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Seesink, H.-J.; Klokkenburg, P.; Schaap-Jonker, H.; Ostafin, B.D.; Wiers, R.W.

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Without Your Therapist: Contemplative Prayer During Treatment as a Religious Exposure Intervention to Reduce Religious Struggle and Anxious God Representation

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Henk-Jan Seesink^{1,2,3}, Pieter Klokkenburg¹, Hanneke Schaap-Jonker^{3,4},
Brian D. Ostafin⁵, and Reinout W. Wiers²

Abstract

This case study focuses on the treatment of a 44-year-old Dutch man presenting with an anxious God representation and religious struggles according to DSM-5 criteria. Having received prior treatment for a panic disorder and alcohol use disorder, the patient was given a 60-day treatment in which the Jesus Prayer intervention was used to address his religious and spiritual problems. To our knowledge, this is the first case study involving the Jesus Prayer in the treatment of a patient. The intervention had positive effects on the patient's religious and spiritual problems concerning an anxious God representation, religious struggles, stress levels and surrender to God. The intervention may also play a supporting role in decreasing symptoms of depression and anxiety and in promoting global mental health, as reliable change index analyses revealed symptom reduction between baseline levels and at post-assessment levels for all measured symptoms, with a semi-gradual decrease over the course of treatment. These improvements were continued in a 3-month follow-up assessment, suggesting promise for the Jesus Prayer as an effective treatment method for religious and spiritual problems. Recommendations regarding the importance of assessing the religious life of patients and implementing spiritual interventions are discussed, as well as the relevance of the therapist's own assumptions when treating a religious or spiritual problem.

Keywords

religion, addiction, religious struggle, surrender, prayer

¹De Hoop ggz, Dordrecht, The Netherlands

²Department of Psychology, University of Amsterdam, Amsterdam, The Netherlands

³Centre for Research and Innovation in Christian Mental Health Care, Hoevelaken, the Netherlands

⁴Department of Religion and Theology, Vrije Universiteit, Amsterdam, The Netherlands

⁵Experimental and Clinical Psychology, Department of Psychology, University of Groningen, Groningen, The Netherlands

Corresponding Author:

Henk-Jan Seesink, Department of Research, De Hoop ggz, Provincialeweg 70, Dordrecht 3329 KP, The Netherlands.

Email: seesinkh@yahoo.com

I. Theoretical and Research Basis for Treatment

For centuries, the position of religion as part of recovery of the mental health has fluctuated in Western culture (Kao et al., 2020). Depending on the eye of the beholder, the role of religion has been seen as ranging from unhelpful, in which religion has a negative influence on mental distress to helpful, in which religion is a positive resource for individuals on their way towards recovery (Cook, 2019).

Research findings further suggest the contradictory relations between religion and mental health. For example, negative and threatening views of God are related to psychopathology (Schaap-Jonker et al., 2008). Further, experiencing conflict between personal and normative views of God (Schaap-Jonker et al., 2007) or conflict due to religious struggles (Weber & Pargament, 2014) can be related to increased levels of psychopathology. Religious struggles, often described as *negative religious coping*, reflect the degree to which hardships are understood as punishment from God and the belief of insufficiency to solve the problem by oneself as only God is in complete control (Puffer et al., 2012). Negative religious coping is therefore characterised by feelings of religious anxiety and perception of abandonment by God or a higher power (Pargament, 1999) and has been shown to be associated with greater psychological distress, suicidal ideation, alcohol problems and greater feelings of grief, anxiety and depression (Weber & Pargament, 2014).

On the other hand, there is increasing evidence that some individuals may experience religion as an important part of their recovery (Kerley et al., 2014; Zebracki & Stancin, 2007). Religious involvement has been associated with less psychopathology and less substance abuse (Bonelli & Koenig, 2013). Regarding specific practises, previous studies indicate that religious rituals like prayer (Lambert et al., 2010) and reading the Bible (Krause et al., 2018) show supportive effects on mental well-being. In contrast to negative religious coping noted above, other forms of religious coping are related to better mental health, including approaches such as *collaborative* and *positive religious coping* (Ross et al., 2009; Weber & Pargament, 2014) and *surrender to God* (Clements & Ermakova, 2012), which all have an active and supportive God representation during stressful events. Research on the state of surrender has shown that individuals report peacefulness and calmness (Rosequist et al., 2012). It can be associated with religious rituals like prayer and holding a benevolent view of God (Cole & Pargament, 1999) while also recognizing the authority of God (Dyslin, 2008).

Given the role of religious struggles, practises and coping strategies on mental health, clinicians should take religion into account by recognizing patients' religious problems and by supporting positive methods of religious coping. Although clinicians may find it difficult to recognise the various types of religious struggles relating to intra-individual (e.g. feelings of conflict between religious ideal and behaviour), divine (e.g. judgement of God) and interpersonal (e.g. conflict with church members) problems (Harris et al., 2019), it may nevertheless be worthwhile to attend to such issues given findings that attention to the patient's religious and spiritual values in therapy can improve treatment effectiveness (Captari et al., 2018).

