And, behold, the LORD passed by, and a great and strong wind rent the mountains, and brake in pieces the rocks before the LORD; but the LORD was not in the wind:

and after the wind an earthquake; but the LORD was not in the earthquake:

[12]And after the earthquake a fire; but the LORD was not in the fire: and after the fire a still small voice.

[13]And it was so, when Elijah heard it, that he wrapped his face in his mantle, and went out, and stood in the entering in of the cave. And, behold, there came a voice unto him, and said, What doest thou here, Elijah?

[14]And he said, I have been very jealous for the LORD God of hosts: because the children of Israel have forsaken thy covenant, thrown down thine altars, and slain thy prophets with the sword; and I, even I only, am left; and they seek my life, to take it away.

[15]And the LORD said unto him, Go, return on thy way to the wilderness of Damascus: and when thou comest, anoint Hazael to be king over Syria:

[16]And Jehu the son of Nimshi shalt thou anoint to be king over Israel: and Elisha the son of Shaphat of Abelmeholah shalt thou anoint to be prophet in thy room.

[17]And it shall come to pass, that him that escapeth the sword of Hazael shall Jehu slay: and him that escapeth from the sword of Jehu shall Elisha slay.

[18]Yet I have left me seven thousand in Israel, all the knees which have not bowed unto Baal, and every mouth which hath not kissed him.

Appendix F

Weekly Activity Monitoring Schedule

Rank the activities *D* for Depression and *E* for Enjoyment on 0 to 5 scales, where 5 signifies no depression and the greatest amount of Enjoyment you have had in the last few weeks.

	day 1	*day 2*	*day 3*	*day 4*	*Day 5*	*day 6*	*day 7*
5 to	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*
9 to	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*
10 to	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*
11 to	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*
12 to	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*
1 to	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*
2 to	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*
3 to	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*
4 to	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*
5 to	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*
6 to	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*
7 to	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*
8 to	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*	*D* *E*

Appendix G

Weekly Checklist

Name	Monday	Tuesday	Wednesday	Thursday	Friday
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Appendix H

Cognition Log

Change in Affect- Positive to Negative.	*What was I just thinking?????*

Appendix I

Spiritually- Informed Dysfunctional Thought Record

Situation: What led to the unpleasant emotion? What unpleasant sensations did you have?	Automatic Thought(s) Described any irrational or nonbiblical/sinful thoughts that you had about yourself, others, the future and God. How much did you believe that thought? (0-100%)	Feelings Specify sad, anxious, angry etc. How intense was the emotions? 0-100 %	Adaptive Response: Use the questions below to respond to the automatic thoughts about yourself, others, the future and God. How much do you believe each response? 0-100%.	Outcome How much do you believe yo ATs now? (0-100%) What emotions do you feel no and at what intensity?

Questions to elicit an adaptive response: 1) What is the evidence that my automatic thought is true? Not true?2) If my cognition is true, what's the worst that could happen? Could I live through it? How would my life be different 3 months (6 months, 1 year) from now? 3) What's the best that could happen? 4) What will probably happen? 5) Is there an alternative explanation--Another way of looking at the situation? 6) If a friend was in the same situation experiencing the same automatic thoughts, what would I tell him or her? 7) What are the advantages of my believing the automatic thoughts? 8) What are the costs to thinking this way? The benefits? 9) What is in my best interest, to continue accepting the automatic thoughts as true, or to challenge this kind of thinking? 10) What would God say about this situation? 11) What does the Bible say about the thoughts I am having? 12) Would Jesus agree with my thoughts?13) What should I do about it?

Appendix J

Biblical Passages that are Related to Various Cognitive Distortions

All-or-nothing thinking: see self as a total failure when fall short of perfection. Some Christians falsely believe this thinking pattern. Having thoughts such as "if I am spiritual enough, I will have no pain or sinfulness." These beliefs hold the individual to continue to drive towards being perfect. Eventually, the individual may feel defeated, as sin is a part of his or her life and perfection is impossible. Therefore, the individual feels that he or she is a total failure and if that person cannot be perfect, it must mean that he or she is always bound to be a failure.

References to perfectionism in the Bible:

My grace is sufficient, for power is perfected in weakness. (II Cor. 12:9)

If we claim we have no sin, we are only fooling ourselves and not living in the truth. (1 John 1:18)

[8]For by grace are ye saved through faith; and that not of yourselves: it is the gift of God: Not of works, lest any man should boast.
Ephesians 2:8-9

Biblical story related to perfectionism:

Story of Martha and Mary - (Luke 10:38-42).

[38]Now it came to pass, as they went, that he entered into a certain village: and a certain woman named Martha received him into her house.

[9]And she had a sister called Mary, which also sat at Jesus' feet, and heard his word.

[40]But Martha was cumbered about much serving, and came to him, and said, Lord, dost thou not care that my sister hath left me to serve alone? bid her therefore that she help me.

[41]And Jesus answered and said unto her, Martha, Martha, thou art careful and troubled about many things:

[42]But one thing is needful: and Mary hath chosen that good part, which shall not be taken away from her.

Overgeneralization: single negative event is a never-ending pattern of defeat. The person may believe that one wrong choice or sin is the end for that person. The individual will experience feelings of defeat and begin to see everything as being negative. He or she is doomed to continue to fail and as a result fall further away from his or her spiritual goals and walk.

References related to defeat:

So let's not get tired of doing what is good. At just the right time we will reap a harvest of blessing if we don't give up. (Galatians 6:9)

And we know that God causes everything to work together[a] for the good of those who love God and are called according to his purpose for them. (Romans 8:28)

[16]For a just man falleth seven times, and riseth up again: but the wicked shall fall into mischief. (Proverbs 24:16)

Biblical story related to defeat:

Jesus' defeat again Satan –(Matthew 4)

[1]Then was Jesus led up of the Spirit into the wilderness to be tempted of the devil.

[2]And when he had fasted forty days and forty nights, he was afterward an hungred.

[3]And when the tempter came to him, he said, If thou be the Son of God, command that these stones be made bread.

[4]But he answered and said, It is written, Man shall not live by bread alone, but by every word that proceedeth out of the mouth of God.

[5]Then the devil taketh him up into the holy city, and setteth him on a pinnacle of the temple,

[6]And saith unto him, If thou be the Son of God, cast thyself down: for it is written, He shall give his angels charge concerning thee: and in their hands they shall bear thee up, lest at any time thou dash thy foot against a stone.

[7]Jesus said unto him, It is written again, Thou shalt not tempt the Lord thy God.

[8]Again, the devil taketh him up into an exceeding high mountain, and sheweth him all the kingdoms of the world, and the glory of them;

[9]And saith unto him, All these things will I give thee, if thou wilt fall down and worship me.

[10]*Then saith Jesus unto him, Get thee hence, Satan: for it is written, Thou shalt worship the Lord thy God, and him only shalt thou serve.*

[11]*Then the devil leaveth him, and, behold, angels came and ministered unto him.*

[12]*Now when Jesus had heard that John was cast into prison, he departed into Galilee;*

[13]*And leaving Nazareth, he came and dwelt in Capernaum, which is upon the sea coast, in the borders of Zabulon and Nephthalim:*

[14]*That it might be fulfilled which was spoken by Esaias the prophet, saying,*

[15]*The land of Zabulon, and the land of Nephthalim, by the way of the sea, beyond Jordan, Galilee of the Gentiles;*

[16]*The people which sat in darkness saw great light; and to them which sat in the region and shadow of death light is sprung up.*

[17]*From that time Jesus began to preach, and to say, Repent: for the kingdom of heaven is at hand.*

[18]*And Jesus, walking by the sea of Galilee, saw two brethren, Simon called Peter, and Andrew his brother, casting a net into the sea: for they were fishers.*

[19]*And he saith unto them, Follow me, and I will make you fishers of men.*

[20]*And they straightway left their nets, and followed him.*

[21]*And going on from thence, he saw other two brethren, James the son of Zebedee, and John his brother, in a ship with Zebedee their father, mending their nets; and he called them.*

[22]*And they immediately left the ship and their father, and followed him.*

[23]*And Jesus went about all Galilee, teaching in their synagogues, and preaching the gospel of the kingdom, and healing all manner of sickness and all manner of disease among the people.*

[24]*And his fame went throughout all Syria: and they brought unto him all sick people that were taken with divers diseases and torments, and those which were possessed with devils, and those which were lunatick, and those that had the palsy; and he healed them.*

[25]*And there followed him great multitudes of people from Galilee, and from Decapolis, and from Jerusalem, and from Judaea, and from beyond Jordan.*

<u>*References on discouragement:*</u>

For I know the plans I have for you, says the Lord. They are plans for good and not for evil, to give you a future and a hope. (Jeremiah 29:11)

When I pray, You answer me, and encourage me by giving me the strength I need (Psalm 138:3).

My brethren, count it all joy when ye fall into divers temptations; Knowing this, that the trying of your faith worketh patience. [4]But let patience have her perfect work, that ye may be perfect and entire, wanting nothing.(James 1:2-4)

<u>*Biblical story related to discouragement*</u>

Moses leading the Israelites out of the desert (Exodus 15:22-27)

[22]So Moses brought Israel from the Red sea, and they went out into the wilderness of Shur; and they went three days in the wilderness, and found no water.

[23]And when they came to Marah, they could not drink of the waters of Marah, for they were bitter: therefore the name of it was called Marah.

[24]And the people murmured against Moses, saying, What shall we drink?

[25]And he cried unto the LORD; and the LORD shewed him a tree, which when he had cast into the waters, the waters were made sweet: there he made for them a statute and an ordinance, and there he proved them,

[26]And said, If thou wilt diligently hearken to the voice of the LORD thy God, and wilt do that which is right in his sight, and wilt give ear to his commandments, and keep all his statutes, I will put none of these diseases upon thee, which I have brought upon the Egyptians: for I am the LORD that healeth thee.

[27]And they came to Elim, where were twelve wells of water, and threescore and ten palm trees: and they encamped there by the waters.

<u>*Bible passages on encouragement*</u>*:*

Therefore, since we have been justified through faith, we[a]have peace with God through our Lord Jesus Christ, through whom we have gained access by faith into this grace in which we now stand. And we[b] rejoice in the hope of the glory of God. Not only so, but we[c] also rejoice in our sufferings, because we know that suffering produces

perseverance; character; and character, hope. And hope does not disappoint us, because God has poured out his love into our hearts by the Holy Spirit, whom he has given us. (Romans 5:1-5)

For I am the LORD, your God, who takes hold of your right hand and says to you, Do not fear; I will help you. (Isaiah 41:13)

[8]Or he that exhorteth, on exhortation: he that giveth, let him do it with simplicity; he that ruleth, with diligence; he that sheweth mercy, with cheerfulness. (Romans 12:8)

Biblical story about encouragement:

Story of Noah's Ark (Genesis 6)

[1]And it came to pass, when men began to multiply on the face of the earth, and daughters were born unto them,

[2]That the sons of God saw the daughters of men that they were fair; and they took them wives of all which they chose.

[3]And the LORD said, My spirit shall not always strive with man, for that he also is flesh: yet his days shall be an hundred and twenty years.

[4]There were giants in the earth in those days; and also after that, when the sons of God came in unto the daughters of men, and they bare children to them, the same became mighty men which were of old, men of renown.

[5]And God saw that the wickedness of man was great in the earth, and that every imagination of the thoughts of his heart was only evil continually.

[6]And it repented the LORD that he had made man on the earth, and it grieved him at his heart.

[7]And the LORD said, I will destroy man whom I have created from the face of the earth; both man, and beast, and the creeping thing, and the fowls of the air; for it repenteth me that I have made them.

[8]But Noah found grace in the eyes of the LORD.

[9]These are the generations of Noah: Noah was a just man and perfect in his generations, and Noah walked with God.

[10]And Noah begat three sons, Shem, Ham, and Japheth.

[11]The earth also was corrupt before God, and the earth was filled with violence.

[12]And God looked upon the earth, and, behold, it was corrupt; for all flesh had corrupted his way upon the earth.

[13]And God said unto Noah, The end of all flesh is come before me; for the earth is filled with violence through them; and, behold, I will destroy them with the earth.

[14]Make thee an ark of gopher wood; rooms shalt thou make in the ark, and shalt pitch it within and without with pitch.

[15]And this is the fashion which thou shalt make it of: The length of the ark shall be three hundred cubits, the breadth of it fifty cubits, and the height of it thirty cubits.

[16]A window shalt thou make to the ark, and in a cubit shalt thou finish it above; and the door of the ark shalt thou set in the side thereof; with lower, second, and third stories shalt thou make it.

[17]And, behold, I, even I, do bring a flood of waters upon the earth, to destroy all flesh, wherein is the breath of life, from under heaven; and everything that is in the earth shall die.

[18]But with thee will I establish my covenant; and thou shalt come into the ark, thou, and thy sons, and thy wife, and thy sons' wives with thee.

[19]And of every living thing of all flesh, two of every sort shalt thou bring into the ark, to keep them alive with thee; they shall be male and female.

[20]Of fowls after their kind, and of cattle after their kind, of every creeping thing of the earth after his kind, two of every sort shall come unto thee, to keep them alive.

[21]And take thou unto thee of all food that is eaten, and thou shalt gather it to thee; and it shall be for food for thee, and for them.

[22]Thus did Noah; according to all that God commanded him, so did he.

Mental filter: single negative event and dwell on it. The Christian individual may dwell on ~~a~~ one sinful event and believe that as a result of this event he or she is doomed for all eternity. His or her future and present actions do not matter, since failure already happened once and the individual may feel as if there is nothing that can be done about this mistake/sin.

References on Mistakes in the Bible:

Indeed, we all make many mistakes. For if we could control our tongues, we would be perfect and could also control ourselves in every other way. (James 3:2)

But you, keep your head in all situations, endure hardship, do the work of an evangelist, discharge all the duties of your ministry (2 Timothy 4:5).

[32]*And be ye kind one to another, tenderhearted, forgiving one another, even as God for Christ's sake hath forgiven you. (Ephesians 4:32)*

Biblical story on mistakes:

David and his affair with Bathsheba – (2 Samuel 11)

[1]*And it came to pass, after the year was expired, at the time when kings go forth to battle, that David sent Joab, and his servants with him, and all Israel; and they destroyed the children of Ammon, and besieged Rabbah. But David tarried still at Jerusalem.*

[2]*And it came to pass in an eveningtide, that David arose from off his bed, and walked upon the roof of the king's house: and from the roof he saw a woman washing herself; and the woman was very beautiful to look upon.*

[3]*And David sent and enquired after the woman. And one said, Is not this Bathsheba, the daughter of Eliam, the wife of Uriah the Hittite?*

[4]*And David sent messengers, and took her; and she came in unto him, and he lay with her; for she was purified from her uncleanness: and she returned unto her house.*

[5]*And the woman conceived, and sent and told David, and said, I am with child.*

[6]*And David sent to Joab, saying, Send me Uriah the Hittite. And Joab sent Uriah to David.*

[7]*And when Uriah was come unto him, David demanded of him how Joab did, and how the people did, and how the war prospered.*

[8]*And David said to Uriah, Go down to thy house, and wash thy feet. And Uriah departed out of the king's house, and there followed him a mess of meat from the king.*

[9]*But Uriah slept at the door of the king's house with all the servants of his lord, and went not down to his house.*

[10]*And when they had told David, saying, Uriah went not down unto his house, David said unto Uriah, Camest thou not from thy journey? why then didst thou not go down unto thine house?*

[11]*And Uriah said unto David, The ark, and Israel, and Judah, abide in tents; and my lord Joab, and the servants of my lord, are encamped in the open fields; shall I then go into mine house, to eat and to drink, and to lie with my wife? as thou livest, and as thy soul liveth, I will not do this thing.*

[12]And David said to Uriah, Tarry here today also, and tomorrow I will let thee depart. So Uriah abode in Jerusalem that day, and the morrow.

[13]And when David had called him, he did eat and drink before him; and he made him drunk: and at even he went out to lie on his bed with the servants of his lord, but went not down to his house.

[14]And it came to pass in the morning, that David wrote a letter to Joab, and sent it by the hand of Uriah.

[15]And he wrote in the letter, saying, Set ye Uriah in the forefront of the hottest battle, and retire ye from him, that he may be smitten, and die.

[16]And it came to pass, when Joab observed the city, that he assigned Uriah unto a place where he knew that valiant men were.

[17]And the men of the city went out, and fought with Joab: and there fell some of the people of the servants of David; and Uriah the Hittite died also.

[18]Then Joab sent and told David all the things concerning the war;

[19]And charged the messenger, saying, When thou hast made an end of telling the matters of the war unto the king,

[20]And if so be that the king's wrath arise, and he say unto thee, Wherefore approached ye so nigh unto the city when ye did fight? knew ye not that they would shoot from the wall?

[21]Who smote Abimelech the son of Jerubbesheth? did not a woman cast a piece of a millstone upon him from the wall, that he died in Thebez? why went ye nigh the wall? then say thou, Thy servant Uriah the Hittite is dead also.

[22]So the messenger went, and came and shewed David all that Joab had sent him for.

[23]And the messenger said unto David, Surely the men prevailed against us, and came out unto us into the field, and we were upon them even unto the entering of the gate.

[24]And the shooters shot from off the wall upon thy servants; and some of the king's servants be dead, and thy servant Uriah the Hittite is dead also.

[25]Then David said unto the messenger, Thus shalt thou say unto Joab, Let not this thing displease thee, for the sword devoureth one as well as another: make thy battle more strong against the city, and overthrow it: and encourage thou him.

[26]And when the wife of Uriah heard that Uriah her husband was dead, she mourned for her husband.

[27]And when the mourning was past, David sent and fetched her to his house, and she became his wife, and bare him a son. But the thing that David had done displeased the LORD.

<u>Disqualifying the positives:</u> Positive experiences don't count. The Christian individual might feel that it is selfish or boastful to admit his or her strengths. Even thinking about his or her strengths could lead to guilt and shame. Therefore, the individual does not believe in the positive experiences and instead may continue believe that it is best to focus on his or her weaknesses in order to be more humble in his or her daily living.

See references on perfectionism, encouragement and defeat that are listed above.

<u>Jumping to conclusions</u> The Christian client might jump to conclusions when negative events begin to occur. He or she may believe that it is a punishment from God and not fully reflect upon the situation. This could lead to faulty thinking and development of increased amounts of emotional distress.

<u>References about haste</u>:

Therefore I tell you, do not worry about your life, what you will eat or drink; or about your body, what you will wear. Is not life more important than food, and the body more important than clothes? (Matthew 6:25)

Do not be quick with your mouth, do not be hasty in your heart to utter anything before God. God is in heaven and you are on earth, so let your words be few (Ecclesiastes 5:2).

The thoughts of the diligent tend only to plenteousness; but of every one that is hasty only to want. (Proverbs 21:5)

<u>Biblical story about haste:</u>

The prodigal Son- (Luke 15:11-32)

[11]And he said, A certain man had two sons:

[12]And the younger of them said to his father, Father, give me the portion of goods that falleth to me. And he divided unto them his living.

[13]And not many days after the younger son gathered all together, and took his journey into a far country, and there wasted his substance with riotous living.

[14]And when he had spent all, there arose a mighty famine in that land; and he began to be in want.

[15]*And he went and joined himself to a citizen of that country; and he sent him into his fields to feed swine.*

[16]*And he would fain have filled his belly with the husks that the swine did eat: and no man gave unto him.*

[17]*And when he came to himself, he said, How many hired servants of my father's have bread enough and to spare, and I perish with hunger!*

[18]*I will arise and go to my father, and will say unto him, Father, I have sinned against heaven, and before thee,*

[19]*And am no more worthy to be called thy son: make me as one of thy hired servants.*

[20]*And he arose, and came to his father. But when he was yet a great way off, his father saw him, and had compassion, and ran, and fell on his neck, and kissed him.*

[21]*And the son said unto him, Father, I have sinned against heaven, and in thy sight, and am no more worthy to be called thy son.*

[22]*But the father said to his servants, Bring forth the best robe, and put it on him; and put a ring on his hand, and shoes on his feet:*

[23]*And bring hither the fatted calf, and kill it; and let us eat, and be merry:*

[24]*For this my son was dead, and is alive again; he was lost, and is found. And they began to be merry.*

[25]*Now his elder son was in the field: and as he came and drew nigh to the house, he heard musick and dancing.*

[26]*And he called one of the servants, and asked what these things meant.*

[27]*And he said unto him, Thy brother is come; and thy father hath killed the fatted calf, because he hath received him safe and sound.*

[28]*And he was angry, and would not go in: therefore came his father out, and intreated him.*

[29]*And he answering said to his father, Lo, these many years do I serve thee, neither transgressed I at any time thy commandment: and yet thou never gavest me a kid, that I might make merry with my friends:*

[30]*But as soon as this thy son was come, which hath devoured thy living with harlots, thou hast killed for him the fatted calf.*

[31]And he said unto him, Son, thou art ever with me, and all that I have is thine.

[32]It was meet that we should make merry, and be glad: for this thy brother was dead, and is alive again; and was lost, and is found.

Mind reading
See references about haste.

The Fortune Teller Error
Ecclesiastes 8:7

Magnification (Castastrophizing) or Minimization The Christian client may revert to looking at the struggles and pains of being a Christian. These experiences might be magnified, for the individual may believe that suffering and pain are important for spiritual growth.

References on Hope:

Trust in the LORD, and do good; Dwell in the land, and feed on His faithfulness. *Delight yourself also in the LORD, And He shall give you the desires of your heart (Psalm 37:3-4)*

Be anxious for nothing, but in everything by prayer and supplication, with thanksgiving, let your requests be made known to God; and the peace of God, which surpasses all understanding, will guard your hearts and minds through Christ Jesus.(Philippians 4:6-7)

[28]And we know that all things work together for good to them that love God, to them who are the called according to his purpose.(Romans 8:28)

Biblical story on Magnification/Minimization:

The story of Abraham and Isaac (Genesis 22)

[1]And it came to pass after these things, that God did tempt Abraham, and said unto him, Abraham: and he said, Behold, here I am.

[2]And he said, Take now thy son, thine only son Isaac, whom thou lovest, and get thee into the land of Moriah; and offer him there for a burnt offering upon one of the mountains which I will tell thee of.

[3]And Abraham rose up early in the morning, and saddled his ass, and took two of his young men with him, and Isaac his son, and clave the wood for the burnt offering, and rose up, and went unto the place of which God had told him.

[4]Then on the third day Abraham lifted up his eyes, and saw the place afar off.

[5]And Abraham said unto his young men, Abide ye here with the ass; and I and the lad will go yonder and worship, and come again to you.

[6]And Abraham took the wood of the burnt offering, and laid it upon Isaac his son; and he took the fire in his hand, and a knife; and they went both of them together.

[7]And Isaac spake unto Abraham his father, and said, My father: and he said, Here am I, my son. And he said, Behold the fire and the wood: but where is the lamb for a burnt offering?

[8]And Abraham said, My son, God will provide himself a lamb for a burnt offering: so they went both of them together.

[9]And they came to the place which God had told him of; and Abraham built an altar there, and laid the wood in order, and bound Isaac his son, and laid him on the altar upon the wood.

[10]And Abraham stretched forth his hand, and took the knife to slay his son.

[11]And the angel of the LORD called unto him out of heaven, and said, Abraham, Abraham: and he said, Here am I.

[12]And he said, Lay not thine hand upon the lad, neither do thou anything unto him: for now I know that thou fearest God, seeing thou hast not withheld thy son, thine only son from me.

[13]And Abraham lifted up his eyes, and looked, and behold behind him a ram caught in a thicket by his horns: and Abraham went and took the ram, and offered him up for a burnt offering in the stead of his son.

[14]And Abraham called the name of that place Jehovahjireh: as it is said to this day, In the mount of the LORD it shall be seen.

[15]And the angel of the LORD called unto Abraham out of heaven the second time,

[16]And said, By myself have I sworn, saith the LORD, for because thou hast done this thing, and hast not withheld thy son, thine only son:

[17]That in blessing I will bless thee, and in multiplying I will multiply thy seed as the stars of the heaven, and as the sand which is upon the sea shore; and thy seed shall possess the gate of his enemies;

[18]And in thy seed shall all the nations of the earth be blessed; because thou hast obeyed my voice.

[19]So Abraham returned unto his young men, and they rose up and went together to Beersheba; and Abraham dwelt at Beersheba.

[20]And it came to pass after these things, that it was told Abraham, saying, Behold, Milcah, she hath also born children unto thy brother Nahor;

[21]Huz his firstborn, and Buz his brother, and Kemuel the father of Aram,

[22]And Chesed, and Hazo, and Pildash, and Jidlaph, and Bethuel.

[23]And Bethuel begat Rebekah: these eight Milcah did bear to Nahor, Abraham's brother.

[24]And his concubine, whose name was Reumah, she bare also Tebah, and Gaham, and Thahash, and Maachah.

Emotional reasoning The Christian client may believe that I am engaging in sin, therefore I am a bad Christian. In doing so, the client is discounting Jesus' death and his salvation for all those that believe in Him.

References about emotions:

But the LORD said to Samuel, "Do not look at his appearance or at his physical stature, because I have refused him. For the LORD does not see as man sees;[a] for man looks at the outward appearance, but the LORD looks at the heart (1 Samuel 16:7)

For His anger is but for a moment, His favor is for life; Weeping may endure for a night, But joy comes in the morning (Psalm 30:5).

[13]Forbearing one another, and forgiving one another, if any man have a quarrel against any: even as Christ forgave you, so also do ye. (Colossians 3:13)

Biblical story related to emotional reasoning:

The Story of Gideon (Judges 6 to Judges 7)

Should statements: emotional consequence is guilt; directed at others- emotions-anger, frustration and resentment. Many Christian individuals lead their lives with certain spiritual rules and guidelines. It is important for the clinician to explore these rules and help the client to re-establish those rules that are unhealthy and not in agreement with God's love and messages.

Bible passages on guilt:

If we confess our sins, he is faithful and just and will forgive us our sins and purify us from all unrighteousness. (1 John 1:9).

Godly sorrow brings repentance that leads to salvation and leaves no regret, but worldly sorrow brings death. (2 Corinthians 7:10)

[3]For I acknowledge my transgressions: and my sin is ever before me. (Psalm 51:3)

Biblical story related to shoulds:

The story of Lazarus – (Luke 16:19-31)

[19]There was a certain rich man, which was clothed in purple and fine linen, and fared sumptuously every day:

[20]And there was a certain beggar named Lazarus, which was laid at his gate, full of sores,

[21]And desiring to be fed with the crumbs which fell from the rich man's table: moreover the dogs came and licked his sores.

[22]And it came to pass, that the beggar died, and was carried by the angels into Abraham's bosom: the rich man also died, and was buried;

[23]And in hell he lift up his eyes, being in torments, and seeth Abraham afar off, and Lazarus in his bosom.

[24]And he cried and said, Father Abraham, have mercy on me, and send Lazarus, that he may dip the tip of his finger in water, and cool my tongue; for I am tormented in this flame.

[25]But Abraham said, Son, remember that thou in thy lifetime receivedst thy good things, and likewise Lazarus evil things: but now he is comforted, and thou art tormented.

[26]And beside all this, between us and you there is a great gulf fixed: so that they which would pass from hence to you cannot; neither can they pass to us, that would come from thence.

[27]Then he said, I pray thee therefore, father, that thou wouldest send him to my father's house:

[28]For I have five brethren; that he may testify unto them, lest they also come into this place of torment.

[29]Abraham saith unto him, They have Moses and the prophets; let them hear them.

[30]And he said, Nay, father Abraham: but if one went unto them from the dead, they will repent.

[31]And he said unto him, If they hear not Moses and the prophets, neither will they be persuaded, though one rose from the dead.

<u>Labeling and Mislabeling:</u> language is highly colored and emotionally loaded. Many Christian clients hold themselves to high standards. When these individuals fall short of their high standards the individual may apply different labels to themselves.

<u>References in the Bible related to blame:</u>

Now there were some present at that time who told Jesus about the Galileans whose blood Pilate had mixed with their sacrifices. Jesus answered, "Do you think that these Galileans were worse sinners than all the other Galileans because they suffered this way? I tell you, no! But unless you repent, you too will all perish. Or those eighteen who died when the tower in Siloam fell on them—do you think they were more guilty than all the others living in Jerusalem? I tell you, no! But unless you repent, you too will all perish (Luke 13: 1-5).

See to it that no one misses the grace of God and that no bitter root grows up to cause trouble and defile many (Hebrews 12:15)

<u>Biblical story on Labeling and Mislabeling:</u>

Parable of the Good Samaritan- (Luke 10:25-37)

[25]And, behold, a certain lawyer stood up, and tempted him, saying, Master, what shall I do to inherit eternal life?

[26]He said unto him, What is written in the law? how readest thou?

