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Christian Therapists' Perspectives on the Use of Prayer in Therapy

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Christian Therapists' Perspectives on the Use of Prayer in Therapy

by

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May, 2014

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social work
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Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

Research has been demonstrating the benefits of utilizing spiritual and religious interventions to mitigate symptoms of emotional difficulties in clients that enter therapy. This study specifically aims to investigate Christian therapists' perceptions on the use of prayer in psychotherapy. Four licensed Christian therapists were interviewed in regard to the following areas: demographics, how prayer is used in therapy, therapist's perceptions on the use of prayer in therapy, and therapist's perceptions on the effectiveness of prayer in mitigating symptoms of emotional difficulty. The major themes from the data demonstrate that Christian therapists approach the use of prayer in a client-focused and non-directive way, the use and efficacy of prayer is dependent upon the client, and that prayer has positive outcomes for the client in regard to mitigating symptoms of emotional difficulties. The findings of the current study highlights the sensitive nature of utilizing prayer in therapy with clients, and that it can also be beneficial, both for the therapeutic relationship and in mitigating symptoms of emotional difficulties in clients.

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First off, I would like to thank my Lord and Savior, Jesus Christ, for answering my many prayers for strength and endurance throughout the process of writing this paper. If it were not for my faith, I would not have chosen the use of prayer as a topic for research. Also, I would not be pursuing a masters in Social Work. Secondly, I would like to thank my wife for being a large part of the answers to the aforementioned prayers, because without her unwavering support and encouragement, this process would have been exceedingly more difficult. Thirdly, I would like to thank my loving and sacrificial mom, for consistently providing childcare so that I could have 2-3 nights out of the week to focus on my research. Fourthly, I would like to thank my research chair (Colin Hollidge) and my committee members (Kerin Logstrom, and Ben Kimball) for your patience, advice, and support. Lastly, but not at all leastly, I would like to extend a special thanks to all of my friends and family for their prayers and support, and for being so patient and understanding when I couldn't hang out for pretty much the majority of the time I've been working on this paper. I love you all!

Table of Contents

Abstract.....2

Acknowledgments.....3

Introduction.....5

Literature Review.....8

 Assessing the Correlation between Religious Practices and Psychological Well-being.....8

 Prayer as the Primary Tool of Intervention.....18

Methodology.....28

 Sample.....28

 Protection of Human Subjects.....29

 Measurement.....29

 Data Collection.....30

 Data Analysis.....30

Conceptual Framework.....31

 Systems Theory.....31

Results.....34

 How Prayer is Used in Therapy.....34

 Therapists’ Perceptions on the Use of Prayer in Therapy.....38

 The Effectiveness of Prayer in Promoting the Mental Health of Clients.....42

Discussion.....45

 Summary.....45

 Comparisons to Previous Literature.....45

 Implications for Further Research.....47

 Implications for Social Work Practice.....49

 Limitations of the Study.....50

 Conclusion.....50

References.....52

Appendix A.....56

Appendix B.....57

Introduction

The use of spiritual and/or religious interventions with clients has been a topic of research for many years (Trier & Shupe, 1991; Lindgren & Coursey, 1995; Taylor, 2001; Drescher et al., 2004; Kuchan, 2008; Hodge, 2010; etc.). Since nine out of ten Americans claim to believe in God or another higher power (Pew Forum, 2008), it is logical to conclude that such interventions in therapy could be useful for many clients.

Previous literature has reported on the positive impacts of spiritual interventions for those experiencing painful deficits, both physically and mentally (Wills, 2007; Richards et al., 2003; Trier & Shupe, 1991; etc.). These findings also make important implications for the mental health clinician in his/her practice. One implication involves promoting the use of spiritual interventions in client therapy. For example Hodge (2006) argues for the use of “spiritually modified cognitive therapy” for the simple fact that “Christians represent the largest faith community in the United States.” This supports what Taylor (2001) found concerning a Gallup Poll, taken in 1995, that reported that 96% of Americans either believe in God and/or a supreme being. Hodge (2006) also stated that since depression is “one of the most common mental health problems”, practitioners may receive clients for whom such interventions are appropriate.

Dane and Moore (2005), in their study of care for the older adult population, highlight the validity of incorporating more training in graduate level courses, of different forms of spiritual interventions. For example, Dane and Moore argue that “social work education has lagged

behind in training professionals to work with clients who struggle with death/dying, serious illness, and disability”; and that “social workers and other health care professionals often do not attend to an individual’s spirituality when working with people with advanced cancer (Dane & Moore, 2005, pp. 66, 68). However, according to the literature reviewed for the current study, spiritual interventions have been found to be utilized in many different populations, such as those suffering from severe and persistent mental illness; couples dealing with marital conflicts; depression among the older adult population; individuals suffering from chemical dependency issues; etc.

The existing research takes a very broad approach, in the sense of assessing the value of spiritual/religious interventions, as a whole, in therapy. Although this research has proven useful in demonstrating the validity of spiritual interventions, the current research will have a much narrower focus, with regards to Christian therapists perceptions of the use of prayer in therapy, to the exclusion of other spiritual/religious interventions that have been used with clients (i.e. scripture reading, worshipping, attending religious services, etc.).

There are several reasons why this research is important. First, only a few studies have focused specifically on the benefits of prayer in therapy, to the exclusion of all other forms of spiritual interventions. Second, prayer appears to be a frequently (if not one of the more) utilized spiritual intervention that serves to manage, control, and mitigate symptoms of depression and other forms of illnesses (Lindgren & Coursey, 1995; Taylor, 2001; Rogers et al., 2002; Dane & Moore, 2005; Aranda, 2008; Jackson et al., 2010). Third, people who believe in God and/or a higher power may desire for prayer to be incorporated in their therapy (Hodge, 2006). Therefore, it would be worthwhile to further assess the uses of prayer in therapy, therapist perceptions of it, and how effective it is in terms of mitigating symptoms of mental illness.

Previous studies have assessed the use of a variety of spiritual/religious interventions to address the biological and psychological aspects of various types of clients. The current research will hope to contribute to the existing knowledge-base by examining how therapists (who profess a Christian faith) use prayer in therapy, what their perceptions are regarding its use in therapy, and how they perceive prayer to be effective in mitigating symptoms of mental illness. The research question focuses on Christian therapists' perceptions on the use of prayer in therapy.

Literature Review

The literature review will assess the relationship between religious/spiritual practices (of which prayer is a subtype) and psychological well-being. The first section of this literature review will look at the spiritual and religious involvement with youth, older adults, individuals suffering from severe mental illness, and in group work. The second part of this literature review will assess prayer as the primary tool of intervention in therapy and how it impacts marital therapy, and substance abuse programs.

Assessing the Correlation between Religious Practices and Psychological Well-being

Religious Involvement and Youth

Jackson et al. (2010) did a study about the use of spirituality among a group of youth in foster care. The majority of the participants in this study were children of color, who (at the time of this study) resided in the U.S. foster care system. Over half of the participants in this study were females (51.1%). Forty-one percent of the participants were African American, 22.1% were Hispanic/Latino, 32.3% were white, and 4.2% included individuals that identified as American Indian/Alaska Native, Asian, and Native Hawaiian/Pacific Islander. The purpose of this study was to determine the spiritual beliefs of the youth in this particular population, spiritual problems, and activities that they associated with spirituality. Jackson et al. reported that 59% of the adolescents studied used prayer “when something bad or tragic happened” (Jackson et al., 2010, p. 112). In the same study, Jackson et al. maintained that “it is clear that

many young people who have experienced significant trauma derive strength and support for healing in their spiritual beliefs, spiritual practices and spiritual communities” (Jackson et al., 2010, p. 114).

The study by Jackson et al. also corresponds with other research previously done in the area of “religious attendance”. Pearce et al. (2003) assessed the relationship between religiousness and depressive symptoms in a sample of middle school and high school students, in an ethnically and socioeconomically diverse district, in southern New England. There were 744 participants in this study. Half of the participants were female (50%). There were 257 participants from the 7th grade, 284 in the 8th grade, and 203 in the 9th grade. This study focused on the two largest ethnicities, which were European American (n=607, 81.6%) and African American (n=137, 18.4%). Pearce et al. (2003) found that “higher levels of religious attendance, self-ranked religiousness and positive religious experiences were associated with significantly lower levels of depression” (Pearce et al., 2003).

