

SPIRITUALLY FOCUSED MINDFULNESS MEDITATION: AN INTERPRETATIVE
PHENOMENOLOGICAL ANALYSIS OF THE EFFECT OF SPIRITUALLY FOCUSED
MINDFULNESS MEDITATION ON DEPRESSION WITH A CLINICAL POPULATION

by

Grace Lynn Bellingham

Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Philosophy

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ABSTRACT

This interpretative phenomenological analysis explored the use of spiritually focused mindfulness meditation for clinical depression. Although antidepressant medication and cognitive behavioral therapy are the leading evidence-based treatments for clinical depression, major depressive disorder is recurrent, and progressive and relapse rates are increasing. Numerous studies examining the use of complementary and alternative medicine therapies, which include the use of meditation to treat depression, have emerged in the literature. In this study, three individuals who met diagnostic criteria for major depressive disorder used spiritually focused mindfulness meditation for three weeks and participated in in-depth interviews to explore their experiences. Findings revealed significant improvement in the biological, psychological, social, and spiritual symptoms of clinical depression. Findings also supported the importance and value of clinicians including consideration of spiritual beliefs as part of the intake process and gave support for the use of spiritually focused mindfulness meditation to improve treatment outcomes for depression. Considering that biological, psychological, social, and spiritual impairments coinciding with depression often persist following treatment and increase risk of relapse, the capacity of spiritually focused mindfulness meditation to positively affect these changes would provide important meditation-based treatment and prevention.

Keywords: major depressive disorder, meditation, spiritually focused mindfulness meditation, biological, psychological, social, spiritual, treatments, Christian mindfulness.

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List of Abbreviations

American Psychiatric Association (APA)

Antidepressant Medication (ADM)

Christian Devotional Meditation (CDM)

Cognitive Behavioral Therapy (CBT)

Complementary and Alternative Medicine (CAM)

Diagnostic and Statistical Manual of Mental Disorders, 5th ed. (DSM-5)

Interpretative Phenomenological Analysis (IPA)

Major Depressive Disorder (MDD)

Mindfulness-Based Cognitive Therapy (MBCT)

Mindfulness-Based Stress Reduction (MBSR)

Religiosity/Spirituality (R/S)

Spiritually Focused Mindfulness Meditation (SFMM)

Treatment as Usual (TAU)

World Health Organization (WHO)

CHAPTER ONE: INTRODUCTION

One of the most feared forms of mental illness, major depressive disorder (MDD) affects some 350 million people, and tragically, one million die by suicide each year. These individuals have a 40 to 60% greater chance of dying prematurely than the general population because of unattended physical health problems such as cancers and diabetes (World Health Organization [WHO], 2013). In that same report, WHO (2013) predicted MDD to be the second leading cause of disability worldwide by the year 2020. In light of a 1999 report by the National Institute of Mental Health indicating that 20 million were suffering from depression that year, it is apparent that the prevalence of the disease is growing exponentially (Yapko, 2006). The National Alliance on Mental Illness (2013) reported depression to be the third most common cause for an individual to be hospitalized. Furthermore, depression accounts for 4.3% of the global burden of disease and is the leading cause of disability, as measured by years lived with disability, and was the fourth greatest contributor to the global burden of disease in 2000 (Martin-Agueda et al., 2006; WHO, 2013).

Adding to that, the incidence of depression is increasing worldwide and is now striking at an earlier age than ever before (Abela & Hankin, 2008; Abela et al., 2005; Birmaher et al., 1996). By the year 2020, Martin-Agueda et al. (2006) predicted, depression is projected to reach second place in the ranking of disability adjusted–life years calculated for all ages and both sexes. Currently, it is reported that depression is already the second cause of disability adjusted–life years in the age category of 15–44 years for the two sexes combined (Martin-Agueda et al., 2006). Finally, Kessler et al. (2005) reported major depression is a common disorder with a lifetime prevalence of about 16%, causing more disability worldwide than any other illness except cardiovascular disease.

Major depression is recurrent and progressive, and impairment can be severe. The pervasive impact of an episode of depression on an individual's life and relationships and the high likelihood that depression will recur, often repeatedly, over the life course make depression a serious mental disorder (Britton, Shahar, Szepsenwol, & Jacobs, 2012; Kessler et al., 2003). More than 20 years ago, studies done in American communities found that people who suffer with MDD average about five episodes during their lifetime (Klein et al., 1985), and those numbers have been steadily increasing (Hilt & Pollak, 2012). Furthermore, per Hammen (2005), theoretical and clinical interest in the causes of depression has shifted from a predominant emphasis on acute, single episodes to a longitudinal perspective on the life course of depression due to the high likelihood that people suffering from depression will experience repeated recurrences of the disorder over their lifetimes (Romero, Sanchez, & Vazquez, 2013).

Additionally, existing research shows an increased understanding of the relationship between depression and, which includes the effects of childhood exposure to stress or stressful major life events and later reactivity to stress in the form of depression, adding to the life course causes of depression (Abela & Hankin, 2008; Folland-Ross & Gotlib, 2012; Hammen, 2005; Hilt & Pollak, 2012; Mazure, 1998; Monroe & Hadjiyannakis, 2002; Monroe & Harkness, 2005). On every front, depression is rising.

Millions of American adults live with major or chronic depression, which disrupts their ability to work well at their jobs; engage in deep, satisfying sleep; eat; connect with others in meaningful interpersonal relationships; and generally, enjoy life. Tragically, some 15% of major depressives will end their lives by suicide (Center et al., 2009). In light of such evidence, the availability and use of effective and safe antidepressant treatments should be considered to lower both morbidity and mortality associated with depression.

In the last two decades, numerous studies examining the use of complementary and alternative medicine (CAM) therapies, which include the use of meditation to treat depression, have emerged in the literature (Kessler et al., 2001). Furthermore, per Kessler et al. (2001), the use of CAM therapies for depression is on the rise. For instance, a recent national survey indicated that more than half of respondents (54%) with self-diagnosed depression indicated that they used some form of CAM treatment for their depression, as compared to 36% that stated that they sought out a physician or other mental health counselor for depression (Kessler et al., 2001). The increased public interest and use of CAM therapies and the simultaneous increase in criticism of current treatments, which include pharmacology, demand detailed exploration of these alternative therapies. Therefore, this query focused on one particularly promising CAM intervention that, in its early stages of research, has been found to be helpful in improving depressive symptoms and preventing relapse—spiritually focused mindfulness meditation (SFMM). More detailed discussion of the literature for treating depression and the substantial results using mindfulness meditation will be found in Chapter Two.

Interpretative Phenomenological Analysis

As a final point, the research modality chosen for this inquiry requires introduction. Because of the intense personal characteristics of depression, especially for a Christian population in whom depression is so often coupled with guilt and shame (Bonelli, Dew, Koenig, Rosmarin, & Vasegh, 2012; Daniels & Fitzpatrick, 2013; Dearing, Stuewig, & Tangney, 2005), an interpretative phenomenological analysis (IPA) was chosen to explore the details of how each participant makes sense of their experience with SFMM as an adjunct to evidence-based treatment for depression therapy (Bloomberg & Volpe, 2012; Smith & Osborn, 2008). Qualitative research, per Kazdin (2011), offers the investigator the means for studying

“individuals and human experience much more intensively” (p. 398) than other research modalities. Using IPA offered this investigator the opportunity to look at the phenomena of depression by facilitating an exploration of the experiential world of the individual participant suffering from depression, something that can neither be analyzed nor quantified, which a quantitative approach purposely evades (Kazdin, 2011). Although there is a profusion of quantitative research on the effects of and treatment for depression, studies investigating the lived experience of depression are minimal, and for the Christian segment of society, almost nonexistent (Center et al., 2009; Craighead & Dunlop, 2014; Cuijpers et al., 2013; Kim, Kim, Ahn, Seo, & Kim, 2013; Symington & Symington, 2009). Consequently, to expand our understanding of depression, IPA as the research methodology is well suited for this investigation. This chapter introduces the purpose and significance of the study, conceptual framework, research questions, assumptions and limitations, and theoretical framework and provides definitions of terms used throughout the study and an introduction to the researcher, ending with a summary.

Purpose of the Study

While much information exists in the current literature contributing to the understanding of the effectiveness of meditation and mindfulness for anxiety, stress, and depression, the significance of this study is that little is available specifically for the religious population, and even less specifically utilizing a spiritually-focused form of mindfulness (Brown, Ryan, & Creswell, 2007; Grepmaier et al., 2007; Kim, 2014; Sephton et al., 2007; Spowart, 2014). Additionally, it appears there are no qualitative studies with a religious clinical population which could reveal possible clinical relevance of SFMM as an aspect of antidepressant therapy. This study was intended to explore the experience and effectiveness of SFMM as a component of

therapy to mitigate the effects of depression. Therefore, the purpose of this qualitative IPA was to explore in detail the lived experience of a select clinical sample presently suffering from MDD, using SFMM for reduction in depression symptomatology.

Conceptual Framework

The conceptual framework is a visual representation of the entire conceptualization of the research, philosophically, theoretically, and methodologically, presenting why the subject is important and why the chosen process is appropriate and rigorous (Ravich & Riggan, 2012). The conceptual framework that grounds this study draws on five theoretical and research-based premises and models: The *Diagnostic and Statistical Manual of Mental Disorders*'s (5th ed.; *DSM-5*; 2013) conceptualization of MDD, current evidence-based treatments for MDD, complementary and alternative treatments for MDD, MDD and the Christian population, and SFMM. The various aspects of this study are presented in a diagrammatic version of this conceptual framework in Figure 1 (Berman, 2013). This conceptual framework provides a structure for organizing and understanding the components of this study (Ravich & Riggan, 2012). A rationale for using an IPA to answer the research questions was also part of the conceptualization of this study and is provided at the conclusion of this section.

The *DSM-5* Conceptualization of Major Depressive Disorder

Although all depressive disorders are characterized by sadness, irritability, and a feeling of emptiness affecting an individual's ability to function, MDD requires an experience of at least one major depressive episode and is distinguished by discrete episodes of depression present nearly every day and for most of the day for at least two weeks (although it can last significantly longer). The first major criterion includes depressed mood (dysphoria) and/or loss of interest or pleasure in nearly all activities. Beyond this, four additional symptoms, including changes in

appetite or weight, sleep, and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thoughts of death or suicidal ideation or suicide plans or attempts, must be present for more than two consecutive weeks for most of the day, every day, and must be accompanied by impaired functioning or cause clinically significant distress. Most often the episodes are recurrent, and therefore acknowledging the risk of relapse is vital when considering treatment (American Psychiatric Association [APA], 2013). Evidence-based practices guide treatment intervention for MDD.

