

THE EFFECTIVENESS OF CHRISTIAN ACCOMMODATIVE MINDFULNESS IN THE  
TREATMENT OF SHAME

by

Tracy Lynn Jones

Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

School of Behavioral Sciences

Liberty University

2019

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APPROVED BY:

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Dr. Fernando Garzon, Committee Chair

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## ABSTRACT

Shame is a destructive moral emotion experienced by a vast majority of the population and is found at the core of numerous mental illnesses and spiritual crises. Unfortunately, Christians seeking help for these conditions are often left with unmet cultural needs in the process of treatment, potentially hindering full healing or even entrance into needed treatment. The current small N time series case study research addresses this dilemma utilizing a culturally accommodated form of mindfulness, which is an existing treatment known to promote healing in the physical and mental health realms. Mindfulness has been demonstrated to be useful in the treatment of a multitude of mental health conditions as well as in reducing the experience of shame; therefore, this intervention was adapted to incorporate constructs common to the Christian culture and protocols were created to be used with Christians at a community-based Christian psychotherapy clinic. Utilizing a set of Christian Accommodative Mindfulness (CAM) meditations and exercises, levels of shame, depression, anxiety and resiliency were measured using psychometrically researched scales to determine the effect of CAM on the clinical presentation of recipients of professional counseling. Results of the study demonstrated that mindfulness was able to be successfully adapted for and delivered to Christian clients seeking therapy for depression or anxiety in an outpatient clinic with significant desired effect to decrease shame, depression and anxiety as well as to increase resiliency. These findings provide initial empirical support for the development and utilization of mindfulness interventions that are culturally sensitive to the unique worldview of the Christian clinical population. Future research considerations and recommendations are provided.

*Keywords:* shame, mindfulness, resiliency, Christian mindfulness, meditation, cultural competency

**Copyright Page**

## Dedication

This dissertation is dedicated first to God for your patience, steadfast love, grace, discipline, lovingkindness and constant presence. You are the reason for my being and my desires to make a difference and live a transformed life. I pray for my life and this study to shout glory to you! You have believed in me when I gave you no reason to and you have guided me to opportunities to grow and then provided the strength and courage needed to do so. Every step on this journey is due to your hand and your efforts and I am filled to overflowing with gratitude.

I also dedicate this to my husband, Tyrone, my four amazing children, Rowan, Zachary, Teigan and Tobias as well as my family and friends whose support, love and prayers have made this dream a reality. Tyrone, your grace, partnership, sacrifice of time and taking on duties in our family and home during the crunch times made me feel loved and supported beyond measure and your prayers and encouragement were so needed and appreciated! Rowan, I am so grateful for your expertise and encouragement in making the recordings. Zachary, thank you for expressing so often your praise and support. Teigan and Tobias, thank you for your joy and your understanding. Mom, thank you for your constant prayers, your unwavering belief in me and for your faithful love. Mom Jones, thank you for your reassurance, support, prayers and wisdom throughout the process. To my family, friends and classmates in the program who have offered so much encouragement, practical help with life duties, prayers and confidence without which I would not have been able to persevere. I am deeply indebted.

Lastly, I dedicate this to those seeking mental health wellness. Those I have had the privilege to work with have inspired me with their resilience, vulnerability and courage. You have made this work a joy and I have grown tremendously because of you. I pray to give back

by helping to provide some of the tools needed for true healing and deep connection to the God, the Comforter and Counselor who has the Power to make whole what the world has broken.

## Acknowledgments

A project like this does not happen without the dedication of others. I would first like to acknowledge the mentorship and guidance of my dissertation Chair, Dr. Fernando Garzon. You were my first professor in the program and your encouragement set the stage for me to believe this could be done after being out of school for 20 years! When you offered to advise and mentor me, I truly knew God had shown favor to me. Your prayers, wisdom, enthusiasm, reassurance, commitment and example have called me higher these past few years and I am forever changed and enriched spiritually, personally, professionally and educationally. Your academic wisdom, your capacity to always look to what is ahead and your ability to connect me to resources that could advance my thought process have been invaluable. I am grateful for your motivation to strive for excellence in character, in faith and in research for this study and beyond. I look forward to many more projects together as we strive to make accessible the healing power of Christ to those who are hurting.

I would also like to acknowledge my dissertation reader, Dr. Kristy Ford, whose enthusiasm, academic excellence and insights have been instrumental in the completion of this study. I am so honored to have built a relationship with you through this process and your work before me helped lay the foundation for this study. Thank you for your constant encouragement, your faith and passion for this work. It has inspired me to seek to reach higher and I am immensely grateful. I look forward to continued collaboration.

Lastly, I would like to acknowledge the research and development that has been done to bring Christian mindfulness and meditation to the foreground. The hard work, attention to sound exploration, thorough and accurate investigation and careful development of interventions, meditations and exercises by those who have gone before makes this study possible.

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### **List of Abbreviations**

Acceptance and Commitment Therapy (ACT)

American Counseling Association (ACA)

Brief Experiential Avoidance Questionnaire (BEAQ)

Brief Religious Coping Scale (Brief RCOPE)

Christian Accommodative Mindfulness (CAM)

Depression Anxiety Stress Scale (DASS)

Diagnostic and Statistical Manual of Mental Disorders (DSM)

Dialectical Behavioral Therapy (DBT)

Mindfulness-Based Cognitive Therapy (MBCT)

Mindfulness-Based Intervention (MBI)

Mindfulness-Based Stress Reduction (MBSR)

Percentage of Data Exceeding the Median (PEM)

Percentage of Nonoverlapping Data (PND)

## **CHAPTER ONE: INTRODUCTION**

### **Overview**

This chapter will offer a basic understanding of the topics of shame and mindfulness as well as the unique cultural perspective needed in working with clients who are of a Christian worldview. It will explain the need for research in the area of Christian accommodative mindfulness (CAM) and will identify the problem that will be addressed by the current research as well as the purpose and significance of this study. Research questions will be clarified and terms pertinent to the study will be defined.

### **Background**

The field of psychology has increasingly embraced the need for multicultural understandings and approaches in the clinical treatment of various mental health conditions and it has been noted that ethical counselors have an obligation to explore a client's spirituality as part of treatment (Pargament & Zinnbauer, 2000). The American Counseling Association (ACA; 2014) ethical guidelines dictate that culturally sensitive counselors respect the culture of any religion and avoid discrimination based on such; however, Tan (1994) has cautioned that clinicians need to be appropriately trained and able to balance both the psychological and religious goals of clients without arguing over doctrinal issues, imposing the therapist's own beliefs, misusing spiritual resources or offering only spiritual solutions for psychological problems that also require medication or other psychotherapeutic interventions. It has been noted that more and more clients are seeking a spiritual component to their counseling treatment and positive mental health outcomes such as decreased depression and anxiety and increased confidence or sense of worth or well-being are correlated with having spiritual or religious belief systems (Morrison, Clutter, Pritchett, & Demmitt, 2009). However, finding therapeutic

interventions that incorporate a Christian worldview with evidence-based practices has been a challenge for therapists seeking to meet this cultural sensitivity (Morrison et al., 2009).

Therefore, expanding holistic evidence-based therapeutic options for therapists to use with Christian clients is an important gap that needs to be filled.

### **Shame**

When contemplating the therapeutic strategies to employ in the treatment of Christian clients, it is critical to understand a core issue that often leads to the need for clinical care which is the manifestation of shame in its many forms. Carl Jung the renowned Swiss psychiatrist and founder of analytical psychology, who also believed that religion and spirituality were essential constructs of the psyche that needed to be considered within the context of therapy (James, 1985), called shame the “swampland of the soul” and a “soul-eating emotion.” Shame can be a significant barrier to successful treatment outcomes as it can restrict a client’s vulnerability and therefore, ability to share negative or distressing information for fear of criticism, rejection or out of a sense of self-blame (Watson, 2011). Developing treatments for the symptoms of shame that are culturally sensitive to the needs of clients who adhere to a Christian worldview is important to meeting the needs of this specific cultural group.

### **Mindfulness**

A treatment that has received attention for its ability to effectively manage symptoms in a transdiagnostic manner is the practice of mindfulness (Sauer-Zavala et al., 2017). It has been successfully utilized in the treatment of anxiety and depressive disorders (Hofmann, Sawyer, Witt, & Oh, 2010) which can be associated with the experience of shame. Although mindfulness is often considered to be of a Buddhist origin, it is also an important part of the Christian tradition. The words mindful, meditate and meditation themselves are used 42 times in the New



King James Version of the Bible and additionally the concepts of mindfulness are found many more times in the Bible. Consequently, many Christians who seek treatment for psychological symptoms may greatly benefit from the use of mindfulness practices that specifically embrace the Christian worldview.

### **Christian Integration in Counseling**

In recent years, literature regarding the integration of Christianity and psychological services has increased, and therapists working with Christian clients have sought more culturally sensitive ways of treating these clients. As with people from other cultural backgrounds, Christians have been noted to sometimes be reluctant to seek psychological services for fear of it contradicting their cultural belief system; therefore, clients who are seeking specifically Christian counseling are best served by a clinician who shares their basic spiritual beliefs, though the therapist and client may differ on doctrinal specifics (Tan, 2003). This can increase the safety and acceptance needed for a therapeutic relationship to be effective and promote change in the client's presenting issues.

To a Christian, it may be imperative that the counselor is able to facilitate the "spiritual growth of clients, and not just the alleviation of symptoms and resolution of problems" (Tan, 2003, p. 15). Therefore, utilizing interventions that are specifically Christian and psychologically endorsed can be a way to meet the presenting needs of the client in a holistically healing manner. As with all treatments, it is helpful if empirically supported interventions are made available and proper training of the clinician as to the administration is accessible. It is also important that any intervention utilizing spiritual components, such as prayer or scripture, has been explained to the client and agreement has been achieved as to which interventions are appropriate (Tan, 2003). The exploration of existing recognized treatments that can be readily

adapted to include culturally sensitive components specific to Christians can build upon the current foundation of these interventions in ways that meet the needs of the Christian population. Research regarding the efficacy of these accommodations as well as the creation of accessible therapeutic protocols can increase the utilization and effectiveness of therapy within the Christian culture.

### **Problem Statement**

According to the Pew Research Center (2015a), as of the year 2010, Christians comprise about one third of the world population and 70.6% of those living in the United States identify themselves as either Christian or Catholic (Pew Research Center, 2015b). In a climate in the field of psychology in which multicultural perspectives are the ethical standard of practice (ACA, 2014), it is important for clinicians to be adequately equipped to meet the specific needs of this cultural group. It has been noted that therapy outcomes are positively impacted by the recognition of a client's spiritual struggles and an ability to allow for the exploration of these in the therapy context (Harris, Pargament, Sisemore, & Brown, 2014).

While the topics of shame and its many resultant psychological symptoms are becoming more fully understood (Hoffman et al., 2010) as is the effectiveness of mindfulness treatments in transdiagnostic settings (Sauer-Zavala et al., 2017), mindfulness integrated with a Christian worldview has not been studied adequately and specifically CAM protocols have not been researched to determine effectiveness with Christian clinical populations. Furthermore, the use of accommodative mindfulness interventions to treat the symptoms of shame found in the Christian population have not been studied. The effects of shame on a specifically Christian population are less understood by the current research and the manifestation of shame may be the cause of psychological and spiritual distress symptoms in a client population whose worldview is

largely impacted by the concept of relationship with God as the solution to shame as the Bible states in 1 Peter 2:6b “the one who trusts in Him will not be put to shame” (New International Version). The problem is that there are Christians whose cultural perspective has not been fully met by current mindfulness practices researched to date and therefore, the destructive results of shame have not been adequately overcome by the utilization of the current mindfulness techniques in Christians who suffer from psychological disorders.

### **Purpose Statement**

The purpose of this current study is to address the gap in the current research regarding the use of mindfulness to treat psychological symptoms that are often the result of shame in Christian clients. Using a set of CAM modules as an independent variable, the dependent variables of shame, depression, anxiety and resiliency will be measured to determine the effect of a mindfulness intervention adjusted to meet the cultural needs of the Christian clinical population.

### **Significance of the Study**

Because mindfulness has demonstrated efficacy in the treatment of many psychological disturbances (Alsubaie et al., 2017; Burg & Michalak, 2011; Hjeltnes, Binder, Moltu, & Dundas, 2015; Hofmann et al., 2010) and in reducing shame (Goldsmith et al., 2014), the investigation as to its capacity for accommodation to the cultural sensitivities of the Christian worldview has potential to be an important multicultural contribution to the field of clinical psychology and has potential to advance the sphere of the clinical practice of Christian psychotherapy. This study aims to demonstrate CAM with a clinical population in ways that can be replicated by future clinicians or researchers. It proports to begin building the foundation for a body of research in

the real-world setting designed to develop clinical mindfulness interventions specific to the needs of Christian clients.

### **Research Questions**

Research questions (RQ) that emerge from this are as follows:

**RQ1:** Does the use of Christian Accommodative Mindfulness (CAM) correlate with the decrease of negative experience of shame in Christian clients diagnosed with depression or anxiety?

**RQ2:** Does the use CAM correlate with the increase of resiliency in Christian clients diagnosed with depression or anxiety?

**RQ3:** Does a decrease in depressive symptoms in Christian clients diagnosed with depressive disorders correlate with the use of CAM?

**RQ4:** Does a decrease in anxiety symptoms in Christian clients diagnosed with anxiety disorders correlate with the use of CAM?

### **Definitions**

The following definitions will be used in this study:

1. *Christian Accommodative Mindfulness (CAM)*- CAM is the adaptation of mindfulness techniques to the cultural considerations of the Christian population (Garzon & Ford, 2016).
2. *Grace*- Grace is the demonstration of kindness, acceptance, mercy or generosity when such provisions are not warranted and wherein the recipient is neither worthy nor perhaps even capable of returning the gesture (Bufford, Sisemore, & Blackburn, 2017).
3. *Meditation*- Meditation is the practice of adopting of a nonjudgmental observation of mental phenomena or meta-awareness of sensations, thoughts, images and feelings which

are allowed to enter and pass through awareness without in-depth analysis (Davidson & Kaszniak, 2015).

4. *Mindfulness*- Mindfulness is the purposeful, non-judgmental focus on a present-moment mind-body connection that develops increased awareness and acceptance (Cardaciotto, Herbert, Forman, Moitra, & Farrow, 2008; Kabat-Zinn, 2011).
5. *Resiliency*- Resiliency is a person's ability to successfully adapt to negative life experiences and to potentially be positively transformed by these events (Nguyen, Bellehumeur, & Malette, 2015; Prestia, 2016).
6. *Shame*- Shame is a predominantly destructive moral emotion that leads to negative states of being producing the experience of the self as bad or worthless and is found at the root of many psychological disturbances (Pattison, 2000; Van Vliet, 2008).
7. *Transdiagnostic*- Approaches that address the underlying psychological processes that are common regardless of Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnoses are considered transdiagnostic (Sauer-Zavala et al., 2017).

## **CHAPTER TWO: LITERATURE REVIEW**

### **Overview**

This chapter will review the current literature related to the use of mindfulness as a psychotherapeutic intervention that has the potential to be effectively adapted to be culturally sensitive to the belief systems of Christian clinical populations as well as the need for clinical interventions that focus on the treatment of shame. Shame is a destructive moral emotion that is the product of psychological, spiritual or interpersonal injury (Pattison, 2000), and it is persistently found in the clinical presentation of many mental illnesses (Van Vliet, 2008) as well as internal spiritual conflicts. An intervention found to effectively alleviate the negative indications of shame, especially within the Christian culture where shame is a foundational topic, has significant therapeutic potential to improve functioning in many if not all domains of the lives of Christian clients. This chapter will provide a rationale for the necessity of the current transdiagnostic study due to a lack of studies within clinical populations related to the use of mindfulness techniques that have been enhanced to meet the unique cultural considerations of Christians seeking professional counseling services. It will provide an overview of the conceptual framework for the study, as well as the current literature regarding shame, mindfulness, the emergence of transdiagnostic treatments, resiliency factors such as grace and acceptance, the implication for Christian integration as well as future thoughts for consideration.

### **Conceptual Framework**

Psychology and spirituality, although separated in the healing professions by a difference of focus on either science or God, are not separated in the individual who is experiencing the inner emotional world, life and the environment as a holistic occurrence. Considering about 40% of people seeking help for emotional concerns are doing so from a spiritual leader and this

person subsequently either offers assistance or refers to mental health professionals while the rest seeking help do so from the professional psychological community (McMinn, Ruiz, Marx, Wright, & Gilbert, 2006), it is imperative for both spiritual and psychological caregivers to gain the skills necessary to address the most damaging and most common emotional health crises in ways that address these needs from an integrated faith and scientific perspective. For those within the Christian community, a lack of integration of faith and psychology has the potential to be prohibitive as it can create a sense of mistrust for providers who are unaware of the cultural needs related to obtaining treatment that is sensitive to the specific belief systems inherent in this population.

The literature describes shame as a self-conscious or moral emotion (Black, Curran, & Dyer, 2013; Czub, 2013; Garfinkle, 2012; Schalkwijk, Stams, Dekker, Peen, & Elison, 2016; Silfver, Helkama, Lönnqvist, & Verkasalo, 2008; Tangney, Stuewig, & Mashek, 2007). A moral emotion is a higher-level emotion that is experienced by beings who have a capacity to exhibit self-reflection and self-evaluation and shame has been defined by researchers and practitioners as arguably the most damaging moral emotion experienced by people (Pattison, 2000); therefore, it is imperative that those in the healing professions, whether it be psychological or spiritual, understand the factors that are associated with it and build competency in treating it. Shame creates a psychological and spiritual situation wherein a person is left feeling defective, flawed and undeserving of love and connection; resulting in a sense of needing to hide their authentic self from others and even from God. The experience of this immensely destructive emotion has been linked to many mental illnesses, interpersonal dysfunctions, spiritual crises and social issues. Consequently, shame is a source of psychological and spiritual injury that is in critical need of a remedy.

In the absence of adequate resiliency resources, negative situations often lead to shame and to people eventually requiring therapeutic services for depression and anxiety disorders that may emerge as a result. Furthermore, clients whose spiritual beliefs are ignored in the therapy context demonstrate a restricted therapeutic relationship and therefore, a limited ability to utilize the corrective techniques being offered. Since mindfulness has been shown to be effective at reducing the symptoms of depression and anxiety, participants report both gratification and sustained use from learning the techniques and it promotes a nonjudgmental awareness of the self and others. Creating meaningful connection, mindfulness may foster growth and healing from harmful shame experiences and the use of mindfulness-based treatments that have been adapted to incorporate the Christian cultural perspective may further promote the capacity for resiliency from this destructive sense of the self in Christian clients. Recent research by Knabb and colleagues (2019) demonstrated that Christian meditation was correlated with a significant decrease in perseverative thinking, a known component in anxiety and depressive disorders as well as a predictor of such, with a large effect size compared to a wait-list group which demonstrated no significant change. It also showed an increase in surrender, which is a resiliency factor, with a medium effect size compared to the wait-list group which increased only slightly and it showed a decrease in anxiety as compared to the wait-list group which demonstrated an increase in anxiety (Knabb et al., 2019). This study used a non-clinical group and supported the proposal of a manualized version of Christian meditations that could be used for the prevention of ruminations and therefore, ultimately, mental health disorders (Knabb et al., 2019). Additionally, research by Ford and Garzon (2017) found that CAM skills showed a greater reduction in reports of stress-related symptoms as well as psychological distress symptoms than did regular mindfulness skills when taught to students at a Christian college.



This study also showed that the group utilizing the Christian mindfulness training demonstrated greater adherence to the treatment (Ford & Garzon, 2017), which indicates that therapeutic mindfulness interventions, when adapted to the preferences of the Christian cultural group, may result in better treatment outcomes. Research is needed to determine the efficacy of CAM and meditations for treating the shame symptoms experienced by Christians who meet the clinical criteria for the diagnoses of depressive and anxiety disorders.

### **Related Literature**

#### **Shame**

To understand the experience of shame requires first gaining a clear definition of shame and clearly differentiating it from guilt. Along with elevation, embarrassment, pride and gratitude, both guilt and shame are considered to be moral or self-conscious emotions and as such are believed to create a link between moral standards, moral decisions and moral behaviors (Tangney et al., 2007). By definition, moral emotions are the result of self-reflection, self-evaluation or perceived evaluation by others (Tangney et al., 2007; Woods & Proeve, 2014) that is implicit or explicit as well as either conscious or outside the realm of awareness. Because shame and guilt are among the emotions used to determine whether behavior is reinforced or adjusted, and whether a person consequently is accepted or rejected on a social and moral level (Tangney et al., 2007), it is important to define and discriminate between them. Though not intuitively simple to differentiate due to the common social uses of these concepts as well as language limitations in the articulation of shame (Pattison, 2000), one must recognize these two emotions have been found to be distinct constructs (Silfver et al., 2008; Tangney et al., 2007; Teroni & Deonna, 2008; Woods & Proeve, 2014). Indeed, researchers have measured this by the dissimilarities found on the scores of the Test of Self-Conscious Affect-Shame and Test of Self-

Conscious Affect-Guilt measures among the same participants (Silfver et al., 2008; Teroni & Deonna, 2008). Guilt and shame are experienced and displayed differently in people and therefore have unique consequences. Often shame is produced as the effect of an action for which one experiences guilt (Pattison, 2000) and can be experienced simultaneously as is described in Job 10:15 where Job states in response to his suffering and the accompanying public scorn he experienced, “If I am guilty—woe to me! Even if I am innocent, I cannot lift my head, for I am full of shame and drowned in my affliction” (New International Version). As an example of this concurrent experience of shame and guilt, a person may experience guilt because they have been insensitive or verbally cruel to another and may also feel shame because of how they perceive others to view them for having done this. The guilt of this interaction has the possibility of being remedied by way of an apology or public acknowledgement of positive attributes of the other person; however, the shame that is experienced may linger for a lifetime as a sense of being a defective individual incapable of positive interaction who is unworthy of the company of others.

Unlike guilt, which can serve as a useful tool for change, shame has few redeeming qualities. Whereas guilt is understood to be the experience of feeling badly when one has done something bad, shame is the experience of self as bad or worthless; it is an attack on the very essence of the self (Pattison, 2000; Van Vliet, 2008). Though it has been noted to have adaptive qualities in that it can motivate socially desirable behaviors and result in suppressing the less desirable ones (Pattison, 2000; Van Vliet, 2008), shame is a form of social control based on fear of alienation rather than a desire to perform in ways that are perceived to be moral, good or right. The root for shame comes from the Indo-European word, *skam* or *skem* meaning “to hide” and it affects all levels of human experience from internal to interpersonal (Garfinkle, 2012; Pattison,

2000; Van Vliet, 2008) to spiritual. It causes people to hide the parts of themselves that are perceived to be socially or spiritually undesirable rather than to seek help for these very characteristics. Consequently, shame has been linked to mental health disorders whereas guilt has not (Van Vliet, 2008).

There are three identified components of shame: the precipitating event, the affect and the action (Garfinkle, 2012). A person experiences an event which produces an emotion that leads to attitudes and behaviors toward the self or others. Shame is a complex emotion in that it can have an external etiology, such as abuse, trauma, exploitation and environmental circumstances or an internal one such as body image or personal failures or it can be the combination of these factors that lead to shame (Garfinkle, 2012; Pattison, 2000; Van Vliet, 2008). In general terms, states of shame have been found to be related to body, relationships or competence areas (Pattison, 2000) and accordingly, a person experiences an external or internal event that is interpreted to be a negative judgement of the self, which in turn leads to either avoidant, self-attacking, withdrawal or other-attacking behaviors (Nathanson, 1992) as a means of escaping the unbearable emotion. Whereas guilt has mechanisms for change such as confession, repentance and atonement (Pattison, 2000), shame attacks a person's measure of self-worth producing a negative self-assessment. It produces self-criticism and a sense of being devalued by others (Castilho, Pinto-Gouveia, & Duarte, 2017; Sznycer et al., 2012; Van Vliet, 2008). Unlike guilt, which is associated with an event or a specific behavior, shame is an evaluation of the person as a whole (Teroni & Deonna, 2008; Wetterneck, Singh, & Hart, 2014; Van Vliet, 2008) and this totality therefore, becomes inescapable, permeating most if not all areas of a person's life. Guilt encourages a person to correct a behavior whereas shame encourages a person to hide, cover up or withdraw to escape the excruciating feelings of non-rectifiable worthlessness.

A significant element of the experience of shame is the desire to “hide” the vulnerability created by it. This “hiding” can be evident in a variety of manifestations. Shame can be demonstrated in how people think, avoidant behaviors, assumptions of the thoughts of others, grandiosity, fear, shyness, as well as viewing the self with disgrace, scorn or contempt and as weak, defective or worth less than others (Garfinkle, 2012; Pattison, 2000; Van Vliet, 2008). The thoughts and behaviors that emanate from a place of shame are an attempt to alleviate this powerful emotion by covering it with a more tolerable, albeit unhealthy, one. Therefore, feelings of shame are often interpreted as guilt because guilt implies responsibility and consequently, the hope of remedy. Both spiritual and psychological leaders have often confused these two emotions and even after a person has corrected the undesirable behaviors, there has been confusion as to why there is still a sense of disconnection, isolation and a lack of willingness to engage with others because the shame was left unaddressed.

As a feedback system for the moral standard of a person’s thoughts and behaviors any one of the four commonly recognized moral emotions, shame, guilt, embarrassment and pride (Tangney et al., 2007) can be further strengthened by each experience of the emotion. Over time, a person grows to anticipate whether a particular behavior or event will produce one of these emotions even before it has been experienced. Therefore, these moral emotions can be experienced either in anticipation of an event or as a consequence of it (Tangney et al., 2007). Of the four moral emotions, shame is the most painful and potentially damaging because it is the only one in which the core self is at risk of being condemned or deemed unworthy rather than the behavior committed or experienced.

The experience of shame is often sought to be averted as it is an acutely distressing circumstance (Schoenleber & Berenbaum, 2010) and experiential avoidance is employed

because it is the attempted circumvention of the negative effects of a disturbing emotional state or experience (Woods & Proeve, 2014). Although these strategies are an effort to decrease the intensity or frequency of emotional states such as shame, they are maladaptive and can inadvertently lead to the maintenance of shame as well as psychological disorders (Hofmann et al., 2010) such as depression or anxiety rather than the alleviation of these. While the evasion of feared stimuli by the use of experiential avoidance has been found to impede the healing process of some therapeutic strategies, mindfulness may be a useful approach that leads to more distress tolerance and acceptance skills (Frye & Spates, 2012) which in turn may increase the effectiveness of other therapeutic strategies.

### **Mindfulness**

Mindfulness is a term used by many disciplines, traditions, groups and even popular culture, each of which has its own theoretical, conceptual and practical use of the word; therefore, it is important to understand the elements that constitute a mindfulness-based intervention (MBI) in a therapy context. In an analysis of 33 definitions used for mindfulness in various peer-reviewed articles, five core elements of mindfulness have been identified including attention and awareness, external events, present-centeredness, cultivation and ethical mindedness (Nilsson & Kazemi, 2016). The first four of these are commonly discussed elements of mindfulness practices; however, the final one, ethical mindedness, is an important addition to these. Attention and awareness describe the process of focusing on a specific word, state or object, such as the breath. Mindfulness encourages one to withdraw from external events such as physical, emotional, social, environmental or cognitive experiences and to become an observer of these phenomena rather than a participant and in this way to remain attentive to the present moment (Nilsson & Kazemi, 2016). Present centeredness is a way of being in the moment

without judgment often utilizing the senses to experience this. Cultivation of mindfulness skills requires practice and daily use of the exercises is often expected of participants with the expectation that it takes time to build the skills and reap the full rewards of mindfulness. Cultivation refers to the development of compassion, empathy, self-compassion and self-acceptance through the consistent practice of meditations and exercises that promote loving-kindness toward self and others (Nilsson & Kazemi, 2016). The resultant lifestyle of cultivating a persistently deeper mind-body connection within the person also promotes a social awareness, acceptance and ability to demonstrate a moral responsibility in interactions with others leading to the ethical-mindedness component of mindfulness (Nilsson & Kazemi, 2016). These five elements have been found to overlap one another as intertwined factors present in the definition of mindfulness (Nilsson & Kazemi, 2016).

Mindfulness, known as the “heart of the Buddhist meditation” therefore, is the mind-body connection, a way of seeing and being rather than a technique, and is the ability to purposefully and non-judgmentally focus one’s attention and energy on both the internal and the external experience of the present moment (Cardaciotto et al., 2008; Kabat-Zinn, 2011), in a sense, a way to provide fertile ground for grace and is in itself an expression of grace. It was brought into the mainstream American culture by Jon Kabat-Zinn, founder of the Stress Reduction Clinic of the University of Massachusetts Medical School and of mindfulness-based stress reduction (MBSR) as well as the Center for Mindfulness (Kabat-Zinn, 2011). The work of this clinic and the research coming from it helped to merge mindfulness with medical healing. According to Kabat-Zinn, mindfulness is not about curing a disorder or illness but rather about healing, which he defines as “a coming to terms with things as they are in full awareness” (Kabat-Zinn, 2011, p. 292).

Two main constructs of mindfulness are awareness and acceptance (Cardaciotto et al., 2008; Kabat-Zinn, 2013). Awareness can be understood as the behavioral component of mindfulness in that it describes the purposeful focus on the present moment through the use of attention to breathing and bodily sensations; whereas, acceptance can be seen as the nonjudgmental, non-avoidant attitude without experiencing a need to evaluate or change, generated from mindfulness (Cardaciotto et al., 2008; Hayes, 1994). Awareness and acceptance work together but are separate constructs.

Increasing awareness in and of itself can be either a health-promoting or a damaging experience depending upon the context in which it is done. One should be cautioned about increasing overall awareness without increasing acceptance as the increased focus on negative experiences or the increased awareness to avoid them can lead to an increase in negative emotions such as anger, shame, hostility, embarrassment, depressive thoughts and rumination to name a few (Cardaciotto et al., 2008). Increased awareness in mindfulness is coupled with acceptance to promote a non-judgmental attitude toward the increased awareness. It is important in mindfulness to practice both constructs and to allow them to work together. Cardaciotto and colleagues (2008) conclude that measuring these components separately is key to understanding the effectiveness of mindfulness-based treatments.

Improvement in mindfulness skills can help a person to be more receptive to specific cognitive restructuring techniques and to cognitive changes through the use of awareness rather than evaluation (Baer, 2003; Hathaway & Tan, 2009; Linehan, 1993; Teasdale, Segal, & Williams, 1995). For instance, in a physical sense, focusing attention on to one's breathing without making an effort to change it, can produce more rhythmic and calm breathing just by awareness alone. Because in mindfulness, thoughts and experiences are seen as being temporary

and static rather than permanent and constant, this awareness allows the person to be less controlled by a particular thought or experience. Observation is an important aspect of mindfulness (Baer, 2003; Hayes, 2004) and practice of observing the self without judgment produces a deeper awareness and acceptance of the self, others and the environment.

A related construct, self-compassion, is also correlated with psychological wellbeing. Although when total scores were used, Baer et al. found that self-compassion was a stronger predictor, mindfulness was also found to be a significant predictor of psychological wellbeing and a possible mediator for the relationship between meditation and psychological wellbeing (Baer, Lykins, & Peters, 2012). In a similar finding, Woods and Proeve (2014) reported that lower self-compassion was also a stronger predictor of mental health conditions such as depression, anxiety and the relapse of depression than was mindfulness. However, when subscales were used, specific elements of both components were found to be equally significant in the prediction of psychological wellbeing utilizing the practice of meditation (Baer et al., 2012). It is important to note that mindfulness is a subscale of the self-compassion scale, so although self-compassion was a separate predictor in these studies, it should be acknowledged that mindfulness was found to be a significant predictor when measured alone as well as was a part of the self-compassion significance.

Mindfulness, or even aspects of it, can be used in conjunction with many other therapy techniques or frameworks. For instance, a key component of mindfulness is the building of a person's capacity to decenter thoughts and feelings that are brought into awareness. By becoming an observer of one's own psychological events, a detachment from the power of the affect creates psychological space for a person to evaluate desired reactions and potentially create new thought patterns. This distancing from unhelpful thoughts and creating of new thought



pathways has been noted by Knabb's review of mindfulness-based cognitive therapy (MBCT) to have been found to significantly reduce the relapse rate of people who have experienced three or more episodes of depression (Knabb, 2012). Several therapeutic approaches utilize this aspect of mindfulness in an attempt to achieve clinically beneficial outcomes, such as dialectical behavioral therapy (DBT), MBCT, MBSR and acceptance and commitment therapy (ACT) to name a few (Dimidjian & Segal, 2015; Trammel, 2018). ACT specifically uses mindfulness techniques that promote the defusion or separation of self from these thoughts as a means of decreasing the problematic symptoms (Hayes, 2004).

Moreover, mindfulness-based therapies have been found to be effective for multiple disorders and conditions and the positive effects have been found to be maintained post-treatment as well (Baer, 2003; Hofmann et al., 2010), making these interventions worthy of further consideration. In her review of studies, Baer found that many people reported mindfulness-based treatments to have satisfactory results and lasting value as the positive results were maintained and the techniques continued to be used even after treatment (Baer, 2003). Baer found a mean rate of participants completing programs of 85% in her analysis of mindfulness-based practices and that those with stress-related disorders were more likely to complete the exercises than those with pain-related disorders (Baer, 2003). Furthermore, she found that a majority of participants continued to use the practices post treatment and that there was an effect size that ranged from medium to large for this (Baer, 2003). It is possible that mindfulness may be useful for the treatment of medical and psychological conditions in general and that these conditions could be impacted in long-term ways.

Although some mindfulness protocols were originally intended to be used in group settings, components can be applied to individual therapy as well (Hathaway & Tan, 2009). It is

especially suited for third-wave cognitive therapies as it encourages an ability to focus on the present moment without judgment and promotes acceptance, making the other aspects of these therapies useful. Mindfulness exercises utilize a focus on bodily sensations and breathing, which are always readily available, to help a person center into the here and now. Through this, distance is then created between the negative emotions, such as anxiety and depression, and the person (Hathaway & Tan, 2009; Hayes, 2004; Hayes, Strosahl, & Wilson, 1999). It is an important component of therapies such as ACT and DBT as well as relapse prevention (Baer, 2003; Hayes, 2004; Linehan, 1994). Overall, these therapies have demonstrated efficacy; however, in her review, Baer found that no research of ACT, DBT or relapse prevention had thus far isolated the effect of the mindfulness component alone separate from the behavioral strategies also utilized in these therapies (Baer, 2003). Therefore, it is difficult to determine the sole efficacy of mindfulness based on these therapies.

Understanding the mechanisms of change for approaches utilizing mindfulness based techniques has been problematic as several factors have been noted to be possibly involved, such as neuroscience mechanisms, psychological mechanisms or physical mechanisms depending upon the focus of the study (Alsubaie et al., 2017). Furthermore, more research to understand the methods most useful for specific populations as well as the effectiveness of MBIs adapted for specific populations has been identified as a need (Alsubaie et al., 2017). Baer (2003) did find support for mindfulness in the efficacy found in the use of MBSR and MBCT, two practices whose main components are mindfulness. Furthermore, a recent metaanalysis indicates that mindfulness is a potential mediator of change in MBCT and MBSR for participants presenting with depression, anxiety or stress and that overall changes in mindfulness skills can be linked to improved outcomes (Alsubaie et al., 2017).

**Mindfulness and shame.** Mindfulness has the potential to specifically increase resiliency toward shame-related symptoms as it decreases the impact of shame on psychological wellbeing. The experience of negative mind states such as shame, fear, frustration and racing thoughts are diminished with the increased nonjudgmental awareness of the present moment and focus on breathing and bodily sensations exercised in mindfulness (Hjeltnes et al., 2015). Some aspects of mindfulness, such as attention to the present moment and a nonjudging and accepting attitude, are negatively correlated with components of shame such as its focus on the self and negative self-evaluation (Woods & Proeve, 2014). Of the trauma related appraisals measured by Goldsmith et al. (2014) only shame was found to exhibit changes with MBSR strategies. This suggests that MBSR can be used to decrease both depression and shame in clients who are diagnosed with Posttraumatic Stress Disorder (PTSD) or depression (Goldsmith et al., 2014).

Furthermore, performance anxiety, which reportedly produces self-criticism and isolation from others, also hallmarks of the self-conscious emotion of shame, has been noted to decrease with the learning of mindfulness as participants were found to connect to one another and alleviation of these negative emotional states were experienced (Hjeltnes et al., 2015). Talking to others about these experiences was found to decrease the shame associated with evaluation anxiety and promoted a sense of normalcy rather than defectiveness and therefore the ability to prevail was highlighted (Hjeltnes et al., 2015). Furthermore, practicing mindfulness can lead to a sense of accomplishment as the work of mindfulness can be difficult and require a great deal of time and effort. Generally, it is expected that mindfulness is to be practiced daily and the intention is for it to become a lifelong exercise rather than a temporary intervention. By promoting a persistent sense of acceptance for things as they are and removing a sense of “good”

or “bad” from the experience of difficult life events or emotions, mindfulness removes the shame associated with them.

An overlap between mindfulness and self-compassion has been demonstrated and may also relate to the experience of reducing shame experiences. Self-compassion was found to be a stronger predictor of shame proneness than was mindfulness; however, increased use of meditation practices was also associated with decreased shame (Woods & Proeve, 2014). Therefore, it may be possible that meditation interventions focused on increasing self-compassion could effectively decrease shame proneness. Research that isolates this factor would be beneficial in evaluating this. Mindfulness techniques such as loving-kindness meditation, compassion focused therapy and mindful self-compassion that increase self-compassion may be found to in turn decrease the experience of shame (Woods & Proeve, 2014). Woods and Proeve (2014) found that for those who meditate at all, mindfulness decreased proneness to shame when participants meditated at least once per month but did not change shame proneness in those who had not ever meditated. This suggests that both no awareness and increased awareness of acceptance and nonjudgment of oneself can assist in decreasing shame but that some awareness does not. Increasing mindfulness initially makes one more aware of shame but with persistent practice of mindfulness skills, a decrease becomes apparent in the experience of shame as the person begins to view themselves with acceptance and without judgment.

**Mindfulness and meditation.** Although there are many forms of meditation, such as yoga, mantras, tai chi and chi gong (Tang, Hölzel, & Posner, 2015), as well as scriptural (Garzon, 2013), and both traditional and contemporary meditations classified as attentional, constructive and deconstructive (Dahl, Lutz, & Davidson, 2015), it has been noted that meditation is a part of most cultures and religions worldwide (Tang et al., 2015). Meditation

practices differ among traditions and even within traditions, but most involve adopting a nonjudgmental observation of mental phenomena or meta-awareness of sensations, thoughts, images and feelings which are allowed to enter and pass through awareness without in-depth analysis (Davidson & Kaszniak, 2015). Research in recent years has found meditation to be useful in the treatment of medical disorders such as renal failure (Vareesangthip et al., 2017), personality disorders such as borderline personality disorder (Feliu-Soler et al., 2017) and mental health conditions such as depression and anxiety (Garzon, 2013; Hofmann et al., 2010) and it is often a component of mindfulness techniques.