Jackson et al. cites another study done by Regnerus & Elder (2003). This study analyzed data taken from the National Longitudinal Study of Adolescent Health, in which 9,000 individuals participated. The purpose of this study was to determine if religion and religious change decreased the vulnerability of low-risk youth in regards to delinquent behavior such as drinking/drug use, poor grades, and other school problems. The sample consisted of 134 schools (both middle and high schools) in 80 communities throughout the country. In order to promote diversity in the sample, schools were chosen in different regions, urban settings, school types (i.e. public and/or private), racial composition, and size. In regards to alcohol use, Regnerus & Elder (2003) found that “higher levels of religious attendance, self-ranked religiousness and positive religious experiences were associated with significantly lower levels of depression”

(Regnerus & Elder, 2003, p.644). In regards to drug use and delinquency, the more religion is important and/or becomes important, the likelihood of being vulnerable to each category drops significantly (Regnerus & Elder, 2003, p. 648).

Corcoran and Nichols-Casebolt (2004) report on the usefulness of a “risk and resilience ecological framework” to guide assessment and intervention strategies for clients at every level of society (i.e. micro, mezzo, and macro). It is a multi-system intervention tool used to shed light on how practitioners can intervene for their clients at the micro, mezzo, and macro levels. They relay findings from previous research on the positive impacts of religious involvement on the bio-psycho-social aspects of individuals. For example, as a mezzo-level intervention strategy, Corcoran and Nichols-Casebolt reported that church attendance was significantly associated to “health-enhancing behaviors” such as exercising and dieting. They also stated that church attendance was significantly related to a decrease in drug use in adolescents, criminal activity, and decreases in symptoms of depression (Casebolt & Nichols-Casebolt, 2004, p. 219).

Loren Marks (2005) develops a conceptual model to demonstrate how religious practices impact psychological well-being. This conceptual model is based on research that highlights the positive relationship between the integration of religious practices, religious beliefs, and religious community on the biological, psychological, and social aspects of a particular individual. Specifically in regards to “spiritual beliefs and psychological health”, Mark reports that the research findings are consistent across “samples, designs, methodologies, religious measures, health outcomes, and population characteristics actually serves to strengthen the inference of a positive association between religion and health” (Marks, 2005 cites Koenig, 1998). Again, Marks cites Koenig et al. (2001) about the “salutary religious effect”: “certain religious practices have also been correlated with positive coping in connection with both ‘acute’

and ‘day-to-day stresses’ of life in a wide variety of contexts”. Marks reports that some of the mental health benefits include “greater personal happiness and/or self-esteem and lower rates of depression” (Koenig, 2005, p. 180). Marks (2005) concluded that “Correlations from the data indicate predominantly positive relationships between the three dimensions of religious practices, beliefs, and communities and bio-psycho-social variables including well-being, physical health, longevity, mental health, psychological coping, and social support” (Marks, 2005, p. 183).

Kuchan (2008), who provides a psychoanalytic viewpoint, reports that prayer “creates space within a spiritual relationship for the creation of inner images that reveal a person’s unconscious relational longings and co-created representations of God” (Kuchan, 2008, p. 263). Kuchan’s concept of “space” comes about from referencing Donald Winnicott, a British Object Relations therapist (Winnicott, 1990). Kuchan writes that this “space” that is created by the spiritual director, the directee, and God recreates that missed attachment environment between the directee and his/her primary caregiver. Kuchan suggests that the goal of such a “space” is to develop that sense of “aliveness” which is “dependent on one’s relational environment and includes affective capacity to feel one’s inner world in relation to one’s outer world” (Kuchan, 2008 cites Winnicott, 1990). Ann Ulanov (2001), in Kuchan (2008) reports that “religion and spiritual direction can provide the “transitional space” for a process of coming alive when subjective God images from within the psyche are allowed, expressed, and ultimately met by objective God images from religious tradition inclusive of God images written in sacred texts and doctrine”. Through this “space” that is created between the spiritual director, directee, and God, one is able to repair what was never achieved in the attachment relationship with the primary caregiver, which is a feeling of being alive and real. In more succinct terms, Ann

Ulanov (in Kuchan, 2008) asserts that via religious interventions (i.e. prayer, etc.) in therapy, we experience God holding us in being. It is in such a reparative environment that, Ulanov (2001) states, we are able “to look into the gaps of dissociation between our bodies and psyches, into the terrors of ground falling away beneath us, into the moments of unreality when we feel the flicker of our uniqueness as persons faltering. Looking into such gaps, we may begin, slowly, carefully to knit together what was broken apart” (Kuchan, 2001, p. 267-268).

Religious and Spiritual Practices in the Older Adult Population

Support for the use of religious interventions and spirituality was also found in studies dealing with the many issues facing the older adult population. Van Hook and Rivera (2004) present findings from a study that focused on 122 older adults in community-living settings in Florida. The participants were given a survey that was self-administered, and assessed life transitions, and religious coping strategies. To assess for religious coping strategies, a brief version of the RCOPE (Pargament, 2002) was used. The RCOPE assess for positive and negative forms of coping strategies. The majority of the participants in this study indicated that their use of religion to cope was generally helpful. 54.3% of the participants indicated that their use of religion to cope was “very helpful”, 28.2% indicated that it was “helpful” (Van Hook & Rivera, 2004, p. 243). Overall, Van Hook and Rivera (2004) found that the most common responses from the participants, to various crises, included the following positive forms of coping strategies: “Asked for forgiveness for my sins”, “Looked for a stronger connection with God”, and “Sought God’s love and care” (Van Hook & Rivera, 2004, p.233).

Dane and Moore (2005) utilized a single occasion cross-sectional design to survey how various social workers employ the use of spiritual practices in palliative care. The sample incorporated professional social workers with an MSW degree or higher. Individuals were

sampled from two different sources. Sample 1 was taken from The New York State Association of Clinical Social Workers (n = 300). Sample 2 was taken from The Members of the Palliative Care and End of Life list serve (n = 327). In their anonymous survey of social workers, Dane and Moore reported the following practices as the most endorsed by social workers: yoga, guided imagery, and prayer (Dane & Moore, 2005, p. 71). Other types of religious practices included reading religious/spiritual material and exploring religious/spiritual elements in dreams. Because of the overall benefit to psychological well-being, Dane and Moore (2005) reported that “spiritual practices are used by social workers particularly for clients living within the arc of palliative care concerns, from serious illness, disability, or handicap, to the end of life” (Dane & Moore, 2005, p,75).

Rajagopal et al. (2002) did a study testing the effectiveness of spiritual interventions on treating, what they call, subsyndromal anxiety and minor depression in the older adult population. The purpose behind this study was to identify non-pharmacological interventions in treating older adults that suffer from minor depression and Dysthymia. There were 22 respondents from 6 different continuing care communities. The 22 respondents were divided into a group cohort and an individual cohort. In the group cohort, there were 14 participants total. Of the respondents in this group, 86% were diagnosed as having minor depression, and 14% were diagnosed as having dysthymia. In the individual cohort, 75% were diagnosed with minor depression and 25% were diagnosed with dysthymia. In their study, Rajagopal et al. (2002) utilized the Prayer Wheel, which was an intervention developed by a Canadian psychiatrist (for his private practice) that provided a structure for praying. Rajagopal et al. (2002) studied the effects of The Prayer Wheel with an individual cohort and a group cohort to assess the different impact the Prayer Wheel made in each cohort. The prayer wheel included

eight different categories that people could choose from, spending five minutes on each category, thus taking a total of 40 minutes to go through the prayer wheel. The study found that, as a result of using the prayer wheel with the older adult population in their study, there was a “significant decrease (19%) in anxiety for the individual cohort” and that “there was a trend toward a significant decrease in depression (16%) for the participants using the group cohort. Rajagopal et al. (2002) concluded that the prayer wheel may be an effective tool in mitigating the symptoms of subsyndromal anxiety and in treating minor depression in the older adult population.

In a study of 230 older U.S.-born and immigrant Latinos, Aranda (2008) reported on the association between religious interventions, private prayer, and depression. Aranda found that an increase in religious attendance was correlated with “lower risk of depressive illness”. To explain the possible reasoning behind this, Aranda states that “religion offers a vehicle by which people can gather to reaffirm social order, cohesion, and meaning” (Aranda, 2008, p. 17).

Hodge (2006), in his meta-analysis of 14 studies that focus on the use of spiritually informed therapy in the amelioration of depression, assesses the effects of spiritually informed cognitive therapy. These studies incorporated a pretest and posttest design to evaluate effectiveness of spiritual interventions. Hodge (2006) concluded from these studies that spiritually modified cognitive therapy was significantly effective in mitigating symptoms of depression. It should be noted that results were similar across varying religions.