[27]And he answering said, Thou shalt love the Lord thy God with all thy heart, and with all thy soul, and with all thy strength, and with all thy mind; and thy neighbour as thyself.

[28]And he said unto him, Thou hast answered right: this do, and thou shalt live.

[29]But he, willing to justify himself, said unto Jesus, And who is my neighbour?

[30]And Jesus answering said, A certain man went down from Jerusalem to Jericho, and fell among thieves, which stripped him of his raiment, and wounded him, and departed, leaving him half dead.

[31]And by chance there came down a certain priest that way: and when he saw him, he passed by on the other side.

[32]And likewise a Levite, when he was at the place, came and looked on him, and passed by on the other side.

[33]But a certain Samaritan, as he journeyed, came where he was: and when he saw him, he had compassion on him,

[34]And went to him, and bound up his wounds, pouring in oil and wine, and set him on his own beast, and brought him to an inn, and took care of him.

[35]And on the morrow when he departed, he took out two pence, and gave them to the host, and said unto him, Take care of him; and whatsoever thou spendest more, when I come again, I will repay thee.

[36]Which now of these three, thinkest thou, was neighbour unto him that fell among the thieves?

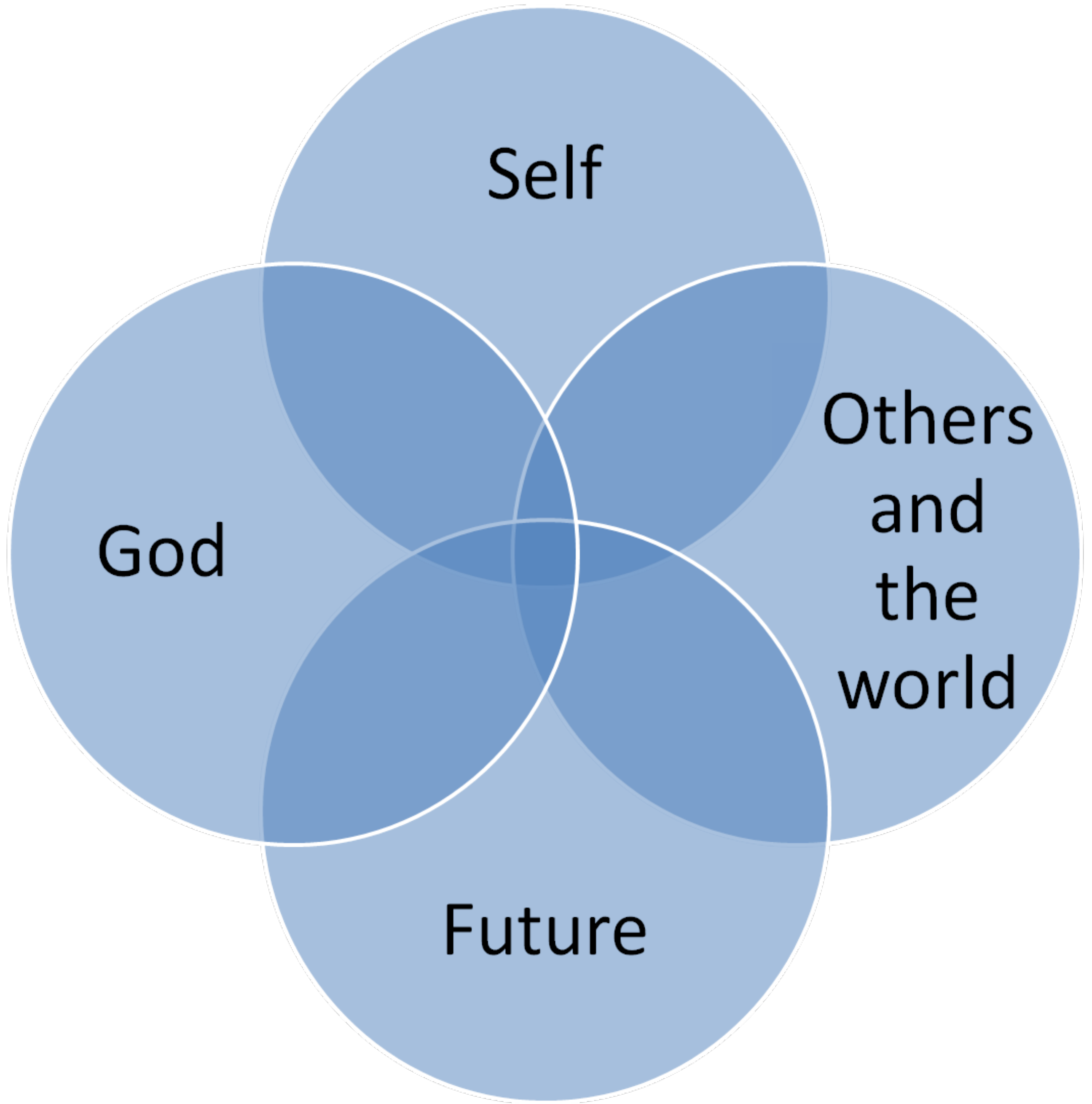
[37]And he said, He that shewed mercy on him. Then said Jesus unto him, Go, and do thou likewise.

Personalization: you are the cause of a negative event. The Christian client may blame himself or herself for the cause of any minor or major event. The individual may believe that the event occurred as a result of his or her sin or not being "spiritual enough." The therapist and client should work together to discount the blame and recognize ways the client is aware of his or her spiritual walk throughout daily actions.

Refer to those passages above that include references on defeat, encouragement and

hope.

Appendix K



Appendix L

Passages of God's Love

Deut 7:8 But it was because the LORD loved you and kept the oath he swore to your forefathers that he brought you out with a mighty hand and redeemed you from the land of slavery,

Eph 2:4-5 But because of his great love for us, God, who is rich in mercy, 5 made us alive with Christ even when we were dead in transgressions --It is by grace you have been saved.

Exodus 34:6 "The LORD, the Lord, the compassionate and gracious God, slow to anger, abounding in love and faithfulness, 7 maintaining love to thousands, and forgiving wickedness, rebellion and sin.

Heb 5:7-8 During the days of Jesus' life on earth, he offered up prayers and petitions with loud cries and tears to the one who could save him from death, and he was heard because of his reverent submission.

I John 13:1 It was just before the Passover Feast. Jesus knew that the time had come for him to leave this world and go to the Father. Having loved his own who were in the world, he now showed them the full extent of his love.

Luke 19:41-42 As he approached Jerusalem and saw the city, he wept over it and said, "If you, even you, had only known on this day what would bring you peace --but now it is hidden from your eyes.

Matt 9:36 When he saw the crowds, he had compassion on them, because they were harassed and helpless, like sheep without a shepherd.

Nahum 1:7 The LORD is good, a refuge in times of trouble. He cares for those who trust in him,

Psalm 145:7-8 The LORD is gracious and compassionate, slow to anger and rich in love. The LORD is good to all; he has compassion on all he has made.

Psalm 86:5 You are forgiving and good, O Lord, abounding in love to all who call to you.

Rom 5:5 And hope does not disappoint us, because God has poured out his love into our hearts by the Holy Spirit, whom he has given us.

Rom 5:8 But God demonstrates his own love for us in this: While we were still sinners, Christ died for us.

Lam 3:22 Because of the Lord's great love we are not consumed, for his compassions never fail.

Isaiah 53:5 But he was pierced for our transgressions, he was crushed for our iniquities; the punishment that brought us peace was upon him, and by his wounds we are healed.

James 5:11 As you know, we consider blessed those who have persevered. You have heard of Job's perseverance and have seen what the Lord finally brought about. The Lord is full of compassion and mercy.

Jer 18:7-8 If at any time I announce that a nation or kingdom is to be uprooted, torn down and destroyed, 8 and if that nation I warned repents of its evil, then I will relent and not inflict on it the disaster I had planned.

Jer 31:3 The LORD appeared to us in the past, saying: "I have loved you with an everlasting love; I have drawn you with loving-kindness.

Joel 2:13 Rend your heart and not your garments. Return to the LORD your God, for he is gracious and compassionate, slow to anger and abounding in love, and he relents from sending calamity.

John 10:28-29 I give them eternal life, and they shall never perish; no-one can snatch them out of my hand. My Father, who has given them to me, is greater than all;

John 3:16-17 "For God so loved the world that he gave his one and only Son, that whoever believes in him shall not perish but have eternal life. For God did not send his Son into the world to condemn the world, but to save the world through him.

Matt 11:28-29 "Come to me, all you who are weary and burdened, and I will give you rest. 29 Take my yoke upon you and learn from me, for I am gentle and humble in heart, and you will find rest for your souls. 30 For my yoke is easy and my burden is light."

Rom 8:35 Who shall separate us from the love of Christ? Shall trouble or hardship or persecution or famine or nakedness or danger or sword?

Titus 3:4-5 But when the kindness and love of God our Saviour appeared, 5 he saved us, not because of righteous things we had done, but because of his mercy.

Rom 8:31-32 What, then, shall we say in response to this? If God is for us, who can be against us? 32 He who did not spare his own Son, but gave him up for us all -- how will he not also, along with him, graciously give us all things?

Psa 36:5 (NIV) Your love, O LORD, reaches to the heavens, your faithfulness to the skies.

Psa 36:7 (NIV) How priceless is your unfailing love! Both high and low among men find refuge in the shadow of your wings.

Jer 31:3 (NIV) The LORD appeared to us in the past, saying: "I have loved you with an everlasting love; I have drawn you with loving-kindness.

Lam 3:22 (NIV) Because of the Lord's great love we are not consumed, for his compassions never fail.

Zep 3:17 (NIV) The LORD your God is with you, he is mighty to save. He will take great delight in you, he will quiet you with his love, he will rejoice over you with singing."

1 John 4:16 (NIV) And so we know and rely on the love God has for us. God is love. Whoever lives in love lives in God, and God in him.

John 3:16 (NIV) "For God so loved the world that he gave his one and only Son, that whoever believes in him shall not perish but have eternal life.

1 John 3:1 (NIV) How great is the love the Father has lavished on us, that we should be called children of God! And that is what we are! The reason the world does not know us is that it did not know him.

Appendix M

Scriptures for Meditation

Philippians 4:8, "Finally, brethren, whatsoever things are true, whatsoever things are honest, whatsoever things are just, whatsoever things are pure, whatsoever things are lovely, whatsoever things are of good report; if there be any virtue, and if there be any praise, think on these things."

1 John 1:9, "If we confess our sins, he is faithful and just to forgive us our sins, and to cleanse us from ALL unrighteousness."

Titus 2:14, "Who gave Himself for us to redeem us from EVERY lawless deed, and to purify for Himself a people for His own possession, zealous for good deeds." (NASB)

Psalms 103:12, "As far as the east is from the west, so far hath he removed our transgressions from us."

Ephesians 1:7, "In whom we have redemption through his blood, the forgiveness of sins, according to the riches of his grace;" (The word 'riches' in the Greek here means abundance and fullness!!)

Romans 8:1, "There is therefore now no condemnation to them which are in Christ Jesus..."

Micah 7:19, "...he will have compassion upon us; he will subdue our iniquities; and thou wilt cast all their sins into the depths of the sea."

Isaiah 1:18, "Come now, and let us reason together, saith the LORD: though your sins be as scarlet, they shall be as white as snow; though they be red like crimson, they shall be as wool."

Joel 2:12-13, "Therefore also now, saith the LORD, turn ye even to me with all your heart, and with fasting, and with weeping, and with mourning: And rend your heart, and not your garments, and turn unto the LORD your God: for he is gracious and merciful, slow to anger, and of great kindness, and repenteth him of the evil."

Psalms 103:2-4, "Bless the LORD, O my soul, and forget not all his benefits: Who forgiveth all thine iniquities; who healeth all thy diseases; Who redeemeth thy life from destruction; who crowneth thee with loving kindness and tender mercies;"

Isaiah 61:1-3, "The Spirit of the Lord GOD is upon me; because the LORD hath anointed me to preach good tidings unto the meek; he hath sent me to bind up the brokenhearted, to proclaim liberty to the captives, and the opening of the prison to them that are bound; To proclaim the acceptable year of the LORD, and the day of vengeance of our God; to comfort all that mourn; To appoint unto them that mourn in Zion, to give unto them beauty for ashes, the oil of joy for mourning, the garment of praise for the spirit of heaviness; that they might be called trees of righteousness, the planting of the LORD, that he might be glorified."

Isaiah 52:2, "Shake thyself from the dust; arise, and sit down, O Jerusalem: loose thyself from the bands of thy neck, O captive daughter of Zion."

Matthew 8:16-17, "When the even was come, they brought unto him many that were possessed with devils: and he cast out the spirits with his word, and healed all that were sick: That it might be fulfilled which was spoken by Esaias the prophet, saying, Himself took our infirmities, and bare our sicknesses."

Isaiah 42:7, "To open the blind eyes, to bring out the prisoners from the prison, and them that sit in darkness out of the prison house."

Isaiah 49:9, "That thou mayest say to the prisoners, Go forth; to them that are in darkness, Shew yourselves. They shall feed in the ways, and their pastures shall be in all high places."

Mark 1:39, "And he preached in their synagogues throughout all Galilee, and cast out devils."

Acts 10:38, "How God anointed Jesus of Nazareth with the Holy Ghost and with power: who went about doing good, and healing all that were oppressed of the devil; for God was with him."

Act 8:7, "For unclean spirits, crying with loud voice, came out of many that were possessed with them: and many taken with palsies, and that were lame, were healed."

Acts 5:16, "There came also a multitude out of the cities round about unto Jerusalem, bringing sick folks, and them which were vexed with unclean spirits: and they were healed everyone."

Luke 13:11, 16, "And, behold, there was a woman which had a spirit of infirmity eighteen years, and was bowed together, and could in no wise lift up herself.... And ought not this woman, being a daughter of Abraham, whom Satan hath bound, lo, these eighteen years, be loosed from this bond on the sabbath day?"

Mark 16:17, "And these signs shall follow them that believe; In my name shall they cast out devils; they shall speak with new tongues;"

Matthew 10:7-8, "And as ye go, preach, saying, The kingdom of heaven is at hand. Heal the sick, cleanse the lepers, raise the dead, cast out devils: freely ye have received, freely give."

Luke 10:17-19, "And the seventy returned again with joy, saying, Lord, even the devils are subject unto us through thy name. And he said unto them, I beheld Satan as lightning fall from heaven. Behold, I give unto you power to tread on serpents and scorpions, and over all the power of the enemy: and nothing shall by any means hurt you."

Luke 7:21, "And in that same hour he cured many of their infirmities and plagues, and of evil spirits; and unto many that were blind he gave sight."

Luke 8:2, "And certain women, which had been healed of evil spirits and infirmities, Mary called Magdalene, out of whom went seven devils,"

Acts 19:12, "So that from his body were brought unto the sick handkerchiefs or aprons, and the diseases departed from them, and the evil spirits went out of them."

John 10:11, 15:13, "I am the good shepherd: the good shepherd giveth his life for the sheep... Greater love hath no man than this, that a man lay down his life for his friends."

John 10:10, "...I am come that they might have life, and that they might have it more abundantly."

Psalm 145:9, "The LORD is good to all: and his tender mercies are over all his works."

Lamentations 3:22-23, "It is of the LORD'S mercies that we are not consumed, because his compassions fail not. They are new every morning: great is thy faithfulness."

Psalms 145:8, "The LORD is gracious, and full of compassion; slow to anger, and of great mercy."

2 Corinthians 5:18-19, "And all things are of God, who hath reconciled us to himself by Jesus Christ, and hath given to us the ministry of reconciliation; To wit, that God was in Christ, reconciling the world unto himself, not imputing their trespasses unto them; and hath committed unto us the word of reconciliation."

1 Corinthians 2:9, "But as it is written, Eye hath not seen, nor ear heard, neither have entered into the heart of man, the things which God hath prepared for them that love him."

Romans 2:4, "Or despisest thou the riches of his goodness and forbearance and longsuffering; not knowing that the goodness of God leadeth thee to repentance?"

Psalms 103:8-13, "The Lord is merciful and gracious, slow to anger, and plenteous in mercy. He will not always chide: neither will he keep his anger forever. He hath not dealt with us after our sins; nor rewarded us according to our iniquities. For as the heaven is high above the earth, so great is his mercy toward them that fear him. As far as the east is from the west, so far hath he removed our transgressions from us. Like as a father pitieth his children, so the Lord pitieth them that fear him." (Remember, I believe the word 'fear' here simply means to respect - not the same kind of fear as being scared or afraid of Him)

John 3:16, "For God so loved the world, that he gave his only begotten Son, that whosoever believeth in him should not perish, but have everlasting life."

1 John 3:1, "Behold, what manner of love the Father hath bestowed upon us, that we should be called the sons of God..."

1 John 4:16, "And we have known and believed the love that God hath to us. God is love; and he that dwelleth in love dwelleth in God, and God in him."

Romans 5:8, "But God showed his great love for us by sending Christ to die for us while we were still sinners." (NLT)

1 John 4:9, "In this was manifested the love of God toward us, because that God sent his only begotten Son into the world, that we might live through him."

Romans 8:38-39, "For I am persuaded, that neither death, nor life, nor angels, nor principalities, nor powers, nor things present, nor things to come, Nor height, nor depth, nor any other creature, shall be able to separate us from the love of God, which is in Christ Jesus our Lord."

2 Peter 3:9, "The Lord is not slack concerning his promise, as some men count slackness; but is longsuffering to us-ward, not willing that any should perish, but that all should come to repentance."

1 Timothy 2:3-4, "For this is good and acceptable in the sight of God our Saviour; Who will have all men to be saved, and to come unto the knowledge of the truth." (God wants everybody possible to go to heaven!!)

Eph 2:4-7, "But God, who is rich in mercy, for his great love wherewith he loved us, Even when we were dead in sins, hath quickened us together with Christ, (by grace ye are saved;) And hath raised us up together, and made us sit together in heavenly places in Christ Jesus: That in the ages to come he might shew the exceeding riches of his grace in his kindness toward us through Christ Jesus."

Luke 11:13, "If ye then, being evil, know how to give good gifts unto your children: how much more shall your heavenly Father give the Holy Spirit to them that ask him?"

Luke 15:10, "Likewise, I say unto you, there is joy in the presence of the angels of God over one sinner that repenteth."

Luke 15:20, "And he arose, and came to his father. But when he was yet a great way off, his father saw him, and had compassion, and ran, and fell on his neck, and kissed him." (This is the parable of the son who took half his dad's money and ran away, then returned home and his father saw his son and was moved with compassion. So is it with our heavenly Father, when we turn to Him and repent, He is moved with compassion and welcomes us with open arms.)

Jeremiah 31:3, "The LORD hath appeared of old unto me, saying, Yea, I have loved thee with an everlasting love: therefore with loving kindness have I drawn thee."

Isaiah 30:18, "Therefore the LORD longs to be gracious to you, And therefore He waits on high to have compassion on you. For the LORD is a God of justice; How blessed are all those who long for Him." (NASB)

Psalm 33:5, "He loves righteousness and justice; The earth is full of the loving kindness of the LORD."

Psalm 107:8-9, "Oh that men would praise the LORD for his goodness, and for his wonderful works to the children of men! For he satisfieth the longing soul, and filleth the hungry soul with goodness."

Psalms 117:2, "For his merciful kindness is great toward us: and the truth of the LORD endureth for ever. Praise ye the LORD."

Psalms 31:19, "Oh how great is thy goodness, which thou hast laid up for them that fear thee; which thou hast wrought for them that trust in thee before the sons of men!"

John 20:31, "But these are written, that ye might believe that Jesus is the Christ, the Son of God; and that believing ye might have life through his name."

John 3:36, "He that believeth on the Son hath everlasting life..."

John 3:16, "For God so loved the world, that he gave his only begotten Son, that whosoever believeth in him should not perish, but have everlasting life."

John 3:14-15, "And as Moses lifted up the serpent in the wilderness, even so must the Son of man be lifted up: That whosoever believeth in him should not perish, but have eternal life."

John 3:18, "He that believeth on him is not condemned: but he that believeth not is condemned already, because he hath not believed in the name of the only begotten Son of God."

Acts 16:30-31, "And brought them out, and said, Sirs, what must I do to be saved? And they said, Believe on the Lord Jesus Christ, and thou shalt be saved, and thy house."

Isaiah 28:16, "Therefore thus saith the Lord GOD, Behold, I lay in Zion for a foundation a stone, a tried stone, a precious corner stone, a sure foundation: he that believeth shall not make haste."

John 6:47, "Verily, verily, I say unto you, He that believeth on me hath everlasting life."

Romans 10:13, "For whosoever shall call upon the name of the Lord shall be saved."

John 6:37, "...Him that cometh to me I will in no wise cast out."

John 6:40, "And this is the will of him that sent me, that every one which seeth the Son, and believeth on him, may have everlasting life: and I will raise him up at the last day."

John 5:24, "Verily, verily, I say unto you, He that heareth my word, and believeth on him that sent me, hath everlasting life, and shall not come into condemnation; but is passed from death unto life."

Matthew 6:32, "(For after all these things do the Gentiles seek:) for your heavenly Father knoweth that ye have need of all these things."

Matthew 6:33, "But seek ye first the kingdom of God, and his righteousness; and all these things shall be added unto you."

Deuteronomy 8:18, "But thou shalt remember the LORD thy God: for it is he that giveth thee power to get wealth, that he may establish his covenant which he swore unto thy fathers, as it is this day."

Psalms 84:11, "For the LORD God is a sun and shield: the LORD will give grace and glory: no good thing will he withhold from them that walk uprightly."

Deuteronomy 28:5, 11-12, "Blessed shall be thy basket and thy store... And the LORD shall make thee plenteous in goods, in the fruit of thy body, and in the fruit of thy cattle, and in the fruit of thy ground, in the land which the LORD swore unto thy fathers to give thee. The LORD shall open unto thee his good treasure, the heaven to give the rain unto thy land in his season, and to bless all the work of thine hand: and thou shalt lend unto many nations, and thou shalt not borrow."

1 John 5:14-15, "And this is the confidence that we have in him, that, if we ask any thing according to his will, he heareth us: And if we know that he hear us, whatsoever we ask, we know that we have the petitions that we desired of him."

John 16:24, "Hitherto have ye asked nothing in my name: ask, and ye shall receive, that your joy may be full."

James 4:2, "...yet ye have not, because ye ask not."

Matthew 6:8, "Be not ye therefore like unto them: for your Father knoweth what things ye have need of, before ye ask him."

Romans 8:32, "He that spared not his own Son, but delivered him up for us all, how shall he not with him also freely give us all things?"

James 1:17, "Every good gift and every perfect gift is from above, and cometh down from the Father of lights, with whom is no variableness, neither shadow of turning."

Jeremiah 29:11, "For I know the thoughts that I think toward you, saith the LORD, thoughts of peace, and not of evil, to give you an expected end."

1 Timothy 6:17, "...God, who giveth us richly all things to enjoy."

Psalms 37:4-5, "Delight thyself also in the LORD; and he shall give thee the desires of thine heart. Commit thy way unto the LORD; trust also in him; and he shall bring it to pass."

Genesis 45:18, "And take your father and your households, and come unto me: and I will give you the good of the land of Egypt, and ye shall eat the fat of the land."

Ezra 9:12, "Now therefore give not your daughters unto their sons, neither take their daughters unto your sons, nor seek their peace or their wealth for ever: that ye may be strong, and eat the good of the land, and leave it for an inheritance to your children forever."

Isaiah 1:19, "If ye be willing and obedient, ye shall eat the good of the land:"

Genesis 45:20, "Also regard not your stuff; for the good of all the land of Egypt is yours."

Deuteronomy 8:7, "For the LORD thy God bringeth thee into a good land, a land of brooks of water, of fountains and depths that spring out of valleys and hills;"

Deuteronomy 30:9, "And the LORD thy God will make thee plenteous in every work of thine hand, in the fruit of thy body, and in the fruit of thy cattle, and in the fruit of thy land, for good: for the LORD will again rejoice over thee for good, as he rejoiced over thy fathers:"

Luke 12:28, "If then God so clothe the grass, which is today in the field, and tomorrow is cast into the oven; how much more will he clothe you, O ye of little faith?"

Jeremiah 1:5, "Before I formed thee in the belly I knew thee..."

Psalm 139:14, "I will praise thee; for I am fearfully and wonderfully made: marvelous are thy works; and that my soul knoweth right well."

Psalm 139:17, "How precious also are thy thoughts unto me, O God! how great is the sum of them!"

Isaiah 62:5, "For as a young man marrieth a virgin, so shall thy sons marry thee: and as the bridegroom rejoiceth over the bride, so shall thy God rejoice over thee."

Psalms 35:27, "Let them shout for joy, and be glad, that favour my righteous cause: yea, let them say continually, Let the LORD be magnified, which hath pleasure in the prosperity of his servant."

Isaiah 49:15-16, "Can a woman forget her sucking child, that she should not have compassion on the son of her womb? yea, they may forget, yet will I not forget thee. Behold, I have graven thee upon the palms of my hands; thy walls are continually before me."

Zephaniah 3:17, "The LORD thy God in the midst of thee is mighty; he will save, he will rejoice over thee with joy; he will rest in his love, he will joy over thee with singing."

Isaiah 43:25, "I, even I, am he that blotteth out thy transgressions for mine own sake, and will not remember thy sins."

Romans 8:1, "There is therefore now no condemnation to them which are in Christ Jesus..."

Titus 2:14, "Who gave Himself for us to redeem us from every lawless deed, and to purify for Himself a people for His own possession, zealous for good deeds." (NASB)

Psalms 103:12, "As far as the east is from the west, so far hath he removed our transgressions from us."

2 Corinthians 5:17, "Therefore if any man be in Christ, he is a new creature: old things are passed away; behold, all things are become new."

Romans 3:22, "Even the righteousness of God which is by faith of Jesus Christ unto all and upon all them that believe: for there is no difference:"

Romans 4:5, "But to him that worketh not, but believeth on him that justifieth the ungodly, his faith is counted for righteousness."

Galatians 3:6, "Even as Abraham believed God, and it was accounted to him for righteousness."

Galatians 4:5-6, "To redeem them that were under the law, that we might receive the adoption of sons. And because ye are sons, God hath sent forth the Spirit of his Son into your hearts, crying, Abba, Father."

Romans 8:15, "For ye have not received the spirit of bondage again to fear; but ye have received the Spirit of adoption, whereby we cry, Abba, Father."

1 John 3:1, "Behold, what manner of love the Father hath bestowed upon us, that we should be called the sons of God..."

1 Corinthians 6:11, "...ye are washed, but ye are sanctified, but ye are justified in the name of the Lord Jesus, and by the Spirit of our God."

Appendix N

Sun	Mon	Tue	Wed	Thu	Fri	Sat

Appendix O

Spiritual Resource for Issues in Treatment

Marriage

- Covenant Marriage *by Gary Chapman*
- Sacred Marriage *by Gary Thomas*
- War of Words *by Paul David Tripp*
- Love & Respect *by Emerson Eggerich, Ph.D.*
- Marriage God's Way *by Henry Brandt and Kerry Skinner*
- The Excellent Wife *by Martha Peace*
- The Complete Husband *by Lou Priolo*
- Intimate Issues *by Linda Dillow*
- Every Woman's Desire *by Fred Stoeker and Steven Arterburn*
- "Song of Solomon" Tape Series *by Tommy Nelson*

Sexual Addiction

- Every Man's Battle *by Fred Stoeker and Steve Arterburn*
- At the Altar of Sexual Idolatry *by Steve Gallagher*
- Addictions: A Banquet at the Grave *by Edward Welch*
- When Good Men Are Tempted *by Bill Perkins*

Codependency / Fear of Man

- When People Are Big and God Is Small *by Edward Welch*

Anxiety

- Overcoming Fear, Worry and Anxiety *by Elyse Fitzpatrick*
- Slaying the Giants In Your Life *by David Jeremiah*

Parenting

- Parenting Teens with Love and Logic *by Jim Faye and Foster Cline*
- Shepherding a Child's Heart *by Tedd Tripp*
- How To Be A Hero To Your Kids *by Josh McDowell*
- The Age of Opportunity *by Paul David Tripp*
- Point Man *by Steve Farrar*

Anger

- The Heart of Anger *by Lou Priolo*
- How To Be Free From Bitterness *by Jim Wilson*

General

- This Was Your Life *by Jamie Lash and Rick Howard*
- The Purpose Driven Life *by Rick Warren*
- The Mature Man *by Dave Dewitt*
- Passion and Purity *by Elizabeth Elliott*
- Fresh Wind, Fresh Fire *by Jim Cymbala*
- Fresh Faith *by Jim Cymbala*
- First Love *by Bill Bright*
- How To Say No To A Stubborn Habit *by Erwin Lutzer*
- The Serpent of Paradise *by Erwin Lutzer*

Prayers and Bible Passages for Issues in Treatment

Grief and Loss

Prayer for times of loss

Dear Lord,
Please help me in this time of loss and overwhelming grief. I don't understand why my life is filled with this pain and heartache. But I turn my eyes to you as I seek to find the strength to trust in your faithfulness. I will wait on you and not despair; I will quietly wait for your salvation. My heart is crushed, but I know that you will not abandon me forever. Please show me your compassion, Lord. Help me through the pain so that I will hope in you again. I believe this promise in your Word to send me fresh mercy each day. Though I can't see past today, I trust your great love will never fail me.