Currently, mindfulness meditations are utilized in many therapeutic approaches. Jon Kabat-Zinn started the work to create MBSR which was later expanded on by others to develop MBCT, both of which utilize mindful meditation as a core intervention (Dimidjian & Segal, 2015). ACT and DBT also incorporate components of mindfulness and meditation practices to decrease unhelpful thought patterns (Dimidjian & Segal, 2015; Trammel, 2018).

Mindful meditation, which Tang et al. (2015) have noted is currently defined as “non-judgmental attention to experiences in the present moment” (p. 214) has been used in each of the above-mentioned treatments and is considered to be part of the Buddhist traditions embraced by mindfulness (Kabat-Zinn, 2011); however, it is also discussed in Christian literature. The Bible guides believers to meditate as well as illustrates its rewards in Joshua 1:8 where it states, “Keep this Book of the Law always on your lips; meditate on it day and night, so that you may be careful to do everything written in it. Then you will be prosperous and successful” (New International Version). In Psalm 77:12, the Psalmist gives an example to followers when he states “I will consider all your works and meditate on all your mighty deeds” and Psalm 119:99 explains that meditation promotes greater understanding in that it states, “I have more insight

than all my teachers, for I meditate on your statutes” (New International Version).

Contemplative meditation traditions are common within the Christian culture and are an important element of mindfulness practices. These contemplative practices have been found to increase awareness which in turn positively affects perceptions and learning abilities (Davidson & Kaszniak, 2015).

**Mindfulness and depression.** Use of mindfulness is correlated with a decrease in depressive symptoms and repetitive negative thinking (Burg & Michalak, 2011). Because rumination on negative thoughts has been associated with persistent depressive symptoms, mindfulness can decrease these harmful symptoms by encouraging a disruption in this unhelpful cogitation by focusing attention elsewhere (Alsubaie et al., 2017; Burg & Michalak, 2011; Hathaway & Tan, 2009). The practice of MBSR has been observed to decrease both depression and shame in participants from pre- to post treatment (Goldsmith et al., 2014). Furthermore, Baer (2003) found that depression, as measured on the Beck Depression Inventory, in some groups showed a decrease from the mild to moderate range pretreatment to the asymptomatic range posttreatment using mindfulness based therapeutic interventions. Additionally, mindfulness has been found to lead to early detection of relapse into depressive symptoms as it promotes awareness of cognitive and physical states of being and changes in these states are then more readily noticed (Alsubaie et al., 2017; Baer, 2003). Knabb (2012) notes that research indicates depression relapse is connected to mental pathways that are forged as a result of persistent and repeated negative thoughts that intensify depressed mood, lead to additional negative thoughts and increase the likelihood of relapse. As mindfulness aims to interrupt this well-worn pathway by centering the person on the present moment, it can create the psychological space needed for a new, healthier mental path to emerge. The acceptance and the

cultivation of a sense of curiosity rather than judgment about thoughts and feelings that is promoted by consistent mindfulness has been found to significantly decrease depressive symptoms as well as relapse (Alsubaie et al., 2017). Mindfulness decreases the rumination found in persistent depressive disorders as it helps to decenter a person's thoughts away from these ruminations by bringing awareness to the present moment and encouraging a nonjudgmental stance toward thoughts and feelings and the person learns to become an observer of these thoughts.

Mindfulness may also help to increase the benefit of other effective practices such as prolonged exposure treatment for PTSD and the teaching of emotional regulation skills (Frye & Spates, 2012; Myers, 2012). Several evidence-based practices readily incorporate the use of mindfulness into the treatment of depressive symptoms such as ACT, DBT and some cognitive based therapies (Hayes, 2004; Linehan, 1993). In their meta-analytic review, Hofmann et al. (2010) isolated the use of mindfulness-based therapies and excluded ACT and DBT because they also use behavioral strategies and found that mindfulness was effective for decreasing depression in adult clinical populations. Mindfulness was noted to decrease depression in people diagnosed with depressive disorders and less so the depressive symptoms of those diagnosed with anxiety disorders (Hofmann et al., 2010). Although mindfulness-based treatments were found to decrease depression and anxiety most in people diagnosed with depressive and anxiety disorders, it was also found to be effective in reducing levels in people of varying degrees of symptoms as well as those with co-occurring disorders or medical conditions (Hofmann et al., 2010). Mindfulness may change the way in which a person relates to the thoughts, feelings and experiences of these various conditions with its non-judgmental acceptance and acknowledgment

of the impermanence of them; thereby reducing the stress levels and the avoidance tendencies typically associated with their management.

**Mindfulness and anxiety.** Mindfulness has been found to help decenter the thoughts of clients with anxiety disorders away from creating feelings of anxiety and to instead observe these thoughts as a mere psychological event or phenomena to be viewed with curiosity. This detachment from the thoughts has been noted to result in a decreased report of the experience of anxiety symptoms (Alsubaie et al., 2017).

Although mindfulness requires repetition to learn and is initially potentially frustrating and difficult as it necessitates a change in a person's overall state of being and relating to the self, others and the environment, over time, with practice, it can grow to become a relief and a respite from the futile feelings of anxiety (Hjeltnes et al., 2015). It is a path to accepting that anxiety is a component of the life experience rather than the entirety of the experience. The nonjudgmental awareness coupled with acceptance that is fostered by mindfulness, has been found to decrease anxiety in clinical populations (Hofmann et al., 2010). In their meta-analytic review, Hofmann and colleagues (2010) found mindfulness was shown to decrease anxiety in clients who were diagnosed with anxiety disorders but did not reduce anxiety in those diagnosed with depressive disorders. However, a decrease in situation-specific anxiety, overall anxiety and worry as well as improvements in sleep patterns, ability to relax, sense of balance and well-being was reported with the use of mindfulness and meditation (Hjeltnes et al., 2015). Baer (2003) found that anxiety, as measured on the Beck Anxiety Inventory, in some groups showed a decrease from the moderate range pretreatment to the minimal to mild range posttreatment using mindfulness based therapeutic interventions. Furthermore, when college students who experienced test anxiety were taught MBSR skills, MBSR was found to help students experience



a sense of inner calm, move from fear to curiosity and maintain focus in learning situations (Hjeltnes et al., 2015).

Mindfulness also has been found to decrease the fear of being anxious, an experience often noted in clients with anxiety disorders, as it allows space for the anxious thoughts without having to battle with them. Awareness without judgement allows these thoughts to be neither negative nor positive, which in turn decreases their control over the person. In time, the recognition of building a concrete set of effective skills can produce a sense of empowerment over the distressful feelings of anxiety (Hjeltnes et al., 2015).

### **Transdiagnostic Treatment**

Although research has often analyzed the use of a single protocol with a single diagnosis, many researchers have noted that various diagnoses exhibit symptom presentations that have more commonalities than differences and that treatment of one disorder can produce positive changes in comorbid disorders as well (McEvoy, Nathan, & Norton, 2009; Titov et al., 2011). Targeting specific approaches that address this has the potential to aid in the advancement and broadening of the clinical uses of existing evidence-based treatments. In recent years, research has more frequently been utilizing the term “transdiagnostic” or “unified” to describe approaches that address the underlying psychological processes that are common regardless of DSM diagnoses (McEvoy et al., 2009; Sauer-Zavala et al., 2017). Sauer-Zavala and colleagues (2017) have contributed to the clarification of transdiagnostic treatment by delineating three distinct categories of approaches termed the universally applied therapeutic principles approach, the shared mechanisms approach and the modular approach. The universally applied therapeutic principles approach calls for the therapist to determine guiding principles of therapy that are meant to be used across the treatment of most, if not all, therapeutic situations (Sauer-Zavala et

al., 2017). There are many theories and components of therapy that have been utilized transdiagnostically without this specific designation since their inception, such as unconditional positive regard which originated in Rogerian therapy or psychodynamic approaches (Leichsenring & Salzer, 2014; Sauer-Zavala et al., 2017). Whereas the shared mechanisms approach identifies the underlying processes that lead to the formation of a wide range of diagnostic presentations and determines an intervention that will affect them (Sauer-Zavala et al., 2017). For instance, a construct such as shame can be viewed as transdiagnostic in that it can be present and maintain similar symptoms across a wide range of diagnoses. Finally, the modular approach advocates the compilation of empirically based strategies to treat presenting problems irrespective of overall diagnosis (Sauer-Zavala et al., 2017). Mindfulness-based treatments, such as meditation and increased awareness, have shown efficacy for being applied as an intervention regardless of diagnoses (Sauer-Zavala et al., 2017) and can consequently be studied from a transdiagnostic lens.

Furthermore, the increase in research from a transdiagnostic approach indicates these methodologies are especially valuable as co-occurrence of DSM diagnoses are common (Allen et al., 2010) and symptoms of multiple diagnoses often overlap. In a transdiagnostic study of anxiety disordered participants, it was found that over sixty percent had co-occurring psychological disorders and nearly one-third had met criteria for a comorbid depressive disorder (Norton, 2012). In his analysis, Norton (2012) found statistically equivalent efficacy for transdiagnostic treatment and diagnosis-specific treatment both across diagnoses and across treatments used. An additional study also demonstrated the efficacy of transdiagnostic treatment in that over sixty percent of the participants in an online Cognitive Behavioral program no longer met criteria for their primary diagnosis of either depression or anxiety at a three month follow

up, more than half did not meet criteria for any of the diagnoses being followed and that the number with co-occurring disorders dropped from nearly ninety percent to just over thirty percent in this same time frame (Titov et al., 2011). Evidence suggests that utilizing one set of approaches can potentially decrease wait times for services, and simplify and shorten the course of treatment as they can affect change across multiple diagnoses simultaneously (McEvoy et al., 2009; Titov et al., 2011). Furthermore, results indicate that the large majority of participants in an online program found the variations of diagnoses in the treatment group to help them to better understand their own circumstances and means of coping effectively, decrease symptoms of subclinical depression or anxiety as well as improve motivation (Titov et al., 2011). Increased unification of treatment modalities may assist clinicians in providing services to a broader range of client needs without the need for multiple trainings, cumbersome costs or bulky manuals which would streamline the process of providing services (McEvoy et al., 2009). Additionally, clients who learn generalized skills can apply them to a variety of symptoms both presently and as new situations occur post-treatment, perhaps decreasing the need for future therapeutic intervention in a professional setting.

Although there are many advantages to a transdiagnostic approach, it is important to note possible limitations. In group therapy settings, cohesiveness and relevance of the material are important components which contribute to the retention of group members and therefore completion of treatment and it may be more difficult for individual participants to achieve this in a setting in which the diagnoses vary (McEvoy et al., 2009). Furthermore, effects of treatment may be diluted if the interventions are too generalized. McEvoy et al. (2009) suggest evaluation of transdiagnostic treatments should include diagnosis-specific symptom measures, measures of

higher-order constructs common to emotional disorders, as well as process variables but the study of this is fairly new and its most effective evaluation is still being determined.

In a review of outcome studies, researchers have noted that few studies have been published to date regarding the efficacy of transdiagnostic treatments for depression and/or anxiety (McEvoy et al., 2009); however, in an analysis of the existing peer-reviewed studies, it has been found that a transdiagnostic approach to treatment demonstrates promising results in decreased symptomology and increased functioning of clients (McEvoy et al., 2009). Furthermore, it has also been revealed that transdiagnostic treatments are associated with elements such as high therapeutic alliance, group cohesion (McEvoy et al., 2009), client satisfaction, and positive treatment expectations which also lend toward successful and productive outcomes (McEvoy et al., 2009; Titov et al., 2011). Developing strategies that have the capacity to address multiple diagnoses equips clinicians to be able to address co-occurring disorders simultaneously decreasing the length of treatment for clients and allows for efficiency in the training time for clinicians.

### **Resiliency**

Resiliency is defined as the ability to adapt successfully to damaging life events and it has the power to allow people to be transformed positively rather than crushed by these hardships and sufferings (Nguyen et al., 2015; Prestia, 2016). It is the flower that blooms out of a crack in the pavement, a man whose leg was amputated who runs in the Olympics or an abused child who grows up to be a gentle, strong adult who starts a foundation that provides safety to hurting children. Resiliency is reaping the opposite of what was sown, of growing strength from the soils of weakness, shame or adversity.

Resilience is needed in all stages of life from childhood through the elder years as various stressors are experienced and is observed in individuals, families and systems (Martin, Distelberg, Palmer, & Jeste, 2015). Factors such as adaptability, spirituality, positive mental states, flexibility and connection to a Higher Power or family, friends or communities who are supportive help to produce the protective mechanisms that comprise resiliency and research is beginning to look at developing theoretical constructs (Brown, 2006; Van Vliet, 2008) as well as measures to evaluate resiliency factors at different stages of life (Martin et al., 2015).

Resilience to shame is of particular interest to researchers who study the adverse effects of this damaging moral emotion experienced by most people that is at the root of many maladaptive behaviors or beliefs about the self and psychopathologies (Brown, 2006; Van Vliet, 2008). A theory of shame resilience from a grounded theory study proposes that resiliency to shame is composed of empathy, connection, power and freedom (Brown, 2006). It is the ability to accept one's own vulnerability, to develop awareness of the expectations of others as well as empathic connection with others and the ability to have the emotional competency required to give voice to and deconstruct shame experiences (Brown, 2006). Resilience is a reconstruction of the self that was damaged by shame and affliction and it produces strength, confidence and acceptance that prepares a person to resist future attacks on the self by shame experiences (Van Vliet, 2008). Therefore, understanding resilience and the mechanisms that can increase it is a valuable segment of research.

**Acceptance and mindfulness.** The acceptance component of mindfulness has been shown to decrease the intensity of the distress of negative emotions, such as depression and anxiety, which in turn decreases the tendency to avoid situations in which the negative emotions may emerge, thus demonstrating an increased capacity for resiliency (Cardaciotto et al., 2008).

For instance, people with social anxiety who practice this acceptance component would be able to see the anxiety that arises when going to an event as temporary and less catastrophic and thereby experience less intensity of symptoms and increase the likelihood of going to another event in the future. With repetition, over time the person may become less attuned to the experience of the anxiety and more attuned to the positive experience of interacting with others and attaining a personal goal. Acceptance allows one to be able to embrace the negative and positive emotions of life as each being temporary and part of a whole rather than each being the totality of the life experience at any given moment. This allows a person to not feel the need to change or avoid these things but rather to hold them gently and feel them fully as part of the intricately woven tapestry of the person's unique journey until these feelings pass.

This ability to accept distressing thoughts and move toward goals and interests has been shown to improve with the use of mindfulness (Hjeltnes et al., 2015). The concept of moving toward what is important to a person despite any negative affect that may be present through the use of mindfulness is a main tenet of ACT (Hayes, 2004). Of the six processes of ACT, acceptance, defusion, the now, self, values, and committed action, the first four are considered processes of acceptance and mindfulness; whereas, the final two are commitment and behavior processes (Hayes, Levin, Plumb-Villardaga, Villatte, & Pistorello, 2013). The combination of these processes is used to produce psychological flexibility which in turn reduces symptoms that impair functioning resulting in increased resiliency. Furthermore, a feeling of more self-acceptance and a sense of balance and stability in difficult life circumstances also emerged in participants who learned and utilized MBSR (Hjeltnes et al., 2015). Participants were observed to increase time spent in mindfulness activities over the course of an 8-week mindfulness group

and this intervention was associated with a positive increase in acceptance qualities (Goldsmith et al., 2014).

Additionally, spiritual acceptance helps to improve mindfulness skills and creates a system of continual growth in these skills, improves relationship with God and acceptance of self which in turn creates resiliency toward depression and anxiety (Hathaway & Tan, 2009). A significant positive correlation has been demonstrated between positive perceptions and feelings toward God and resilience and these Images of God were found to be predictive of resiliency as well (Nguyen et al., 2015). Furthermore, negative feelings toward God have been found to have a strong negative correlation to resiliency (Nguyen et al., 2015). These results were reported in a study conducted predominately with Catholic, Vietnamese subjects; therefore, research into other groups may be helpful to determine across groups findings.

**Grace.** Though not often referenced when guilt and shame occur simultaneously because confession, repentance and repair measures for guilt are more often discussed, grace is the remedy offered in scripture for the overwhelming experience of shame. Grace can be demonstrated between believers and God, from one person to another or from God to creation in general as it is defined as “an act of showing kindness, generosity, or mercy to someone who is undeserving and potentially incapable of returning the kindness shown” (Bufford et al., 2017, p. 57). According to Genesis 2:25 where it is written, “Adam and his wife were both naked, and they felt no shame” (New International Version), human existence begins without shame and shame is then added as sin increases and this leads to an overwhelming, condemned experience for which an answer is provided in Jesus. In Romans 5:20-21 the Bible explains, “where sin increased, grace increased all the more, so that, just as sin reigned in death, so also grace might reign through righteousness to bring eternal life through Jesus Christ our Lord” (New

International Version). This sin in the Christian worldview was atoned for by Jesus' death on the cross, which is described in Hebrews 12:2 as directly conquering the shame that sin had caused in that it says about Jesus, "For the joy set before him he endured the cross, scorning its shame, and sat down at the right hand of the throne of God" (New International Version). Finally, believers are encouraged to seek this grace as a solution to shame where in Hebrews 4:16 it is written, "Let us then approach God's throne of grace with confidence, so that we may receive mercy and find grace to help us in our time of need" (New International Version).

Grace can be conceived as "God's choice to love and accept humans despite their sinfulness" (McMinn et al., 2006) and it is therefore a means of making worthy one who due to shame has lived a painful, isolating existence of feeling undeserving of this. McMinn (2008) has noted after many years as a professional counselor and studying the psychological literature, that "counseling works in large part because it is a place of common grace. . . . Effective counselors provide a safe place where acceptance and kindness abound, a place where struggle and brokenness can be openly explored and grieved without the fear of judgment. This frees people to look honestly at themselves, to become more open in their other relationships, and to move forward into richer and deeper connections with those they love" (p. 53–54). Psychological professionals who are trained with a means of assisting Christian clients with this critical understanding of the journey from overwhelming shame to a perspective of continual grace will be better equipped to effectively address this universally devastating emotional state and promote increased psychological resiliency in their clients.

**Grace and mindfulness.** Mindfulness is a means of expressing grace to oneself and to others as it promotes acceptance and a nonjudgmental stance toward oneself and others despite the inevitability of suffering (Bufford et al., 2017). In a case study presented by Hathaway and



Tan (2009), it was found that although a Christian client may profess to believe in grace from God, there may be expressed difficulty living in response to this belief and that a therapist, Christian or not, can help to facilitate congruity between a client's beliefs and behaviors. Christians who have a stated belief in God's unconditional love may spend so much time on experiential avoidance behaviors that they neglect to remember this love and acceptance available to them (Hathaway & Tan, 2009); and mindfulness offers a means of raising this awareness. Living in God's grace is predicated on the awareness of one's broken and fallen nature in order to fully appreciate and embrace the grace offered. Furthermore, to experience the resultant freedom and emotional resilience that comes from releasing the need to escape negative emotions requires one to accept them and move purposefully toward grace, fulfillment and satisfaction despite them. Using mindfulness techniques, a client can be encouraged to accept without judgment or argument that grace is available based on their faith and movement toward the healing power of this grace and away from shame or mental distress may become more available.

### **Integration of Mindfulness and Christian Spirituality**

Although the trend in recent decades has been for more and more Americans to identify as non-religious, a number that rose to 13% in 2009, 78% identified themselves as being of a Christian faith in the same year and more than half believe that "religion can answer all or most of today's problems" (Newport, 2009). Church membership and attendance has decreased in recent years but the 56% who state that religion is "very important" as of 2009 is a slight increase over the rate 30 years prior (Newport, 2009). In the counseling profession, clinical interventions are expected to encompass the strengths and resiliency factors of the client and it has been found that the effectiveness of the therapeutic relationship may be hindered when the

client has a religious or spiritual belief system that is not accounted for in the techniques chosen by the therapist (Worthington & Aten, 2009).

Of note, Myers (2012) found that collaborative religious coping and mindfulness were correlated in that this religious coping increased as mindfulness increased among graduate counseling students. He also found that emotion regulation-reappraisal increased as mindfulness increased. Upon analysis, he concluded that mindfulness mediated the relationship between collaborative religious coping and emotion regulation-reappraisal (Myers, 2012). Without mindfulness, collaborative religious coping was not found to have an effect on emotion regulation-reappraisal (Myers, 2012). As people become more mindful, they may have more capacity to view God in a collaborative manner and grow in spiritual attributes which may help them to regulate and reappraise emotions more effectively. The ability to regulate emotions may in turn improve a person's ability to participate fully in spiritual disciplines and in a relationship with God. Aspects of mindfulness, such as acceptance and nonjudgment toward self and others have been reported to enable more intimacy in one's relationship with God (Hathaway & Tan, 2009).

Christians who are utilizing MBIs rooted in a Buddhist belief system may be hindered from achieving the full benefits by concerns of incongruency with their own spiritual beliefs; therefore, researchers have advocated for alternative MBIs adapted to the the unique cultural values of the Christian community (Frederick & White, 2015; Knabb, 2012). Because mindfulness has a spiritual component, it is readily accommodated to the specific spiritual beliefs of Christians by adapting the secularized versions of MBIs with Christian concepts (Frederick & White, 2015; Trammel, 2018). For instance, a body scan exercise can be accommodated for a Christian client by altering the script to include a focus on the creator of the body and the breath

in addition to the standard focus on the body itself. These accommodations can be created by utilizing techniques derived from Christian devotion meditation, (Frederick & White, 2015), Christian contemplative practices (Davidson & Kaszniak, 2015; Knabb & Frederick, 2017) and Christian mysticism (Trammel, 2018). Because these practices intentionally orient a person on the present moment through a focus on breath, imagery, scripture, silence or centering prayer (Knabb & Frederick, 2017; Trammel, 2018), it is possible that mindfulness-based practices accommodated with them for Christians may demonstrate effectiveness similar to the secular versions for non-Christians.

Although mindfulness has experienced some resistance from those of the Christian faith as it has its roots in Eastern philosophies of meditation, it has been found that the use of Christian scriptures and prayer within the context of mindfulness skills has been useful to Christian clients (Hathaway & Tan, 2009). Moreover, Christian devotion meditation has been shown to demonstrate significantly lower anxiety, anger, muscle tension, as well as increased pain tolerance and positive mood as compared to secular meditation groups or relaxation training groups (Frederick & White, 2015). Upon further exploration, it can be seen that mindfulness skills are readily capable of being merged with Christian meditative practices and belief systems. Trammel (2018) found that utilization of a recorded version of mindfulness exercises emailed to participants weekly demonstrated significant levels of increased mindful states as well as decreased levels of stress. This study additionally found that mindfulness strategies can be adapted to Christianity with similar results as secularized or Buddhist-based mindfulness techniques which supports the expansion of MBIs to the specific cultural needs of Christians (Trammel, 2018), and this may make mindfulness approaches more appealing to this population.

With a recent Pew Forum on Religious and Public Life finding that 70.6% of those living in the United States identify themselves as either Christian or Catholic (Pew Research Center, 2015b), it is important for clinicians to be able to address the needs of this cultural group. In Christianity, God's grace and unconditional love form the basis of the redemptive relationship between humankind and God. Mindfulness has the potential to assist the Christian counseling recipient in recognizing the truth of God's acceptance by focusing nonjudgmentally on the experience of life and self and theology discourse has supported the connections between spirituality and mindfulness (Highland, 2005; Tweed, 1997). A participant in Hathaway and Tan's study reported that accepting the self as being fully accepted by God helps one to be able to accept others without judgment and extend grace to them (Hathaway & Tan, 2009).

### **Future Considerations**

Davidson and Kaszniak (2015) note that research in the area of the efficacy of mindfulness is lacking and future studies would benefit from including rich descriptions of the techniques or meditations used in order to be able to measure and replicate the methods used in future studies. Furthermore, some of the findings on the efficacy of mindfulness have been based on small studies that need replication or larger, more diverse samples to be able to generalize the results in any way; and mindfulness based treatments require a large investment of time, energy and resources which may lend toward a tendency to over report the effectiveness of it by the people who have devoted so much to it either as practitioners or as clients (Baer, 2003). Additionally, mindfulness-based treatments are often given in group settings and more research is needed to determine both its effectiveness with individuals as well as any adjustments that are needed for individual use or beneficial for use with specifically Christian clients.

Dimidjian and Segal (2015) found in their mapping of the base of evidence regarding the use of MBIs that although there have been many studies centering around the creation of new MBIs, pilot testing and efficacy trials in research settings, there is a scarcity of studies that include efficacy trials in community settings, and even fewer effectiveness studies that examine interventions implemented by community providers under routine treatment conditions. There is a need for studies that examine the effectiveness of MBIs in “real world” circumstances.

Despite the correlation found between spirituality and mindfulness, Hathaway and Tan also note a gap in the ability to transfer this connection to practical therapeutic techniques that combine Christian spirituality with mindfulness in a meaningful and studied manner (Hathaway & Tan, 2009). Dimidjian and Segal (2015) offer recommendations regarding the methodology for future research in the area of MBIs to increase the impact of this research on the usability of the techniques. Of interest are their recommendations to specify intervention targets and populations, to beware of orphaning techniques by not following through on further testing of the interventions at various stages of research as well as to be specific about the benefits of mindfulness such as exploring just how much meditation is required to achieve clinical change (Dimidjian & Segal, 2015). This gap in the research calls for more studies to be done to determine the efficacy of creating and utilizing Christian adapted mindfulness techniques in clinical settings. Little research can be found on the use of such CAM in clinical settings and on whether the use of these techniques is correlated with a decrease in the shame-related symptoms of depressive and anxiety disorders.

### **Summary**

From this review of the current literature, several prominent themes have emerged. To begin with, shame is correlated with a breadth of debilitating mental health conditions and has

the potential to be a life-long emotional experience that persistently damages a person's sense of self, others and God. It results in a view of the self as damaged and worthless which leads to avoidance behaviors, emotional isolation, self-condemnation and self-loathing. It is an injurious moral emotion that necessitates an effective treatment regardless of the psychological diagnosis in which it has manifested; therefore, investigation of interventions found to be transdiagnostically effective may be advantageous in this endeavor.

MBIs have been found to be beneficial in the treatment of a plethora of physical and psychological dysfunctions and are therefore worthy of consideration in the search for the alleviation of symptoms related to shame. Mindfulness incorporates the learning of skills that promote a nonjudgmental awareness, a purposeful focus of energy and attention on the internal and external experience of the present moment as well as a development of self-compassion and acceptance. These components are cultivated into a daily practice of meditations and exercises that result in a decrease of negative emotional states as well as an increase in social connection and responsibility toward self and others. These elements are in stark contrast to the behavioral effects of shame and have the potential to stimulate healing.

While mindfulness has been shown to be a powerful instrument in the recovery of mental health conditions, it may not be readily accessible to those from all cultural backgrounds. Those of the Christian faith, for instance, have expressed resistance to MBIs due to the Buddhist foundation used in many techniques; however, it has been noted that adaptations can be made to potentially meet the specific cultural needs of Christian clients. Through the incorporation of prayer, scripture, Christian devotion meditation and Christian contemplative practices, mindfulness likely has the capacity to be effectively adapted to the Christian population. The creation of effective Christian MBIs would allow more people from this cultural group to access

the power of mindfulness within a framework congruent to their belief system. However, there is a paucity of studies that demonstrate the specific exercises that can be replicated or the effectiveness of the use of CAM techniques in real world therapeutic settings which currently limits the use of these interventions. The need to fill this gap in the research had been made apparent in this review of the current literature.

## **CHAPTER THREE: METHODS**

### **Overview**

This chapter will describe the design of the current research study as well as the methods that were used to conduct it. The hypotheses being evaluated and the research questions that were tested will be defined to give a framework for the design. The questionnaires and scales used to measure the various constructs will be discussed as well as the procedures used to obtain the data. Furthermore, the protocols administered to the participants and the schedule of the presentation of the material throughout the study will be clearly delineated. Lastly, this chapter will conclude with links to the measures, the handouts that were presented, the transcripts of the meditations that were used and the homework that was given to participants to demonstrate uniformity across the sessions.

### **Design**

The current study is a single-subject trial, or N of 1 study, with multiple participants to determine the efficacy of CAM in the treatment of shame among those who self-identify as belonging to a Christian cultural group. It utilized a transdiagnostic set of five participants receiving clinical care at a faith-based non-profit counseling center and was completed over the course of nine weeks beginning at the participants' clinical intake to begin professional counseling services. The counseling center used in the study is located in a part of the United States that has very few psychological services specifically directed at meeting the unique needs of this cultural group.

### **Research Questions**

Research questions (RQ) that emerge from this are as follows:



**RQ1:** Does the use of Christian Accommodative Mindfulness (CAM) correlate with the decrease of a negative experience of shame in Christian clients diagnosed with depression or anxiety?

**RQ2:** Does the use CAM correlate with the increase of resiliency in Christian clients diagnosed with Depression or Anxiety?

**RQ3:** Does a decrease in depressive symptoms in Christian clients diagnosed with depressive disorders correlate with the use of CAM?

**RQ4:** Does a decrease in anxiety symptoms in Christian clients diagnosed with anxiety disorders correlate with the use of CAM?

### **Hypotheses**

The following hypotheses were explored in this study:

**Hypothesis 1:** The use of CAM correlates with a decrease in the experience of shame for Christian recipients of professional counseling services.

**Hypothesis 2:** The use of CAM correlates with an increase in resilience for Christian recipients of professional counseling services.

**Hypothesis 3:** CAM demonstrates efficacy as a clinical treatment intervention for Christian recipients of professional counseling services regardless of a diagnosis of depression or anxiety.

### **Participants and Setting**

#### **Participant Criteria**

**Adult Evangelical Christian sample.** A sample of five participants was recruited from those who had referred for therapy at a nonprofit professional Christian counseling center in the northeastern region of the United States. It was required that they were over the age of 18, self-

identified with an Evangelical Christian faith and met the diagnostic criteria for either a depressive disorder or an anxiety disorder. They were voluntarily involved in the study while receiving treatment for the depression or anxiety. Permission for the study was given by the counseling center as well as the participants.

**Inclusion and exclusion criteria.** For any client who stated interest in participation in the study, an assessment in addition to and distinct from that which is typical for the clinic was completed. This assessment included questions to ascertain criteria needed for the study. Inclusion criteria included the participant being at least 18 years of age, self-reporting to be of an Evangelical Christian faith, a willingness to participate in a mindfulness study, an ability to sign a consent form and having no foreseeable barriers to treatment for the following eight weeks. This study utilized a transdiagnostic model in that although clients needed to meet criteria for either depressive or anxiety disorders, they may also have had secondary diagnoses. The criteria for exclusion in the study were as follows: participants under the age of 18 or who presented with symptoms of disorders other than depression or anxiety as their primary concern such as psychotic disorders, suicidal tendencies or substance use disorders or having any life circumstances that would prevent consistency of treatment for the following eight weeks.

**Recruitment.** Participants were recruited from a population of potential clients of the counseling center. After the initial brief interview that is completed with all potential clients, those who were over the age of 18 and had identified symptoms of depression or anxiety as the main precipitators for seeking treatment were offered the opportunity for possible inclusion in a mindfulness treatment study. If interested, the participant then proceeded to a more extensive interview and completed measures per the study protocol at the end of the intake session as well as after one week and at the end of the first therapy session which was scheduled two weeks after

intake. If not interested, the client entered treatment without delay as would be typical for the clinic.

## **Instrumentation**

### **Measures**

The following measures were used in the study and administered during the intake appointment:

**Initial assessment interview form.** Potential participants completed an assessment questionnaire. This questionnaire helped to ascertain the inclusion criteria were met and the exclusion criteria were not present. See Appendix A for a copy of this form.

**Demographic questionnaire.** Participants completed a demographic questionnaire. This questionnaire was used to track demographic information of the participants. See Appendix B for a copy of this form.

**Consent for treatment.** In addition to the consent for treatment typically signed by clients of the counseling center which includes limits of confidentiality, the participants also signed a consent to inclusion in the mindfulness study. This form described the expectations of the participant and the therapist in the mindfulness treatment as well as the use of measures before the first session as well as after each session and at the end of the study treatment period, in addition to those used by the clinic, explicitly for the purposes of the study. It also outlined the risks and benefits of treatment as well as the option for the participant to opt out of the study at any point and still continue or discontinue treatment as usual. See Appendix C for a copy of this form.

## Scales

The following scales were administered pre, during and post treatment via Survey Monkey outside of session times to quantify the constructs used in the study:

**Brief Experiential Avoidance Questionnaire (BEAQ).** The BEAQ is a brief version of the Multidimensional Experiential Avoidance Questionnaire and measures experiential avoidance, or the inability to maintain presence with emotional distress, a characteristic that has been linked to psychopathology (Gámez et al., 2014). This brief questionnaire consists of a 15-item scale incorporating the six dimensions of the original 62-item scale, behavioral avoidance, distress aversion, procrastination, distraction/suppression, repression/denial and distress endurance (Gámez et al., 2014). The 15 items are self-rated on a six-point Likert scale ranging from 1, (*strongly disagree*), to 6, (*strongly agree*), to statements such as “Fear or anxiety won’t stop me from doing something important” (Gámez et al., 2014, p.45). A three-phased study was conducted to first choose the elements to retain in the brief version, then evaluate for internal validity and finally to cross-validate the new brief 15-item scale that was developed. Through this process, the BEAQ has demonstrated good internal consistency across multiple populations and has been cross-validated (Gámez et al., 2014). The BEAQ was administered at intake, as well as after the first week, before the start of the first session, after the third and fifth session as well as at the follow-up session one week post the completion of the mindfulness protocols. See Appendix J for a link to the article for this scale.

**Brief Religious Coping Scale (Brief RCOPE).** The Brief RCOPE is a 14-item scale that is a shortened version of the RCOPE, a 105-item measure for religious coping, a resiliency factor for coping with life stressors (Pargament, Feuille, & Burdzy, 2011; Pargament, Koenig, & Perez, 2000; Pargament, Smith, Koenig, & Perez, 1998). The 14 items included in the Brief RCOPE

are divided equally into two subgroups measuring positive and negative religious coping skills on a 4-point Likert scale of 0, (*not at all*) to 3, (*a great deal*). The positive skills, measured by statements such as “Tried to see how God might be trying to strengthen me in this situation”, are related to resiliency and the negative skills, measured by statements such as “Questioned God’s love for me” are related to poorer functioning (Pargament et al., 2011). It has psychometric properties that support good internal consistency across a variety of populations, good concurrent validity and has evidence to initially support predictive and incremental validity and sensitivity to changes generated from specific interventions (Pargament et al., 2011) as well as good test-retest reliability (Mohammadzadeh & Najafi, 2016). The Brief RCOPE was administered at intake, as well as after the first week, before the start of the first session, after the third and fifth session as well as at the follow-up session one week post the completion of the mindfulness protocols. See Appendix J for a link to an article for this scale.

**Depression Anxiety Stress Scales (DASS).** The DASS was used to assess pre-treatment, mid-treatment and post-treatment levels of depression and anxiety as well as overall psychological distress. The DASS has two versions, a longer 42-item one and the one that will be used in this study, a 21-item scale that measures psychological distress with subscales for depression, anxiety and stress (Antony, Bieling, Cox, Enns, & Swinson, 1998; Lovibond & Lovibond, 1995). An example of a statement used on the depression axis of the scale is as follows: “I couldn’t seem to experience any positive feeling at all” and a statement on the anxiety axis is “I was worried about situations in which I might panic and make a fool of myself” and on the stress axis is “I tended to overreact to situations”. The items are measured on a four-point Likert scale of 0, (*never*) to 3, (*almost always*) and as a psychometric instrument, the DASS has been shown to have validity and reliability as well as the subscales have been shown to

discriminate between depression and anxiety with consistency (Antony & Barlow, 2010). The DASS was administered at the intake, after the first week, before the first session and after each session thereafter including the follow-up session one week post the completion of the mindfulness protocols. See Appendix J for a link to this scale.

**Dimensions of Grace Scale.** The Dimensions of Grace scale was used to measure a change mechanism or possible resiliency factor for Christians. It is a newly developed 36-item scale created from 3 existing scales, measuring 5 dimensions of grace, Experiencing God's Grace, Costly Grace, Grace to Self, Grace from Others, and Grace to Others (Bufford, Blackburn, Sisemore, & Bassett, 2015; Bufford et al., 2017). The seven items from the Grace from Others subscale were removed as they do not represent changeable factors and the remaining 29 items from the Dimensions of Grace scale was administered at intake, as well as after the first week, before the start of the 1<sup>st</sup> session, after the 3<sup>rd</sup> and 5<sup>th</sup> session as well as at the follow-up session one week post the completion of the mindfulness protocols. See Appendix J for a link to an article for this scale.

**Shame Inventory.** The Shame Inventory was used to assess levels of shame before, throughout and after treatment. It is a 53-item scale that measures both global feelings of shame in the three items included in Part I of the scale as well as situation specific shame cues represented by the 50 items in Part II (Rizvi, 2010). Question 1 of Part I asks how often shame is experienced and is measured on a 5-point Likert scale where 0 is "*never*" and 4 is "*always*"; question 2 refers to the intensity or severity of the shame experienced and is indicated by a 5-point Likert scale where 0 is "*none*" and 4 is "*extreme*"; question 3 inquires about the effect of shame on quality of life where 0 is "*no effect*" and 4 is "*extreme effect*" on a 5-point Likert scale; and Part II is measured on a 5-point Likert scale where 0 is "*no shame*" and 4 is "*extreme*

*shame*” and asks for rating on statements following “A time when I...” such as “Was criticized in front of others” (Rizvi, 2010). It is the first shame measurement to assess cues for shame which may be different person to person. It has demonstrated good psychometric properties in that it has good internal consistency, convergent validity with the existing Test of Self-Conscious Affect and Personal Feelings Questionnaire scales, test-retest reliability as well as predictive validity (Rizvi, 2010). The full Shame Inventory will be administered at the intake, and Part I of the Shame Inventory was administered after the first week, before the first session and after each session thereafter including the follow-up session one week post the completion of the mindfulness protocols. See Appendix J for a link to an article for this scale.

**Surrender Scale.** The Surrender Scale was used to measure surrender style of religious coping which has been found to be a separate factor from the positive coping measured by the Brief RCOPE (Wong-McDonald & Gorsuch, 2000). In comparing coping styles, Wong-McDonald and Gorsuch (2000) found that “people who use surrender coping may also utilize the collaborative and deferring styles but not the self-directing style” (p. 158) which would support their definition of surrender style as being a collaborative problem-solving approach between a person and God while also an active choosing to surrender to the will of God when and if the person’s solution differs from that of God (Wong-McDonald & Gorsuch, 2000). This scale was created by extrapolating 12 items from a 30-item scale and it has been shown to have a reliability estimate of .94. The 12 items of the Surrender Scale consist of 2 items from each of the following six dimensions: define the problem, generate alternatives, select a solution, implement the solution, redefine the problem, and self-maintenance (Wong-McDonald & Gorsuch, 2000). The statements such as “I will select God’s solution to a problem even if it requires self-sacrifice from me” are measured on a 5-point Likert scale, ranging from 1 (*strongly disagree*) to 5

(*strongly agree*). Although Wong-McDonald & Gorsuch (2000) suggest that due to the theological assumptions of the scale, it may not be generalizable outside of those from a conservative Christian perspective, this study is utilizing only subjects with this faith background and is therefore appropriate. The Surrender Scale was administered at intake, as well as after the first week, before the start of the first session, after the third and fifth session as well as at the follow-up session one week post the completion of the mindfulness protocols. See Appendix J for a link to an article for this scale.