Religion and Spirituality in Severe Mental Illness

Rogers et al., (2002) in his study sought to understand the relationship between attitudes towards religion and symptomatology with individuals suffering with severe and persistent

mental illness. The goals of this study were to examine the following three areas: the changes in feelings about religion from those that have a severe and persistent mental illness; the relationship between changes and coping styles; and the relationship between these changes and symptom severity (Rogers et al., 2002, p. 169). The sample was composed of individuals with a severe and persistent mental illness (male = 58%, female = 42%). The participants attended at least one of the 13 Los Angeles County Mental Health facilities. The average age of participants was 40 years old and the mean GAF score was 38.10. This study used both quantitative and qualitative measures to assess the nature of participants' changes in feelings toward religion. To assess religious coping, participants were administered "a 48-item demographic survey and were interviewed on an adapted version of Koenig's (1994) Religious Coping Index" (Rogers et al., 2002, p. 170). Last, participants were administered a version of the Symptom Checklist 90-R, to assess symptom severity.

Overall, Rogers et al. (2002) found that positive feelings about religion, among the mentally ill studied, served as a buffer against adverse symptomatology and promoted religious ways of coping with symptoms. The types of religious activities that were accounted for in coping with adverse symptomatology included prayer, reading the scriptures, meditating, going to religious services, and worshipping (Rogers et al., 2002, p. 170). Of the types of religious activities that were assessed, the majority of respondents (64%) reported prayer as the most utilized (Rogers et al., 2002, p.173).

In regard to changes in feelings about religion, this study showed that 54% reported a change in religious beliefs in that their faith became stronger or weaker. The results showed that 16% reported a change prior to mental illness, 32% experienced a change after onset of mental illness, and 48% reported that change occurred both prior to and after onset of mental illness.

The majority of participants (66%) reported that the changes in feelings about religion were positive, 27% reported negative changes, and 8% reported bizarre or ambiguous feelings.

Descriptive statistics show that over 92% of participants coped with symptoms of mental illness with some type of religious strategy, with half (50%) devoting their coping time to religious strategies. Some of the positive changes in feelings were reflected in a positive self-image.

Participants whose change reflected a positive self-image were more likely to cope via meditation, worshipping God, and by praying.

Rogers et al, (2002) also assessed for the fluctuation of attitudes towards religion in terms of a renewed, revealed, and/or changed use of religion. Renewed, revealed, and/or a changed use of religion, in the positive sense, were correlated with better coping of adverse symptomatology. More specifically, participants who reported a renewed and/or revealed faith were more likely to pray than those who reported a change of faith (Rogers et al., 2002, p. 174). Also, with those who reported a positive change in terms of a renewed form of faith, this reflected the rekindling of an existing faith that was used to alleviate stress or provide strength” (Rogers et al., 2002, p. 176).

Drescher et al. (2004) advocate for the use of spiritual interventions in that they “serve as an important resource that enhances a person’s ability to assimilate and process traumatic events in an adaptive and beneficial manner.” This belief led to the development of a group therapy module for combat veterans at the Menlo Park Division of the VA Palo Alto Health Care System. The group therapy module consisted of group sessions and a manual set for both clinicians and program residents. The purpose of this group treatment was to help veterans understand the relationship between traumatic events and spirituality and the possible benefits of spirituality as a way to cope and heal.

Lindgren and Coursey (1995) did a study incorporating a psychoeducational program among 30 members from three different psychosocial rehabilitation centers. This psychoeducational group was comprised of six groups that met for four sessions. The members included in the study suffered from serious mental illnesses. The purpose of this study was to help clients utilize their spiritual beliefs in order to promote a healthy self-esteem. Lindgren and Coursey (1995) reported on the correlation between spirituality and the psychological wellbeing of the participants in that “Individuals who grew less depressed over the intervention thought about God more often; those who grew more hopeful ... were more likely to feel spirituality positively impacted their illness” (Lindgren & Coursey, 1995, p. 106).

Taylor (2001) supports the above research (and other research) in her article focusing on the use of spirituality and religious interventions with the severely mentally ill population. Taylor (2001) used results from Gallup Polls in 1995 to provide the basis for her assertions about the use of religious/spiritual interventions/practices among the severely mentally ill. According to the Gallup Polls in 1995, 96% of Americans believed in God or a universal supreme being. Taylor (2001) also cited the findings from Poloma (1993) in a study of 911 adults that reported that prayer promoted a significant degree of “life satisfaction, happiness, and overall well-being”, in terms of overall health, not just mental health (Poloma, 1993 in Taylor, 2001). From this foundation, Taylor (2001) argues that religious coping could also be utilized in people suffering from severe and persistent mental illness (Taylor, 2001, p. 385). She concluded that “religion is important to psychiatric patients and the general population alike, indicating the need for increased awareness of patients’ religious beliefs and possible coping responses” (Taylor, 2001, p. 387).

Cornish et al. (2011), examined counselors' perceptions of the use of spiritual and religious interventions in group therapy. The sample consisted of 242 members of the American Group Psychotherapy Association. Participants had to have a mental health degree and to have had experience in group counseling. Participants received an invitation to participate, along with a link to an on-line questionnaire, via e-mail. Cornish et al., (2011) found that participants were willing to facilitate discussions about spirituality (97.1%) and religion (91.7%) if group members brought it up. Secondly, they found that the degree of appropriateness was positively related to the utilization of spiritual and religious interventions (Cornish et al., 2011, p. 129). Cornish et al., (2011) found that participants were more open to talking about issues related to spirituality ($M = 3.8$, $SD = 1.0$) than they were issues related to religion ($M = 3.3$, $SD = 1.1$). The majority of participants also reported positive perceptions regarding the use of spirituality in group sessions, experienced low levels of concern regarding discussions of spirituality, and they felt confident in their ability to address spirituality in group sessions (Cornish et al., 2011, p. 130).

Prayer as the Primary Tool of Intervention

Marital Therapy

In an article about the use of prayer as an intervention tool in marital therapy, Beach et al. (2008) propose a conceptual framework that integrates prayer interventions as an alternative skills-based approach. For example, instead of only taking a "time-out" during relational conflicts, couples are instructed to step away from the argument and practice individual prayer as well. The idea behind this is that the prayer piece will be more likely to encourage a forgiving disposition to the other partner. Whereas, if couples only had a time-out, without prayer, they may have more of a tendency to think about how the other had wronged them, thus nurturing

feelings of animosity versus feelings of reconciliation. In other words, simple time-outs may create a mental environment that amplifies negative feelings about the other person in the conflict. In the words of Beach et al. (2008), prayer “may be used to help individuals regain a sense of perspective. Second, it can help partners shift their focus to constructive concern for the relationship. Third, it can augment or serve as a substitute for relaxation strategies. Fourth, it can give partners a readily available way to ‘take a break’ from interacting with each other.” In this way, prayer can be a benefit as a skills-based approach in marital therapy.

Private Prayer

Aranda (2008) reported on the relationship between private prayer and lessening of depressive symptomatology in her study of 230 older U.S.-born and immigrant Latinos. She found that private prayer was not significantly related to the mitigation of depressive symptoms. As mentioned earlier, the role of utilizing other religious practices (i.e. attending services) demonstrated a much more significant relationship in managing depression. However, this is not to say that prayer is not meaningful and/or useful in clients dealing with depression and other mental illnesses (as is shown to be the case in other literature reviewed) because Aranda reported that prayer is of high importance in both older U.S.-born and immigrant Latinos. For example, Aranda found that, of the 230 respondents in her study, 76.8% of U.S.-born Latinos and 84.1% of immigrant Latinos reported that they “pray daily or more than once a week” (Aranda, 2008, p. 16). One possible caveat to Aranda’s findings in regard to the efficacy of prayer, is that it did not account for different formats that prayer is utilized in, such as in meditation, reading sacred texts, etc.

In their study of the use of prayer in 42 women caregivers of children diagnosed with HIV, Richards et al. 2003 found that “prayer was used to shift attitudes and emotions toward

positive perspectives ... (prayer) nurtured gratitude, faith, trust, and wonder ... used to gain focus and calm, companionship, collaboration, guidance, and moral direction” (Richards et al., 2003, pp. 201-202). Richards et al. (2003) reported that among the respondents who participated in their study, prayer was actually the primary tool used to mediate life situations. In their study, four types of prayer were assessed and these include colloquial, meditative, ritual, and petitionary.

In a quantitative analysis, Richards et al. (2003) reported that respondents used colloquial prayer more than the other three types mentioned above. Richards et al. (2003) define colloquial prayer as prayer that is conversational in nature. It is the type of prayer that is utilized during activities of daily living (i.e. walking down the street, cleaning the house, etc.).