Gone But Not Forgotten

Don't think of me as gone away
My journey's just begun
Life holds so many facets
This earth is only one
Just think of me as resting
From the sorrows and the tears
In a place of warmth and comfort
Where there are no days and years
Think how I am wishing
That we could know today
Now nothing but our sadness
Can really pass away
And think of me as living
In the hearts of those I've touched
For nothing loved is ever lost
And I'm loved so very much

Anonymous

I Am Not Gone

I am not gone, I am changed.
Have faith and please believe me.
God did not take me away from you,
He split the skies and received me.
Now...
I'm an echo in your laughter,
a reflection in your tears,
an extra thread of strength
to help you overcome your fears.
I'm an added ray of sunshine,
more joy for you to share,
a fragrance of the life you live.
Wherever you are - I am there.

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Biblical passages on Grief and Loss

The LORD is a refuge for the oppressed, a stronghold in times of trouble. (Psalm 9:9)

The LORD is my rock, my fortress and my deliverer; my God is my rock, in whom I take refuge. He is my shield and the horn of my salvation, my stronghold. (Psalm 18:2)

For he has not despised or disdained the suffering of the afflicted one; he has not hidden his face from him but has listened to his cry for help. (Psalm 22:24)

The LORD is my shepherd,
I shall not be in want.
He makes me lie down in green pastures,
he leads me beside quiet waters,
He restores my soul.
He guides me in paths of righteousness
for his name’s sake.
Even though I walk
through the valley of the shadow of death,
I will fear no evil,
for you are with me;
your rod and your staff,
they comfort me.
You prepare a table before me
in the presence of my enemies.
You anoint my head with oil;
my cup overflows.

Surely goodness and love will follow me
all the days of my life,
and I will dwell in the house of the LORD
forever. (Psalm 23)

Weeping may remain for a night, but rejoicing comes in the morning. (Psalm 30:5)

The Lord is close to the brokenhearted and saves those who are crushed in spirit (Psalm 34:18)

The salvation of the righteous comes from the LORD; he is their stronghold in time of trouble (Psalm 37:39)

God is our refuge and strength, an ever-present help in trouble. Therefore we will not fear, though the earth give way and the mountains fall into the heart of the sea (Psalm 46:1-2)

Cast your cares on the LORD and he will sustain you; he will never let the righteous fall. (Psalm 55:22)

Though you have made me see troubles, many and bitter, you will restore my life again; from the depths of the earth you will again bring me up. You will increase my honor and comfort me once again. (Psalm 71:20-21)

My flesh and my heart may fail, but God is the strength of my heart and my portion forever. (Psalm 73:26)

For this is what the LORD says:
"I will extend peace to her like a river,
and the wealth of nations like a flooding stream;
you will nurse and be carried on her arm
and dandled on her knees.
As a mother comforts her child,
so will I comfort you;
and you will be comforted over Jerusalem."
When you see this, your heart will rejoice
and you will flourish like grass;
the hand of the LORD will be made known to his servants,
but his fury will be shown to his foes. (Isaiah 66:12-14)

The LORD is good, a refuge in times of trouble. He cares for those who trust in him (Nahum 1:7)

Blessed are those who mourn, for they will be comforted. (Matthew 5:4)

Anxiety

Prayer for Anxiety

Dear Lord,
I need you now because I am full of stress and anxiety.
Reading your Word brings comfort, as I ask you to come and take my heavy burdens. I take each burden, one by one, and lay them at your feet. Please carry them for me so that I don't have to. Replace them with your humble and gentle yoke so that I will find rest for my soul today. I receive your gift of peace of mind and heart. Thank you that I can lie down tonight in peace and sleep. I know that you, Lord, will keep me safe. I am not afraid because you are always with me. Please keep me daily, Lord, in your perfect peace.

Amen

Biblical passages on Anxiety

I'm leaving you with a gift: peace of mind and heart! And the peace I give isn't fragile like the peace the world gives. So, don't be troubled or afraid. (John 14:27)

So do not fear, for I am with you; do not be dismayed, for I am your God. I will strengthen you and help you; I will uphold you with my righteous right hand. (Isaiah 41:10)

I consider our present sufferings insignificant compared to the glory that will soon be revealed to us. (Romans 8:18)

Let not your heart be troubled. You are entrusting God, now trust in Me. (John 14: 1).

I will never fail you nor forsake you. (Heb. 13:5)

But they that wait upon the Lord shall renew their strength; they shall mount up with wing's as eagles; they shall run, and not be weary; and they shall walk, and not faint. (Isaiah 40:31)

Surely goodness and mercy shall follow me all the days of my life. (Psalm 23:61).

God, who shows you his kindness and who has called you through Christ Jesus to his eternal glory, will restore you, strengthen you, make you strong, and support you as you suffer for a little while. (I Peter 5.-10)

Come to me, all who are tired from carrying heavy loads, and I will give you rest. (Matthew 11:28)

If any of you are having trouble, pray. If you are happy, sing psalms. (James 5:13)

Marriage

Marriage Prayer

Thank you Lord for teaching us how to make You the center of our marriage. Humble us to grow beyond our ego, pride and past hurts. Help us to establish and grow the love Christ in us to show each other kindness, trust, patience, forgiveness and divine love. Help me Lord to honor the qualities of my mate. Teach me how to pray for my spouse.

Empower me with courage to speak up for anything out of order in our relationship. Soften my tongue and heart where it has become like stone. Strengthen my flesh and self-esteem where it has become weak.

Whenever we lose the gratitude and passion for each other, guide us in ways to relight the candle of passion that can burn out from stress and time. Bless us to not only see, but honor one another. Help us to not only listen, but hear each other. Bless us to not only cherish one another, but nourish each other's dreams and spiritual gifts.

We surrender our marriage and our personal power struggles to You. Teach us to be less controlling and more collaborative in our decisions and problem solving skills. Quicken our minds so we may know how to please, protect and provide for each other. Bless our union to grow stronger, wiser, peaceful and committed. Bring into our circle of friends, examples of healthy committed marriages. Let our children, family and friends see Christ through our example.

Thank you Lord for covering our home with your grace, mercy and favor. Today is a new day that I choose to love, respect and serve my spouse. Give us both the wisdom, patience, love and faith not to give up on each other." ~ written by Jewel Diamond Taylor

Portrait of a Godly Husband

A Godly husband loves his wife sacrificially. He seeks diligently to understand his wife. He lovingly teaches her the truth of God's word both overtly and through his conduct. He is concerned about the spiritual well being of his wife and prays for her and with her on a regular basis. He does not rule over his wife or family but is instead there to serve not be served. He is the biggest servant in the family. He follows through on his commitments to his wife and children. He finds joy in serving his wife and family. He takes seriously his responsibility to lead and shepherd his family knowing that it is to the Lord he must give an account. He listens attentively to his wife so as to grow in his knowledge of her. He realizes his wife is not 'one of the boys' and treats her with gentleness at all times. He places the interest of his wife above his own.

He is self-controlled, not easily angered, kind and humble. He is not ruled by alcohol or other forms of intoxication. He does not indulge in ungodly passions but instead buffets and disciplines his body to bring it under the authority of God and His word. He is ruled by Christ and places himself completely under His authority. He is not wise in his own eyes but relies on the wisdom of God as revealed in His word. He does not lean on his own understanding. His decisions and actions flow from his study and meditation on God's word rather than from his own desires.

He takes great pleasure in his wife's body and makes love to her joyfully, frequently and unselfishly and is faithful to her. He recognizes that his body is not his own but also belongs to his wife.

He uses his speech to edify and build up his wife and children. He guards his tongue, using it for blessing rather than cursing. He joyfully and abundantly provides for the financial needs of his family. He praises his wife to others and treats her as a precious treasure. His life reflects the fruit of the Spirit as found in Galatians 5. He is a God pleaser not a man pleaser.

* Check it out in Scripture! Ephesians 5, 1 Corinthians 13, Proverbs 31, Colossians 3, 1 Peter 3, 1 Timothy 3, 5 and elsewhere!

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Portrait of a Godly Wife

A Godly wife submits herself to the headship of her husband as ordained by God. She recognizes that the most free place she can be is under the authority of her husband. She 'brings her husband good and not evil all the days of his life.' She is industrious and creative, making the most of the family's resources to provide abundantly for the needs of her children and husband. When her husband is in error before the Lord, she seeks to win him over by her behavior rather than by nagging, complaining or other verbal means. She does not grudgingly minister to her husband but does so joyfully and heartily. She raises her children to respect her and their father and to honor God.

She is ruled by the word of God rather than her own emotions, desires, or her own ideas about the way things 'should be.' She walks in close fellowship with the Lord so that she is ruled by the Spirit of God rather than her own flesh. Her life reflects the fruit of the Spirit as found in Galatians chapter 5.

She realizes her body is not hers alone but also her husbands and she shares it with him in joyful lovemaking on a regular basis.

She looks not only to her own interests but also the interests of her husband. Her husband is able to have full confidence in her. Her behavior brings her husband respect. She is a helper to him in many areas, using her own particular gifts and training to benefit the family. She has a gentle and quiet spirit which makes her beautiful in the eyes of God. She uses her speech to build up and encourage her husband in faith. She is not critical of her husband to him or to others. She is ruled by a fear of the Lord.

* Check it out in Scripture! Ephesians 5, 1 Corinthians 13, Proverbs 31, Colossians 3, 1 Peter 3, 1 Timothy 3, 5 and elsewhere!

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Biblical passages on marriage

Love is patient, love is kind. It does not envy, it does not boast, it is not proud. It is not rude, it is not self-seeking, it is not easily angered, it keeps no record of wrongs. Love does not delight in evil but rejoices with the truth. It always protects, always trusts, always hopes, always perseveres. Love never fails. . .And now these three remain: faith, hope and love. But the greatest of these is love. (1 Corinthians 13:4-13)

My command is this: Love each other as I have loved you. Greater love has no one than this, that he lay down his life for his friends. (John 15:12-13)

And walk in love, [esteeming and delighting in one another] as Christ loved us and gave Himself up for us, a slain offering and sacrifice to God [for you, so that it became] a sweet fragrance. (Ephesians 5: 2)

Love one another with brotherly affection [as members of one family], giving precedence and showing honor to one another. (Romans 12: 10)

Love does no wrong to one's neighbor [it never hurts anybody]. Therefore love meets all the requirements and is the fulfilling of the Law. (Romans 13: 10)

Addiction

Prayer to Overcome Addictions

Dear God,

I come to You as I come to no one else. I am so sorry. I have tried to throw away my life, my body, my soul—through addiction. But recognition of my addiction has never given me power to control it. You know this. You never blame me. You know the truth. Addiction is an attractor field in which minds and bodies become mired to escape emotional pain. But there is another, better way to escape pain. Pain is transcended through an authentic calling from You. Therefore, I surrender myself, now, to You. I demand, now, in this moment, Father, that You call me—that You call me loudly. You raise me up out of addiction and into a higher level attractor field. And as You raise me, so do You raise Humanity out of addiction and into a higher level attractor field. Together we rise, as one force in You, one at a time and together. Because the world needs us. We rise or we fall, together. For You need me. I am Your Thoughts, Your Voice, Your Hands. I rejoice in awe over my inherent holiness: I am where You reside. By Your grace, as I read this, my mind is aligned with Yours. By Your grace, the power of my mind is multiplied exponentially by all who read this. Aligned with You, we are more powerful than any evil—or any substance—can ever be.

Together WE form a conduit of love that reaches into my need for addiction and I am healed. By healing myself, I now heal Humanity's need for addiction.

Joy fills my soul. My gratitude is infinite.

Thank You.

And so it is.
Amen

Parenting

Parenting Prayers

For a daughter: "Lord, we ask for purity in her life and that of her husband. We ask for protection over their innocence and purity; protect them from others and wrong choices, call them to a higher standard. We ask for wisdom and discernment in teaching and preparing her for a life of purity and modesty. I also ask that you grant her husband's parents wisdom as they raise a man of integrity."

For a son: "Lord, we pray against pornography and lust and its evil effects on his life both as a child and as an adult. Give us wisdom in teaching him to respect girls and women. Put a calling of purity upon his life that he will never use, abuse, or take advantage of girls or women. We ask for wisdom and discernment in teaching and preparing him for a life of purity."

I pray blessing and biblical qualities for my children. The Bible has a lot to say about how we speak and the power of the tongue to do damage, but also to bring healing. "The tongue has the power of life and death, and those who love it will eat its fruit" (Proverbs 18:21).

"Father we thank You for (insert your daughter's name here), You have heaped us with bounty and we praise You for entrusting us with her. She is fearfully and wonderfully made. You chose her for us and we thank You for the gift she is to us. We bless her and ask that You fill her with "Whatever things are true, noble, just, pure, lovely, of good report, having virtue, or anything praiseworthy, let her think on these things.""

I pray for wisdom as a parent regarding specific issues for this child. The Bible says whoever lacks wisdom should ask…so I ask a lot! "If any of you lacks wisdom, he should ask God, who gives generously to all without finding fault, and it will be given to him" (James 1:5).

"Lord, grant us wisdom. We ask that you would impress upon him that lying is wrong. Help us to train him to be a man of integrity and honesty starting now. We ask that you would raise him up to be an upright man; one who is pro-active for what is right. May he not be passive, but aggressive for truth and what is honourable."

Relationships will be a lifelong pursuit for your children: relationships with family, friends and especially with the Lord. My dad prayed faithfully for a good Christian friend for me in high school. I am so thankful for those prayers, and I believe God has answered them many times over in my life. I thank God for many wonderful friends over the years.

"We ask Father that you would fill her life with good relationships, first with you Lord. Help her to seek after Godly things. We ask your blessing on our relationship with her, help us to express to her and for her to feel unconditional love; may she rise up and call

us blessed. We ask for good friends for her; that she may feel accepted and influenced by good kids. Keep her path straight. We ask your blessing on her life by causing Godly people to positively influence her life at the crossroads she will face. Go before her and prepare the way."

~ *Beth Scholes is a professional wife and mother who works from her home in Abbotsford, BC. Her job revolves around Darcy, her husband of 14 years, and their three children Olivia, Samuel and Sophie. Beth also freelances from her day job as a speaker, teacher and now a writer. Beth and Darcy are also full time staff with Family Life Canada.*

Biblical passages on Parenting

Children, obey your parents in the Lord, for this is right. (2) “Honor your father and mother” (this is the first commandment with a promise), (3) “that it may go well with you and that you may live long in the land.” (4) Fathers, do not provoke your children to anger, but bring them up in the discipline and instruction of the Lord. (Ephesians 6:1-4)

Do not withhold discipline from a child; if you strike him with a rod, he will not die. If you strike him with the rod, you will save his soul from Sheol.(Proverbs 23:13-14)

“Hear, O Israel: The LORD our God, the LORD is one. (5) You shall love the LORD your God with all your heart and with all your soul and with all your might. (6) And these words that I command you today shall be on your heart. (7) You shall teach them diligently to your children, and shall talk of them when you sit in your house, and when you walk by the way, and when you lie down, and when you rise. (8) You shall bind them as a sign on your hand, and they shall be as frontlets between your eyes. (9) You shall write them on the doorposts of your house and on your gates. (Deuteronomy 6:4-9)

Honor your father and your mother, that your days may be long in the land that the LORD your God is giving you. (Exodus 20:12)

As a father shows compassion to his children, so the LORD shows compassion to those who fear him. (Psalms 103:13)

Anger

Prayer in time of Anger

Lord Jesus, there is anger in my heart and I cannot root it out.
I know that I should calm down and offer the hurt and disappointment to You
but my emotion is running away with me.
Help me to overcome this weakness and give me peace of heart as well as mind.
Let me learn from this experience and grow into a better human being. Amen.

Prayer for Anger

O Lord, must I fear Your wrath?
Retribution is Yours by right!
May I never dishonour Your Divinity,
My soul seeking to maintain Your love.
Shape my being into earnest kindness,
A reflection of Your perfection.
Grant me the grace of self-control,
That I may not display any anger.
Should I have such an outburst,
Instantly remind me to seek redress,
For such is offensive to You.
Anger is Yours alone to avenge!

Amen.

Biblical passages on anger

Refrain from anger and turn from wrath; do not fret—it leads only to evil. (Psalm 37:8)

A quick-tempered man does foolish things, and a crafty man is hated. (Proverbs 14:17)

A hot-tempered man stirs up dissension, but a patient man calms a quarrel. (Proverbs 15:18)

Better a patient man than a warrior, a man who controls his temper than one who takes a city. (Proverbs 16:32)

Do not be quickly provoked in your spirit, for anger resides in the lap of fools. (Ecclesiastes 7:9)

Bitterness and Resentment

Prayer to overcome Bitterness and Resentment

Father, I acknowledge that I've held resentment and bitterness against (name). I confess this as sin and ask You to forgive me. I forgive (name). Remind me, Lord, to not hold any more resentments, but rather to love this person. Father, I ask You to also forgive (name) . Thank You for hearing and answering my prayer. In Jesus' Holy Name, Amen.

Biblical passages on bitterness/resentment

Get rid of all bitterness, rage and anger, brawling and slander, along with every form of malice. Be kind and compassionate to one another, forgiving each other, just as in Christ God forgave you. (Ephesians 4:31-32)

And when you stand praying, if you hold anything against anyone, forgive him, so that your Father in heaven may forgive you your sins. (Mark 11:25)

Do not conform any longer to the pattern of this world, but be transformed by the renewing of your mind. Then you will be able to test and approve what God's will is—his good, pleasing and perfect will. (Romans 12:2)

Brothers, I do not consider myself yet to have taken hold of it. But one thing I do: Forgetting what is behind and straining toward what is ahead (Philippians 3:13)

Bear with each other and forgive whatever grievances you may have against one another. Forgive as the Lord forgave you. (Colossians 3:13)

See to it that no one misses the grace of God and that no bitter root grows up to cause trouble and defile many. (Hebrews 12:15)

But if you harbor bitter envy and selfish ambition in your hearts, do not boast about it or deny the truth. [15]Such "wisdom" does not come down from heaven but is earthly, unspiritual, of the devil. [16]For where you have envy and selfish ambition, there you find disorder and every evil practice. (James 3:14-16)

Appendix P

Transcription of Treatment Sessions

Session One

Therapist: At the beginning of each of the sessions I would like to set an agenda. The purpose to doing this would be for you to know what to expect in the session and then also for it to be collaborative in nature, providing you an opportunity to add to the agenda if needed. Today, the first thing I want to do is give you an overview of the individual session structure and a copy of the treatment schedule, to discuss confidentiality, as well as provide some psychoeducation on depression, assess your specific symptoms and then assess your current levels of suicidality and at the end to review homework. *At this point in the session I explained the session structure and treatment overview which can be found in the treatment manual. I gave the client a copy of an outline of the sessions during this time as well.* Anything that you wanted to add to schedule to make sure that we get to it today?

Client: Nope I'm good.

Therapist: *I then reviewed the importance of completing homework assignments and discussed confidentiality. The client reported understanding. I reviewed the psychoeducational pieces on depression that is detailed in the treatment manual.* So now I want to go through your particular symptoms of depression. Some of these may be fill in the blank and others will be open-ended questions. I would like to fill in the rest of this sentence. Most of the time I am feeling…

Client: I guess most of the time lately I have been feeling like something is missing.

Therapist: Something is missing and are you sure of what that might be?

Client: I don't know…just not content.

Therapist: It almost sounds as like there is some confusion as well.

Client: Yes big time.

Therapist: The times of the day when I am feeling the worst are…

Client: In the evening. Usually 5pm-8pm is my lowest part of the day. I usually get home between 4pm and 4:30pm. I can't calm down because I have things to do. Deal with this, deal with that, deal with everything. Trying to get to a calm place.

Therapist: So you get off of work and it is go, go, go. So you are go, go, go and then you don't have time to regroup, you just go straight back into it when you are home?

Client: No. I guess the lack of help, I guess, things done my way. That is part of my obsessions that I have to re-do or do over.

Therapist: What would you say to answer this: I believe I feel sad/depressed/uncontent __% of my day?

Client: __%...ummm…I would have to say 50/50.

Therapist: There are probably some days when it is less and some days when it is more.

Client: Definitely.

Therapist: Other feelings that come over me throughout the day are….

Client: Well overwhelmed, spacey.

Therapist: What does spacey look like?

Client: I don't know. I'm not listening but I hear. I probably should be or I'm tired. Lately I have been really tired. Between 10am and 1pm I get so tired, I get dizzy and just want to go to sleep and I am at work and it is easy just to go to sleep at work.

Therapist: How are you eating when you feel like this?

Client: I either…depends. I don't always eat breakfast.

Therapist: Any other feelings you can think of?

Client: I am irritable a lot. Agitated.

Therapist: I am feeling my best when…

Client: When I am going to bed. When I don't have to do anything, when I am going to sleep.

Therapist: So at that moment you are able to put everything aside and truly rest?

Client: Yeah if I know I can just to go bed and go to sleep. At night when I am getting to bed is when I feel the best.

Therapist: That is the time when you have some down time.

Client: Yes. I also rush to get to that point. That is my goal to go lay down. So the functions in between from getting home from work and going to bed can be hectic.

Therapist: So sometimes everything you are doing before has more pressure upon it because you really want to get to bed?

Client: Yes. Now yesterday, I tried something different. I went in the door, got a drink and went to lay down. I didn't look at the house, I didn't talk to anyone, I went straight to bed and laid down. That is very very rare for me to be able to do. But I had to. I knew if I got in my mode and looked at the house it would have done nothing for me.

Therapist: Was that hard for you to do?

Client: Oh yeah. I literally had to put black walls on the sides of my eyes as I walked through my house. My daughter was there, her friend was there, my baby and Holland was there. I gave my baby a kiss and say hi to everyone and that I was going back to bed

and not to ask me any questions or nothing until I get up. I told them to wake me up until 6:30pm and I thought yeah right and I crashed. They didn't wake me up until 7pm.

Therapist: What was your day like after that?

Client: It was better.

Therapist: Interesting. When we start talking about the behavioral techniques it will be interesting to see what we can do for you to create this release and time for yourself on a more consistent basis.

Client: I don't know….it was so hard for me to do this, because then I got up at 7pm and it was ok.

Therapist: It sounds like something will need to change. Otherwise you are going to continue to run yourself ragged.

Client: Yeah. Right and I know I have to do something. I was so tired. Last night, I slept better than I ever did in a long time. I woke up once and usually wake up 3 to 4 times. I usually only go to bed at 1am. I get to bed to go to sleep and then I usually wake up at 2am, 3:30am, etc. I usually get up at 6:30am and that is 5 hours of sleep if I slept. That is not very much. Last night, I was in bed by 10:30pm, probably asleep by 11:30pm, I woke up at 3:15am and got up to work at 6:30am. So I probably got 3.5 hours straight for once, which is great for me. So was that nap what did it? I don't know.

Therapist: Or was it just giving yourself that time?

Client: It was something. I was just excited about my sleep.

Therapist: So onto sleep. You said you usually only get 6 hours of sleep. The quality of my sleep is…

Client: lousy

Therapist: You are going to sleep late, waking up early, at least 3 times throughout the night. Why do you usually go to sleep so late?

Client: *chuckles.* Well, I have a baby, children, grandchildren, a live in mate, appointments then groups at the church. I got to run here and there. Something that doesn't put me at home until 9:30pm and then it's usually I can't go straight back to my bed. I need some down time before I go to sleep. I will watch TV or a movie and then it's 12:00pm.

Therapist: Do you have any problems getting to sleep?

Client: No.

Therapist: So you are able to rest once you get there?

Client: Falling asleep is not a problem. Staying to sleep. I can sleep. I used to sleep so many hours. My ex-husband could tell you. When all my kids were in school I didn't have to get up until noon or 11am. I could do 12 hours of sleep no problem. I needed it. Maybe my body isn't needing it anymore. I don't know or just not getting it.

Therapist: Appetite and eating patterns.

Client: Too much or too little and changes all the time. Today I was hungry for real food, yesterday I wanted chocolate and was picking all day. So I didn't hardly have anything yesterday but I had a lot today.

Therapist: What is a lot?

Client: For me, I had waffles this morning and a cheeseburger sub for lunch and some chocolate and I don't normally have that before I go home. Normally, I have eggs and a sandwich and don't eat until 7pm at night if I eat. It is never consistent.

Therapist: What about your energy levels?

Client: They come and go. There are times when I have so much energy I could do it all, but when I don't have it I have to force myself to do anything. Just lethargic.

Therapist: That just varies depending too?

Client: Yeah.

Therapist: What about your sex drive?

Client: It's pretty high and really hasn't been affected at all.

Therapist: Your overall physical health. We talked about asthma and pain from wear and tear and childbirth. Any other health concerns?

Client: Aches and pains of normal life and my age. Lately I am stiff and sore. I don't know what it is. Everything seems stiff and sore. I wonder if it's because I'm not sleep or what is it?

Therapist: Or is it your depression? It has a major impact on your body. Describe a situation in which you felt sad or depressed.

Client: It would have been the other night I was thinking about Holland going to jail. I don't know what I felt it was just something. It is a lil bit of fear, sadness, everything. I started to cry and I don't usually cry. I guess I was scared too. I don't usually take it out on him.

Therapist: Why don't you usually cry? Do you not allow yourself to cry?

Client: If I do it is usually because everything builds up. It takes awhile to get to that point. I can cry at nice happy things. I cry all the time at church. Or if something happens to someone else it is very overwhelming and easy that way.

Therapist: Do you think you do not allow yourself to?

Client: A lot of time I suppose that is true.

Therapist: What kinds of messages do you tell yourself about crying?

Client: Let's stop crying, don't cry. A lot of times I'll tell myself that. I'll say that because once it does I can't stop.

Therapist: So, once it happens you're going to lose control.

Client: Yeah.

Therapist: What kinds of thoughts were going through your mind when you were thinking of Holland going to jail?

Client: What am I going to do? Are we going to make it through this, my child? I don't think about crying about me, it's what he is going to lose. I can be ok, I know I am fine. Of course I am going to miss him, but when I think about how close they are that hurts. It bothers me.

Therapist: So when you are getting upset and crying you are not even allowing yourself to be upset about yourself?

Client: Right.

Therapist: So you are thinking about everyone else and you are almost saying I don't deserve to be upset for me.

Client: Maybe.

Therapist: So you won't allow yourself to cry unless it is for other people and you won't allow yourself to feel yourself.

Client: I guess. I don't really look at it that way, but I suppose I wouldn't.

Therapist: You wouldn't- you don't think about yourself. These are huge messages you're not saying, but you wouldn't say it because it is not something you value. This is

something we definitely will need to work on. Complete the following sentence, when I am feeling sad I am thinking….

Client: Anor not having his father. That is lately what my sadness has been about.

Therapist: Can you think of another situation in which you had been sad lately?

Client: Yeah. I have been sad when I think about what I lost and what I have given up for my marriage, which doesn't have anything to do with Anor or Holland it has to do with my other kids.

Therapist: So I am feeling sad at those times because…

Client: I'm thinking that I took a lot away from them.

Therapist: So once again, you are putting yourself in the mix, but still a focus on them. It's focusing on things you can't change. Not saying that that may have happened and what can I do differently for myself and in turn provide for them differently.

Client: Right.

Therapist: If you're thinking I've taken a lot away from them or Anor would not have his father this would not be good because this would mean…

Client: Anor not having his father this would mean it would be a pattern, not having his father in his life. My other kids don't have that, so I don't know what that is like. All of my kids have their father. Holland didn't have his father and I know the impact that it had on him and the way he turned out.

Therapist: What does that mean about you if he doesn't have his father?

Client: I guess I will have a lot more on my end. No one to help parent, to be the other half. He doesn't work, he stays at home that is a big deal for me. Taking my kid to daycare, I would have to do it all. He does so much that it would be so much for me.

Therapist: So, will I be able to handle it, will I be able to keep it together if it comes to that? Am I strong enough?

Client: Yeah

Therapist: Now this is going to be a tough one. My depression would go away if….

Client: If I could do things right…if I could go back. Not do the things that caused the depression. If I could know how to change it all.

Therapist: So you can't do that, how could it go away now?

Client: I guess eliminating all the stinkin thinking. Really looking at myself inwardly and making changes. Focusing on me, I guess.

Therapist: Did you notice even right there, you said I guess. You want to work on yourself, but there is still that hesitancy.