One recent approach to incorporating religious practice to health involved implementing the Jesus Prayer, a Christian-sensitive contemplative prayer originating from the first half of the first millennium, resulting in increased surrender to God as religious coping and decreased levels of daily stress (Knabb & Vazquez, 2018). Meditation on one's humility before God and correspondingly crying out to God for support in a crisis, are central to the Jesus Prayer which is repeatedly recited as '*Lord Jesus Christ, Son of God, have mercy on me*' (Johnson, 2010). The first part of the prayer is accompanied by an inhalation, in which one dwells on the presence of the representation of Jesus and the last part '*have mercy on me*' is accompanied by the exhalation, whereby one concentrates on the awareness of Jesus's loving compassion. The awareness of

breathing, and the concentration on the prayer, provide this intervention with a sense of focus and an increased present moment awareness. A non-judgemental attitude toward thoughts, feelings and sensations is encouraged (Knabb & Vazquez, 2018).

Little is known about the psychological mechanisms of the Jesus Prayer on mental health outcomes. One possibility is that the prayer could function as an exposure intervention in individuals with high levels of an anxious God representation. From a cognitive behavioural therapeutic perspective, this anxious God representation could be seen as a one-sided maladaptive conditioned response without benevolent God representations, which can be associated with lower levels of mental health (Schaap-Jonker et al., 2008). The Jesus Prayer could interrupt the distressing referential association between a religious ritual or context such as the conditioned stimulus (like prayer), and the cognitive representation of earlier emotional experiences (like feelings of rejection in a religious context), connecting safety (non-danger) associations to the conditioned stimulus. This suggested mechanism provides the opportunity to be open to the formation of new benevolent representations of God and surrender through the encouraged non-judgemental and affirmative approach of the Jesus Prayer.

In the current case study, the Jesus Prayer is used as a religious exposure intervention to reduce experienced religious struggle and to change an anxious God representation, which is seen as a dysfunctional representation by the patient for maintaining the abstinence of alcohol, and treating the DSM-5 religious and spiritual problem.

2. Case Introduction

David¹ is a 44-year-old Dutch male who has previously worked as a mechanic in the steel industry and as a shop manager at a telecom company. He finished a 12-week clinical treatment for alcohol use disorder (AUD) and panic disorder. Subsequent to starting with ambulatory care, David was abstinent and had already completed cognitive behavioural therapy (CBT) for panic disorder. During ambulatory care, diagnostic examination revealed an avoidant personality disorder and a religious and spiritual problem. Accordingly, he followed a 9-month Schema Therapy group to work on his tendencies to avoid social situations of conflict and recognize feelings of rejection. Although abstinence of alcohol remained and general anxiety decreased, he reported no improvement in his religious and spiritual problem, which concerned him as he saw it as being a high risk for relapse in alcohol use. His concern endorsed the need for the current intervention.

3. Presenting Complaints

Generally, David sees his AUD as his main problem, with his religious struggle representing the most influential risk factor for relapse, as he experiences craving, low self-esteem and self-worth during his periods of struggle. In general, the patient feels anxious and depressed about his future. He explains that he wants to maintain his Christian convictions, but feels too anxious to follow his core beliefs, including an attitude of surrendering to God. The Cultural Formulation Interview (American Psychiatric Association, 2013) with the supplementary module about spirituality, religion and moral traditions (American Psychiatric Association, 2013) was used to gain a more precise picture of his religious problems.

David grew up in a Dutch Reformed Pietistic² religious context, a conservative Protestant tradition, in which the Bible has great authority and a strict and sober lifestyle is promoted (Exalto & Bertram-Troost, 2019). As an adult, David felt more comfortable with the Pentecostal church, in which baptism and the work of the Holy Spirit are emphasized. Instead of a communal experience of faith, Pentecostals and Reformed Pietistic traditions highlight the importance of the awareness

of a personal relationship with God and the individual faith experience and salvation (Servis, 2004).

David believes that God provides comfort, but in his case, he feels anxiety that God will reject him. 'I get stuck here, I search, I pray, but I'm afraid that God with His eternal judgement will let me be lost forever.' He has the impression that these thoughts are arising from the devil holding him back from a surrender to God and hindering him from experiencing peace about his past and hope for the future. Although the fear of death drives him to God, his core belief concerning this problem is that God will condemn him for coming to God out of fear. He explains that his fearful and punishing representation of God gets in the way of experiencing God's grace and practising religious rituals. David's financial problems (debts of \$100,000) and the rejection of previous intimate relationships, strengthen his idea that God will abandon him.