In the qualitative analysis of interviews taken with the 42 participants, Richards et al. (2003) was able to elicit seven themes related to the benefits of prayer in maternal caregivers of children with HIV. Respondents were able to have an increased ability to focus on daily activities; an increased sense of calm during stressful moments; prayer strengthened decision-making abilities; prayer assisted participants to persevere during hard times; prayer promoted a sense of companionship (i.e. participants always felt that God was always there to talk to); prayer helped resolve negative emotions; and prayer had the effect of shifting perspectives from negative ones to positive, which in turn promoted a sense of faith, gratitude, trust, and wonder in the participants.

Glueckhauf et al. (2009) assessed the use of Cognitive Behavioral and Spiritual Counseling (CBSC) by Faith Community Nurses (FCN) with caregivers of dementia patients. CBSC is the utilization of cognitive behavioral therapy in spiritual counseling. The CBT portion of treatment included “relaxation training, reframing ineffective thinking, increasing

assertiveness, building in pleasant daily events, and problem-solving skills training”; the spiritual counseling component focused on “the use of religious coping strategies, such as prayer, meditation, positive affirmation, and communal support” (Glueckhauf et al., 2009, p. 453). An example of a FCN utilizing CBSC with a dementia caregiver can be shown in the following statement: “RS (FCN) also provided instruction and rehearsal in the use of redirecting techniques (CBT) in combination with prayer and meditation (spiritual counseling) on acceptance of self and her (the caregiver’s) husband’s limitations” (Glueckhauf et al., 2009, p. 457).

Two separate cases were analyzed where a FCN provided CBSC to a dementia caregiver. In both cases, post-treatment evaluation of the impact of CBSC in caregiver depression was significant. In the posttest of caregiver (TX), it was reported that he experienced a “substantial decrease in average problem severity ratings from 5.2 to 1.0; based on a scale ranging from 6 (severe problem), 3 (moderate problem), to 1 (no problem)”; and in the posttest of caregiver DB, it was reported that she “showed a substantial reduction in problem severity ratings from 5.0 to 3.3” (Glueckhauf et al., 2009, p. 457).

Sharp (2010) studied the impact of prayer in managing emotions among intimate partner abuse victims. Among the sixty-two participants that he interviewed, Sharp found that prayer (as an “imaginary social support interaction”) helped participants manage emotions in five different ways. First, prayer provided an “other” to talk to about negative feelings and circumstances. Participants viewed God in a non-judgmental and loving way, and as a result of speaking to God, participants felt better and seemed to perceive their situation in a more understanding way (Sharp, 2010).

Second, prayer provided “positive reflective appraisals”. Sharp asserts that, to a degree, people form perceptions of themselves based on how they feel significant others view them. For example, children of abusive parents are likely to form ideas about themselves that reflect how they think their abusive parents think about them. Therefore, since participants who pray to God and believe he loves and values them, they will also begin to see themselves as lovable and valuable. In such a way, prayer provided “positive reflective appraisals” for victims in Sharp’s study (Sharp, 2010).

Third, prayer had the effect of restructuring cognitions so that victims of abuse perceived abusive situations as less threatening. In prayer, participants are reminded of things that are true of them as children of God. For example, they are comforted when they read that “God will work all things for the good of those that love him and walk according to his commands”. As a result cognitions are reframed to feel a sense of protection in the midst of unfortunate circumstances (Sharp, 2010).

Fourth, prayer helped participants to “zone out” during moments of abuse. That is, participants reported that during actual moments of abuse, they could retreat into personal prayer to God so that they can avoid feeling the hurt associated with the particular abuse. During abusive moments, God served as a supportive other that was on the side of the person being abused. This appears to be a form of internal redirection in order to manage negative emotions (Sharp, 2010).

Lastly, prayer had the impact of promoting feelings of forgiveness towards the abuser. Through prayer, participants are encouraged to model the example of God who “forgives offenses and harms”. As a result, participants then took on the same approach towards their abusers in letting go of their anger. Sharp reports on the findings from other studies on the

positive impact of forgiveness on managing emotions: “individuals who are able to forgive their transgressors, either on their own or through forgiveness intervention therapies, reported increases in positive self-esteem and happiness and decreases in negative emotions such as hate and anger compared to those who are unable or unwilling to forgive” (Baskin & Enright 2004 and Baskin & Reed, 2006 in Sharp, 2010).

Intercessory Prayer

Hodge (2010), wrote an article on the use of prayer and other forms of “mental energy” in direct practice from an evidence-based perspective. Hodge uses findings from four meta-analyses to determine the effectiveness of intercessory prayer (Astin, Harkness, & Ernst, 2000; Masters, Spielmans, & Goodson, 2006; Hodge, 2007; Roberts, Ahmed, & Hall, 2007), three of which provide the effect size. In the meta-analysis by Astin et al., (2000), four studies were examined and the average effect size was 0.25 ($p = 0.009$). In the meta-analysis by Masters et al., (2006), 14 studies were examined. The effects were significant in 11 of these studies that examined the efficacy of intercessory prayer with client/patient samples ($p = 0.05$). In a meta-analysis of 17 studies on prayer with client/patient samples, Hodge (2007) found that the mean effect size was 0.171 ($p = 0.015$). The fourth meta-analysis (Roberts et al., 2007) that Hodge cited, assessed for the effectiveness of intercessory prayer on diverse outcomes using 10 studies, but he did not report on an effect size (Hodge, 2010, p. 125-126). In his article, Hodge (2010) stated, “relatively similar findings were reported across the four meta-analyses”, and that across three meta-analyses, “effects were significant” in terms of the effectiveness of intercessory prayer for clients. As a result, Hodge (2010) concludes that “prayer produces salutary results” (Hodge, 2010, p. 127). In his article, Hodge (2010) also examines the ethical nature of intercessory prayer, conditions that clinicians should consider before engaging in prayer with

clients, and whether or not informed consent should be obtained prior to clinicians engaging in intercessory prayer for their clients.

Contemplative Prayer

Rajski (2003) reports on the practice of engaging in contemplative prayer. Contemplative prayer is defined as engaging in a period of silence that promotes within the client and therapist “the humble acknowledgement of one’s own ignorance; openness to guidance; and the ability to be ‘here-and-now’” (Rajski, 2003, p. 185). Rajski (2003) also reports that contemplative prayer can assist one in being reflective about his/her irrational and inconsistent thought processes, to challenge them, and replace them with more productive and positive thoughts. For those who profess a belief in God, contemplative prayer is a way of inviting the “transcendental reality” into therapy with the client. Rajski (2003) suggests that the benefits of contemplative prayer include the ability to bring to the conscious mind material that is lost in the unconscious mind, “a sense of balance and harmony ... comfort and a sense of being loved and accepted ... new energy to do things” (Rajski, 2003, p. 189). It may be suggested that contemplative prayer may prove useful in forms of psychoanalytic forms of psychotherapy in that it may assist clients to experience their body and emotions in the present moment (“here-and-now”).

Harris, Schoneman, and Carrera’s (2005) research on the effectiveness of prayer in mitigating symptoms of anxiety support Rajski’s (2003) observations on the use of prayer. In their study on “prayer function preferences” with students in an introductory psychology class at a Southwestern university, Harris et al. (2005) found that those who actively sought assistance from God in prayer coped better with symptoms of anxiety and those who avoided assistance from God.

Prayer in Substance Abuse Programs

Spiritual practices, in the form of praying, are included as interventions in substance abuse programs. Juhnke et al. (2009), investigating patients in a substance abuse program, found that “Clients have reported prayer beneficial when they experience cravings or stressors outside of treatment sessions as well” (Juhnke et al., 2009, p.17). Juhnke et al. discuss four methods that they use to integrate prayer into the counseling session. The first method deals with the association of prayer in helping establish treatment goals. Through prayer, the client is encouraged to ask God to help identify goals to work toward in counseling. In the second method, the counselor offers prayer as an option to facilitate an environment that promotes the idea that the client is in control and has a say in regards to the direction of the session. In the third method, prayer is used as a way for the client to summarize the content of the session, what was learned, and the goals that have been established between them and the counselor. Juhnke et al. report that praying in this way reinforces the perception that the client “has gained knowledge and insight” (Juhnke et al., 2009, p.20). In the fourth method, prayer is used as an intervention for the client when he/she is not in therapy, to support their goals of abstaining from substances when their cravings are being activated. When a client is struggling with thoughts of using a particular substance, they are encouraged to pray a prayer for wisdom from God. For example, Juhnke et al. state that a prayer like this could be something as simple as praying “God, I need your help right now. I feel overwhelmed and like I want to use. Give me wisdom on what I should do right now so I won’t use ...” (Juhnke et al., 2009, p. 21). Juhnke et al. concludes that “Spirituality has been acknowledged within existing literature and the helping professions as important to clients’ successful recovery from substance abuse and addictions. Prayer is a

spiritual activity that has long been used within the recovery community and is an intervention that can be easily integrated within typical addictions treatment” (Juhnke et al., 2009, p. 21).