Client: I know.

Therapist: It's hard. You have been programmed for so long to take care of everyone else, which feels good but you continue to put yourself on that back burner when you can't even see what you are doing for yourself. The future looks…

Client: Scary.

Therapist: When will you know about Holland?

Client: In February he has another hearing at the point we will know if he is going to plead guilty. He doesn't even have a lawyer, we have a public defender. It's going to on and on and that is part of my anxiety. Do I want to do this now? He is scared and doesn't talk about it. He keeps saying that God is with him. He had a hearing before and we waived it. That will keep happening. If he takes it to trial that could take years. If he

pleads guilty that could take a few months, so regardless it would at least take another year. Then it's too much of a question mark. What is going to happen?

Therapist: All of these what-ifs continue to roam around through your head?

Client: It is so confusing to me, because I can't put my life…I don't know. I just hate the not knowing.

Therapist: So even the word future creates so much anxiety and confusion?

Client: I don't even want to think about it.

The therapist gathered information regarding the client's behavioral patterns. She informed the therapist that she isolates when she is depressed. In the past she isolated from her family over the course of several months and currently she has several friendships but is not doing very much to foster this friendship. She often will not return phone calls and does not really spend any free time with her friends. She reported that she also has a difficult time concentrating and reviewed an incident that she failed a medical practicum. She went into great detail about the impact on her emotional well-being that this event had on her life. She focused on all other individuals that were impacted in this situation, and acknowledged that everyone was handling the situation well, except herself. The client also detailed that she does not enjoy activities that she previously enjoyed (going out to eat, visiting family). The client also stated that she engages in arguments frequently. She went into detail about a situation with her daughter and her glasses. The client also reported that her restless and psychomotor agitation at times has placed a strain on her relationships. She discussed a situation with her significant other in which he made her dinner and she had a difficult time just eating and not doing anything else. At the end of the session the therapist assessed for suicidality.

The client denied present suicidal ideation. The therapist finished the session by assigning the client homework.

Session Rating Scale

- Session Number: One
- Completed By: Jennifer Good, MS, MS
- Rank of Session Treatment Efficacy: 1 2 3 4 5 6 7 8 (9) 10 (circle one that best describes session)
- Rank Therapist's Ability to Adhere to Treatment Manual: 1 2 3 4 5 6 7 8 (9) 10 (circle one the best describes session)

Comments: The session was a good initial session. The client spoke freely to the therapist and sufficient material was gathered in regards to the client's baseline depressive symptoms. The client is experiencing a significant amount of distress in most areas of her life and she has very little resources to cope with the stressors. The session revealed that the client often places the needs of others first in her life and she has a difficult time focusing on her own needs and emotions. She reported that she is motivated to make the necessary changes in her life and stated that she is excited to be a part of this study.

Transcription of Treatment Sessions

Session Two

Therapist: Today I want to set the agenda like we did last week. First, I wanted to review any questions that you may have had related to the homework (*client shook head no)* after that I wanted to see if there was anything that you wanted to add to the agenda, and then we are going to talk about what the spiritually-informed cognitive-behavioral model is. Specifically, I am going to review some research, review how thoughts influence feelings, show you a diagram, review your own spiritual coping and then to discuss the interventions that we will be using the upcoming weeks to assist with managing your depression. I'd like to end the session by reviewing homework and prayer. Anything you wanted to add?

Client: No. I did have a horrible week, but I am sure we will get to that in here.

Therapist: Anything in relation to the homework. I saw you shaking your head no.

Client: No.

Therapist: *This part of the session I reviewed research that was listed in the treatment manual.* Now that I reviewed that I would like to review some of your own personal experiences related to your faith. Can you describe your experience when you first became a Christian?

Client: Ok now, recently. I great up with it, but right now. My daughter and I…I was still used and my daughter called me and was crying. She said I had a dream and said I really need you to pray with me. She wasn't brought up religious and wasn't one to usually say something like that. So we prayed on the phone that something would happen that would stop me from my addiction and get out of the chaos and allow me to stay with Holland

and the baby and allow me to stay with the kids. I used to a few days and everything started to fall in place. I know that because of the prayer that things led to how they did. Ever since that prayer I know that it is all where it began and that was how I came to this church. My sister- it was weird because the week before I said I really want to go to that church, it is the home church to my sister's church. I went to my sister's church about a year or two ago and I really like it. Of course I didn't keep going but I said to Holland other people told me that this church up here is really cool and we should really get Anor into something and this was before the prayer with my daughter and I was still using, but I was still reaching out to something and everything little thing. He said we will sometime. That was all that was said. After things happened my sister called me that next week and said we have to go to the church near Gettysburg and we really want you guys to come along and it happened to be the same church. So I thought it was awful funny and we kept covering ever since.

Therapist: Have you ever talked to your daughter about the impact that had on your life?

Client: Everyday. She's here now. She wouldn't step into a church before. I tell her what that prayer led to. Had it not been with her, it if was between me and her older sister, it wouldn't have affected her. As it hasn't yet, not yet. Slowly and surely we are trying. My youngest knows what is impacting on her. She hasn't missed a Wednesday since I brought her the first time. She also holds me accountable when I don't feel like coming

Therapist: What about Christianity first interest you?

Client: How people seem to be more peaceful and have more purpose. My sister as well. She always seem to be at peace with it and she has seemed to be through a lot of things and she never gave up her faith. Young and up.

Therapist: So seeing her and saying to yourself I want some of that?

Client: Yes but not at first. She was the only one at first that was not hypocritical in her life and religion. I always said that I am not going to go to church and then smoke a beer or go to church and then smoke pot. I have always said that if I go to church I am going to be committed and do it all the way. We used to live in McSherrystown where we would watch people walk out of church and then go to bars. I'm not saying you can't drink. I used to have a problem with Christian people- you are supposed to give and be there for people. Christian people you shouldn't judge, but so many people do. That was always a very big turn off to church. I know we all judge, but as Christians we need to be more aware of it and try to control it more. I didn't see it in too many people growing up.

Therapist: What about prayer, the Christian community and the bible…what impact do they have on your life right now?

Client: A lot.

Therapist: Can you think of specific times when your faith has helped you through difficulties?

Client: There have been so many. I couldn't even tell you. It's been one after the other, faith and…a little story today I can tell you. Holland and I aren't getting along with a certain situation. I was texting him and in a funk. I was crying and driving and praying. I said God forgive me and I looked up and saw a sticker that said shining stars of Freedom Valley and I was like whoa…you tell me. You're here ok.

Therapist: How did that change your thought processes?

Client: When I saw that sticker, well…I had belief. I was like wow. I dropped the phone and started to be able to be cool and texted and told him that I calmed down and we will talk later and I would never do that. It was in my face.

Therapist: So all of these signs in your life.

Client: Yes that happen all the time to remind me that He is there. It was like him telling me you need to chill out. I am here watching you and I am here to carry you through this. Never have I seen anything to do with shining stars until I came to this church. It's the mentally handicapped ministry and I work for the mentally handicapped and I was in my work van doing a transport and I was like WHOA….this is a sign.

Therapist: *In this part of the session I reviewed the stories that is titled God Answers Prayer. The client cried a bit throughout the reading of this story.* I felt that this was a good story that depicted the power and presence of God throughout one woman's struggle. I know that you have been through a lot of hard times in your life and I felt that this story would have some personal meaning to you as well. It also helped to depict how God can place people in our lives and the powerful effect that this can has over our lives.

Client: Yes it was a great story. It started to make me cry. I'm a big baby with stories like that though. I'm crying at church all the time.

Therapist: I think it is a good thing though, as we talked last week that you need to allow yourself to feel and allow your emotions to come out.

Client: I agree. I don't cry about my situations, only when it is an emotional moment.

Therapist: But in some ways you are emotionally connecting so it is your moment as well and you are then working through some of your own issues.

Client: Yes that is true.

Therapist: The next part of the session I would like to talk about the cognitive-behavioral model. *During this part of the session I educated the client on the cognitive-behavioral model and gave an example of a negative and positive cycle.* I would like for you to come up with an example from your life of the negative and positive cycle.

Client: There are so many. First one that comes to my mind is Holland on the phone texting.

Therapist: So that was the event. What was the thought that popped into your head?

Client: I wonder who this…what is he hiding?

Therapist: How did that lead you to feel?

Client: Mad, upset, mistrusting

Therapist: Then what happened after that?

Client: We fought.

Therapist: And then that probably led to another negative thought.

Client: Yes, everything and then it just spiraled downward.

Therapist: Yes, like I was saying it keeps going and going. Now, this may be a bit more difficult, can you come up with a positive situation?

Client: ummm…I came in the house and saw it was clean and straightened.

Therapist: So then what did you think?

Client: I thought he was really trying to make me happy and I felt good. We got along the rest of the night. It was weird.

Therapist: So you can see the power and impact that your thoughts have over your feelings and your behaviors. *At this point in the session the therapist gave the client a visual diagram of this cycle.* I want to talk about next is your own spiritual coping.

Sometimes people have a negative view of God, or they only look at certain selections in the Bible or at times they may even place certain rules upon their spiritual practices and beliefs. This can lead to negative spiritual coping which will make you feel worse. How often do you pray and what are you prayers usually about?

Client: I pray often. Some days not as much as others, but usually in the morning and at night. In the mornings I pray to get by this day and at night thank God for getting me through the day. Throughout the day I might pray for others during the day and don't focus on me much. In the evening I always pray at night for everyone in the family and thankfulness and give Him throughout the day and try to have some alone time with God as well.

Therapist: I noticed that you said it is often about everyone else and everything else and being thankful. Are there certain rules that you place upon your prayers?

Client: No. I guess the most I pray for myself is when I have done something wrong. I tell him I am sorry and I know you forgive me and I am going to try to forgive myself. I am working on forgiving myself and getting through this. I lately have been praying that he holds me tighter and allows me to walk closer to Him. I feel this distance lately. I feel like I am pulled. I guess the time away as well the break we didn't have to be here did me bad. Being here makes a difference.

Therapist: So you are able to pray for yourself, do you think it is more difficult when you are doing this?

Client: Most of the time. There are times that it isn't, but most of the time.

Therapist: Do you have rules about how often you should pray or are there times when you don't think you are praying enough?

Client: At times that does happen. I feel that I should be praying more. Sometimes I haven't prayed and I think that is why it has happened. This is not often as I pray a lot more than I used to.

Therapist: What about reading the bible. Do you do that often?

Client: Right now I am reading A Purpose Driven Life. I love it. There is another one that I am reading on spiritual depression as well. I have a recovery bible that I read very often and am also in a bible study group. I bounce back and forth in the bible. Is it as often as I like? But I do pick up my bible and read from it at least three or four times a week. Way more than I ever did in my life.

Therapist: So it sounds like it is a part of your daily routine?

Client: Yes. It is something I am trying to do every day. I also have little devotionals that I read every day so I can center myself and focus. It has really helped.

Therapist: What about any certain passages or stories that help you to get by?

Client: There is a lot with Paul and all the bad he did and then Job is a very powerful one. There are so many, but like I stated before I would never be able to tell you that.

Therapist: Have you ever read any scripture that placed additional stress or demands on you?

Client: No.

Therapist: I know sometimes people read through certain passages and say to themselves I am not doing that or reads a scripture that places undue stress upon them. So there is nothing you can recall related to this?

Client: There is the not being married and living with Holland. You should not be married…that does a lot when I am trying to be spiritual and Godly and then look at what

I am doing. I am living with a man and sleeping with a man that I am not married to. We have baby. It's not something that should happened and I have talked to the pastor about it and Holland would like to be married. We actually have an appointment with the pastor and his wife to talk about what my issues are. I was kind of put on the spot with that. Pastor Gerry told me that if you are living together and have a baby together you should be preparing for marriage and until then you should not be living or we could live in the same house and sleep in separate rooms and ask God for forgiveness for what we have done and try to abstain from sex. It's not going to work.

Therapist: So there is a lot of guilt in regards to those ideals and standards?

Client: Yes. Not wanting to be married yet. Stuff like that where he wants to be married and doesn't know why we aren't. He wants to go to the JP so we are living properly for Anor and for God. He doesn't understand why I don't want to be married and why I'm not ready to do that and then pastor Gerry backs him up because if we aren't ready what are we doing.

Therapist: It's a big roadblock.

Client: That is one of my racing thoughts. It drives me crazy.

Therapist: Are there any other passages in the bible that you do not feel that you are obliging by or that make you feel as if you are not living up to certain standards?

Client: No, besides the marriage one. I should probably though.

Therapist: We'll talk more about these shoulds later. This is a hard one. How does God feel about you?

Client: I think that He knows that I struggle, sometimes unnecessarily. I feel like He loves me. I feel like He feels like I can handle a lot more than I can . I feel like He is

giving me all of this in my life for a reason I am not quite seeing yet. I feel like he is carrying me , carrying me and carrying me and I feel like at times He thinks I am just taking advantage of it. I take him for granted.

Therapist: Sounds like a mixed bag of different emotions.

Client: That is a question I have often asked myself. How does God feel about me and a question that I think about often.

Therapist: It probably depends a lot on how you are doing and what you are feeling.

Client: Yes sometimes when I am doing well I think God must be so proud of me and other times I think he just wants to shake me.

Therapist: How do you think God views your life?

Client: Hmm…views it as a whirlwind a spiral…like a cyclone. He is probably dizzy. At times He has viewed is as chaotic, calm, back on track, on the track, off the track, I don't know. Bumpy. He is probably dizzy and tired and getting whip lashed.

Therapist: Any questions that you wanted to ask or add on.

Client: I think a lot of time I make choices, God doesn't make them for me. I think a lot of people blame God. I make the choice to do something wrong or right. There are always ways to get out of bad. I used to always question why but now I see that things happen for a reason. Certain situations when people don't follow the way that they should that is when things happen. When things don't work out I try to understand things instead of question God, like I used to. I try to find the good part of anything bad and what I can gain from it.

Therapist: So now you look for the meaning behind the situation.

Client: Yes.

The end of the session the therapist reviewed the different interventions that will be used in the following 10 sessions. The description for each of these is included in the treatment manual. The therapist then assigned the client with homework and ended the session with a prayer.

Session Rating Scale

- Session Number: Two
- Completed By: Jennifer Good, MS, MS
- Rank of Session Treatment Efficacy: 1 2 3 4 5 6 7 8 (9) 10 (circle one that best describes session)
- Rank Therapist's Ability to Adhere to Treatment Manual: 1 2 3 4 5 6 7 8 9 (10) (circle one the best describes session)

Comments: The treatment manual was pretty much followed exactly as written. I was able to get through all of the topics that were needed and made the session individualized for the client and her concerns. The client has strong religious beliefs and her spiritual coping skills have helped her many times throughout her struggles. The client was open during the session and continued to express excitement and motivation to participate in this study.

Transcription of Treatment Sessions

Session Three

Therapist: Today I want to check in and see how you are doing, review the homework from last week, kind of see a good baseline of your behavior, what's going on weekly, when you are feeling good and not feeling good and review the behaviors related to depression. Some of this we already talked about, but there are going to some specific question that I haven't asked in the past that I haven't asked you and then after I have gathered those things to look at the behaviors and create some goals for you to work towards throughout the week and ways to monitor these goals and then rewards. Which is going to be a toughie for you, which is essential to create some effective behavioral goals for you. Is there anything that you wanted to add to the agenda?

Client: Just basically, if we have time to talk about some of the other things that are going on in my life.

Therapist: Yes definitely. Once we get to some of the cognitive pieces we will definitely be reviewing those themes. Do you have your homework with you?

Client: Yes and brought my book with me too. The only thing I didn't get done was a little bit of last night which I remember clearly in my head. I had to work 14 hours yesterday which was not expected.

Therapist: Let me take a gander. Depression appeared to be the worse when you were at work on Wednesday, that must have been pretty stressful day. Then it dropped and it went down right before bed. Thursday wasn't as bad of a day, it looks like it got worse when you driving home and then when you got home. What was going on that day on Thursday?

Client: It was our problem. It wasn't all Holland, but our communication problems.

Therapist: Friday…that was a good day. Then towards the end it looks like you were depressed when driving home. Those drives were not good. Saturday- sleep, sleep, sleep, sleep, sleep. What was going on that day?

Client: I slept all day. I don't sleep in any other day. I normally sleep until 11am or 12pm, but the baby just didn't get up.

Therapist: So it wasn't…

Client: It wasn't that I wasn't feeling well, I just didn't want to get out of bed.

Therapist: So some of it was related to your depression and then some of it was your re-coup time.

Client: Yes and that is my re-coup time.

Therapist: Sunday looks like it was a great day.

Client: Yes we had a good time that day.

Therapist: So you were at church from 9 until…

Client: Forever, on Sundays and Wednesdays you will see church a lot.

Therapist: Monday wasn't too stressful but yesterday it looks like it got really bad.

Client: Yes between me and Holland.

Therapist: By doing this was it easier to see it all in a visual representation? This is what is happening when I am feeling my worse and my best and my enjoyment and how you can see how you can control what is going on with your life. So, it was a helpful tool?

Client: Yes, yes it was. Looking at it and seeing what was going on.

Therapist: The bad times were work and then when you got home.

Client: Work that day I think I was just so tired from the weekend and then going home, that evening I was terribly depressed. That was the night that we had a lot of problems.

Therapist: So a lot of the problems throughout the week was work and then relational?

Client: Uh huh. Work usually Mondays are really hectic. On Monday morning I had too much to do and then the girl called in sick, usually at work I am cool, calm and collective. That usually doesn't happen.

Therapist: I am going to review some of this kind of quickly because we have already reviewed some of this. How was your sleep when you weren't depressed?

Client: It was good. I didn't wake up throughout the night and slept well.

Therapist: You slept a good 8 hours.

Client: Actually a good 8 to 10 hours.

Therapist: So you weren't sleeping when you weren't supposed to?

Client: It was just. I wasn't depressed. I would go to bed at 10 and wake up and it was normal. I wasn't working.

Therapist: How would you like your sleep to change?

Client: I just want to go to sleep. I have no problems getting to sleep. I just want to stay asleep. Last night I went to bed at 11:30pm. I was up at 12:30pm, 2am, 3:45am and I was so frustrated.

Therapist: What are you doing when you get up?

Client: Someone told me to talk to God or do something different. The other night that really worked. I woke up once and said there is a reason I am up and what is it. Here the water is running in the kitchen and I am thinking ok the water is running and now can I go back to sleep. I was thinking what is the purpose…there was food in the drain and if I

wouldn't have gotten up it was have overflowed. Then I was thinking if that wasn't the case would I have stayed sleeping? That was the other night and then since I was up I said let's talk about it. Then I went to bed and I stayed to sleep the whole night.

Therapist: What do you other nights when you are up?

Client: Toss and turn, move my pillow.

Therapist: So you stay in bed?

Client: Yeah. Always stay in bed.

Therapist: Then when you do that does your mind start going?

Client: Yes and when I do that I can't get back to sleep. Or it takes 20 minutes to get back to sleep and sometimes I just lay there and then I get mad because I look and Holland is still asleep.

Therapist: So ideally, it would be get to sleep and stay asleep.

Client: Yeah.

Therapist: We talked about your appetite and that it is not consistent….that you eat a lot for you and then other days hardly at all. How was your appetite before you were depressed?

Client: Probably over. I was always an over-eater so too much. I like food. It is one of those things I love food. Probably overindulged it wasn't always healthy choices. It was consistently not healthy. Basically always overeating.

Therapist: How would you like your eating habits to change?

Client: I wish I could choose healthier foods or eat more of healthier foods. I am on a chocolate fast. Everyone is taking away or doing a diet here on leadership. My family is doing the ch fast. Aja is chicken, mine is chocolate, Holland is chips and Brittany's is

cheetos. Aja is going crazy because she can't have chicken. Me and chocolate it is going crazy.

Therapist: How long are you doing this for?

Client: Three weeks, it just started on Sunday. So I might be really depressed because of not having chocolate. I am dying for chocolate really bad.

Therapist: Once it gets out of your system a bit more.

Client: Yes. I didn't think about it today as much as I did yesterday. I just really wanted one M&M and then it would get out of control.

Therapist: So you would like to be able to choose healthier choices and eat healthier in general?

Client: Yeah

Therapist: Problems with social patterns. I know you said you have a couple of close friends and that you feel you should be connected with them more and that you feel guilty when you don't. How was your social life before you were depressed?

Client: Good very good, excellent.

Therapist: Did you have those kinds of worries before with your social connections or friends?

Client: No. I spoke to one today and we talked a long time and then always seem to call at good times. They seem to know when they need to get a hold of me. The timing is almost perfect.

Therapist: How would you like this area to change for you?

Client: I would like to be able to spend an hour or two with friends with coffee.

Therapist: How often?

Client: At least every other week or at least once a week. Just something that puts me out there with my friends.

Therapist: That is a good goal to be connected to see that you are growing socially and have that support that you need and deserve. Physical illnesses, we talked about your body aches and pain, how do you feel it was before you were depressed?

Client: Much less, so much less. I have a lot.

Therapist: What about your migraines?

Client: You know what I haven't even had any lately and I was getting them horribly. I can't even think about them. They are horrible. Mine would develop right here and my ear would get so sore that I couldn't even brush. My neck has a lot of tension and that has been really bad lately. I have to stretch it when I am driving.

Therapist: That has been all new since your depression?

Client: Yes my neck, I have never had such horrible pain. I mean it is just more.

Therapist: This is kind of a silly question, but how would you like it to change?

Client: I want it to go away. To get better.

Therapist: I know said your sex drive has been good.

Client: I don't know. It has not been effected until the last week.

Therapist: What's changed?

Client: I don't know maybe it is because I'm tired but that usually would not bother me before. Right now I don't have the desire and I don't feel like a participant. I know he has noticed before he has a very high sexual drive. First of all, by nature his sex drive is very high and that is his intimacy and makes him feel love and cared for and he has felt like I am pushing him away and does not feel cared for. That never happened before.

Therapist: So the intimacy is missing.

Client: Exactly. That is what it is. I am still participating but it lost something.

Therapist: Also, it probably stems from your depression and you not feeling as if you are being taken care of so it is almost like you are taking it out in that area. You needs aren't being met, and now his aren't either. *We briefly discussed a book called the 5 love languages and the client stated that she was going to get the book.* How was your sex drive before depression?

Client: High it was always high.

Therapist: I am assuming how you would like it to change would be to get it back to where it was- to have the intimacy.

Client: Yeah, to have that intimacy again.

Therapist: OK- the next part is your spiritual life. Do you feel like your depression is impacting your depression?

Client: There are times when it happens. There are times when I won't get into God's word or I stay in that instead of doing something Godly or when it is bad, I don't want anything to do with it. I will lay here and normally I can read Joyce Meyers book and feel better. There are times when I don't pick the book up and just am really depressed.

Therapist: So there are some times when it really inhibits you from doing what you know would be best. How would you say you spiritual life was before you were depressed?

Client: I would say it was balanced to what I knew at that point. Now, even in the depression it is much better but not as balanced. I was just telling them our best times is when we are in a Godly situation or involved in God's word. That is when we are beaming together.

Therapist: Do you guys find a Bible study together yet?

Client: Where…yeah. It does helps. We have a life group that we go to. I have a women's bible study that I just can't seem to get there. It was last night. I had to work 14 hours. It as a choice, can you stay until 9. I knew I needed to go, but they asked me to work-money….so I choose to stay at work even though I knew the Bible study would be good for me. It probably would have pulled me out of a funk but money talked to me.

Therapist: So you had to weigh it out?

Client: Yeah and in the end I worked. I knew I would be here tonight and at a depression support group on Monday. I figured I would be ok.

Therapist: So it seems like you kind of put your needs behind the money and everyone else- a theme we have seen.

Client: Yeah and because I was thinking I should just go…I should have went with that thought because I would have had my women time. I need that. Sunday we went to a NA meeting and Holland was with me on Monday we had a support group but I need time with woman and to talk and I should have made that important but I didn't.

Therapist: How would you like the way that depression impacts your spiritual life to change?

Client: I really would like it not to have an impact or for my spiritual life to triumph the spiritual life or my depression to make me want to go more spiritually and get out of the funk.

Therapist: It is so hard to do what you need to do but you when you get there you are so glad you did.

Client: Getting up and doing it is so hard but once I am there it is great.

Therapist: So now we are going to focus on some of those things that you stated that you want to do in your life and work on creating some goals to focus on in the upcoming week. It's all doing more, increasing those activities that make you feel good. Basically, what activities do you enjoy?

Client: Activities if I had the time-reading.

Therapist: Special interests or hobbies?

Client: I don't really have to much- seeing a play or going to the theater or the eichelberger center. I enjoy them so much but Holland doesn't really. He does when he is there but it is getting him there.

Therapist: What activities would you like to be doing more of?

Client: I don't know.

Therapist: You already said going to the Bible study.

Client: Yes I want to go to that. More Bible study, but we do so much. The women's- doing more activities with women.

Therapist: I think that is so important to have that network outside of your family. Right now you are spending most of your time with them. You need that balance. In regards to spiritual activities are there any areas that you need to devote more time to?

Client: There is always more you can do- with the kid's ministry. I need to go see Candice…I didn't go to…I was supposed to go to a couple of different businesses I only went to one or two and donations. I know I could get stuff from anybody. It would be beneficial to do this. I do want to do this on Friday while I am working. I feel like I should have done it more.

For this part of the session we created three different goals. Karen stated that she wanted to get two donations for the children's ministry, spend an hour of 1:1 woman time, and to spend an evening with her significant other. She reviewed ways that she would monitor this throughout the week and the rewards that she would provide once she accomplished these goals.

Therapist: I know that you stated there are a few things that you want to bring up at the end of the session here with you relationship what's going on?

Client: He's struggling to get a job. I understand that it's hard to get a job when you have a felony but he isn't getting anywhere. I still don't think he is doing everything he can and it is bothering me a lot. I will ask if he called different agencies. I tell him you are a felon, you are black, you have no work history. You have to work three times harder than the average person. *Karen continued to review different ways that Holland is not contributing to the household expectations. She stated that she is now going to write things down for him to do over the course of the week. Karen stated that in the past she reviewed the different things that needed to be done over the course of the week, but that it did not work, as he continues to forget. She discussed what was reviewed when she met with one of the pastors with her significant other prior to the scheduled individual therapy session. Karen reported that she is going to work on understanding where Holland is coming from but also stated that he needed to make movements in his own goals. The session ended with a prayer.*

Session Rating Scale

- Session Number: Three
- Completed By: Jennifer Good, MS, MS

- Rank of Session Treatment Efficacy: 1 2 3 4 5 6 7 8 (9) 10 (circle one that best describes session)
- Rank Therapist's Ability to Adhere to Treatment Manual: 1 2 3 4 5 6 7 8 9 (10) (circle one the best describes session)

Comments: This third session went very well. The client responded favorably to the items on the agenda. She recognized several areas of her life that she wanted to work towards. Specifically, Karen stated that she wanted to get involved in the kid's ministry, broaden her social network and to increase her time with her significant other. She agreed that she is control of her own behaviors and recognized that her behaviors have a direct impact on her emotional well-being. Karen denied any suicidal/homicidal ideation and denied any substance abuse throughout the week.

Transcription of Treatment Sessions

Session Four

Therapist: One thing before we get started my supervisor asked that we fill out the BDI and BAI after session. Is that ok?

Client: That is fine.

Therapist: Today I want to do is set the agenda. I would like to first start out by reviewing the homework and how it went and then to talk about doing more, stimulus control and sleep hygiene. Then we will focus on being more which is the inward spirituality and then doing less which would be issues related to bitterness, unforgiveness and overindulgence. Some of those areas we are going to touch on today. Is there anything that you wanted to add to that schedule?

Client: Same thing every week. How Holland and I are getting along.

Therapist: So how did the homework go?

Client: It went well. The woman time I did. I went with Nicole on Saturday for about 3 hours. We went to Kohls. It was just she and I. Actually Holland I went to her house. Her husband does not socialize much. Holland took the baby over. It wasn't such a good thing because she could spend the money and I couldn't. But that didn't bother me.

Therapist: It was more about spending the time together then spending money.

Client: Yeah and I talked to her and we had some nice talks. Then we got back and chit chatted a bit with them and then Holland and I left together. It went well. I did not reward myself though by playing yahtzee. We were going to, but my daughter called and I had to leave. My other daughter called and needed me. That didn't pan out. I spent an evening alone with Holland without the baby with my oldest daughter and her boyfriend. It was

hard to spend 18 dollars but we did it, and we brought our own food and snuck it in, which we weren't supposed to but we did anyways. That was about 2 hours that we were away. That was fine and I did have my 20 minutes alone then.

Therapist: So you did reward yourself then. Was it nice to get out together and enjoy one another's company?