The Limitations of Evidence-Based Practices for MDD

There are several evidence-based treatments for MDD, including: behavior therapy (Sinha & Rush, 2006), cognitive-behavioral therapy (Cuijpers et al., 2017), and interpersonal therapy (Cuijpers et al., 2013). Per a review by Craighead and Dunlop (2014), antidepressant medications (ADMs) and cognitive psychotherapies are among the top two evidence-based outpatient treatments for MDD. The verification for effectiveness of cognitive therapy (Beck, Guth, Steer, & Ball, 1979) for depression is substantial (Butler, Chapman, Forman, & Beck, 2006; Cuijpers et al., 2013; Cuijpers et al., 2017; DeRubeis et al., 2005; DeRubeis, Strunk, & Lorenzo-Luaces, 2016; Tolin, 2010), and it is considered an empirically supported treatment (Chambless et al., 1998). Additionally, what patients learn from cognitive therapy has also demonstrated relapse-preventive effects (DeRubeis et al., 2016; Strunk, DeRubeis, Chiu, & Alvarez, 2007). However, although these treatments are effective for many, some do not find substantial relief from them (Jacobson & Hollon, 1996; Luborsky et al., 2006; Lynch, Laws, & McKenna, 2010; Nemeroff et al., 2003).

Medication treatment is also considered evidence based, either alone or in combination with cognitive behavioral therapy (CBT) or other evidence-based treatments (DeRubeis et al.,

2005; Schramm et al., 2007; Sigal, Dinger, McCarthy, Barrett, & Barber, 2013). According to Preston, O'Neal, and Talaga (2005) a variety of psychotropic medications are currently used to treat MDD. These are divided into five groups: (a) antipsychotic medications, (b) ADMs, (c) mood stabilizers, (d) benzodiazepine/antianxiety drugs, and (e) other drugs (for a full review, see Preston et al., 2005).

Regarding ADMs, no antidepressant class or individual medication has been shown to be more effective than others for treating MDD (Craighead & Dunlop, 2014; Kirsch et al., 2008). Kirsch et al. (2008) conducted a meta-analysis on ADM and revealed numerous concerns in relation to clinical efficacy. Additionally, in trials of ADM treatments, it is difficult to detect true treatment effects due to high placebo response rates in well-controlled trials, as well as explain observed treatment effects in trials with less robust controls (Craighead & Dunlop, 2014; DeRubeis, Siegle & Hollon, 2008; Kirsch et al., 2008). Further, the effect size of antidepressants has been shown to have been exaggerated, due to lack of reporting or selective publication of negative clinical trial data (see Turner, Matthews, Linardatos, Tell, & Rosenthal, 2008). Likewise, while CBT is the most empirically tested of the first-line treatments currently available for individuals with major depression (Barlow, 2008; Carter et al., 2013; Nathan & Gorman, 2007; Sipe & Eisendrath, 2012), there are those who question the validity of the findings based on methodological flaws or insufficient data (Luborsky et al., 2006; Lynch et al., 2010; Parker, Roy, & Eyers, 2003).

Due to the limitations of CBT, medication, and other evidence-based interventions for treating MDD (e.g., interpersonal psychotherapy, dialectical behavioral therapy, behavioral therapy, and behavior activation treatment), complementary and alternative treatments are being explored.

Complementary and Alternative Treatments for MDD

Resulting from persistent symptoms and real or alleged adverse effects of conventional treatments, CAMs have emerged as possible MDD treatment additions/alternatives (McEachrane-Gross, Liebschutz, & Berlowitz, 2006; Shumay, Maskarinec, Kakai, & Gotay, 2001; Thompson & Feder, 2005). One such treatment is mindfulness-based stress reduction (MBSR). MBSR is a manualized skills-training program designed to teach individuals to disengage from automatic thinking or cognitive routines (i.e., depression-related rumination) and become more cognizant of their thoughts, feelings, and bodily sensations, and in turn relate differently to them, that is, recognizing them as passing events in the mind rather than identifying with them, being swept away by them, or relating to them as reality (Tan, 2011; Teasdale et al., 2000). Presently there is considerable evidence for the effectiveness of MBSR and mindfulness meditation for improving mood and reducing stress, anxiety, and depression in various populations (Brown et al., 2007; Grepmaier, 2007; Kim, 2014; Sephton et al., 2007; Spowart, 2014). Moreover, this CAM has robust empirical evidence of effectiveness (Baer, 2003; Barlow, 2008; Blanton, 2011; Brown et al., 2007; Davidson et al., 2003; Kessler et al., 2001; Manheimer, Berman, Dubnick, & Beckner, 2004; Miller, Fletcher, & Kabat-Zinn, 1995; Nathan & Gorman, 2007; Osborn, Demoncada, & Feuerstein, 2006; Tan, 2011; Teasdale et al., 2000; Thachil, Mohan, & Bhugra, 2007). Due to this research base, SFMM was the CAM selected for this study. In this study, SFMM was added to evidence-based treatment for MDD to explore if participants experienced additional relief from their symptoms.

Rationale for Focusing on Christian Population

There is a strong connection between spiritual health and mental health (Aten & Leach, 2009; Edwards & Edwards, 2012; Fayard, Pereau, & Ciovica, 2009; Garzon, 2013; McMinn &

Campbell, 2007). Furthermore, to many people seeking help through means of counseling and psychotherapy, religion and spirituality are vitally important (Rose, Westefeld, & Ansley, 2001; Sperry, 2014; Tan, 2011). Cultural sensitivity and being appropriately knowledgeable about cultural factors are essential to competent psychotherapist training (American Counseling Association, 2014; APA, 2013; Lopez et al., 1989; Sperry, 2014). The APA (2013) differentiates race, ethnicity, and culture and underlines that the specific features of culture, including religion and spirituality, make it imperative not to “overgeneralize cultural information or stereotype groups in terms of fixed cultural traits” (p. 749). Additionally, code C.5 of the American Counseling Association Ethics Code states,

Counselors do not condone or engage in discrimination against prospective or current clients, students, employees, supervisees, or research participants based on age, culture, disability, ethnicity, race, religion/spirituality, gender, gender identity, sexual orientation, marital/partnership status, language preference, socioeconomic status, immigration status, or any basis proscribed by law. (p. 9).

Moreover, Pargament et al. (1988) emphasized the significance of religion for people coping and dealing with stressful life events. The authors noted that beliefs are often cited as a source of comfort and examined several problem-solving coping strategies religiously minded individuals engage in when experiencing stressful events. To quote Sperry (2014), “effective spiritually oriented psychotherapy practice is culturally sensitive practice” (p. 245). Also, Koenig, McCullough, and Larson (2001) noted a positive relationship between religiosity and positive physical and mental health.

However, little is known about the effectiveness of specific Christian-accommodative interventions (e.g., Christian mindfulness meditation, Christian devotional meditation [CDM],

and Biblical meditation) for depression for individuals seeking a spiritually based treatment in a clinical population (Garzon, 2013; Speca, Carlson, Goodey, & Angen, 2000; Symington & Symington, 2012; Tan, 2011). Although widespread dissemination trials (see McHugh & Barlow, 2010) and randomized clinical trials have been conducted for the treatment of depression, no single Christian-accommodated treatment has yet been tested (Worthington & Johnson, 2010). Due to the need for culturally sensitive Christian-accommodated treatments, a Christian population was chosen for this study.

The Potential of Spiritually Focused Mindfulness Meditation for this Population

Ben-Arye, Bar-Sela, Frenkel, Kuten, & Hermoni (2006) considered the integration of CAM themes into a biopsychosocial-spiritual approach to enrich the dialogue between patients and healthcare providers. However, regardless of the recent interest in spirituality and mental health, to date there are yet few interventions available to the therapist treating Christian clients facing not only mental and emotional but spiritual struggles (Moriarty & Hoffman, 2013). Considering the pervasive impact of depression and the multiple domains of life affected, including both religious and spiritual, it is important to translate cultural sensitivity into treatment for an effective outcome (Baetz & Toews, 2009; Daniels & Fitzpatrick, 2013; Faiver, Ingersoll, O'Brien, & McNally, 2001; Griffith & Griffith, 2002; Hanley, Warner, & Garland, 2015; Plante, 2014; Sperry, 2014; Tan, 2011). Meditation as a complementary alternative therapy is growing in popularity among healthcare professionals and the general population (Brown et al., 2007; Grepmaier et al., 2007; Grossman, Niemann, Schmidt, & Walach, 2004; Hanley et al., 2015; Kuyken et al., 2008; Sephton et al., 2007; Shapiro, Walsh, & Britton, 2003; Tan, 2011). However, Plante (2014) reported that all too often professional psychology is silent and seemingly uninterested in cultural factors that involve religious and spiritual diversity,

specifically citing meditation, where the emphasis is on Eastern spiritual and religious traditions like the Buddhist tradition mindfulness and the Hindu tradition yoga. Although multiculturalism is highlighted in much of the research on meditation including spirituality and religious traditions, the emphasis has been on Eastern traditional forms of meditation with far less attention to Western deism including Judaism and Christianity (Plante, 2014).

For the religious or Christian population, although they are few, empirical studies using Christian mindfulness meditation and CDM do exist, and the results show that spiritual meditation results in not only lower levels of anxiety and depression, but also a heightened sense of communion with God and a greater sense of attachment to God (Carlson, Bacaseta, & Simanton, 2001; Fayard et al., 2009; Symington & Symington, 2009; Wachholtz & Pargament, 2005, 2008). Finally, when spirituality is a significant aspect of a client's worldview, it is vital to the effectiveness of the treatment for the clinician to implement spirituality into the treatment methodology (American Counseling Association, 2014; APA, 2013; Aten & Leach, 2009; Carlson et al., 2001; Clinton & Ohlschlager, 2002; Clinton & Straub, 2010; Jones & Butman, 2011; McMinn, 1996; Symington & Symington, 2009; Tan, 2011). Due to this research base, SFMM was chosen as the therapeutic modality for this study.