4. History

Until the age of four, David grew up with his biological parents, and his two older sisters (six and eight years older) in a Reformed Pietistic tradition. Around that time, his father told the family about a homosexual affair he had been having over the past six years. Given that extra-marital affairs and homosexual relationships are not tolerated in the conservative Christian culture in which the family lived, his parents divorced. David met his father regularly until he was 12 years old. He stated that he enjoyed his father's laissez-faire parenting style with a lack of rules (few limits on watching TV and eating sweets). David remembers that his mother had a 'cleansing ritual' in which David was directly commanded to shower and to wash his clothes after he had visited his father. He reports that the relationship with his father felt superficial and he felt that his father was not really interested in him. This led to his decision to terminate contact with his father when he was 12 years old. When he was 38 years old, David was informed that his father had died via a letter about his father's pension. In contrast, David reports that his relationship with his mother involved good communication, sufficient attention and enjoyable activities. The relationships with his sisters was also experienced as pleasant, as they played games, had meaningful conversations and enjoyable holidays together. He reports that his sisters perceived him as spoilt because he had few household obligations and rules during his childhood. Currently, his mother and sisters maintain weekly contact with David.

In the past, David has had eight intimate relationships, three of which were long-term relationships of more than a year. He reports that after the end of the three serious relationships, he increased his alcohol use to a daily consumption of 6–15 units of alcohol and that each time he sought treatment for his use. The first long-term relationship ended at the age of 23 due to his dishonesty about drinking and wasting money and because of an emotionally intimate (but non-sexual) contact with another woman. In the second long-term relationship when he was 28 years old, he and his partner shared the dream of a house, a job and children together. According to David, they lived happily with his partner's 5-year-old daughter and were expecting a child together. He reports that without warning he found his suitcases packed with the announcement that his partner had aborted the child, the relationship was ended, and that he must leave because she had found a new lover. At a later point, her family members explained to David that she sought other men because she thought that their relationship lacked sufficient physical intimacy. The third long-term relationship began when David was 36 years old with a woman he met at a Pentecostal church. David reports that they bonded in part through the shared experience of having a previous partner who cheated on them. The relationship became serious and they planned to get married and start a family together. From David's perspective, his partner unexpectedly broke up with him because she was dissatisfied with their level of physical intimacy and thus began a relationship with their neighbour.

5. Assessment

David presented his complaints, symptoms and history at the beginning of the study, as described above. This was his baseline after having followed a clinical programme and a subsequent ambulatory trajectory. Before the current intervention, David provided informed consent and agreed to complete the self-report measures to assess symptom change over the course of treatment. He completed self-report measures for depressive, anxiety, stress and craving at baseline and then weekly during eight weeks, followed by a post-assessment one week after the end of the intervention. A follow-up measurement was taken three months after the end of the intervention. He also completed measures for total symptoms and symptom distress and negative religious coping at baseline, in week four of the intervention and one week after the end of the intervention (post-assessment), followed by a follow-up measurement 3 months after the end of the intervention.

5.1. Outcome Measures

Symptoms across treatment were measured using five self-report questionnaires and a 10-point Likert Scale. Before and after each individual exposure session for 60 consecutive days using the Jesus Prayer as religious intervention, stress levels were measured with the 10-point Likert Scale ranging from 1 = 'no stress' to 10 = 'most stress'.

General psychological functioning was measured by using the Outcome Questionnaire (OQ-45; Lambert et al., 1994). The OQ-45 consists of 45 items, each scored from 0 to 4. Total scores range from 36 to 144. The total scale includes the subscale of symptom distress, as well as the subscales interpersonal relations and social roles.

Symptoms of depression, anxiety and stress were measured with the Depression Anxiety Stress Scale (DASS-21; Lovibond & Lovibond, 1995). The DASS-21 comprises of 21 items, each scored from 0 to 3. Total scores range from 0 to 63, with higher scores reflecting a greater symptomology of depression, anxiety and/or stress.

Craving was measured using the Penn Alcohol Craving Scale (PACS; Flannery et al., 1999). The PACS consists of 5 items, each scored from 0 to 6. Total scores range from 0 to 30, with higher scores reflecting more craving.

Religious struggle was measured using the negative religious coping scale from the Brief Religious Coping Scale (Brief-RCOPE; Pargament, 1999). The Brief-RCOPE negative religious coping scale consists of 7 items, each scored from 0 to 4. Total scores range from 0 to 28.

Surrender to God was measured using the Surrender to God Scale (StGS; Wong-McDonald & Gorsuch, 2000). The StGS consists of 12 items, each scored from 1 to 5. Total scores range from 12 to 60, with higher scores reflecting more surrender to God.

Anxious God representations were measured using the anxious God representation subscale from the Questionnaire God Representations (QGR; Schaap-Jonker et al., 2016). The QGR anxious subscale consists of 5 items, each scored from 1 to 5. Total scores range from 5 to 25.