Client: Yes we laughed and it was a good movie. Today I got 2 donations one from Hanover packing and one from Gladstone Smith. I didn't reward myself yet, but I will and I can say that I was able to read. I have actually spent some time. I am reading this little this by Joyce Meyer, but I can't find it. It's somewhere along my travels. It's not a lot of reading but I'm reading it.

Therapist: How was doing the homework and accomplishing the goals? They were smaller things but I believe they were things that you need in your life.

Client: It was fun. It wasn't easy to because I always want to push things off that are for me, but when my daughter called and asked to go to the movies and I asked if she was paying for it she said no but don't you have 17 dollars to spend on the movie and she stated that we had been putting it off and then I asked if when I need to go to work if she would give me gas money and she stated that her brother would and he did so it was good. He gave 3 dollars towards my 5 dollars which got us through and it felt good to not have the baby with us. A little bit of would be not to take Holland whenever I go somewhere. On Monday I made up for it, I went straight after work and I met my ex-husband at my daughter's appointment and took my son for a drive. I didn't get home until 7 pm and it felt good. It was kind a bit of defiance but it felt good to spend some time with the kids and not have Holland along.

Therapist: It sounds like it was a bit, but also that it was needed as you told me that there was a lot of conflict that has been going on so it is important to be able to have that time together and some chill time as well.

Client: I got that as well and I made the decision not to go to the depression support group because I needed some time to relax. For 3 hours I didn't do anything. I actually went to bed at 10:30pm and got a good night's sleep, I only woke up once that night. Last night was bad. I had a rough night last night. It seems like the night before Wednesday- maybe it is because we haven't been to church since Sunday because I usually sleep well on Sunday nights.

Therapist: The first thing I want to talk about is doing more. The first thing is shaping. Shaping involves dividing things into smaller components in order to work towards a larger goal. One example that I have is working out. One might pack their gym bag the night before, and their water bottle, then bring the gym bag to work and change at work and then go work out and afterwards provide some sort of reward. Is there something that you can think of that you would like to break apart and work towards?

Client: So a little bit of a bigger goal that I want to do? It is so hard for me to think of stuff. You help me. What? What did I say?

Therapist: A lot of things are social. Something at home

Client: I actually do have a goal with the house I have to get Anor and Aja's bedroom . It is crowded in there. I want to organize the room. Actually let's scratch that I want to get my things hung up on the walls, which is actually really important because I have nothing hung up and that's not like me. When we moved in I didn't feel like doing it, I was so depressed. My house is usually decorated very well and this is not like me.

Therapist: So that is the end goal, what do you think is the next step in this process?

Client: The next step is to, I already did that I bought the picture hangie stuff and nails. I just did that.

Therapist: That must feel good, you are already ahead of the game.

Client: So the next step would be…

Therapist: How many items is it and is the whole house?

Client: It's the whole house and I already have the boxes organized and where I want to put the items.

Karen continued to note the necessary steps that were needed to complete this goal. They were as follows: 1)buy nails and hanging items 2)place the boxes in the living room and organize 3)sort items and decide where they would go 4)nail up the items and 5) enjoy your accomplishments.

Client: I would be so relieved when that was done.

Therapist: I will write the steps down on a paper to help you out and will ask you about the progress over the course of the week.

Client: And it will be done. I was meaning to do this over the course of this past week and with the kids having off. I really wanted Aja to do this with me, but things just turned on me this week and I wasn't able to get it done.

Therapist: I expect you to be working on it. The next part I wanted to talk about was stimulus control. This involves removes distractions and different things that keep you from accomplishing what you are working towards. This was when I wanted to review this with you (handed her the sleep hygiene worksheet). Sleep hygiene tips. Part of the stimulus control would be making your room dark, comfortable, temperature, using a

sound machine. These are things that you can control. When you have caffeine last. It could have an impact on your system. What do you do when you wake up in the night? Do you lay down and ruminate or do you get up? Only sleep and sex and bed. Do you do other things in bed?

Client: Watch TV in bed and it's not often but that is our relax time and lately not too much. It might have been two weeks ago. We put a movie in. The other is next to Anor's bedroom and we don't want to wake up him. I don't have problems with keeping it on. I turn it off before I go to bed. I don't have a problem falling asleep.

Therapist: It's when you wake up.

Client: You mean you want me to get up every time I wake up?

Therapist: Yes. Does lying there in bed help you to get back to sleep?

Client: No. This past week I got up and thought I can go back to bed and lay there or… I went out to the kitchen and got a drink. I sat at the end of the table and thought what can I do? So I sat at the table to read to verses and then went to bed because I got tired. I went right back to sleep.

Therapist: That's what they say to get up do a tiny bit of something that does not stimulate you and then to go back to bed when you are tired. Don't turn on the mind to keep going.

Client: Sit in the chair in the dark? I guess I did. I sat at the table. Don't drink caffeine inappropriately.

Therapist: It could have an impact on your sleep quality.

Client: If you drink caffeine only do it before noon (reading off the sheet). Are you crazy? That is a problem. I can tell you when I run out of Mountain Dew or forgot. Last

time I had it would be 3pm or 3:30pm at work. I know the other night I didn't have any and I slept very well.

Therapist: So it might not be effecting when you get to sleep but it may be causing you to get up?

Client: Right. It could be. I usually have a sip of something in the middle of the night that is caffeine or tea. Holland tells me to put water over there. Water gives me this choking thing lately. I gag and it's almost like it's choking me. It's only a nighttime. If I am up during the day I can drink water. It might just be my sinuses. Inappropriate substances that interfere with sleep (reading the brochure). Cigarettes- yeah. Alcohol, I don't drink. The cigarettes might be it but we are getting better. They will be gone soon. I just went to the eye doctor and I have macular degenerative disease and he told me if I quit smoking it might slow it down. He said the whole main reason is a result of my smoking. Exercise- I do that all day.

Therapist: I think it is more a warning of people who do it late at night. I know when I am exercise regularly I sleep better and my mood is better as well.

Client: Yeah it is. Turn your clock away. I usually do. I don't watch it. I do get a shower before bed and it helps me to sleep better. I think I know what I need to work on.

Therapist: Ways that you can control your environment to remove distractions. It could be other things in your life. If you are trying to read the bible you are going to do it when your kids are sleeping. It is about removing distractions and increasing the likelihood of doing what you are going to do. Ways to control your own behaviors. The next part is being more. I want to ask you some questions about your own inward spiritual growth. How would you see your grow in your own spiritual walk?

Client: I read the bible more, I listen to Christian music, reading, being more involved in the church, taking things, praying a lot more. I can't even say…it's done a 360 from not even wanting to be in a church to being here all the time and being involved in so many things. They got me tonight. They want me to start leading in youth group. I am going to see where I fit in and do best. Then Sundays they have me leading the kid's ministry. It is just weird how it is all working all out. Between the youth on Sunday night and the kids, it will be fun I think between those two things and our regular life groups I will be getting a balance instead of trying to figure out where I am going to be and a routine.

Therapist: It sounds like you also are at a good balance between giving and receiving at the church as well.

Client: Yes. I think it was very nice that they asked me. Did I tell you about overhearing them talk about me? I was listening to the kids talking and heard them say, I think it should be Karen. She is so cool and has life experiences. Why don't we all ask her? I said I know you are talking about me and why are you saying these things about me? They said they need adult supervision and need adult presence since a lot when to Tulsa. So it is the young teen leaders and they wanted to know if I could help out. I was like am I cool enough? I said how about I come and see how it was? It really felt good and they were happy and then it was my daughter and I asked her how she felt how it and she said whatever mom. So, I know for her it was acting like she didn't care but I could tell she was ok with it and she will still accepting. Sunday afternoon someone asked if I could help out with Kid's ministry. They said I was good with the kids because I do the registration table. They asked if I would please and I said I would come in and Sunday

and see if I could handle it. It's a lot of motivation for me and I am anxious to just get it started.

Therapist: Onto doing less. Things that would contribute to your depression. Do you think there are certain excesses that would contribute to your depression?

Client: Yeah. Thinking. It's the thoughts, because I can't get them always out of my mind and lately it is too many with Holland. I don't know. I guess I am worrying too much. A lot of anxiety and I just don't even know.

Therapist: I have some questions about Holland and what happened. *Karen then detailed Holland's legal history. He served 8 years in prison as a result of sexual assault. Karen explained that he had sex with a 15 year old girl when he was 21. She stated that she read the papers and the file and that his ex-girlfriend drugged him and had consensual intercourse and lied to her parents once she found out that he cheated on her. She reported that she went to the books and read about what happened, as she was working within the legal system at the time. She reported that every three months Holland has to be registered and have his pictures taken. She reported that they stated that he failed to register with Karen and as a result he was given charges for not registering with his new address. She then discussed some of the problems that she was having with paying her bills.*

Client: Now Holland has a job. He has an interview tomorrow. I talked with my babysitter and she told me that his husband works in New Castle and that they just got rid of a bunch of people and they most likely that they would be hiring individuals with felons. She stated that he needed to call in and that he needed to use my husband's name and get it in as soon as possible. I wrote on his application that I had a felony that I was

charged with, I have no work history as I was in prison. I have not been given the chance to prove myself. I have children and I need the mistakes from my staff to stop defining who I am. And they called and I told him this is what you should be doing the whole time. He said that sounded so sappy, but I told him he would pull one someone's heart strings. This was Friday and we had someone from the church take him around everyone. All the temp agencies put him to the top because he has been calling every day. One of them called yesterday and he was able to get this interview on Thursday. He got off the phone and was so excited. For him this would be so phenomenal. This is the place that I wrote this statement and he is going in with this knowing what happened.

Therapist: This sounds like something that you both need. He needs, you needs, financially both of you need.

Client: I agreed but I am little concerned with where all of his money is going. He will be in control of it and I hope that they do direct deposit because if it is not I worry because he still has issues with what is his and what is mine and it scares me because we are really behind and have a lot of money issues. Even when he dealt drugs he never the paid the bills. He always said that I was smoking because that was where the money went. I'm not now so he can't say that. We are behind on bills and I heard something that went throw me. He said when I get a job we will be going places. I hope he gets direct deposit so I can pay the bills immediately. He needs to have the chance to prove it.

Therapist: Then you go thinking the worst case scenario.

Client: Yes. But I have another job interview. Everyone is calling me. I applied for other jobs. I had a nursing call today. I have an interview and am signing paperwork tomorrow. They are lower paying, but I need to start doing it to get that extra money. I love my job

now, the hours are great but the money is not cutting it. If I could find a higher paying fulltime job I would. I have a nursing call today, and I will start with them. *Karen proceeded to discuss ways that she is going to continue to pursue employment opportunities in order to keep all the doors open.*

Therapist: Do you feel that bitterness is a problem area in your life?

Client: Yes. Top.

Therapist: Top? And who would you say you have this problem with?

Client: Holland and myself.

Therapist: What about unforgiveness?

Client: No. I do forgive I just don't forget.

Therapist: What about overindulgence?

Client: Definitely. With eating, at times. Lately I'm not getting anything to eat. *The client briefly reviewed how she was dealing with her chocolate fast.*

Therapist: Eating at times any other areas?

Client: Before it was spending.

Therapist: What would you say are your sources of bitterness?

Client: Memories or flashes of things. When we are fighting I remember it.

Therapist: So holding onto things at times?

Client: Yeah. Which I really have let go of…

Therapist: But not entirely.

Client: Right.

Therapist: *The Biblical passages in the manual were read to help to portray how one should deal with bitterness and anger.*

Client: That's a good. That was really good.

Therapist: *The research on bitterness and unforgiveness was reviewed briefly.* What ways do you think your bitterness has impacted your life?

Client: It doesn't let me more forward it keeps me stuck. I keep picturing the worst case scenario and it's frustrating.

Therapist: Do you feel feelings of bitterness have an impact on your spiritual growth?

Client: Sometimes. Last night they did. After we fought he asked if we could read and I said no. It probably would have helped and made things better but I choose not to.

The tape ended at this point in the session. The client proceeded to state that her bitterness at times makes her stubborn and halts spiritual growth. She stated that she wanted to use her spiritual tools to combat the bitterness and not allow it to control her life. The therapist ended the session by reviewing the homework (the shaping exercise and sleep hygiene tools) and then ended with prayer.

Session Rating Scale

- Session Number: Four
- Completed By: Jennifer Good, MS, MS
- Rank of Session Treatment Efficacy: 1 2 3 4 5 6 7 (8) 9 10 (circle one that best describes session)
- Rank Therapist's Ability to Adhere to Treatment Manual: 1 2 3 4 5 6 7 8 (9) 10 (circle one the best describes session)

Comments: This session went well overall. Karen completed the homework assignment from the previous session and reported a lot of success with her accomplishments. She continues to have stress related to her relationship. Karen noted that when she is by

herself or with her children she usually is feeling well, but lately the depression and anxiety are stemming directly from her relationship. She continues to be motivated in sessions and completing all assignments asked of her. She continues to seek out resources in her life and is now working towards balancing her spiritual life. The treatment manual was followed pretty well and it seemed to work well within the content of this session.

Transcription of Treatment Sessions

Session Five

Therapist: I wanted to discuss some of the issues that came up with Holland. Your safety is paramount as well as your daughter's. Basically, when we were talking last week at one point you mentioned that Holland was alone with your daughter. I guess I first wanted to ask if he was on parole or probation?

Client: No

Therapist: He is not on parole. I wanted to ask that because I wasn't sure if there were any rules established if he could not be unsupervised with minors.

Client: No.

Therapist: Can you tell me what you have done to establish trust especially in regards to Holland being alone with your daughter? I know we have talked about in the past the kind of harm that would be done if something were to occur. Specifically, the irreparable harm to your daughter and possible removal of your daughter from the home and permanent removal of Holland from the home. In addition, you could even be charged with endangerment of your child's welfare.

Client: Holland was labeled as a violent sexual predator. It comes from 10 tens ago when he was 20 and dating a 15 year old. It was ok, he thought that she was 18 and he was 20, which really is not the big of an age difference. However when I found out which was 2 years ago when he was released when I met him, he waited several weeks to tell me about it. I didn't believe him or take his word for it. I went to his family, I didn't believe them. I didn't particular care for them because I didn't want to hear their version. Finally I went and got the brief from the lawyer's office. I do have children and anybody can tell you

anything about what they had done and make it sound very minor. I read about a 3 inch brief about the trial and what he was on trial for. It was for sexual assault, which was labeled that because there alcohol and drugs involved, because he was with a minor in a hotel room. They were dating for several months with the parents knowing. When he found out that he was cheating on her she said that I am going to tell my dad that you forced me to have sex with you.

Therapist: This is in the documents?

Client: Yes this is in the documents. She found him in the hotel room one night and she knew that he was in there with a girl. He opened the door, she was in a fight with someone. They thought that it was a girl in the room's sister. So, she was in there crying and having a fit. She threw things in the hotel room. The managers were called as a result of the disturbance. They went up and she was in the room doing stuff. They testified for Holland stating that she was screaming in there. They called her father and when he got there she stated that Holland raped her. He didn't have sex with him. Even her own sister testified against her. They were others that testified against her, but because of the laws of Pennsylvania he had sex with a minor. He was young and stupid. He had a public defender and thought it was a small thing that happened. It does state that he is not a rapist and that it was a sex with a minor. It didn't say anything with sexual assault. It was coercion. He didn't even have sex with her. He got charges and he can't change that. He was dumb, naïve, ignorant. He thought statutory rape sounded worse than sexual assault. He found out that he should have pled guilty to statutory rape and not sexual assault. He maxed out. I read the whole thing and went through it over and over in my head. I spoke to my kids. I told my oldest daughter first and then my others. For a long time we would

always be together. I never thought that Holland would do something to my children. I did before I looked at this brief. At the time he was 20 and she was 15 that is not that unusual. Especially for kids in the projects. I talked to my ex-husband and we went through everything. He took several weeks to read the thing. He came back and we all sat down and talked about the charges and stated that he trusts Holland with his children. Holland understands why anybody would question him, there is some shame and embarrassment but he knows that the Lord has forgiven him and he at peace with that and himself. Aja knows every little thing. He is not a rapist. Unfortunately he was in a bad circumstance. He wasn't taught anything like that. He struggles with a bit of shame for the label, but he put all the stuff in the past. By no means at all am I afraid for him to be alone with my children. She would kick his butt anyways .That would never cross his mind. That would be disgusting to him.

Therapist: You have communicated with Aja if he ever did anything?

Client: Oh yeah with anybody. More mainly when he was violent to me. I told her if you are ever alone with him and feel afraid you tell me. It was more about the violent stuff. She has forgiven him. I found out that she actually signed up for a bible class at school, which is really great.

Therapist: So you have already had the conversation about violence and she knows that she can communicate with you and feel comfortable with that. You have already thought through all the things that could have happened.

Client: Yes. I would not have introduced no man to my children with that behavior and I didn't introduce him to them for a few months. They didn't spend much time with him early in the relationship. Basically, my youngest one has only been around him alone in

the last 6 months and this was 2 years ago when this all occurred. I trust him and it was investigated it thoroughly.

Therapist: And you have all the paperwork?

Client: Yes. I have it all. I understand why people would be concerned. If I heard that I would be concerned about any child.

Therapist: It wasn't that there was any reported or suspected abuse, I needed to gather more information from you. If something does happen in the future that there is any perceived imminent danger child line would be contacted and you could contact child line as well. I knew you looked over all the paperwork and I know the most important thing in your life is your children. Now, I would like to set the agenda. I would first like to talk about your homework, your sleep diary and the shaping exercise. As I stated last week I want to start focusing on the cognitive processes. We will review some of the depressive cognitions that you noted in the first session and then talk about the CBT model a bit more, how thoughts are connected to feelings, ways that we are going to utilize spirituality to combat negative cognitions and then focus on becoming aware of your thoughts processes and ways to connect your current beliefs to past beliefs. Is there anything you wanted to add?

Client: No I had a really good week.

Therapist: So let's start off with reviewing the sleep diary.

Client: Looking at it, it is kind of cool. You can definitely see the problems that do occur.

Therapist: It doesn't take long to fall asleep.

At this point the sleep diary was reviewed. All in all, Karen continues to wake up throughout the night but noted that she was able to get back to sleep quite easily. She reported that she did not allow the stressors to get to her over the course of the week. It seems that when she dealt with stressors in an appropriate manner, she was able to rest.

Therapist: What about the shaping exercise, getting the things on the wall? You made a funny noise when I asked about this.

Client: They are still sitting there. I thought about it. Monday night I had my son. These kids can't be together because when they are together they want time with me. They spend time with their dad most of the week. My son is driving and doesn't want to be in the house. He wants to run in the area. He actually went to church. We went driving and he came inside when I had my meeting. He wanted to sit in the car but I told him that wouldn't happen because he needed to watch his brother, because Holland had something else to do. It was very good, one step into the church. One step closer. I didn't do anything that day. I got home and we relaxed and straightened up things like I had to. Tuesday night I got home at 4pm and got into my robe and we watched 2 movies and just went to bed and then we played with the baby. We had dinner at the table, which doesn't happen which is a big thing to me. I wanted to sit down and eat as a family. I always did that with my children.

Therapist: That wasn't something you had to nag Holland to do?

Client: No he made the dinner and I made the vegetables. All I had to say is we are going to sit at the table and eat. He said ok. He sat there and we ate and I thought about it after supper, but then I thought that will take time away from Holland and the baby.

Therapist: You have to balance things out.

Client: So I didn't do it and here we are tonight. The weekends are busy. I will get it done. I was also thinking why would we do this if we are moving out?

The client then went into detail about being behind on the rent. Her landlord eventually went to the court house and at this point the client has until next Tuesday to pay all of her back payments or she will be evicted. She recently has asked her sister for help and plans to meet with her sister this coming Friday to figure out if she can help her out financially or if she will be living with her sister.

Client: I just put in for a transfer to another place for more hours. My job is 40 hours and will not give me any overtime. I told them they schedule people for 56 hours and they yell when you are over. I was talking to my supervisor's supervisor and she let me know that the Lancaster home is hiring and it is the ltsr house, which is more mental health. That is psych and I want to do it, but it is change in the shift. 4pm-12pm Monday through Friday and every one weekend. It sounds good because it is more money. I really like my shift, but what is coming first. Holland is at a loss for jobs and I would be home with the baby all day. If he gets a job he could still take him back and forth. The only thing I couldn't do was Wednesday night, which is very important to me.

Therapist: That was what I was just thinking. Especially since you talked about getting involved with the youth and how good that made you feel last week.

Client: I had to make this decision, I said God I will put the transfer in because it was in my path and I will assume it is something in your plan. They e-mailed me from headquarters and told me that they will consider my resume. If I get it was meant for me. I am still looking for a part-time job. Another friend text messaged me today that they are

looking for a homeless case worker. I have all kinds of resumes out and all kinds of phone calls. The penn mar didn't pan out. They is something in his plans.

Therapist: Trying to figure it out.

Client: I'm not going to try to figure it out I am just going to guide me where He goes.

Therapist: You have a very good outlook on everything.

Client: I have no other option but to do that. I have been praying every night.

Therapist: God must have really instilled a lot of peace within you. You came in and told me that you had a really good week and I am hearing a lot of negative things.

Client: I just have faith that He will get me through this. I do believe that all the things that I have gone through is because of His plan, if I think anything different I will crack. If we can't get the money to pay the rent, there is a reason. I don't think that my sister will allow that to happen. She knows the circumstances at home about registering. She has a home and a basement, but I know it would be hard on them. We would be far from the church and she wouldn't want that to happen. It would take about 30 minutes to get here. I don't think she wants a sexual offender registered in her area. It would be a mess, but whatever happens, happens. Something is going to happen. If it is not going to happen and if I have to pack I need to start doing it, because I have to be out at Tuesday. He will be there with a flashlight and padlock. I pray for him as well, someone to be that cruel does not have God in his life. I pray for him every single night to show some compassion. He is the landlord and he deserves his money and if he could see what we have already done and what we are trying to do. He is trying to hang me with a rope.

Therapist: I want to go back to some of the thoughts that we had in the first session and see if they are still ringing true. One of the thoughts you had the first week, was related to

the future. What am I going to do? I know with your son in particular you said that you have taken a lot away from them already. The future is scary as well. The CBT model talks about how thoughts, feels and behaviors are related and how this can go in a positive or negative cycle. Like you are doing now, you state this is in God's hands and I will learn from this instead of thinking all of the negative thoughts that could be running through your head.

Client: That's why I thought about that. When everything was going on around me, I thought take a minute and think or it all would crumble. It is a choice of how I want my mind, which is creating the feelings I have of hope, peace. It could totally be the opposite I could be lying in bed in a ball and crying.

Therapist: Telling yourself messages and then as a result not coming today. Thoughts bring many emotions up. It is important to identify those thoughts when we are going through a difficult time, how you are thinking when depressed. When you are thinking sad the whole time what thoughts were going through your head?

Client: If I, If I, If I, what if…what if…what if…I just had a long talk with my ex-husband. He texted me and said that mom texted him. He asked if I talked to my mom and then why I hadn't. He said out of the blue I forgive you for everything that happened and then I said that I didn't ask for his forgiveness but while we're at it have you forgiven me for everything that I've done. You do forgive me and I apologize for what happened in our marriage and what I did. I had a horrible crying fit. I was driving and crying. It was closure I think.

Therapist: Was it a cry of sadness or everything coming out?

Client: It was just everything. It was finally the closure for me. We talked a bit about our marriage and said that we never looked each other like husband and wife should. How we will always have love for each other because of our children and how he still wanted to be friends because he could use all the Godly friends that he could have. I was wondering how to talk to him about Holland and getting married. He asked me what we were going to do about the situation with Holland and if he was going to go to jail and I said probably and that I was scared, because the fear of the unknown always scared me but as far as I know I will be ok. He said that I might need that time while he is away to find out what kind of peace I need. I told him I might as well put this out there that Holland wants to get married and he asked what I wanted and then I told him that we did sign up for the marriage classes. I asked him I am just worried about what he kids will say and he said isn't it ironic that we both said we would never be married to anyone else and you have a child with another man and about to get married. He then said he was very happy for me. Holland is not happy about it though. He knows we had something and that there is a connection and children. He knows we had a decent life. I think Holland was a little bit fearful. I told him that I needed this to go on.

Therapist: This is part of the piece of your life that he is not connected with.

Client: I told him that it was intense and needed conversation and I was telling him about it, because it was a different peace that was brought about as a result of this conversation. I will always love Kevin, but it was an immature love and that door is closed now. To hear him say he forgives me it was great and is part of my recover and addiction. To forgive myself, to ask for forgiveness from others, to talk to those that I have hurt. It was my first step. My first step was him and the second is my mother and the third one is each

one of my kids and then that is it. The other people I don't think I really hurt. Then I am going to go on with my mom and it takes time to do that.

Therapist: You have to be strong in those moments.

Client: Right and I didn't expect it to happen then, but now I have a close door that needed to be closed. Also, Kevin isn't with anyone else, he is fearful that I could go back and then on Sunday someone spoke that they were divorced for 2 years and got back together. I felt awful, but that is what happened that would be God's plans. Nobody knows his plans and I am living one day at a time.

Therapist: We are going to look at scripture and prayer to challenge these distortions. For homework I want you to note on a chart when you notice change in your affect to note this on the chart and what you were thinking at the time. *I then gave her an example from her life.* I want to know about some of the family rules or messages received that you still transfer with you that might not be still healthy.

Client: Smoking.

Therapist: What about any beliefs?

Client: Believe that you don't talk bad about your parents. Lying is not fine, stealing is not tolerated. I guess the belief that money solves everything with my mother. My mother would just give me the credit card.

Therapist: Money was more important than spending time with you?

Client: She gave me money. She didn't live with us, she was away when I was 10 years old and left me with my 18 year old brother and pregnant sister. I had to deal with my drunken brother and his abusive ways. None of them were there and I had to deal with the baby. She was there. We know now why she left, to protect us from what she did. If I

would ask if we go to the mall and go eat, she would give me the credit card and drop me off. I had everything that you could ask for. When I would say mom can we go out to eat? She would pay the bill and drop us off somewhere. She just thought it…she had a hard time of being close to me, I don't know why. I think she still does.

Therapist: It almost sounds like you had to grow up pretty fast. That you were taking care of everyone else. Any should that you remember growing up that you still do now?

Client: I should supper by this time…I should be on time, stuff like that. There wasn't too much bad. I mean there really wasn't. I had a pretty decent childhood just a lacking mother. My father, my mom was older when she had us, so that contributed. She did have a baby for my father and she didn't want to have any more kids. When he left her she wanted to have a baby. I always heard that all my life, the reason I had you was for my life. So that might be connected to her. She never physically abused me. I can remember my mother slapping me across the face twice. Once when I used the s word and once when I was 16 and had a cigarette in my mouth.

Therapist: So some of your negative beliefs had to do with when you were using and what you weren't doing at the time? So pressure to being a good mother and maybe some of the beliefs are connected to the lack of support that you had in your life from your own mother?

Client: Right. What I want to have for my kids. My father on the other hand we had a really close relationship. I could talk to him about everything. He took me to baseball games, we went camping and he had money but didn't give it. My mom she would buy us anything.

The session ended by explaining the cognition log and then in a prayer. The therapist explained that in the upcoming sessions that we would look at the client's feelings of helplessness for the future and how we would combat her negative cognitions through cognitive rehearsal and problem solving.

Session Rating Scale

- Session Number: Five
- Completed By: Jennifer Good, MS, MS
- Rank of Session Treatment Efficacy: 1 2 3 4 5 6 7 (8) 9 10 (circle one that best describes session)
- Rank Therapist's Ability to Adhere to Treatment Manual: 1 2 3 4 5 6 7 8 (9) 10 (circle one the best describes session)

Comments: This session was good in adhering to the treatment manual and working towards exploring the cognitions that the client has regularly. It is apparent that she has anxiety related to the future. Presently, she is dealing with these concerns very well. She has problem solved difficulties that she has experienced in her life and then is placing her trust in God to help her to get through these hard times. Overall, Karen's depression scores and anxiety scores have declined. I believe that this decline can be attributed to the support Karen has in her life, her increased activities and ways that she is beginning to battle and confront negative cognitions.

Transcription of Treatment Sessions

Session Six

Therapist: Today I want to set the agenda. I want to review how your homework went, then talk about cognitive distortions, review the ones that you have, review different spiritual interventions and then to review the spiritually-informed DTR. Any questions or things that you want to add?

Client: Just my normal concerns. I think you know what is going on.

Therapist: We will review the homework once we get to discuss this form. Let's review the cognitive distortions. *At this point in this session I reviewed the 10 cognitive distortions and gave Karen the biblical scriptures that combated the cognitive distortions.* So do you see any of these distortions in your thinking patterns?

Client: Definitely. All or nothing usually, I guess overgeneralization as well. I say I can never win quite often. I don't know about mental filtering.

Therapist: I think you may do it more to yourself.