Rationale for Interpretive Phenomenological Analysis

Qualitative research, per Kazdin (2011), offers the investigator the means for studying “individuals and human experience much more intensively” (p. 398) than other research modalities. The all-pervading personal characteristics of depression, especially for a Christian population, who are so often afflicted by guilt and shame, renders an IPA to explore the details of how each participant makes sense of their experience with SFMM to mitigate the effects of depression a valid choice (Bloomberg & Volpe, 2012; Smith & Osborn, 2008; Williams,

McManus, Muse, & Williams, 2011). The important role that patients play in research today and the personal contribution they make toward finding effective treatments makes this type of study an important one for treating MDD (Hodgetts & Wright, 2007). Through this systematic and epistemologically coherent framework, IPA offers a unique way to look at the phenomenon of depression by facilitating exploration of the experiential world of the individual participant suffering from depression (Hodgetts & Wright, 2007; Kazdin, 2011; Smith, Flowers, & Larkin, 2009). As qualitative inquiry has the potential to engender new insights into existing problems and produce distinct descriptions of explicit experiences, IPA offers an opportunity to assess the added element of spirituality to the treatment-as-usual (TAU) modality being offered to Christians clinically diagnosed with MDD (McLeod, 2011; Ponterotto, 2005). This modality offered the opportunity for deeper scrutiny of the experience of the presenting problem of depression and the effect meditation does or does not have on the depressed mood (McLeod, 2011; Morrow, 2005; Moustakas, 1994). Consequently, to expand the current understanding of depression, IPA as the research methodology was well suited for this investigation.

Conceptual Framework

Figure 1 diagrams the conceptual framework for this qualitative IPA to show the impact of SFMM as an adjunct for reducing symptomatology of MDD in a clinical population. There are five major components to this study. First, the population chosen for this study was three individuals currently diagnosed with MDD. According to Smith et al. (2009), three participants is ideal for a student study to conduct a detailed analysis of each case. Second, the first-line treatments are discussed, including CBT and ADM. Third, the complementary alternative treatments, including Eastern meditation, Western meditation, mindfulness-based cognitive therapy (MBCT), and dialectical behavioral therapy, are discussed. Fourth, the rationale for

using a Christian population in this study is discussed based on the need for cultural sensitivity, religious diversity, and religiously accommodative treatments. And finally, SFMM will be defined and discussed as a culturally sensitive treatment for this population.

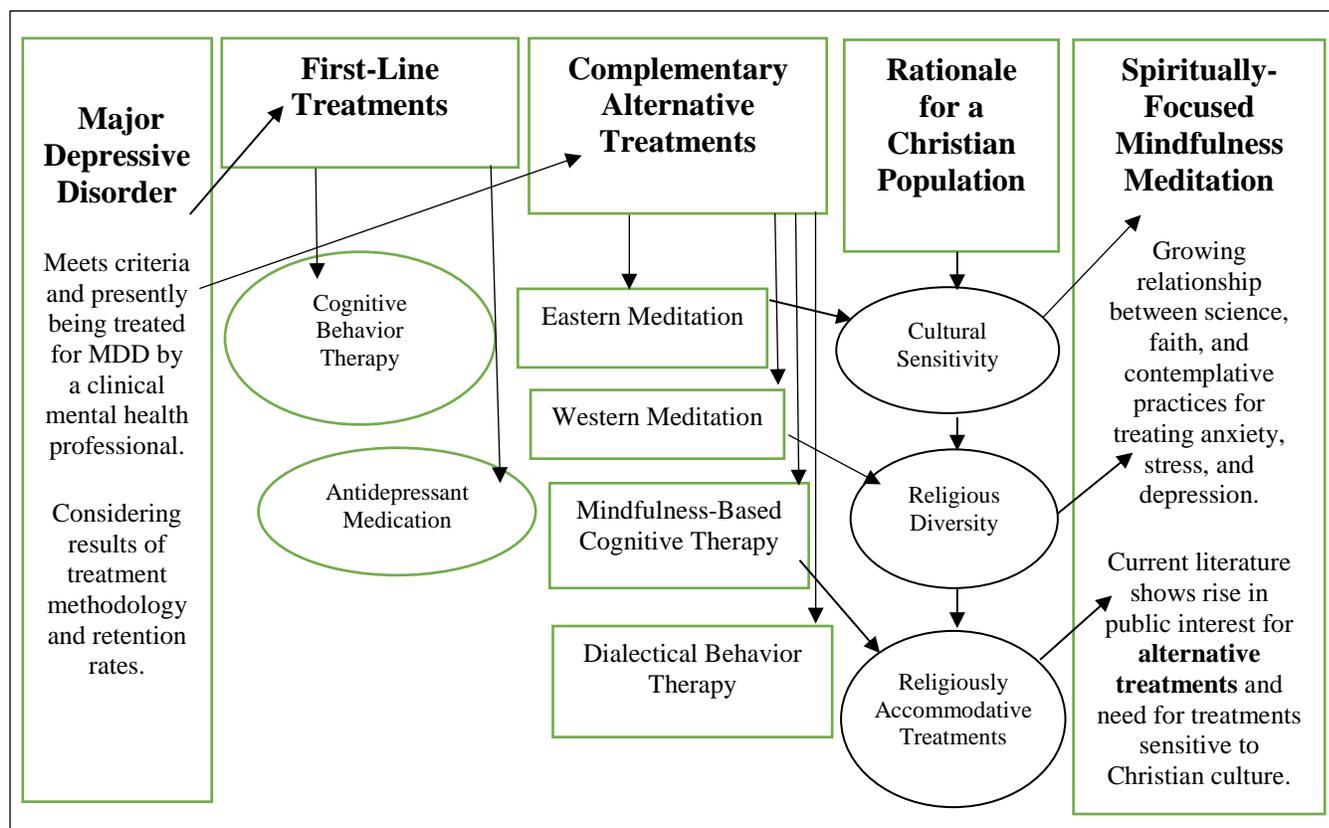


Figure 1. Initial conceptual framework: Assessment of SFMM as a complementary alternative treatment for a Christian population. For more information, see “Utility of a Conceptual Framework Within Doctoral Study: A Researcher’s Reflections,” by J. Berman, 2013, *Issues in Educational Research*, 23(1), 1–18.

Significance of the Study

Researchers have identified the effectual attributes of meditation for mitigating depressive symptoms. An analysis by Shapiro, Walsh and Britton (2003) summarized significant findings from several hundred meditation research studies from the past 40 years, including every facet of its effect on cognition, personality, and self-esteem. Collectively, the researchers reported that meditation practices have the potential to positively affect physiological,

psychological, and transpersonal well-being (Brown & Ryan, 2003; Brown et al., 2007; Farb, Anderson, & Segal, 2012; Kuyken et al., 2008; Sipe & Eisendrath, 2012). However, there is currently no qualitative study in the literature that explores the lived experience of a clinical population of religious clients diagnosed with MDD using SFMM as an adjunct to evidence-based treatment for depression. Shapiro, Walsh and Britton (2003) described qualitative research about meditation as essential to understanding the “interplay between subjective and objective” experiences (p. 106). Clearly, understanding the characteristics of a patient’s depression and experience with meditation through in-depth interviews “to explore in detail how participants are making sense of their personal and social world” (Smith & Osborn, 2008, p. 58) can help determine the course for managing it. It is important to note that SFMM is generally defined for this inquiry as a selection of deliberate strategies to keep one’s mind attuned in the present moment to the role of God the Father’s love, Jesus the Savior’s grace, and the Holy Spirit’s restorative communion (Garzon, 2013) while remaining “non-judgmentally detached from potentially destructive thoughts and feelings” (Symington & Symington, 2012, p. 71).

A dissertation work by Kim (2014) showed reduction in the levels of perceived anxiety and perceived depression when examining the comparative effectiveness of CDM and progressive muscle relaxation among a sample of nonclinical Korean Christian adults. The most notable result was the greater level of reduction in depression scores using CDM as compared to progressive muscle relaxation. The Christian population used in Kim’s (2014) study and the result of increased spiritual health is important when considering the present study. Another significant aspect of the present study is the use of a clinical population. Additionally, a Christian model of mindfulness was presented by Symington and Symington (2012), who proposed a structure based on three pillars: presence of mind, acceptance, and internal

observation. From these three pillars a foundation is laid for a “strengthened sense of self and increased value-based behavior” (Symington & Symington, 2012, p. 72). More information follows in Chapter Two.

Because there is still much to be learned about implementing Christian spiritual interventions into psychotherapy, the data collected from this study may prove valuable when considering Christian meditation as a part of the therapeutic process. As Garzon (2004) stated, “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” (p. 243). To date, there is no data on a clinical population. Furthermore, there is no rich qualitative study looking at the effect of meditation on depression (Brocki & Wearden, 2006). The findings from this study provide information to clinicians seeking an effective spiritual component for treating the spiritually oriented client suffering with MDD.

Research Question

This IPA was designed to explore in detail the lived experience of a select clinical sample presently suffering from MDD, using SFMM for reduction in depression symptomatology. The primary research question was: How does a clinical sample of research participants describe the experience and effectiveness of SFMM as a component of therapy to mitigate the effects of their depression?

Theoretical Framework

Depression is a deeply personal experience often accompanied by a sense of worthlessness or guilt; for the Christian, this is often a contradiction to a life of faith and praise, often resulting in feelings of hopelessness (Clinton & Straub, 2010). IPA is a research design that explores the depth of the personal experience from the client’s perception (Smith & Osborn,

2008). The strategy of inquiry for this study is IPA, including a workshop to teach SFMM, individual in-depth interviews, and a reflective journal to record the daily experience of meditation.

Definition of Terms

The following key terminology used throughout this study will be operationally defined, including SFMM, Christian mindfulness meditation, CDM, meditation, Eastern meditation, God attachment, and depression.