### Schedule of measures

Table 1 outlines the schedule of the administration of the measures.

Table 1

#### *Schedule of Measures*

	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9
Session	Intake	None	1*	2	3	4	5	6	7
CAM			1	2	3	4	5	6	Follow-up
DASS	X	X	X	X	X	X	X	X	X
Shame I	X	X	X	X	X	X	X	X	X
Shame II	X								
BEAQ	X	X	X		X		X		X
Brief RCOPE	X	X	X		X		X		X
DGS	X	X	X		X		X		X
SS	X	X	X		X		X		X

\*measures given prior to start of this session

*Note.* DASS: Depression Anxiety Stress Scale: 21 Items; BEAQ: Brief Experiential Avoidance Questionnaire: 15 Items; Shame Inventory Part I: 3 Items; Brief RCOPE: Brief Religious Coping Scale: 14 Items; Shame Inventory Part II: 50 Items; DGS: Dimensions of Grace Scale: 29 Items; SS: Surrender Scale: 12 Items.

### Procedures

This study consisted of seven treatment sessions with five individual participants. The initial meeting, prior to the first treatment session, was an intake in which preliminary diagnosis



and interest in the research study was established and all consent forms were signed followed by administration of the DASS, the full Shame Inventory, BEAQ, Brief RCOPE, Dimensions of Grace and Surrender Scales. One week after intake as well as prior to the start of the first session, the DASS, Part 1 of the Shame Inventory, BEAQ, Brief RCOPE, Dimensions of Grace and Surrender Scales were administered via electronic communication of the surveys to establish a post-intake baseline. Treatment Session 1 through Session 6 included teaching and practicing the six pre-established CAM protocols and a pre-recorded meditation of the week was assigned for daily homework. Midway through each week, a text with an inspirational quote or Scripture verse was sent to the participant as a gentle reminder to be completing the homework of practicing the mindfulness exercise of the week. Following Sessions 2, 4 and 6, the DASS and Part 1 of the Shame Inventory were administered. Sessions 3, 5 and 7 were followed by administration of the DASS, Part 1 of the Shame Inventory, BEAQ, Brief RCOPE, Dimensions of Grace and Surrender Scales. The scales were taken by the participants via Survey Monkey outside of the sessions and the questions of each measure were randomly shuffled each time to decrease the likelihood of bias due to repetition.

## **Variables**

**Independent variable.** The independent variable in this study is the treatment condition that was utilized which is termed CAM. A set of six CAM modules was developed and the therapist used them over the course of six clinical sessions with each participant.

**Dependent variables.** There are four dependent variables in this study, broadly defined as depression, anxiety, shame and resiliency. The depression and anxiety variables were defined as the scores on the DASS. The shame variable was defined as the scores on the Shame Inventory and the resiliency variable was defined as the scores on the BEAQ, Brief RCOPE, the

Dimensions of Grace and the Surrender Scale. The dependent variables were measured at intake, throughout treatment and after treatment to determine points of change.

### **Validity**

**Internal validity.** The quasi-experimental design of this N of 1 study was expected to have a low to moderate amount of internal validity. It was conducted in a non-laboratory setting and had potential threats to validity because of this as there was less control, but the treatment component was conducted utilizing a pre-made set of protocols which helped to standardize parts of the experiment. To ensure the CAM modules were presented and utilized uniformly, treatment for the participants was provided by the same therapist/researcher and the protocols given for homework were delivered electronically via a pre-recorded version of the mindfulness meditation eliminating any variability of the deliverance of the protocols between participants. Another possible threat to validity to be guarded against was experimenter expectations. The therapist was the researcher and it was important to not have expectations for specific results from the treatment. Causality and generalizability were limited as there were uncontrolled factors, but correlations between the independent and dependents variables were able to be determined.

**External validity.** The overall study was expected to be higher in external validity than internal because was being conducted by an experienced therapist in a real clinical setting with participants who were clients seeking treatment for mental health disorders rather than in a laboratory setting. However, threats to external validity existed because of the use of pre- and during assessments. Participants may have reacted to these in ways that would alter the course of the treatment outcome by trying to get the perceived “desired” results. Also, the participants may have been heterogeneous in some ways which may also alter the outcomes; for instance,

some of the participants may have had some familiarity with meditation or techniques used in mindfulness with or without knowledge of the term mindfulness and others may not.

Homogeneity of sample increases validity but would decrease generalizability and the value of the real-life aspect of the findings.

### **Data Analysis**

The statistical procedures that were conducted on this set of five N of 1 cases included graphic analysis for visual inspection of the data, comparing pre-, during and post-treatment data for each participant and then comparing to one another, time series analysis and both within subject and between subject analyses. The AB time-series design of the study wherein there are two treatment phases, a baseline and an intervention phase, as well as multiple points of assessment allows for comparison before, during and after the intervention of CAM has been applied. Statistical power is typically limited in single-subject studies (Heppner et al., 2015), therefore, the descriptive analyses were important. Visual depiction of the data was used to analyze baseline to intervention phases, the slopes within the phases ( $r^2$ ), the range and standard deviations, the immediacy of the effect of the intervention as well as the consistency of data patterns across the multiple participants (Ray, 2015).

Some researchers utilizing N of 1, or single case study designs, consider parametric analyses to be inappropriate because the assumptions of independence of observations and normal distributions of data for inferential statistics are not met as a consequence of the low data size (Ray, 2015). Therefore, effect size estimations were determined in this study by hand calculation of percentage of nonoverlapping data (PND) which has been found to be useful for small sets of data. Using only one data point from the baseline increases the possibility of experiencing Type 2 error (Lenz, 2013); therefore, to minimize this, three baseline data points

were used at intake, one week post intake in which there was no session and prior to the start of the first treatment session. From these baseline data points a median was calculated and compared to the treatment data points to estimate effect size. This form of PND calculation known as percentage of data exceeding the median (PEM) is useful for determining the effect of an intervention when using small sets of data in which there is variability or outliers (Lenz, 2013).

## CHAPTER FOUR: FINDINGS

### Overview

This chapter will describe the findings from the current N of 1 research study. The participants' demographic composition will be described as well as their diagnoses and prior familiarity with the concepts of mindfulness and meditation. The results of the data analysis for each hypothesis will be described.

### Research Questions

The research questions (RQs) identified by this study are as follows:

**RQ1:** Does the use of Christian Accommodative Mindfulness (CAM) correlate with the decrease of a negative experience of shame in Christian clients diagnosed with depression or anxiety?

**RQ2:** Does the use of CAM correlate with the increase of resiliency in Christian clients diagnosed with depression or anxiety?

**RQ3:** Does a decrease in depressive symptoms in Christian clients diagnosed with depressive disorders correlate with the use of CAM?

**RQ4:** Does a decrease in anxiety symptoms in Christian clients diagnosed with anxiety disorders correlate with the use of CAM?

### Hypotheses

The following hypotheses were explored in this study:

**Hypothesis 1:** The use of CAM correlates with a decrease in the experience of shame for Christian recipients of professional counseling services.

**Hypothesis 2:** The use of CAM correlates with an increase in resilience for Christian recipients of professional counseling services.

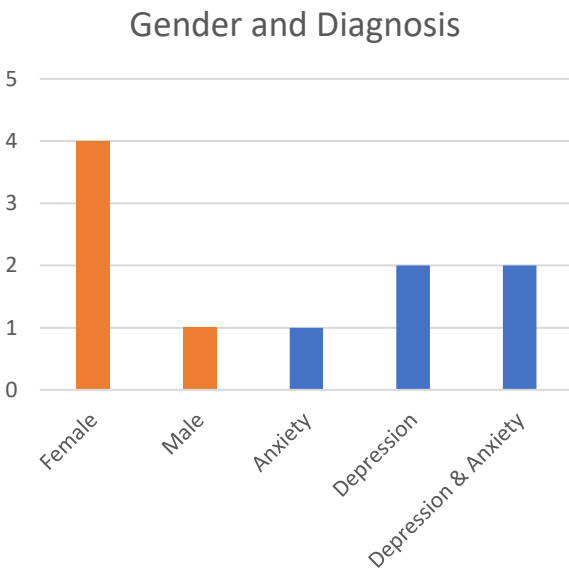
**Hypothesis 3:** CAM demonstrates efficacy as a clinical treatment intervention for Christian recipients of professional counseling services regardless of a diagnosis of depression or anxiety.

### **Descriptive Statistics**

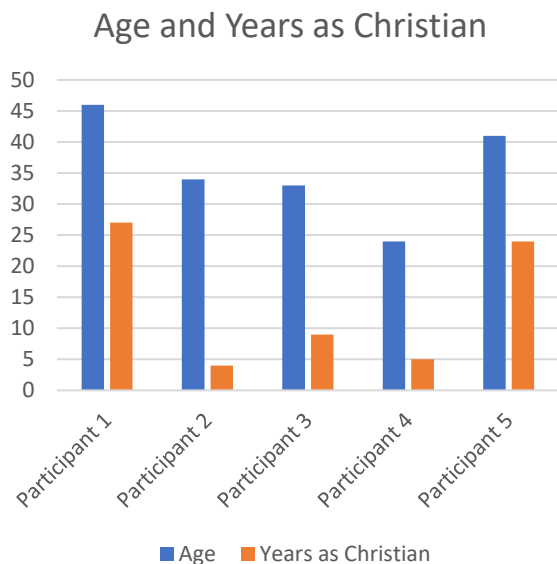
This N of 1 study consists of data from five participants out of an original seven who were identified as candidates for the study. One participant decided to not continue in the study before the first treatment session and did not complete any of the measurements as they stated they suspected from a conversation with their psychiatrist that they may have a diagnosis outside the scope of the study and therefore did not feel capable of completing the surveys. A second participant completed the study but was eliminated from inclusion in the results as they disclosed having given inaccurate data in the answering of the first few weeks of the surveys. This participant stated they had initially been fearful of being honest about the high level of symptomology on both the research surveys and the original clinic assessments and that they had become more comfortable during the course of the treatment, eventually disclosing the true nature of the symptoms to the clinician. Due to the inaccuracy of this data, it was not included in the final findings. Both of these participants continued in treatment as usual at the clinic with the clinician.

All five of the remaining participants in the study met the qualifying criteria as all self-identified as from an Evangelical Christian faith, having been Christians from 4 to 27 years and two had a primary diagnosis of depression, one a diagnosis anxiety and two were diagnosed with depression and anxiety. There were four women and one man in the study ranging in age from 24 to 46 years, three of whom were married, one single and one divorced and all were college educated ranging from one year of college to doctoral level education. The participants were

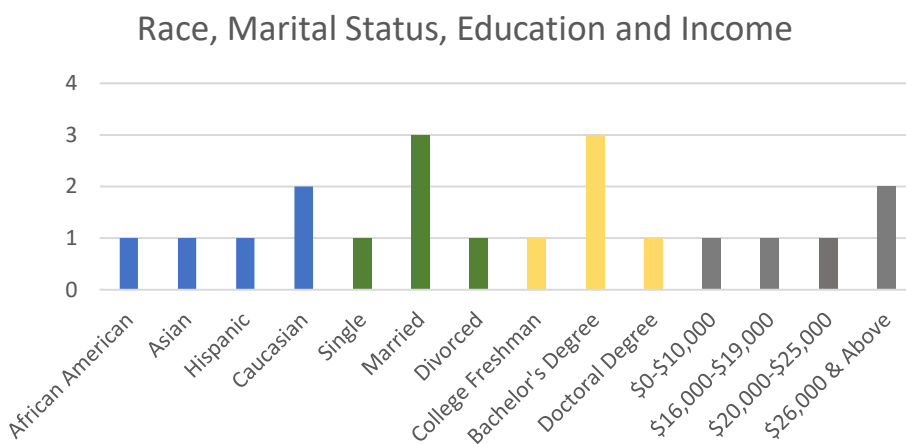
from a diverse racial background as represented by two who identified as Caucasian, one as African American, one as Hispanic and one as Asian. Four of the participants reported having no previous experience with either mindfulness or meditation while one had limited experience in the form of Yoga meditative practices. The following charts, Figures 1a, 1b and 1c, depict the demographic data of these participants:



*Figure 1a.* Gender and diagnosis.



*Figure 1b.* Age and years as a Christian.



*Figure 1c.* Race marital status, education and income.

### **Participant Descriptions**

For the purpose of providing brief qualitative information to enhance the understanding of the research findings about this small set of participants, a description of each will be provided excluding gender or racial information due to the risk for unintentional deductive exposure with only one male and four races represented within five participants in the study. The remaining identifying information has been altered so as to protect the identity of each.



**Participant 1.** This participant is 46 years old, reports to have been a Christian for 27 years, is college educated and has worked as a support staff at a church for the past six years after retiring from the military. This participant has been married for 16 years and has three children, ages 10, 13 and 14. As a military veteran, this participant has coped with moving many times and has successfully managed difficult family events as well as demonstrated resiliency from multiple childhood traumas. In the midst of yet another life transition, this participant displayed symptoms of depression, difficulty with sleep, loss of motivation and feelings of shame and was diagnosed with adjustment disorder with depression. As a Christian, this participant had believed in the past that faith should be enough to help a person overcome difficulties, but was referred to therapy by a respected friend who expressed it may be helpful for the current symptoms. Upon entering treatment, this participant had no prior experience with mindfulness or meditation and had never been in therapy but expressed hopefulness that it may be helpful at this time. This participant was consistent with all appointments throughout the nine weeks. However, life circumstances changed in week 7 of the treatment at which time a transition occurred resulted in an increase in responsibilities and stress.

**Participant 2.** This participant is 34 years old, reports to have been a Christian for the past four years, is college educated and has worked in a factory for the past 12 years. This participant is divorced and has no children. This participant reports to have suffered from anxiety and depression off and on for many years and comes to therapy seeking help to break this pattern and to develop healthy ways to manage the persistent symptoms of isolation, withdrawal from meaningful activities, worry, fear, poor sleep and ruminations about past mistakes along with feelings of shame and was diagnosed with major depressive disorder, recurrent, moderate as well as unspecified anxiety disorder. Upon entering treatment, this

participant had no prior experience with mindfulness or meditation and had been in therapy a few years ago but only briefly, stating they had difficulty finding a therapist who understood the cultural needs of their faith and cultural background. This participant experienced a difficult personal situation which required an acute appointment in the midst of the treatment but was able to complete the study.

**Participant 3.** This participant is 33 years old, reports to have been a Christian for the past nine years, attended college briefly and currently owns a business as a consultant. This participant is single, has one child and has been in therapy intermittently for several years to cope with depressive symptoms and stress but has struggled to find therapeutic strategies that incorporate faith which they state they believe is essential to their ability to grow and heal. This participant experiences feelings of shame, poor sleep patterns, lack of energy, isolation, rumination and loss of interest in meaningful activities and was diagnosed with major depressive disorder, recurrent, moderate. This participant has had some, though minimal, prior meditative experience in the context of Yoga but has never used meditation or mindfulness outside this context. This participant was consistent with all appointments throughout the nine weeks and life circumstances remained relatively stable for the duration.

**Participant 4.** This participant is 24 years old, married for three years with one child age 14 months and reports to have been a Christian for the past five years. This participant is college educated and currently works as a pastor but is in transition out of this role. This participant reports to have experienced depression and anxiety for the past year and saw a therapist briefly for stress while in adolescence but has not been in therapy since. As a pastor, this participant has struggled with feelings of shame, feeling that faith should be enough to overcome anxiety and depression. These feelings have prevented them from seeking assistance from a therapist until

recommended by their spouse after being unable to leave the house for several days due to lack of energy, loss of interest in meaningful activities, poor appetite, over-sleeping, anxiety about the perceptions of others, general worry in several domains, poor concentration, irritability, ruminations of guilt and feelings of sadness and was diagnosed with generalized anxiety disorder as well as major depressive disorder, recurrent, moderate. This participant has no prior experience with mindfulness or meditations. This participant was consistent with all appointments throughout the nine weeks and life circumstances remained relatively stable for the duration.

**Participant 5.** This participant is 41 years old, has been married for the past five years with two children ages three and newborn, is college educated and works as the corporate manager of a company. This participant reports to have been a Christian for the past 24 years and reports to have struggled with anxiety since adolescence. Although this participant was in therapy once for about one year at age 27 and found this to be very helpful, they have not sought therapeutic services since then. A colleague recently recommended therapy due to concern regarding visible changes during the past six months at work with poor concentration, increased irritability as well as physical agitation and restlessness during meetings and a peer at her church expressed concerns about the level of worry about seemingly small or solvable issues at church events or within relationships. This participant also expressed symptoms of fatigue, marital conflict and feelings of guilt and shame and was diagnosed with generalized anxiety disorder. This participant reports to have no prior experience with mindfulness or meditative practices, expresses motivation to change anxiety symptoms and a desire to utilize faith-based practices. This participant experienced a difficult life transition prior to the last session resulting in an increase in stress but was able to complete the study.

## **Results**

The results of the study will be reviewed considering each of the proposed research questions and the associated hypotheses. The results of the data analysis of each measure used in the study will be presented and evaluated for support or lack of support for the hypotheses. Furthermore, charts of the individual participant's data can be found in Appendix K.

### **Research Question 1**

The first research question addresses the possibility of a correlation of the use of CAM with the decrease of a negative experience of shame in Christian clients diagnosed with depression or anxiety. To understand the baseline experience of shame, each participant was administered Part II of the Shame Inventory at the start of the study which collects data as to the prevalence of shame experiences that have occurred throughout the lifespan as well as the Shame Inventory Part I both during the baseline points and after each session of the study to measure the ongoing experience of shame.

### **Hypothesis 1**

The Shame Inventory Parts I and II were analyzed to test the hypothesis that the use of CAM correlates with a decrease in the experience of shame for Christian recipients of professional counseling services. The results from both parts of the measure were compared within subject as well as between subjects to analyze for effect size. This Shame Inventory Part II revealed that the five participants ranged from a reported 39 to 99 shame experiences with a mean of 59.40 experiences as illustrated in Figure 2.



*Figure 2.* Shame Inventory Part II, total shame experiences.

Each participant completed Part I of the Shame Inventory which measures frequency, intensity and overall experience of shame once each week of the study for a total of three baseline measurements and 6 treatment measurements, the last of which was one week after the completion of the final CAM protocol, as a post-treatment measurement. This measure demonstrated that four of the five participants experienced a decrease in total shame from the mean of baseline scores to the mean of the treatment and post treatment scores while one experienced an increase. The range of scores was 6.00–7.60 for baseline with a mean baseline for all participants combined of 6.87, an *SD* of 0.81 and a standard error of the mean of 0.47. The range of scores for the treatment/post treatment phase was 5.40–6.60 with a mean for all participants combined of 5.73, an *SD* of 0.55 and a standard error of the mean of 0.22. The mean of the individual  $r^2$  scores for the treatment/post treatment phase was 0.33. The effect sizes were further evaluated using two forms of calculations of nonoverlap methods, the PND and the PEM as these are both used for small sets of single case data such as this study. PEM is recommended for use with data that contains outliers or variability within the baseline data (Lenz, 2013) as is

the case with this study. Interpretation of effect scores using these analysis methods are as follows: 0.90 and greater suggest very effective treatments, 0.70–0.89 indicate moderate effectiveness and 0.50–0.69 indicate debatable effectiveness and scores less than 0.50 indicate the treatment is not effective (Lenz, 2013). PND for the mean of the participants yielded an effect score of 0.67 and PEM yielded a score of 1.00. Table 2 illustrates the individual mean scores of each participant along with the combined mean, *SD*, PND, PEM and  $r^2$  of the Shame Inventory Part I.

Table 2

*Shame Inventory Part I*

Participant	Baseline			Treatment			$r^2$	PND	PEM
	Mean	<i>SD</i>	<i>SE</i> Mean	Mean	<i>SD</i>	<i>SE</i> Mean			
1	5.67	1.53	0.88	4.50	1.38	0.56	0.66	0.17	0.83
2	4.67	2.52	1.45	6.00	1.10	0.45	0.04	0.00	0.00
3	8.00	0.00	0.00	4.67	1.63	0.67	0.43	0.00	0.67
4	9.00	0.00	0.00	8.83	0.41	0.17	0.43	0.20	0.20
5	7.00	0.00	0.00	4.67	1.03	0.42	0.10	1.00	1.00
Combined mean	6.87	0.81	0.47	5.73	0.55	0.22	0.33	0.67	1.00

These results offer support to Hypothesis 1, that the use of CAM correlates with a decrease in the experience of shame for Christian recipients of professional counseling services. Effect sizes using PEM ranged from 0.00 (not effective) to 1.00 (very effective) on individual scores, and using the mean of the participants revealed a score of 1.00 (very effective) as can be seen in Figure 3.

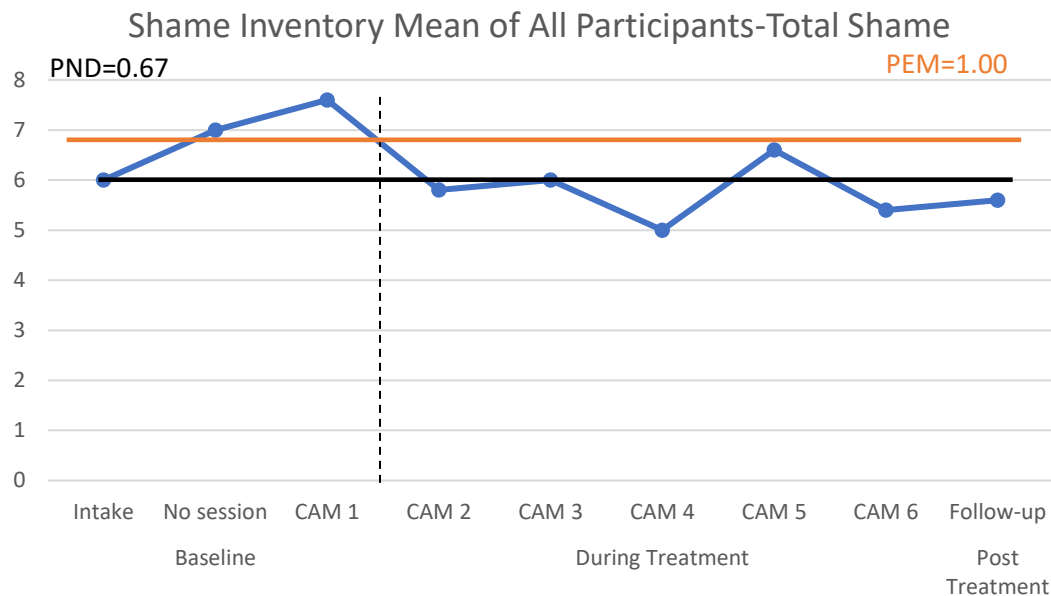


Figure 3. Shame Inventory mean of all participants-total shame.

## Research Question 2

The second research question addresses the possibility of a correlation between the use of CAM and the increase of resiliency in Christian clients diagnosed with depression or anxiety-related conditions. Several measures were utilized to explore various forms of resiliency; the BEAQ measured experiential avoidance, the Brief RCOPE measured both positive and negative religious coping, the Surrender Scale was used to measure a separate style of religious coping and the Dimensions of Grace measured the participants experience of various forms of grace.

## Hypothesis 2

The second hypothesis, Hypothesis 2, states the use of CAM correlates with an increase in resilience for Christian recipients of professional counseling services. The analysis of the BEAQ, Brief RCOPE, Surrender Scale and Dimensions of Grace were used to evaluate this hypothesis. The BEAQ which is expected to decrease with effective treatment, revealed baseline scores ranging from 55.20–57.20, with a combined baseline mean of 56.33, an *SD* of 1.03 and a

standard error of mean of 0.59. It also demonstrated a range of treatment/post treatment scores of 49.20-52.60, with a combined mean of 50.80, an *SD* of 1.71 and a standard error of the mean of 0.99. The mean of the individual  $r^2$  scores was 0.38, the PND of the combined mean was 1.00 and the PEM was 1.00. All five participants reported a decrease in experiential avoidance.

Table 3 illustrates the individual mean scores of each participant along with *SD*, PND, PEM and  $r^2$  as well as the combined mean scores of the BEAQ.

Table 3

*BEAQ*

Participant	Baseline			Treatment			$r^2$	PND	PEM
	Mean	<i>SD</i>	<i>SE</i> Mean	Mean	<i>SD</i>	<i>SE</i> Mean			
1	46.33	5.13	2.96	45.67	2.89	1.67	0.00	0.00	0.67
2	71.00	3.61	2.08	63.00	3.00	1.73	1.00	1.00	1.00
3	63.00	1.73	1.00	51.67	4.51	2.60	0.31	1.00	1.00
4	56.00	2.00	1.15	53.33	2.08	1.20	0.06	0.33	1.00
5	45.33	5.03	2.91	40.33	4.73	2.73	0.55	0.33	1.00
Combined mean	56.33	1.03	0.59	50.80	1.71	0.99	0.38	1.00	1.00

The PEM for the individual scores ranged from 0.67 (debatably effective) to 1.00 (very effective), and using the mean of the participants demonstrated a score of 1.00 (very effective) as can be seen in Figure 4a.



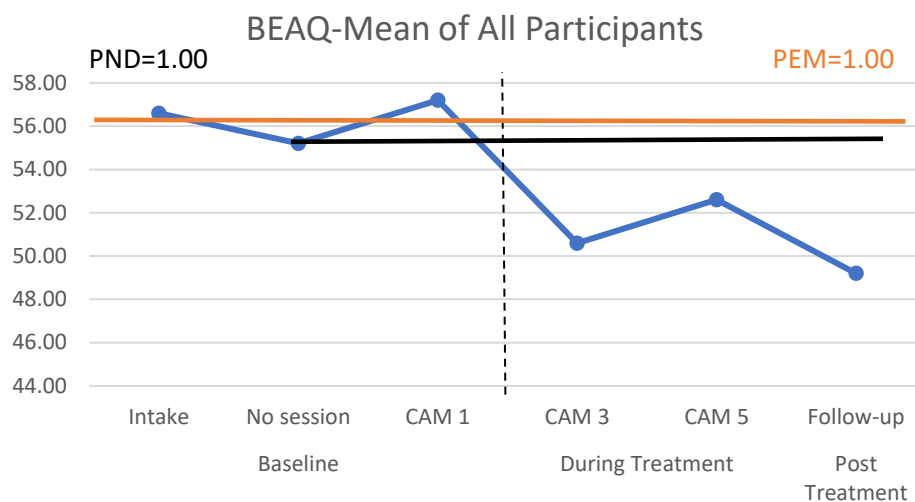


Figure 4a. BEAQ-mean of all participants.

The Brief RCOPE subset that measures positive religious coping is expected to increase with effective treatment. In this study, the baseline scores ranged from 20.40-21.60 with a mean of 21.20, an *SD* of 0.69 and a standard error of the mean of 0.40 while the treatment/post treatment scores ranged from 21.40-23.60 with a mean of 22.73, a *SD* of 1.17, a standard error of the mean of 0.68 and a mean of individual  $r^2$  scores of 0.69. The PND for the combined mean was found to be 0.67 and the PEM was 1.00. Three of the five participants demonstrated a significant increase in positive religious coping by an average of 3.67 points while two reported a slight decrease by an average of 1.67 points during the time of the study. Table 4 illustrates the individual mean scores of each participant along with *SD*, PND, PEM and  $r^2$  as well as the combined mean scores of the Brief RCOPE-Positive Religious Coping.

Table 4

## Brief RCOPE-Positive Religious Coping

Participant	Baseline			Treatment			$r^2$	PND	PEM
	Mean	<i>SD</i>	<i>SE</i> Mean	Mean	<i>SD</i>	<i>SE</i> Mean			
1	18.67	2.08	1.20	20.00	1.00	0.58	1.00	0.00	1.00
2	19.00	3.46	2.00	24.00	3.61	2.08	0.94	0.67	1.00
3	28.00	0.00	0.00	27.00	1.73	1.00	0.75	0.00	0.00
4	21.00	2.65	1.53	18.67	0.58	0.33	0.75	0.00	0.00
5	19.33	4.51	2.60	24.00	0.00	0.00	0.00	0.00	1.00
Combined mean	21.20	0.69	0.40	22.73	1.17	0.68	0.69	0.67	1.00

PEM for the individual scores of the Brief RCOPE-Positive Religious Coping ranged from 0.00 (not effective) to 1.00 (very effective) and when utilizing the mean of the participants, the PEM was found to be 1.00 (very effective) as can be seen in Figure 4b.

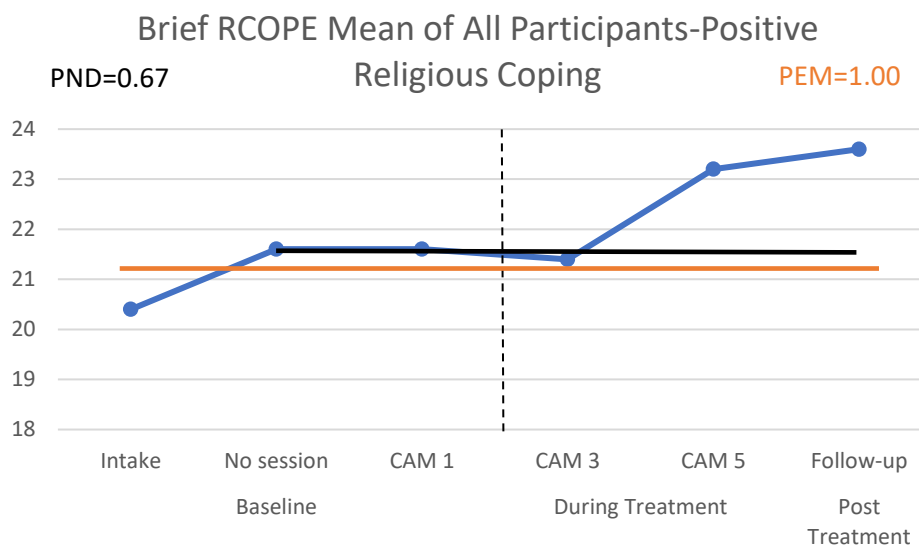


Figure 4b. Brief RCOPE mean of all participants-positive religious coping.

The Brief RCOPE subset that measures negative religious coping is expected to decrease with effective treatment. In this study, the baseline scores ranged from 11.40–12.40 with a mean of 11.87, an *SD* of 0.50 and a standard error of the mean of 0.29 while the treatment/post treatment scores ranged from 9.40–10.80 with a mean of 10.20, an *SD* of 0.72, a standard error

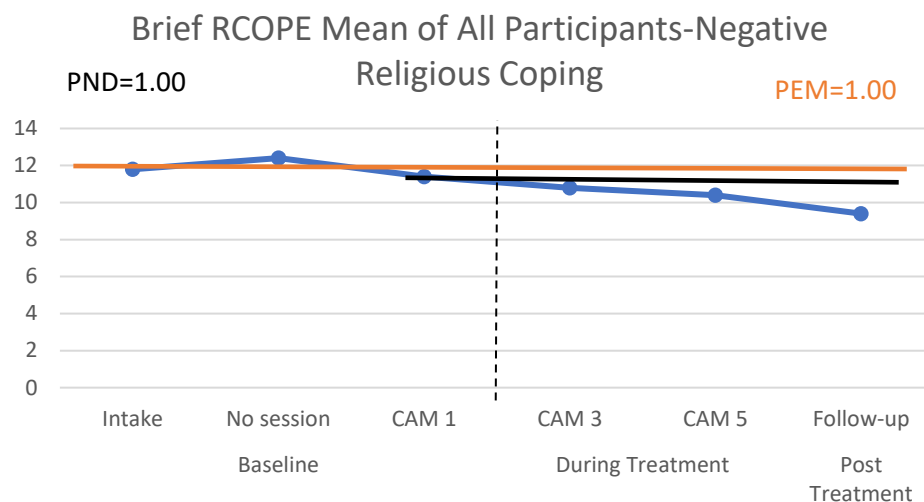
of the mean of 0.42 and a mean of the individual  $r^2$  scores of 0.43. The PND was found to be 1.00 and PEM was 1.00 for the combined mean of the participants. Four of the five participants reported a decrease in negative religious coping while one reported no change. Table 5 illustrates the individual mean scores of each participant along with *SD*, PND, PEM and  $r^2$  as well as the combined mean scores of the Brief RCOPE-Negative Religious Coping.

Table 5

*Brief RCOPE-Negative Religious Coping*

Participant	Baseline			Treatment			$r^2$	PND	PEM
	Mean	<i>SD</i>	<i>SE</i> Mean	Mean	<i>SD</i>	<i>SE</i> Mean			
1	9.00	1.73	1.00	7.33	0.58	0.33	0.00	0.00	1.00
2	15.67	1.53	0.89	12.67	1.53	0.89	0.43	0.67	1.00
3	7.33	0.58	0.33	7.00	0.00	0.00	0.00	0.00	1.00
4	12.67	0.58	0.33	12.67	1.15	0.67	0.75	0.00	0.67
5	14.67	0.58	0.33	11.33	1.53	0.89	0.96	1.00	1.00
Combined mean	11.87	0.50	0.29	10.20	0.72	0.42	0.43	1.00	1.00

PEM for the individual scores of the Brief RCOPE-Negative Religious Coping ranged from 0.67 (debatably effective) to 1.00 (very effective) and when utilizing the mean of the participants, the PEM was found to be 1.00 (very effective) as can be seen in Figure 4c.



*Figure 4c.* Brief RCOPE mean of all participants-negative religious coping.

The Surrender Scale measures an additional form of religious coping in that it measures surrender to God. The scores on this scale are expected to increase with effective treatment. Scores on this measure ranged from 48.20–49.40 in the baseline phase with a mean of 48.73, an *SD* of 0.61 and a standard error of the mean of 0.35. The treatment/post treatment scores ranged from 49.80-51.40 with a mean of 50.40, an *SD* of 0.87, a standard error of the mean of 0.50 and a mean of the individual  $r^2$  scores of 0.37. The PND yielded an effect score of 1.00 and the PEM was 1.00. Two of the five participants reported an increase in surrender while three reported a decrease. Table 6 illustrates the individual mean scores of each participant along with *SD*, PND, PEM and  $r^2$  as well as the combined mean scores of the Surrender Scale.

Table 6

*Surrender Scale*

Participant	Baseline			Treatment			$r^2$	PND	PEM
	Mean	<i>SD</i>	<i>SE</i> Mean	Mean	<i>SD</i>	<i>SE</i> Mean			
1	50.33	2.89	1.67	49.67	1.15	0.67	0.00	0.00	0.33
2	35.00	4.58	2.65	43.67	3.21	1.86	0.60	0.67	1.00
3	60.00	0.00	0.00	59.67	0.58	0.33	0.00	0.00	0.00
4	52.00	3.00	1.73	48.67	0.58	0.33	0.75	0.00	0.00
5	46.33	2.89	1.67	50.33	2.08	1.20	0.52	0.67	1.00
Combined mean	50.33	2.89	1.67	49.67	1.15	0.67	0.00	0.00	0.33

PEM for the individual scores of the Surrender Scale ranged from 0.00 (not effective) to 1.00 (very effective) and when utilizing the mean of the participants, the PEM was found to be 1.00 (very effective) as can be seen in Figure 4d.

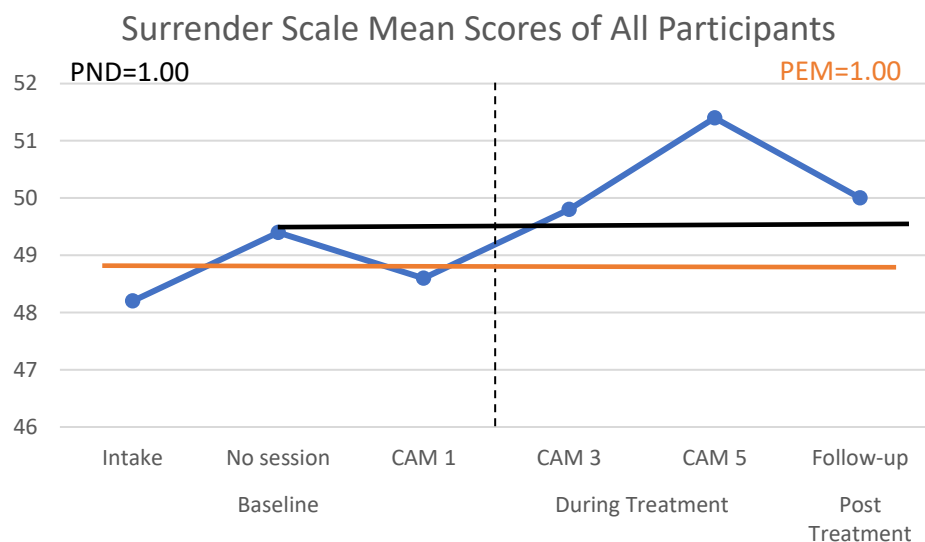


Figure 4d. Surrender Scale mean scores of all participants.

The Dimensions of Grace was also used as a resiliency measure and scores on this scale are expected to increase with effective treatment. Baseline scores from this measure ranged 137.60–141.00 with a mean of 139.47, an *SD* of 1.73 and a standard error of the mean of 1.00 while treatment/post treatment scores ranged from 146.40–146.40, with a mean of 146.40, an *SD*

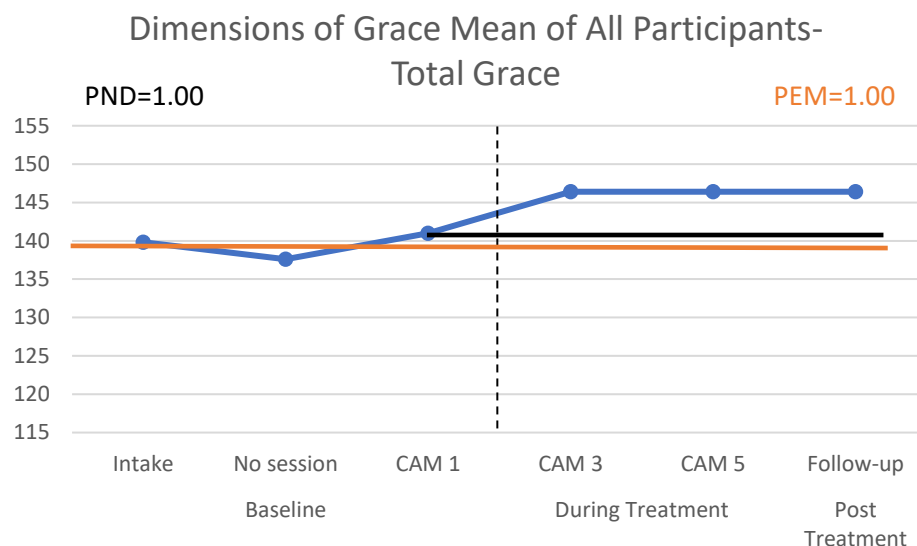
of 0.00 and a standard error of the mean of 0.00 and a mean of the individual  $r^2$  scores of 0.30. The PND of the combined mean was calculated to be 1.00 and the PEM was 1.00. Four of the five participants reported an increase in grace while one reported a decrease. Table 7 illustrates the individual mean scores of each participant along with *SD*, PND, PEM and  $r^2$  as well as the combined mean scores of the Dimensions of Grace.