6. Case Conceptualisation

David experiences problems of anxiety and demoralisation with feelings of guilt, shame, and inadequacy regarding his representation of God. From a clinical perspective, David seems to cope with these feelings by using alcohol and avoiding religious rituals. These coping strategies are morally reprehensible for him and could consequently increase his anxious God representation. Clinician impressions of David include his having average intelligence, and introverted, conflict-avoidant and compliant personality characteristics. In addition to his mother and two sisters, he has a small social support system of two friends. The theme of being rejected goes beyond the representation of God as it also manifests in intimate relationships and in the relationship to his father.

Further, David presents a clinical impression of a fearful-avoidant attachment style concerning both intimate partners and his representations of God (Granqvist & Kirkpatrick, 2013). Avoidant tendencies in the attachment style with partners can lead to higher levels of stress (Brennan et al., 1998) as can a fearful attachment to God (Reiner et al., 2010). This increased stress may be problematic for David by eliciting increased alcohol craving and heavy use (Wemm et al., 2019).

Earlier treatment supported skills to stay abstinent, to endure panic attacks without disturbing daily life (both by CBT) and to register and adjust schemas of failure, mistrust, self-sacrifice and insufficient self-control (Schema Therapy). Nevertheless, earlier therapy did not change David's anxiety towards God, leaving his religious struggle intact and putting him at risk for increased craving and alcohol use (Brewer et al., 2015; Medlock, 2017; Parenteau, 2017).

The current treatment consisted of a 60-day Jesus Prayer intervention presented via a 10-minutes audio file (Knabb, 2019). The prayer is intended as an exposure intervention to stop avoidance behaviour of his experienced relationship with God and to create other God representations.

7. Course of Treatment and Assessment of Progress

7.1. Course of Treatment

David was always on time for treatment appointments and handed in the completed questionnaires, including the follow-up questionnaires, exactly on the scheduled dates. He completed 53 of the 60 days using the intervention (88%). In the first week he reported that his upcoming birthday was experienced as a stressful event. He worried that his family would reject him or judge his present situation as a patient with AUD problems. But the intervention helped to reduce stress levels with feelings of compassion. In the second to fifth week, he worried more about his future. He reports that the intervention helped him become more aware of his breathing and that during the intense periods of worry, he recognized that his out-breath reminded him of the loving God representation. Even though he was feeling physically unwell during the sixth week, he experienced the intervention as attainable and performed the intervention. In weeks seven and eight, he noticed that the intervention was helpful in reducing his worries concerning his future and to start dating again.

After the 60 days, he explained that the implementation felt more natural, which supported feelings of self-forgiveness as well. Consequently he reported that he was developing a more caring representation of God and that he rarely experienced an anxious representation of God anymore. He stated that he continued to use the intervention after the initial 60 days and that he now uses it in everyday life situations such as the stresses he experiences while shopping. He expressed gratitude for having found this resource for finding calm in tense and anxious moments.

7.2. Assessment of Progress

We used the reliable change index (RCI; Jacobson & Truax, 1992) to assess clinically significant change in David's symptom levels. Following Jacobson and Truax, we defined clinically significant change as occurring when the patient's symptom levels are near those of the community sample or general population as opposed to the average symptom levels of a clinical population. The change in symptom levels is statistically significant ($p < .05$) when the calculated RCI is less or greater than the 97th percentile Z-score (-1.96 to 1.96). Changes were assessed in David's depressive, anxiety and stress symptoms (DASS-21), total symptoms (OQ45), symptom distress (OQ45) and craving (PACS) using RCI analyses. Means and standard deviations of community and clinical populations as well as test-retest reliabilities in RCI analyses are included for the DASS-21 (Brown et al., 1997; Antony et al., 1998), OQ-45 (Lambert et al., 1996), PACS (Flannery et al., 1999; Schneekloth et al., 2012) and the Brief-RCOPE (Pargament et al., 1998;

Pargament et al., 2011; see Table 1). As no test-retest reliability was available, the RCI analyses could not be performed for the QGR and StGS.

David experienced a significant decrease in stress symptom severity between baseline and week 2, baseline and week 5, baseline and week 8, baseline and post-assessment level, with the largest decrease between baseline and week 2 and also between baseline and post-assessment level ($RCI = -3.44, p < .05$). He demonstrated statistically significant anxiety symptom reductions between baseline and post-assessment level ($RCI = -2.50, p < .05$). Depressive symptom reductions were significant between baseline, week 5 and post-assessment with the larger decrease between baseline and post-assessment level ($RCI = -2.62, p < .05$; see Figure 1).