Spiritually Focused Mindfulness Meditation

According to Shapiro and Carlson (2009), an operational definition of mindfulness involves a two-component model:

The first component involves the self-regulation of attention so that it is maintained on immediate experience, thereby allowing for increased recognition of mental events in the present moment. The second component involves adopting a particular orientation that is characterized by curiosity, openness, and acceptance. (p. 232)

The Christian form of mindfulness, per Tan (2011), includes traditional contemplative, meditative, and centering prayer, which can be considered features of mindfulness and acceptance. Contextualizing mindfulness techniques used within a Christian contemplative tradition emphasizes the sacredness of intimacy with God, surrendering to Him and “letting go and letting God” take control of the moment, and learning to “be still and know that He is God” (Tan, 2011; Ps. 46:10, New King James Version). The focused attention that Siegel (2010) termed *mindsight* becomes focused on God the Father, the Lord Jesus Christ and the Holy Spirit and a characteristic of their love, grace, peace, mercy, forgiveness, or one of the many other attributes found in Them. Rather than Buddhist concepts, Christian concepts and principles are

emphasized (Tan, 2011). Turning the compassionate, purposeful awareness and nonjudgmental acceptance defined by Shapiro, Carlson, Astin, and Freedman (2006) toward one's purposeful experience of intimacy with God in the moment (e.g., breathing meditation and lovingkindness meditation) will define SFMM (Garzon & Ford, 2016).

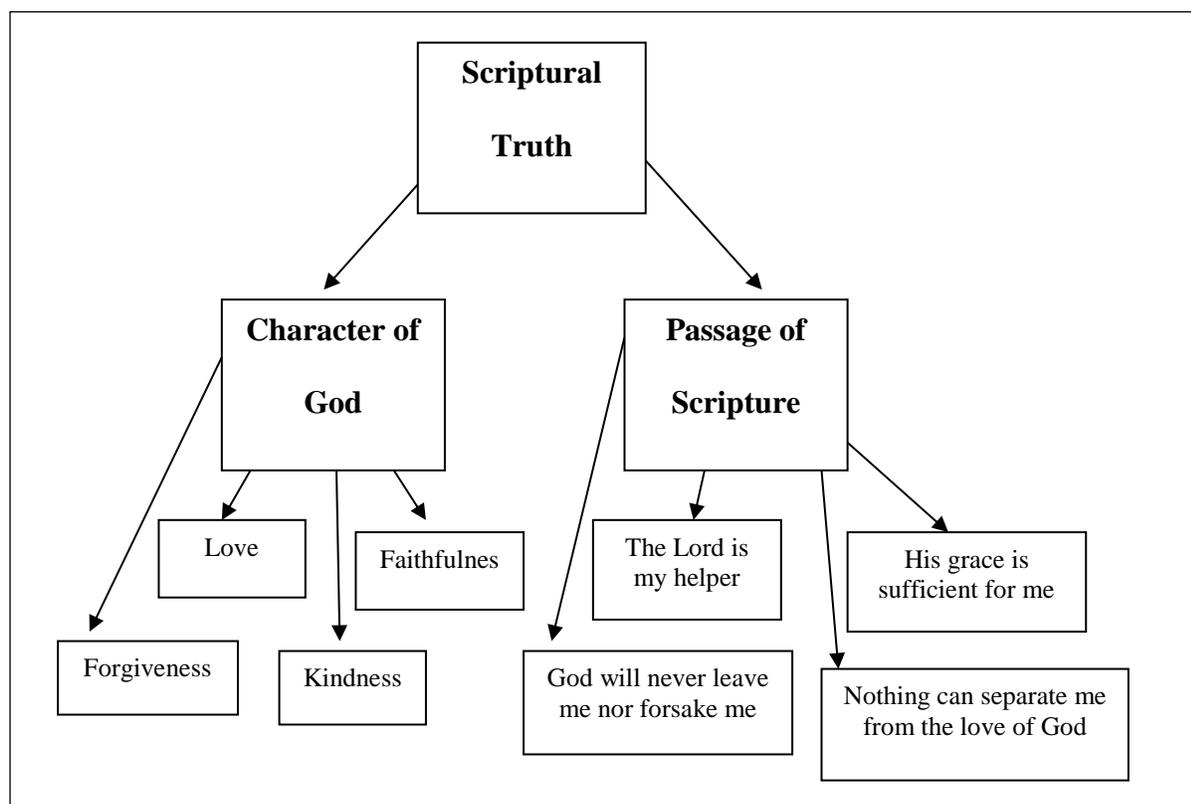


Figure 2. Flow chart showing examples of various strategies for spiritually focused mindfulness meditation. Adapted from “Christian Devotional Meditation for Anxiety” by F. L. Garzon, (2013), in J. Aten, E., Johnson, E. Worthington, & J. Hook (Eds.), *Evidence-based practices for Christian counseling and psychotherapy* (pp. 59–76). Downers Grove, IL: Intervarsity Academic Press.

Christian Devotional Meditation

According to Garzon (2013), CDM is defined as “a variety of strategies designed to enhance focused attention” (p. 1) on God the Father, Jesus the Savior and Friend, and the Holy Spirit’s anointing on specifically chosen scriptures for personal use. Those strategies include scriptural truth meditation, which involves: (a) focused attention on the character of God (e.g.,

love, faithfulness, kindness); (b) a passage of Scripture for deeper understanding (e.g., I will never leave you nor forsake you, so we can boldly say, “The Lord is my helper; I will not fear. What can man do to me?” Hebrews 13:5–6, New King James Version); and (c) Christ-centered present moment awareness, which is similar to mindfulness meditation in that it involves inviting the individual to become more fully aware of God’s presence, love, and purpose in the present moment as well as the ongoing self-experience (e.g., “God loves me,” “I am His,” “I am safe in His presence”; Garzon, 2013). Furthermore, the emphasis of the meditation involves: (a) deepening one’s relationship with the Father and the Son, (b) promoting spiritual growth and/or emotional healing, and (c) increasing in love towards others and one’s self (Garzon, 2013). Another aspect of CDM is personal healing. Jesus is quoted saying, “Come to Me, all you who labor and are heavy laden [*depressed*], and I will give you rest. Take My yoke upon you and learn from Me [*meditate*], for I am gentle and lowly in heart, and you will find rest for your souls” (Matt. 11:28–29, NKJV, emphasis added).

Meditation

Meditation, as defined by West (1980), is “an exercise which usually involves the individual turning attention or awareness to dwell upon a single object, concept, sound, or experience” (p. 265). The word *meditation* originates from Latin *meditatio* (a noun), a derivative of the verb *meditari*, which is interpreted to mean *to think, contemplate, devise, or ponder* and can be defined as both a process and a state (Roche, 1998). A means of communion with God, like prayer, meditation is silent contemplation. According to Harris, Archer, and Waltke (1980), the Hebrew words for meditation are *sichah*—reflection, meditation, prayer, contemplation, babbling, complaint (See Ps. 64:1; 104:34), and *higgayon*—resounding music, meditation, musing (e.g., a low sound, characteristic of the moaning of a dove or the growling of a lion over

its prey). According to Strong (2010), the Greek words for meditation are *logizomai*—to dwell, count, think, calculate (See Phil. 4:8) and *meletaō*—to care for, study, practice, think about, revolve in the mind (See 1 Tim. 4:15). As Paul described the process he followed, taking him from being a powerful, strong-willed killer of Christians, to becoming the man God used to write most of the New Testament, he wrote,

Be anxious for nothing, [don't allow it to take hold] but in everything by prayer and supplication, with thanksgiving, let your requests be made known to God [rely on Him fully]; and the peace of God, which surpasses all understanding [goes beyond your perceptions], will guard your hearts and minds through Christ Jesus [disarm the enemy on your behalf]. Finally, [to sum up how to accomplish this] whatever things are true, whatever things are noble, whatever things are just, whatever things are pure, whatever things are lovely, whatever things are of good report, if there is any virtue and if there is anything praiseworthy—*meditate* on these things . . . and the God of peace will be with you (Philippians 4:6–9, NKJV, emphasis added).

Eastern Meditation

Transcendental meditation, a prevalent form of Eastern meditation, is a mantra-based technique established by Maharishi Mahesh Yogi around 1955 (Carrington & Ephron, 1975). It promotes the principle of a solitary focus to induce a meditative state, similar to the technique employed by a hypnotist (i.e., bypasses the frontal lobe, helping the subject enter a trance-like state), focusing on a single word (i.e., a mantra), a single shape, or a body part (Carrington & Thornton, 1975; Rice, 1987). Further, like in hypnotism, in transcendental meditation, thoughts are repressed and reasoning is absent, and a passive attitude—similar to the sleep state (alpha brain activity; Carrington & Ephron, 1975; Niedemeyer, 1997)—is promoted, whereas Christian

meditation promotes the reasoning powers of the brain (beta activity and frontal lobe involvement; Amen, Paldi, & Thisted, 1993) and emphasizes communion with God, thinking His thoughts, and sensing His presence. The frontal lobe is the seat of judgment, reasoning, intellect, and the will; it is commonly known as the control center of our entire being (Amen et al., 1993). Simply put, Christian meditation, as compared to transcendental meditation, involves connecting one to God rather than repeating a mantra to enter a sleep-like state.

God Attachment

According to Clinton & Straub (2010), Christians know all is right in the world when all is right with God; that is, they are in intimate relationship with the God of all love, salvation, healing, mercy, grace, and truth is the ultimate health-promoting aspect of any Christian's life (Drummond, 2010). According to Rasar, Garzon, Volk, and O'Hare (2013), the concept of God attachment was derived from Bowlby's (1969, 1982) work. It included the fundamental dynamics of Christian thought by promoting God as a loving Father, available to His children throughout their lifetimes, regardless of the circumstances in which they find themselves. In essence, this availability promotes great security of acceptance and approval contrasted with any kind of separation, which, when removed, can create great insecurity and fear-based behavior (Rasar et al., 2013). Kirkpatrick (1999) regarded insecure attachment to God as a form of spiritual and emotional distress. Subsequently, because of the vital role this relationship has in a Christian's peace of mind, an assessment of spirituality based on the quality of the relationship and awareness of Him is considered an essential element for any therapist working with Christian clientele (Clinton & Straub, 2010).

Depression

MDD is diagnosed, per the *DSM-5* (APA, 2013), when at least five of the following symptoms are present during the same time period, with at least one of the first two symptoms present. In addition, according to the APA (2013), the symptoms must be present most of the day, nearly daily, for at least two weeks: (a) depressed mood (sadness or emptiness), (b) a marked, diminished interest or pleasure in almost all activities (apathy), (c) significant weight loss/gain, (d) insomnia or hypersomnia (disturbed sleep), (e) agitation or retardation of thinking, memory, etc. (restlessness), (f) fatigue or loss of energy (tiredness), (g) impaired concentration and indecisiveness, or (h) recurring thoughts of death or suicide (morbid thoughts). Accordingly, the APA (2013) emphasized that the common feature of all depressive disorders is “the presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual’s capacity to function” (p. 155).