Table 7

*Dimensions of Grace*

Participant	Baseline			Treatment			$r^2$	PND	PEM
	Mean	<i>SD</i>	<i>SE</i> Mean	Mean	<i>SD</i>	<i>SE</i> Mean			
1	151.00	14.00	8.08	154.33	3.51	2.03	0.99	0.00	0.67
2	132.33	4.04	2.33	143.33	7.77	4.48	0.07	1.00	1.00
3	143.00	12.77	7.37	147.33	6.51	3.76	0.29	0.00	0.67
4	144.67	5.77	3.33	138.00	2.65	1.53	0.04	0.00	0.00
5	126.33	7.09	4.09	149.00	4.58	2.65	0.11	1.00	1.00
Combined mean	139.47	1.73	1.00	146.40	0.00	0.00	0.30	1.00	1.00

PEM for the individual scores of the Dimensions of Grace ranged from 0.00 (not effective) to 1.00 (very effective) and when utilizing the mean of the participants, the PEM was found to be 1.00 (very effective) as can be seen in Figure 4e.



*Figure 4e.* Dimensions of Grace mean of all participants-total grace.

These results from the BEAQ, Brief RCOPE, Surrender Scale and Dimensions of Grace offer support to Hypothesis 2, that the use of CAM correlates with an increase in resilience for Christian recipients of professional counseling services.

### Research Questions 3 and 4

The third research question addresses the possibility of a correlation between a decrease in depressive symptoms in Christian clients diagnosed with depressive disorders with the use of CAM and the final research question addresses the possibility of a correlation between a decrease in anxiety symptoms in Christian clients diagnosed with anxiety disorders and the use of CAM. The DASS was administered each week of the study to assess clinical symptoms, including depression, stress and anxiety.

### Hypothesis 3

The final hypothesis, Hypothesis 3, states that CAM demonstrates efficacy as a clinical treatment intervention for Christian recipients of professional counseling services regardless of a diagnosis of depression or anxiety. To evaluate this, scores on the Depression, Stress and

Anxiety subscales of the DASS were analyzed. Comparisons were made both within subject and between subjects comparing individual baseline to treatment means as well as the combined means. The depression subscale would be expected to decrease with effective treatment. The DASS-Depression demonstrated a baseline range of 14.00–17.20 with a mean of 15.47, an *SD* of 1.62 and a standard error of the mean of 0.93 for this group of five participants. It revealed a treatment/post treatment range of 6.40-10.80 with a mean of 9.00, an *SD* of 1.57, a standard error of the mean of 0.64 and a mean of the individual  $r^2$  scores of 0.30. The PND for the sample mean was calculated to be 1.00 and the PEM was 1.00. All five participants demonstrated a decrease in reported depression between baseline and treatment phases. Table 8 illustrates the individual mean scores of each participant along with *SD*, PND, PEM and  $r^2$  as well as the combined mean scores of the DASS-Depression subscale.

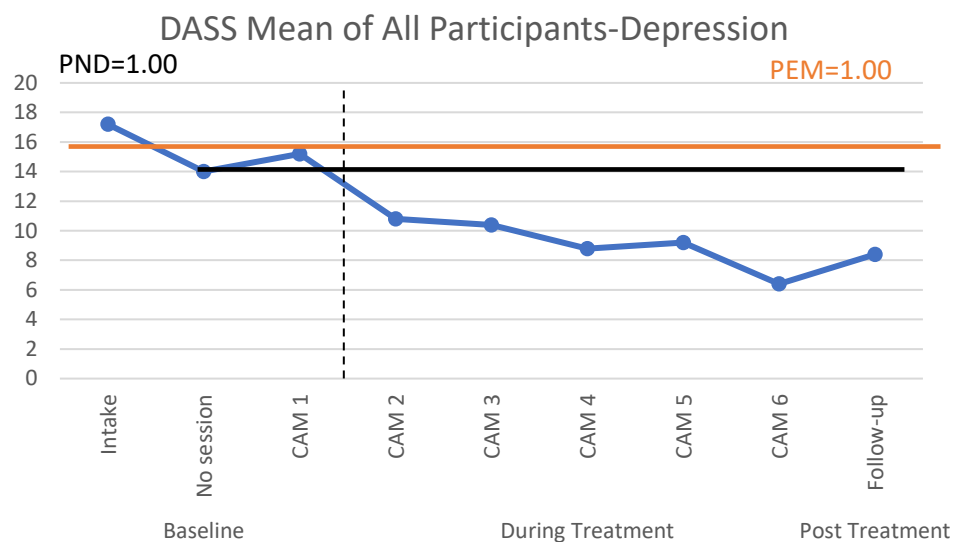
Table 8

*DASS-Depression*

Participant	Baseline			Treatment			$r^2$	PND	PEM
	Mean	<i>SD</i>	<i>SE</i> Mean	Mean	<i>SD</i>	<i>SE</i> Mean			
1	12.67	3.06	1.76	5.67	1.51	0.61	0.05	1.00	1.00
2	16.67	1.15	0.67	6.67	3.93	1.61	0.01	1.00	1.00
3	9.33	1.15	0.67	3.67	4.27	1.74	0.69	0.00	0.33
4	32.00	3.46	2.00	28.33	5.85	2.39	0.74	0.50	0.67
5	6.67	2.31	1.33	0.67	1.03	0.42	0.00	1.00	1.00
Combined mean	15.47	1.62	0.93	9.00	1.57	0.64	0.30	1.00	1.00

PEM for the individual scores of the DASS-Depression ranged from 0.33 (not effective) to 1.00 (very effective) and when utilizing the mean of the participants, the PEM was found to be 1.00 (very effective) as can be seen in Figure 5a.





*Figure 5a.* DASS mean of all participants-depression.

The Stress subscale measures a person's inability to relax, as well as levels of irritability and nervous tension, similar to the DSM criteria for generalized anxiety disorder whereas the Anxiety subscale corresponds to other forms of anxiety. The expectation is that scores on both scales would decrease with effective treatment. The Stress subscale in this study revealed baseline scores ranging from 12.00–17.20, with a mean of 14.80, an *SD* of 2.62 and a standard error of the mean of 1.51. The treatment/post treatment scores ranged from 3.60–9.60 with a mean of 6.87, an *SD* of 1.95, a standard error of the mean of 0.80 and a mean of the individual  $r^2$  scores of 0.26. The PND was calculated to be 1.00 and the PEM was 1.00. All five participants demonstrated a decrease in reported stress between baseline and treatment phases.

The Anxiety subscale of the DASS had baseline scores of 2.80–4.40 with a mean of 3.60, an *SD* of 0.80 and a standard error of the mean of 0.46 while the treatment/post treatment scores ranged from 0.40–4.80 with a mean of 2.00, an *SD* of 1.79, a standard error of the mean of 0.73 and a mean of the individual  $r^2$  scores of 0.36. The PND revealed an effect score of 0.67 and a PEM of 0.83. Four of the five participants demonstrated a decrease in reported anxiety while

one reported the same. Tables 9 and 10 illustrate the individual mean scores of each participant along with *SD*, PND, PEM and  $r^2$  as well as the combined mean scores of the DASS-Stress and the DASS Anxiety subscales.

Table 9

*DASS-Stress*

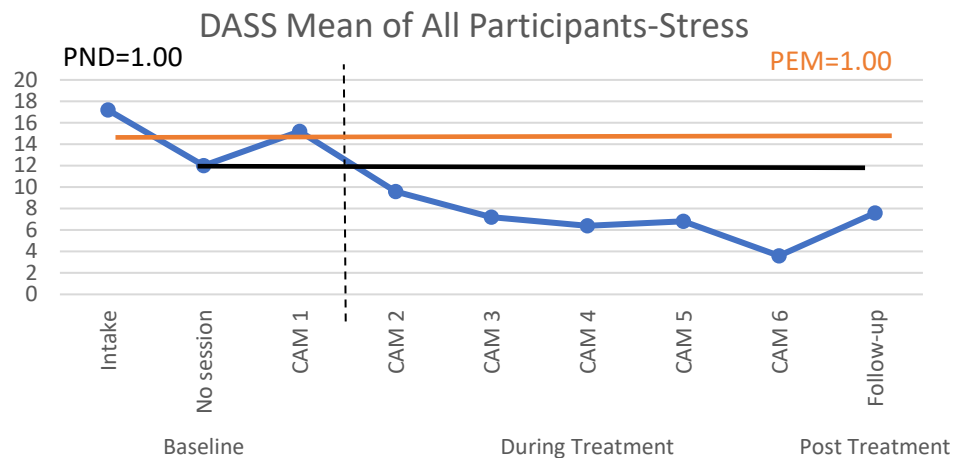
Participant	Baseline			Treatment			$r^2$	PND	PEM
	Mean	<i>SD</i>	<i>SE</i> Mean	Mean	<i>SD</i>	<i>SE</i> Mean			
1	10.67	3.06	1.76	2.33	3.20	1.31	0.25	0.83	1.00
2	16.00	3.46	2.00	6.00	5.22	2.13	0.24	0.83	0.83
3	10.00	2.00	1.15	6.67	3.93	1.61	0.30	0.50	0.83
4	18.00	3.46	2.00	13.00	5.18	2.11	0.46	0.50	0.67
5	19.33	2.30	1.33	6.33	3.67	1.50	0.04	1.00	1.00
Combined mean	14.80	2.62	1.51	6.87	1.95	0.80	0.26	1.00	1.00

Table 10

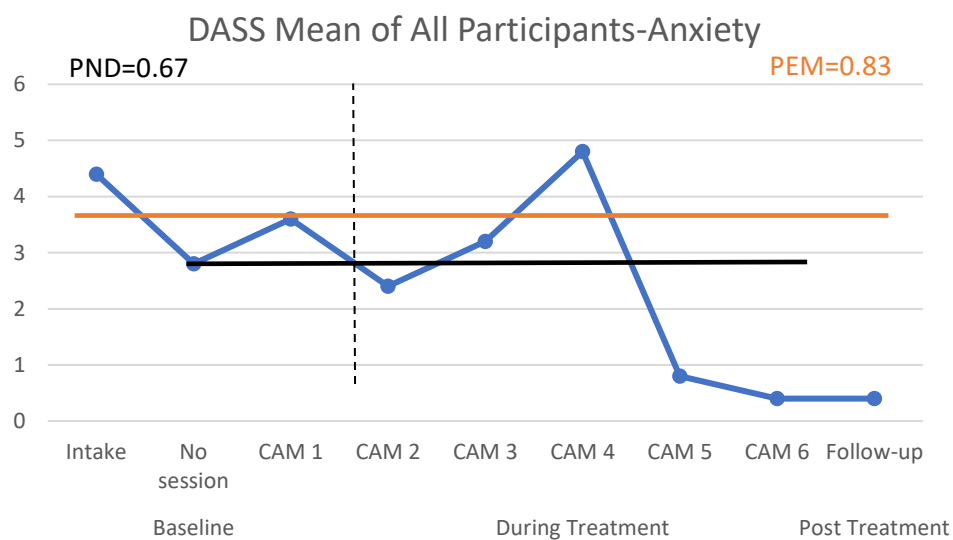
*DASS-Anxiety*

Participant	Baseline			Treatment			$r^2$	PND	PEM
	Mean	<i>SD</i>	<i>SE</i> Mean	Mean	<i>SD</i>	<i>SE</i> Mean			
1	3.33	2.31	1.33	2.33	2.94	1.20	0.00	0.33	1.00
2	2.00	2.00	1.15	0.33	0.82	0.33	0.02	0.00	0.83
3	1.33	2.31	1.33	1.33	1.03	0.42	0.69	0.00	0.33
4	6.00	2.00	1.15	5.67	5.72	2.33	0.67	0.50	0.50
5	5.33	3.06	1.76	0.33	0.82	0.33	0.43	0.83	1.00
Combined mean	3.60	0.80	0.46	2.00	1.79	0.73	0.36	0.67	0.83

PEM for the individual scores of the DASS-Stress ranged from 0.67 (debatably effective) to 1.00 (very effective) and PEM for the individual scores of the DASS-Anxiety ranged from 0.33 (not effective) to 1.00 (very effective). When utilizing the mean of the participants, the PEM was found to be 1.00 (very effective) on the Stress subscale and 0.83 (moderately effective) on the Anxiety subscale as can be seen in Figures 5b and 5c.



*Figure 5b.* DASS mean of all participants-stress.



*Figure 5c.* DASS mean of all participants-anxiety.

These data offer support to Hypothesis 3, that CAM demonstrates efficacy as a clinical treatment intervention for Christian recipients of professional counseling services regardless of a diagnosis of depression or anxiety.

### Narrative Results

The small sample size of this study allows for contemplation of some qualitative responses from the participants in addition to the quantitative outcomes. The participants in the

study offered narrative results during the follow-up and throughout the study. Four of the five requested to have the meditations emailed to them and listened to the meditations on their phone outside of session and one requested a flash drive that was updated at the end of each session with the addition of the current exercise and listened to it on their computer. All five stated the meditations as a whole were more helpful than they had predicted having had little to no prior experience with mindfulness or meditative practice. Samples of statements from the participants regarding this were as follows: “I was such a skeptic, but I’m completely sold! These meditations are reframing my thoughts more than anything else ever has!” “I was a little worried about coming to therapy, but I appreciate being able to make a connection to God in therapy; that’s really helpful!” “My [spouse] has been talking about how much I’m changing, I’m more motivated and less depressed since I’ve been meditating every day,” “I can’t believe how much this is helping me,” “I have struggled with anxiety many years and I can’t believe how quickly this is helping me to let go of the anxiety and live my life!” “My [spouse] is seeing so much change in me, they’ve asked to be able to do the meditations too!” and “To be honest, I had kind of thought this was going to be a ‘hippy thing,’ I can’t believe how quickly it has been so helpful! I really am shocked! I really am different now!”

The participants reported various responses to the individual meditations during treatment and on which meditations they found most and least helpful upon reflection during the follow-up appointment. Three of the five participants cried during the breathing meditation exercise in the first CAM session and expressed surprise at how this brought up an emotional response. They made statements such as “I guess I don’t usually stop and be still; I didn’t realize how much emotion I was holding,” “I never just sat with God in my breathing before, such a simple and powerful thing,” and “Are meditations supposed to make you cry? I wasn’t expecting that, but it

felt good to be still and let go.” All five stated they often returned to the breathing meditation throughout the study and found it easily accessible throughout their days whether or not they had access to the audio at the time. Statements from the participants about this were as follows: “The breathing one is very calming and helps me be able to think,” “It re-centers me,” “I sometimes just stop and realize I need to breathe now,” and “I can’t believe how much just breathing calms and reframes me.”

Four of the five stated they did not connect well with the body scan exercise outside of the sessions, but one stated using it every night before sleep and finding it to be very helpful. Participants statements about this meditation were as follows: “I don’t like that one as much,” “that one doesn’t hold my attention as well,” “I love the body scan one; it really relaxes me” and “that one is really hard for me.”

All five stated the scripture meditation was useful and that after doing it in the morning they would find themselves returning to a shortened version of it throughout the day without the audio, on their own while at work, while going for a walk or in their car during their lunch break. Two people stated it was their favorite of all the meditations because it helped them to attain a deeper connection with God which calmed the depressive or anxiety symptoms. Participants used statements such as the following to describe this: “It’s really powerful to meditate on a scripture instead of just reading it; it seems to get deeper into me and I find myself thinking so much more about it when I normally would be worrying,” “The scripture meditation helps me to refocus on God and stop worrying about fixing it on my own,” “Meditating on a scripture is different from reading or thinking about one. When I meditate on it, it helps me to really believe it; then it’s on my heart deeper and I can pull it up easier when I start to feel overwhelmed,” “It’s helpful to just think about God’s words and not my own,” and “I’ve been a Christian for over 20

years and the scripture meditation exercises have helped my relationship with God more than anything else has.”

All five participants found the Jesus Prayer meditation to be helpful in session, but in subsequent weeks, they did not report to return to it as much as they did the scripture, breathing and acceptance meditations. When asked to think through the various meditations in the follow-up session, a common reaction was to think back to the meditation, remember that it was helpful and then state they need to remember to do that one again now. Two of the participants cried when doing the Jesus Prayer mediation in session and stated it brought them to tears when doing it at home, remembering that they have help when they are feeling down or overwhelmed using statements such as “This meditation helps me to remember God’s presence and his help.”

All five of the participants stated the Releasing of Shame meditation was helpful in session but had difficulty returning to it consistently using statements such as, “That one seems harder than the others, it’s really deep” or “I have to have the energy to do that one.” Four of the five stated they want to return to this meditation with a concentrated focus as they continue in therapy. Sample statements from the participants about this meditation are as follows: “I didn’t realize how much I have felt shame; I never understood that before, I’m seeing it a lot now,” “It’s powerful to release the control shame has on me,” “I’m really starting to notice how present shame is,” “It’s emotional, but not in a bad way,” “It’s a powerful release,” “I’m noticing shame more now, but it’s strange, it doesn’t bother me as much. I’m kind of relieved to know what it is and that I can do something about it now,” “It doesn’t feel as happy as the other meditations, but I know I need to go there,” and “I didn’t realize how much my past shame shapes my current reactions. It helps me to be able to change that.”

The Wisdom of Accepted Tenderness meditation was found to be helpful by all five participants and it was one that was returned to during the follow-up week by three of the five participants. Participants used the following statements to describe their reactions to this meditation: “It helps me see that God is for me; I don’t have to judge myself,” “I like the acceptance one, it helps me let go of the ruminations and bad thoughts,” “I realize now that I am often telling myself about the things I am doing wrong. It reminds me that even when I make mistakes, God still accepts me.”

From these narrative results, it can be seen that all five participants, from a self-reported and subjective standpoint, experienced a positive and significant response to the meditative mindfulness exercises. All five reported a decrease in the self-reported experience of their presenting symptoms and all five credited the exercises with helping to achieve this. All five also stated a desire to continue to use Christian based meditative practices as they move forward to assist with improving their mental health as well as their spiritual health as all five indicated a connection with God was important to their healing process.

### **Summary**

A summary of the treatment effect sizes for all of the measures as well as the effect size of the treatment mean of all the participants using the PEM as a measure finds that significant effect sizes (0.83 on the DASS-Anxiety and 1.00 on all others) were demonstrated on each measure for the sample as a whole using the mean treatment scores with individual differences between the subjects. A summary of these findings can be found in Table 11.

Table 11

*PEM Treatment Effect Sizes for All Measures*

	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5	Group
Diagnoses	Adjustment disorder with depression	MDD (recurrent, moderate); unspecified anxiety disorder	MDD (recurrent, moderate)	GAD; MDD (recurrent, moderate)	GAD	Anxiety(1) Depression(2) Depression & Anxiety(2)
Shame Inventory Part I	0.83	0.00	0.67	0.20	1.00	1.00
BEAQ	0.67	1.00	1.00	1.00	1.00	1.00
Surrender Scale	0.33	1.00	0.00	0.00	1.00	1.00
Brief RCOPE						
Positive Religious Coping	1.00	1.00	0.00	0.00	1.00	1.00
Negative Religious Coping	1.00	1.00	1.00	0.67	1.00	1.00
Dimensions of Grace	0.67	1.00	0.67	0.00	1.00	1.00
DASS						
Depression	1.00	1.00	0.33	0.67	1.00	1.00
Stress	1.00	0.83	0.83	0.67	1.00	1.00
Anxiety	1.00	0.83	0.33	0.50	1.00	0.83

*Note.* GAD = generalized anxiety disorder; MDD = major depressive disorder.



## **CHAPTER FIVE: CONCLUSIONS**

### **Overview**

This chapter will discuss the purpose of the study and review the research questions in the context of the results of the current study as well as the relevant literature and relation to other studies. Additionally, the implications that the current study has on therapeutic practice and the existing body of knowledge within the field of counseling will be discussed as well as the limitations of the current study, recommendations for future research and conclusions.

### **Discussion**

The purpose of this study is to address the gap in the current research regarding the use of mindfulness to treat psychological symptoms that are often the result of shame in Christian clients. Although culturally sensitive approaches are considered the ethical standard in professional counseling (ACA, 2014), many Christians who may benefit from counseling services are reluctant to seek them for fear that these services may either contradict their cultural spiritual beliefs or fear that these beliefs will not be incorporated in the process of healing and change. Using a set of CAM modules as an independent variable, the dependent variables of shame, depression, anxiety and resiliency were measured to determine the effect of a mindfulness intervention adjusted to meet the cultural needs of the Christian clinical population. This study found that CAM significantly correlated with a decrease in the experience of shame, depression, anxiety and stress as well as with an increase in resiliency factors for a group of Christian clients seeking therapy for either depressive or anxiety-related disorders at sample effect sizes considered “very effective” on eight of the nine outcome measures and moderately effective on one. Individual differences were present between subjects; however, effect sizes of significance were found for all of the five subjects on at least five of the nine outcome measures

administered with three of the participants demonstrating effectiveness on at least eight of the nine. Additionally, more than half of the total individual effect sizes measured were found to be “very effective.”

The most prevalent mental health conditions treated by outpatient therapists are depression and anxiety and the symptoms of these are often correlated to an experience of shame (Hofmann et al., 2010). This pervasive and destructive moral emotion is at the core of the need for healing in the Christian worldview as evidenced by Hebrews 12:2 which states “For the joy set before him he endured the cross, scorning its shame, and sat down at the right hand of the throne of God” (New International Version). This scripture refers to Jesus’ redemptive and healing work at the cross, which is the foundation of the Christian faith, to be that of removing shame and the separation from God it has caused. When shame continues to be present in the life of a Christian, it can lead to both emotional and spiritual distress and internal conflict which may manifest as depression or anxiety. Furthermore, when these Christians then seek help from a mental health professional, there may be a need to combine the healing aspects of their faith with the counseling services. Therefore, having access to strategies and interventions that incorporate the spiritual background of Christian clients with current evidenced-based practices may be a way to equip professional counselors with culturally sensitive tools to utilize with this population. Since best practice in professional counseling is to utilize evidence-based treatments (ACA, 2014), it is important to begin to bridge the gap in the research regarding the development and use of adapted mindfulness strategies with the Christian clinical population. Protocols must be developed and evaluated to determine the effectiveness of these treatments. To this end, the current study examined four research questions.

### **Research Question 1**

The first question was as follows: Does the use of CAM correlate with the decrease of negative experiences of shame in Christian clients diagnosed with depression or anxiety? By definition, shame causes a person to hide parts of the self that are perceived to be socially or spiritually undesirable or defective (Pattison, 2000). It is an emotional state that generates psychological distress and dysfunction that is correlated with mental health conditions such as depression or anxiety (Van Vliet, 2008). Because shame promotes a desire to conceal perceived defects, in the cultural context of the Christian community, a Christian may be fearful of seeking services for the resultant disorders out of fear of being perceived as “unspiritual” or “weak” by their own community. Therefore, offering strategies that address the need for a spiritual connection and a spiritual context may be a powerful tool in the counseling process. Because mindfulness teaches a person to view the self and others in a nonjudgmental manner, it can combat this desire to hide and allow a person to address the symptoms that have been produced by shame, decreasing its effect (Hjeltnes et al., 2015). In a study by Goldsmith et al. (2014), mindfulness was found to reduce shame in a non-Christian specific sample; and using the PEM scores of the sample mean data points, the current study supports these findings but in an explicitly Christian sample. Furthermore, comparing baseline mean to treatment mean for each individual participant demonstrated a decrease in the negative experience of shame for four of the five participants. Also, four of the five participants demonstrated an increase in the reported experience of shame the week that the releasing of shame meditation was delivered which may indicate an increased awareness of the feelings of shame. One participant noted “I’m noticing shame more now, but it’s strange, it doesn’t bother me as much. I’m kind of relieved to know what it is and that I can do something about it now.” Three of the four who experienced an

uptick in reported shame demonstrated a decrease by the end of the study. No research was found to further support or contradict these findings in a specifically Christian population, indicating that more research is needed to fully evaluate this.

### **Research Question 2**

The second question to be addressed by the research is as follows: Does the use of CAM correlate with the increase of resiliency in Christian clients diagnosed with depression or anxiety? Resiliency is defined as a demonstration of positive growth despite negative or damaging circumstances (Nguyen et al., 2015; Prestia, 2016). Resiliency in the current study was measured utilizing several scales including the BEAQ which measures experiential avoidance and would be expected to decrease with increased resiliency, the Brief RCOPE Positive Religious Coping subscale which would be expected to increase and the Negative Religious Coping subscale which would be expected to decrease with increased resiliency as well as the Surrender Scale which would be expected to increase with increased resiliency and the Dimensions of Grace which would be expected to increase with increased resiliency. Previous research has noted that spirituality is among the factors that produce the protective mechanisms present in resiliency (Brown, 2006; Van Vliet, 2008). Because clients whose spiritual struggles are explored and addressed in the therapy context demonstrate positively impacted treatment outcomes (Harris et al., 2014), it is possible that utilizing strategies that are specific to a Christian client's spiritual beliefs will increase resiliency factors which can improve treatment outcomes.

Using the PEM as a measure of effectiveness, all five of these measures yielded an effect size that would support a finding of correlation between the use of CAM and increased resiliency in Christian clients diagnosed with either depression or anxiety. Comparing the individual

participant baseline to treatment means for the BEAQ demonstrated a decrease in experiential avoidance in all five participants as evidenced by a combined mean baseline score of 56.33 and a combined mean treatment score of 50.80. Because experiential avoidance is the tendency to maladaptively circumvent feared emotional states such as depression or anxiety (Woods & Proeve, 2014), a decrease in this indicates an increased ability to tolerate these negative emotional states. In a single case study conducted by Frye and Spates (2012), mindfulness skills training was correlated to a decrease in anxiety sensitivity. Therefore, an improvement in distress tolerance as well as acceptance skills produced by CAM may help to explain the current findings of decreased scores on the BEAQ and support the findings of Frye and Spates (2012).

Although using the PEM with the mean of the total scores yielded significant effect sizes, comparing the baseline to treatment means of the individual participants for the Positive Religious Coping demonstrated an increase in positive coping for three of the five participants and a decrease in two. This finding of no effect in two of the participants can be compared to that of Ford (2016) which found that positive religious coping did not significantly increase in the group of Christian non-clinical subjects used in a study comparing regular mindfulness to CAM. With a possible range of scores on this subscale of 7–28, the participants of the current study had a baseline positive coping score similar to that of the study by Ford (2016) in that it was relatively high at 21.20, leaving less ability to demonstrate an increase.

In comparing baseline to treatment means of the participants on the Negative Religious Coping subscale this study found that four of the five showed a decrease in negative coping while one remained the same. With a possible range of total scores from 7-28, this sample had a mean baseline score of 11.87 and a mean treatment score of 10.20. In a study by Myers (2012) a correlation between mindfulness and religious coping was determined in that the religious coping

increased as mindfulness increased. The current study also demonstrated an overall increase in religious coping by showing an increase in positive coping and a decrease in negative coping while clients were taught Christian mindfulness exercises.

Spiritual acceptance has been noted to improve mindfulness skills, relationship with God, and acceptance of self which in turn leads to increased resiliency toward depression and anxiety (Hathaway & Tan, 2009). In a study by Nguyen et al. (2015), it was found that a positive perception of God was predictive of resiliency while a negative perception of God was predictive of a lack of resiliency. Surrender as measured on the Surrender Scale is a form of spiritual resiliency in that higher scores indicate a positive reliance on God. In this study only two of the five participants showed an increase on this measure; however, with a possible range of scores of 12-60, the baseline mean of the participants was quite high at 48.73, leaving little room for an increase in scores. Though the overall findings of this scale are in support, the findings of the three participants who demonstrated a decrease on this scale contradict the findings of Knabb and Vazquez (2018) who found that an online contemplative prayer program administered over a two-week period demonstrated medium effects on the surrender levels of a non-clinical Christian sample. However, the sample of Knabb and Vazquez's (2018) study was much larger at 44 and had a lower baseline mean score of 42.93 that rose to 46.55 post-intervention which was still lower than the baseline mean of the current study which may account for some of this contradiction.

Within the Christian worldview, grace is the remedy for shame in that it is "God's choice to love and accept humans despite their sinfulness" (McMinn et al., 2006) and as such has the potential to promote an increase in psychological and spiritual resiliency. Grace, which can be defined as "an act of showing kindness, generosity, or mercy to someone who is undeserving and

potentially incapable of returning the kindness shown” (Bufford et al., 2017, p. 57), has been measured in the current study utilizing the Dimensions of Grace. Four of the five subscales were used, Experiencing God’s Grace, Costly Grace, Grace to Self and Grace to Others and combined to give a total grace score. With a possible range of scores of 29–203, the combined mean of the current study was 139.47 and four of the five participants demonstrated an increase in the experience of total grace. Because mindfulness increases acceptance of self and others, it is a means of expressing grace (Bufford et al., 2017). Although Christian faith is predicated on the need for and acceptance of grace, a study by Hathaway and Tan (2009) found that Christians may have difficulty living in response to this belief and that therapists can facilitate congruity between the professed belief and the lived life. This was supported in the current study with the demonstration of increased experience of grace with the use of CAM.

### **Research Question 3**

The third question to be addressed by the research is as follows: Does a decrease in depressive symptoms in Christian clients diagnosed with depressive disorders correlate with the use of CAM? Although MBIs have demonstrated efficacy for decreasing the symptoms of depressive disorders due to decreasing repetitive negative thinking (Alsubaie et al., 2017; Burg & Michalak, 2011; Hathaway & Tan, 2009), Christians can be reluctant to utilize mindfulness strategies that are rooted in Buddhist traditions as this may be perceived as in opposition to their own faith perspective. However, traditional versions of mindfulness exercises have been shown to be capable of accommodation to the Christian worldview. Utilizing techniques of Christian devotion meditation (Frederick & White, 2015), Christian contemplative practices (Davidson & Kaszniak, 2015; Knabb & Frederick, 2017), centering prayer (Knabb, 2012) and Christian mysticism (Trammel, 2018), researchers have demonstrated the effectiveness of these

accommodations to decrease psychological symptoms utilizing non-clinical samples of Christian populations (Knabb & Frederick, 2017; Knabb & Vazquez, 2018). The current study supported this research using a clinical population in that it demonstrated a decrease in the report of depressive symptoms on the DASS-Depression subscale for all five participants with a combined mean baseline score of 15.47 and a combined mean treatment score of 9.00 utilizing CAM from a potential score range of 0-42. The current study contradicted the findings of Ford (2016) in which no significant difference on the DASS-Depression subscale was noted within the subjects who were taught CAM. However, the sample in Ford's (2016) study was not clinical and presented with a baseline mean of combined Depression, Anxiety and Stress of 18.89, whereas the current study had a combined Depression, Anxiety and Stress baseline mean of 34.8 indicating a higher level of clinical presentation.

#### **Research Question 4**

The final question to be addressed by the research is as follows: Does a decrease in anxiety symptoms in Christian clients diagnosed with anxiety disorders correlate with the use of CAM? Traditional mindfulness-based approaches have demonstrated efficacy in the treatment of anxiety disorders due to the promotion of an increased nonjudgmental awareness and an improved sense of acceptance (Hofmann et al., 2010); however, Christians may have difficulty accessing these benefits due to a fear of utilizing a strategy that may be viewed as contrary to their cultural faith belief system in that these approaches are largely presented from a Buddhist perspective. Knabb and Frederick (2017) have developed a workbook of Christian based prayer approaches that can be used with Christian clients who experience chronic worry in an effort to demonstrate a means of accommodating the cultural needs of Christian clients in therapy, one of which was used in the current study. Hjeltnes et al. (2015) found that meditation and



mindfulness produced a decrease in overall anxiety and worry, which is supported by the current study in that participants reported decreased generalized anxiety symptoms after learning mindfulness meditations. Researchers have advocated for the development of Christian MBIs to replace the existing secular or Buddhist techniques (Frederick & White, 2015; Knabb, 2012) to improve access to the benefits of mindfulness for Christian recipients of therapeutic services and the current study supports this as the participants expressed reluctance to believing that mindfulness or meditation would be helpful in relieving symptoms but agreed to the use because of the explicitly Christian nature of the interventions. Furthermore, in a study conducted by Ford (2016), it was found that Christian participants in a non-clinical setting who were taught Christian mindfulness exercises were more likely to adhere to the treatment than Christian participants who were taught regular mindfulness exercises which the aforementioned narrative response of the current study participants also supports, though no comparison to a non-Christian approach was made.

In a clinical setting, treatment adherence increases the potential of treatment effectiveness. In the current study, the DASS-Stress subscale was used to measure symptoms of generalized anxiety and the DASS-Anxiety subscale was used to measure symptoms of other forms of anxiety, both of which have potential score ranges of 0–42. All five participants demonstrated a decrease from baseline mean scores to treatment mean scores on the DASS-Stress subscale with a combined baseline mean of 14.80 and a combined treatment mean of 6.87. These findings support the findings of Ford (2016) in that her study also noted a significant decrease on this scale for non-clinical subjects who were taught CAM. These findings also support the findings of Knabb and Vazquez (2018) who found that an online contemplative prayer program administered over a two-week period demonstrated medium effects on the stress

levels of a non-clinical Christian sample. Furthermore, these findings are supportive of those of Knabb, Frederick, and Cumming (2017) who found that an increase in surrender is correlated with a decrease in worry in a Christian sample. The findings of the DASS-Anxiety were less significant in that four of the five participant scores decreased, and one remained the same. Of note, the combined mean baseline score was 3.60 while the combined treatment mean was 2.00 which indicates a very low overall score on this scale, leaving little room for improvement.

### **Implications**

This study offers data to begin to fill the gap in the current research regarding the development and use of CAM modules to effectively treat the psychological symptoms of depression and anxiety that are often the result of shame in Christian clinical populations. It offers a template for building cultural competency in the treatment of Christian clients who are sometimes reluctant to seek treatment due to fear of contradicting their faith beliefs. From this research, clinicians who treat Christian clients can have accessible strategies for providing culturally sensitive interventions that promote growth and healing in these clients by building on both existing evidence based mindfulness approaches and the Christian faith components of healing.

The current study indicates that mindfulness strategies which are overtly Christian have the potential to be used effectively with Christian clients in an outpatient therapy setting to reduce the negative experiences of shame, depression and anxiety in a Christian clinical population. Mindfulness is a way that therapists can raise acceptance and awareness and thereby increase a Christian client's connection to the love and acceptance of God professed by their faith which in turn has the potential to increase resiliency to these negative emotional states. Myers (2012) found that without mindfulness, religious coping, a resiliency measure, did not

demonstrate an effect on emotion regulation-reappraisal; therefore, mindfulness was found to mediate the relationship between religious coping and emotion regulation-reappraisal. Teaching mindfulness skills that are specifically Christian may further help to solidify the resiliency found in religious coping and help to regulate the negative emotional states of shame, depression and anxiety.

Additionally, mindfulness that is overtly Christian has the potential to increase acceptance and surrender to God which in turn has been demonstrated to correlate to a decrease in worry (Knabb et al., 2016). Using CAM skills in a therapeutic setting with Christian clients may improve not only a person's presenting mental health concerns, but also may contribute to a deeper spiritual connection to God. The combined effect of this may result in improved resiliency, a stronger spiritual coping base, improved mental health and less need for future services.

### **Limitations**

Due to the real world, non-laboratory setting of this quasi-experimental N of 1 study, several limitations are inherent. Although the protocols were standardized with the CAM sessions delivered by the same therapist/researcher and the homework given in the form of pre-recorded meditations to eliminate any variability in the deliverance of the protocol components between participants, the study is expected to have low to moderate internal validity due to the possibility of confounding variables found in this setting. Causality and generalizability are limited due to the small sample size and the setting but correlations between the independent variable of the CAM modules and the dependent variables of shame, depression, anxiety and resiliency can be made. Experimenter expectations is also a threat to internal validity; therefore, the measures were delivered via Survey Monkey or in a written form for one of the participants

who found that easier. Participants were allowed to complete the surveys outside of the therapy session and the experimenter did not try to influence the answers in any way by reminding the participants to complete the surveys based on their own understanding of their experiences and symptoms. The experimenter reminded the participants at several points of the voluntary nature of the study and that deciding to leave the study at any point would not alter their treatment with the therapist or the clinic in any way.

This study is expected to have higher external validity due to the real world setting of an outpatient clinic with an experienced therapist and real clients who have referred for clinical services and who meet DSM criteria for an anxiety or depressive disorder rather than a laboratory setting. However, this is also limited in this study by the small sample size that restricts generalizability. Although homogeneity increases validity, this study was conducted with a small but diverse group of participants. The variance in age, race, income level, marital status and education limits validity but also increases generalizability and the value of the real-life aspect of the findings. Also, in a real clinical setting, clients experience variability in life circumstances during the course of treatment with increases and decreases in external stress due to these events and this happened in this study which limits internal validity but increases external validity as this is the treatment as usual setting that these interventions would be delivered outside of a study. Therefore, clinicians and researchers who review the study could expect similar variances in another clinical population.

This study is also limited by some of the tools used to measure the variables. Some of the participants answered the Surrender Scale consistently with the upper threshold score and some answered the Positive Religious Coping subscale of the Brief RCOPE consistently nearing the upper threshold as well. These measures may limit the change data of this sample simply

because the questions were worded such that a person of an Evangelical Christian background would be predisposed to answer in a particular way, leaving little room to measure change. This study also lacks a narrative follow-up tool which limits the validity of the qualitative data that is received at the end of the study. A more uniform and perhaps even anonymous survey may further contribute to the understanding of the qualitative experience of the CAM modules.

### **Recommendations for Future Research**

There are several recommendations for continued research as the body of research regarding the use of CAM in clinical settings is just beginning. Future studies would benefit from considering a longer duration in which additional time is spent on each intervention and perhaps additional time for psychoeducation around the use of the individual meditations. Garzon and Ford (2016) offer suggestions such as allowing the participant to read the meditation script and ask questions about any terms before delivering the meditation or spending time looking at scriptures that reference meditations before delivering such interventions to a Christian clinical participant who may question the adherence to their cultural beliefs in the use of meditation due to its Eastern philosophical context in popular society. Suggestions such as these could be incorporated into the study design of future studies.

Another consideration for future studies is that of sample size. This was a relatively small sample and a larger sample would offer more data and more validity. Comparisons between subjects and within subgroups could be made with a larger sample size. Also, effectiveness could be better evaluated with more subjects.