David's symptom distress showed no statistically significant reduction in symptoms, with the most symptom decrease measured between baseline and post-assessment ($RCI = -1.57, ns$). Total symptoms, however did significantly decrease between baseline and post-assessment ($RCI = -1.98, p < .05$; see Figure 2). Craving measures showed a statistically significant decrease in craving during all time points, except for week 3 and 8, with the largest decrease between baseline and week 1,2 and 4 ($RCI = -2.95, p < .05$). Notable is the rather large increase in craving during week 6 ($RCI = 2.11, p < .05$). As can be seen in Figure 3, the overall pattern of decrease in craving shows an unstable trend in which increase and decrease of craving alternate. David's negative religious coping decreased over time, with a significant change between baseline a post-assessment ($RCI = -2.71, p < .05$; see Figure 4).

Levels of stress before and after the intervention were measured with a 10-point Likert scale. This descriptive data provides clinical insight and the possibility to draw clinically relevant conclusions. As seen from Figure 5, David experienced an overall decrease in stress level across time. Also, the stress level pre intervention is systematically higher than the stress level post intervention, which indicates a stress reducing effect not only over time, but also at daily individual session levels.

Figure 5. From the perspective of clinical importance, another result that should be mentioned is the increase in scores on the Surrender to God Scale and the decrease in scores on the anxious God representations scale (Figure 6). Combined with the findings of decreases in negative religious coping, this result indicates the direction of the restorative effect of the intervention.

Table 1. Clinical and General Population Descriptive Statistics Used for RCI Calculations.

Instrument	Clinical population	General Population	Test-retest reliability	Cut-off threshold
	M (SD)	M (SD)		
DASS-21 ^a				
Depression	12.75 (10.15)	2.12 (3.64)	0.71	7.44
Anxiety	18.72 (10.77)	1.22 (1.77)	0.79	9.97
Stress	20.00 (11.60)	3.51 (3.78)	0.81	11.76
OQ-45 ^b				
Distress	40.86 (15.08)	22.71 (10.07)	0.78	31.79
Total	76.27 (26.53)	42.73 (15.89)	0.84	59.50
PACSC ^c	12.2 (8.0)	4.0 (4.2)	0.82	8.10
Brief RCOPE ^d				
Negative	25.38 (3.66)	13.53 (4.45)	.90	19.46

^aDepression, Anxiety and Stress Scale;

^bOutcome Questionnaire-45;

^cPenn Alcohol Craving Scale;

^dBrief Religious Coping Scale.

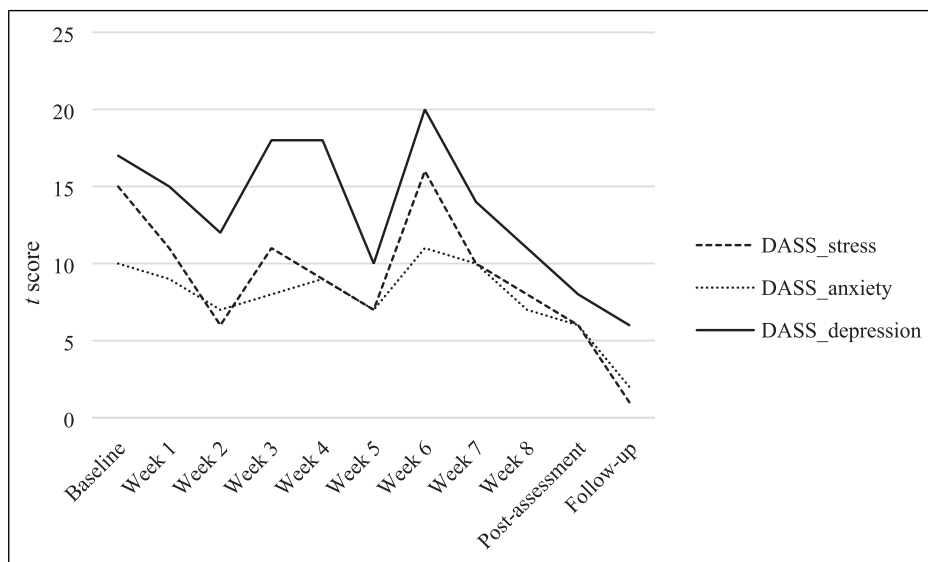


Figure 1. Changes across sessions on the DASS-21^a

^aDepression, Anxiety and Stress Scale.

