

2004

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Fernando L. Garzon

Liberty University, fgarzon@liberty.edu

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Recommended Citation

Garzon, Fernando L., "Cognitive Restructuring Through Contemplative Inner Healing Prayer: Clinical Demonstration and Current Research" (2004). *Faculty Publications and Presentations*. 41.
https://digitalcommons.liberty.edu/ccfs_fac_pubs/41

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Cognitive Restructuring Through Contemplative Inner Healing Prayer: Clinical Demonstration and Current Research

Fernando Garzon

Introduction

At times, when spiritual interventions are adapted to the clinical context, the overtly spiritual dimensions of the intervention are omitted to permit research and to expand the client base available for the intervention. For example, forgiveness protocols have been developed for the clinical context (Enright, 2001; Worthington, 2001); however, these protocols are secular in that they do not intentionally use the client's spirituality in their implementation or in the research supporting them (Garzon et al., 2002). Now is the time to examine in the clinical and research context overtly spiritual interventions in a form that intentionally uses a client's religiously congruent resources.

Many Eastern and Western religious traditions use contemplative prayer forms in the spiritual and emotional healing process. For instance, Mindfulness Therapy (Segal, Williams, & Teasdale, 2002) demonstrates the value of resources found in an Eastern religious tradition. More exploration of diverse religious faiths is needed however.

This sample clinical demonstration continues the exploration through describing the specific use of resources found in a Western faith tradition. Contemplative inner healing prayer in a form that specifically uses this client's spiritual resources in the cognitive restructuring process will be seen.

Identifying Information and Presenting Problem

George T. is a 30-year-old, single, White construction worker who has never been married and is high school educated. He presented for counseling with complaints of depression, suicidal ideation, low self-esteem, and insomnia. He describes depressive episodes occurring “on and off” over the last 10 years and agreed to a contract with his therapist to monitor thoughts of self-harm. “I’ll never amount to anything . . . I’m a loser” are his common statements.

Presently, George is most discouraged about his lack of progress in any career goals. He has held various blue collar jobs since high school, but he really wants to be a pilot; however, “They’d see right through me,” he laments.

Clinical History

George has never been in therapy. He reports having had suicidal thoughts as an adolescent, although he states he never attempted suicide. His father, an alcoholic, physically abused both him and his mom. The father died 3 years ago of cirrhosis of the liver. His mother suffered from recurrent bouts of depression and thus was periodically absent from George in terms of supplying maternal nurturing when he was growing up. He did not know of any other mental illness in his family.

George’s medical history is unremarkable. His developmental history also appears normal. He was involved in several sports growing up and did have some friends. These friendships, however, lacked depth and primarily involved common sporting events. George started dating when he was 16, but sadly his relationships from then until now have all been short-lived (1 week to 4 months at the most). He was sexually active until his religious conversion a year ago. Partly in reaction to his father’s behavior, George has not used alcohol or other drugs throughout his life.

George’s family did not have a religious affiliation when he was growing up. He “got saved” a year ago primarily through a coworker friend who became a born-again Christian and took him to a revival

meeting. His newly found religious faith has given him added incentive to keep from attempting suicide despite the recurrent depressive episodes. Since then, he has attended a local Baptist church and experiences more social support; however, he also worries that one day they will find out just “how much of a loser I really am.” “I know God loves me, but I still feel good-for-nothing,” he states.

Therapy Progress

Despite 3 months of cognitive therapy, George still believes he is worthless and a failure. He has honored his suicidal contract, and presently he is trying his second antidepressant under a psychiatrist’s supervision. Thus far, little remission of symptoms has occurred. Last week, I discussed with George the possibility of using some inner healing prayer that is tailored to his faith tradition as a part of treatment. He appeared very interested and took some general information on the prayer form home with him to read.

