A Randomized Investigation of Evangelical Christian Accommodative Mindfulness

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Abstract

The purpose of this study was to investigate the impact of religiously accommodative mindfulness compared to traditional mindfulness on stress, anxiety, and depression in an evangelical Christian college sample using a randomized trial design. Volunteer participants (n=78) were randomly assigned to one of two treatment conditions. The Christian mindfulness training (CMT) group protocol was explicitly adapted to the evangelical Christian faith, while the conventional mindfulness training (MT) group protocol utilized typical mindfulness meditations. Participants completed three weeks of treatment that included psycho-educational group sessions and prescribed daily applications of the mindfulness techniques. Post-treatment differences between the two groups were then compared on the measures. Measures used included the Perceived Stress Scale (PSS, Lee, 2012) and the Depression Anxiety and Stress Scale (DASS, Lovibond & Lovibond, 1995). Results indicated significant differences within and between groups, with the CMT group reporting lower levels of stress and depression compared to the MT group, as well as lower overall negative symptoms based on total DASS scores. CMT group participants also reported significantly greater treatment compliance in comparison to MT group participants. Findings provide preliminary support for potential differences in treatment outcomes when religious accommodations are made to mindfulness. Limitations and recommendations are considered.

Keywords: mindfulness, religiously accommodative treatments, Christian meditation
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Multicultural sensitivity requires the conscientious consideration of a client’s personal belief system in the administration of ethical and effective clinical treatments (Sperry, 2010). *Religiously accommodative treatments* seek to enhance empirically supported treatments and increase therapeutic effectiveness by adapting or adjusting interventions as needed to respectfully incorporate the worldview of the client (Tan, 2013). Religious clients may be cautious and resistant toward psychotherapy due to concerns that the therapist may disregard, misunderstand, or even disdain their faith (Hathaway & Tan, 2009). By maintaining a knowledgeable respect for the unique cultures that contribute to personal worldviews and developing increased spiritual awareness (Miller, 2011), practitioners that employ religiously accommodative treatments may avoid unnecessary resistance and encourage a collaborative dialogue on the integration of religion and spirituality in psychotherapy (Tan, 2013).

Second wave cognitive behavior therapy (CBT) has led the way in research on spiritually integrated treatment by encouraging religious accommodation in clinical treatment (Worthington, Hook, Davis, & McDaniel, 2011). For example, Hawkins, Tan, and Turk (1999) compared the effectiveness of a traditional CBT protocol to a Christian CBT protocol, finding that while both were effective in reducing symptoms of depression, the accommodated CBT resulted in greater improvements on measures of spiritual well-being in a religious sample. Empirical support for religious accommodation continues to grow, with several outcome studies demonstrating the efficacy of religiously or spiritually modified second wave CBT (Tan & Johnson, 2005).
Mindfulness as a Religiously Accommodative Treatment

As research on religiously modified CBT expands, third wave CBT approaches, such as dialectical behavior therapy (DBT; Linehan, 1993), acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 1999), and mindfulness based cognitive therapy (MBCT: Segal, Williams, & Teasdale, 2002) contribute consistent empirical support for the inclusion of techniques that emphasize spirituality (Tan, 2011). Specifically, the clinical application of mindfulness, which serves as an essential element of these approaches, is correlated with multiple mental health benefits (Shapiro, Oman, Thoresen, Plante, & Flinders, 2008). Meta-analytic reviews indicate impressive empirical support for mindfulness practice in the alleviation of a wide variety of mental health symptoms including stress, anxiety, and depression (Goyal, Singh, Sabinga, et al., 2014; Hofmann, Sawyer, Witt, & Oh, 2010).

Although common in mental health practice, the methodology of mindfulness may be difficult to define due to differing religious traditions and varying instructions for the practice of mindfulness (Chiesa & Malinowski, 2011). Buddhist approaches to mindfulness include Vipassana meditation (Gunaratana, 1993) and Zen meditation (Kapleau, 1965), while the modern psychotherapeutic practice of mindfulness includes evidence-based, standardized protocols such as mindfulness-based stress reduction (MBSR; Kabat-Zinn, 1990). Religious traditions often focus on mindful meditation as a spiritual activity that serves to enhance personal reflection, concentration, and the experience of transcendence, rather than just as an intervention to reduce psychological distress (Davidson & Kaszniak, 2015). Nevertheless, purposeful awareness and non-judgmental acceptance of moment-to-moment experience seem to comprise the essence of the mindfulness definition, regardless of tradition (Keng, Smoski, & Robins, 2011).
Mindfulness practice also claims origins in Christian contemplative tradition (Tan, 2011). However, the methodologies associated with both secularized protocols for mindfulness and Buddhist meditation practice present philosophical problems for some individuals that are devoted to a Christian worldview. For example, because Christian doctrine asserts that God is personal, knowable, and nameable (Erickson, 1998), a Christian religious accommodation of mindfulness practice suggest that an awareness of God within each present moment as a personal being who is separate from internal and external experience may be useful (Garzon & Ford, 2016). Without such an inclusion, some evangelical Christians might consider mindfulness meditation to be too closely aligned with eastern religions or to go against various dogmas within their tradition. Accordingly, studies on such participants are needed to compare mindfulness techniques that exclude critical Christian worldview components with those that include such components.