Client: Probably disqualifying the positives, I tend to jump to conclusions, I am not big about making a mountain of a mole hill but I am sure I probably do. I try to see all sides of the situation before I make a decision.

Therapist: I think you are pretty good about problem solving. You usually come and state this is what happened and then the steps you have taken

Client: Mislabeling I used to do a lot but it's not a problem as much as it used to be

Therapist: So some of these used to be more significant problem areas, but you have worked to reduce them already. To really look at the evidence at hand.

Client: Right.

Therapist: I gave you the list of scriptures to challenge these distortions. We are going to look at the cognitive log that I have you for home work *I reviewed the 3 different kinds of Biblical passages that are in the manual.* Looking back at your cognitions, are there any specific biblical passages that you use to combat some of these cognitions?

Client: Lately Matthew with the one day at a time that is very big. Jeremiah 33:3 where God will help me. It is just a lot right now with what is going on. I am really really, we have got to lean on our faith right now. There is nothing that I am not reading that isn't helping me. The ones where he has his promises to us. I am faithfully believing that God knows where I am at, I don't believe that he caused it. I think that He will intervene and get us out of this. I think He will meet us in our place and I believe that if we don't believe that how can He? Our house has been quite full of the word lately.

Therapist: Did you guys have church yesterday?

Client: Yeah.

Therapist: Did you have the prayer request for the lawyer?

Client: I just put it up today. Nothing came to me until today. I just asked that by no means am I trying to get Holland out of his wrong doing. I need to do some leg work for Holland. Without representation we have no chance. Biblically, in the eyes of God we are forgiven. I asked that if anyone was a lawyer if they could represent him or if anyone knew of a lawyer that could represent him. We beg and plea for a pro bono case. The pastor called me because he got that and he said that God is speaking to him and that

something is going to happen. He can't tell me and doesn't even know but has this good feeling. I know that what I am going to go through is consequences and strength building.

Therapist: Even the best case scenario he is going to be gone.

Client: I would assume that. He went from 6 to 12 to 5 to 10. My prayer would be 2 to 4. With the lawyer that we did have a free consultation with, he stated that if we did have proper representation Holland could get off with house arrest.

Therapist: But you are trying to think realistically as well. I don't think you are castastrophizing the situation because it is very real that he could go to prison.

Client: He is going to go to prison unless he gets representation. I can't say he won't he has 2 months. My sister just keeps saying that we just need to keep praying and that we need to call God on it and to keep praying. He does answer. He knows where we are at. In the mean time mentally preparing myself.

Therapist: It came up out of nowhere.

Client: It was just not fair. We weren't scheduled until Feb 16th. We left the house on Monday at 4:30pm, there was nothing at my house or in my mailbox. On my door was taped that we had to be at the hearing at 4:30pm. I was back and forth about whether to take Anor. So we got a babysitter, because if they would have taken him then I would not have been able to handle that with Anor. I know now that I will not go alone, because they could take him. From experience that my friends have had, my one friend told me that when she was involved with a man and he had his son, they were trying to plea and they were going back and forth and got it down to 4 to 8 and asked if there was anything else that they could do and to please lower it. The judge said that they would give him the 2 to 4 but he had to leave then. They cuffed him and it took 3 minutes and he was gone.

So she stated that we need to take a bag of underwear and prepare because if he is going that I need to let him go. She said that I need to prepare myself that April 20th he is going. He will not go to county prison, because he already went to state prison. He will go to Camp Hill and then they will take him. I will see him for approximately 3 weeks there and then he will be shipped out. She told me that I could file for hardship because I have his child and the hardship will keep him 2 to 4 hours away. She said that won't happen right away but I can put it in as soon as it goes. She told me that I have to face this. That she feel to her knees on the ground. She said that she thought it was going to take forever, but now he is out. She was serious about this man, but not marriage. That's another thing, Holland wants to get married before he goes.

Therapist: What's his motivation to?

Client: Well he was talking about it before. I can't say that is the only reason. I know a lot of it would be for security reasons and motivation and part of me will think that God will keep him in there so he can reach people. Part of me thinks that we should wait until he get out and then Jeremiah and Cory state that God will bless when you do what is right and getting married is right, we have a child. God tends to bless you 10 times more when you are doing His will. I have a child with Holland, I love Holland why am I holding back? I read things that he wrote to Jeremiah and he was so sweet. Part of my mind trips when I am alone, if I am even questioning this should I do it and I am lost..I am lost…We are scheduled for this premarriage class March the 2nd I guess we will start to figure it out then.

Therapist: So marrying Holland before he leaves, what are the benefits to doing that.

Client: There are several. I just don't want to say no we aren't going to get married and imagine that rejection. I can't make a decision and it bothers me that I can't make a decision. He will be at much more ease, I will be right in the eyes of God with my son having a child with him, maybe it will be a stronger chord to for me to hold onto while he is gone, of course taxes, I am thinking of everything. There isn't anything I haven't thought of.

Therapist: What about the costs of marrying him before he leave? The negatives?

Client: Not knowing how much time, and being lonely. Not being able to just say I'm finished I can't do this anymore, but why would I want to do that? What would I want to do that if I 'm not doing anything wrong.

Therapist: You have forgiven for the past, but it's still in your mind and you want to make sure that it doesn't happen again.

Client: That this doesn't repeat itself. Right now I went on my trip last week and stated that he went to prison before and was in there for 8 years and came out and sold drugs rights after he came out and he was hardened, he was hardened. How do I know this won't happen again? He said that he wasn't that person anymore and that he wouldn't do that.

Therapist: That there is a fear that it could happen.

Client: I am afraid of what will harden him. He is going to state prison and that is difficult. He will have to be the one that is committed to his faith. I know he did a good job before. He was a loner. He worked out, he did cooking classes. He told me that time will go fast, because he will have a routine and be busy. That is where he learned about the Bible. He read it repeatedly. He plans to get an education when he is in there. His

goals are clear and I have to believe. He thinks that it will make us stronger. I have horrible, horrible, horrible visions of Anor. He is extremely attached to him. That's where my…that kills me. What's going to happen, he is going to want to know where daddy disappeared to one day and I can't tell him that he will be right back.

Therapist: What does Anor need in his life?

Client: Anor, he needs strength, he needs God. I got to think that God will be his father during this time and I will take Anor to see his father. Everyone says that will be horrible, but he has to see him. I am going to write Holland and tell him everything about Anor and I am going to let him hear him…that is another thing we don't have a house phone, so I will need to get that taken care of in the next 2 months.

Therapist: What happened with your house?

Client: My sister helped us out. We are all worked out with that. We are there and I decorated and I feel really good about it. Anor needs love and support and he will have all of that.

Therapist: He is going to have what he needs and you are an awesome mom. You know that you do what your kids need. You would do anything for them. He will have his father.

Client: Right just not his physical father. Holland says I will talk to him on the phone and his will see him, but because of his offense I don't know if he will ever have contact with him in prison unless I take him. In state prison you can have contact with holding hands and one hug, but they may have eliminated that. If Anor, because of his offense, he may not be able to have any contact with Holland.

Therapist: The good thing is that Anor is very young and he won't start forming most of his early memories until he is 3 or 4.

Client: Yes, so he won't remember this. The bond is already formed so that is one thing I have thought about and he will be out before he is in kindergarten and he will have a strong sense of who his father is and I know it will be fine. I have told myself this and I know in one little breath Holland could lose it because I know how it is and I have been thinking about myself and Anor.

Therapist: You are keeping it real and you know that you need to take care of yourself and Anor.

Client: He told me to stop being so negative and that I wasn't having faith in God and that he was trying to be strong and I told him that it doesn't help me if I don't need some sort of feeling from him.

Therapist: Maybe you need to explain to him that you need to have that time together where he breaks for a while.

Client: I need him to break and that is what is scary. He is hardened and in the mental strain of that he is going to prison. He doesn't want to freak and wants to be strong.

Therapist: You don't want him to break when he isn't there.

Client: I don't know what I want from him.

Therapist: I think you just want him to be up front about his feelings.

Client: Right. He knows how he needs to be. We are going to talk to Julie together on Saturday. Holland tends to open up with her and even if I am there he tends to get the realness out. I know that my sister and everyone that will be around will help out and now I have this second shift job.

Therapist: When does that start?

Client: I don't know I have things to do first. One of the girls from church who is close to Anor stated that she would stay with us over the summer. So some things are going into place and maybe by that time I can say I have no babysitter can I be moved to this shift? They need someone from 4 to 12 right now. If he goes in April I don't know what I will do.

Therapist: Do you have any family that can watch them?

Client: My kid Aja, but she doesn't want to be there every night and has already stated that.

Therapist: So maybe there can be certain nights that she can help out?

Client: Right. I have already told her you have to be prepared a few nights and she is already jumping to the defense. If he goes in April I won't have it all together yet. It will take some time and learning what to do. I hate that I would have to take him out at 12pm at night. It is a dollar more, it is closer to the home. He has family in York I am sure they could help out.

Therapist: So between the family that you have, you should be able to find the help that you need?

Client: I have to get it all together. I just want someone to be at the house and Ashley being able to come there would be great. She has some issues in the house and it would be great for her to be there. She needs to know what is going on and we are getting her to that point. She texts me all the time and she wants to get out. She has a really hard life at home. I am thinking there is a reason that this is going to happen and she loves Anor.

Even when the summer is over she might go to college, but if I can get to that point I feel confident that I could change shifts.

Therapist: I want to get to the homework and explain the DTR. So let's get out your cognition log. *For the next part of the session we reviewed the spiritually-informed DTR and I explained to Karen how it is used and ways to fill it out.* Does this sheet make sense and can you see its value? I want to try to fill this out throughout the week. Then we have the scriptures that I gave you that can help you out as well. I am going to give you this to keep. That is what I want you to do for homework. We will review it to see how it went. I think you are doing a good job of preparing yourself. We are going to continue to hone in on what you do have to offer. I think you get shaken about it and the thought of am I going to be enough? Any questions or things that you want to make sure that we address before we wind down here?

Client: I think my big thing is that he is so calm.

Therapist: You want to see something or hear something.

Client: We do talk. I left there on Tuesday and I was a mess. I could not stop crying. I tried to stop crying and I went in deep. I got in bed and stayed in bed. I was ill. I was sick. I was still in a funk on Thursday and he pulled me out of it. Part of me feels myself pulling away. My niece told me that I have to enjoy the time that we do have. My girlfriend bought me a snack wrap and said I knew that you wouldn't eat. She called me today and told me that her son would baby-sit. He has watched him a couple of times with me. He hated Holland. He got my clothes for me when I tried to sneak away from Holland when he was abusive. When Holland changed, he has slowly allowed him to prove to him that he has changed. He let him cut his hair and then I needed a babysitter

and he baby sat for him. He is 18 and so good with him. My girlfriend said that she would help. I know that I will have to stay very busy. What gets to me the most is sleeping at night and am I going to stay at the trailer. Why should I do that? I made it a home and it is cheap. It is going to be hard. I guess I should just stop thinking about it. Take it one day at a time and pray that something will intervene that will lessen his time. Anor turned 1 today and I am thinking how fast that went. I am trying to put some perspective into it.

Therapist: Probably the first month will drag.

Client: That's the thing. I know myself and I know that I won't be able to be alone.

Therapist: That is when you will get closer to those people. As it is a time for growth to explore what you want. Your relationship with others and God.

Client: I asked God, what is the purpose and what are you going to do with me now? I tell God that I am strong, you don't need to keep proving it to me. It's not that I didn't think he wasn't going to serve time. When we were in court and he said 5 to10 and the judge said founded. And the judge went (shakes head no) I didn't know what that meant. It meant that he wasn't going to take him.

Karen continued to review the events that happened and her initial reactions. The session ended with a prayer.

Session Rating Scale

- Session Number: Six
- Completed By: Jennifer Good, MS, MS
- Rank of Session Treatment Efficacy: 1 2 3 4 5 6 7 8 (9) 10 (circle one that best describes session)

- Rank Therapist's Ability to Adhere to Treatment Manual: 1 2 3 4 5 6 7 8 (9) 10 (circle one the best describes session)

Comments: The session adhered to the manual very well. Karen is going through a lot of real life problems and is utilizing her problem solving skills to deal with these problems. Understandably, she is experiencing an increase in her levels of depression and anxiety as she is working to cope with the fact that her significant other will be most likely going to jail in the upcoming months. We will continue to utilize problem solving and look into her core beliefs in order to empower her during these next few weeks.

Transcription of Treatment Sessions

Session Seven

Therapist: Today I am going to set the agenda. I wanted to review your homework.

Client: I don't have my black book. I didn't do anything this morning, I was so beside myself. We had the other kids and Anor.

Therapist: Did you do your homework?

Client: Uh huh.

Therapist: So we can still review it. Then I would like to talk about verbal and visual beliefs. Then to talk about ways to use the Bible and counterstatements from the Bible to challenge the depressive cognitions that we had. Anything you would like to add to that?

Client: Nothing more, nothing less.

Therapist: Do you remember what you wrote on your DTR?

Client: It was with my daughter. Watching her- her boyfriend this whole thing with them is driving me crazy. When she talks to me and the way she answers me, that was what we wrote down.

Therapist: Did you find that the form helped you to sort out your thoughts- or were your thoughts accurate for this situation.

Client: It helped, but for the most part it was accurate. The one that I kind of went through was with Holland. Again, it has to do with his lack of speaking and communicating and my thoughts on that. I think it was when he got up and walked out of the room after a conversation. It comes from me expressing myself, like something simple. I am just telling myself to explain something to him and he calls it lecturing. I

was telling him something and he just walked out on me. So, naturally I was mad. It was rude. I thought it is rude when you get up and walk out on something.

Therapist: So how did you combat the thoughts that you had? What thought did you have that made you upset?

Client: The thought that I had was he was ignoring me or trying to avoid knowing what annoyed me.

Therapist: After you went through all of those questions what counterstatement did you come up with to combat this thought?

Client: Basically, I need to talk to him first instead of assuming he was mad or ignoring me. Maybe he wanted to avoid conflict instead of ignoring me.

Therapist: How much did you believe this new counterstatement after answering all those questions?

Client: About 50/50.

Therapist: It was still a battle. How did you work through it afterwards? Did it continue throughout the week?

Client: A couple of times. We talked throughout the week how I don't know…he has never been in a relationship, has never taken care of someone. I always here that he doesn't know and that I need to help him, but when I do help him he takes it as a lecture. Or he rolls his eyes. There is frustration there because of the lack of maturity and responsibility.

Therapist: It almost puts in you in the parental role.

Client: I don't mind that if you are learning and listening, but if you are downright ignoring me, that's just rude. That is where we are at right now with a couple of things. I

am frustrated he had to make a phone call. I told him to call this number and make a voicemail. *The client proceeded to review some specific frustrations that she is trying to work through with her significant other.*

Therapist: So it is almost like he is avoiding the one conflict that he had with you, and he is avoiding phone calls.

Client: Yes, I feel like I am doing a lot for him and I don't know why he can't take care of two minor things, but there is always an excuse.

Therapist: Did you say that to him?

Client: Yes I did. I told him if I had to tell him all the excuses and the drain that I feel what excuse would that be to make sure he didn't get to his appointment or wear his new eyeglasses or to not get groceries or to not buy diapers. I am mentally drained too and he is not getting things done that he needs to. Then, he stated that he could see where this was going. I walked away and left it alone. Earlier today I figured it out, I am so sick of the immaturity. If he wants to be the family man and take care of everyone, he needs to do this with me 50/50 and take care of life.

Therapist: I just wonder what his goals are and if going away he has stopped working towards this.

Client: I said that to him too. What do you feel like you don't need to get a job because you could be going away, but it would make it ten times better if he did get the job. Anything that he could do for his situation. Anything he can do to show that he is living on the outside. I wanted to know how long it has been that he hasn't answered phone calls. Every time I call he doesn't, I know the church has said he doesn't and now with social security that we could use as income and he doesn't. I would have it by my ear for

employers and the social security office. Then he said I have to smoke. That is what he tends to do when it gets heated.

Therapist: There is a conflict, I have to go.

Client: Yeah. When he gets to the fact that he knows I have a really good point, he will get up and put his boots on and walk outside.

Therapist: Then it is never really resolved.

Client: Then he comes back in and is quiet, because that has shut me up. I say nothing and he says nothing and we go for an hour in silence and he gets up randomly and asks if I am alright. I just say whatever. In his mind he thinks it is resolved, but in my mind it is still there. But I know not to even talk about it, but the same thing will happen.

Therapist: Then something even smaller, could trigger the same response in you, because issues are not being resolved.

Client: Right. That is where it is really frustrating me. Then other times I see how much work he has done. He does a lot of things to try to impress me. We had counseling with Julie last night and she said that I am not him and he is not me and I can't expect him to do what I want to be done. We should have a meeting and he needs to listen to what we want to do together. If he lies on the couch all day long and still gets the stuff done that is fine. If he isn't doing anything it is like he is not putting in the effort. My example is I don't see how hard it is to do the dishes and put the laundry in the dryer before I get in. I feel that he can do the dishes, take care of a child and do the laundry. The baby sleeps during the day and he is able to do this. The baby takes two naps and Holland would have time to do all of this.

Therapist: Have you laid it out to him that these are some of the things that are making you have reservations about marriage too?

Client: No.

Therapist: I just wonder if he understands how serious it is and how frustrated and angry you get.

Client: He sees it at the moment, but doesn't recognize that it continues. There are days when he does get it done, but that is frustrating. It is stupid little things. In make my bed when I get up. It is made before I leave the house. When I come home, I have to say that he used to never make the bed, now it at least looks like it is made. When I get home and see that it looks like it is made but the sheet is down at the bottom of your feet- you never pull the sheet up- he said I don't know how to do it, but I make it 90% of the time. I have to give him credit though for trying. It doesn't take that much time to do.

Therapist: It is interesting. We talk about how you feel that you are helpless about him going away. But with him there you need to be so helpful to get stuff done.

Client: I know. My friend asked me that if I would feel good because I won't have to do these things when he goes away and I said no, I will have to do these things just like I have been doing. The only thing I won't have to do is dishes, because he does do them. I probably won't have to do them either because the kids are there. It's not like I am going to be missing so much of what he does for me other than the companionship and the father thing. Just being there. Sometimes I wonder if he just acts like this to get out of doing it. There are times when I feel that I should not have to tell him to do things. But I know he is not a woman and he can't read my mind. Then I tell him and I am lecturing him or being a mother. Where do I have some leeway? If I write it on a list, for the day or

the week…it could be 5 things and I would be happy. It's not that much. His job is to take the trash out. He never has to be told to do this. That's something that does.

Therapist: Do you thank him for it?

Client: Yeah I always do. Stupid other little thing. He clips his beard or his hair, so there are tiny whiskers on the sink. He doesn't take a rag and clean it. I purposefully leave a rag there. He also uses oil and it will go down the sides of the bottle and it will leave a mark.

Therapist: You keep saying these are small stupid things, but they add up and is activating something deeper. The frustration and it is almost like he is acting helpful.

Client: *The client went on to discuss ways that her significant other was respectful when he was living with his sister. He cleaned up his hair and helped with the household chores. The client stated that this was frustrating since he cannot do this when he is living with her.* Another stupid thing. I don't know if it is stupid.

Therapist: You shouldn't be labeling it.

Client: I feel that if you see something that you should do something about it. I have a bird and if you see that he has pooped, clean it up. I am not asking to do lots of things, I am asking to maintain.

Therapist: I feel that you need to let him know the seriousness of it.

Client: We get to this point where I tell him that he thinks I am being petty. I tell him that if you care about me, you should care about what aggravates me as well.

Therapist: It's one of those things, you can tell him that I love you but if you really want to make this work and get married, something has to changed, and if you don't marriage might not be an option.

Client: Right. He is extremely picky with his stuff. He wears do-rags when he goes to bed and puts a lot of grease on his face, because his skin needs to be baby fine or self.

Therapist: It is interesting to how he takes care of his physical appearance but not the environment around him.

Client: Exactly. I say to him constantly. If I came in and just hit the thing on it and it moves back on his head- that is something that irritates him and tell him that it is what happens to me. He cannot stand when someone touches his head, he does not like that. I don't know it because he tells me that it is something he doesn't like, but I respect it. So I say that I don't like leaving whiskers on the sink, but he does it. There is one last thing I want to say then I will move on. I freaked out the other day when I went into the bathroom after him. He didn't put the seat up and he splattered it on the seat. I sat down on the seat on his pee. *The client continued to review this frustration and discussed ways that her significant other made excuses and did not work towards resolve this issue.* Three times he put me over the edge. I was so mad the last time. I was going to take the tissue from the toilet and throw it at him. He came in and didn't know why I was mad. I told him and he said I was sorry, but I heard it three times this week. You get from everyone that this is a guy thing and they don't think about it. No, when you tell someone this all the time it needs to change. It has gotten better in a lot of ways. Before he was focusing on the little things that made me mad, but now he is focusing on the bigger things and not the smaller things. I have made changes in order for me to make the changes in his life.

Therapist: That is why I stated it would be interesting to ask what his goals are for this day, the week, etc.

Client: I told him Sunday night we were going to sit down and write down what we wanted to get done this week. So we are going to sit down and discuss household chores, each other, the kids, with the house and check them off as we go. Do I put I don't want to sit on the toilet, should I get to that point? That bothers me. What do I want to have done- I want to not sit down on the toilet seat? What do I write?

Therapist: I think write it in a respectful manner. I keep hearing respect in my mind.

Client: Yes he demands it and I don't get it. There is a lot of hypocrisy with him right now and he didn't do this before. I was reading a book and he wanted to talk and I asked if he could give me 5 minutes. So I finished and then we talked. An hour later he told me that it was rude. 3 or 4 days later I was trying to talk to him about the kids and he was reading a book. But he never put the book down. He asked me can you wait minute, so an hour later I just stopped talking. An hour later I said something about it and he said that it what you did to me. I told him that it was different because he just kept reading. It was kind of stupid but it was there.

Therapist: Let's talk about verbal beliefs and visual beliefs. *I explained the definitions of the verbal and visual beliefs from the manual.* What are some messages that you say to yourself lately? As in I am…

Client: I am going to be ok. I have been saying that quite a lot.

Therapist: How much do you believe that?

Client: About 90%

Therapist: What are some different sub-statements that you back up that belief with?

Client: I have my friends, I have my church, I will still see Holland, and I will be ok. That is basically it.

Therapist: The support that you do have in your life and when Holland is gone that will not all be taken away from you.

Client: People have really been stepping up and talking to me about it.

Therapist: Even though there is a lot of stressors it sounds like there has been a lot of good things going on with your thought processes and externally.

Client: A lot of people in church have come up to me to let me know they are there.

Therapist: What are your beliefs about other people? They are…

Client: They are rude- my kids. I have said that a few times, they are downright selfish. They are nice; they are so sweet- a few people from church.

Therapist: Then about the future, it will be…

Client: It will be ok. It will be hard but ok.

Therapist: What about God?

Client: I feel as if he is doing His work. I feel like He is moving something. I feel as if He is I don't know. I explained a lot earlier to someone. He is a bigger presence in my life now than ever. I think too that He is a little shell-shocked because I have been asking for so many things.

Therapist: Is there a limit?

Client: I don't know. I have been asking a lot. I have been asking to take the sadness away a lot.

Therapist: How has that been?

Client: It has been working well. Every day I tell him you need to fill this emptiness because I can't fill it with anything but you. Keep me strong, keep me filled, and keep me

happy, because I can't do it without this. The emptiness- as soon as I feel Him going out of it I feel this fear.

Therapist: I was thinking about you and believing and having faith. The story of Lazarus and having the faith and believing.

Client: Right and the sermon last night was about the cage of fear and how it is affecting my life. It is the fear of the unknown.

Therapist: What is the known and reality of your life right now?

Client: I know that God is going to be there, I know that my family is going to be there and I know that I am going to be alive. I know.

Therapist: I hear God, family, I will be ok. What is specific about yourself that will help you to be ok?

Client: I am strong.

Therapist: I want more than that.

Client: I am going to be able to do a lot of things for people. I don't know. For some reason I just think that my future is going to be very good for me and others. I think I am going to be able to help people. I think I am already starting to. When a 72 year old women showed up because she wanted me to help her.

Therapist: What do you think she sees in you?

Client: Strength, honesty, the ability to bring things out of her that she has held in for such a long time.

Therapist: You are someone that she can trust.

Client: It has been so amazing. I want to call my mom and tell her that I am helping someone.

Therapist: So you are proud of yourself?

Client: Yes. It's a good pride. I worked through the 12 steps with someone and I ran to get some steps from Walmart and no one is usually here. I do work with someone else sporadically and she really has changed. I helped her, but no big deal. I worked with one of the other ladies who had gone through NA but she wanted to work through a few things with the steps. I have been on Sunday mornings that if there is anyone that wants to work 1:1 from 2pm-3pm with denial, guilt, turning life over to a high power than I would work 1:1 with you. This lady just found herself back at the church. God is putting people there for a reason right? It is kind of neat that she is older than me and how much she helped me.

Therapist: You get so much even when you help out others.

Client: I told her that I was getting so much just from her coming here. She didn't think she could help others.

Therapist: When you are saying some of these things to her, you are repeating this to yourself.

Client: I went to this depression support group and she wasn't talking. I saw this tear in her eye and I told her that she needed to talk to me and to us in this group because she is the wiser one and the oldest one in the group and that maybe it wasn't like anything that we are dealing with but that maybe her depression and what she experienced that we could learn from her and that a women of her age it would be hard but that she was lonely and that was what we were there for her. She told me that she never had anyone say that to her. She couldn't stop talking about me the rest of the night. I saw her last night at church. *The client continued to talk about the impact that this woman had on her life.*

At this point the tape cut off in the session. For the remainder of the session, I reviewed healthy counterstatements of God's love. The session ended in assigning homework and prayer.

Session Rating Scale

- Session Number: Seven
- Completed By: Jennifer Good, MS, MS
- Rank of Session Treatment Efficacy: 1 2 3 4 5 6 7 8 (9) 10 (circle one that best describes session)
- Rank Therapist's Ability to Adhere to Treatment Manual: 1 2 3 4 5 6 7 8 (9) 10 (circle one the best describes session)

Comments: Even though we discussed a lot of different issues that the client was dealing with in regards to her significant other we were able to get to the verbal and visual beliefs that the client has embedded into her being. She has been able to alter past negative beliefs about herself as a result of relying on her relationship with God and reading the scriptures. During the session we reviewed areas of her life that have allowed the client to grow in a positive and healthy manner. We also discussed the traits that the client has within herself to make positive changes in her life. Overall, the client continues to progress in therapy and she is really working towards examining the evidence in her life before jumping to conclusions based on her thought processes.

Transcription of Treatment Sessions

Session Eight

Therapist: I want to set the agenda. I want to review how the homework went and then we will talk about the cognitive quadrant and explore that more and then review the homework. Anything that you wanted to add to that?

Client: Pretty much no, I am pretty good. The same normal stuff. The normal everyday stressors and how to deal with the extra. Now I have to get up earlier. I have to get up at 5 now and get to the babysitter by 5:30am. There is no sense not to get up and then get back home and she agreed to do this earlier this morning and to see how it goes. She is someone we have had on standby for so long and we have periodically taken him over there. It is still hard to leave him there and think that here is there all day. There were other kids there as well.

Therapist: Which is good for him to have that social interaction.

Client: Yeah. It's still just hard for me. He was fussing when I got there to pick him up. It will take a little while. When I dropped him off I laid him down in the pack and play and he fell asleep. When I woke him up he had no idea what was going on.

Therapist: He will get used to it soon.

Client: When I got there she was changing his diapers and he was fussy. *The client continued to discuss her son's adjustment to being at babysitting. She also reviewed her own adjustment to this process.* I decided to tell my supervisor to tell my other supervisor not to take the transfer.

Therapist: So you are going to stick with what you have?

Client: I kept asking God about what to do. It would be such a hard thing. I stated I guess I would trust in him and said somebody give me strength. I just thought and prayed to give me an answer before something went through and I was going to let it go because it would be part of the plan. Holland called me yesterday and told me that he had a job and he would start tomorrow. I said ok do your paperwork and you will have to call your mom, because I am working until 9pm because today he had an 11:30am scheduled psychiatric evaluation with the court. I rearranged my schedule in order to be able to take him to the evaluation. It is too hard for me to switch my schedule around since I do transportation. *The client went on to discuss an incident that she had with her significant other. He signed up for his shift and forgot about his psychiatric evaluation. The client stated that she was upset with her significant other, but that he called and rescheduled the appointment and contacted other agencies to inform them of this change in employment status. She informed the therapist that he is also being mandated to receive monthly counseling sessions.* His hours are 6 to 5, really will be 6 am to 2:30pm. I am not sure how the 5pm thing will work, because I had off today. It was easy because I picked up Anor and the kids. He won't get off until 5pm.