This study utilized several measures to evaluate resiliency, some of which may be less revealing when administered to an Evangelical Christian population as was the case in this study. For instance, the surrender scale was largely scored high for the participants in both the baseline

and treatment phases with participants sometimes reporting the highest levels possible. This measure may be worded in such a way as to not be a useful tool for measuring change in this population. Considering the use of other measures of resiliency may be beneficial in future studies. Likewise, exploration of more extensive shame measurements may be useful as well since the current study used a measure that offered little variability as it asked only 3 questions each week after the initial more lengthy questionnaire. Also, a follow-up questionnaire that asks for subjective feedback about the experience of the CAM modules would be useful in future studies.

Furthermore, future studies may want to consider comparing two groups of clinical participants, one in which the therapist utilizes CAM as the interventions and one in which the therapist utilizes a traditional mindfulness approach to compare the results as has been done with non-clinical samples by researchers such as Ford (2016). This would help to further understand the difference in effectiveness of these approaches with Christian clinical populations.

Lastly, future studies regarding the use of CAM modules may want to consider having the therapist be non-Christian to evaluate the effectiveness of the modules regardless of the beliefs of the therapist. This would help to determine the ability of the CAM modules to produce cultural competency in a therapist who is from a different cultural belief system from the clinical participant. This would be beneficial to the field as there are many areas in which access to a Christian therapist is limited though the need of Christians to receive culturally sensitive services may be great.

### **Conclusion**

This study demonstrated several significant results. The first being that CAM modules can be developed and successfully delivered by a Christian therapist to Christian recipients of

professional counseling services. Also, the administration of CAM as an intervention is correlated with a decrease in depressive and anxiety symptoms, a decrease in shame symptoms and an increase in resiliency in a Christian sample of clinical participants, making it a useful tool for clinicians to promote positive growth and healing in their clients. These results indicate that further research is needed to validate and broaden this field of research and that doing so may be significantly beneficial to Christians who are in need of professional mental health services as it may increase access to services by decreasing resistance to services as well as improve the cultural competencies of clinicians who serve Christian populations.

## REFERENCES

- Allen, L. B., White, K. S., Barlow, D. H., Shear, K. M., Gorman, J. M., & Woods, S. W. (2010). Cognitive-behavior therapy (CBT) for panic disorder: Relationship of anxiety and depression comorbidity with treatment outcome. *Journal of Psychopathology and Behavioral Assessment, 32*(2), 185–192.
- Alsubaie, M., Abbott, R., Dunn, B., Dickens, C., Keil, T. F., Henley, W., & Kuyken, W. (2017). Mechanisms of action in mindfulness-based cognitive therapy (MBCT) and mindfulness-based stress reduction (MBSR) in people with physical and/or psychological conditions: A systematic review. *Clinical Psychology Review, 55*, 74–91.
- American Counseling Association. (2014). *2014 Code of ethics: As approved by the ACA governing council*. Alexandria, VA: American Counseling Association.
- Antony, M. M., & Barlow, D. H. (2010). *Handbook of assessment and treatment planning for psychological disorders* (2nd ed.). New York, NY: Guilford Press.
- Antony, M. M., Bieling, P. J., Cox, B. J., Enns, M. W., & Swinson, R. P. (1998). Psychometric properties of the 42-item and 21-item versions of the Depression Anxiety Stress Scales in clinical groups and a community sample. *Psychological Assessment, 10*(2), 176.
- Baer, R. A. (2003). Mindfulness training as a clinical intervention: A conceptual and empirical review. *Clinical Psychology: Science and Practice, 10*(2), 125–143.
- Baer, R. A., Lykins, E. L. B., & Peters, J. R. (2012). Mindfulness and self-compassion as predictors of psychological wellbeing in long-term meditators and matched nonmeditators. *The Journal of Positive Psychology, 7*(3), 230–238.
- Ball, J. (2016). *A treatise of divine meditation*. Crossville, TN: Puritan.
- Baxter, R. (2015). *The saints' everlasting rest*. Louisville, KY: GLH.



- Beeke, J., & Jones, M. (2012). *A Puritan theology: Doctrine for life*. Grand Rapids, MI: Reformation Heritage Books.
- Black, R. S. A., Curran, D., & Dyer, K. F. W. (2013). The impact of shame on the therapeutic alliance and intimate relationships. *Journal of Clinical Psychology, 69*(6), 646–654.
- Brown, B. (2006). Shame resiliency theory: A grounded theory study on women and shame. *Families in Society, 87*(1), 43–52.
- Bufford, R. K., Blackburn, A., Sisemore, T. A. & Bassett, R. L. (2015). Preliminary analyses of three measures of grace: Can they be unified? *Journal of Psychology & Theology, 43*(2), 86–97.
- Bufford, R. K., Sisemore, T. A., & Blackburn, A. M. (2017). Dimensions of grace: Factor analysis of three grace scales. *Psychology of Religion and Spirituality, 9*(1), 56–69.
- Burg, J. M., & Michalak, J. (2011). The healthy quality of mindful breathing: Associations with rumination and depression. *Cognitive Therapy and Research, 35*(2), 179–185.
- Burroughs, J. (2014). *A treatise on earthly-mindedness*. Louisville, KY: GLH.
- Cardaciotto, L., Herbert, J. D., Forman, E. M., Moitra, E., & Farrow, V. (2008). The assessment of present-moment awareness and acceptance. *Assessment, 15*(2), 204–223.
- Castilho, P., Pinto-Gouveia, J., & Duarte, J. (2017). Two forms of self-criticism mediate differently the shame psychopathological symptoms link. *Psychology and Psychotherapy: Theory, Research and Practice, 90*(1), 44–54.
- Czub, T. (2013). Shame as a self-conscious emotion and its role in identity formation. *Polish Psychological Bulletin, 44*(3), 245–253.
- Dahl, C. J., Lutz, A., & Davidson, R. J. (2015). Reconstructing and deconstructing the self: Cognitive mechanisms in meditation practice. *Trends in Cognitive Sciences, 19*(9), 515–

523.

- Davidson, R. J., & Kaszniak, A. W. (2015). Conceptual and methodological issues in research on mindfulness and meditation. *American Psychologist, 70*(7), 581–592.
- Dimidjian, S., & Segal, Z. V. (2015). Prospects for a clinical science of mindfulness-based intervention. *American Psychologist, 70*(7), 593–620.
- Ehring, T., & Watkins, E. (2008). Repetitive negative thinking as a transdiagnostic process. *International Journal of Cognitive Therapy, 1*, 192–205.
- Ehring, T., Zetsche, U., Weidacker, K., Wahl, K., Schonfeld, S., & Ehlers, A. (2011). The Perseverative Thinking Questionnaire (PTQ): Validation of a content-independent measure of repetitive negative thinking. *Journal of Behavior Therapy and Experimental Psychiatry, 42*, 225–232.
- Feliu-Soler, A., Pascual, J. C., Elices, M., Martín-blanco, A., Carmona, C., Cebolla, A., . . . Soler, J. (2017). Fostering self-compassion and loving-kindness in patients with borderline personality disorder: A randomized pilot study. *Clinical Psychology and Psychotherapy, 28*, 278–286.
- Ford, K. (2016). *The impact of a Christian adaptation to mindfulness training on stress, religious coping, and God attachment: A randomized trial* (Doctoral dissertation). Retrieved from ProQuest Dissertations & Theses Global. (UMI No. 10117935)
- Ford, K., & Garzon, F. (2017). Research note: A randomized investigation of evangelical Christian accommodative mindfulness. *Spirituality in Clinical Practice, 4*(2), 92–99.
- Frederick, T. & White, K. M. (2015). Mindfulness, Christian devotion meditation, surrender, and worry. *Mental Health, Religion & Culture, 18*(10), 850–858.

- Fresco, D., Frankel, A., Mennin, D., Turk, C., & Heimberg, R. (2002). Distinct and overlapping features of rumination and worry: The relationship of cognitive production to negative affective states. *Cognitive Therapy and Research, 26*, 179–188.
- Frye, L. A., & Spates, C. R. (2012). Prolonged exposure, mindfulness, and emotion regulation for the treatment of PTSD. *Clinical Case Studies, 11*(3), 184–200.
- Gámez, W., Chmielewski, M., Kotov, R., Ruggero, C., Suzuki, N., & Watson, D. (2014). The Brief Experiential Avoidance Questionnaire: Development and initial validation. *Psychological Assessment, 26*(1), 35–45.
- Garfinkle, E. (2012). Shame: The hidden resistance. *Canadian Journal of Psychoanalysis / Revue Canadienne de Psychanalyse, 20*(1), 44–69.
- Garzon, F. (2013). Christian devotional meditation for anxiety. In E. L. Worthington, Jr., E. L. Johnson, J. N. Hook, & J. D. Aten (Eds.), *Evidence-based practices for Christian counseling and psychotherapy* (pp. 59–78). Downers Grove, IL: IVP Academic.
- Garzon, F., & Ford, K. (2016). Adapting mindfulness for conservative Christians. *Journal of Psychology & Christianity, 35*(3), 263–268.
- Goldsmith, R. E., Gerhart, J. I., Chesney, S. A., Burns, J. W., Kleinman, B., & Hood, M. M. (2014). Alternative medicine mindfulness-based stress reduction for posttraumatic stress symptoms: Building acceptance and decreasing shame. *Journal of Evidence-Based Complementary & Alternative Medicine, 19*(4), 227–234.
- Hall, J. (2016). *The art of divine meditation*. Mulberry, IN: Sovereign Grace Publishers.
- Harris, N., Pargament, K. I., Sisemore, T. A., & Brown, G. S. (2014). The relationship of decline in spiritual struggles to psychotherapy outcomes: Evidence from a large scale survey of psychotherapy clients. *Christian Psychology, 8*(2), 40–48.

- Hathaway, W., & Tan, E. (2009). Religiously oriented mindfulness-based cognitive therapy. *Journal of Clinical Psychology, 65*(2), 158–171.
- Hayes, S. C. (1994). Content, context, and the types of psychological acceptance. In S. C. Hayes, N. S. Jacobsen, V. M. Follette, & M. J. Dougher (Eds.), *Acceptance & change: Content and context in psychotherapy* (pp. 13–32). Reno, NV: Context Press.
- Hayes, S. C. (2004). Acceptance and commitment therapy and the new behavior therapies: Mindfulness, acceptance, and relationship. In S.C. Hayes, V. M. Follette, & M. M. Linehan (Eds.), *Mindfulness and acceptance: Expanding the cognitive behavioral tradition* (pp. 1–29). New York, NY: Guilford Press.
- Hayes, S. C., Levin, M. E., Plumb-Villardaga, J., Villatte, J. L., & Pistorello, J. (2013). Acceptance and commitment therapy and contextual behavioral science: Examining the progress of a distinctive model of behavioral and cognitive therapy. *Behavior Therapy, 44*(2), 180–198.
- Hayes, S. C., Strosahl, K., & Wilson, K. G. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change*. New York, NY: Guilford Press.
- Heppner, P. P., Wampold, B. E., Owen, J., Wang, K. T., & Thompson, M. N. (2015). *Research design in counseling* (4th ed.). Boston, MA: Cengage Learning.
- Highland, J. (2005). Transformation to eternity: Augustine’s conversion to mindfulness. *Buddhist-Christian Studies, 25*(1), 91–108.
- Hjeltnes, A., Binder, P. E., Moltu, C., & Dundas, I. (2015). Facing the fear of failure: An explorative qualitative study of client experiences in a mindfulness-based stress reduction program for university students with academic evaluation anxiety. *International Journal of Qualitative Studies on Health and Well-Being, 10*(1), Article 27990.

- Hofmann, S. G., Sawyer, A. T., Witt, A. A., & Oh, D. (2010). The effect of mindfulness-based therapy on anxiety and depression: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 78*(2), 169–183.
- Hunt, J., & Eisenberg, D. (2010). Mental health problems and help-seeking behavior among college students. *Journal of Adolescent Health, 46*, 3–10.
- James, W. (1985). *The varieties of religious experience: A study of human nature*. Cambridge, MA: Harvard University Press.
- Johnston, R. (n.d.). *Christian mindfulness six session online course: Exploring mindfulness from a Christian perspective*. Retrieved from <http://www.christianmindfulness.co.uk>
- Kabat-Zinn, J. (2011). Some reflections on the origins of MBSR, skillful means, and the trouble with maps. *Contemporary Buddhism, 12*(1), 281–306.
- Kabat-Zinn, J. (2013). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain, and illness*. New York, NY: Bantam Books.
- Killingsworth, M., & Gilbert, D. (2010). A wandering mind is an unhappy mind. *Science, 330*, 932.
- Knabb, J. J. (2012). Centering prayer as an alternative to mindfulness-based cognitive therapy for depression relapse prevention, *Journal of Religious Health, 51*, 908–924.
- Knabb, J. (2016). *Acceptance and commitment therapy for Christian clients: A faith-based workbook*. New York, NY: Routledge.
- Knabb, J. J., & Frederick, T. V. (2017). *Contemplative prayer for Christians with chronic worry: An eight-week program*. New York, NY: Routledge.

- Knabb, J., Frederick, T., & Cumming, G. (2017). Surrendering to God's providence: A three-part study on providence-focused therapy for recurrent worry (PFT-RW), *Psychology of Religion and Spirituality*, *9*(2), 180-196.
- Knabb, J. J., & Vazquez, V. E. (2018, January 25). A randomized controlled trial of a 2-week internet-based contemplative prayer program for Christians with daily stress. *Spirituality in Clinical Practice*. Advance online publication.
- Knabb, J. J., Vazquez, V. E., Garzon, F. L., Ford, K. M., Wang, K. T., Conner, K. W., ... Weston, D. M. (2019, November 18). Christian meditation for repetitive negative thinking: A multisite randomized trial examining the effects of a 4-week preventative program. *Spirituality in Clinical Practice*. Advance online publication.
- Leichsenring, F., & Salzer, S. (2014). A unified protocol for the transdiagnostic psychodynamic treatment of anxiety disorders: An evidence-based approach. *Psychotherapy*, *51*(2), 224–245.
- Lenz, A. S. (2013). Calculating effect size in single-case research. *Measurement and Evaluation in Counseling and Development*, *46*(1), 64–73.
- Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York, NY: Guilford Press.
- Linehan, M. M. (1994). Acceptance and change: The central dialectic in psychotherapy. In S. C. Hayes, N. S. Jacobson, V. M. Follette, & M. J. Dougher (Eds.), *Acceptance and change: Content and context in psychotherapy* (pp. 73–86). Reno, NV: Context Press.
- Lovibond, P. F., & Lovibond, S. H. (1995). The structure of negative emotional states: Comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. *Behaviour Research and Therapy*, *33*(3), 335–343.

- Mahoney, A., & McEvoy, P. (2012). A transdiagnostic examination of intolerance of uncertainty across anxiety and depressive disorders. *Cognitive Behaviour Therapy, 41*, 212–222.
- Martin, A. S., Distelberg, B., Palmer, B. W., & Jeste, D. V. (2015). Development of a new multidimensional individual and interpersonal resilience measure for older adults. *Aging & Mental Health, 19*(1), 32–45.
- McEvoy, P. M., Nathan, P., & Norton, P. J. (2009). Efficacy of transdiagnostic treatments: A review of published outcome studies and future research directions. *Journal of Cognitive Psychotherapy, 23*(1), 20–33.
- McEvoy, P. M., Watson, H., Watkins, E. R., & Nathan, P. (2013). The relationship between worry, rumination, and comorbidity: Evidence for repetitive negative thinking as a transdiagnostic construct. *Journal of Affective Disorders, 151*(1), 313–320.
- McLaughlin, K., & Nolen-Hoeksema, S. (2011). Rumination as a transdiagnostic factor in depression and anxiety. *Behaviour Research and Therapy, 49*, 186–193.
- McMinn, M. R. (2008). *Sin and grace in Christian counseling: An integrative paradigm*. Downers Grove, IL: IVP Academic.
- McMinn, M. R., Ruiz, J. N., Marx, D., Wright, J. B., & Gilbert, N. B. (2006). Professional psychology and the doctrines of sin and grace: Christian leaders' perspectives. *Professional Psychology: Research and Practice, 37*, 295–302.
- Mohammadzadeh, A., & Najafi, M. (2016). Factor analysis and validation of the Brief Religious Coping Scale (Brief-RCOPE) in Iranian university students. *Mental Health, Religion & Culture, 19*(8), 911–919.
- Morrison, J. Q., Clutter, S. M., Pritchett, E. M. & Demmitt, A. (2009). Perceptions of clients and counseling professionals regarding spirituality in counseling. *Counseling and Values,*

- 53(3), 183–194.
- Myers, M. (2012). *Examining the relationship between mindfulness, religious coping strategies and emotion regulation* (Doctoral dissertation). Retrieved from ProQuest Dissertations & Theses. (UMI 3642816)
- Nathanson, D. L. (1992). *Shame and pride: Affect, sex, and the birth of the self*. New York, NY: W. W. Norton.
- Newport, F. (2009). *The Gallup poll: Public opinion 2009*. Lanham, MD: Rowman & Littlefield.
- Nguyen, T., Bellehumeur, C., & Malette, J. (2015). God images and resilience: A study of Vietnamese immigrants. *Journal of Psychology and Theology*, 43(4), 271–282.
- Nilsson, H., & Kazemi, A. (2016). Reconciling and thematizing definitions of mindfulness: The big five of mindfulness. *Review of General Psychology*, 20(2), 183–193.
- Norton, P. J. (2012). A randomized clinical trial of transdiagnostic cognitive-behavioral treatments for anxiety disorder by comparison to relaxation training. *Behavior Therapy*, 43(3), 506–517.
- Pargament, K., Feuille, M., & Burdzy, D. (2011). The Brief RCOPE: Current psychometric status of a short measure of religious coping. *Religions*, 2, 51–76.
- Pargament, K. I., Koenig, H. G., & Perez, L. M. (2000). The many methods of religious coping: Development and initial validation of the RCOPE. *Journal of Clinical Psychology*, 56(4), 519–543.
- Pargament, K. I., Smith, B. W., Koenig, H. G. & Perez, L. (1998). Patterns of positive and negative religious coping with major life stressors. *Journal of the Scientific Study of Religion*, 37(4), 710–724.
- Pargament, K. I., & Zinnbauer. (2000). Working with the sacred: Four approaches to religious



- and spiritual issues in counseling. *Journal of Counseling & Development*, 78, 162–171.
- Pattison, S. (2000). *Shame: Theory, therapy, theology*. Cambridge, United Kingdom: Cambridge University Press.
- Pew Research Center. (2015a, April). *The future of world religions: Population growth projections, 2010–2050*. Retrieved from <http://www.pewforum.org/2015/04/02/religious-projections-2010-2050/>
- Pew Research Center. (2015b, May). *Religious landscape study*. Retrieved from <http://www.pewforum.org/religious-landscape-study/>
- Prestia, A. S. (2016). Transformational resiliency. *Nurse Leader*, 14(5), 354–357.
- Ray, D. C. (2015). Single-case research design and analysis: Counseling applications. *Journal of Counseling and Development*, 93(4), 394–402.
- Rizvi, S. L. (2010). Development and preliminary validation of a new measure to assess shame: The Shame Inventory. *Journal of Psychopathology and Behavioral Assessment*, 32(3), 438–447.
- Sauer-Zavala, S., Gutner, C. A., Farchione, T. J., Boettcher, H. T., Bullis, J. R., & Barlow, D. H. (2017). Current definitions of “transdiagnostic” in treatment development: A search for consensus. *Behavior Therapy*, 48(1), 128–138.
- Schalkwijk, F., Stams, G. J., Dekker, J., Peen, J., & Elison, J. (2016). Measuring shame regulation: Validation of the compass of shame scale. *Social Behavior and Personality: An International Journal*, 44(11), 1775–1791.
- Schoenleber, M., & Berenbaum, H. (2010). Shame aversion and shame-proneness in cluster C personality disorders. *Journal of Abnormal Psychology*, 119(1), 197–205.
- Segal, Z., Williams, M., & Teasdale, J. (2012). *Mindfulness-based cognitive therapy for*

- depression* (2nd ed.). New York, NY: Guilford Press.
- Silfver, M., Helkama, K., Lönnqvist, J. E., & Verkasalo, M. (2008). The relation between value priorities and proneness to guilt, shame, and empathy. *Motivation and Emotion, 32*(2), 69–80.
- Strong, J. (2001a). *The new Strong's expanded dictionary of the words in the Hebrew Bible*. Nashville, TN: Thomas Nelson.
- Strong, J. (2001b). *The new Strong's expanded dictionary of the words in the Greek New Testament*. Nashville, TN: Thomas Nelson.
- Sznycer, D., Takemura, K., Delton, A.W., Sato, K., Robertson, T., Cosmides, L., & Tooby, J. (2012). Cross-cultural differences and similarities in shame activation thresholds: An adaptationist and ecological approach. *Evolutionary Psychology, 10*(2), 352–370.
- Tan, S. Y. (1994). Ethical considerations in religious psychotherapy: Potential pitfalls and unique resources. *Journal of Psychology and Theology, 9*, 25–33.
- Tan, S. Y. (2003). Integrating spiritual direction into psychotherapy: Ethical issues and guidelines. *Journal of Psychology and Theology, 31*, 14–23.
- Tang, Y., Hölzel, B. K., & Posner, M. I. (2015). The neuroscience of mindfulness meditation. *Nature Publishing Group, 16*(4), 213–225.
- Tangney, J. P., Stuewig, J., & Mashek, D. J. (2007). Moral emotions and moral behavior. *Annual Review of Psychology, 58*(1), 345–372.
- Teasdale, J. D., Segal, Z., & Williams, J. M. G. (1995). How does cognitive therapy prevent depressive relapse and why should attention control (mindfulness) training help? *Behaviour Research and Therapy, 33*, 25–39.
- Teroni, F., & Deonna, J. A. (2008). Differentiating shame from guilt. *Consciousness and*

- Cognition*, 17(3), 725–740.
- Titov, N., Dear, B. F., Schwencke, G., Andrews, G., Johnston, L., Craske, M. G., & McEvoy, P. (2011). Transdiagnostic internet treatment for anxiety and depression: A randomised controlled trial. *Behaviour Research and Therapy*, 49(8), 441–452.
- Trammel, R. (2018). Effectiveness of an MP3 Christian mindfulness intervention on mindfulness and perceived stress mindfulness and perceived stress. *Mental Health, Religion & Culture*, 21(5), 500–514.
- Tweed, R. G. (1997). The psychology of Gregory the Great (AD 540–AD 604). *International Journal for the Psychology of Religion*, 7(2), 101–110.
- Van Vliet, K. J. (2008). Shame and resilience in adulthood: A grounded theory study. *Journal of Counselling Psychology*, 55(2), 233–245.
- Vareesangthip, J., Malai, T., Otsu, B., Aiyasanon, N., Srithongkul, T., Sritippayawan, S., & Vareesangthip, K. (2017). The effect of Buddhist meditation on the quality of life using short form-36 in continuous ambulatory peritoneal dialysis patients, *Nephrology Dialysis Transplantation*, 32(Suppl. 3), iii632.
- Watkins, E. (2016). *Rumination-focused cognitive-behavioral therapy for depression*. New York, NY: Guilford Press.
- Watson, J. C. (2011). Treatment failure in humanistic and experiential psychotherapy. *Journal of Clinical Psychology: In Session*, 67(11), 1117–1128.
- Watson, T. (2012). *A treatise concerning meditation*. Charleston, SC: Waxkeep.
- Wetterneck, C. T., Singh, S., & Hart, J. (2014). Shame proneness in symptom dimensions of obsessive-compulsive disorder. *Bulletin of the Menninger Clinic*, 78(2), 177–190.

Wong-McDonald, A., & Gorsuch, R. L. (2000). Surrender to God: An additional coping style?

*Journal of Psychology and Theology*, 28(2), 149–161.

Woods, H., & Proeve, M. (2014). Relationships of mindfulness, self-compassion, and meditation

experience with shame-proneness. *Journal of Cognitive Psychotherapy: An International*

*Quarterly*, 28(1), 20–33.

Worthington E. L., Jr., & Aten, J. D. (2009). Psychotherapy with religious and spiritual clients:

An introduction. *Journal of Clinical Psychology: In Session*, 65, 123–130.

## APPENDIX A: Initial Assessment Interview Form

### Initial Assessment Interview Form

Please provide the following information as an initial assessment of your appropriateness for participation in the study. This information will be kept confidential, unless ethical guidelines present a limit to confidentiality, such as in the case of reported suicidal or homicidal ideation. If you do not understand any question, please leave it blank and contact the researcher.

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_

Phone: \_\_\_\_\_ May I call you? ( Y / N ) May I text you? ( Y / N )

Email: \_\_\_\_\_ May I email you? ( Y / N )

1. Are you Christian? ( Y / N )

If yes, please specify denomination: \_\_\_\_\_

2. Are you currently experiencing any mental health concerns? ( Y / N )

If yes, please specify: \_\_\_\_\_

3. Are you experiencing any physical health concerns? ( Y / N )

If yes, please specify: \_\_\_\_\_

4. Are you currently experiencing thoughts of suicide or homicide? ( Y / N )

5. Are you experiencing any condition or life circumstance that would hinder your participation in twelve weeks of intervention? ( Y / N )

6. Are you willing to complete an initial assessment that will include the completion of a psychometric inventory for investigating exclusion criteria? ( Y / N )

7. Are you willing to complete a survey at the end of each session that will include the completion of several assessments? ( Y / N )

Please direct any questions about this interview form to the researcher via:  
phone number, \_\_\_\_\_, or email address, \_\_\_\_\_

**APPENDIX B: Demographic Questionnaire**

## Demographic Questionnaire

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
(Last) (First) (M Initial)

Address: \_\_\_\_\_  
(PO Box or Street) (City) (State) (Zip)

Telephone: \_\_\_\_\_ (Home/Cell)

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: M \_\_\_\_ F \_\_\_\_

Marital Status: Single / Living with Partner / Married / Separated / Divorced / Widowed

Place of Employment: \_\_\_\_\_

Income Level: \$0-\$10,000 / \$11,000-\$15,000 / \$16,000-\$19,000 / \$20,000-\$25,000  
/ \$26,000 & Above (Annual Funds in US Dollars)

Race: African American / Asian / Latino / Native American / White / Other \_\_\_\_\_

Highest Education Level: High School / College Freshman / Sophomore / Junior / Senior /  
Bachelor's degree / Master's degree / Doctoral degree

Medical Insurance Coverage: Yes \_\_\_\_ No \_\_\_\_

Outpatient Therapist: \_\_\_\_\_ Phone: \_\_\_\_\_

In Case of Emergency Contact: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

How long have you been a Christian? \_\_\_\_\_

What is your denominational affiliation? \_\_\_\_\_

## APPENDIX C: Consent to Inclusion in Research Study

### CONSENT FORM

The Effectiveness of Christian Accommodative Mindfulness in the Treatment of Shame

Tracy Jones

Liberty University

Department of Education/School of Behavioral Sciences

You are invited to be in a research study regarding the effectiveness of the use of mindfulness exercises adapted to the cultural considerations of Christians. You were selected as a possible participant because you are an adult who self-identifies with an Evangelical Christian faith, you are presenting for treatment due to either depressive or anxiety symptoms, you have expressed a willingness and an ability to participate in the study as well as sign consent forms and you have no foreseeable barriers to treatment for the next nine weeks. Please read this form and ask any questions you may have before agreeing to be in the study.

Tracy Jones, LMHC, a doctoral candidate in the Department of Education/School of Behavioral Sciences at Liberty University, is conducting this study.

**Background Information:** There is currently a gap in the research regarding the use of mindfulness to treat psychological symptoms that are often the result of shame in Christian clients. The purpose of this study is to determine the correlation of Christian Accommodative Mindfulness (CAM) with the negative experience of shame, the symptoms of depression or anxiety and with the experience of resiliency in Christian clients.

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

1. You will complete an intake session. At the completion of this intake, you will schedule an appointment to take place in two weeks and you will complete a set of assessments via Survey Monkey.
2. You will complete a set of assessments via Survey Monkey at home one week after the intake session.
3. You will attend six therapy sessions at which you will learn and practice a CAM module for part of the session, and you will complete a set of assessments via Survey Monkey at the end of each of these. You will be provided a recorded version of the exercise each week which you will be expected to practice with during the week between sessions. A text with an inspirational quote or Scripture verse will be sent to you midway through each week.
4. You will attend a follow-up session one week after completing the six modules after which you will complete a set of assessments via Survey Monkey.

**Risks:** The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life. As a recipient of psychotherapy services, you will be subject to the mandatory reporting conditions. If you express a risk of harm to self or others, if you disclose the abuse of a child, an elder, or one who is disabled, this information will need to be disclosed per the mandatory reporting laws.

**Benefits:** The direct benefits participants may expect to receive from taking part in this study are the development of a therapeutic alliance, education and training in new mindfulness skills and assistance with practicing these skills. These benefits may result in the reduction of clinical symptoms and an increase in mindfulness skills.

**Compensation:** Participants will not be compensated for participating in this study.

**Confidentiality:** The records of this study will be kept private. In any sort of report I might publish, I will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records. I may share the data I collect from you for use in future research studies or with other researchers; if I share the data that I collect about you, I will remove any information that could identify you, if applicable, before I share the data.

- Participants in the study will be assigned a pseudonym. I will conduct all sessions in the privacy of the therapy office.
- Data will be stored on a password locked computer and may be used in future presentations.

**Voluntary Nature of the Study:** Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with Liberty University or [REDACTED]. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

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

**Contacts and Questions:** The researcher conducting this study is Tracy Jones, LMHC. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at [REDACTED] or [REDACTED]. You may also contact the researcher's faculty chair, Dr. Fernando Garzon at [REDACTED].

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

*Please notify the researcher if you would like a copy of this information for your records.*

**Statement of Consent:** I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

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Signature of Participant

Date

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Signature of Investigator

Date



## APPENDIX D: Week 1 Module

### Week 1: Introduction to Christian Accommodative Mindfulness/Breathing Exercise

#### Week 1: Handout 1

#### Introduction

“Then Peter got down out of the boat, walked on the water and came toward Jesus. But when he saw the wind, he was afraid and, beginning to sink, cried out, ‘Lord, save me!’” (Matthew 14:29-30)

As a Christian who is struggling with negative thinking, you may feel like Peter in his futile effort to walk towards Jesus on the water. You want to faithfully follow Jesus, but quickly begin to sink when you notice the choppy waves around you. Likewise, when you get stuck in repetitive negative thinking that leads to anxiety and shame—whether dwelling on the past or worrying about the future—you might feel like you are sinking, struggling to walk with Jesus along the roads of life. Yet, we believe Christianity has quite a bit to offer in helping you to overcome anxiety and shame through focusing your attention on God, pivoting away from your preoccupation with the past or future and yielding to God’s active, loving presence. In this six-week program, you will formally practice different types of biblically-based Christian meditation and Christian mindfulness techniques in order to develop a more focused, long-term strategy for dealing with the negative thoughts that fuel anxiety, worry, and shame. By practicing repeatedly turning your attention to Jesus, trusting in Him in the process, we believe you will be in a better position to live the life you want, rather than becoming entangled with negative thinking and difficult emotions. In the first week, you will learn about the role that repetitive negative thinking (i.e., rumination and worry) plays in the development of depression, anxiety, and shame, including a strategy for shifting your focus from the stormy waters of life to God’s active, loving presence.

*Repetitive negative thinking* is a type of thinking that has been linked to anxiety and depressive disorders, which, when combined, are referred to as *emotional disorders*.<sup>1</sup> People who struggle with thinking about past or future events in a negative way can be more vulnerable to emotional disorders.<sup>2</sup>

There are two types of repetitive negative thinking on which we will be focusing—*rumination* and *worry*. We will also be looking at shame.

- *Rumination* involves dwelling on negative thoughts about yourself (e.g., “I’m worthless”) or painful emotions (e.g., “Feeling sad is unbearable”), without taking action to change

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<sup>1</sup> Ehring and Watkins (2008); McEvoy, Watson, Watkins, and Nathan (2013).

<sup>2</sup> McEvoy et al. (2013).

these inner experiences.<sup>3</sup>

- Why do we ruminate? The purpose of rumination is to think about past conversations, relationships, events, and so forth, along with current inner emotional states, in order to prevent yourself from behaving in a way that may lead to future mistakes.<sup>4</sup>
- *Worry* involves repeatedly thinking about a worst-case scenario happening in the future (e.g., “I’m going to lose my job”) and rehearsing ways you might address it (e.g., repeatedly thinking about ways to solve the problem).<sup>5</sup>
  - Why do we worry? The purpose of worry is to achieve a false sense of certainty when you are facing an uncertain future.<sup>6</sup>
- *Shame* can be understood by how it is different from guilt. Guilt can be described by the sentiment, “I feel bad because I have done something bad,” which has hope of being changed through correction or repentance; whereas shame is the sentiment, “I am bad.” It is a sense of the core self being defective or unsalvageable in some way and it points people in one of four directions: toward either withdrawal, attacking the self, avoidance or attacking others<sup>7</sup>. Rumination on negative thoughts or feelings can feed and reinforce the experience of shame which can in turn lead to further rumination and worry and the continuation of a powerful cycle of negative thoughts, feelings, behaviors and deeper shame.

*Repetitive thinking*, whether ruminations, worries or shame, involves getting stuck in a type of thinking where you fixate on the past or future. This process is sort of like a cow chewing cud in a field, with the mind constantly “chewing” the negative thought(s).

- The purpose is possibly to gain a false sense of control through passive avoidance (rumination) or active problem solving (worry).

As you are ruminating or worrying, though, you may find that you get lost in these negative thoughts, which means you are unable to focus on the task at hand or the road ahead.

Even more unfortunate, many people who struggle with these types of problems do not seek out professional mental health services.<sup>8</sup> However, without tools to deal with this kind of inflexible thinking, you may be vulnerable to developing anxiety or depressive disorders later in life. What is more, this type of distracting, distressing thinking and overpowering shame can get in the way of the intimacy and communion you desire with God.

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<sup>3</sup> McLaughlin and Nolen-Hoeksema (2011).

<sup>4</sup> Watkins (2016).

<sup>5</sup> Ehring et al. (2011); Fresco, Mennin, Turk, and Heimberg (2002); McEvoy et al. (2013).

<sup>6</sup> Mahoney and McEvoy (2012).

<sup>7</sup> Nathanson (1994).

<sup>8</sup> Hunt and Eisenberg (2010).

## Meditation in the Bible

Meditation may be an effective tool for dealing with rumination, worry, and shame. Though some Christians associate all forms of meditation with Eastern religions, the Bible frequently addresses the importance of this practice. Two Hebrew words are translated as meditation in scripture. The Hebrew word, *hagah*, is used 25 times in the Hebrew Old Testament (see, e.g., Joshua 1:8; Psalm 1:2, 63:6, 77:12, 143:5; Isaiah 33:18).<sup>9</sup> Some of these passages are quite familiar to Christians:

Blessed is the one who does not walk in step with the wicked or stand in the way that sinners take or sit in the company of mockers, but whose delight is in the law of the Lord, and who meditates on his law, day and night. That person is like a tree planted by streams of water, which yields its fruit in season and whose leaf does not wither—whatever they do prospers. (Psalm 1:1-3)

‘Be strong and very courageous. Be careful to obey all the law my servant Moses gave you; do not turn from it to the right or to the left, that you may be successful wherever you go. Keep this Book of the Law always on your lips; meditate on it day and night, so that you may be careful to do everything written in it. Then you will be prosperous and successful.’ (Joshua 1:7-8)

In Psalm 119, the longest chapter in scripture, the Hebrew word, *siyach*,<sup>10</sup> is used for meditation, and occurs several times (Psalm 119:15, 23, 48, 78, 148). It also occurs in two other psalms: “I will consider all your works and meditate on all your mighty deeds” (Psalm, 77:12), and “I remember the days of long ago; I meditate on all your works and consider what your hands have done (Psalm 143:5).

Clearly, the Bible invites us to learn how to meditate on God’s word, character, works, creation, and ways, among other attributes, actions, and so on. Over the centuries, Christians have developed a variety of strategies to honor this exhortation. Through the next several weeks you will learn several of these.

## Balancing Words and Silence When Spending Time with God

Through the use of several forms of meditation, we believe you can develop an attitude of detachment, allowing you to shift from repetitive negative thinking to an awareness of God’s active, loving presence. Through the practice of meditation, our hope is that you will be getting to know who God is by way of His character, attributes, and actions, especially His infinite goodness, wisdom and power. The more you come to know God and these three attributes, we believe you

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<sup>9</sup> Strong (2001a).

<sup>10</sup> Strong (2001a).

will find that you can trust in His providential care as you turn away from your own control efforts and towards Him.

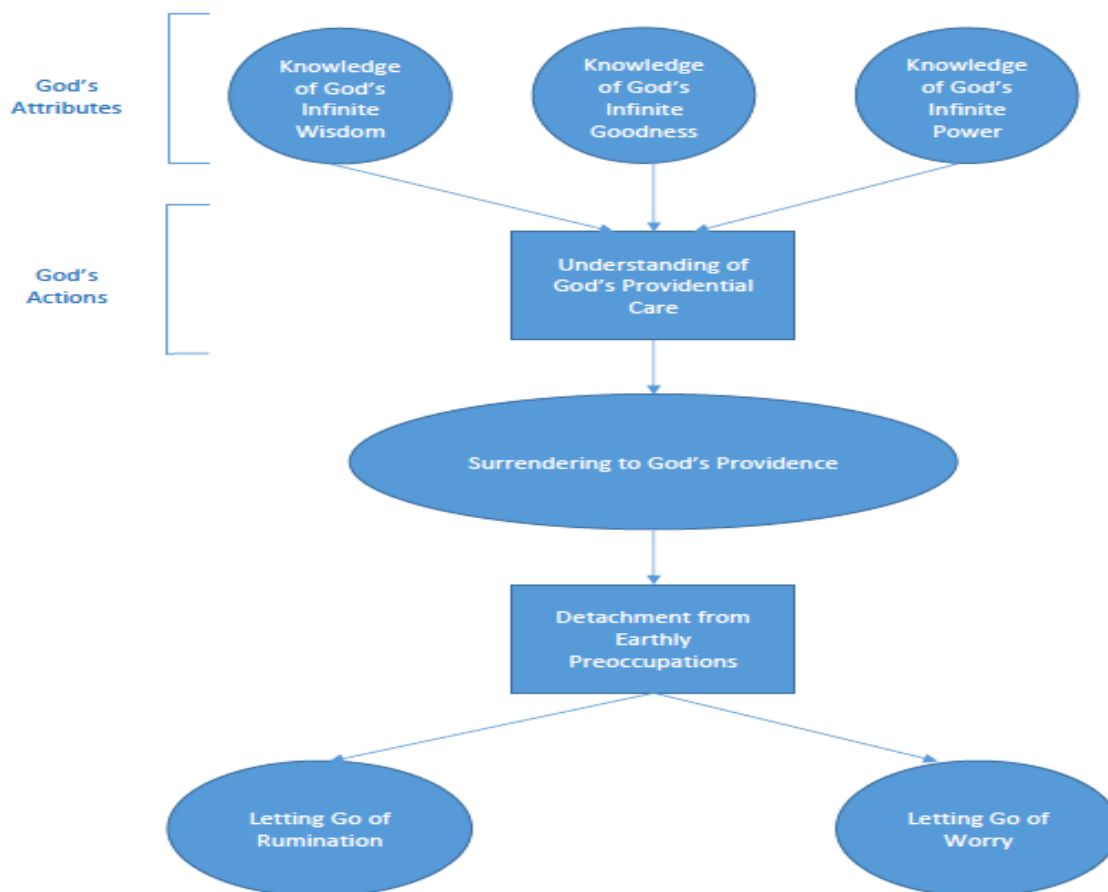
You will practice scriptural and character meditations with God's Word, and you will be learning contemplative meditation. Just like you would get to know a close friend, you would get to know *about* your new friend through information that captures who he or she is (as in scriptural meditation). Next, you would get to know him or her through having direct conversations with your new friend. Finally, you would have more and more experiences of enjoying your friend's company without having to always fill the time with talking, surrendering to the moment (as is the case with contemplative meditation). Along the way, you would be learning to focus your attention on him or her, given that your friend is the most important thing to you. When this happens, you would be able to tune out information that is less important, like you will be learning to do when you shift from focusing on ruminations and worries towards consenting to God's active, loving presence through detachment.