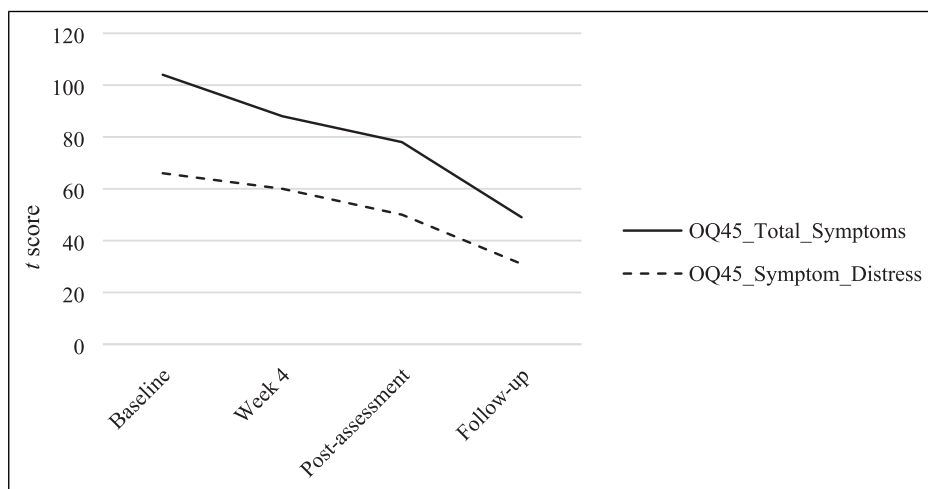


Figure 2. Changes across sessions on the OQ-45^a

^aOutcome Questionnaire-45.

8. Complicating Factors (Including Medical Management)

The current study has limitations that should be considered when interpreting the results. During the 60-day treatment period, David participated in three 60 minute support group sessions focussing on general treatment goals. He also received two 90 minute schema therapy follow-up group sessions about avoiding social situations of conflict and rejection. Regarding medical management, David uses the antidepressant paroxetine. In that light, it is important to interpret the decrease in levels of depression, anxiety, stress and general mental health with care. However,

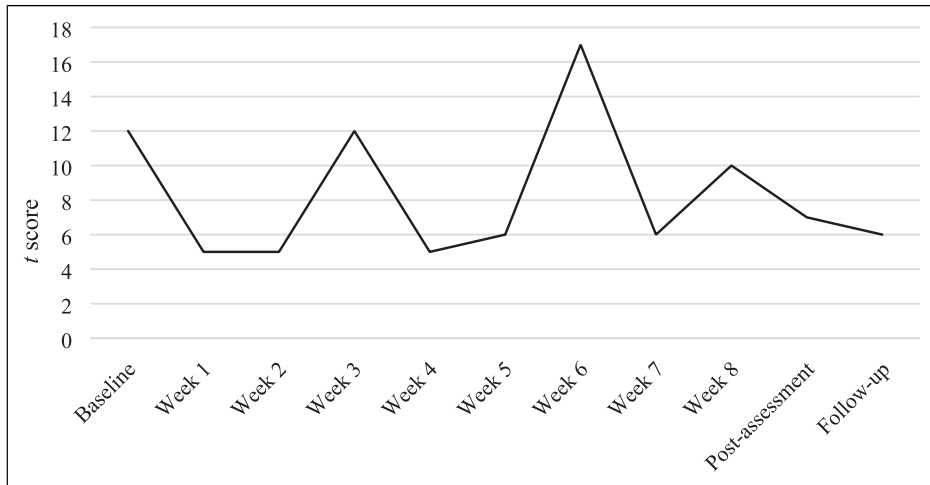


Figure 3. Changes across sessions on the PACS^a
^aPenn Alcohol Craving Scale.

prior to the Jesus Prayer, David reported no improvements regarding his religious struggle using the other therapeutic interventions. Although the religious and spiritual problem was not targeted by the antidepressant and in the parallel therapy sessions, changes in mood as a result of medication and new relational experiences by the schema therapy group could also affect the representation of God and religious struggle (Moriarty & Davis, 2012). For instance, a reduction in distress through other interventions might also enable more adequate religious coping. Accordingly, when looking specifically at the increase in surrender to God and decrease of anxious God representations and religious struggles, these changes could be due either directly to the Jesus Prayer intervention or indirectly via distress reduction from the other treatments.

9. Access and Barriers to Care

There were no issues regarding access and barriers to care for this case study.

10. Follow-Up

David participated in a follow-up session three months after the completion of the 60-day Jesus Prayer intervention. Symptoms of depression ($RCI = -5.34, p < .05$), anxiety ($RCI = -4.99, p < .05$) and depression ($RCI = -3.20, p < .05$) further reduced from baseline levels at follow-up. Total symptoms ($RCI = -4.03, p < .05$) and symptom distress ($RCI = -3.44, p < .05$) also showed further decline from baseline levels at follow-up. David reported decreased levels of craving at follow-up ($RCI = -2.53, p < .05$). Negative religious coping showed the greatest reduction from baseline levels at follow-up ($RCI = -5.88, p < .05$). As graphically shown in Figure 6, levels of surrender to God further increased and levels of anxious God representations further decreased at follow-up. The fact that David continued using the Jesus Prayer intervention out of free will after the official intervention ended, plays an explanatory role in the further restoration of symptoms at follow-up level.