Inner Healing Prayer Session

The prayer form was again discussed with George at the beginning of the session, and he understood that he could stop the prayer at any time. He was asked to close his eyes and focus on his core belief, “I’m a loser.” I encouraged him to feel the feelings around this belief and to signal when he was in touch with some strong emotions. George readily got in touch with feelings of discouragement, despair, and hopelessness. At this point, a religiously congruent affective bridge took place. God was asked to take George to the key place in the past where these feelings and beliefs originated, and George was encouraged to report anything he saw, sensed, heard, or felt in his body.

George immediately drifted to one of his many baseball games when he was 10 years old. It was the ninth inning with two outs. His father was in the stands and the bases were loaded. George bunted the ball and was thrown out. As he walked off the field, his father was cursing and screaming at him about what a loser he was. In the

session, tears streamed down George's face as he described the scene. He then drifted to being in the bathroom after the game, contemplating killing himself with a razor blade. As George described the painful memory, I jotted down the key thoughts I heard: "You're just a loser . . . I can't believe you're my son . . . You're a piece of _____."

Instead of doing what is normally done in working on the cognitive restructuring, George was asked to focus on his thoughts, permitting the feelings they involved without resisting them. This was similar to an exposure treatment commonly seen in Post Traumatic Stress Syndrome (PTSD) work (e.g., Foa & Keene, 2000). As George got in touch with the feelings, focus was placed primarily on his deep anger and shame. He was able to acknowledge their depth and the fact that the anger was now hurting him. Here again is a divergence from typical cognitive PTSD work. Instead of restructuring beliefs around the harmful anger, we prayed together and asked God for the grace to do what George could not—lift the anger off his soul. George felt God's presence and help in lifting it off, then we returned to the mental image he had in the bathroom after the game.

At this point, we repeated the cognitive-affective exposure sequence, except this time when George got in touch with the feelings, Jesus was asked to come and reveal His truth to George about these beliefs in whatever way He chose. George grew quiet and calm. "I have a sense of Jesus here with me in the bathroom," he said. "He wants me to know He loves me. I'm not a loser. I'm His son." George's tears changed from anguish to joy. I asked him how strong his desire was to kill himself now and he stated it was not there. It was lost in God's love. The prayer time ended with me asking God to fill up the wounded parts of George's soul with His loving Spirit.

After the prayer, we processed what had happened. He felt deeply moved and very positive about the experience. He believed it had significantly diminished the intensity of his core negative belief about being a loser, and together we agreed to use the prayer form as an ongoing part of his treatment. Although his suicidal ideation now felt greatly diminished, we would still monitor it in the future. The prayer form would be combined with regular cognitive therapy and his antidepressants as appropriate.

Summary

Clearly, the culturally specific use of George's spiritual resources was helpful in this case. The religiously congruent form of prayer applied with George appeared to begin the restructuring of his key maladaptive cognition ("I'm a loser."). He now has a deeply meaningful faith-related treatment experience to provide alternative evidence to dispute a very negative life-long belief. Indeed, this form of prayer will be drawn upon in the future to help in the cognitive restructuring process because it appears to be a useful part of George's on-going treatment.

It is extremely important in tailoring an intervention like the above to do a thorough religio-spiritual assessment in order to prevent spiritual abuse in the counseling setting. For example, had George come from an Eastern or Native American tradition, other prayer forms would have been available for consideration instead of this one. Provided careful assessment is done and appropriate ethical guidelines are applied, adapting interventions to capitalize overtly on a client's spiritual resources in therapy shows great potential.

Conclusion

With the exception of Mindfulness Therapy (Zindel, Williams, & Teasdale, 2002), research is at a very early stage with other forms of contemplative inner healing prayer. Current case study and survey data on one form of such prayer (Theophostic Ministry) has yielded clinically significant changes in client symptom levels and high degrees of client and practitioner satisfaction (Garzon et al. 2002a, 2002b). More such research is needed and randomized clinical trials appear warranted.

Because counseling now embraces spirituality as a legitimate part of treatment, let us learn all we can about strategies that are more specifically tailored to the particular faith dynamics of our clients. Future clinical and empirical evaluation of these strategies will be informative as we tap this very important area of our clients' experience.

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