Assumptions and Limitations

There is an overwhelming variety of existing approaches to qualitative inquiry (Morrow, 2005; Ponterotto, 2005). Therefore, locating the current phenomenological inquiry philosophically and conceptually within a specific paradigm will assist the reader in judging the rigor of said study. From a constructivist/interpretivist paradigm for study, which supports a hermeneutical approach (i.e., exposing hidden meaning through deep reflection) to the study of phenomena, this research presents a philosophical and conceptual framework for discovering how SFMM will affect MDD in a small sample of three individuals (Morrow, 2005; Moustakas, 1994; Ponterotto, 2005). The nature of this inquiry is idiographic—seeking a descriptive and detailed presentation of the results focusing on the uniqueness of each individual and understanding of their lived experience with the phenomenon—rather than nomothetic—

focusing on general patterns of behavior from a normative base (Ponterotto, 2005). To this end, several philosophical assumptions about the research, the methodology, the assessments, and the participants will be considered (McLeod, 2011; Morrow, 2005; Moustakas, 1994; Palinkas et al., 2015; Ponterotto, 2005).

An assumption for this inquiry was that through intense interaction and dialogue between the researcher and the participant, fresh vantage points and deeper insights relating to the individual's lived experience using SFMM to mitigate depression would be acquired. Finding meaning or meaning-making is what Moustakas (1994) considered the heart of phenomenological research. Unlike the systematic observation and description of phenomena framed within a model or theory, through journaling and the interactive, in-depth interviews between researcher and participant, deep reflection was stimulated to uncover the deeper meaning of the experience as they pieced together the findings from their dialogue and interpretation (McLeod, 2011; Morrow, 2005; Ponterotto, 2005). To this end, the central goal was an expanded understanding of the lived experience from the personal point of view of the one who lived through it each day and how meditation impacted the symptoms of MDD. As one who helped establish constructivism, Dilthey (1894/1977) emphasized the importance of recognizing that finding meaning in the individual's lived experience may well be beyond the consciousness of immediate awareness; therefore, the researcher is an intricate component in this inquiry (McLeod, 2011; Ponterotto, 2005). However, researcher influence on the experimental process, such as the personal attention paid to the subjects during the initial workshop and semi-structured interview could affect trustworthiness of analysis and interpretation of data.

Pertaining to researcher bias as a limitation of this study, the researcher's expectations, values, and experience with the phenomena are widely considered a necessary part of the

constructivist's paradigm for study (McLeod, 2011; Morrow, 2005; Ponterotto, 2005; Sciarra, 1999). Therefore, rather than trying to eliminate them from the process, the researcher acknowledges, describes, and "brackets" personal values throughout the interdependent researcher-participant interaction, using them sensitively to enhance rapport and create a richer dialogue (Moustakas, 1994; Morrow, 2005; Ponterotto, 2005). Consistent with the constructivist paradigm, the individual's accounting of the experience using SFMM to mitigate the effects of depression will be influenced by their subjectivity and perceptions, their social environment, and the interaction between the individual and the researcher. This interaction fundamentally determines the role of the investigator, unlike, for example, a criticalist paradigm that presumes to influence the research through value biases (Ponterotto, 2005; Sciarra, 1999). Considering that there are multiple meanings of a lived experience or phenomenon, it makes sense that there will be multiple interpretations of the data; hence, the researcher will not attempt to discover any type of certain truth or single outcome (McLeod, 2011; Morrow, 2005; Moustakas, 1994). This establishes the justification for using the same person to conduct the interview who also presents the themes and subthemes (Smith et al., 2009). The narrowly focused purposeful sample used in this study decreased inference quality/trustworthiness (internal validity) and generalizability/transferability (external validity; Palinkas et al., 2015). The participants were homogeneous in terms of race/ethnicity, religious affiliation, clinical diagnosis of MDD, and experience of two or more depressive relapses.

As each of the participants were asked to keep a journal of their lived experience with depression and how SFMM mitigated their individual experience with depression. An assumption was that each participant would process and reflect meaningfully on their experience, adding richness to the data. As can be seen in the literature (Kim et al., 2013; Saeed, Antonacci,

& Bloch, 2010; Srivastava, Talukdar, & Lahan, 2011), different forms of meditation can help decrease depression, anxiety, stress, and pain; an assumption in the current study was that SFMM is one form of meditation that can impact the individual's experience with depression in a positive way. Furthermore, Perich, Manicavasagar, Mitchell, and Ball (2013) found that the participants that meditated more often (more than three times a week) had lower depression scores after 12 months, showing improvements in depression and anxiety symptoms; it was assumed that participants would, in fact, meditate each day to ease the depression.

As qualitative inquiry has the potential to engender new insights into existing problems and produce distinct descriptions of explicit experiences, another important assumption for this inquiry was the need to add an element of spirituality to the TAU modality being offered to Christians diagnosed with MDD (McLeod, 2011; Ponterotto, 2005). Because individuals create their personal world and their understanding of it through thoughts, stories, memories, relationships, and the various pieces that make up an individual life story, this IPA examined the certain lived experience of three Christians with depression who used meditation (McLeod, 2011; Morrow, 2005). This offered deeper scrutiny of the experience of the presenting problem of depression and the effect meditation does or does not have on the depressed mood (McLeod, 2011; Morrow, 2005; Moustakas, 1994). The results of this inquiry add valuable information and insight into the experience of Christians living with MDD, which can generate new sensitivities to therapists dealing with similar patients.

In conclusion, rather than verify or test a methodology for treating depression, this study sought to offer possible new discoveries through narrative to add to the toolbox therapists draw from to treat their patients suffering from MDD. Essentially, the goal was to generate new knowledge for the treatment of MDD using the complementary adjunct of SFMM to TAU.

Locating Myself as Researcher

It has been said that perspective is everything, and this is especially true for the qualitative research study (Bloomberg & Volpe, 2012). The perspective of the individual doing the research can impact the study greatly; therefore, knowing the background and experience of the author is an essential part of this endeavor. Consequently, a vital aspect of qualitative writing is distinguishing between personal influences and focused research in order to achieve intellectual goals not subjected to the researcher's personal perspective (Maxwell, 2012). However, that said, personal experience on the part of the researcher can influence the motivation for the study by facilitating personal investment and interest, increasing the richness and depth of the study (Maxwell, 2012). The following disclosures afford the reader an opportunity to understand and to critically analyze the contribution of the writer (Moustakas, 1994).

In my work with Christian families for the last 25 years, anxiety, stress, and subsequent depression have been a common presenting problem for many of my clients. Dysfunctional family life, tragic loss, defeat and failure, and the world around them becoming increasingly unpredictable, appeared to overwhelm these clients, rendering them unable to utilize their faith as a resource to effectively address their hopelessness and depression. Thus, added to depression, guilt and shame for not trusting God and having hope in Him has often appeared to complicate the mood disorder and make it even more difficult. In other words, although the Christian scriptures are replete with exhortations to rejoice, be glad, trust in God, cast all care on Him, and be assured that He cares and that He will come through, these sincere Christians suffered silently with feelings of emptiness or sadness, inexplicable feelings of loss and sorrow, and even fear and a diminished interest in life itself but did not have a safe place to articulate

these experiences due to the stigma they experienced as Christians who “didn’t trust their God.” Some were so stressed and anxious, feeling defeated so much of the time, that even thoughts of suicide impinged on their daily lives, the “ultimate betrayal” of their faith.

My personal experience with depression, which was similar to the preceding description, followed a series of events that resulted in great loss and trauma and forced incredible changes into my life. Although I have been a Christian since my teens, I was unprepared for the impact of such overwhelming and unwanted emotions all at once. The resulting loss of my ability to find pleasure in my life started a downhill slide that lasted for several years. I was not prepared for, nor aware of, the depressed state that I had become accustomed to until good counsel began to help me unravel my feelings and expose my state of mind. I loved God with all my heart and could not imagine life without Him; however, legalistic religion had taught me that when Christians fail, God turns His back, and this created such darkness for me that only by His grace was I able to recover. Good counsel, the Bible, and meditating on His promises and His love for me turned my mourning into dancing and the heaviness into praise for all that He is to us, no matter how far we fall. This time in my life deepened my understanding of what Christians face when depression becomes a daily part of living and extended my knowledge of the disease by experience this devastating disorder.

As noted by Sorajjakool, Aja, Chilson, Ramírez-Johnson, and Earll (2008), a great stigma exists within the formal church, one that renders its members as failing, weak, or even sinful if they admit to needing counsel or help with feelings of depression, sadness, anxiety, hopelessness, or anything less than the joy-filled enthusiasm regarded as normal or spiritual for a Christian. Not only have individuals, throughout my career as a therapist, come for help with depression and all its manifestations, but ministers, their wives, children, and other more

prominent workers within the church have also needed help with its devastating effects. Depression is no respecter of persons; anyone can struggle with the dark thoughts that rob people of the joy of living and looking forward to another day. Despite the available empirical evidence for meditation as a helpful adjunct to evidence-based treatment for depression (Levin et al., 2014), evidence for Christian meditation needs more attention and research to support the use of it and make it a valid choice for therapists treating individuals suffering from MDD (Wachholtz & Pargament, 2005).

According to Brocki & Wearden (2006), there is no rich qualitative study looking at the effect of meditation on depression, and stronger study designs are needed to determine the effects of Christian meditation as a component of therapy to mitigate the effects of depression. Additionally, there is no evidence of a qualitative study that supports the use of SFMM with a clinical population. Consequently, my aim through this IPA is twofold: first, to enlarge our understanding of the impact of meditation through individuals' lived experience with depression and how SFMM affected their personal experience with MDD, and second, to improve our ability to help those clients with a spiritual orientation suffering with MDD.

Chapter Summary

Chapter One answers the *what*, *why*, and *how* questions and lays the groundwork for this qualitative IPA exploring SFMM as a component of treatment for depression by acquainting the readers with the background and context for the problem. The purpose of this qualitative IPA was to explore in detail the lived experience of a select clinical sample presently suffering from MDD, using SFMM as an adjunct to evidence-based treatment for depression. The conceptual framework, significance, research questions and research design for the study were presented.