In this ongoing process of letting go through multiple forms of meditation, you will be focusing your eyes on God, just like Jesus asked Peter to do in Matthew's gospel when Peter started walking towards Jesus on the choppy, stormy waters. When you begin to sink in the waters of life by ruminating, worrying and living out shame, we believe these Christian meditations can help you to refocus on Jesus, yielding to Him as you detach from worldly concerns.

\* Adapted from Knabb, et al., 2019, *Christian meditation for repetitive negative thinking: A multisite randomized trial examining the effects of a 4-week preventative program*.

## Week 1: Handout 2

### The Relationship Between God's Attributes, God's Providence, Yielding to God, Detachment, and Repetitive Negative Thinking<sup>11</sup>



<sup>11</sup> Adapted from Knabb et al. (2017).

## **Week 1: Breathing Exercise**

### **Verse**

“The Spirit of God has made me; the breath of the Almighty gives me life.” (Job 33:4)

### **Theme**

God has breathed into you the breath of life and this breath is what gives you life and being. The average person breathes about 16 times per minute or over 23,000 breaths per day; however, you may have been aware of only a few of these. Learning to be in tune with your breath takes practice and is a way to grow in being mindful of yourself and who God has made you to be. When we are struggling with negative emotions such as depression, anxiety, shame or fear we can easily lose sight of the moment-to-moment gift of breath; we can even sometimes hold our breath, preventing oxygen and blood flow from healing and giving life. In this exercise you will learn to be more aware of taking in the presence and love of God and letting go of the emotions that have distracted you from this. It is an exercise you can carry with you throughout your day and throughout all of the other exercises and meditations you will learn as you move forward.

### **Goals**

1. Understand the specific types of thinking patterns (i.e., rumination, worry) that are involved in repetitive negative thinking.
2. Understand the relationship between repetitive negative thinking and emotional disorders (i.e., depression, anxiety) and the experience of shame.
3. Explore the role that Christian meditation plays in helping you to effectively respond to the ruminations, worries and expressions of shame that may be keeping you stuck in life.
4. Understand how to be aware of your breath and how to breathe mindfully.
5. Understand the relationship between your breath and life and healing.
6. Learn a skill that can be used daily to center and quiet yourself from the distractions of negative emotions.

### **Tasks**

1. Review the verse and theme for the week.
2. Review the handouts for the first week (Week 1: Handout 1, Handout 2, Handout 3, and Handout 4).
3. Discuss the handouts, including any comments or questions.
4. Practice breathing exercise for 10 minutes with the corresponding audio recording.
5. Review the homework wherein you will be practicing the breathing exercise every day for the next week and recording your efforts on the handout (Week 1: Handout 4).

## **Week 1: Handout 3**

### Breathing Exercise

I'd like you to make yourself comfortable, sitting in a relaxed posture, closing your eyes or finding a spot in the room to let your eyes focus on. Allow yourself to switch from the usual active or doing mode to a mode of simply being, of resting in God's caring presence. As you allow your body to become still, bring your attention to the fact that you are breathing. The breath is a reminder of God creating us, "And the LORD God formed man of the dust of the ground, and breathed into his nostrils the breath of life;" ... "and man became a living soul." [Gen. 2:7]. As you breathe in, you can recognize God breathing His life into you. With every breath out you can place yourself the LORD's hands, resting in God to take away all the stress and heavy weight that burdens you...Breathe in His life, and breathe out resting in Him. Breathe in God's Peace and breathe out resting in Him. Breathe naturally...God is with you in the moment. You can relax in God's Grace...

And now focus on your breath more intently. If your mind wanders into other things, this is normal. No need to criticize yourself. Simply release those thoughts into God's loving hands and return to your breath.

Become aware of the movement of your breath as it goes in and as it leaves your body. Notice how it feels to you. No need to change your breath in any way. Simply be aware of it and of any feelings associated with breathing. Notice how the air feels going into your nostrils...Notice how the breath feels deep down in your belly...Observe the abdomen as it expands when you breathe in, and as it falls when you breathe out...Expanding and falling...Expanding and falling. Observe how the air feels going out...Be completely here in each moment with each breath...No need to try to do anything, no need to get any place, simply be with your breath.

Ride the waves of your breath, observing the rhythmic pattern...If your mind wanders, gently release those thoughts into God's hands and your attention back to sensing the flow of your breathing...Your breath is an anchor to focus your attention, to bring you back to the present moment whenever you notice that your mind is becoming absorbed or reactive to something....Just relax and breathe.

In a moment, the breathing meditation will end. When you are ready, gently bring your awareness back to the room, and open your eyes.

Adapted from:

Kabat-Zinn, J. (2002). *Mindfulness meditation, CD series 1*. <<http://www.mindfulnesscds.com/collections/cds/products/series-1>>

\*Garzon & Ford, 2016.

(This script will be provided in both a paper form and as a recording via email or flashdrive)

### Week 1: Handout 4

#### Homework Form: Breathing Exercise

Please fill out this form each day of the week, noting the date, whether or not you practiced, and anything else that comes up in the “comments” section. Please remember to use the corresponding audio recording titled “Breathing Exercise.”

Day/Date	Practice (Yes/No)	Comments/Any Actions Taken Corresponding to the Focus of the Meditation
Monday Date: _____	Breathing Exercise Practice (Yes/No)	
Tuesday Date: _____	Breathing Exercise Practice (Yes/No)	
Wednesday Date: _____	Breathing Exercise Practice (Yes/No)	
Thursday Date: _____	Breathing Exercise Practice (Yes/No)	
Friday Date: _____	Breathing Exercise Practice (Yes/No)	
Saturday Date: _____	Breathing Exercise Practice (Yes/No)	
Sunday Date: _____	Breathing Exercise Practice (Yes/No)	

This form is adapted from Segal et al. (2012).



**Week 1****Weekly Text and/or Email Inspiration**

Job 33:4: “The Spirit of God has made me; the breath of the Almighty gives me life.”

Breathe in His life and breathe out resting in Him. Breathe in God’s Peace and breathe out resting in Him.

## **APPENDIX E: Week 2 Module**

### **Week 2: Body Scan Exercise**

#### **Verse**

“Just as a body, though one, has many parts, but all its many parts form one body, so it is with Christ.” (1 Corinthians 12:12)

#### **Theme**

You have been fearfully and wonderfully made and your body is an integral part of the path to healing from the experience of negative emotions. More and more we hear of holistic approaches that embrace the mind-body connection, and this connection is part of the original design of God. The body has been divided by medicine into organs and systems in an attempt to understand how each part works but, although the body is made up of many parts, each part affects the others and life is experienced by your body as a whole. Have you ever gotten a headache when you felt stressed or felt nauseas when you were anxious? We walk around often not realizing that our negative emotional experiences can get stuck and be stored in our bodies. When you build more awareness with your body, these same connections can bring about healing. This exercise will give you the opportunity to practice being still with God and with the creation that is you.

#### **Goals**

1. Understand how to be aware of your body and mindfully observe how it is connected to each moment.
2. Understand the relationship between your body and healing negative emotions.
3. Explore the role that Christian meditation and mindfulness plays in helping you to effectively respond to the negative emotions that may be keeping you stuck in life.
4. Learn a skill that can be used daily to center and quiet yourself from the distractions of negative emotions.

#### **Tasks**

1. Review last week’s log (Week 1: Handout 4).
2. Review the verse and theme for the week.
3. Review the handouts for the second week (Week 2: Handout 1).
4. Discuss the handout, including any comments or questions.
5. Practice body scan exercise for 15 minutes with the corresponding audio recording.
6. Review the homework wherein you will be practicing the body scan exercise every day for the next week and recording your efforts on the handout (Week 2: Handout 2).

## **Week 2: Handout 1**

### **Body Scan Exercise**

Make yourself comfortable in your chair, closing your eyes or finding a spot in the room to let your eyes focus on. Allow yourself to switch from the usual mode of doing to a mode of simply being, of resting in God's caring presence. He is here with you, loving you and accepting you as you are.

As you do this exercise, your mind will naturally wander. That's normal. It's just what minds do. When you find yourself wandering, just gently release these things into God's hands and bring your mind back to this exercise.

So, make yourself comfortable in your chair, and as you are sitting there, begin by focusing on the sounds going on in the room today. You hear my voice, what else do you hear? Perhaps you hear your breath...What else? ... Notice how the sounds come and go. If your mind starts analyzing the sounds somehow, just notice that and gently bring yourself back to simply experiencing the sounds as they are, as they enter your awareness and leave...

Now, gently bring your awareness to your breathing. See if you can be aware of where the sensations of breathing are most prominent. This may be at the nostrils, the mouth, the throat, in the rising and falling of the chest, or at the abdomen as the belly rises and deflates. Allow the breath to do what it naturally does without manipulating it or changing it. Be with the physical sensations of the breath just as they are. Allow your body to let go with each breath out, as the chair or floor takes on the work of holding you up, and let yourself be just where you are, right here, right now, in this moment. And in the midst of all this—the sounds...your breath, God is here, loving you and accepting you just as you are. He is with you, giving you grace.

Now notice the general state of the body and any sensations you may be experiencing. Perhaps there is a feeling of calm or tension, restlessness or maybe even agitation. Your task is simply to notice, to register it in your consciousness, in your awareness, the body as a whole, as best you can in this moment.

Now gently shift your awareness to the back, top and sides of your head. See if you can detect any physical sensation that presents itself. Try not to interfere with that sensation, just notice it. Keep in mind that a sensation may involve warmth, coolness, tingling, moisture.... if you experience no sensation or numbness see if you can be fully present and experience that, as you explore the back, sides and top of the head.

On the next breath out, let your awareness move to the face; from forehead to chin and from ear to ear. Allow your awareness to float freely around the face, experiencing any sensation that arises and bringing your attention to that area as best you can. Become aware of the chin, the lips, inside the mouth, your tongue, the cheeks, the eyes, the eyebrows, the ears, the forehead simply noticing whatever sensations arise and let them come and go. Let your attention linger, becoming aware of sensations as they change.

And now, on the next breath out, gently move your awareness to the neck and throat, softening and releasing as best you can, allowing your attention to hover in this region of the body – noticing any sensations that well up – give them your full and undivided attention as you become aware of the neck and throat.

From time to time your attention will be pulled away by thoughts arising in your mind – perhaps into the past, the future or fantasy – into worry or judgment or critical thoughts or your attention may also be hijacked by other sensations elsewhere in the body- if this happens – you can simply yield it to God, placing it in His caring hands. Just gently escort your attention back to the body – in this moment, which at present, involves returning your focus to the neck and throat.

Now, on the next breath out, guide your attention into the shoulders, allowing your awareness to focus on any sensations large or small arising. If there are more intense sensations, see if you can attend to them in the same way, exploring or opening up to them rather than resisting or fighting them as you attend to the front, sides and back of the shoulders.

Now surveying the arms– you can explore both arms at the same time or each one individually. Exploring the fronts, sides and backs of the arms elbows and wrists – moving deeply into each of the joints. Sensations might enter your field of awareness due to your clothes as they touch your skin or as you notice the contact of your arms upon the surface you are resting on. Your task is to observe these sensations with curiosity and openness, noticing as much detail as possible.

Now, on the next breath out, let your awareness move down and freely float throughout your hands. Attend to any sensation that crops up – exploring each hand individually or together. There may be tingling, pressure, numbness or warmth. Observe as best you can the quality of the sensations that arise in the hands. And again, if your awareness is pulled away by thoughts or another sensation of the body, release whatever you are experiencing into God’s hands, gently letting these be in the background and returning to the hands.

Now, on the next breath out move your attention to the upper back and survey this area. There may be sensations of pressure or temperature. Your task is to simply observe each sensation without having to change anything. Give yourself permission to explore and feel each sensation as you explore the upper back.

Direct your attention now to the lower back. Draw your attention to any sensation that comes up and explore it in detail. The lower back is a region that presents, for many of us, challenging sensations. See if you can open up to these, lean into them, allowing whatever sensations arise to follow their own course.

Now, become aware of the chest as it rises and falls. There may be sensations made by the clothing against your skin as the chest rises and falls with each breath. You may become aware of the sensation of your beating heart. Let your awareness fully penetrate into each sensation as it arises, allowing it to do whatever it does as you observe moment to moment.

Now allow your attention to turn to your lower body. Observe your hips pressing against the chair... Notice how your thighs feel in your clothes, against the chair, notice your knees, your calves... If your mind wanders, just gently release those thoughts to God and bring

it back to focusing on your legs.

Of course, when the mind is taken away into thought or elsewhere in the body, come back to the object of meditation in a kind way, a compassionate way, a way that acknowledges that getting lost in thought is just the nature of the mind. In fact, noticing that the mind has wandered is just as much a part of this meditation as is staying on the body part itself which in this moment is the legs.

And now, releasing the legs and allowing this special kind of attention to move into your feet, observe how your feet feel inside your shoes on the floor...the tops of the feet, the toes, the nails, the soles, the heels.

Once again, become aware of the physical sensation of the breath as it enters and leaves the body. As you open up to things just as they are in each moment, see how this openness is healing and nourishing. Allow the world to be as it is, beyond fears, worries, tensions, and beyond the tendencies of the mind to want things to be a certain way, release all these tendencies into God's hands. Be awake to your experience as it unfolds in this moment and in this moment, remember that this state of clarity is available to you at any time by simply bringing your attention or your awareness to the breath.

Continue for a moment to observe any feelings you are experiencing in this moment. And in the midst of all this—the body sensations...the breath...the feelings, God is here, loving you and accepting you just as you are. You can yield, if you like, all your experience, whatever it is, into His caring hands. He is with you, giving you grace.

When you're ready, you can bring your awareness back to the room and you can open your eyes.

Adapted from:  
Ford, 2016.

(This script will be provided in both a paper form and as a recording via email or flashdrive)

**Week 2: Handout 2**  
**Homework Form: Body Scan Exercise**

Please fill out this form each day of the week, noting the date, whether or not you practiced, and anything else that comes up in the “comments” section. Please remember to use the corresponding audio recording titled “Body Scan Exercise.”

Day/Date	Practice (Yes/No)	Comments/Any Actions Taken Corresponding to the Focus of the Meditation
Monday Date: _____	Body Scan Exercise Practice (Yes/No)	
Tuesday Date: _____	Body Scan Exercise Practice (Yes/No)	
Wednesday Date: _____	Body Scan Exercise Practice (Yes/No)	
Thursday Date: _____	Body Scan Exercise Practice (Yes/No)	
Friday Date: _____	Body Scan Exercise Practice (Yes/No)	
Saturday Date: _____	Body Scan Exercise Practice (Yes/No)	
Sunday Date: _____	Body Scan Exercise Practice (Yes/No)	

This form is adapted from Segal et al. (2012).

**Week 2****Weekly Text and/or Email Inspiration**

Mindfully notice that you are fearfully and wonderfully made. (Psalm 139:14)

## APPENDIX F: Week 3 Module

### Week 3: Scriptural Meditation

#### Verse

“Finally, brothers and sisters, whatever is true, whatever is noble, whatever is right, whatever is pure, whatever is lovely, whatever is admirable—if anything is excellent or praiseworthy—think about such things.” (Philippians 4:8)

#### Theme

We all think about things throughout our day. It is easy to allow our minds to wander. In fact, recent research revealed that 50% of a sample of adults reported their mind was wandering when they were supposed to be focusing on a specific task.<sup>12</sup> Unfortunately, mind wandering can lead to repetitive negative thinking, which can lead to a long-term battle with shame, depression or anxiety. Interestingly, we also tend to meditate on things all day long,<sup>13</sup> with meditation simply defined as thinking deeply about a specific topic. Yet, what we choose to meditate on can either help us to feel love, joy, contentment, and so on, or result in rumination, worry, sadness, feelings of shame and anxiety. This week, you will have the opportunity to practice a form of meditation, called scriptural meditation, focusing on God’s characteristics, attributes, and actions, including His infinite wisdom, goodness, power, and providence. We believe these attributes and actions of God, when regularly meditated upon, can begin the process of deepening your relationship with Him, and, simultaneously, help you shift your focused attention from negative thinking to yielding to God’s active, loving presence and grace via detachment. When practiced over time, we hope that daily scriptural meditation on God’s Word, the Bible, and His character can help you to think about things that are noble, right, pure, lovely, admirable, excellent, and praiseworthy. As a result, you will be attempting to shift from “earthly-mindedness” to “heavenly-mindedness.”<sup>14</sup>

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<sup>12</sup> Killingsworth and Gilbert (2010).

<sup>13</sup> Hall (2016).

<sup>14</sup> Burroughs (2014).



### **Goals**

1. Define “scriptural meditation”, “earthly-mindedness,” and “heavenly-mindedness,” and discuss the ways in which these terms relate to submitting to God’s providence via detachment.
2. Learn about the potential benefits of scriptural meditation, including its possible role in helping you with repetitive negative thinking.
3. Differentiate “occasional” and “deliberate” forms of Christian scriptural meditation.
4. Break down the specific steps of scriptural meditation in order to learn how to think deeply about God from a Christian perspective.
5. Practice scriptural meditation by meditating on God’s attributes and actions, including His infinite wisdom, love, power, and providence (see Week 3: Handout 2). Keep track of your meditative practice with the weekly log (see Week 3: Handout 3).

### **Tasks**

1. Review last week’s log (Week 2: Handout 2).
2. Review the verse and theme for the week.
3. Review the handouts for the third week (Week 3: Handout 1 and Week 3: Handout 2).
4. Discuss the handout, including any comments or questions.
5. Practice scriptural meditation for 20 minutes with the corresponding audio recording.
6. Review the homework wherein you will be practicing scriptural meditation every day for the next week and recording your efforts on the handout (Week 3: Handout 4).

\*Adapted from Knabb, et al., 2019, *Christian meditation for repetitive negative thinking: A multisite randomized trial examining the effects of a 4-week preventative program.*

## Week 3: Handout 1

### Scriptural Meditation

#### A Definition of Scriptural Meditation

As noted in the first week, in the Old Testament, the Hebrew word, *hagah*, is often used for meditation, whereas the Greek word, *melatao*, is sometimes used in the New Testament.<sup>15</sup> Among Protestants from England in the 1500s and 1600s who believed strongly in turning to God's Word, the Bible, to guide life, meditation was defined in several different ways:

- “[Meditation] is the steadfast and earnest bending of the mind on some spiritual and heavenly matter, discoursing on it with ourselves, until we bring it to some profitable point, both for the settling of our judgments, and the bettering of our hearts and lives.”<sup>16</sup>
- “Meditation is the soul's retiring of itself, that by a serious and solemn thinking upon God, the heart may be raised up to heavenly affections.”<sup>17</sup>

In terms of a more contemporary definition, we define scriptural meditation as follows:

- “A focused, sustained cognitive process derived from...Christianity that shifts the mind from earthly- to heavenly-thinking in order to cultivate a corresponding feeling state that leads to Christ-like behavior and action.” (Knabb et al., 2017).

#### Types of Scriptural Meditation

Scriptural meditation can be *occasional*, meaning you might say very brief meditations throughout the day; or, scriptural meditation can be *deliberate*, which involves a more formal practice, in solitude and for a set amount of time.<sup>18</sup> Although we recognize that these two forms of meditation may overlap, we distinguish between the two with a focus on *deliberate* meditation this week by asking that you choose a specific time each day to engage in the practice.

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<sup>15</sup> Strong (2001a, 2001b).

<sup>16</sup> Ball (2016, p. 25).

<sup>17</sup> Watson (2012).

<sup>18</sup> Beeke and Jones (2012).

## Reasons for Daily Scriptural Meditation

There are a variety of reasons to use scriptural meditation in your daily life, including, but not limited to, the following:

- It is rooted in scripture (e.g., Psalm 1:2).
- It can help you to shift your focus from negative thoughts to God.<sup>19</sup>
- It can help you cultivate a deeper awareness of God’s active, loving presence and grace.<sup>20</sup>
- It can help your mind to find rest.<sup>21</sup>
- It can help you to develop focused, sustained attention,<sup>22</sup> which can help with repetitive negative thinking.
- It can help you to meditate on the right things, given that we are always meditating on something.<sup>23</sup>

## Possible Benefits of Daily Scriptural Meditation

From our perspective, scriptural meditation can help you to gain a deeper awareness of God’s active, loving presence and grace, especially when meditating on God’s infinite goodness, wisdom, and power. In addition, meditating on God’s providential care can help you to begin the process of learning to trust in Him and in his grace when you are stuck in repetitive cycles of thinking by shifting from “earthly-mindedness” to “heavenly-mindedness.” In other words, as you learn to meditate on God, you are simultaneously learning to pivot away from rumination, worry and shame so you can untangle yourself from repetitive thinking cycles that get in the way of living life and live instead in a state of grace.

## Scriptural Meditation: A Nine-Step Process

In order to simplify the meditative process, we have organized the various instructions from a range of writings<sup>24</sup> into nine clear steps for you to practice in 10-minute blocks of time, once per day. Also worth mentioning, remember to select a set time each day, find a quiet space, free from

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<sup>19</sup> Ball (2016).

<sup>20</sup> Ball (2016).

<sup>21</sup> Ball (2016).

<sup>22</sup> Ball (2016).

<sup>23</sup> Hall (2016).

<sup>24</sup> These nine steps are integrated from Ball (2016), Baxter (2015), Beeke and Jones (2012), Hall (2016), and Watson (2012).

distractions, silence your smart phones/tablets/computers, etc., and sit up straight with your eyes closed.

1. Choose a short biblical passage/verse (or character trait of God) to focus all of your attention on.
2. Say a short prayer to God, asking Him for guidance during the next 10 minutes.
3. Shift your focus from “earthly-mindedness” to “heavenly-mindedness,” letting go of rumination and worry and pivoting towards a single point of focus—the short passage/verse in scripture that reveals the biblical topic.
4. Repeat the passage in scripture with focused, sustained attention.
5. When your mind inevitably wanders to something other than the pre-selected verse, exercise a spirit of grace toward yourself by non-judgmentally refocusing your attention on the biblical passage.
6. Begin to move from your “brain” to your “heart,” focusing on the feeling that corresponds with the biblical topic and short passage in scripture.
7. Deeply experience the feeling that corresponds with the biblical topic and passage in scripture.
8. As you conclude the meditation, make a commitment to act on what you have just focused all of your attention on in a Christ-like manner.
9. Say a short prayer to God, thanking Him for revealing Himself to you via the biblical topic and short passage in scripture.

Use the Handout 2 and/or Handout 3 to guide your 10-minute meditation each day.

\* Adapted from Knabb, et al., 2019, *Christian meditation for repetitive negative thinking: A multisite randomized trial examining the effects of a 4-week preventative program*.

## Week 3: Handout 2

### Scriptural Truths Meditation (Bible Passage Version)

The purpose of Scriptural Truth Meditation (Bible Passage Version) is to help us slow down and quietly reflect on a significant truth from Scripture.

1. Choose a Scripture phrase that is meaningful and comforting. Below are a few samples. Add others that are also encouraging. I will be glad to help you find other passages if you like.

*Psalms 23:1, "The Lord is my shepherd."*

*I John 4:8b, "... God is love."*

*Philippians 4:13, "I can do all things through Christ who strengthens me."*

*Romans 8:1, "There is therefore now no condemnation for those who are in Christ Jesus"*

*Proverbs 3:5a, "Trust in the Lord with all your heart..."*

*Psalms 37:7a, "Be still before the Lord and wait patiently for him..."*

*I John 1:9a, "If we confess our sins, he is just and faithful to forgive us our sins..."*

*Matthew 11:28, "Come to me, all you who are weary and burdened, and I will give you rest."*

2. As you sit in a comfortable position, say a short prayer asking for guidance for the next 10 minutes.
3. Close your eyes and shift your focus from "earthly-mindedness" to "heavenly-mindedness," letting go of rumination and worry and pivoting towards a single point of focus—the short passage/verse in scripture that reveals the biblical topic.
4. Take a deep breath in and breathe out repeating the Scriptural phrase with focused, sustained attention. If you chose a longer scripture, you may want to do half the Scripture in one breath and the other half in your second breath.
5. When your mind inevitably wanders to something other than the pre-selected verse, exercise a spirit of grace toward yourself by non-judgmentally refocusing your attention on the biblical passage.
6. Quietly reflect on the passage, focusing on the feeling that corresponds with the biblical topic and short passage in scripture, pondering its meaning and how its message is expressed in your life as you move from your "brain" to your "heart."
7. Your mind will eventually wander. This is normal. You do not need to beat yourself up but simply return to the Scripture phrase and deeply experience the feeling that corresponds with the biblical topic and passage in scripture.
8. As you conclude the meditation, make a commitment to act on what you have just focused all of your attention on in a Christ-like manner.

9. Say a short prayer to God, thanking Him for revealing Himself to you via the biblical topic and short passage in scripture.

\*Garzon, (2013).

### Week 3: Handout 3

#### Scriptural Truths Meditation (God's Character Version)

The purpose of Scriptural Truth Meditation focused on God's character is to help us slow down and quietly reflect on a significant truth about who God is. You are not studying this truth in an overly analytical manner, but rather receiving the depth of the truth at the heart level.

1. Choose a characteristic of God that is meaningful and comforting. Below are a few examples. You may add others as well. I will be glad to help you identify additional traits if you like.

*God is love*  
*God is in control*  
*God is good*  
*Jesus loves me*

*God forgives me*  
*God is faithful*  
*God is merciful*  
*Jesus is Lord*

2. As you sit in a comfortable position, say a short prayer asking for guidance for the next 10 minutes.
3. Close your eyes and shift your focus from "earthly-mindedness" to "heavenly-mindedness," letting go of rumination and worry and pivoting towards a single point of focus—the character trait of God.
4. Take a deep breath in and breathe out repeating the characteristic (eg. "God is...") with focused, sustained attention.
5. When your mind inevitably wanders to something other than the pre-selected character trait of God, exercise a spirit of grace toward yourself by non-judgmentally refocusing your attention on the biblical truth.
6. Quietly reflect on the characteristic, focusing on the feeling that corresponds with this part of God, pondering its meaning and how it is expressed in your life as you move from your "brain" to your "heart."
7. Your mind will eventually wander. This is normal. You do not need to beat yourself up but simply return to the trait and deeply experience the feeling that corresponds with this characteristic of God.
8. As you conclude the meditation, make a commitment to act on what you have just focused all of your attention on in a Christ-like manner.
9. Say a short prayer to God, thanking Him for revealing Himself to you via the focus on His character trait.

When you are done, you may want to jot down any thoughts about your experience. Feel free to share them with me in our next session or to keep them private.

**Stress Reliever:** Jot down the Scripture on an index card or put it in your smart phone. During the day, when you feel stressed, take a deep breath and repeat quietly or in your mind the Scripture phrase you meditated on during your 10 minutes 1-3 times. You might look at your index card (or smart phone reminder). Then, return to what you were doing.

\*Garzon, (2013)

### **Week 3: Script for Handout 2**

#### **Scriptural Truth Meditation (Bible Passage Version)**

In this Scriptural Truth Meditation, the Bible Passage Version, you will practice slowing down and quietly reflecting on a significant truth from Scripture. First choose a Scripture phrase that is meaningful and comforting to you, such as Exodus 14:14: “The LORD will fight for you, you need only to be still”; or Philippians 4:13: “I can do all things through Christ who strengthens me”; or 1 John 4:8 “God is love”; whatever scripture is helpful to you in this moment today.

Take a moment to sit in a comfortable position and say a short prayer asking for guidance for the next 10 minutes as you complete this meditation.

Close your eyes and purposefully shift your focus from “earthly-mindedness” to “heavenly-mindedness,” letting go of rumination and worry and pivoting towards a single point of focus—the short passage of scripture that you have chosen.

Take a deep breath in and breathe out repeating the Scriptural phrase with focused, sustained attention. If you chose a longer scripture, you may want to do half the Scripture in one breath and the other half in your second breath. Repeat this breathing in and breathing out of the scripture slowly and intentionally several times.

Your mind will inevitably wander to something other than the verse you have selected. When this happens, gently exercise a spirit of grace toward yourself by non-judgmentally refocusing your attention back on the biblical passage. Breathing in and out the scripture.

Quietly reflect on the passage, noticing the feeling that arises with the biblical topic and short passage in scripture, pondering its meaning and how its message is expressed in your life as you move from your “brain” to your “heart.” Take a few more minutes to breathe in and breathe out saying the scripture a few more times.

Again, if your mind starts to wander, remember this is normal. Simply return to the Scripture phrase and deeply experience the feeling that corresponds with the biblical topic and passage in scripture.

As you conclude the meditation, make a commitment to act on what you have just focused all of your attention on in a Christ-like manner.

Say a short prayer to God, thanking Him for revealing Himself to you through His Word knowing it is always available to you. You can return to it at any point throughout your day breathing in and saying the scripture as you breathe out.

When you are ready, open your eyes and bring your awareness back to the room and your surroundings.

(This script will be provided in both a paper form and as a recording via email or flashdrive)



### **Week 3: Script for Handout 3**

#### **Scriptural Truth Meditation (God's Character Version)**

In this Scriptural Truth Meditation, the God's Character Version, you will practice slowing down and quietly reflecting on a significant truth about who God is. First choose a characteristic of God that is meaningful and comforting to you, such as "God is merciful" or "God is love" or "God is in control" or "God is good", whatever trait of God that is helpful for you in this moment today.

Take a moment to sit in a comfortable position and say a short prayer asking for guidance for the next 10 minutes as you complete this meditation.

Close your eyes and purposefully shift your focus from "earthly-mindedness" to "heavenly-mindedness," letting go of rumination and worry and pivoting towards a single point of focus—the character trait of God that you have chosen.

Take a deep breath in and breathe out repeating the characteristic of God with focused, sustained attention. Repeat this breathing in and breathing out of the characteristic slowly and intentionally several times.

Your mind will inevitably wander to something other than the characteristic you have selected. When this happens, gently exercise a spirit of grace toward yourself by non-judgmentally refocusing your attention back on the characteristic of God. Breathing in and out the character trait.

Quietly reflect on the characteristic, noticing the feeling that arises with the thought and knowledge of this part of God, pondering its meaning and how it is expressed in your life as you move from your "brain" to your "heart." Take a few more minutes to breathe in and breathe out saying the characteristic a few more times.

Again, if your mind starts to wander, remember this is normal. Simply return to the character trait and deeply experience the feeling that corresponds with this part of God.

As you conclude the meditation, make a commitment to act on what you have just focused all of your attention on in a Christ-like manner.

Say a short prayer to God, thanking Him for revealing Himself to you through His character knowing it is always available to you. You can return to it at any point throughout your day breathing in and saying the characteristic as you breathe out.

When you are ready, open your eyes and bring your awareness back to the room and your surroundings.

(This script will be provided in both a paper form and as a recording via email or flashdrive)

### Week 3: Handout 4

#### Homework Form: Meditating on God's Attributes and Actions<sup>25</sup>

Please fill out this form each day of the week, noting the date, whether or not you practiced, and anything else that comes up in the “comments” section. Please remember to use the corresponding audio recordings titled “Scriptural Truth Meditation 1 and 2.”

Day/Date	Practice (Yes/No)	Comments/Any Actions Taken Corresponding to the Focus of the Meditation
Monday Date: _____	Scriptural Meditation (_____):	
Tuesday Date: _____	Scriptural Meditation (_____):	
Wednesday Date: _____	Scriptural Meditation (_____):	
Thursday Date: _____	Scriptural Meditation (_____):	
Friday Date: _____	Scriptural Meditation (_____):	
Saturday Date: _____	Scriptural Meditation (_____):	
Sunday Date: _____	Scriptural Meditation (_____):	

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<sup>25</sup> This form is adapted from Segal et al. (2012).

**Week 3****Weekly Text and/or Email Inspiration**

Truths from God's Word are always available for you to slow down and quietly reflect on as you move throughout your day.

## **APPENDIX G: Week 4 Module**

### **Week 4: Jesus Prayer Meditation**

#### **Verse**

“in order that in the coming ages he might show the incomparable riches of his grace, expressed in his kindness to us in Christ Jesus.” (Ephesians 2:7)

#### **Theme**

Shame causes people to hide from others, from themselves and from God and grace is God’s answer to the negative emotion of shame. Grace allows people to accept the flaws, imperfections and negative life events they have experienced, the very things by which shame has indicted them, and even to grow and change without a sense of condemnation or judgement. God’s love and kindness shown through Jesus’ willingness to scorn shame on the cross (Hebrews 12:2), rendering it powerless, can promote positive emotions and actions, gratitude and kindness from people to others and to themselves. This in turn, allows them to follow God’s urging to approach His throne of grace with confidence in order to find the mercy and grace needed to alter the negativity and sin that binds people (Hebrews 4:16). This prayer meditation will allow you to explore ways to experience God’s presence, grace and mercy to alleviate and prevent negative emotions and overcome shame.

#### **Goals**

1. Understand and reinforce the concept of Jesus’ mercy and grace.
2. Learn how to use prayer meditation to calm negative emotions.
3. Practice Jesus Prayer Meditation.

#### **Tasks**

1. Review last week’s log (Week 3: Handout 4).
2. Review the verse and theme for the week.
3. Review the handouts for the fourth week (Week 4: Handout 1 and Week 4: Handout 2).
4. Discuss the handouts, including any comments or questions.
5. Practice Jesus Prayer Meditation for 10 minutes with the corresponding audio recording.
6. Review the homework handouts (Week 4: Handout 2).

## **Week 4: Handout 1**

### **Jesus Prayer Meditation Transcript**

Try to get comfortable in your chair, placing your feet on the floor and closing your eyes. Rest your hands on your legs or the arms of your chair. When you are ready, begin to notice that you are breathing, recognizing that God is giving you your breath as a gift from moment to moment. In this very instance, you do not need to do anything to control your breath. Instead, God is sovereign over your breathing cycle. After a minute, begin to gently recite the Jesus Prayer in your mind, “Lord Jesus Christ, Son of God, have mercy on me.”

Breathe in by saying “Lord Jesus Christ, Son of God,” recognizing that Jesus is residing within your inner world in this very moment. Also, breathe out by saying “have mercy on me,” exhaling in order to let go of your own efforts to control the challenges and pressures in your life. Over and over again, inhale and exhale, aligning the prayer with your in-breath and out-breath in a gentle, compassionate manner. Breathe in Jesus’ presence, finding rest in your relationship with him, given he is with you and caring for you. Recognize that he is the Lord of your life; therefore, you do not need to do anything in this moment, other than acknowledging his sovereignty, love, and infinite wisdom.

Breathe out as you say, “have mercy on me,” truly letting go of the grip you have on the demands of life. See if you can imagine actually surrendering your life to him, including all of the things that have overwhelmed you in the last week. In this moment, you are asking Jesus for loving compassion, recognizing that he understands your predicament and is responding to you in your time of need.

Over and over again, breathe in “Lord Jesus Christ, Son of God,” and breathe out, “have mercy on me.” Each time you say the prayer, try to sink deeper and deeper into an awareness of Jesus’ presence. In this very moment, he is with you and sustaining you, offering you loving compassion in your time of need. Because God is infinitely wise, loving, and powerful, he knows the best path for you, and is walking with you as you face the demands in your life.

As this practice comes to a close, see if you can give thanks to Jesus, recognizing that he has been ministering to you in your time of need over the last 10 min. See if you can ask him to continue to be with you throughout the rest of your day, turning to him over and over again by reciting the Jesus Prayer.

\*Knabb, 2018.

(This script will be provided in both a paper form and as a recording via email or flashdrive)

### Week 4: Handout 2

#### Homework Form: Jesus Prayer Meditation

Please fill out this form each day of the week, noting the date, whether or not you practiced, and anything else that comes up in the “comments” section. Please remember to use the corresponding audio recording titled “Jesus Prayer Meditation.”

Day/Date	Practice (Yes/No)	Comments/Any Actions Taken Corresponding to the Focus of the Meditation
Wednesday Date: _____	Meditation Practice (Yes/No)	
Thursday Date: _____	Meditation Practice (Yes/No)	
Friday Date: _____	Meditation Practice (Yes/No)	
Saturday Date: _____	Meditation Practice (Yes/No)	
Sunday Date: _____	Meditation Practice (Yes/No)	
Monday Date: _____	Meditation Practice (Yes/No)	
Tuesday Date: _____	Meditation Practice (Yes/No)	

\* This form is adapted from Segal et al. (2012).

**Week 4****Weekly Text and/or Email Inspiration**

God's love and kindness is able to overcome the power of shame through the grace and mercy of Jesus.

## **APPENDIX H: Week 5 Module**

### **Week 5: Releasing of Shame Meditation**

#### **Verse**

“And let us run with perseverance the race marked out for us, fixing our eyes on Jesus, the pioneer and perfecter of faith. For the joy set before him he endured the cross, scorning its shame, and sat down at the right hand of the throne of God. Consider him who endured such opposition from sinners, so that you will not grow weary and lose heart.” (Hebrews 12:1b-3)

#### **Theme**

Shame is experienced by all people in different ways. In the beginning, the book of Genesis (verse 2:25) teaches us that people were created with no shame, but it comes as the result of living in a fallen world. Shame may be created from negative experiences of others who were meant to love us or care for us or from destructive messages we have internalized. It leaves us believing we are unworthy, irrevocably damaged, unlovable or hopelessly inadequate in some way. It leaves us feeling worthless and often manifests in our body. We can feel the shame and carry it in our body, sometimes in slumped shoulders, head, back or stomach tension or pain or other places. On the cross, Jesus scorned shame. To scorn means to make worthless. Jesus conquered shame and took away its power, but so often we remain ensnared by shame in our thoughts, feelings and in our physical being. This meditation is intended to help release the power of shame in our hearts, minds and bodies by taking on a curious compassionate stance toward shame and releasing the avoidant or defensive stance previously experienced by claiming the power of the cross.