**Experimental Religiously Accommodative Mindfulness Outcomes**

While qualitative studies exploring mindful meditation from various Christian traditions exist (e.g., Knabb, 2012; Blanton, 2011; Bingaman, 2011), few quantitative experimental studies exist. Some have examined the impact of a broad-based spiritual meditation that could be tailored for participants preferring religious accommodation in mindfulness treatment. For example, in 2005, Wachholtz and Pargament compared spiritual meditation to secular meditation and relaxation, finding better outcomes for spiritual meditation participants on measures of anxiety, mood, spirituality, and pain tolerance. In 2008, Wachholtz and Pargament further examined the impact of spiritual meditation, with positive outcomes for physical pain endurance and the reduction of psychological symptoms.
Current experimental explorations of religiously accommodative mindfulness specific to monotheistic religions such as Islam, Judaism, and Christianity are lacking. Researchers have examined at least one method of Christian meditation that has similarities with transcendental meditation (a form of eastern meditation with some similarities to mindfulness). Centering prayer, a meditative prayer form used by some Orthodox, Catholic, and Protestant Christians, is an exercise that emphasizes silence, stillness, and the repeating of a sacred term to ponder when the mind wanders. It is contrasted with other well-known methods of prayer that are more verbally and mentally active (Pennington, Keating, & Clarke, 2002). Ferguson, Willemsen, and Castaneto (2010) found positive outcomes in an exploration of the impact of centering prayer on stress. An additional study examined the impact of centering prayer on women receiving chemotherapy treatment for ovarian cancer, finding positive outcomes on measures of mood, spiritual well-being, and quality of life (Johnson et al., 2009). More studies on strategies reflective of accommodation to varying religious worldviews are needed, including the impact of such accommodation on distinctive categories within the broader Christian community such as Protestant, Roman Catholic, and Eastern Orthodox. The current randomized study compared an accommodative mindfulness protocol tailored for evangelical Protestant Christians with a traditional mindfulness protocol on stress, anxiety, and depression in a mixed Christian college sample of faculty, staff, and students.

Method

Participants

Participants were recruited from individuals associated with a private, Christian college, including current students, alumni, faculty, staff, and/or spouses of any of these groups. This sample consisted of volunteers (n=78), both male (42%) and female (58%), who self-reported as
belonging to the evangelical Christian faith. Participants reported an average age of 27 years (range: 18-66), with 73% ranging in age from 18-25. 37.2% of participants were married, 61.5% were single, and 1.3% were divorced. In terms of ethnic identity, 91% identified as Caucasian, 5.1% as African-American, 2.6% as Latino, and 1.3% as Other. Participants reported an average of length of time as a Christian of 15.26 years (range: 0.42-57).

Ninety-nine study applicants completed intake, with random assignment resulting in 49 participants in the CMT group and 50 participants in the MT group. Ninety-one participants completed all pre-assessments and attended the first group meeting, resulting in a total of 42 participants assigned to the CMT group and 49 participants assigned to the MT group. Immediately following treatment, 36 CMT participants and 42 MT participants completed post-assessments, resulting in a final sample of \( n = 78 \). The completion rate for both groups was identical at 84%.

**Procedure**

In this study, the two treatment groups were distinguished as either Christian mindfulness training (CMT), defined as open present-moment awareness that has been explicitly adapted to accommodate a Christian worldview, or conventional mindfulness training (MT), defined as open present-moment awareness that lacks explicit adaptation to accommodate a Christian worldview. Screened participants were randomly assigned to one of two conditions: CMT or MT. Three distinct mindfulness protocols were used in each group, one for each of the three weeks, to reflect the core principles of mindfulness practice as proposed by Shapiro, Carlson, Astin, and Freedman (2006) including attention, attitude, and intention. The first week’s protocol, a breath exercise, focused on the principle of attention by increasing awareness of the breath. The second protocol, a body scan exercise, emphasized the principle of attitude by
encouraging an open and compassionate stance toward personal experience. The third protocol, a prayer meditation for the CMT group (Johnston, n.d.) and a loving-kindness meditation for the MT group (Levine, 1991), provided an opportunity to practice the principle of goal-oriented intention through the experience of giving and/or receiving love and grace. The accommodative mindfulness transcripts may be found in Garzon and Ford (2016). The traditional mindfulness transcripts were adapted from Levine (1991) and Kabat-Zinn (2002).