Additionally, researcher perspective, rationale and significance, and definition of terms used in the study were presented.

Organization of Remaining Chapters

The remainder of the study is organized into four chapters, references, and appendixes in the following manner. Chapter Two examines current literature involving meditation as a component of therapy for depression, anxiety, and stress, building a sound case for the importance of this study. Furthermore, Chapter Two continues to build on the conceptual framework for SFMM as a component of therapy for depression for spiritually-minded individuals. Chapter Three clearly defines the methodology for the study, including rationale for using qualitative design and an IPA. Chapter Four presents a detailed description of the results and findings of this study, and Chapter Five presents an interpretation of findings and a summary of the research, conclusions drawn, and recommendations for further research.

CHAPTER TWO: LITERATURE REVIEW

The purpose of this study was to explore the lived experiences of a select clinical sample of individuals suffering with MDD who used SFMM as an adjunct to their current treatment. To establish the need for the study, this chapter presents the status of empirical inquiry related to this topic based on the conceptual framework presented in Chapter One. The chapter first covers the *DSM-5* (APA, 2013) conceptualization of MDD, followed by discussion covering the empirical status of (a) evidence-based treatments for MDD, (b) mindfulness-based treatments used to treat MDD, (c) the integration of spirituality into mindfulness-based treatment of MDD, and (d) SFMM in the treatment of MDD. The review clarified that although the study of alternative treatments for MDD is recommended, little has been done to explore SFMM in particular. The chapter closes with a review of the use of IPA to provide a rationale for its use in this study.

Primary research for this review was obtained through the online databases of Liberty University. EBSCOhost research databases used included the following search engines: APA PsycNET, JSTOR, ProQuest Central, Psychology and Behavioral Sciences Collection, Religion and Philosophy Collection, Google, and Google Scholar, which included both published articles and unpublished dissertation research. Additionally, reference lists and bibliographies, as well as local university libraries, were scanned to find additional published research. Terms searched were *MDD*, *meditation*, *spiritual meditation*, *spiritually-focused mindfulness*, *Christian mindfulness meditation*, *Christian meditation*, *CDM*, *contemplative meditation*, *mindfulness meditation*, *pathophysiology of depression*, *Christianity* and *depression*. The following section describes the development of depression, the *DSM-5* criteria, and the chronic course of MDD.

Major Depressive Disorder

Mood disorders, such as major depression, subthreshold depressive symptoms, and anxiety, are among the most commonly diagnosed psychiatric disorders that prompt individuals to seek psychotherapy (Barlow, 2008; Martin-Agueda et al., 2006; Nathan & Gorman, 2007; Wulsin, 2000). They are also among the most treatable of all mental health disorders due to the prevalence of research and subsequent treatments developed (Barlow, 2008; Nathan & Gorman, 2007). MDD requires an experience of at least one major depressive episode and is distinguished by discrete episodes of depression present nearly every day and for most of the day, lasting at least two weeks (although they can last significantly longer). Criteria include depressed mood (dysphoria) and/or loss of interest or pleasure in nearly all activities; changes in appetite, weight, sleep, or psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thoughts of death or suicidal ideation or suicide plans or attempts. Accordingly, symptoms must be present for more than two consecutive weeks for most of the day, every day, and must be accompanied by impaired functioning or cause clinically significant distress (APA, 2013).

Furthermore, according to the Substance Abuse and Mental Health Services Administration (2014), depression, once experienced, is likely to recur, with each depressive episode increasing the probability of recurrence. Research reveals that individuals who have found relief from depression through any type of treatment are at risk for relapse (Dobson et al., 2008; Hollen et al., 2005; Keller, Lavori, Lewis, & Klerman, 1983; Kuyken et al., 2008; Ma & Teasdale, 2004; Paykel et al., 1995; Piet & Hougaard, 2011; Segal et al., 2010; Segal, Williams, & Teasdale, 2013; Solomon et al., 2000).

The importance of treating this debilitating disorder cannot be overstated, and adding an adjunct like SFMM, which includes techniques that people can practice for themselves daily, to current treatment modalities may have significant benefits for patients and therapists. The following section provides an overview of two of the leading treatments currently used for treating major depression.

Evidence-Based Treatments for MDD

Reducing the anxiety and stress of daily living, which are concomitants of mood disorders such as MDD, is an essential aspect of treating MDD (Georgiades et al., 2012; Ramel, Goldin, Carmona, & McQuaid, 2004). Currently, ADMs and psychotherapies, CBT specifically, are two principal outpatient evidence-based treatments for MDD (Craighead & Dunlop, 2014).

In a systematic review of 10 randomized controlled trials, Spijker, van Straten, Bockting, Meeusissen, and van Balkom (2013) looked at 17 comparisons between ADMs, psychotherapy, or the combination of both interventions. They concluded that there was weak evidence for both ADMs alone and psychotherapy alone. They also found that a combination of both ADMs and psychotherapy was most effective, but that studies reviewed were somewhat heterogeneous in design and quality. Clearly, more research is needed, particularly for treatment-resistant depression, and exploring alternative treatments, like mindfulness meditation, is recommended in the research literature (Brown et al., 2007; Ramel et al., 2004; Roemer & Orsillo, 2007; Teasdale et al., 2000).

Much of the current literature reports numerous difficulties for patients seeking treatment for MDD with ADMs. For example, one report (APA, 2010) stated that no antidepressant class or individual medication is more effective than others for treating MDD and that many have health risks such as dose-limiting adverse effects and potential suicidal responses (Craighead &

Dunlop, 2014). In their depression treatment guide, Gilson, Freeman, Yates, and Freeman, (2009) provided a systematic approach for treating MDD with CBT and included specific techniques and a workbook to teach patients how to reorient their lives to live depression-free. Essentially, the authors emphasized teaching the individual how to “tame the BEAST,” (p. 27), which is an “acronym representing the effect of depression on the body, emotions, actions, situations, and thoughts” (p. 27). They presented the neurological impact of depression and discussed how CBT can impact brain chemistry and affect brain processes. Included in their guide is a thorough discussion of ADMs and the successes and failures of using ADMs in the treatment of depression. For a complete review of why medication alone, when not included in a plan utilizing ongoing coping skills, so often fails to provide lasting relief from depression, please see Gilson et al. (2009).

Evidence for the effectiveness of cognitive therapy (e.g., Beck et al., 1997; DeRubeis et al., 2008; Jakobsen, Hansen, Storebø, Simonsen, & Gluud, 2011) and CBT (e.g., Cuijpers et al., 2013; DeRubeis et al., 2016; Dobson et al., 2008) for MDD is substantial (Butler et al., 2006; Cuijpers et al., 2013; DeRubeis et al., 2005, 2016; Tolin, 2010), and they are considered empirically supported treatments (Barlow et al., 2011; Chambless et al., 1998; Gilson et al., 2009; Seligman & Reichenberg, 2007). Despite the effectiveness of cognitive therapy and CBT treatments, however, some individuals do not obtain substantial and long-lasting relief from them (Cuijpers et al., 2017; Jacobson & Hollon, 1996; Luborsky et al., 2006; Lynch et al., 2010; Nemeroff et al., 2003).

For example, a meta-analytic review of well-controlled trials by Lynch et al. (2010) revealed CBT was as effective for treating major depression as ADM, both as a treatment for acute symptoms and for relapse prevention; however, the effect size was small in the 10 studies,

implying only modest therapeutic benefit. Thus, although CBT is the most empirically tested of the first-line treatments currently available for individuals with major depression (Barlow, 2008; Carter et al., 2013; Cuijpers et al., 2013; Nathan & Gorman, 2007; Sipe & Eisendrath, 2012), some question the validity of the findings based on methodological flaws or insufficient data (Cuijpers et al., 2017; Luborsky et al., 2006; Lynch et al., 2010; Parker et al., 2003). In addition to the limitations of ADM, cognitive therapy, and CBT treatments for those who do find relief in treatment, many lose treatment gains to relapse during the first year or two posttreatment (Cuijpers et al., 2017; Lynch et al., 2010).

Specifically, Dobson et al. (2008) conducted a trial to examine relapse risk in the 12- and 24-months following ADM compared to behavioral activation and cognitive therapy. Although they found behavioral activation and cognitive therapy at least as effective as the continuation of medication, only 45% of the treatment responders survived without relapse or attrition to complete the second year. These results are similar to the Hollen et al. (2005) trial that examined relapse risk in the 12 months following antidepressant versus cognitive treatment, in which only 58% of the ADM group and the same proportion of the cognitive therapy group met predefined criteria for recovery and were able to proceed to the relapse phase of the study. These studies reveal that a significant number of patients fail to meet criteria for remission, leaving much yet to be accomplished for those patients often termed treatment resistant. The purpose of this study was to address this recidivism by exploring if, as an adjunct to treatment, SFMM provides a relapse-preventive way to cope with the ongoing stress, anxiety, and rumination that keep depression running in cycles (Teasdale et al., 2000). The addition of this mindfulness practice makes sense considering the findings regarding mindfulness training for MDD. Mindfulness meditation shows evidence for reducing depressive relapse, which is often the result of

reactivated patterns of thinking (Keller et al., 1983; Paykel et al., 1995; Ramel et al., 2004; Solomon et al., 2000).

To summarize, evidence-based treatments for MDD include cognitive therapy, CBT, and ADMs. Empirical studies document that these treatments have limited effectiveness. Therefore, researchers emphasize the need for studies that explore additional treatment options. The present study used a form of mindfulness meditation, a faith-based version. To clarify findings in the empirical literature regarding mindfulness additions to MDD treatment, the next section examines mindfulness-based treatments for MDD and provides a summary of empirical findings related to them. The section that follows it provides the empirically based rationale for the use of the faith-based version of mindfulness meditation explored in this study.

Mindfulness-Based Treatments for Depression

Mindfulness-based treatments are manualized skills-training programs designed to teach individuals to disengage from automatic thinking or cognitive routines (i.e., depression-related rumination). The focus is on helping people become cognizant of thoughts, feelings, and bodily sensations and how to relate differently to them (i.e., recognize them as passing events in the mind rather than identifying with, being caught up in, or connecting to them as valid; Tan, 2011; Teasdale et al., 2000). There is strong support in the empirical literature for mindfulness interventions in impulse control and the treatment of anxiety disorders and recurrent depression (Kabat-Zinn, Massion, & Kristeller, 1992; Miller et al., 1995; Roemer & Orsillo, 2007; Teasdale et al., 2000; Williams, Russell, & Russell, 2008).