Wills (2007) also supports the inclusion of spiritual interventions when she asserts that “spirituality is both a process nurtured by a positive outlook as well as one that fosters positive outcomes” (Wills, 2007, p. 430). Wills (2007) reports on the findings of a study by Magura et al. (2003) who found that “many participants credited 12-step affiliation, inclusive of hope, with reconnecting them with a spiritual belief system discarded when they began using drugs. Such reconnection facilitated the addicts’ spirituality, which then facilitated their recovery” (Magura et al., 2003 in Wills, 2007, p. 430). Wills concludes this thought by stating that spirituality promotes increases in hope, which then promotes “positive perceptions of one’s health” (Wills, 2007, p. 430).

Washington and Moxley (2001) report on the use of prayer as an intervention in group therapy, with 27 African-American women suffering from chemical dependency issues. They observed that prayer can “stimulate internal contemplation about the readiness and desire for change, and prepare the person for action to change problematic or destructive behaviors” (Washington & Moxley, 2001, p. 58). They also observed that prayer can be a form of communication that helps patients express feelings and experiences they otherwise would not disclose to others. The participants in this chemical dependency group would express their hopes and dreams to God through prayer, which would elicit similar hopes and dreams from others in the group. In this way, prayer served a unifying function, bonding the group together through like-minded desires/goals. Therefore, “using prayer as a therapeutic intervention can make barriers to chemically-dependent women’s recovery more accessible to problem-solving and action” (Washington & Moxley, 2001, p. 58). These findings resonate with what Juhnke et

al. observed in their experiences with patients suffering from substance abuse issues in that prayer can be a “helpful intervention that has augmented their (the patients) overall treatment success” (Juhnke et al., 2009, p. 22).

In conclusion, Washington and Moxley (2001) report that prayer promotes the patient’s ability to express themselves; it can serve as a source of personal strength; and prayer can promote a sense of self-resiliency during adversity (Washington & Moxley, 2001). They also report that prayer can stimulate meditation, contemplation, and self-reflection; it can serve to calm patients down, to orient them to their current situation, reduce anxiety, and to re-direct their attention in a positive direction (Washington & Moxley, 2001). However, it is important to note that the patients that experience recovery from the utilization of spiritual and religious interventions are spiritual and religious themselves.

Methodology

Introduction

The purpose of the current study was to examine the use of prayer in therapy. More specifically, the focus was on the use of prayer from a Christian perspective and its perceived impacts on symptomatology resulting from mental illness. In order to address this subject, a qualitative study was conducted. Data was be collected via semi-structured interviews with therapists who identified as Christians. This study utilized a grounded theory design to examine therapist's perceptions on the use of prayer in therapy and the relationship between prayer and client symptomatology resulting from mental illness. The research question for this study is: What are Christian therapist's perceptions on the use of prayer in therapy?

Sample

This research was based on a purposive sampling of licensed Christian therapists in the Twin Cities Metro Area (Minneapolis – St. Paul area). Inclusion criteria included having a masters-level education in a mental health field and licensure in the state of Minnesota. Participants had to have at least 3 years of experience as a licensed professional. Participants also needed to have experience with the utilization of prayer in therapy with clients so that the

researcher could elicit first-hand data regarding perceptions on the efficacy of prayer in mitigating symptoms of mental illness. The researcher interviewed four participants that met the above requirements to be in the study. Each participant had their own private practice. Two of the participants (50%) were licensed psychologists, one participant (25%) a licensed independent clinical social worker (LICSW), and the other participant (25%) a licensed professional clinical counselor (LPCC).

Protection of Human Subjects

Before this study was conducted, it was approved by the Research Chair, the Committee Members, and the Institutional Review Board (IRB) of the University of St. Thomas. Prior to interviews being conducted, a consent form was administered to each potential participant, clearly outlining the terms of consent and confidentiality. This consent form was based on the template provided by St. Catherine University/University of St. Thomas. Interviews were recorded via an audio recorder and later transcribed by a professional transcriptionist. The transcriptionist signed a consent form in which she agreed to not disclose any information, given in the interviews, to any other party. No personal identifying information is included on the transcriptions. The transcribed interview data is secured in a locked cabinet in the researcher's home, and only the researcher has access to the raw data. Each participant was informed in regard to how data will be collected, stored, analyzed, and that all collected data will be destroyed as of May 31, 2014. Participants were also given the opportunity to obtain a copy of the findings of this study and were invited to attend the formal presentation of the findings from this study on May 19, 2014.

Measurement

The interviews conducted for this study were in the form of a semi-structured questionnaire (Appendix A). The interviews were based on ten questions that were guided by the suggestions of the research chair and committee members. The questions elicited demographic information, as well as information from the participants according to the major themes in this study, which were the use of prayer in therapy, therapist perceptions of the use of prayer, and how therapists perceive prayer as being effective in mitigating symptoms of mental illness.

Data Collection

The researcher searched for potential participants through an online search of licensed Christian therapists in the Twin Cities Metro area. Once selected, the researcher sent an email (Appendix B) to each potential participant. Each email included an introduction of the researcher, information about the study, and what was expected of each participant. The participants were instructed, in the email, to call the researcher to confirm their participation. Once each participant agreed to partake in the study, a time and location for the interview was determined. The researcher interviewed each participant at their private practice setting. Data was collected through interviews. Consent forms were signed prior to each interview and collected by the researcher. Each interview was approximately 30-45 minutes long.

Data Analysis

The transcribed interview data was analyzed using a Grounded Theory approach. The transcriptions from the interviews were read line-by-line, through an inductive approach, to establish themes from the data. The researcher identified and made note of words and phrases

that were repeated in all four interviews. Various categories were identified by grouping these words and phrases together and from these categories, the major themes were established. The themes that were developed sheds light on how the therapists that were interviewed use prayer in therapy, what their perceptions of it were, and their perceptions on how effective they believe prayer is in terms of mitigating symptoms of mental illness.

Conceptual Framework

The use of spiritual approaches to help manage emotional difficulties is an area that is getting more attention in the research literature (Rajagopal et al., 2002). Mental health practitioners are understanding that there is a lot of value in the use of spiritual practices to mitigate emotional difficulties. The current study specifically seeks to assess Christian therapists' perspectives on the use of prayer in therapy with the client. This highlights a process by which different groups interact with each other, within a particular environment. Because of this, it is best to view this topic within the context of Systems Theory.

Systems Theory

Miley et al. (2011) state, "The systems with which practitioners work may be as small as a single element of the internal processes of one individual (prayer) or as large as the entire human population. Generalist social workers develop skills to comprehend, support, and change behaviors of many kinds of human systems, because systems at all levels are potential clients and targets for change" (Miley et al., 2011, p. 35).

Corcoran and Nichols-Casebolt (2004) state, "First, social work is unique to the helping professions in expecting practitioners to understand, assess, and ultimately intervene at a variety

of system levels” (Corcoran & Nichols-Casebolt, 2004, p. 211). According to Systems Theory, therapists, clients, culture, religion, and spirituality are all examples of various systems.

Furthermore, it can be said that therapists and clients are smaller systems of larger systems such as culture, religion, etc. This highlights the complex nature of different systems and how they interact with each other, and part of the focus of Systems Theory is to understand how these systems interact with each other. For example, Green and Ephross (1999) state that a “social system is a structure in which interdependent people interact” (Miley et al., 2011, p. 35).

Miley et al. (2011) talk about the following kinds of systems: the holon; the subsystem; and the environment. The term “holon” refers to the idea that each system is a part of a larger system, and comprised of smaller systems as well. In the case of the current study, the Christian therapist is part of a larger system of “Christianity”. As part of the larger system of Christianity, beliefs and practices are likely to be informed by the tenets of that religion. A person’s beliefs and practices are some of the smaller systems that make up the Christian person. Prayer would be seen as a way Christian’s operationalize part of their belief system.

The smaller systems within larger systems are called “subsystems”. Christian therapists would be viewed as a subsystem of “Christianity”. Miley et al. (2011) states that the environment, “influences and provides the context for the systems functioning within it” (Miley et al., 2011). This emphasizes the importance of the therapeutic relationship, because in order for good therapy to take place, the therapist needs to gain a good understanding of how the client’s systems impact his/her current functioning. The therapeutic relationship could be said to be the environment of both the system of the therapist and the system of the client, since it informs and provides the context for the direction of therapy and guides whether prayer is used.