Individuals in both groups participated in three weeks of treatment including weekly large-group meetings and prescribed daily mindfulness exercises. The CMT and MT groups met separately on the college campus for weekly sessions that consisted of a psycho-educational lecture on mindfulness by the researcher followed by the demonstration and collective practice of one of the three mindfulness protocols. After each group session, CMT and MT participants were asked to practice the prescribed exercise throughout the following week by listening to an audio of the same exercise practiced in group and then recording their experience in a daily log. The audio recordings ranged from 7-20 minutes in length and the log included columns to detail the date, time started, and time ended, as well as a rating scale to self-report perceived success in application of the mindfulness technique in terms of remaining aware and open throughout the exercise. The logs were collected by the researcher for review at the end of the three weeks.

Measures

**Depression Anxiety Stress Scales (DASS).** The DASS is comprised of 42 items that measure the frequency of symptoms of psychological distress during the previous week, loading on three subscales for Depression, Anxiety and Stress (Lovibond and Lovibond, 1995). Research has established the validity and reliability of the DASS as a psychometric instrument and a shortened version with 21 items has been developed (Antony & Barlow, 2010), which was used
in this study.

**Perceived Stress Scale (PSS).** The PSS uses 10 self-report items to assess levels of generalized stress by evaluating the degree to which an individual perceives life as unpredictable, uncontrollable, and overloaded during the previous month (Lee, 2012). Initial research indicated good internal consistency (Cohen, Kamarck, & Mermelstein, 1983), and continued research suggests strong support for the validity and reliability of the scale (Lee, 2012).

**Results**

Statistical analyses consisted of a series of paired samples and independent samples t-tests to compare within and between group differences, assessed at the $p < .05$ level of significance.

**Within groups.** Post-treatment data from the DASS-S indicated statistically significant CMT within-group differences [$t(35) = 3.51$, $p=.001$] and medium effect size ($d=.6$), with a mean difference of 3.94 from baseline ($M=10.22$, $SD=7.36$) to post-treatment ($M=6.28$, $SD=5.56$), and smaller MT within-group differences that were not statistically significant [$t(41) = 1.56$, $p = .126$], with a mean difference of 1.74 from baseline ($M=11.02$, $SD=7.25$) to post-treatment ($M=9.29$, $SD=6.99$). Post-treatment data from the PSS indicated statically significant CMT within-group differences [$t(35) = 3.42$, $p=.002$] and small effect size ($d=.46$), with a mean difference of 2.97 from baseline ($M=16.92$, $SD=6.9$) to post-treatment ($M=13.94$, $SD=6.1$), as well as for the MT group [$t(41) = 2.63$, $p=.012$] with a small effect size ($d=.36$) and a mean difference of 2.76 from baseline ($M=18.29$, $SD=7.8$) to post-treatment ($M=15.52$, $SD=7.6$).

**DASS-S.** The assumption of homogeneity of variance was assessed with Levene’s test and indicated no significant differences between groups prior to treatment on either the DASS-S ($F=0.01$, $p=.94$) or the PSS ($F=0.01$, $p=.92$). Following treatment, independent samples t-tests
comparing post-assessment means indicated significant between-group differences for participant data on the DASS-S \[t(76) = -2.08, p=.04, \text{two-tailed}\], indicating that participants from the CMT group reported significantly lower levels of perceived stress post-treatment \((M = 6.28, SD = 5.56)\) than the MT group participants \((M = 9.29, SD = 6.99)\), with a medium effect size \((d=.5)\). The CMT group reported a greater change in means on the DASS-S from pre-test to post-test \((M=3.94, SD=6.74)\) compared to the MT group \((M=1.74, SD=7.2)\), but this difference between groups was not statistically significant \[t(76) = 1.39, p=.17, \text{two-tailed}\].

**PSS.** No significant between-group differences were found on the PSS \[t(76) = -1, p=.32, \text{two-tailed}\]. The combined results of the DASS-S and PSS partially indicated greater reductions in the perception of stress for the CMT group compared to the MT group.