Therapist: Will there be someone who works with him to help?

Client: I told him to start planting seeds that the ride home would be best. I am going to get to work early and sleep until I have to get up. I got there at 6am today and slept in the bed downstairs. They have an overnight and she got up and got the guys ready. I remade the bed and slept and she actually let me sleep until 8am. I am supposed to be on the clock at 7:30am and if I do that every day I am fine. If they need me I am there. The morning will be fine. If he meets someone I won't have to do it, but I still have to take the

baby to the sitter. So it worked out and I just hope the evening works out because at 3:30pm when I get off I have no idea what I would do until 5pm. 4pm is really nice to be at home because I can do things before I have to go to places.

Therapist: So if he can find someone you would have some of your own time.

Client: If he gets hired on, it's more than 40 hours. That's 11 hours, 55 hours a week. He already did what he was supposed to do and signed up for overtime. I would have to be here I have a whole thing to do with the baby. I figure I would tell my boss, because I am just taking one thing at a time and not really thinking of the what-ifs. I have what I have now and it's working out well with me.

Therapist: This will be so much better for him as he will be able to help support the family.

Client: Right and we will both be home in the evening. It will be a family life.

Therapist: Then you can continue to do your Wednesdays evenings.

Client: I thanked God for this opportunity. I know it was God at work , because who gets a first shift job on their first opportunity. We were mentally preparing for whatever happened and we were going to do it because we needed the income. It is definitely a sign from God that he is working on our send. We are going to meet next Friday with the public defender and pray that he gets some sort of out mate or even if he gets house arrest, he would be allowed to go to work and church and that is all he needs. Even if he goes to prison for a year, if he would serve that on out mate and a year on house arrest. That sounds pretty cool. He would have to go to prison after work, but we would get money, I would still see him, he would still be able to go to church. Then the next year, maybe he gets time off early, I think this is a good offer to the DA.

Therapist: The job is an excellent thing as well.

Client: Right, he can go in there and tell them about the job. He has letters from everyone here. I don't know.

Therapist: Whenever he can start the counseling as well.

Client: He starts that on March 4th. He has a job, he has a family to support, he has the marriage counseling. Hopefully this is God's plan to get all our ducks in a row before the pre-trial conference. The state has a right to accept anything. We don't technically have to do a mandated sentence if the DA agrees with this. Pray for that. So that is the next pray that will be answered. I am firm in believing that it might. He was determined about getting the job and it was really weird. I have only 95 dollars left for 2 weeks. We always seem to make it because my son gives me money to take him around. I was thinking how are we going to do this with the next week check and most going to rent. He gets paid weekly.

Therapist: We talked about the cognitive quadrant before. It has to do with how individuals view themselves, *etc. I educated the client on the cognitive quadrant that is detailed in the manual.* I would like to do this- you fill out this sheet while I ask you several questions. Here is a visual representation of what I just talked about. We are going to fill in your beliefs about yourself, others, the future, the world and God. I am going to ask you to fill in these blanks. I am a __________ person.

Client: Strong.

Therapist: What would you say are some words you would use to described yourself.

Client: The first thing I would say is that I am very strong willed. I don't want to say bossy but…

Therapist: A leader.

Client: I am very organized.

Therapist: These are positive so far. I know there are some negative messages that you have said before. When I look at your scores from the BDI I noted you circled a response that is I am disappointed in myself. When do you say that or for what reasons?

Client: Well there is a lot. How did I get to the point that I am at. How I am worried about all the things that I am worried about when I wasn't before. My life was so different. It is just amazing at this age all the things that I did to make my life come to this.

Therapist: This point, what do you mean by that?

Client: Just sometimes in awe at the things I did. I always had it together, when I look back at the last three years it is a trunk of time when I made bad choices.

Therapist: What about right now? I feel like you are bringing your past into right now. So what is missing for you right now?

Client: Well right now, I guess it would be you know disappointed in some of my thinking process, what it would be some of the thoughts of my finances. That I can't, that I will buy a soda and I know I shouldn't. We don't have something and I buy something even though we don't need it.

Therapist: In your own defense how are you tackling that?

Client: I am doing better because I only make sure to have a couple of dollars in my pocket. If we don't need gas or anything else I don't get it. My thing is my cigarettes, because we don't have money for it but we have it. We always have money for cigarettes. Or we will have 7 dollars and spend the last 7 dollars on cigarettes.

Therapist: You said you are making process with it.

Client: We are making progress with it but it's a long road and I just want them gone and I pray every time I light a cigarette and I pray every day about it. When will you let me get away from this? We both this, we don't smoke the whole cigarette and we will save it. Instead of spending 30 dollars a week, we are now spending 15 dollars a week. I counted them up.

Therapist: This is what I want you to do, to noted when you are making progress in order to eliminate the black or white thinking.

Client: I did that. In January I noted every time that we bought cigarettes. I bought cigarettes 14 times, you times that by 6 that is a good bit of money. I am thinking so far it is the 17th and I am not going to buy 9 more pack of cigarettes. That's a big difference to me and I think that started when we started to save them and it is probably worse to relight a cigarette. We smoke in the car and I try not to smoke around my kids. My oldest daughter hated cigarettes and she just started them.

Therapist: All you can think of is your finances. What are some ways that you are proud of yourself?

Client: I am proud of myself for maintaining my relationship with God, I am proud of myself for watching my tongue. I am proud of myself for handling my children better. I am proud of myself for going to work every day, which I have always been a work person. But getting up and being able to do it. I am proud of myself for being without drugs. I am really proud of myself for that. I am proud of myself for leading a group. For celebrate recovery. That's it.

Therapist: I think there could be more if I really pushed you. When you said this you came up with your thoughts, but there are 6 achievements that you do daily. If you look at these two areas it is obvious that you are working hard in your life. If you look at the stuff you are disappointed about it is shrinking down. I am glad that you are looking at ways that you are making changes in your finances. Are there any negative thoughts about yourself? I know in the beginning you talked about your ability to be enough.

Client: I guess right now I have come to an agreement with the marriage. I guess I feel like I am enough now, but I still worry about all the boots I have to fill. Even if he doesn't have to go to prison, I still worry as Holland is still learning. I was arguing with this girl at work, she doesn't know me or Holland. She is reading this book that talks about getting rid of the fools in your life. She said every time that she reads it she thinks about Holland. She said I don't want to hurt your feelings but he is so irresponsible. She is big on the fact that- we had a big discussion this morning. *The client continued to discuss a conversation that she had with this lady and her sister. This lady stated that she felt the she was still married to her ex-husband through God's eyes. Her sister that God was not approving of the way that she lives- being unmarried and sleeping in the same bed and having a child. The client stated that other sins are being corrected and repented for and that she cannot ask for forgiveness for her relationship as she is not going to stop these sins at this point.* So, I am struggling with that. Then I argued with my sister because God knows we are preparing and she said that he needs to sleep in another bed or he needs to move out. Or she said that we just need to get married and I told her that we are starting next week with pre-marriage classes and will probably be married within a month. I am looking into April and she thought that we were going to wait until April

until we know what's happening. I am arguing with my friend at work and told her that I put my marriage at rest. My final resting point was this week when I talked to my ex-husband. We talked about getting married, our divorce. *The client went on and discussed this closure conversation that she had with her ex-husband.* We worked it all out. The kids, he told me that Ace got into an argument with him last week and Ace called him a hypocrite. He stated the only reason that he went to God was because that he lost mom, was an alcoholic and needed help. He told him that it does happen, but that I am not a hypocrite and that I love God and am continually working towards a relationship with Him. *The client then discussed reviewed ways that her son is working towards understanding the Bible and then also discussed a conversation that her daughter had with her father as well.*

The rest of the session we discussed the rest of the cognitive quadrant. Karen discussed how she felt that the world is rough and that most other people are lost. She now believes that the future is looking better and that she is optimistic about the future. Finally, Karen revealed that she felt that God is her strength and that he is smiling down on her with where she is headed in her life. The session ended with assigning homework and a prayer.

Session Rating Scale

- Session Number: Eight
- Completed By: Jennifer Good, MS, MS
- Rank of Session Treatment Efficacy: 1 2 3 4 5 6 7 8 (9) 10 (circle one that best describes session)

- Rank Therapist's Ability to Adhere to Treatment Manual: 1 2 3 4 5 6 7 8 (9) 10 (circle one the best describes session)

Comments: Karen's depression scores continue to decline. She reported that she feels that she is really learning tools to help combat negative thinking patterns and that the use of the scriptures have farther assisted with combating her negative beliefs. She is actively working towards pursuing her goals in her life and is excellent when utilizing her problem solving skills. I was able to stick to the manual and further assist Karen with different problem areas that she is still working through in her life.

Transcription of Treatment Sessions

Session Nine

Therapist: Today I would like to first set the agenda, to review your homework and we are going to specifically today focus on God's love and you belief of God, spiritual incongruence, and then at the end if we have time to do a guided imagery exercise with you? Did you have anything that you wanted to add to that?

Client: Not really. We started pre-marriage counseling last night.

Therapist: How did that go?

Client: It was interesting.

Therapist: I think it will be good for the two of you as it will bring of some of these issues that you have discussed here with me.

Client: We had a pretty intense disagreement the other day. It was about sex of course. Because those are the top two things, money and sex. It got intense and it was not right. I told him that we would discuss this as it would be brought up in pre-marriage counseling. I think it was a good thing because it brought up a lot of stuff. However, we disagreed and I even slept on the couch that evening. I never do that.

Therapist: What night was that?

Client: Monday and then we had the class last night. It was kind of perfect timing. It was actually brought up in class and I had already given him the whole run down on my opinion on that. So maybe we can talk about that some if we have some time.

Therapist: So I want to look at your homework.

Client: I don't know if I got everything as it was a horribly busy week.

Therapist: What did you put for the I/self beliefs?

Client: I put Psalm 139:23-24. (read the scripture). It is to be closer to God. Then, for others and the world was Ephesians (4:31- read the scripture), then for my future to have all that I need which is Philippians 4:19- read scripture. So am I doing it right?

Therapist: Yeah.

Client: The only one that I didn't get to was God.

Therapist: We will talk about that more today. With the I messages I know last week we talked about your strengths and I want to create a coping card for you to take with you. We were talking about achievements and I wanted to fill this out with you. What are some achievements that prove that you are enough?

Client: My children, my job, my sobriety, my endurance through many chaotic situations, my attitude right now is not like it was.

Therapist: So your positive outlook?

Client: Right. My ability to adapt is improving. I think that is good enough isn't it. I don't want to go on.

Therapist: I think you could think of more. I think one that you might not say, for awhile you were the soul bread winner and provider.

Client: My ability to provide under stress and my ability to be there for others is now very important. That is a big one right now, finding out that I am helping others whether I know it or not. That would be it.

Therapist: I want to do another card. I am not sure what I want to put on the front, but a card that you would have on paper about why you are trying to stop smoking.

Client: That is a good one. It is nasty. Health- mine and Anor. Taste buds, when I quit before I could taste things. For God, of course. Overall, because of money, it's an addiction. I want to rid myself of addiction.

Therapist: What about the inherent messages that you are sending your kids?

Client: It is making them think that there is an unhealthy way to deal with stress and I think that is when they see me smoke the most. I don't want them to think they have to smoke because they need that to deal with stress. Like eating properly or talking. For them to think that they can foolishly spend money for something that you don't need. What is the difference between a case of beer- that is money. Probably shows them a lack of will and self-control.

Therapist: The reason I am bringing up this is because I know how important your children are to you. I know you think of these things all the time, but it is one more thing to hold you accountable. What do you want me to put on the front?

Client: Quit smoking. Holland and I were talking about this yesterday because he stated now we are going to have more money so does that mean we will start buying more cigarettes and I told him no and he said good because that was what I was supposed to say.

Therapist: Good. I was going to ask you what his thoughts were about smoking and if he was planning to stop smoking with you.

Client: He says we need to really fast about it and really wants to. He said that everything is so good at times and we are really blessed and what is left for us to do to get more right. I said light that cigarette up and tell me. He was thinking the same thing. We are thinking that if we quit cigarettes that we would be blessed even more. We wanted to

know when we would start this seriously. We had one full pack left and we stated that it would be best to just stop, but agreed not right now. We get halfway to Hanover or church and we can make it until after where we are going. I told him that we need to start preparing on moment at a time and past the gas station and if we pass it then state that we already passed it and that we can't smoke now. We agreed to pray and fast about it and then decide when we are going to start.

Therapist: I am just glad that the two of you have agreed to do this together.

Client: Yes and that was what he said. He is working now and I told him that we can't keep making excuses. I can go smoke at my work, but I don't. I might smoke 2 cigarettes an entire day. I would have 3 cigarette breaks at a normal job, but I am keeping it less than that. I might smoke 4 times a work but half a cigarette each time. On my way home I smoke before I get the baby, then when I am at home and then one on the way. Holland is a bit more now. He is at work. When he was a home he wouldn't go outside. Before he would do 2 a day and then when I was at home. He is probably at 8 a day. We are at half a pack a day. We aren't at a pack like we used to. We just have to make the decision to do it and it is done. I called my sister and told her and she stated that we need to fast about what is going on. I called to tell her that we were and it will be about cigarettes.

Therapist: So I want to review your beliefs about God. What do you currently believe about God and how He views your life?

Client: I believe that if it wasn't for God that I wouldn't even be sitting here right now. He has kept me alive. I believe He has a plan for me. I believe that He has given me strength and endurance- the endurance that He has made me have for some significant reason. I believe that I am one of His chosen ones. I believe that He loves me so much

and has made me go through so much that I have gone through because He wants me to have so much more. I think that I believe I know if it wouldn't be for my faith and accepting, I would probably be still doing drugs, still depressed, probably be near in prison myself. I believe that is just what He is here for. I believe that He is going to be forever. Holland and I were talking about this last night and asking how he would do his Christian thing. He asked me how I would do it. *Karen went on to discuss little ways that she tells others in her life that are agnostic about her faith. She has advised friends to pray, read the Bible, left the work van on Christian music stations and also left little Bible verse cards around the house. She reviewed ways that these events have changed the lives of those that she works with. She stated with one friend she asked her friend to pray and she was standing in the grocery and asked God to please answer her and to tell her what she wants out of life and a little boy came up to her and stated that her hair was pretty and that she felt that God sent this boy to her in order to help her at that moment.*

Therapist: Small things lead to big things and you don't always have to give them your testimony.

Client: Right, I pray all the time for my friend that isn't a Christian.

Therapist: Sometimes I think it is living the Christian principals as well.

Client: It's with cursing as well. I have never been a curser, just at times when I am angry. This girl at work curses all the time and around her children. She had her children at work with her the other day and I told her that she needed to love them a bit more and holler at them at bit less and that she said the f word to them about 10 times and that they aren't listening to her. I told her that all the anger that she has maybe she should pray or read the Bible. She rolled her eyes, but the other day I came in and she was reading the

Bible. She said I was just nosy and I told her some scriptures to read. My other friend and I at work pray all the time. My boss always says “you girls” and she told us that we have her reading things and she even said Amen in the car. She has never thought about anything of God or Jesus.

Therapist: I wrote down different events that formed this belief- I think has been your life experiences and even day to day things.

Client: Life is always a learning adventure.

Therapist: I know we talked about spiritual incongruence and unconfessed sins with you and Holland sleeping together. Do you feel that there are other unconfessed sins?

Client: Maybe a lie or two, but it wasn’t anything that I didn’t’ deal with it. Just one of those why did I lie about those things? I guess a lot was with my dad, I never have been a liar and it has bothered me that I lied about a couple of things and it was to Holland. I haven’t confessed the actual things to him and I don’t know if I should.

Therapist: What were they about?

Client: It was when we were fighting and he was cheating on me. I slept with my husband 2 times and he does not know about that. I haven’t told him about it. I can’t explain it. It’s not like we were committed. I knew that we weren’t together. I didn’t consider it cheating because at that point I just found out that he slept with these other people and I was hurt and I thought if he was doing it we didn’t have a commitment anyways.

Therapist: To bring it up now…

Client: Would that be beneficial or should I choose my battles. I chose to forgive myself and to let that go.

Therapist: I could see all these questions come to his mind even though you closed that door.

Client: Right and we continue to close that door. We had a little issue because I didn't have a babysitter and I couldn't bring the baby here for pre-marriage class. I didn't want to pick her up, take her here, etc. I figured I would call my other daughter, who by the way is pregnant. Third grandchild on the way, she said she couldn't because she bowls, which I knew she couldn't. *Karen went on in a detailed account to explain that she arranged for Aja to watch his son at a friend's house. Later she decided to see what her ex-husband would say if she asked if Aja could watch her son at his home. Her ex-husband became very upset and stated that he did not Aja to watch her son at his home. He had a difficult time communicating his concern, and that he has had a difficult time even looking at Karen's son. She stated that she thought that the two of them moved forward and that this would be an issue that would need to be explored continuously. She stated that her daughter, Aja, was also upset that her father would not allow her brother to be at his home.*

Therapist: So you thought the two of you were at a different point.

Client: Yes and there will be different things that he will be at- he is their brother and will be more involved. My son was upset too and didn't understand why I would ask him either, but Aja said something to him and was mad that I would even ask him.

Therapist: Is your son ok with Anor? He does not like kids. Even my daughter's kids. He doesn't know how to interact with them because we aren't in the same house and Aja was 2 years younger. He hasn't been around babies. The other night in Walmart he wanted to go across the store but I told him to take his brother for a bit. His eyes got huge and at

first said he didn't know what to do with him. It was so funny to see him with him for a moment. He came back and said to take him. I wanted to make it wasn't' an embarrassment thing that he was black, but that wasn't the issue. I did ask him a week or two or ago if he loved his brother and he said that when he is older that he would spend time with him. I told him that he would babysit for me and that it would be a perfect thing for him to do with his girlfriend. I told him that he needs to be a mature boy and make decisions that are appropriate and that I don't need to make with them. *She reviewed ways that she is continuing to enforce different rules and expectations with her son and her daughter. Her daughter did not want to spend the night at her mother's house one even and threw a temper tantrum. Karen did not cave into her daughter's fit and her significant other helped to calm her down.*

Therapist: I am going to give you these. These are all scriptures of God's love for you to keep and have an review as needed. The last part is a guided imagery exercise that I want to do with you. *At this point in the session I reviewed the breathing exercise depicted in the manual and the guided imagery. Karen reported that the exercise was really helpful. She stated that she felt a sense of inner peace and that it helped to relax her. She reviewed ways that she has been attempting to release her burden in to God's hands and how this has helped her to increase her relationship with God and reduced feelings of depression and anxiety. The session ended with a prayer and assigning homework for Karen to complete throughout the week.*

Session Rating Scale

- Session Number: Nine
- Completed By: Jennifer Good, MS, MS

- Rank of Session Treatment Efficacy: 1 2 3 4 5 6 7 8 (9) 10 (circle one that best describes session)
- Rank Therapist's Ability to Adhere to Treatment Manual: 1 2 3 4 5 6 7 8 (9) 10 (circle one the best describes session)

Comments: I was able to adhere to the manual and complete all of the modules that were listed in this session. Karen continues to express positive beliefs in self, her future and God. She is working on re-scripting her core beliefs and schemas. She is able to verbalize ways that her thoughts impact her feelings and her beliefs. She continues to strengthen her relationship with God and is working towards pursuing the goals in her life actively. As a result of reaching these goals and working towards stability in her life her depression and anxiety scores have decreased significantly.

Transcription of Treatment Sessions

Session Ten

Therapist: Today I want to review your homework and see how that went. I wanted to talk to you a bit more about quitting smoking and different points that I wanted to bring up with you to consider. Then we are going to talk about more about serenity, Christian meditation and anything else that you wanted to add to that.

Client: Normal issues.

Therapist: Normal issues. Ok let's review your homework. Do you mind reading it to me?

Client: I guess. I don't even remember what I wrote. It says: Dear God, I have struggling with some issues that I need some help me. Holland and I are getting along well for the most part; however, I feel as if we could use your guidance in the communication are. I feel that Holland doesn't listen to me or just shuts me out many times. Please help us to learn each other's needs. I am also worried about Holland's possible incarceration and the burdens that I will face without him. Finances, companionship, these are the main fears and being without him. Please guide me to give my burdens to you and have faith that you will provide for my needs. One last thing that I wanted to say to you is that I know that a lot of the reasons our relationship is not growing is because of my stinking thinking and I'm not totally trusting him because of our past and Lord please give me the faith in you to grow in my relationship with you as well as Holland. Thank you Lord for being with me in the struggle with myself and trusting in you. Love, Karen.

Therapist: So how was it to read and write that letter?

Client: I had to think a little bit, but it is what it is.

Therapist: What about reading it out loud?

Client: I didn't read it out loud. I actually wrote it in a hurry one day. I never have any time. I opened the book and thought I better do it now. I think I was sitting in the car line waiting for the guys to get off of work and then I put it away and this was the first time I read it. It's kind of neat, because I probably would have read it 50 times and changed it 100 times. It was my first writing and my original and I didn't change it.

Therapist: You didn't knit pick at it.

Client: Yeah and I would have.

Therapist: With talking to God you don't need to knit pick. So you said you week was…

Client: It was ok. Up until yesterday Holland and I had a bit of nit picking going on. Of course he has a job now so it's a bit more of a burden for life on him. My main issues are that we talk about something and I know it is a man thing in a lot of areas, a lot of women I talked to told that it wouldn't change and that I need to own my part in it and he does as well. That if I told him 2-3 times that it is his nature and if it is that important to him…my example is yesterday in the morning, which is 5:30am when we are leaving. I asked if we had everything and I told him that we are going straight to the church. *Karen detailed a situation in which her significant other stated that he had everything that he needed in the morning, but when it was time to go the marriage class that he forgot his book. She attempted to remind him the previous evening, but he did not follow through with doing what was needed to have his materials. She was frustrated that she was trying to help him out, but he cut her off the previous evening and did not have his materials. She then told him the previous evening that she would pick up his check in order to deposit it in the bank. Holland filled out a paper so she could pick it up, but the company*

did not process the note in time. As a result they would need to go to the bank, but she informed Holland that they could not go to the bank on Wednesday as a result of being at the church as soon as he was off work. Holland asked the following morning if they were going to the bank. She stated that again she felt as if he was not focusing and listening to her. She stated that she did not feel that he was listening to her needs and that she felt shut out. Karen reported that she talked about this issue in her pre-marital counseling class. In the class she was told that she had to pray about it and to let Holland know that it was something that was important to her.

Therapist: And to allow expect small changes.

Client: So. That's frustrating and there is one other thing. He got in the car today at 5pm and I was happy to see him. He told me that he had good news. They offered a full time position.

Therapist: I feel a but coming on.

Client: There is. I said really and he said yeah it is 5pm-3am. I said what do you want me say? He was like they didn't' approach anyone else about this job and I told him that I was glad they did this and asked if he took this job and that I needed to talk to you.

Karen discussed her issues with this situation. She stated that Holland did not think about her situation. She believed that the agency should hire him on first shift since that was when he was working and to prepare for setting up for this shift. He stated that the company would hire him for the 1st shift and was frustrated that now he is being offered a 3rd shift position. Karen reviewed some of the negative aspects of the situation. She stated that she could take him to work at 5pm but that if she would wake up at 2:30am that she would have very little sleep and would have to wake up the baby and disturb his sleep

patterns. In addition, Karen did not feel that her significant other would be able to babysit the baby during the day. She asked if Holland would go in and try to get first shift and if that was not possible to find out if he could have transportation home before he gave them an answer. She stated that she would be able to do everything else if he was able to get a ride home. She did discuss the concern about sexual intercourse as well. When this would occur and how this may not meet his needs if he is getting home in the middle of the night. Holland only has the ability to keep his temporary job for 2 weeks. He then asked if the client would go to part-time. She stated that she could not do this as she had to prepare for Holland going to jail. She stated that she believes that God will be faithful to them, but that she is not sure what His plans are for their lives. She stated that she was hopeful that he was talking to some of the people from the church to get an outside opinion of what he should do.

Therapist: You are facing the possibility that he might not be there.

Client: Yes and that is why we are talking to Julie. He doesn't get it. She told me to talk to someone else about the reality of it.

Therapist: You are prepared for this.

Client: But he isn't. I got to turn it around. If I was going to prison or facing prison I would be in denial about it.

Therapist: Until you know for sure.

Client: Right. So to him it's probably a safety mechanism or a guard because he can crumble. I have been trying to put myself in his situation. My whole thing would be that I am not going, because as soon as I thought I was going it was be a mess. So I have to think that is what he is thinking, but when he finds out that he could be going he will

crumble. He could have been talking about this before and then what am I going to get he is going to crumble and all these letters and I will have to deal with his stuff that he could have dealt with right now. By God's grace he won't go in and it could all be wonderful, but I don't know, which is why I can't base all in my decisions on that.

Therapist: You need to be prepared to take care of your family.

Client: He's not seeing this and now I am really stuck because it will be 3 dollars more an hour. We need that money. If he doesn't quit for 2 months I could save some money and get ahead and not be behind. It would nice to be a little bit of a safety. I could keep adding to it and always make sure to have my bills paid. But that 2am or 3am in the morning…

Therapist: It sounds like he needs to find that ride home and there will still be disadvantages. Would he work 7 days a week?

Client: No it would be Mondays through Thursdays. So we would still have the weekend. It was be a good idea but they will offer overtime and he will want to take it.

Therapist: That would be when you want to talk to him and tell him that you are supportive…

Client: Yes. I would say to him that's fine we will do this but you can choose one day Friday or Sunday. It would still allow him to go to church. He still is expected to be at church and have his obligations. He will have to go to this guy and tell him that I would like to take this job that I have a family and a baby and I do not have a license which would put me in a situation that my fiancé would have to wake up and so would my baby is there anyone that you know of that could take 20-30 dollars week for gas and drive me

home? Or give me a few phone numbers to call so I can get this done. I told him that this would be the next step to do in order for us to make a decision.

Therapist: You are happy and excited for him but you are looking at the details and he is just focused on the fact that he has a job.

Client: He is just thinking that I am being negative.

Therapist: You are just thinking about how this will impact everyone else. You are a detailed oriented person, he is not.

Client: That is what I said to him. That I am happy for you, I am proud of you, but he wasn’t hearing it. I was complaining and nagging and I was just snapping. First of all it has to be talked about it has to be real. Before I came up he asked me what should I do and I told him not to ask me that because I told him what to do. That he needed to go to the guy and tell him that he was grateful that he was asked for the job, but that he needed help. Even if I could do it for a month, I would not do it to the baby. He said what’s the big deal he will just go back to sleep and I stated that I would not to that to the baby that he is just getting used to this change.

Therapist: And then with the new babysitter.

Client: We switched babysitters and that is working. It is hard enough to get up and leave at 5:30am.

Therapist: So maybe when the emotions are calmed down you can say that logically this is what is going on and I am very happy for you but we need to figure these things out.

Client: So if he doesn’t take it he is worried that he could lose all of it there. That is when he would go to the temp agency and say I need another job and we see what happens.

Therapist: You had some extra money for these few weeks.

Client: That's life. Then maybe after the 24th when we know a bit more, which will we know then, no, probably not. We will present something, but- ok I am going to stop that stinking thinking. I am going to call my sister and shoot this at her too and see what she says. Hopefully he is downstairs talking to 50 people to figure out what to do and that is what he needs to do. He needs someone else to tell him to think about this and this.

Therapist: An outside perspective, not just from you.

Client: Yes. I am really hoping that is what God has him doing down there. I am not going to let it ruin my night. I am so excited that it is a fulltime job and we would have some time apart.

Therapist: You would have some alone time and some alone time with the kids.

Client: Yes and I won't know what to do. I won't. I am serious. I will probably pace the floors. I will be relaxed. Read books, spend time with the parents with my children.

Therapist: You are thinking about the positive too.

Client: Yes and I think when he starts thinking to he will start thinking oh I won't be with her as much. He needs a little bit of time too and was struggling. He probably was asked this in the morning and he didn't have his cell phone and if he has his cell phone we probably could have worked through this throughout the day instead of it being a big boom, which is one thing that I talk to him about as well.

Therapist: The next part that I have is the serenity prayer in here and I know that you know it in an out. In talking about it, giving your burdens and concerns to God. I know right now it is fresh incident, but it will work its way out and relying on God that it will. One thing that I wanted to do today to also talk about the power and impact on music. I

wanted to share a song with you that have had a powerful impact on my life in what I have been going through. At the last session I am going to ask that you share a song with me as well. *Played the song.*

Client: That was good.

Therapist: It is a powerful song. Did it say anything to you?

Client: Why am I fighting God is going to hold me. He's got me. That is one of Holland's favorite sayings, I've got you maybe. My friend recently we borrowed money from her. She'd be like I'd gotchya baby. One day we were at the grocery store and I texted her to see if I could borrow some money for gas. She didn't text me back but I got in the card and there was this a black envelope and there was 15 dollars in it and in the inside of the card there was the message that stated this is for Holland, I gotchya baby!