#### **Goals**

1. Recognize the ways shame is affecting both the mind and the body.
2. Learn to use meditation to release the power of shame and connect to the healing power of Jesus by allowing a curious, compassionate experience of shame held in the body and releasing the avoidant or defensive experience of the shame.
3. Practice a meditation that addresses shame experiences when you are struggling with emotions of shame (see Week 5: Handout 1). Keep track of your daily meditative practices with the weekly log (see Week 5: Handout 2).

#### **Tasks**

1. Review last week’s log (Week 4: Handout 2).
2. Review the verse and theme for the week.
3. Review the handouts for the fifth week (Week 5: Handout 1).
4. Discuss the handout, including any comments or questions.
5. Practice the Healing of Shame Meditation for 10 minutes with the corresponding audio recording.
6. Review the homework handouts (Week 5: Handout 1 and Week 5: Handout 2).



## Week 5: Handout 1

### Releasing of Shame Meditation

Take a moment to get comfortable and relaxed in your chair. You may close your eyes to free yourself from any distractions in the room or focus on a spot on the floor in front of you. As you settle into this time, notice your breath moving in and out. You may notice it becoming deeper and more rhythmic as you focus on it. Spend a few moments just allowing yourself to breathe with awareness.

The goal of this meditation is to help you understand and release shame you may be carrying. As you continue to breathe in and out, allow your mind to focus on a shaming experience or a message of shame from your life. Often these have originated somewhere in our childhood, so you may find your mind going there. Allow your mind to go to the time, place or words that it needs to right now.

As you focus on this thought, phrase or picture of shame in your mind, notice where you are holding it in your body. What physical sensations are you feeling? It may be tension, pain or distress somewhere in your body. Bring your awareness to this part of your body that is holding the shame. Notice the feelings and sensations it is feeling and become aware of how long you have felt this. This sensation, the container for the shame, may have started at a young age and may feel quite familiar to you, even though it is uncomfortable. Be gentle with this tender, vulnerable part of you, as if it were a small, hurting child and bring your awareness once again to your breath.

As you continue to breathe in and out, meditate on the following scriptures from Hebrews (12:2; 4:16): “For the joy set before him (Jesus) he endured the cross, scorning its shame, and sat down at the right hand of the throne of God” and “Let us then approach God’s throne of grace with confidence, so that we may receive mercy and find grace to help us in our time of need.”

Take a moment to invite this Jesus who has scorned shame, making it powerless, into the place of shame inside of you. Allow him to carry that tender, vulnerable part of you, as if it were a small, hurting child, to the throne of God. The throne made of grace. Release the negative sensations you noticed earlier to this throne and relax that part of you. Allow the mercy, love, grace and goodness found there to repair the damage shame has done; to change the message you have carried. Notice also the message you take from God at the throne to replace it and the confidence you can carry with it. This new message may be “you are loved” or “you are precious” or “I am here to help you; you are not alone.”

Become aware of your breath once again flowing in and out as you take a moment to notice what it feels like to accept this healing. Notice how it feels in your body, especially that part that held the shame. Notice the sense of joy, calm and relaxation and imagine what it will be like to walk around healed and confident. Take a moment to sit with the truth of this healing.

When you are ready, bring your awareness back to the room, knowing you can return to this meditation again and can connect to the healing power of God’s throne of grace at any time.

(This script will be provided in both a paper form and as a recording via email or flashdrive)

## Week 5: Handout 2

### Homework Form: Releasing of Shame Meditation

Please fill out this form each day of the week, noting the date, whether or not you practiced, and anything else that comes up in the “comments” section. Please remember to use the corresponding audio recording titled “Healing of Shame Meditation.”

Day/Date	Practice (Yes/No)	Comments
Monday Date: _____	Healing of Shame Meditation	
Tuesday Date: _____	Healing of Shame Meditation	
Wednesday Date: _____	Healing of Shame Meditation	
Thursday Date: _____	Healing of Shame Meditation	
Friday Date: _____	Healing of Shame Meditation	
Saturday Date: _____	Healing of Shame Meditation	
Sunday Date: _____	Healing of Shame Meditation	

\*This form is adapted from Segal et al. (2012).

**Week 5****Weekly Text and/or Email Inspiration**

As you continue in your week, release the power of shame by claiming the power of the cross.

Hebrews 4:16: “Let us then approach God’s throne of grace with confidence, so that we may receive mercy and find grace to help us in our time of need.”

## **APPENDIX I: Week 6 Module**

### **Week 6: Wisdom of Accepted Tenderness Prayer Meditation**

#### **Verse**

“The Lord appeared to us in the past, saying: “I have loved you with an everlasting love; I have drawn you with unfailing kindness.” (Jeremiah 31:3)

#### **Theme**

God’s lovingkindness is unfailing and everlasting and yet we can often not be grounded in this which can lead to negative thoughts, emotions or feelings of shame. This meditation will help to reinforce these positive and powerful concepts to prevent and calm negative emotions.

#### **Goals**

1. Understand and reinforce the concept of God’s tenderness and lovingkindness.
2. Learn how to use prayer meditation to calm negative emotions.
3. Practice Wisdom of Accepted Tenderness Prayer Meditation.

#### **Tasks**

1. Review last week’s log (Week 5: Handout 2).
2. Review the verse and theme for the week.
3. Review the handouts for the sixth week (Week 5: Handout 1).
4. Discuss the handout, including any comments or questions.
5. Practice the Wisdom of Accepted Tenderness Prayer Meditation for 10 minutes with the corresponding audio recording.
6. Review the homework handouts (Week 6: Handout 1 and Week 6: Handout 2).

## Week 6: Handout 1

### Wisdom of Accepted Tenderness Prayer Meditation

*The Wisdom of Accepted Tenderness* by Richard Johnston  
© RHH Johnston Consultancy Ltd.

This prayer meditation is focused on the tenderness and love of God. By praying and meditating on these themes, the goal is to internalize these biblical truths as an experiential reality in our hearts.

First, seek to be still in God's presence. Sitting in a straight-backed chair make yourself comfortable and relaxed. Your posture should be upright so that you can remain alert during this time. You can close your eyes if you wish, allowing my voice to guide you through the prayer.

Now gently come to focus on your breathing remembering that the Holy Spirit himself is described as the breath of God. As you breathe in physically seek to breathe in the very presence of God who is with you right here and right now. Spend a few moments simply breathing in the presence of God. The Scriptures describe the Holy Spirit as the breath of God. Welcome now the presence of the Holy Spirit who is the breath of God in you and around you.

TODAY O LORD I ACCEPT YOUR ACCEPTANCE OF ME

Notice any questions or commentary that arise in your mind at this time. As you become aware of any thoughts arising in the mind gently seek to let these come and go, returning your focus to God and the words of the Prayer.

TODAY O LORD I ACCEPT YOUR ACCEPTANCE OF ME  
I CONFESS THAT YOU ARE ALWAYS WITH ME AND ALWAYS FOR ME

As much as you are able, use these words to express your own faith to God, but if you sense any resistance in your heart don't criticize yourself in any way. Simply acknowledge with kindness your honest response. As much as you are able – seek to identify with and pray these words from your own heart.

I CONFESS THAT YOU ARE ALWAYS WITH ME AND ALWAYS FOR ME  
I RECEIVE INTO MY SPIRIT YOUR GRACE, YOUR MERCY, YOUR CARE

God is the most gracious, kind, merciful and caring being who exists, And he cares for you personally. In these moments, seek to accept and receive his grace and mercy at the core of who you are. Spend a few moments in the silence seeking to be aware of these realities. If your mind wanders, gently bring your awareness back to the silence, and back to the presence

of God, here with you now.

I RECEIVE INTO MY SPIRIT YOUR GRACE, YOUR MERCY, YOUR CARE  
I REST IN YOUR LOVE O LORD

Knowing that God loves you and accepts you for who you are right now you are free to rest in his love. Notice if any struggling, or arguments or questions arise in your mind. Gently watch these thoughts come and go. And return your focus to the love and tenderness of God towards you personally.

I REST IN YOUR LOVE O LORD

In these moments continue to rest in the accepted tenderness of God towards you personally. Using the stretches of silence to simply enjoy being with him. In a few moments I will say amen to signal the end of this Prayer meditation.

Breathing in your presence,  
I REST IN YOUR LOVE O LORD  
AMEN

(This script will be provided in both a paper form and as a recording via email or flashdrive)

Reference:

Johnston, R. (n.d.). Christian mindfulness six-session online course: Exploring mindfulness from a Christian perspective. Retrieved from <<http://www.christianmindfulness.co.uk/onlinecourse.html>>

Permission to use Johnston's Meditation:

From: Jones, Tracy Lynn [mailto: ]  
Sent: 01 March 2018 00:30  
To: [redacted]  
Subject: Request to utilize meditation

Dr. Johnston,

I am a doctoral student at Liberty University and I am doing my dissertation on the utilization of Christian mindfulness in the treatment of shame. I am working with Dr. Garzon as well as Dr. Kristy Ford on this as it will be a next step in the research started by Dr. Ford in her dissertation. I am writing to request your permission to utilize your meditation "The Wisdom of Accepted Tenderness" in my study please as a means of providing continuity with the previous study. Thank you for your consideration and for the resources you have developed.

Sincerely,  
Tracy Jones



Thu 3/1/2018 4:51 AM  
To: Jones, Tracy Lynn

Reply all

Tracy,

That's fine. Please ensure that you mention authorship and the Christian Mindfulness website. I would be very interested to see your paper and results.

Kind Regards,

Richard H H Johnston

Director, Christian Mindfulness  
[www.christianmindfulness.co.uk](http://www.christianmindfulness.co.uk)

## Week 6: Handout 2

### Homework Form: Wisdom of Accepted Tenderness Prayer Meditation

Please fill out this form each day of the week, noting the date, whether or not you practiced, and anything else that comes up in the “comments” section. Please remember to use the corresponding audio recording titled “Wisdom of Accepted Tenderness Prayer Meditation.”

Day/Date	Practice (Yes/No)	Comments/Any Actions Taken Corresponding to the Focus of the Meditation
Wednesday Date: _____	Meditation Practice (Yes/No)	
Thursday Date: _____	Meditation Practice (Yes/No)	
Friday Date: _____	Meditation Practice (Yes/No)	
Saturday Date: _____	Meditation Practice (Yes/No)	
Sunday Date: _____	Meditation Practice (Yes/No)	
Monday Date: _____	Meditation Practice (Yes/No)	
Tuesday Date: _____	Meditation Practice (Yes/No)	

This form is adapted from Segal et al. (2012).

**Week 6****Weekly Text and/or Email Inspiration**

God's lovingkindness can calm negative emotions or feelings of shame. Accept His acceptance of you today.



**APPENDIX J: Permissions and Articles or Links to Scales****Brief Experiential Avoidance Questionnaire (BEAQ)**

Gámez, W., Chmielewski, M., Kotov, R., Ruggero, C., Suzuki, N., & Watson, D. (2014).

The Brief Experiential Avoidance Questionnaire: Development and initial validation. *Psychological Assessment*, 26(1), 35–45.

**Re: Permission request for BEAQ**

Wakiza Gámez <[REDACTED]>

Wed 9/4/2019 4:51 PM

To: Jones, Tracy Lynn <[REDACTED]>

Tracy,

You can use the BEAQ for the purposes of your dissertation study. Good luck!

Waki

On Tue, Sep 3, 2019 at 9:23 PM Jones, Tracy Lynn <[REDACTED]> wrote:

Dear Dr. Wakiza Gamez,

I am a doctoral student at Liberty University and am completing my dissertation entitled "The Effectiveness of Christian Accommodative Mindfulness in the Treatment of Shame." I would like to request your permission to utilize your assessment, the BEAQ, for my study, please. Feel free to contact me should you have any questions or require additional information. Thank you very much.

Sincerely,  
Tracy Jones

**Brief Religious Coping Scale (Brief RCOPE)**

Pargament, K., Feuille, M., & Burdzy, D. (2011). The Brief RCOPE: Current psychometric status of a short measure of religious coping. *Religions*, 2, 51-76.

**Re: Permission request for Brief RCOPE**

Kenneth I Pargament <[REDACTED]>

Wed 9/4/2019 11:51 AM

To: Jones, Tracy Lynn <[REDACTED]>

Dear Tracy:

You have my permission to use the Brief RCOPE. Please keep me posted on your findings.

Sincerely,

Kenneth I. Pargament, Ph. D.  
Professor  
Department of Psychology  
Bowling Green State University  
Bowling Green, OH 43403

Author, *Spiritually Integrated Psychotherapy: Understanding and Addressing the Sacred*, Guilford Press, 2007  
Editor-in-Chief, *APA Handbook of Psychology, Religion, and Spirituality* (Vols. 1 and 2), APA Press, 2013

---

**From:** Jones, Tracy Lynn <[REDACTED]>

**Sent:** Tuesday, September 3, 2019 4:16 PM

**To:** Kenneth I Pargament <[REDACTED]>

**Subject:** [EXTERNAL] Permission request for Brief RCOPE

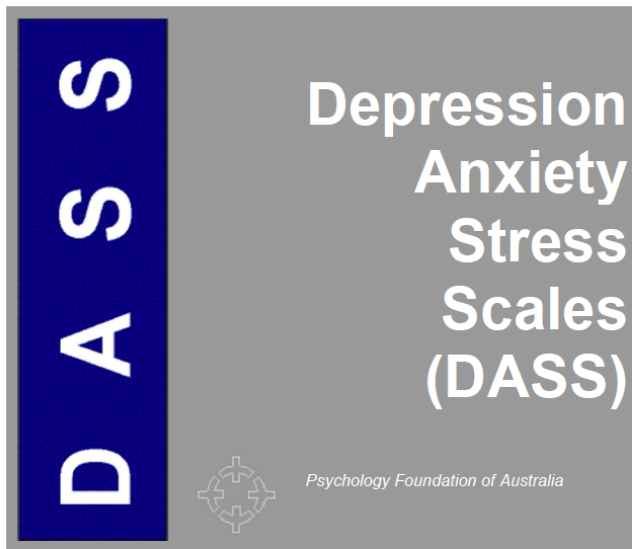
Dear Dr. Kenneth Pargament,

I am a doctoral student at Liberty University and am completing my dissertation entitled "The Effectiveness of Christian Accommodative Mindfulness in the Treatment of Shame." I would like to request your permission to utilize your assessment, the Brief RCOPE, for my study, please. Feel free to contact me should you have any questions or require additional information. Thank you very much.

Sincerely,  
Tracy Jones

## Depression Anxiety Stress Scale (DASS)

[www2.psy.unsw.edu.au/groups/dass](http://www2.psy.unsw.edu.au/groups/dass)



The DASS is a 42-item self report instrument designed to measure the three related negative emotional states of depression, anxiety and tension/stress. The DASS questionnaire is in the public domain, and may be downloaded from this website.

Last updated July 26, 2018

[www2.psy.unsw.edu.au/groups/dass](http://www2.psy.unsw.edu.au/groups/dass)

## Dimensions of Grace Scale

Bufford, R. K., Sisemore, T. A., & Blackburn, A. M. (2017). Dimensions of grace: Factor analysis of three grace scales. *Psychology of Religion and Spirituality*, 9(1), 56–69.

**Re: Permission to use Dimensions of Grace**

Rodger Bufford <[REDACTED]>

Tue 9/3/2019 7:54 PM

To: Jones, Tracy Lynn <[REDACTED]>

Yes--you are welcome to use the Dimensions of Grace Scale.

Rodger Bufford

On Tue, Sep 3, 2019 at 3:32 PM Jones, Tracy Lynn <[REDACTED]> wrote:

Dear Dr. Bufford,

I am a doctoral student at Liberty University and am completing my dissertation entitled "The Effectiveness of Christian Accommodative Mindfulness in the Treatment of Shame." I would like to request your permission to utilize your assessment, the Dimensions of Grace Scale, for my study, please. Feel free to contact me should you have any questions or require additional information. Thank you very much.

Sincerely,  
Tracy Jones

--

Rodger K. Bufford, Ph.D.  
Professor of Psychology  
Graduate School of Clinical Psychology  
George Fox University  
414 N Meridian, # V104  
Newberg, OR 97132

E-Mail: [REDACTED]

Phone: [REDACTED]

Fax: [REDACTED]

Cell: [REDACTED]

## Shame Inventory

Rizvi, S. L. (2010). Development and preliminary validation of a new measure to assess shame: The Shame Inventory. *Journal of Psychopathology and Behavioral Assessment*, 32(3), 438-447.

### RE: Permission request for Shame Inventory

Shireen Rizvi <[REDACTED]>

Thu 9/5/2019 12:22 PM

To: Jones, Tracy Lynn <[REDACTED]>

Hi Tracy, thanks for reaching out. The measure is published and therefore in the public domain, you do not need permission to use it. Good luck with your research!

---

**From:** Jones, Tracy Lynn [mailto:[REDACTED]]

**Sent:** Thursday, September 5, 2019 12:19 PM

**To:** [REDACTED]

**Subject:** Permission request for Shame Inventory

Dear Dr. Shireen Rizvi,

I am a doctoral student at Liberty University and am completing my dissertation entitled "The Effectiveness of Christian Accommodative Mindfulness in the Treatment of Shame." I would like to request your permission to utilize your assessment, the Shame Inventory, for my study, please. Feel free to contact me should you have any questions or require additional information. Thank you very much.

Sincerely,  
Tracy Jones

## Surrender Scale

Wong-McDonald, A., & Gorsuch, R. L. (2000). Surrender to God: An additional coping style? *Journal of Psychology and Theology*, 28(2), 149–161.

### RE: Permission request for Surrender Scale

Ana McDonald <[REDACTED]>

Tue 9/3/2019 4:19 PM

To: Jones, Tracy Lynn <[REDACTED]>

Sure. Blessings on your dissertation.

**Ana Wong McDonald, Ph.D.**  
**Mental Health Director**

Los Angeles Christian Health Centers  
311 Winston Street  
Los Angeles, CA 90013

Phone: [REDACTED]

Fax: [REDACTED]

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**From:** Jones, Tracy Lynn [mailto:[REDACTED]]  
**Sent:** Tuesday, September 3, 2019 12:18 PM  
**To:** Ana McDonald <[REDACTED]>  
**Subject:** Permission request for Surrender Scale

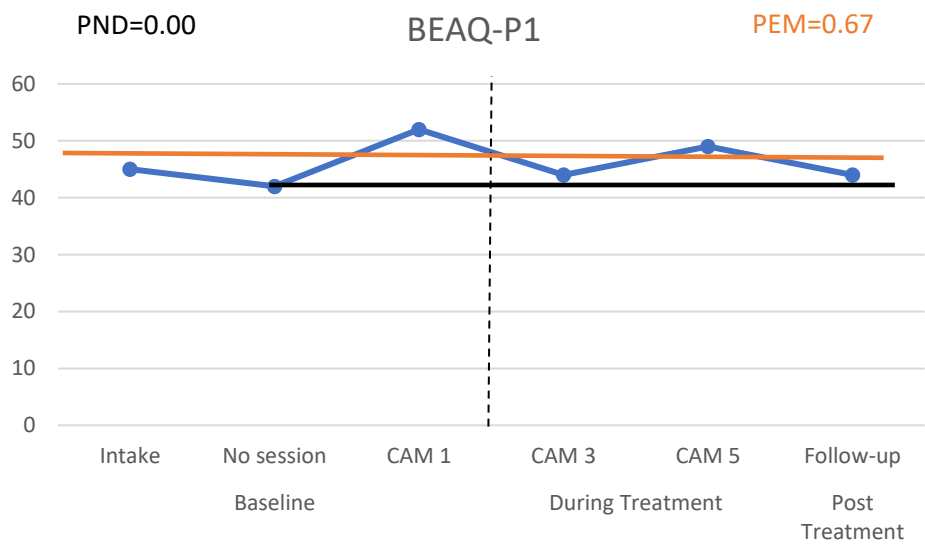
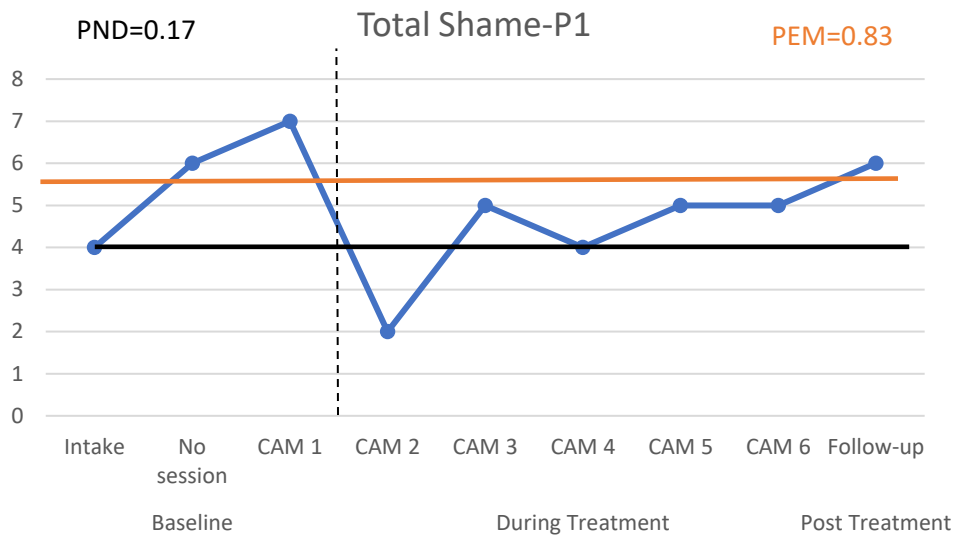
Dear Dr. Ana McDonald,

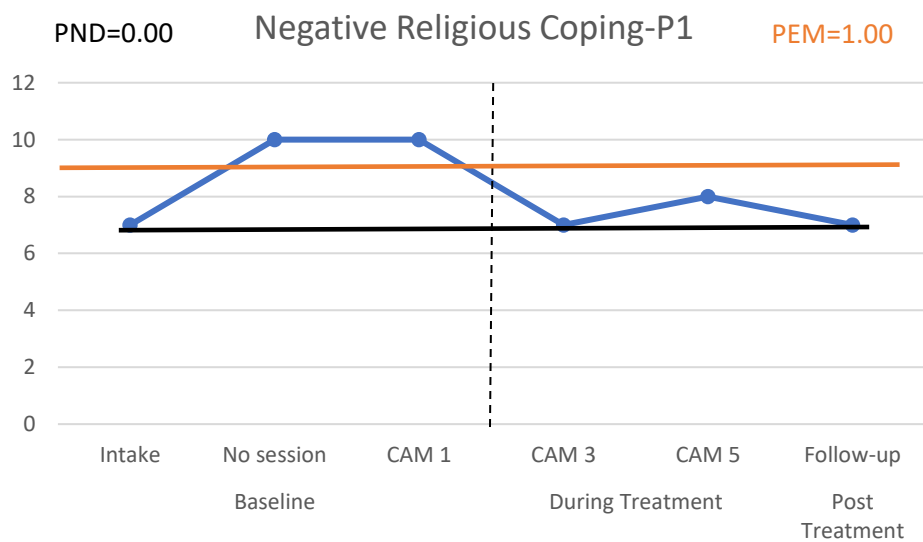
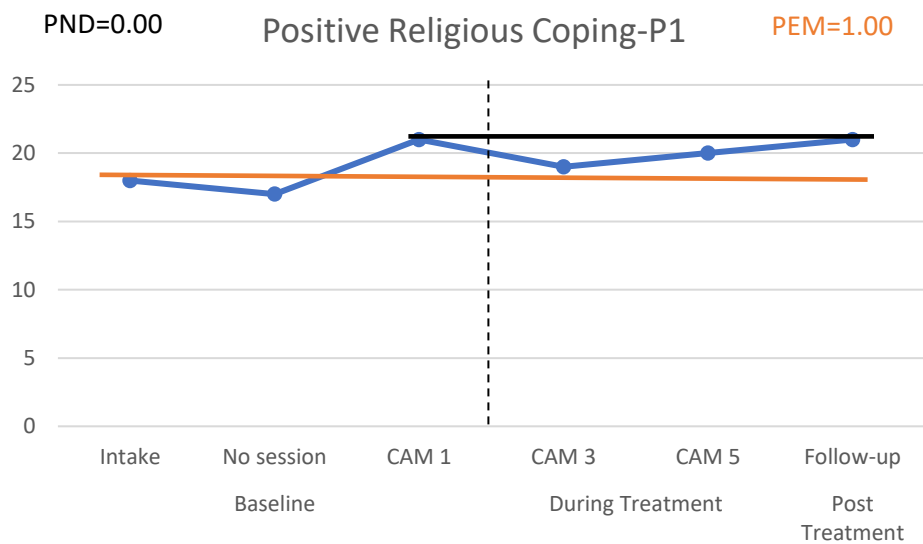
I am a doctoral student at Liberty University and am completing my dissertation entitled "The Effectiveness of Christian Accommodative Mindfulness in the Treatment of Shame." I would like to request your permission to utilize your assessment, the Surrender Scale, for my study, please. Feel free to contact me should you have any questions or require additional information. Thank you very much.

Sincerely,  
Tracy Jones

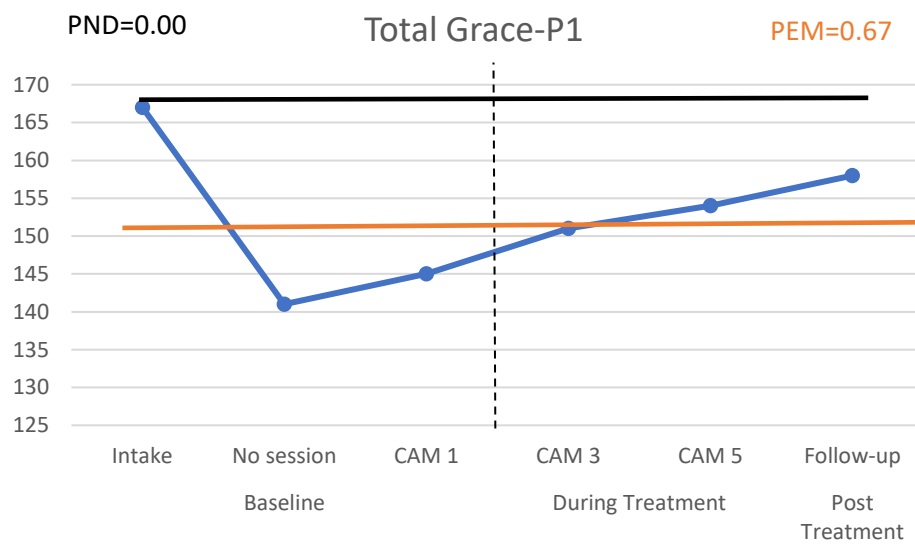
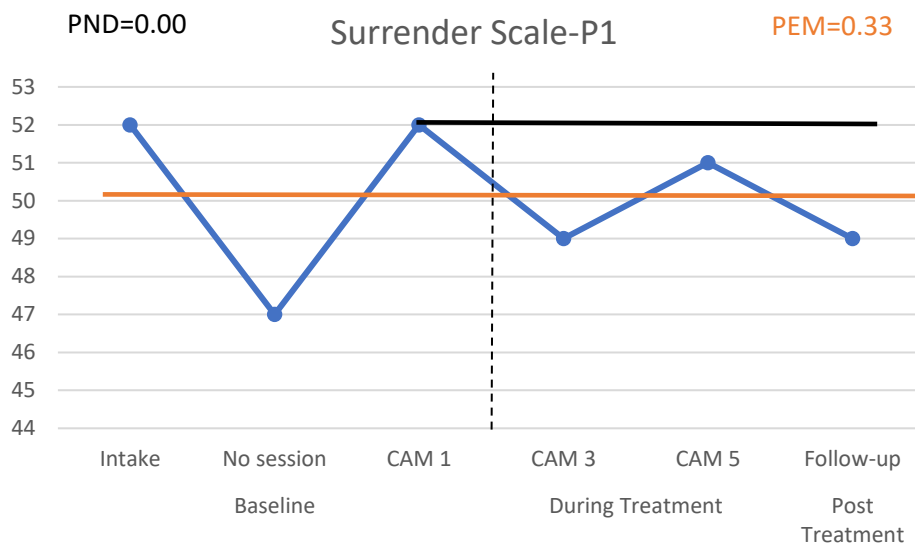
## APPENDIX K: Individual Results

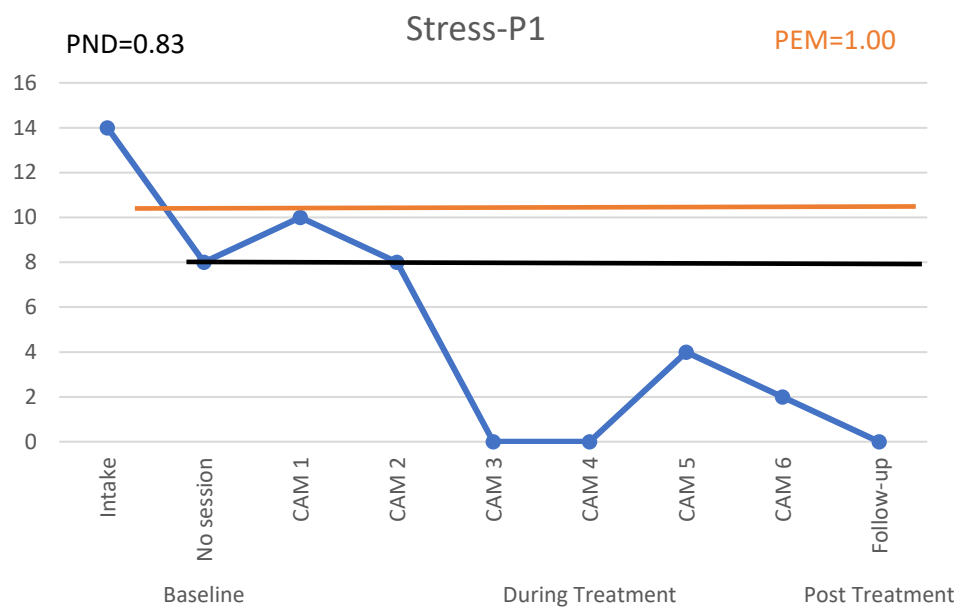
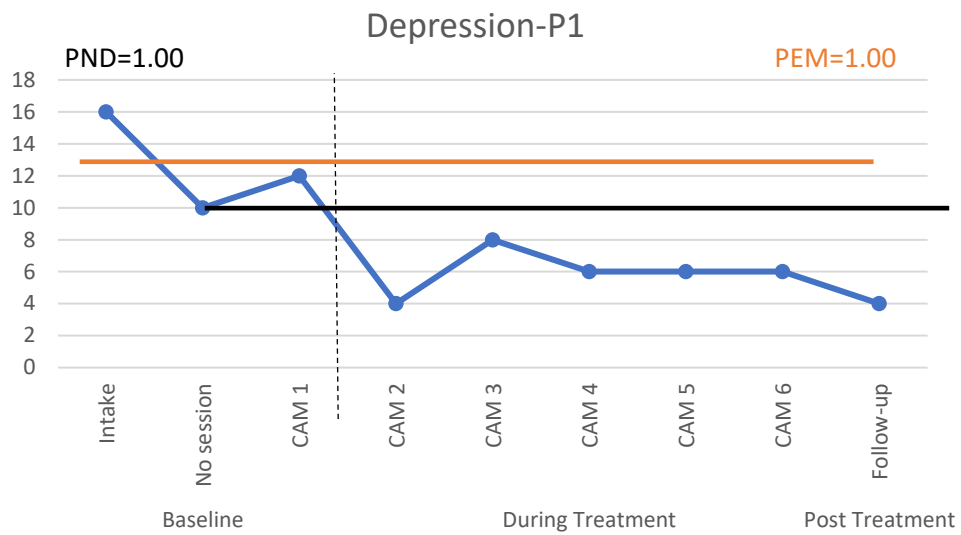
### Participant 1

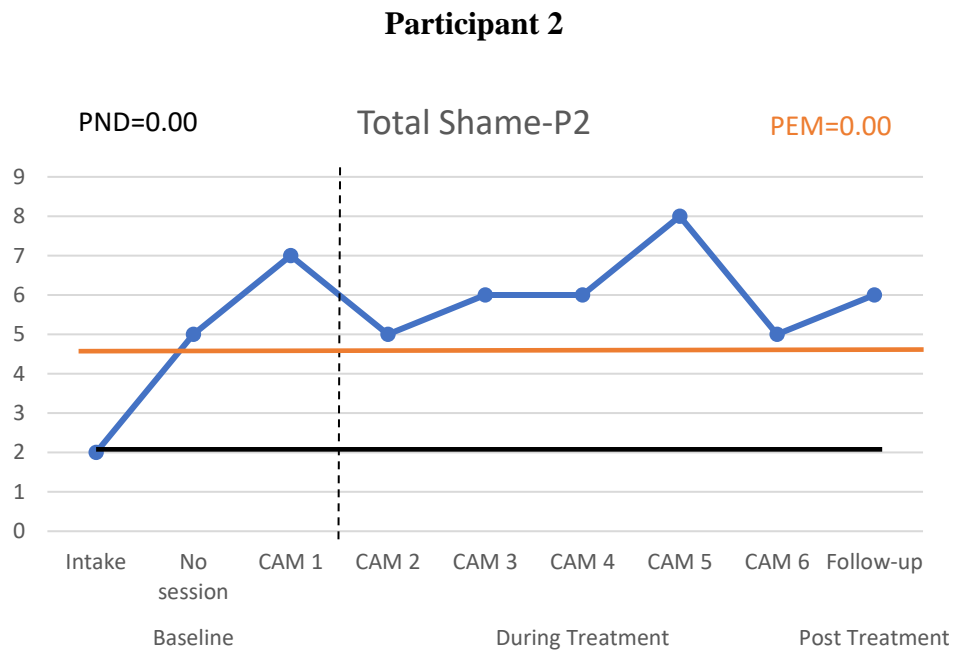
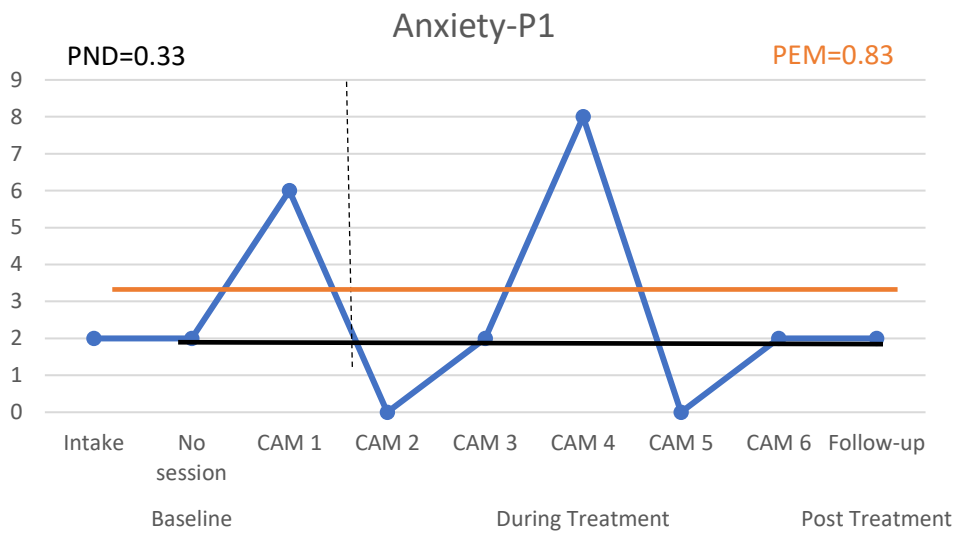


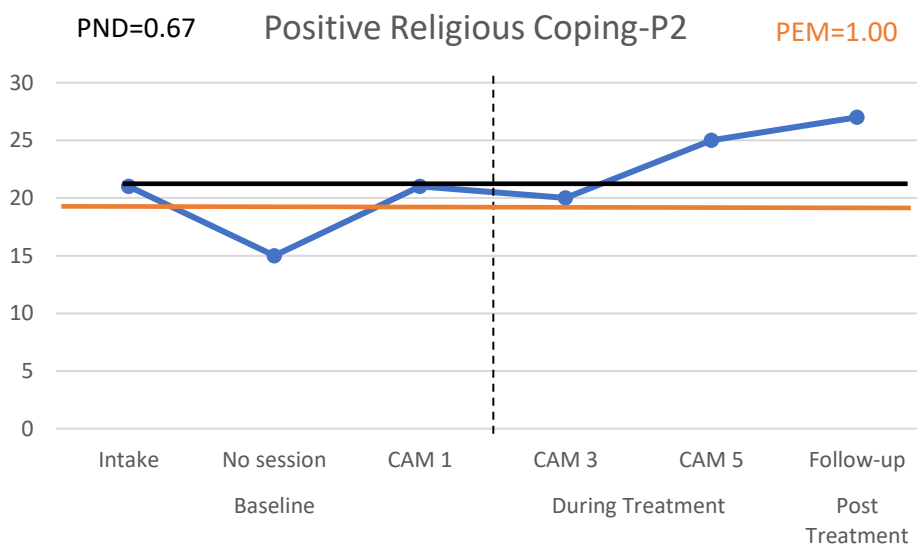
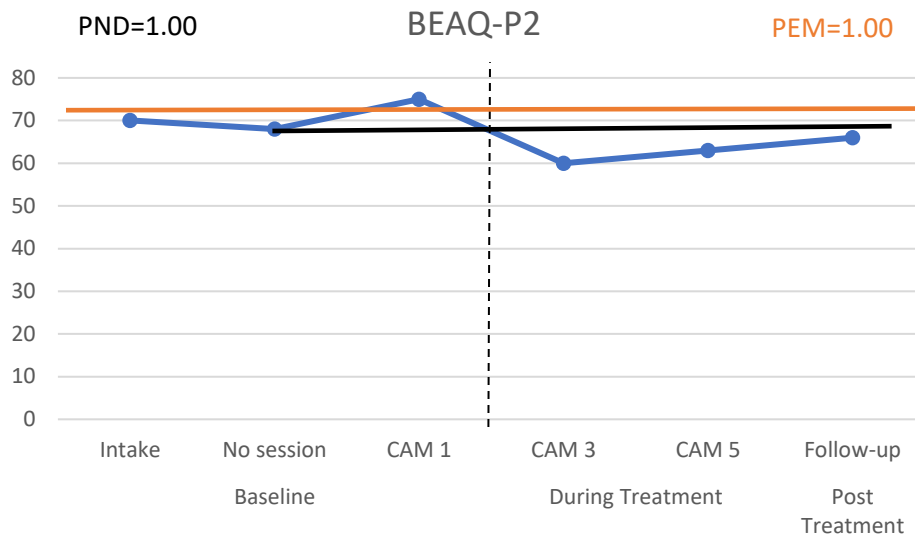