Following the introduction of MBSR by Jon Kabat-Zinn in the late 1970s to treat patients suffering from chronic pain and reduce the relative stress associated, healthcare professionals began using it to treat numerous symptoms and mental disorders, including personality disorders,

sexual dysfunction, and depression and anxiety (Symington & Symington, 2012). MBCT was developed specifically as a treatment for depression (Fraser, 2013). Brown et al. (2007) reported that mindfulness-related studies increased from fewer than 80 in 1990 to over 600 in 2006. Presently, there is considerable evidence for the effectiveness of MBSR and MBCT for reducing stress, anxiety, and depression in various populations (Brown et al., 2007; Grepmaier, 2007; Kim, 2014; Sephton et al., 2007; Spowart, 2014). Although, to date, the vast majority of proposed mechanisms have been cognitive (Klein, Jacobs, & Reinecke, 2007; Sipe & Eisendrath, 2012), meditation programs, particularly mindfulness programs, touch on several promising lines of research in stress reduction, depression management, learning enrichment, and quality of life (Brown et al., 2007; Brown & Ryan, 2003; Farb et al., 2012; Kuyken et al., 2008; Sipe & Eisendrath, 2012). Williams et al. (2008) conducted a review of the status of MBCT, expounding on randomization procedures, posttreatment and follow-up data, and experimental designs. They found that MBCT significantly reduced the risk of a further episode of depression and significantly decreased mean scores on the depression inventory following treatment.

According to Kenny and Williams (2007), one of the benefits of MBCT is its focus on the repetitive and passive thinking about symptoms that are characteristic of MDD. Watkins and Teasdale (2004) called this type of thinking rumination. Evidence from studies on rumination reveals that maladaptive, self-focused attention perpetuates MDD (Watkins & Teasdale, 2004). For example, Watkins and Teasdale (2004) conducted an experiential study using 28 depressed patients to examine whether different modes of self-focus could produce “distinct functional effects on overgeneral memory,” (p. 5) a measure predictive of poor long-term course in depression. Their findings indicated that, in depressed patients, experiential self-focus would reduce overgeneral autobiographical memory compared to analytical self-focus. In depressed

patients, the experiential self-focus condition significantly reduced categoric memory recall, as compared to the analytical self-focus condition that had little effect on categoric memory recall, aspects of which can train depressed patients to be more aware of their negative thinking processes and patterns (Watkins & Teasdale, 2004). These results are significant when considering meditation as an adjunct to TAU for major depression.

Along these same lines, several studies reveal that repeated connections between depressed mood and negative thinking patterns during successive episodes of MDD increase the propensity for depressogenic thinking to be reactivated afterward by depressed mood (Kuyken et al., 2008; Piet & Hougaard, 2011; Segal et al., 2010; Watkins & Teasdale, 2004). For example, Kendler, Thornton, and Gardner (2000) completed a longitudinal study involving 2,395 women over a nine-year period to examine the interaction between life event exposure and number of previous depressive episodes in the prediction of episodes of MDD. They found that risk of further episodes of depression increases with every consecutive episode and that successive episodes of MDD require less and less external provocation by stressful life events (Kendler et al., 2000). In an earlier information-processing analysis of depressive relapse and its prevention by cognitive therapy, Teasdale, Segal, and Williams (1995) identified three interlinked targets for reducing or even preventing relapse rates in major depression using attentional control taught in mindfulness meditation. The authors presented an information-processing analysis of reducing relapse rates for patients with MDD, wherein the researchers introduced mindfulness-based skills of attentional control, training the individual how to divert or redistribute his or her attention. The analysis provided a basis for the development of attentional control training, integrating cognitive therapy and mindfulness training for recovered depressed patients used today in MBCT and MBSR (Teasdale et al., 1995).

Similarly, Teasdale et al. (2000) conducted a 60-week study to assess relapse/recurrence in MDD with 145 recovered recurrently depressed patients, using mindfulness-based skills to train them to disengage from dysphoria-activated depressogenic thinking. The participants were randomized to either continue with TAU or to additionally receive MBCT training for the eight-week treatment phase followed by a 52-week follow-up phase. Teasdale et al. (2000) utilized the Hamilton Rating Scale for Depression (Hamilton, 1960) interview-based measure of severity of depressive symptomatology and the Beck Depression Inventory as assessment measures. The occurrence of relapse or recurrence, as assessed by the Structured Clinical Interview (First, Williams, Karg & Spitzer, 2015), was the primary outcome variable. The results showed significant reduction in relapse/recurrence rates in patients with recurrent MDD and a reversal of the processes hypothesized to underlie depressive symptomatology. This is important when considering that MDD has been established in the literature as a chronic, lifelong illness. The evidence of recurrence supports the need for the present study, considering the importance of teaching specific coping skills to target the core reasons people remain depressed even after treatment.

Kenny and Williams (2007) conducted a clinical audit of relapsed depressed patients who had continuing symptoms of depression despite treatment with ADMs or CBT or both. These patients were referred for MBCT, designed to prevent relapse in severely depressed patients who responded minimally to standard treatments. Each of the participants ($N = 50$, symptomatic at the start of MBCT course) had to meet *DSM-IV* criteria for MDD (three or more episodes of depression or chronic course greater than one year following a major depressive episode related to the presence of ruminative thought patterns), bipolar affective disorder, depressed phase, or dysthymia. Results showed MBCT was associated with reductions in depression symptoms,

with a large pre-post effect size ($d = 1.04$), a high degree of acceptability, and low dropout rates, even considering the levels of severity and the disabling effects of numerous prior episodes of depression (Kenny & Williams, 2007).

Similarly, Barnhofer et al. (2007) conducted a study exploring the effect of MBCT for preventing relapse to depression using 22 participants with a history of suicidal depression. They measured resting electroencephalogram before and after an eight-week course of MBCT ($n = 10$) or TAU ($n = 12$). The TAU group showed a decrease in positive affective style and an increase in avoidance-related affective style, while the MBCT maintained a balanced pattern of baseline emotion-related brain activation, suggesting that the meditation-based treatment offered a protective effect toward vulnerability to depression (Barnhofer et al., 2007). They concluded that meditation potentially plays a significant role in retaining a balanced pattern of prefrontal asymmetry, and thereby a balanced affective style, which are important to self-management and the “likelihood and frequency of negative affective responses” (Barnhofer et al., 2007, p. 712) associated with the downward spirals of negative mood and cognition found to be prominent in relapse to depression.

Specifically related to targeting relapse prevention for patients treated for MDD, Segal, Williams, and Teasdale (2002) developed a model of “maintenance CBT” including MBSR. MBSR is a manualized skills-training program designed to teach individuals to disengage from automatic thinking or cognitive routines (i.e., depression-related rumination) and become more cognizant of their thoughts, feelings, and bodily sensations, and in turn relate differently to them (i.e., recognize them as passing events in the mind rather than identifying with, being swept away by, or relating to them as reality; Teasdale et al., 2000; Tan, 2011). Several independent studies of people with recurrent depression receiving MBSR after TAU showed significant

reductions in relapse rates, even when compared to those receiving pharmacotherapy following treatment (Ma & Teasdale, 2004; Segal et al., 2013; Teasdale et al., 2000, 2002). For example, Teasdale et al. (2000) conducted a 60-week study with a sample of recovered recurrently depressed patients ($N = 145$) randomized to continue TAU or, in addition, to receive MBCT. Over the 60-week period, patients with a history of three or more episodes of depression (77% of the sample) showed significantly reduced risk of relapse. Ma and Teasdale (2004) conducted a replication trial, and found that MBCT reduced relapse rates from 78% to 36% in 55 patients with three or more previous episodes of major depression. In another study conducted by Kuyken et al. (2008), a parallel two-group randomized controlled trial comparing patients on ADM ($n = 62$) with patients receiving MBCT plus support to taper/discontinue antidepressants ($n = 61$) found that relapse/recurrence rates over 15-month follow-ups in MBCT were 47%, compared with 60% in the m-ADM group. Overall, the trial revealed that MBCT was more effective than m-ADM in reducing residual depressive symptoms and psychiatric comorbidity and in improving quality of life in the physical and psychological domains (Kuyken et al., 2008). These studies reveal that MBSR, MBCT, and mindfulness meditation reduce recidivism for patients suffering with MDD and provide a rationale for including this component in treatment in further empirical studies.

Mindfulness and meditation as components to effective psychotherapy is not a new idea but one that is established as effective for a variety of conditions (Brown et al, 2007; Brown & Ryan, 2003; Carlson et al., 2001; Farb et al., 2012; Fraser, 2013; Garzon, 2011, 2013; Goyal et al., 2014; Hofmann, Sawyer, Witt, & Oh, 2010; Jain et al., 2007; Kim et al., 2013; Kuyken et al., 2008; Sephton et al., 2007; Sipe & Eisendrath, 2012).

This section of the literature review presented empirical support for using mindfulness-based approaches as a component of MDD treatment. Because of the robust empirical support for these practices, a form of mindfulness meditation was selected for this study. In the next section, to establish the rationale for the specific approach used in this study, empirical support for the use of spiritually integrated mindfulness practices in the treatment of MDD are described.

Mindfulness-Based Treatments for Depression for People Who Want to Integrate Their Faith/Spirituality into Treatment

Regarding the pervasive impact of depression and the multiple domains of life affected, including both religious and spiritual, current literature reveals increasing interest in the relationship between science, faith, and contemplative practices for treating depression and various psychopathologies (Anyfantakis et al., 2015; Baetz & Toews, 2009; Daniels & Fitzpatrick, 2013; Faiver et al., 2001; Garzon & Ford, 2016; Gonzalez et al., 2014; Griffith & Griffith, 2002; Hanley et al., 2015; Hathaway & Tan, 2009; Propst, Ostrom, Watkins, Dean, & Mashburn, 2009; Sorajjakool et al., 2008; Wachholtz & Pargament, 2005; Worthington, Hook, Davis, & McDaniel, 2010). For example, in the past two decades, at least 22 clinical trials or experimental studies have examined the effects on depressive symptoms using various religious/spiritually based treatments, including meditation, and a variety of other psychospiritual interventions, of which nearly two thirds (67%) reported significant benefits (Koenig, King, & Carson, 2012).