Therapist: So the same thing with God- he's gotch you baby!

Client: Right.

Therapist: I am wanted to review some different meditation techniques. *At this point in the session I reviewed the meditation exercises listed in the manual and the benefits. I practiced the breathing exercises with Karen in the session and reviewed the meditation processes. Specifically, we practiced counting breath and discussed mantra meditation* Have you tried either one of those in your past? (referring to breathing and mantra meditation)

Client: I do both. I do the breathing on a lot. When I get tired of hearing noises at work I tell them I will be back and take a few deep breaths if I don't I will go crazy. There is only so much you can tolerate. *She reviewed a situation that she dealt with in the morning where she used breathing and mantra meditation.*

Therapist: Have you developed any mantras for the future and when you get anxious?

Client: Yes, God is going to provide for me. Or a lot of times it will be, I focus on fellowship. I have fellowship, I have people. That I have to say a lot because I lost a lot of socialness because of the drug world and I am a social person. I tend to think about the aloneness. So I have to say that to myself so I don't even think about the aloneness.

Therapist: What about any statements for yourself? I know in the past on several occasions you have told me that I am strong.

Client: I still do say that. My friend at work is always saying you know you are strong-say it. She is funny. She makes me say that I am strong and I will be ok and I tell her right after you do.

Therapist: That's another one. I am enough, my past doesn't define me.

Client: That's a hard one. I can say my past doesn't define me. I still can't get this I am going to be enough.

Therapist: What do you think is holding you back still?

Client: I don't know, because it goes to the pattern I always had a spouse with me when I raised my children I was never alone raising those kids. I never was a single mother. I never wanted to be without my children's father. When they were little I wasn't. My oldest was not my husband's father but he was with her since she was 11 months old. That was my choice. He took over as their father. He was never not there. I had him and I never had a baby without their father there. That is where-myself can I be enough.

Therapist: What specifically are you lacking?

Client: No there is nothing more that I can do but I guess it is that I cannot replace his father.

Therapist: I don't think Holland would ask that of you either.

Client: No. He wouldn't want that. But is he going to have a man in his life. Who is going to be his mentor and who will learn from? If he goes away for 5 years that is a chunk of his life.

Therapist: I know you are close to your sister, what about your brother-in-law?

Client: I am sure he will help a lot. It is just time consuming and making sure. How am I going to put Anor and make him be around a man? He has his older brothers. He has Shannon, but he is not mature enough, he will need someone for himself. My 16 year old son has his life planned out; he is going to college and won't be here. He wants to go to Philadelphia that is scary for me. I am dealing with him leaving and that will be hard for me. *The client then went on to discuss some of the concerns with her son going away to school. The session ended with talking about the Christian meditation and scripture meditation. The therapist gave the client a list of scriptures for meditation. The session ended with assigning homework and a prayer.*

Session Rating Scale

- Session Number: Ten
- Completed By: Jennifer Good, MS, MS
- Rank of Session Treatment Efficacy: 1 2 3 4 5 6 7 (8) 9 10 (circle one that best describes session)
- Rank Therapist's Ability to Adhere to Treatment Manual: 1 2 3 4 5 6 7 8 (9) 10 (circle one the best describes session)

Comments: The therapist was able to get through the main objective listed in the treatment manual. Karen reported that she does utilize breathing, mantra meditation and

scripture mediation. She reviewed the positive impact that all of these relaxation techniques have upon her current situation. Karen also problem solved different situations that she was going through in her life and reviewed the steps that she was taking to overcome these difficulties. In addition, the therapist continued to work with Karen to combat her schema of not being enough. Karen recognizes that she has a lot of strength in her character and is able to list the evidence for this characteristic but continues to worry that she will not be enough for her children if her significant other goes to prison.

Transcription of Treatment Sessions

Session Eleven

Therapist: Today I want to set the agenda. First I want to review your homework, then to talk about being enough even more and today to do a progressive muscle relaxation with you.

Client: Do I get to lay on the couch and you can psychoanalyze me?

Therapist: You will get comfortable. Then we want to talk about music a bit more and how I would like you to bring in someone for the last session. Then at the end to talk about the therapy ending and to develop a plan if you felt it was necessary to continue to see someone else. Is there anything else that you wanted to add to that?

Client: No

Therapist: One thing that I wanted to address before we get to the homework. I was talking to my supervisor about Holland's attentional difficulties and he was wondering if when he went to counseling if they would be able to assess him for ADHD.

Client: He has ADHD.

Therapist: Oh ok that was already assessed.

Client: Our family doctor that we have seen, he has been told his entire life that he probably has ADHD. His mom of course didn't put him on medicine and I don't blame her. I am a firm believer that you can change behaviors without being on medication and it was Ritalin which can really mess with your mind. I think that at times children can develop their own level of hyperactivity at times. Children who are not disciplined are usually ADHD. Their parents gave them or they never made them do something on their own. I wouldn't say in all cases that has happened because I know that there are

chemicals that cause it but a lot of them are misdiagnosed by improper treatment and structure. I have said to Holland, there was time when I looked back when he was extremely focused. Once his life started he would act out in more hyper ways to get attention. A lot of times he said that he would try to do his homework and his mom would scream and holler at him. I don't think he ever learned how to focus. We did explain this to the family doctor and she does think because of his behaviors that there is a chemical problem in his brain. He was given the choice to maybe take something. She started with the Rispherdone which is for the bipolar which is for the mood swings. Once again he went off of them for three days and there was a big blow up.

Therapist: I know you have told me before that he does better on his medications and that his moods are more stable.

Client: Ever since time this happens. I thought I won't babysit him and I won't do this. At the beginning of the week I counted his pills and I didn't say anything to him about this. I noticed there were two days were his mood really went up and down from happy to sad and they were all over. I said what was wrong with him and he couldn't pinpoint what was wrong. I wrote it down and found out that he didn't take the pills for 3 days. It seems once he misses 2 pills that he seems to start reacting. I asked him how he has been taking his pills and he said uhhh. I said right now you are telling me, think about before you lie. He said well I wanted to see and now he said you just and I said you just didn't take your pills. It is your body and your mind and it is also your relationship. I don't share your mind, I don't share what you put in your body but I share your relationship with me. So therefore you need to make a choice that involves a behavior technique that doesn't involve putting pills in your body or take them but you need to include me in that

decision because I am not able to keep doing this because it is effecting me. He said that he never looked at it like that and he is back on his pills and he is fine.

Therapist: So is his attention better when he is on his pills?

Client: Yes. It is completely better when he is on. It is still whatever. He has another appointment coming up and she is going to talk to him about if he wants to be on something else; however, we lost our insurance. He makes too much money. I can't cover him under mine.

Therapist: So you still have yours and your kids are covered?

Client: My kids are covered under my husbands. Anor is covered because he is still in his first beginnings and he will not lose his. Me and Holland as adults have lost ours which is a big problem since we both have Advair. My Advair is 300 dollars a month. I didn't use every inhaler that I have because I knew this could happen but I am still scared.

Therapist: Do you take it every day?

Client: I take it 4 times a day or as needed. I take my Advair everyday if I don't take it for 3 days I am very bad. I have one more left which will get me for one more month and it will be right at the time when I need it the most. However, I can get medical insurance through my work within 30 days of notice. So, I have 30 days to let my company know; however, I cannot afford it.

Therapist: Is it out of pocket?

Client: It's a lot of money. It is like 70 dollars a week. I can't afford that.

Therapist: There goes a lot of your pay.

Client: Child support is out of it now and I would end up with maybe 300 dollars a paycheck. I can't do that. I filled out paperwork for adult basic and my girlfriend is looking into some programs with people that have low income and no insurance. So she is getting all the paperwork together and said that she would let me know this weekend. That's an option too.

Therapist: So you are looking into it, but it is a big stressor.

Client: Yes a huge stressor. Well I am also looking into whether the medications with be covered because he has bipolar and that is considered a mental health disorder, I can go to the MH/MR and have him evaluated to his need for it and his income and he can get vouchers for it. It would help. I have to look into my thing because I have more asthma issues and I can't go off of it. I have nebulizer treatments if I need it.

Therapist: I am surprised that they cut you so quickly.

Client: Well I am an honest person and I sent the paychecks as soon as we got it. I also included a note that stated that Holland's work was through a temp agency. It is not a permanent position. She got it last Friday and it was cut yesterday. I am thinking we get food stamps too and that will be cut and she know it wouldn't because we have a child and they might modify it but that we will be able to keep it. 200 dollars is better than nothing. I am stressing because I just don't know what will happen, will I still…that is what I want to add things with finances now that he has paychecks coming up.

Therapist: What happened with the position?

Client: He told them that they needed a first shift job and nothing was ever mentioned again. They took him the next day for an interview for a first shift position Monday

through Thursday 6 to 2:30pm and we haven't heard anything. The guy said that they would extend the temp job through this week.

Therapist: At this point you are just waiting. He has a job until this Friday.

Client: Yes and if he doesn't get it I have to call the welfare office again and reapply. I will have to do it all over again. Holland said he wasn't thinking that way because he believes that he got the job. He is so naïve about how things run. He has never had a job or an account. We really had to go through some things with depositing money. *At this point Karen reviewed frustrations that she had with Holland regarding budgeting and making deposits in the bank account. He has been having a difficult time understanding that the money is being put towards the bills. Karen reviewed ways that she was trying to explain budgeting with Holland and ways that their funds are being spent.*

Therapist: I could hear when you tell the story frustration from him. He is working and not seeing anything from it.

Client: It upset me too because he told my daughter that he would take her shopping next week. He doesn't understand t hat we haven't been on time for bills, that we have been borrowing money and I haven't even got anything for working. I asked him what the last thing that it was that I got. He got a flannel shirt, a pack of socks and a t-shirt. I made sure he had those things. I haven't gotten anything new. Then I said that I did get that shift from Wal-Mart that was on sale for 3 dollars. That has been the only thing that I have bought myself. I did buy Anor a toy and a birthday present. I haven't gotten anything. You know what I got- I got my bills paid and that is great for me. But he doesn't get it- he hasn't had to do this in the past. I have to understand that he hasn't had this stressor.

Therapist: Right and he is thinking now I have money and I can afford to do this, this or this.

Client: When he was doing drugs it was nothing to get a thousand dollars and he could just spend it on whatever he wanted. We could go to Lancaster and blow out the outlets. That was drug money and it was realistic and you might be doing time for that. I said what do you have Holland you have your freedom and the ability to sit in your household with your bills. After I said that he said that we were done talking about it. I said Amen and that was the end of the story. He was a little nicer when he came instead. I think that he knew that I couldn't take any more of it and that I was trying my best to explain it to him.

Therapist: Part of it too is him trusting you and that you paying the bills and taking care of it.

Client: That is what he is having an issue with it and I guess in some part I have to give it to him. He has heard me say when I was in the last months of rehab I have taken money out of accounts. Holland before said he couldn't believe that I took all that money. I took it from credits card, paid it back, took it, paid it back and so on. Holland doesn't understand, he thinks I stole that money. I took it out of our account, my husband had a business and eventually my addiction came that we were in the negative. He has heard that so many times.

Therapist: That fear creeps in even though it isn't you anymore.

Client: So I said to him Holland I am not on drugs. Everything that comes out of the account has got to be ours. I said that we should come up with a plan that nothing comes out of the account without the other one knowing it. I told him that has to be trust and that

is on him. He stated that he wanted to have access to the account as well. I showed him his debit card and told him that he has access too, but that we always use my card. He has exactly what I do.

Therapist: You are just the one paying the bills.

Client: Right I just have to deal with the bills. I asked who had the money in his pocket and I know that a man likes to have a couple of dollars in his pocket. I thought that was my way of being nice and told him that he could probably give me a couple of dollars. It is frustrating me. He constantly tells me that I need to forget about all the things that he has done to me, which I am working towards but this is driving me nuts. Then he says what about a savings account. He said that he wanted one where both of us had to be there in order to withdrawal which I think we can do. I am fine with that.

Therapist: You are fine with it too as it holds both of you accountable.

Client: Right both of us are accountable for what is in there. I told him that this checking account and bill thing, he has to give up. Nothing is going to come out until I give him a reason not to trust me.

Therapist: You have been working for 6 months so there is plenty of proof right now.

Client: Exactly. I said to him when I have taken any money for anything other to pay the bills.

Therapist: It has become a problem now that he is contributing.

Client: He thinks he is a bigger thing and that he has to worry about all over this. I told him that I have been clean since I have had a job and that he is basing something that has never even been a part of our relationship and that he needs to get over that. He didn't say anything about that.

Therapist: Well because you don't need to have him putting those past feelings on you when you are working towards feeling good about yourself.

Client: Right I told him that you aren't going to be doing that.

Therapist: You are fighting those messages that you are no longer that person and that you are a stronger person.

Client: I am and that is what I told him. We are not going there like that. We are 2 individuals that are working towards having a family and a future and that we are going to deal in the here and now. He asked if we needed 2 separate accounts and I said that if that was the case he could move out and pay me child support and to make sure that he paid his own bills. *She reviewed ways that she tried to help him understand all the bills that he would need to do if he was on his own.*

Therapist: So did you do your homework throughout the week?

Client: I wrote. During frustrations with not knowing what is going on with Holland's case- I have shown a lot of strength there because I could have crumbled. I know I am enough to get through it. When bills were paid- it made me feel good.

Therapist: That what I was thinking when you were reviewing the issue with Holland- that all of these things prove that you are competent and enough.

Client: Right. When I was able to talk someone through relapse, when I help to encourage others, when my son asked me for advice this week, when my grandkids are loving on me- I know I am enough for them, when my oldest daughter calls me and tells me mom you need to call someone and tell them to fix my van- I felt like her mommy again. I was a little mad because I thought you had fingers but I did it and I thought if that is what she wants me to do as her mommy I will do it. When Aja calls me just to talk. It

made me feel good. When my kids show growth from what I instilled in them and what I am trying to teach them. Then when I can walk calmly away from Holland without throwing something at him. I am just kidding.

Therapist: I want you to do something for me; I want you to define the word enough.

Client: Content. When you don't need anything else. I don't know. When you could get more but you have enough. You have what you need. I guess.

Therapist: Now I want you to define not enough.

Client: When you don't have what you need. When you can't get by. When you only have 1 cup of milk and need 2.

Therapist: So for enough you said when you are content, when you don't need anything else and when you have what you need. In your life, specifically with your kids and possibly Holland going away do you feel like that definition holds true, that they have what they need, they are content?

Client: Yes. Of course they always have wants but they won't need anything. I struggle right now with the babysitter. I don't know that I will be able to maintain everything. Right now I can, I struggle with rent and gas, but I do worry about that. I don't know. I am just handing that over to God, because I have no way of telling what will happen. My thing is I am looking at it now. What happens if the income is not there, how will I function? How will I do this? I might have to get a part-time job and have Aja watch him in the evening.

Therapist: What about the one girl that is thinking about living with you in the summer?

Client: That is still an option, but I still need to figure out what to do in the next few months and I cannot rely on that. I am not sure what I will do. I am trying to take one day

at a time and not think about it, because I don't know what will happen. I keep telling God that I am just trying to think of one thing at a time because right now if I knew he was leaving I don't know if I would be able to handle it, but I usually find some peace that God will put something in my life that will make me able. I think I have a hold on how to deal with my emotions, how to deal with Anor and everything. I know I will struggle, but I know I will be ok. I have to get to the financial part, but I am struggling with that. I am better than I was before. *Karen reviewed her desire to maybe take some classes and get supplemental loans to help manage her financial concerns. She reviewed ways that she could get a part-time job and the pros and cons to each situation.*

Therapist: So even though you don't want to think about it, you are thinking about it enough so that if it does happened you will be somewhat prepared?

Client: Right. I filled out my FAFSA. *Karen then discussed some of the concerns that she is having with filling out the FAFSA. The application stated that she is not an eligible citizen and she believes that this has happened as a result of past loans.*

Therapist: So emotionally you feel like you can handle it, financially you are worried about it but you are thinking through it and you can't think about it too much or else it will drive you batty. What about with Anor?

Client: That is when I get choked up and upset. I still don't want him to see his father through glass.

Therapist: You were talking about wanting to find a good role model for Anor; do you feel as if you find a good role model for him during that time then you would be enough?

Client: Yes. I think I will be. I don't know that relationship now because the relationship now is always with Holland. I am hardly alone with Anor now, but will I have

frustrations because it will be all on me. It's not that I don't think someone will be there, I guess it is more the abandonment that I know he will feel. No one can tell me to seeing Holland everyday to not at all, it will affect my baby and that hurts me. Do I think I can get through it? Yes. Do I have pain about it? Oh yeah. It's not fair for my baby to have to go through that, but that's called life and it's out of my control and I can't do anything about that. I am pretty confident that he won't remember that. I am going to make sure that he sees him on a monthly basis. Even if he 8 hours a day, I will take him to see his father.

Therapist: That is what you can do to provide him with that connection.

Client: Everyone has told me that I wouldn't do that every month. I am not doing it for me- I am doing it for my baby.

Therapist: That will drive your heart.

Client: That will drive my heart. I can do it. I will do what I have to do to get him there.

Therapist: He will see his father every month. If he goes to state prison he may not have contact with Anor and when he comes out he might not be able to live with him due to Megan's law. I am dealing with that right now and am a bit angry with that because I just found this out.

The session ended with completing a progressive muscle relaxation exercise. The therapist then prayed and assigned homework.

Session Rating Scale

- Session Number: Eleven
- Completed By: Jennifer Good, MS, MS

- Rank of Session Treatment Efficacy: 1 2 3 4 5 6 7 (8) 9 10 (circle one that best describes session)
- Rank Therapist's Ability to Adhere to Treatment Manual: 1 2 3 4 5 6 7 8 (9) 10 (circle one the best describes session)

Comments: The therapist was able to meet the main goals of the session. Karen was able to work through her schema about being enough and continued to voice ways that she has overcome this belief and formulated a new belief that she is strong and enough. She had been experiencing stressors with financial matters with her significant other and discussed ways that she worked through these issues. At the end of the session the therapist was able to do a progressive muscle relaxation exercise with Karen. Karen reported that the exercise helped to alleviate feelings of anxiety and distress.

Transcription of Treatment Sessions

Session Twelve

Therapist: Today is our last session and I would like to set the agenda. I wanted to talk about areas of change in regards to your depression, your spirituality and the different skills that we have learned. I will review them with you and answer any questions that you have about them. Then to create some goals for yourself for continued change and then to talk about relapse prevention- cognitive rehearsal strategies that you can use and then to end on the song that you selected. Is there anything that you wanted to add to that?

Client: We had a really big blow out on Monday night and it was about money. It was bad. It was a fight.

Therapist: What triggered it?

Client: Him. Both of us are getting paid this week, which makes it a higher amount of money. Asking question about things that we have gone over the past three weeks. I said why do we have to go over this again. *Karen went into detail about how her significant other continues to struggle with understanding the finances and the bills. She reported that this is making her very frustrated and she is done with explaining the budget and bills with him. The client reviewed how her significant other did not need to pay the bills in the past and how this was not a priority for him. She explained that he did not learn how to do this and that he needs guidance or some sort of class in order to understand these new financial responsibilities. She brought this issue up during the marriage counseling at the church. One of the leaders of the marriage counseling linked up the client and her significant other with a third party to assist them and mediate the financial*

problems. What do you think happens today- he gets his paycheck. We pulled up to the bank and I told him that he has been doing this for 3 weeks so you do it. He said what are we putting in the bank? I told him you put the 500 in and we will keep what is leftover. He then asked what are the bills this week. I told him that we decided that we would sit down and review this over the week so I did not prepare it and that it had nothing to do with what we are doing right now to put this money in the bank. He just put it in the bank and I told him that we should not talk about it until we had our meeting with the third party. It is the same thing that he asks and it starts the same cycle every week. He doesn't understand that these bills are there every week and they won't magically disappear. He doesn't understand about the cell phone bill. We paid two weeks late and he doesn't understand why it is due already now. I am trying to explain to him that we are trying to pay ahead so we can afford these things. I told him that we weren't going to talk about this until we meet with someone else, as it is bringing us down and farther apart. *She then discussed ways that they are going work in their budget extra spending money for themselves and the children. She also reviewed ways that she is going to save for all of her children as she is able.*

Therapist: I think it is good that you are sitting down with someone else. You are getting frustrated and he is not getting it.

Client: Martin told him do you not understand because you are not seeing something visual. You have your food, your shelter, shampoo, toilet paper- are you thinking about all those things that you are not doing without. You are driving in your car, you are doing what you need to do, and your baby is getting fed. I got him a 4 dollar toy today do you know what that felt like? It was on sale. I texted Holland and told him that I think I am

going to get the baby a toy or two. I got myself a pair of 2 dollars shoes, a 5 dollar ball and a 4 dollar toy. I spent 11 dollars and I am really happy that I spent that 11 dollars and he asked why I didn't get something better. I am ecstatic about that. My baby was as happy as he could be to play with that. *The client went on to explain that she values getting more with less and that her significant other values getting the best that he can.*

Therapist: It might be that you need to set up several sessions of he will have to keep going to that person until he understands.

Client: That might be it. There is a little over a thousand dollars in there right now, so I wrote out everything and it came out to 929 with the things that we needed. I took all that off and told him that we were really good and should be very happy and he just turned his head and said we have that money in the bank and I told him that it will come down when we go through the bills. He still didn't understand everything that we have to pay and that needs to go out. I told him we would have money left over to put towards rent next week that isn't there.

Therapist: So he is still working?

Client: Yeah they came to him and told him that they were going to keep him on until they could find something for him. They really like him and he has been dependable. He told the guy that next Wednesday we have a hearing, a pre-trial conference, he told him about it and was honest and the guy told him that he could have off at 11 o'clock and he seems to be in his corner. I want to read you the letter later to tell me your honest opinion.

Therapist: So let's talk about what changes you have noticed as a result of coming here and working with me these past 12 weeks.

Client: I am not depressed. I feel like I can handle a lot more and have better coping skills.

Therapist: What coping skills do you think were the most helpful that you have learned?

Client: To read the Bible and put them with what I am going through, knowing that God is stronger and everything. The coping cards, breathing, the relaxation techniques.

Therapist: Do you think that becoming more aware of your thought processes have helped and to challenge those beliefs that may not be completely accurate?

Client: Oh definitely. Know that what I think is effects how I behave and all comes from a choice I make or how I think. There are some things that I have to take the way they are.

Therapist: Yes there are some things that you can't change.

Client: I try now to look at the good or react in different ways.

Therapist: The thing is that everyone else still have their own distorted beliefs and the main one that we kept hitting on with you is am I enough, am I component? With everything that you have been through in your life you have overcome them and you are such a strong person now. You are so strong and I kept trying to hammer that with you to reconstruct that message.

Client: I know and that helps me. I do say that to myself. I know it. I get it.

Therapist: Specifically with your depression what do you think has changed? With your thinking, you're feeling, your sleep…

Client: I sleep better. I feel like I am not depressed. I feel more-I can't explain it. I have more energy. I have more everything.

Therapist: What about your spiritual life- do you think that has changed as a result of these sessions?

Client: Yes. It's unreal. I'm growing in my spiritual life.

Therapist: How so?

Client: I am learning more, I know more and I am trying to believe more and I guess it is a lot more trusting in God then I used to.

Therapist: *I shared the scores with Karen over the course of treatment and explained what the scores meant.*

Client: Wow.

Therapist: The interventions that we talked about I will give you some things that we talked about. *At this point in the session I gave Karen the activity monitoring sheet, goal setting sheets, the DTR and he cognitive quadrant sheet. After I explained these sheets, I reviewed the behavioral strategies, cognitive strategies and relaxation techniques. Karen stated that she did not have any questions related to these skills that were learned.* I wanted to create a coping card, the main adaptive response something you can take away from what we did. One specific response to say to combat when you say to yourself- am I enough?

Client: I am enough.

Therapist: Because…

Client: I can endure- anything I think and because what I have already done there can't be too much more of anything else that I can't do. I was telling my friend that I work with we were talking about things and she said that any other person would have been broken and been a mess and said that she didn't think that there was any one else that she knows

in her realm of people to have dealt with what I have dealt with and am continuing to deal with and to be doing as well as I am. She said to say what that is in one word – she said uhhh, she said a rock. I said I don't want to be a rock because they aren't soft anywhere, but she said that she knew she couldn't do that and I told her that you don't know that until you have been there. She pointed a lot of things out- getting up and going to work is an accomplishment and first and foremost my belief in God, my addiction and then third my forgiveness for a man that has done some pretty horrible things to me. She said right there that was way too much for her. She said she could start naming many others.

Therapist: She has good points, but it is important for you to see that in yourself. So, I am enough because I can endure almost anything because of what I have already accomplished. I am strong. I wrote 2 for you to keep wherever you need it. On that back I would like for you to find scriptures that are in line with this message as well. Also, maybe to laminate it so you really can keep this in good condition and use it as often as you need it.

Client: I probably will laminate it.

Therapist: This is really your souvenir and the take home message of what I want you to get out of the therapy that we did together. You need to burn this message into your brain. Really find those scriptures that will back up this belief as well. So, what are some goals that you have for yourself for the future.

Client: Well, I think my goal is to memorize scripture. I can't seem to do it. I can for a minute, but I can't for a day. I am very good with memory.

Therapist: To be able to memorize scripture.

Client: I would really like to be able to say well in Psalms it say this or whatever. I can find it when it is needed or tell people where to go but I would really like to have it already. I would like to become or know that I can handle- my goal is to never slip, to catch the signs when I am slipping and to reach out to someone when I start to slip. At this point, I believe that it won't even happen anymore but I have to think in reality and there are a lot of things that will come up in the near future that will put me in a frenzy and that I got to talk to someone and stay close to someone and not pull myself away because I tend to do that.

Therapist: So a lot is to try to maintain your current emotional state and if you feel yourself slipping to utilize skills and supports to help you not get into a deep depression. We talked about some last week are you going to try to schedule an appointment with someone here at Freedom Valley Counseling?

Client: Probably periodically, I don't think I need it every week, but I don't think it will be healthy for me not to talk to anyone. My girlfriend called me this morning and said that she missed we and we talked and agreed that we need to be able to maintain our contact at least every 2 weeks. It's a shame because we work different shifts, but we did come up with that we will maintain a visual relationship at least one every month or every two months. Honestly, with our work schedules and everything else that is going on that is the best that we can do at this point. I need that and so does she.

Therapist: Is this one of your best friends?

Client: Yes for life…pretty much forever. 25 year or so. My other friend which I talk to weekly or sometimes biweekly. She is the one that has gave us money and helped us when we needed it. I speak to her, text her, quite often. We don't do much together but

we have a good relationship. She knows everything that is going on. Both of them are good supports and I want to make sure to continue to allow those relationships to grow. *Karen then discussed a friend that was supportive when she was going through her addiction. She reconnected with this person and feels that it is important to have this person in her life as this is a person that knew her in her addiction and how much she has changed over the past year.* I know that these ladies will be very important to be if Holland does go to prison and I will need to have those supports available to me in my life.

Therapist: Yes I was thinking the same thing, that it will be very important for you to surround yourself with those people.

Client: They will always be there and I know that.

Therapist: Did you ever get a letter from the doctor to tell of his diagnoses and the medications that he is on to help with this? I would think that would be very helpful, especially with the ADHD as he is now in therapy and taking medication, whereas before when he was getting into trouble he wasn't and with ADHD it if difficult to regulate your impulses and emotions. Then the letter could explain why it may have happened and what Holland is doing now to present that in the future.

Client: Yeah we did talk about that and I think the public defender will be calling the doctor and I will call the doctor to see if she can write something up.

Therapist: Ok good.

The tape ended at this point. We developed a relapse prevention plan together. Karen stated that she knew if she was involved with her social connections, the church and attending work that she would be able to maintain her emotions. She discussed the skills

that she could utilize and different supports that would be needed in her life. Karen shared her musical selection and the session ended in a prayer.

Session Rating Scale

- Session Number: Twelve
- Completed By: Jennifer Good, MS, MS
- Rank of Session Treatment Efficacy: 1 2 3 4 5 6 7 8 (9) 10 (circle one that best describes session)
- Rank Therapist's Ability to Adhere to Treatment Manual: 1 2 3 4 5 6 7 8 9 (10) (circle one the best describes session)

Comments: This was a good final session. Karen was able to review her current emotional status and ways that she has changed over the past twelve weeks. She informed the therapist that she felt that she was no longer depressed and that she learned tools to cope with her depression. In addition, Karen was able to review her new adaptive schema and discussed the evidence that support this schema throughout her life and in her daily actions. She reviewed her desire to continue to work towards her goals in her life and to grow in her faith. She was able to review ways that she could maintain her current moods and those skills and supports that are needed in her life.