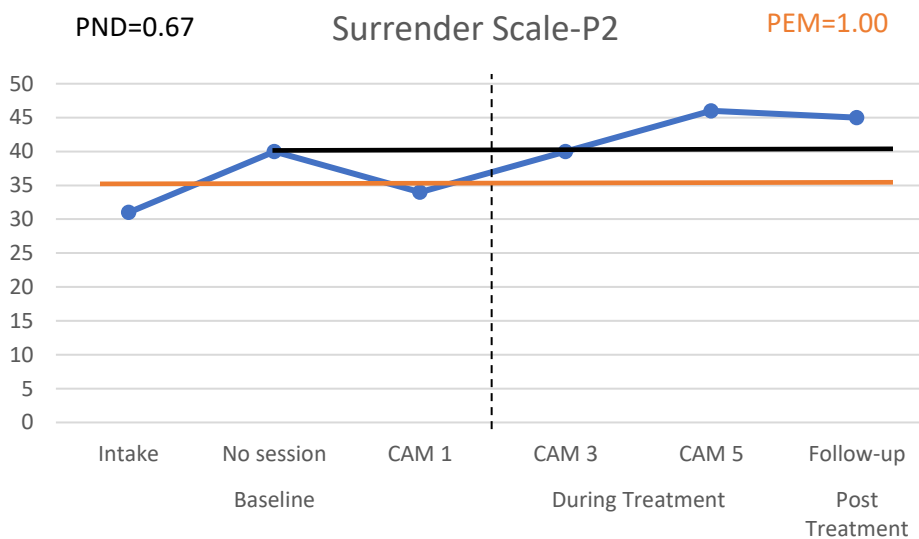
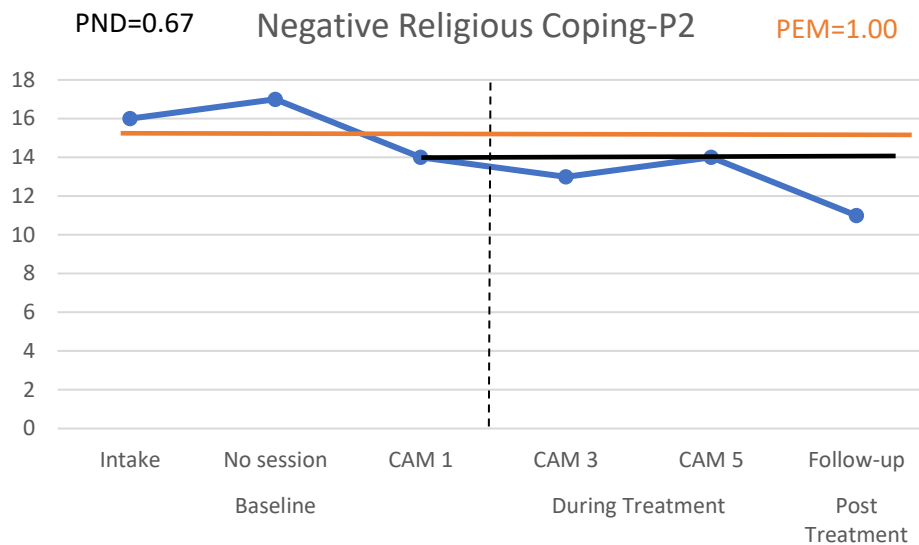


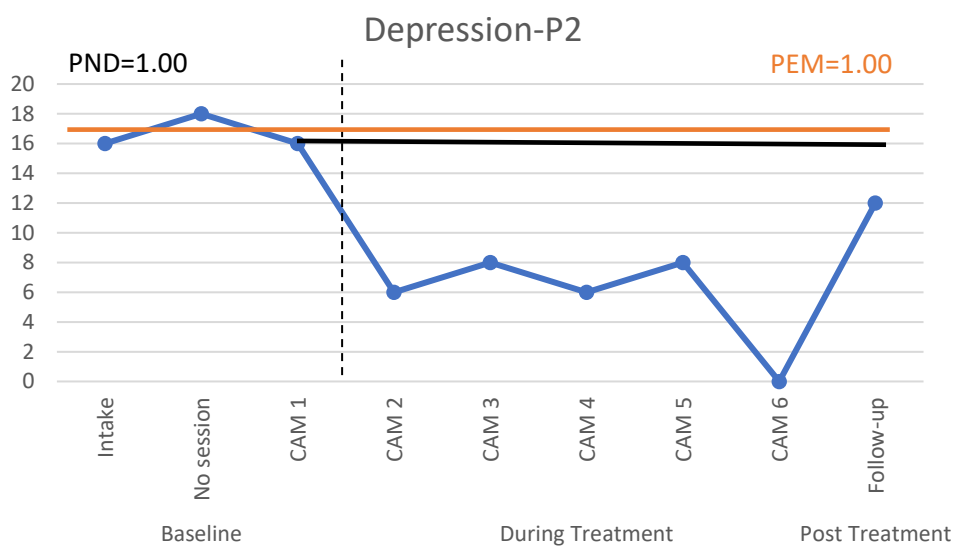
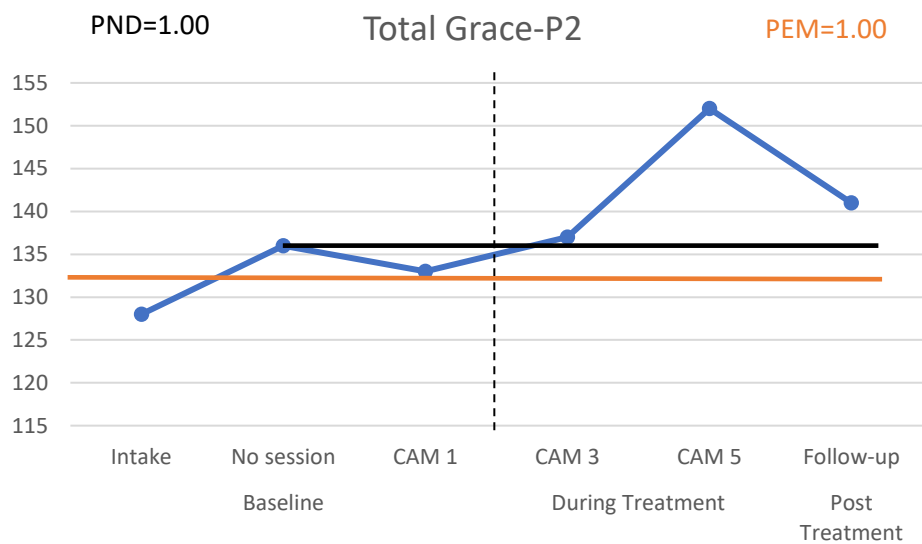


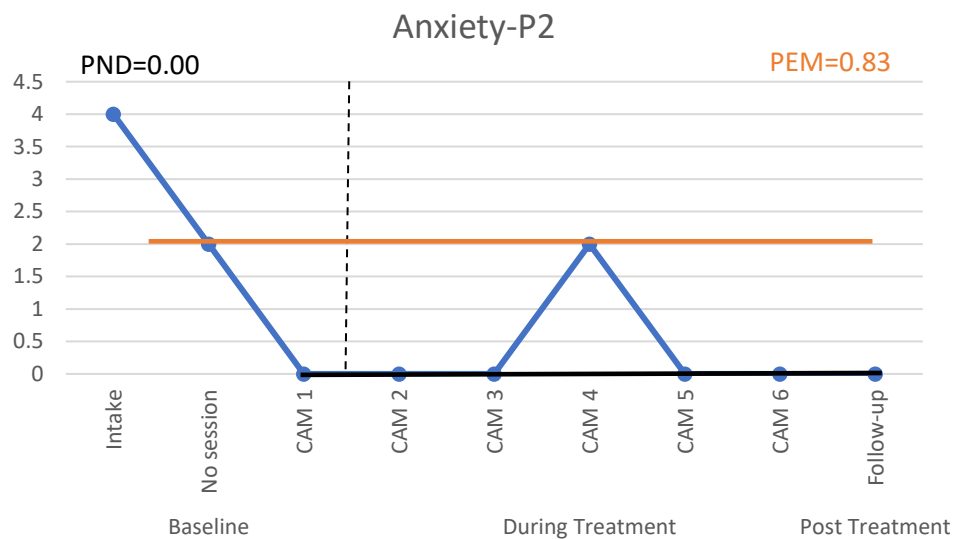
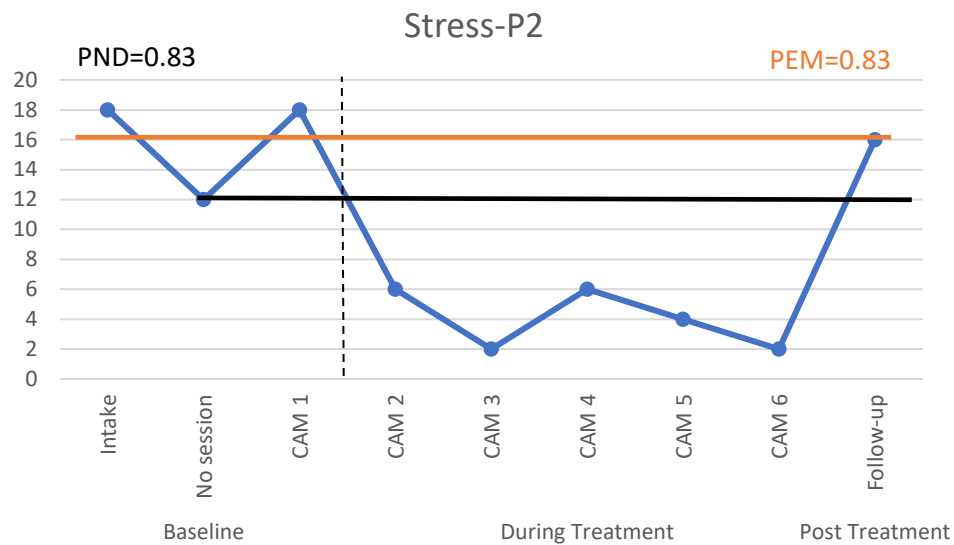




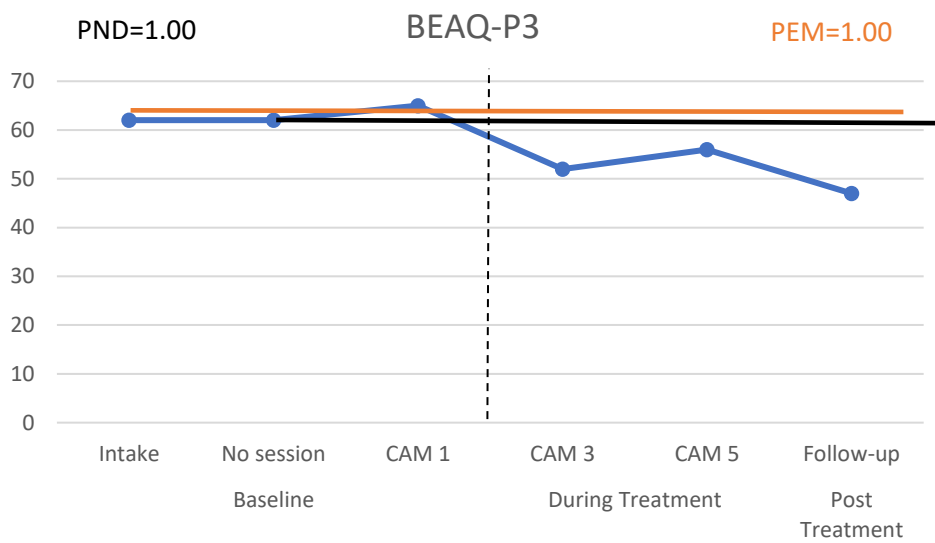
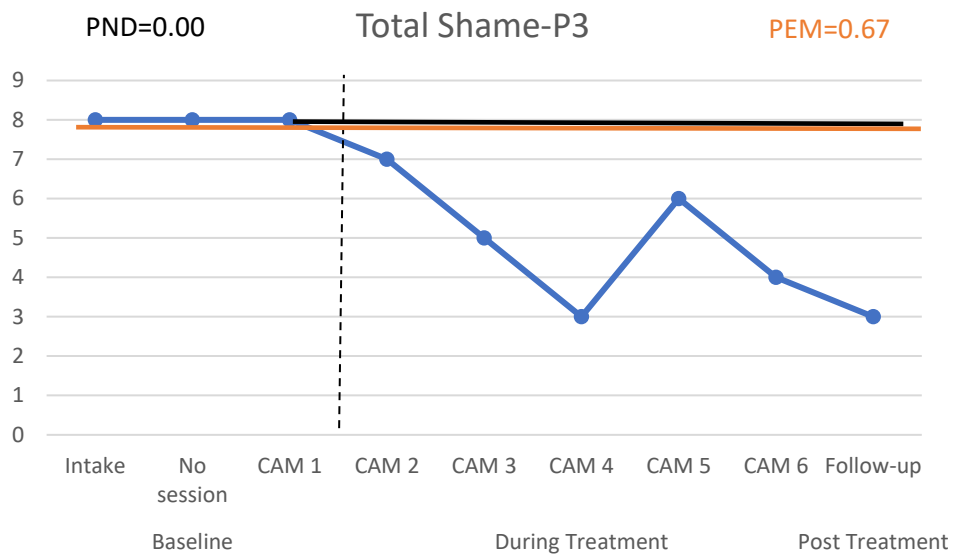




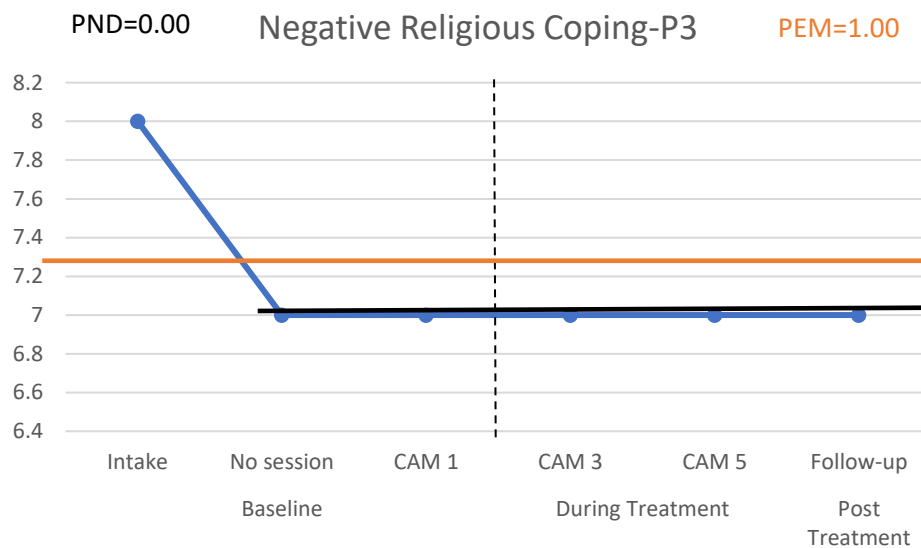
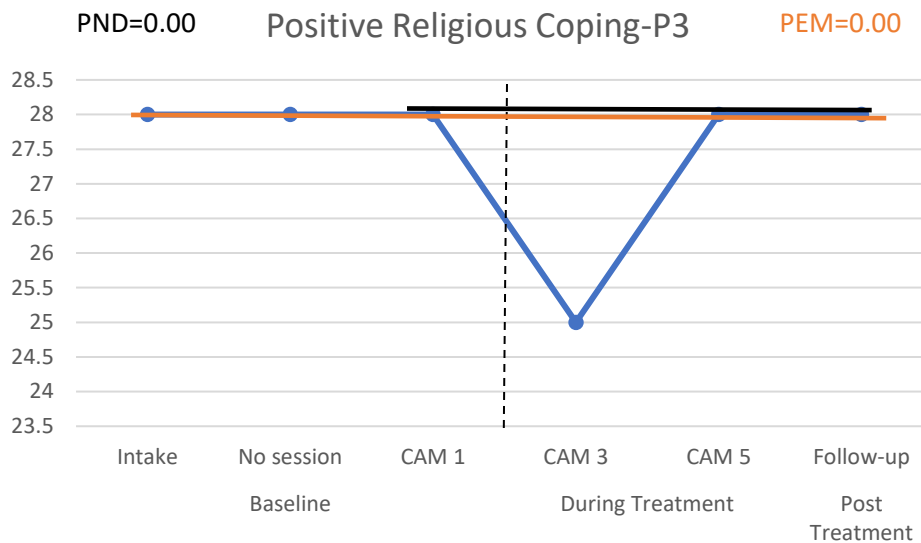


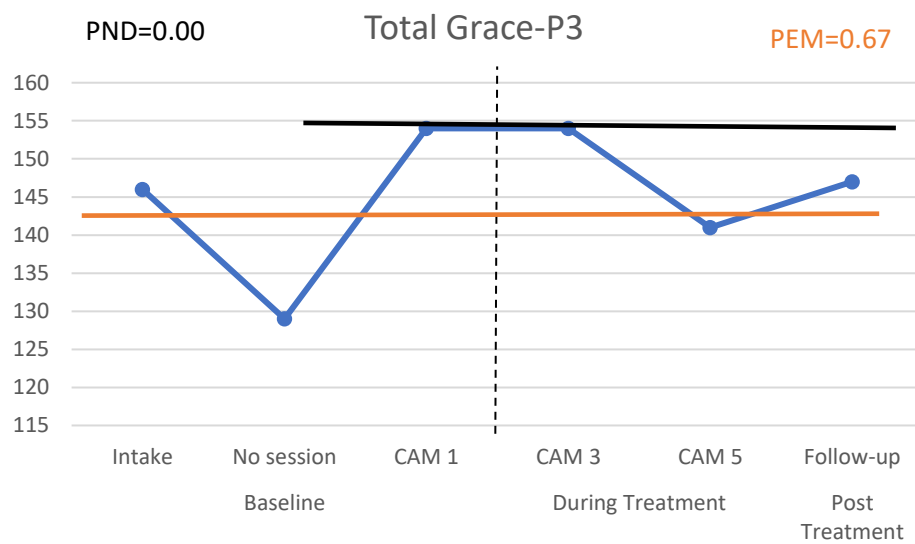
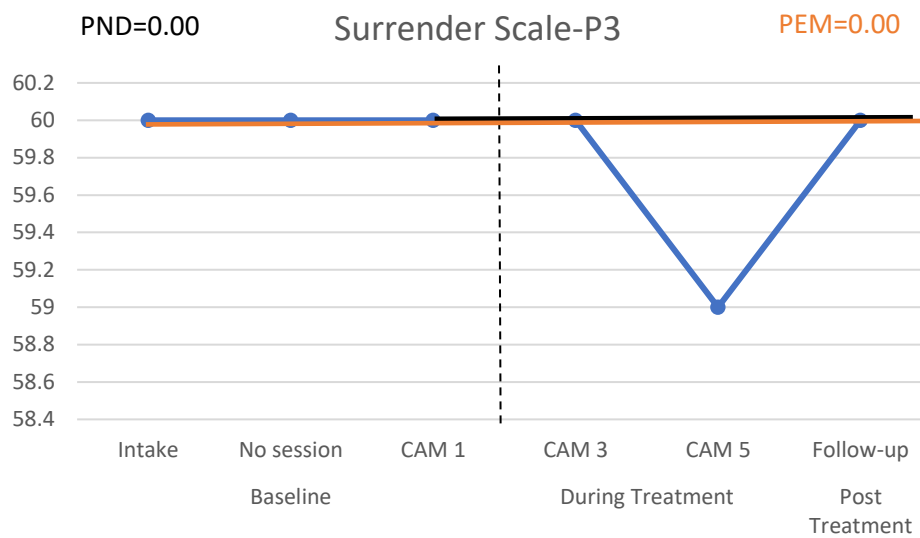


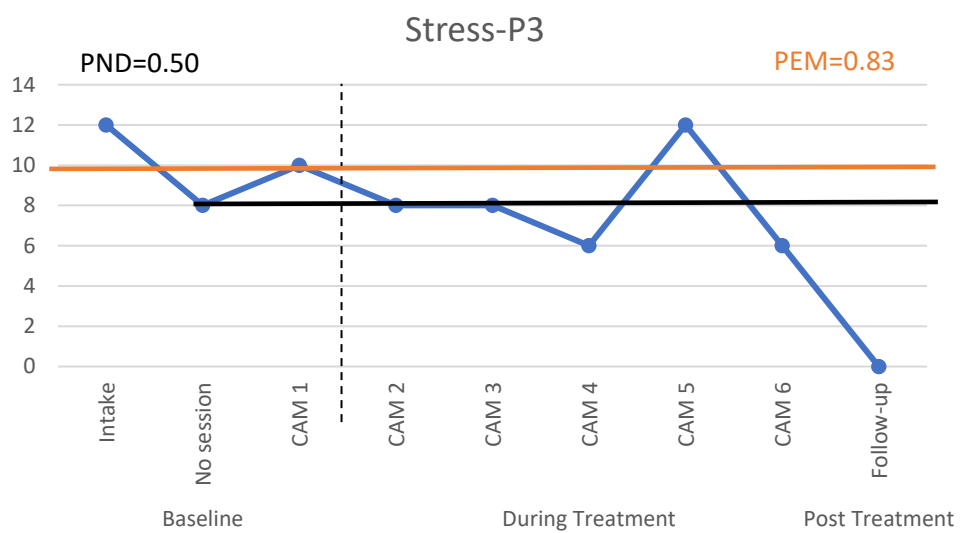
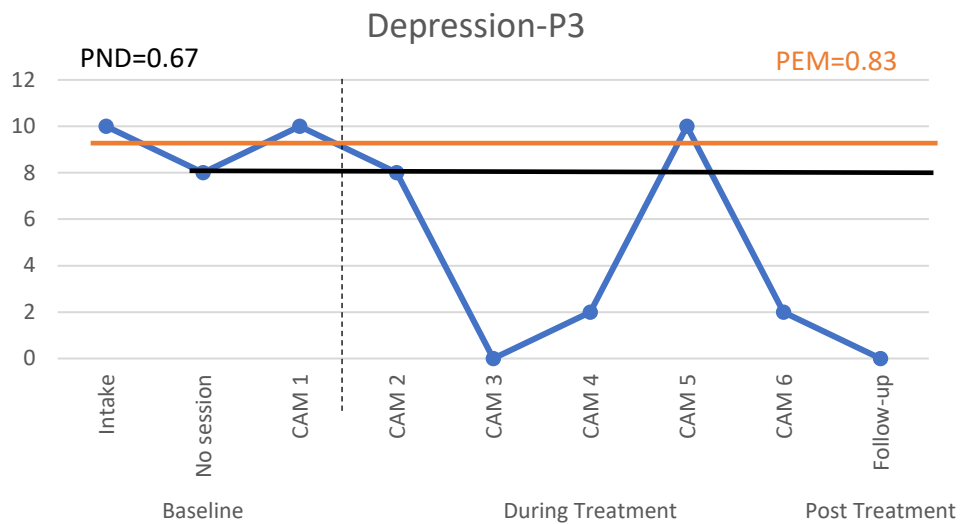
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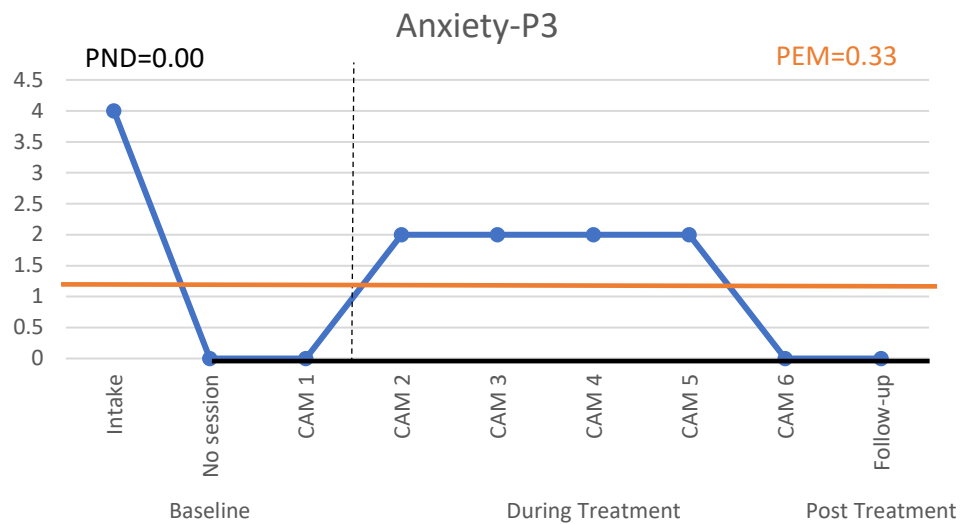




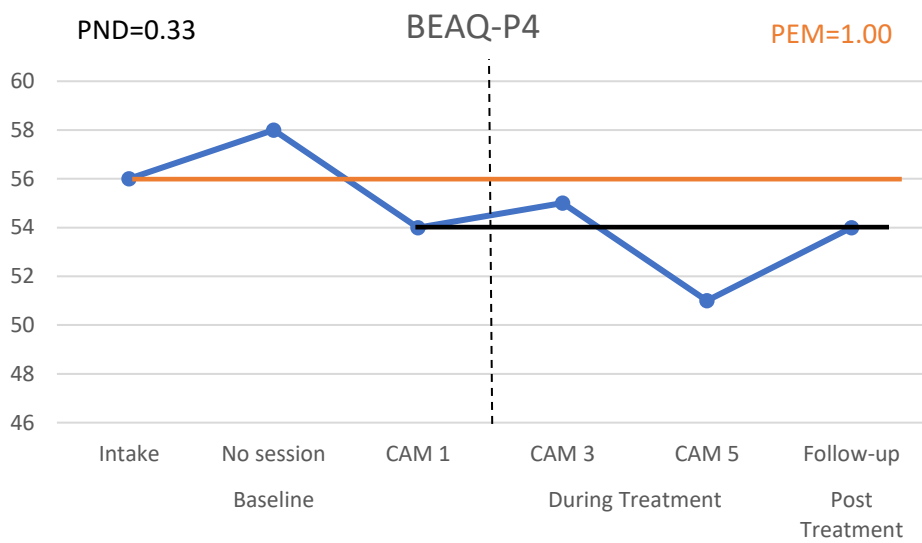
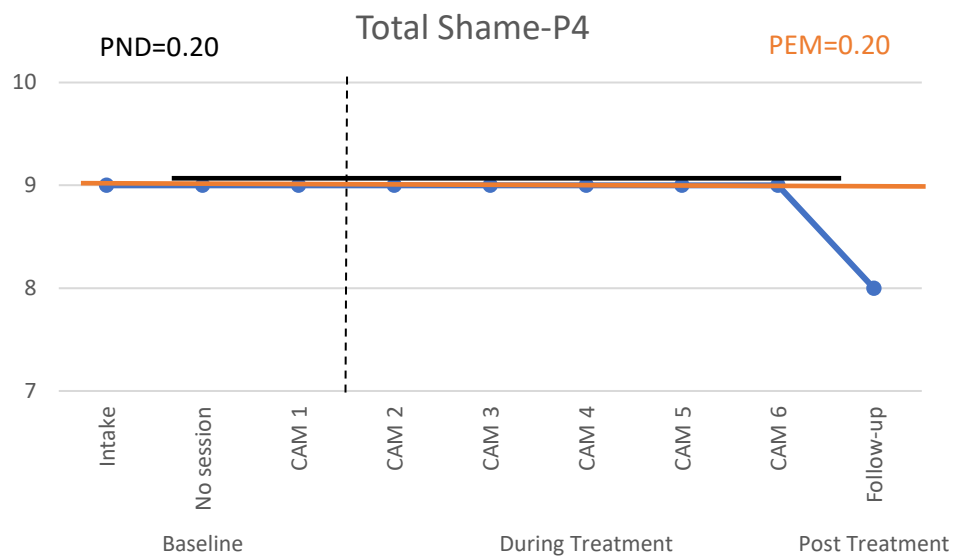


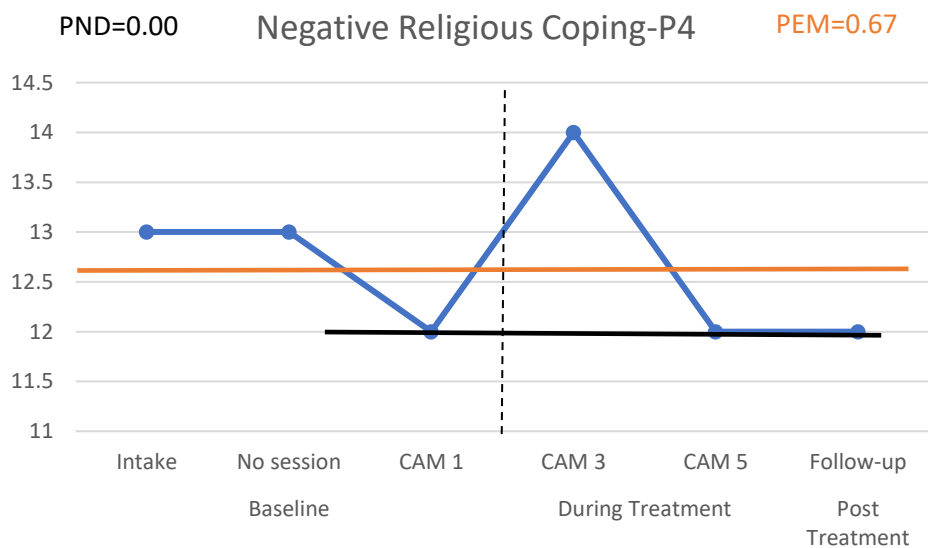
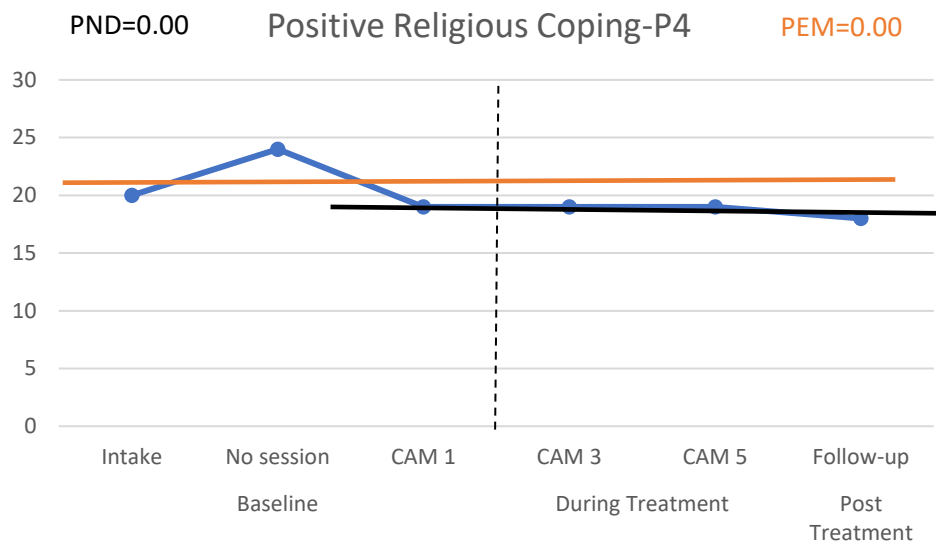


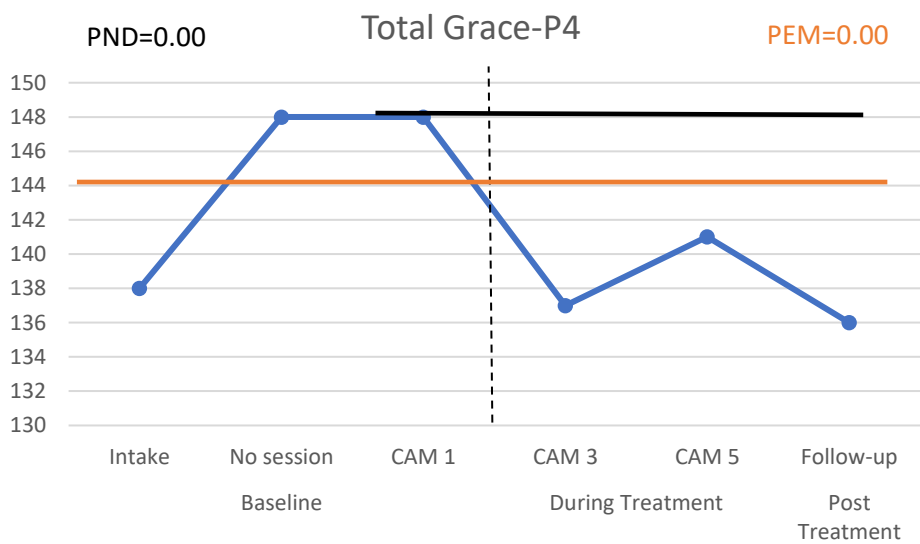
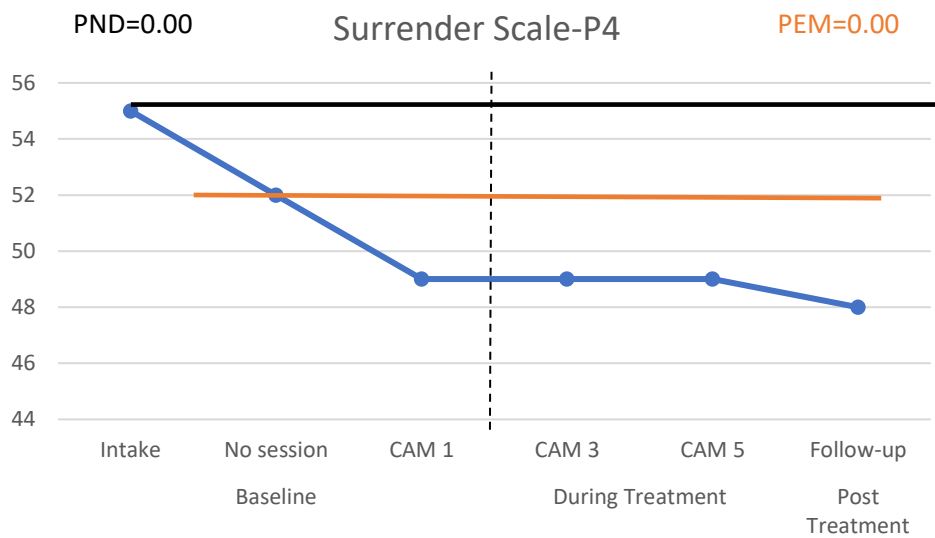


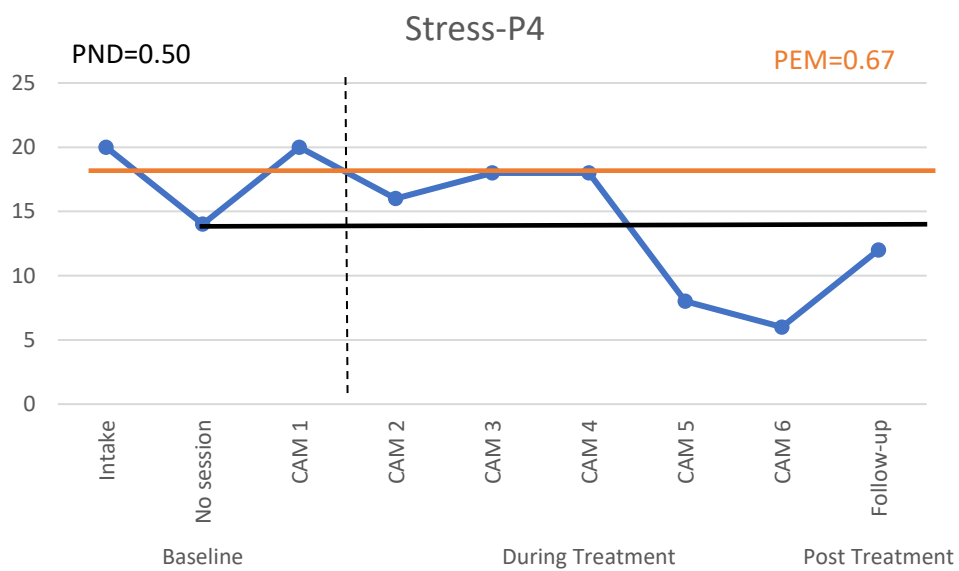
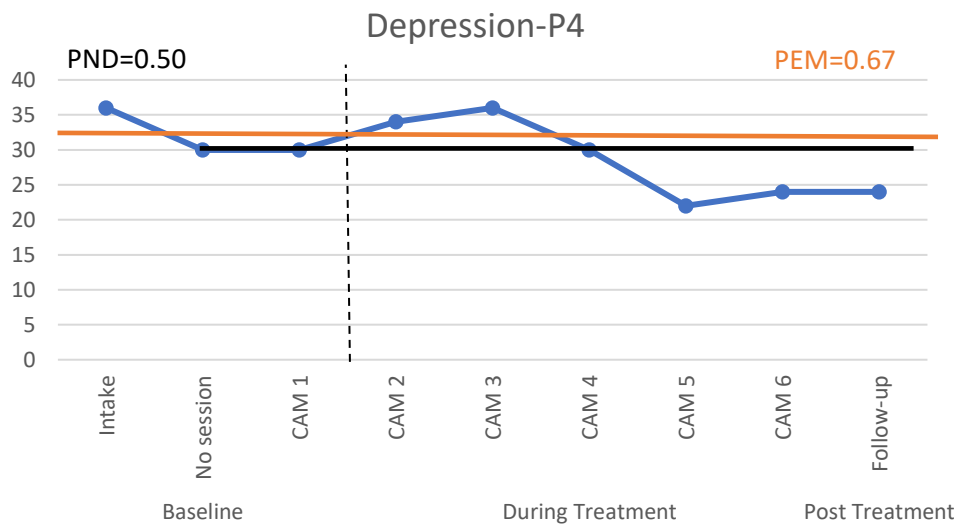


### Participant 4

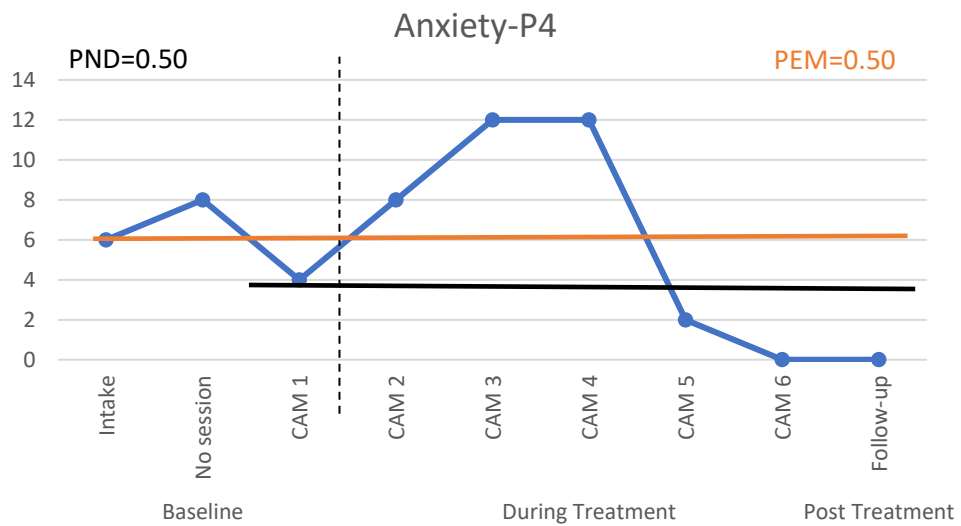












### Participant 5