Christian therapist's perception on the use of prayer in therapy is going to be informed by the system(s) that the therapist is a part of. Not only is a Christian therapist informed by the beliefs of Christianity, but also the Christian therapist is going to be informed by the environment in which he/she was a part of in the past (i.e. his/her family, education, religious denomination, etc.). The same can be said for the client. All these factors can impact the way prayer is used in therapy. Although the client and the therapist are representations of different systems, that may be completely different from one another, it is important to note that there are also similarities (Miley et al. 2011). This study seeks to address the intersection of prayer between the microsystem of the individual and the microsystem of psychotherapy.

Results

To determine “Christian therapist’s perspectives on the use of prayer in therapy”, the research focused on the three main areas: 1.) how prayer is used in therapy, 2.) therapist’s perceptions on the use of prayer in therapy, and 3.) the effectiveness of prayer in promoting mental health of clients.

How Prayer is Used in Therapy

From discussing how prayer was used in therapy, two themes were identified by the participants: “knowing your client” and “prayer as non-directive and client-focused”.

Knowing your Client

Three participants (75%) stressed the importance of understanding who their clients are before they utilize prayer in therapy. Some of the areas that participants felt were important to assess first, before prayer was utilized, were the client’s diagnostic presentation, the client’s current spirituality, the client’s spiritual history, and the client’s use of language in prayer. One participant spoke to the importance of a client’s particular diagnosis as having something to do with whether or not prayer would be involved in therapy. They stated,

“I think their diagnostic presentation sometimes will have to do with that and how severe that is, whether they’re psychotic – you know, where on the scale are they, from neurotic to psychotic, you know, borderline, in the middle, in terms of a range of reality testing. So that will be an experience that might impact what I will do, because I’m very careful about how I use prayer in session.”

Another participant reported that before prayer is explored and utilized, it is important to find out what form their spirituality takes and help tap into whatever sources of strength they have. The same participant stated that if prayer is an area of strength in the client’s life and if it’s conducive to therapeutic goals, the therapist would help the client to explore that in therapy. They stated,

“So my first goal is to put away my bias and really listen for whatever it is that their spirituality sounds like and feels like to them and then to help them access whatever sources of strength that they have. The same participant stated, “I ask about faith on my intake measures, you know, any range of faith or religious practice – I’m very careful to first learn what that means for them and what role it plays and if it has a restorative or a health function, like a coping strategy, that if it’s a part of their lives like that, or if it’s more like a cultural affiliation.”

Three (75%) subjects concluded that if prayer was brought into therapy before the therapist had a good understanding of who the client was and what their history entailed, results could be devastating. One participant reported,

“in situations where there has been any form of spiritual abuse, whether directly through the church or depending upon their family structure, the understanding of faith within their

family, you know, to have a dad who's distant and removed and yet did a lot of family devotions or prayer ..."

One participant discussed the importance of establishing a definition of what prayer meant to the client. They stated,

"I have no idea what prayer means or what the person's history with prayer is, so for me to lead with prayer feels very much more about my agenda than it is about what the client needs ... my idea of prayer and their idea of prayer could be very, very different."

Two participants (50%) discussed how important it was to know the type of language that the client used according to their faith system. One participant highlighted the potential damage that could result from using language that does not coincide with that of the client. This participant stated,

"faith is so diverse that I wouldn't begin to presume to know the right language and the words and the terms to use that match that client's connection with God, and that could be more harmful than helpful, depending on where I would go with it." Another participant took this idea further when she reported, *"And so if I don't have a good sense of how they view God – you know, for some clients, even to refer to God as 'He' incites all their sexual abuse issues ... and equally, if I were to refer to God as 'She', it could freak somebody else out."* So, there is a heightened sense of awareness in regards to the type of language a client may use.

Another participant stated that it was through hearing his clients pray, that he got an idea of who the client was and where they were in relationship with God. The participant continued to say that he utilized prayer in therapy with clients in this way in order to *"get a window into*

their heart and to their current situation and in some way what they're hoping to accomplish for that hour."

Prayer as Non-Directive and Client-Focused

Regarding the use of prayer in therapy, three participants (75%) reported that they do not initiate prayer in session with their clients and that if prayer is incorporated in the session, it will generally be because the client has asked for it and/or initiated it. These participants stated that occasions do occur where the therapist suggests praying in the session with the client, but this is only after enough of the therapeutic relationship has been established and the therapist knows it would be appropriate.

One subject stated that she does pray for her clients outside of the session or during the session without the clients knowing about it. This participant stated that, in the case of clients with severe pathology, she will pray for the client outside of the therapy session rather than including prayer in session with the client. This participant stated,

"Their history is full of traumatic events or just bad luck or bad – you know, they just haven't had any attachment figures that have been positive in their life, and their biology is all messed up. They don't know how to live. You know, they don't know how to even get organized, you know, without any – and then because of the way they are, you know, they drive people away from them. So, they're not on top of it. They can't emotionally regulate themselves and then can't get the social support that they need for their relationships. So in those kinds of cases, it's more like on my side, where maybe I'm praying for them outside of session ..."

Another participant stated,

“I let them ask for it and prompt it, and then I ask them to lead it, that they lead the prayer, and I more join them in a spirit of prayerfulness ... it would be so client-led that it wouldn't be mine to maybe use it or not use it.” Another participant echoes this same type of approach by stating, *“I feel like I am in an ongoing posture of prayer with listening. So just in my own way of being present to the client feels prayerful for me, to feel like I'm always really listening for God's prompting and truth and also how to intervene and that kind of thing.”*

When focusing on the utilization of prayer in therapy, one participant stated, *“What prompts me to use prayer with clients? Well, if they ask, you know, I'm all for it. If it's on my side and I suggest it, it's more because I know they're – I might ask them, you know, if that's okay or if they think it would be helpful, but usually that's only when I know that they have a Christian viewpoint.”* Another participant echoed the same idea by stating,

“The primary one is they ask for it. I don't start my sessions with prayer. I don't. I can count on one hand the number of times I offered prayer without it being asked for by the client first. And I have a lot of reasons for that, but I'd say the primary reason why prayer gets introduced is the client asks for it.”

One subject had a more directive approach regarding the use of prayer with his clients. This participant stated that he prays in every session with all of his Christian clients. He stated,

“And so for those people who I know are Christians or call themselves Christian, we pray. And so every Christian client I have, our sessions open with them praying ... and then at the end of the session I close in prayer.” The same participant also stated, *“There have been other situations where right in the middle of the session something calls for an intervention that*

would be helped by prayer, and so there are times when just in the middle of the session I'll stop and say, 'Why don't we just pray about that?'"

Therapists' Perceptions on the Use of Prayer in Therapy

When discussing the use of prayer in therapy, respondents focused on three themes: “The efficacy of prayer is relative to client spirituality”, “Prayer is efficacious”, and “Prioritizing prayer is dependent on the setting and the client”.

The Efficacy of Prayer is Relative to Client Spirituality

In regard to this theme, three participants (75%) stated that the efficaciousness of prayer depends on the client's “faith journey” and whether or not a client is a Christian and/or has a relationship with God. One participant reported,

“Yeah. There are times with certain people, particularly people with anxiety, I find it helpful. There are a couple of different prayer forms that I think are really valuable, and depending upon where they're at in their faith journey ...” Another participant stated, *“Yes. I mean, I think if it's part of that client's experience and part of their sort of culture, I think it's very powerful.”* Another participant stated, *“And I think that there's also those clients that I've had that are practicing Christians, you know ... you hear them talk about their faith story or hear about how they're involved spiritually.”* Another participant echoed this same idea when she stated, *“I believe there is a connection to the divine, to God, that is powerful.”* One participant clarified that he does not utilize prayer in order to mitigate emotional suffering, per se, but that prayer sometimes will do that. This participant stated, *“Am I motivated to use prayer*

to mitigate symptoms? No. Is prayer often – does prayer often result in mitigating symptoms? Yes.”

Prayer is Efficacious

Some of the concepts that arose from the data, in regard to this theme, refer to the “centering”, “grounding”, and “emotionally regulating” properties of prayer. One participant spoke to the relationship with Christ as beneficial in and of itself. This participant stated,

“I will say that if people have Christianity, if they have Christ, if they are a believer, you know, I definitely think that that, in and of itself, mitigates their emotional difficulties.” The same participant also reported, *“I definitely think it’s a protective factor, and I think it – you know, there have been times where if I’ve got a really good relationship with somebody ... and we have a good therapeutic alliance ... and I know ... Christianity fits with their culture, faith system ... I feel like it can be a support to them.”*

One participant focused on the “centering” and “emotionally regulating” qualities of prayer. This participant reported,

“having a centering experience where a client is routinely grounding themselves and is taking stock of their thoughts and their feelings and their arousal, and typically my clients who frequently pray are good at that, at that pausing and gathering of themselves, which is, I think, really helpful in managing emotional arousal.”