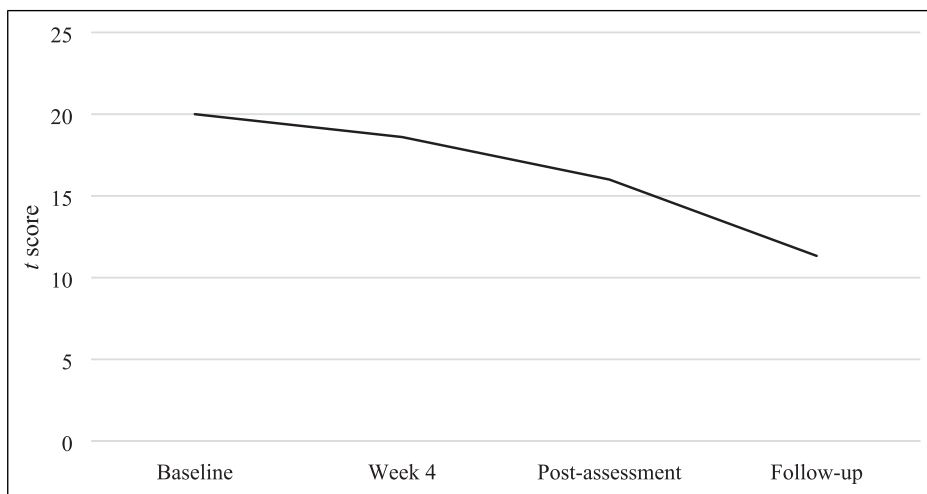


Figure 4. Changes across sessions on the Brief RCOPE^a

^aNegative Religious coping Scale.

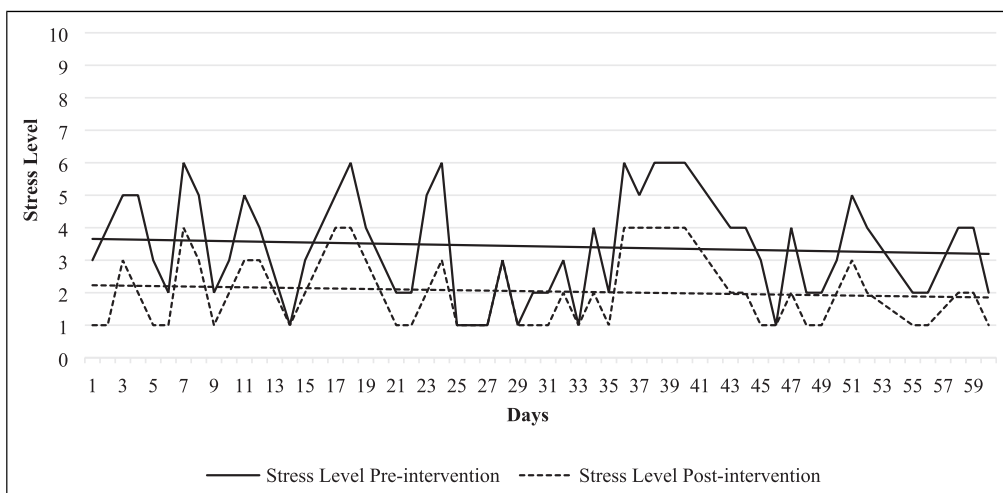


Figure 5. Stress levels at pre- and post-intervention level for each session, measured with a 10-point Likert Scale.

II. Treatment Implications of the Case

Altogether, these preliminary findings provide both illustrating and promising results for the effects of a Jesus Prayer intervention. The influence of religious struggles on mental health is acknowledged in the DSM-5 with a V-code, which relates to religious and spiritual problems (V62.89). Further, previous research shows that religious struggles indeed are related to symptoms such as depression, anxiety and substance use (Weber & Pargament, 2014). Despite the findings above, most mental health professionals do not use the spiritual problem V-code in clinical practice (Hathaway et al., 2004). When religious struggles are not detected and