**Total DASS.** Post-treatment analysis of the overall DASS scores (the sum of the three subscales: Depression, Anxiety, and Stress) indicated significant results both within and between groups. A paired samples t-test indicated statistically significant within-group differences on the DASS for the CMT group \[t(35) = 2.81, p=.01\] and small effect size \((d=.43)\), with a mean difference of 5.86 from baseline \((M=18.89, SD=15.29)\) to post-treatment \((M=13.03, SD=11.41)\), but did not indicate statistically significant within-group differences for the MT group \[t(41) = 1.32, p=.2\], with a mean difference of 3.1 from baseline \((M=23.4, SD=15.87)\) to post-treatment \((M=20.31, SD=16.27)\). Additionally, results suggested significant between-group differences for participant data on the total DASS score \[t(76) = -2.25, p=.03, \text{two-tailed}\] with a medium effect size \((d=.52)\), indicating that CMT participants reported significantly lower overall scores on the combined Depression, Anxiety, and Stress subscales post-treatment \((M = 13.03, SD = 11.41)\) than MT participants \((M = 20.31, SD = 16.27)\).
**DASS-D.** Post-assessment means also indicated significant between-group differences for participant data on the depression (DASS-D) subscale \[ t(76) = -2.29, p=.03, \text{two-tailed} \] with a medium effect size \((d=-.53)\), with the CMT group reporting significantly lower overall scores on the Depression subscale post-treatment \((M = 3.39, SD = 3.74)\) compared to the MT group participants \((M = 6.19, SD = 6.47)\). No significant within group differences were indicated.

**DASS-A.** No significant between-group differences were indicated on the anxiety (DASS-A) subscale.

**Treatment adherence.** Results from this study indicated significant between-group differences in treatment compliance, defined as the percentage of self-reported days that the participant completed the mindfulness practice as prescribed. Participants were asked to keep a daily log indicating the date and the start and stop time for each completed mindfulness exercise, with a total of 21 possible treatment days. Participants in the CMT group reported a greater percentage of treatment compliant days \((M=.99, SD=.04)\) in comparison to participants in the MT group \((M=.83, SD=.21)\), with statistically significant results \([t(76), p<.001]\).

**Discussion**

In this Christian college sample, both the regular mindfulness training (MT) and Christian accommodative mindfulness training group (CMT) lowered participants reported stress, with the CMT group finding more consistent (both measures of stress significantly reduced) and slightly greater stress reduction than the MT group. The CMT group participants also reported greater overall reduction of psychological distress suggested by significant post-treatment differences on the total DASS score compared to MT group participants. The CMT group also exhibited a significantly higher rate of treatment adherence.
The findings are informative on the potential for developing religiously accommodative mindfulness treatments. Religiously accommodative treatments seek to yield to client preference (Hook, Worthington, Davis, Jennings, & Gartner, 2010) in an effort to enhance treatment outcomes. Numerous empirical studies and meta-analytic reviews have supported the effectiveness of mindfulness as an intervention for lowering stress, anxiety, and depression (e.g., Fang et al., 2010; Chiesa & Seretti, 2009; Shapiro, Oman, Thoresen, Plante, & Flinders, 2008). In this study with a normal sample and with the psychological measures’ scores all within the subclinical range, religious accommodations resulted in preliminary potential differences in treatment outcomes. The effect sizes for these differences ranged from small to medium, but invite further research (See Limitations and Recommendations for Future Research below).

The finding of treatment adherence differences reinforces a premise for religious accommodation, that being that such culturally sensitive adjustments can decrease client resistance and increase treatment compliance (Worthington, Hook, Davis, & McDaniel, 2011). This finding has been noted in some religiously accommodative second wave cognitive behavior therapy studies (Worthington, Hook, Davis, Gartner, & Jennings, 2013) and now has appeared in this third wave mindfulness study. The accommodated intervention may be useful for clinical settings as well as for pastoral and lay counseling contexts, where the need for researched techniques that have been purposely adapted for religiously conservative clients may be even more critical.

**Limitations and Recommendations for Future Research**

Several limitations of this study should be considered. A clinical sample would be particularly optimal for assessing the impact of Christian accommodated mindfulness on various mental health concerns in future studies. Additionally, the impact of mindfulness
accommodation on measures of spirituality and religious coping is recommended. Future studies should consider multicultural factors beyond religious worldview such as personal values, belief systems, or individual personality differences that may contribute to resistance toward mindfulness practice. Moreover, previous research on mindfulness practice suggests that a longer time frame for treatment application may result in increased measurable outcomes. For example, an 8-week protocol would approximate the treatment length for some Mindfulness-Based Stress Reduction programs, while the addition of a control group would further strengthen the study design. Finally, due to an acquaintance with the personal faith of the researcher, participants in the MT group may have presumed an inherent Christian worldview in the treatment, lending to increased trust and credibility for the researcher that might not be present with a therapist whose worldview was hidden or unknown.
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