Another participant stated the following in regards to the “centering” and “grounding” properties of prayer: *“the centering prayer is a way of learning how to come to a quiet mind so that you’re not all monkey-mind, you know, but it helps people who have a lot of anxiety in learning how to ground and come back into their bodies and come back and be with where they*

are rather than so future and anxiously oriented ... the breath prayer is another form of prayer, of just taking in peace and releasing as they exhale whatever it is they're anxious about or angry about ... to help them in regulating themselves and their emotions."

Prioritizing Prayer is Dependent on the Setting and the Client

Participants were asked to rank the value of prayer against other forms of spiritual/religious interventions (i.e. scripture reading, worship, meditation, attending religious services, etc.). One participant stated that it depends on the setting in which they do therapy. This participant stated,

"that question is also going to depend on the setting of where – you know, if it was a church and they're coming to their pastor for counseling."

Another subject, who practices from a "Biblical counseling" framework, stated that they pray in every session with their participants. This participant stated that he does not see prayer as an intervention to be ranked against other spiritual/religious interventions, in order to mitigate emotional and/or mental suffering. This participant stated,

"I don't see prayer as an intervention in the classic sense of what it means in a psychotherapy office...I see it as a conversation with another person in the office. And so, you know, when we think of interventions from a classic therapy model, we're thinking about a deeper understanding of the client to mitigate symptoms and make them happier ...But is there a high value on it? Is it potentially the most important thing I do here? Yes."

Three participants (75%) stated that the value of prayer, to the exclusion of other interventions, depends on the client. Two participants (50%) stressed the important characteristics of client strengths, spirituality, and symptoms in determining whether or not

prayer is prioritized above other interventions. One participant stated, *“good psychotherapy is all about the client becoming more of who they are. And I think that there are some really great Christians that are terrible prayers, and so being careful not to put that on them ... I don’t know if I would necessarily rank prayer, other than it is a great centering experience for a lot of clients, but I know that there are other manifestations that are equally helpful, depending on who the people are.”*

When focusing on issues of spirituality, one participant stated, *“it depends on how you define prayer, but, you know, prayer is – if we hold it like kind of our way of being with God, communicating and expressing and listening to God, I think that’s pretty central to any of those other activities – worship, community... and I think it just takes on different expressions, whether we’re with other people or in a worship setting or that kind of thing.”*

Participants discussed the intersection of discussing symptoms with prayer. One participant summed it up when they stated: *“But if someone is struggling with, let’s say, pessimistic thinking or obsessive-compulsive behavior, I’m probably not going to – I mean, I’m not saying that prayer wouldn’t be of value at all to them, but I’m probably going to more lean on cognitive behavioral strategies for how to deal with that behavior as a behavior with them first. But that doesn’t mean that I don’t value prayer ... If I start praying with them and they have no connection to that, they’re not going to come back to me, because they’re going to go, ‘What in the world? I’m having obsessive-compulsive behavior, and you’re praying to God about helping me to stop hoarding or help me to ...’ you know, and maybe there might be someone who might say, ‘Hey, it might work.’ But, you know, another person might think, ‘Well, that’s totally irrelevant. I don’t believe that.’ ... So I think it depends on the setting and the population ...”*

The Effectiveness of Prayer in Promoting the Mental Health of Clients

To assess therapist's perceptions on the effectiveness of prayer in promoting the mental health of clients, participants were asked to tell a story about how prayer was particularly effective for a client. The stories that the therapist's told covered a wide range of psychological issues.

One participant reported that in their experience, prayer generated many positive results that impacted clients both physically and emotionally. *"The ones who are already Christian, and if they use it on their own, I think it can be a great support to them. I think that they, you know, are able faster to get off medications, just because they're – it's almost like they're strengthening their own immune system by doing that in a way, and when their immune system is – it's just their emotional system is better. Their immune system can be better, and that affects their physical system, in my view. There's a connection between all of those, spiritual, emotional, you know, immune, biological. So I think those are all stories about how it can be effective."*

Another participant reported a story where prayer was helpful to a client in helping him overcome his addictions. This participant reported, *"This particular person had a real long history of sexual addiction, prostitutes. He just really had a lot of different kinds of addictions, drugs, alcohol, all kinds of stuff. And we worked together for a year and a half or so, two years, and he one by one quit all those addictions, which was pretty amazing ... there was a lot of spiritual abuse in his history. But I'll tell you the two times that I had been more excited than him quitting any drug or anything was when he came in here and he said, 'You know, I was just desperate, and I prayed.' And for him to pray was a big deal, you know, not that he – he has a heart for God, definitely, but God came to him and revealed himself to him and in just really*

precious, precious ways that it was just ... we were just like, wow. But he had two real experiences where God broke through and in a very unique way met him ... it was a real authentic experience he's had with his maker, with God, and from there, we can build an authentic self with him ... it's the foundation of – in the first time, then, he broke all his addictions ... he didn't do any AA or any of the interventions. He didn't go to treatment or anything. He quit alcohol, cocaine, pot, prostitutes, and has been in a serious relationship for a year and a half ... it's very incredible, but that's the power of God.”

Another participant shared the following story about a client who had a poor attachment history with her parents and how, through prayer, the client was able to re-integrate negative emotions and feelings and have a corrective emotional experience with God:

“I've also had a client who – she had a very poor attachment history in which the parenting was very variable and on and off. You're loved, you're kicked out. That just happened throughout her growing up such that she had a lot of rage and a lot of like stops and starts on and off. Her relationship with God very much mirrored that with her parents, and yet she would still pursue God, and she would still pray. And a shift in our therapy came when she was able to be angry with God and pray through the anger that she was having towards her parents, and it was cathartic, and it helped her get perspective and move to like a really healthy place such that at the end of our work together, she had a more integrated view of both her growing up time and then also of God as somebody who was present even, you know, in the midst of pain and was present with her then.”

Another subject shared a story of prayer being effective with one of his clients in helping her to gain insight into how her anxiety was rooted in her narcissism. This participant stated, “I mean, she just fell apart, and she cried harder than I've ever seen her cry. And yet she was

crying tears of deep remorse and sadness and deep tears of joy, because someone had finally helped her pull it apart, and she knew I was speaking truth to her.” At the end of the session, the above participant stated, “I was able to ask God to comfort her, to help her see that her identity and her righteousness is in Christ, that she should find great comfort in that ... And that was the closing prayer, you know, and when I was done, she looked up, again, with tears of joy and said, ‘Thank you’, because that ministered deeply to her, and I believe there were elements in that prayer that really were Holy Spirit fueled.”

Discussion

Summary

The data suggest that prayer is effective, and that the degree of effectiveness depends on a variety of factors (e.g. client spirituality, setting of therapy, client’s abuse history, client’s culture, diagnostic presentation, etc.). The same is true regarding therapist’s positions on the value of incorporating prayer with a particular client. All participants that were interviewed placed a high value on prayer in general, but not all participants seemed to be in agreement with the purpose of incorporating prayer into psychotherapy. For example, one of the participants reported that the purpose of prayer is not necessarily to mitigate symptoms of emotional difficulties and that an individual could pray for comfort and may or may not receive it.

Comparison to Previous Literature

One of the main themes from participants suggests “knowing your client” before making a decision as to whether prayer is a useful resource. This theme suggests that the use of prayer is relative to the client’s subjectivity. For example, three of the participants stated that they would not initiate prayer with a client if they did not know what meaning prayer had for them. Three

participants stated that before utilizing prayer in session with a client, it is important to know what their spiritual history is. Second, prayer may not be an area of strength for a particular client and, therefore, an alternative such as meditation could be utilized. Only one participant would initiate prayer and use it in every session with clients who identify with the Christian faith. Aranda (2008), in her study of 230 Latinos living in the United States sided with using prayer in a cautious manner.

Closely related to this theme of “knowing your client”, is the theme of prayer as “non-directive and client focused”. Three participants, based on their knowledge of who the client was, would not utilize prayer in therapy with a client unless they knew it was something that the client wanted and if it would promote the goals of therapy. Participants suggested that it is important for the client to initiate prayer in the psychotherapy sessions. These results coincide with previous research in this area. Cornish et. al (2011) reported from their study that therapist’s generally will not bring up issues regarding spirituality and religion unless the client initiates those conversations. The research suggested that the use of prayer in therapy is client-sensitive and about meeting the client where they are at. One participant summed it up well when they stated that prayer is a matter of fit, not priority.