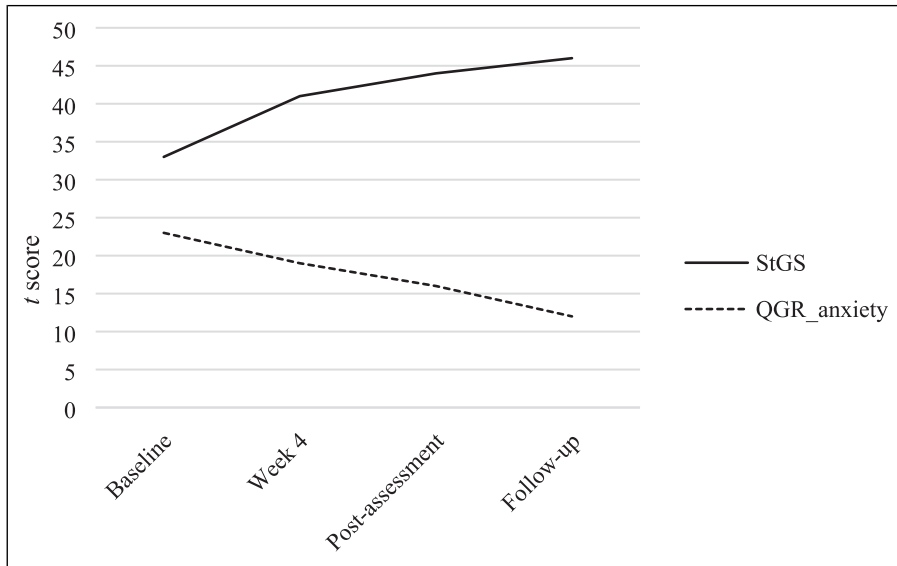


Figure 6. Changes across sessions on the StGS^a and QGR^b

^aSurrender to God Scale; ^bQuestionnaire God Representations (Anxious God Representation).

included in the treatment, the intervention plan may have suboptimal results (Weber & Pargament, 2014).

The current case study examined whether an intervention specifically designed to address the V-code diagnosis would benefit the spiritual problem and psychological distress. As the results indicate, Christian patients with anxious God representation could profit from interventions such as the Jesus Prayer. The intervention may perhaps best play a supporting role for other, symptom-focused treatments. A benefit of such interventions as the one used in this study is that they represent an easy to administer add-on, as patients carry out the intervention independently.

12. Recommendations to Clinicians and Students

Although there are clear limitations in making statistical generalizations from one or even multiple case studies (Yin, 2009), these results may hold promise for helping to augment treatment of religious (spiritual)-related problems that contribute to clinical outcomes.

A first point is that the current case study supports the idea that overlooking religious and spiritual problems may result in a treatment plan that omits potentially helpful religious intervention elements. Religious problems may be likely to be overlooked in therapeutic situations given the evidence of a religiosity gap in the West, with lower rates of religious involvement among therapists compared with that of mental health patients (Van Nieuw Amerongen-Meeuse, et al., 2018). As a result, religious patients seek support in religious institutions and explicitly religious therapists. The study described here aims to be a helpful resource for therapists who want to reduce the religiosity gap.

Secondly, it provides preliminary evidence that the Jesus Prayer could help to reduce an anxious God representation and religious struggle while simultaneously increasing surrender to God as a religious coping approach. The intervention may even benefit mental health outcomes by decreasing distress, anxiety, depression and craving. Thirdly, this case study underlines the importance of screening for religious behaviour and problems, as these may impact treatment

outcome. One option for such assessments is represented by the tools used in the current study – that is, the supplementary module regarding spirituality, religion and moral traditions from the Cultural Formulation Interview (American Psychiatric Association, 2013) and the negative religious coping scale (Pargament, 1999).

We would also suggest the importance of therapists to consider their own religious and spiritual assumptions about the patient's recovery and their skills in delivering a religious/spiritual intervention element. Some therapists may feel competent regarding the implementation of religion into treatment with interventions such as Religious CBT (Pearce et al., 2016) or schema therapy (Hersberger, 2016; Stevens & Miner, 2017). Other clinicians may have more limitations regarding the use of religious and spiritual aspects in therapy. In such cases, the support of self-administered interventions such as the Jesus Prayer may be effective. Last, the findings of the present study suggest promise for examining the effectiveness of a Jesus Prayer and similar interventions on a larger scale by using a multiple case-study method or a randomized controlled trial with patients who experience religious struggles.

Declaration of Conflicting Interests

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Author Contributions

HJS conceived of the study and initiated the study design. PK helped with implementation. PK conducted the primary statistical analysis. All authors contributed to refinement of the paper and approved the final manuscript.

ORCID iD

Henk-Jan Seesink  <https://orcid.org/0000-0002-2817-8148>

Notes

1. The name has been altered.
2. To our knowledge, there is no official English translation of the Dutch denomination, which refer to themselves as 'bevindelijk' Reformed. This study uses the term 'Reformed Pietists', which is used in another study (De Lely et al., 2019).

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Author Biographies

Henk-Jan Seesink, MSc., is a Healthcare psychologist and currently a PhD student at the University of Amsterdam. His research involves surrender to God as relational religious coping and implicit process during the treatment of addiction.

Pieter Klokkenburg, MSc., is currently working as a psychologist in addiction care and mental health.

Hanneke Schaap-Jonker, PhD, is an endowed professor at the faculty of religion and theology at the Vrije Universiteit of Amsterdam. Her studies focus on compassion and God representations.

Brian D. Ostafin, PhD, is an associate professor of psychology at the University of Groningen. His research involves the subjects of addiction, awe, implicit measures of attention and association, meaning in life and mindfulness.

Reinout W. Wiers, PhD, is a faculty professor at the University of Amsterdam. His focus is to increase understanding into the (neuro-)cognitive processes involved in the aetiology of addiction and related disorders and to use this knowledge to develop interventions.