The data suggested that prayer is most effective when it happens in the context of a strong therapeutic alliance. Participants also felt that a non-directive style best fits the use of prayer in therapy and allows the client to take the lead in therapy. Juhnke et. al (2009) reciprocated this same finding when they reported that one of the functions prayer served was to create an environment that promotes a sense of leadership and control in the client in regards to the direction of the session. The participants conveyed that if prayer is a strength of the client

and if it is used appropriately, and with a view of sensitivity to the client, it can be effective in mitigating symptoms of emotional suffering.

Data from the current research demonstrated that practitioners who utilize prayer feel that prayer can help facilitate emotional regulation as well as promoting a reparative emotional experience with clients who have had traumatic pasts/childhoods and insecure attachments with primary caregivers. Drescher et al. (2004) reciprocated this finding by reporting that spiritual interventions in general help to promote an environment where clients can process traumatic events. The findings from Sharp's (2010) research study explained this process in more detail, as their data showed that prayer provided an "other" (in the form of God) to disclose negative feelings and emotions to.

Much of the data from this research demonstrated that prayer assists clients in cultivating a sense of being grounded and centered amidst emotional suffering and anxiety. One participant reported a relationship between prayer and the ability to center one's self. The participant stated that clients who frequently pray are also good at centering/grounding themselves, being reflective, and managing emotional arousal. Sharp (2010) reported that as people pray, they are reminded of what is true for them as children of God, which generates a sense of being protected in the midst of emotional arousal. Washington and Moxley (2001) also found that prayer can help clients express themselves and their emotions, and promote self-resiliency in the face of adversity. Washington and Moxley (2001) also echo the same idea that prayer can generate a state of self-reflection in clients that assists in managing emotions (Washington & Moxley, 2001).

Implications for Further Research

In the data, there were ideas and concepts related to attachment theory that would frequently emerge, such as emotional regulation, integration, and insecure/secure attachments with caregivers. It was interesting to see that for some, who express a belief in God, have a relationship with God that follows the same relational patterns as their caregivers in childhood. According to one participant, if the early relational patterns consisted of inconsistent attunement and conflicting/mixed signals of acceptance/abandonment from the parent, clients are likely to experience the same relational patterns with God. The idea that prayer could be used as a way of creating a “holding” environment to recreate and reshape the early negative attachments of childhood within the framework of a secure attachment experience with God is an interesting concept. Secondly, within this framework of a secure attachment with God, some clients are able to process and integrate past trauma and hurt through prayer to God. Future research could explore the nature of the relationship between prayer and secure/insecure attachment relationships.

It was also interesting that, for the majority of the participants, the approach to the utilization of prayer in therapy is a cautious one. It is generally not initiated by the therapist, but by the client, and even when it is initiated by the client, the therapist will still treat the area with the utmost sensitivity. Only after the therapist thoroughly assesses what prayer means for the client, and if it would serve to promote the goals of therapy, they will explore prayer in a way that is meaningful for the client, with the client taking the lead.

Christian therapists should be aware that if prayer is initiated in session with the client without sensitivity to the client’s background, history, and culture, it could potentially be damaging to the therapeutic relationship. If prayer is utilized inappropriately in this way, the findings suggest that it would not only be seen as a demonstration of the power differential

between therapist and client, but it may also run the risk of enabling clients to use prayer in a manipulative way, in order to give air to the interpersonal grievances they experience in their relationships. The findings also suggest that if prayer is used inappropriately, it may only give the illusion of work being done. That is, sometimes clients use prayer as a means of avoiding real work and dealing with real issues. Future research could explore the use of prayer in therapy from the perspective of the client.

Implications for Social Work Practice

From the findings, it is suggested that prayer is not a “cure-all” approach to mitigating symptoms of mental illness. In some cases, prayer may not be a part of therapy process at all. Therefore, Christian social workers should be open to explore a variety of spiritual practices with their clients. However, because clients are subsystems of other systems/environments of religion, Christian social workers are likely to engage clients with spiritual practices that are foreign to or go against their belief system. Therefore, it is the ethical and professional responsibility of the Christian social worker to be honest with their clients about their limitations and boundaries with some spiritual practices.

The findings also suggest that Christian social workers should allow the client to initiate prayer. The implication from the findings is that if Christian social workers initiate prayer, it may run the risk of potentially offending the client and/or damaging the therapeutic alliance. The findings suggest that if the therapist initiates prayer in therapy, it may be more about the therapist’s agenda than the clients. Therefore, one suggestion is that Christian social workers practice self-awareness in order to identify biases and areas of countertransference that may

inform their decision to initiate prayer. Practicing self-awareness will also inform the Christian social workers' development as a competent clinician.

The findings of this research stress the importance of the therapeutic relationship and “knowing the client” as more important than whether or not prayer is used in therapy. If the therapist does not know much about the client and the client wants to engage in prayer in the session, the findings encourage Christian social workers to promote an atmosphere of exploration with the client instead of strictly prohibiting certain spiritual practices. Secondly, in order to get a better understanding of a particular client's spirituality, Christian social workers can account for this on their intake measures.

The findings of this research suggest the importance of being trained in the use of spiritual practices. Hodge (2010) reported the following: “Practitioners receive little guidance regarding the use of spiritual interventions ... during their graduate educational programs.” Therefore, in the name of competent and ethical practice, Christian social workers should supplement their practice knowledge with continual education on the various types and uses of spiritual interventions.

Limitations of the Study

A weakness of this study is that only four participants were able to be interviewed and these participants were all professed Christians. Therefore, the findings cannot be generalized to a larger population. Another weakness of the study was that only the perception of therapists were studied and not the perception of the client. It would be interesting to determine if clients, who utilize prayer in therapy, share the same perspective as the therapist.

Conclusion

The use of prayer in therapy is a practice that needs to be client-led if it is to have any significance for the client and for therapy. If it is initiated by the therapist and unwelcome by the client, it could be potentially devastating for the therapeutic relationship and the goals of therapy. However, if prayer is approached in a client-sensitive way, it is shown to be effective for the client and in promoting trust in the therapeutic relationship. Prayer promotes the ability for clients to center and ground themselves in the face of anxiety-provoking stimuli. Prayer can also help clients manage their emotions, process/integrate past events in an adaptive way, and gain perspective. If both therapist and client share the same faith (as in the current study), and prayer is something that is meaningful for the client, therapists should be encouraged to explore the use of prayer in therapy.

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Appendix A

Interview Questions

- 1.) What license do you hold?
- 2.) How long have you been practicing as a licensed clinician?
- 3.) What has your theoretical training been?
- 4.) Has your faith played a part in becoming a mental health therapist?
- 5.) Are there specific experiences with the client that promote the utilization of prayer as an intervention in therapy?
- 6.) What prompts you to use prayer with your clients?
- 7.) Are there situations with clients where you wouldn't use prayer?
- 8.) Do you experience prayer as a major variable in mitigating symptoms of emotional difficulties?

9.) In terms of prioritizing the value of religious/spiritual interventions in psychotherapy, how would you rank prayer?

10.) Tell me a story about how prayer was particularly effective for a client.

Appendix B

Email Script

Hello. My name is Paul Dirkse, a graduate student of the University of St. Thomas's and St. Catherine's Masters of Social Work program. I'm currently in the beginning stages of embarking on the research project for my clinical paper. The area I want to focus on is Christian therapist's attitudes and perspectives on the efficacy of prayer in Christian settings. The purpose of the study is to see how prayer is used, from a Christian perspective, with clients in therapy; how it is believed to be effective; and Christian therapist perceptions of its use in therapy.

I believe that the role of Christian prayer in Christian therapy is not a topic strongly addressed in current research literature. There are many studies done on the use of "spiritual interventions" and/or "religious interventions", in general, in mitigating symptoms of mental illness in various different populations and demographics. Out of these studies, prayer (not necessarily Christian) is generally indicated as one of the most helpful of the spiritual interventions used. Other spiritual interventions include things such as scripture reading, meditation, and attending religious services. Since prayer has been indicated, in many studies, as being the more utilized of spiritual interventions, I would like to provide a closer look at the use of prayer, by Christian therapists, in Christian settings with a purpose of gaining insight as to how it is believed to be effective in lessening the symptoms of mental illnesses.

I'm seeking to interview Christian LICSWs and/or Christian psychologists for my research in this area, and if you are receiving this email, it means that your name has been obtained through a random internet search of Christian therapists, in the Twin Cities Metro area. I would like participants to have 3+ years of experience as licensed clinicians. What I'm asking of potential participants is that they commit to meeting for a one-on-one interview with me, which will last

anywhere between 30 and 45 minutes. I can also provide you a copy of the interview questions prior to the interview.

I would be greatly appreciative if you would be willing to be a part of this process!

If you would be willing to participate in my study, please call me at 123-456-7890

Thanks,

Paul Dirkse