Furthermore, a task force appointed by the APA in 1977 evaluated the benefits of integrating spirituality into the therapeutic process (for a review, see La Torre, 2002). Subsequently, for the first time, the *DSM-IV* included a category for religious and spiritual problems, separating psychological problems from spiritual issues (APA, 2000). Since that time,

numerous forms of mindfulness meditation specifically considering the individual's spirituality have emerged in the literature and have been growing in popularity among healthcare professionals and the general population (Barlow, 2008; Carter et al., 2013; Hofmann et al., 2010; Nathan & Gorman, 2007; Segal et al., 2002, 2010; Sipe & Eisendrath, 2012).

Spiritually focused empirical research looking at mindfulness and other related forms of meditation has revealed profound effects on numerous physiological systems, many of which are believed to play a role in the pathophysiology of depression (for a review see Baer, 2006; Shapiro et al., 2003; Sorajjakool et al., 2008; Sperry, 2014; Tan, 2011). Therefore, when spirituality is a significant aspect of a client's worldview and there is a desire to integrate spirituality into MDD treatment, it is both ethical and efficacious to do so (American Counseling Association, 2014; Anyfantakis et al., 2015; Aten & Leach, 2009; Carlson et al., 2001; Buttle, 2015; Clinton & Ohlschlager, 2002; Gonzalez et al., 2014; Hathaway & Tan, 2009; Johnson et al., 2011; Jones & Butman, 2011; La Torre, 2002; McMinn, 1996; Nelson et al., 2009; Sorajjakool et al., 2008; Wachholtz & Pargament, 2005, 2008; Worthington et al., 2001).

Although the studies on meditation all indicate its effectiveness, there is little empirical evidence to support specific treatment for the faith-based or Christian population. Studies do show, however, that a broader spectrum of spiritual meditation results not only in lower levels of anxiety and depression, but also in a heightened sense of communion with God and a greater sense of attachment to God for this population (Anyfantakis et al., 2015; Bonelli et al., 2012; Carlson, Bacaseta, & Simanton, 2001; Daniels & Fitzpatrick, 2013; Fayard et al., 2009; Garzon, 2013; Garzon & Ford, 2016; Gonzalez et al., 2014; Johnson et al., 2011; Kim, 2014; Nelson et al., 2009; Sorajjakool et al., 2008; Wachholtz & Pargament, 2005).

Anyfantakis et al. (2015) did an observational study to examine the impact of high levels of religiosity/spirituality (R/S) on Sense of Coherence and Beck Depression Inventory scores for 195 subjects, 50% female with a mean age of 67.2 ± 15.2 years, of whom 98.5% were Christian Orthodox. Each of the samples were administered a homogenous procedure (i.e., given validated questionnaires to evaluate a sense of coherence, depression levels, and religious and spiritual beliefs). Using a multiple linear regression analysis of the Beck Depression Inventory in relation to demographic characteristics, scores on the Royal Free Interview for Spiritual and Religious Beliefs scale and Sense of Coherence were analyzed. The findings indicated that the more religiously minded participants showed a lower probability of depression presence, as indicated by the depression scale.

Bonelli et al. (2012) reported on a review synthesizing quantitative research from the last 50 years that examined associations between R/S involvement and depressive symptomology. Of the 444 studies, 60% reported less depression and faster recovery from depression in those with higher R/S or a decrease in depression severity in response to an R/S intervention when compared to other treatments or controls. When they examined the 178 most methodically rigorous studies, results revealed 119 (67%) found inverse relationships between R/S and depression. Bonelli et al. (2012) concluded that the evidence indicates an individual's religious beliefs and practices help people to cope more effectively with stressful life circumstances by providing meaning and hope, and oftentimes supportive friends and family surround the depressed individual, creating a buffer against depression and suicide.

Sorajjakool et al. (2008) did a qualitative study to determine and further understand the importance of spirituality and meaning in the lives of 15 participants suffering from severe depression. Two of the questions asked were "How does depression affect spirituality?" and

“Can spirituality function as a tool in coping with depression?” (p. 522). Various studies have found a positive correlation between meaning and depression, and Sorajjakool et al. (2008) reported that most of the participants, when depressed, reported feeling disconnected from their spirituality, themselves, God, and their community; however, most of the participants also reported that their spirituality or connection with God helped them cope with the dark mood of depression. This is important when considering the impact of Christian meditation as a means to enrich spiritual life (Edwards & Edwards, 2012).

Gonzalez et al. (2014) conducted a cross-sectional study to examine the association between spiritual well-being and depressive symptomology. From self-report data of 102 diverse cancer survivors, depression was measured using the Patient Health Questionnaire-8, and spiritual well-being was measured with the Functional Assessment of Chronic Illness Therapy—Spiritual Well-Being, which is composed of two subscales (Meaning/Peace and Faith). The results suggested that spiritual well-being is a significant coping mechanism to combat depressive symptomology.

Regardless, however, of the recent interest in spirituality and mental health, to date there are yet few interventions available to the therapist dealing with Christian clients facing not only mental and emotional but also spiritual struggles (Moriarty & Hoffman, 2013). Because of the intense personal characteristics of depression and individuals’ perceived failure to live up to possible religious standards, alternative therapies such as SFMM may be especially advantageous for a Christian population so often coupled with feelings of guilt and shame (Bonelli et al., 2012; Daniels & Fitzpatrick, 2013; Dearing et al., 2005; Moriarty, 2006; Sorajjakool et al., 2008; Young, Neighbors, Dibello, Traylor, & Tomkins, 2016).

For many Christians facing depression, there are often substantial feelings of guilt—not so much the effect of having done something wrong, but the feeling of shame that accompanies feeling like something is fundamentally wrong with them (Moriarty, 2006). Guilt, per Lewis (1971), is an attitude toward one's self after committing some type of wrongdoing, whereas shame, per Tangney and Dearing (2002), is more often attached to negative feelings about specific behavior (e.g., being depressed when they are told that the joy of the Lord should be their strength). Dearing et al. (2005) emphasized that seeing oneself as flawed or intrinsically wrong fosters depression, devaluing the self and leading to more severe depression and even suicide.

For the Christian or religious population, feelings of guilt and shame extend toward their relationship with God, believing He has rejected them for being less than optimal and feeling worthless and defeated, often leading to more or worsening depression (Daniels & Fitzpatrick, 2013; Moriarty, 2006). As a final note, Andrews, Qian, and Valentine (2002) found evidence, using the Experience of Shame Scale, that shame has a significant part in the onset and course of depression. One important aspect of the present study is that it offers a form of meditation to mitigate the effects of depression for spiritually minded individuals. The next section will examine three studies that explored the use of Christian-based mindfulness treatments to mitigate the effects of depression.

Christian Mindfulness-Based Treatments for Depression

For the religious or Christian population, empirical studies using Christian mindfulness meditation and CDM do exist, although they are few, and the results show that spiritual meditation results in not only lower levels of anxiety and depression, but also a heightened sense of communion with God and a greater sense of attachment to God (Carlson et al., 2001; Fayard

et al., 2009; Wachholtz & Pargament, 2005, 2008). Considering the increase in public interest and the lack of evidence in the literature on the use of alternative Christian spiritually-based forms of treatment for depression, the present study's exploration of the use of SFMM as a component of therapy is an important addition to the discourse (Gonzalez et al., 2014; Johnson et al., 2011; Nelson et al., 2009; Worthington et al., 2011).

In an early study conducted by Carlson et al. (2001), it was hypothesized that the person engaged in devotional meditation would experience physiological and psychological changes similar to progressive relaxation, including a reduction in muscle tension, anxiety, and negative emotionality. The 36 subjects were divided into three equal groups: devotional meditation (using the 23rd Psalm), progressive relaxation, and wait-list control. Each group engaged in its respective activity 20 minutes a day for two weeks. The study was conducted at the Behavioral Psychophysiology Laboratory of Wheaton College using a Coulbourn Physiograph to record the physiological measurements. The results showed significant reduction in several psychological and physiological variables in the devotional meditation group. The subjects reported less anger and anxiety, with a more significant reduction in muscle tension than either the progressive relaxation or the wait-list control group, suggesting spiritual practices included in the relaxation techniques are associated with better results than progressive relaxation (Carlson et al., 2001). This is important to the present study, considering negative emotionality is a baseline for MDD and the benefit of adding SFMM to treatment to improve outcomes for individuals suffering from MDD.

Two studies were conducted by Wachholtz and Pargament (2005, 2008) using spiritual meditation. In the Wachholtz and Pargament (2005) comparison study, 68 college-age students were divided into three groups: spiritual meditation ($n = 25$), secular meditation ($n = 21$), and

relaxation ($n = 22$). Two well-established psychological measures were used—the Positive and Negative Affect Scale and the State-Trait Anxiety Inventory. Three spiritual health measures were used—Spiritual Well Being, Religious Well Being, and Existential Well Being. Additionally, the Daily Spiritual Experiences Questionnaire, the Mysticism Scale, and objective measures of stress reactivity and pain tolerance were used. The authors stated the spiritual meditation group reported lower anxiety, more positive mood, greater spirituality, and an ability to withstand pain for longer periods of time than the other two groups, indicating spirituality is a critical component of meditation, altering the technique's impact on affect, spirituality, pain perception, and tolerance (Wachholtz & Pargament, 2005).

In the Wachholtz and Pargament (2008) study, 83 meditation-naïve participants suffering from frequent migraine headaches were randomized into one of four groups and taught spiritual meditation ($n = 22$), internally focused secular meditation ($n = 21$), externally focused secular meditation ($n = 20$), or muscle relaxation ($n = 20$); each group performed its assigned activity for 20 minutes a day for one month. This study tested the relative efficacy of a spiritual form of meditation on headache frequency, pain tolerance, mood, anxiety, quality of life, and spiritual variables. The spiritual meditation group reported a greater reduction in number of headaches, more pain tolerance, and a significantly larger decrease in negative mood and trait anxiety than any other group. The uniqueness of this study was the exploration of the differences between spiritual and secular forms of meditation, making it applicable to the current study. Although meta-analysis reveals general forms of meditation are effective in improving mental health (see Grossman et al., 2004), in this study, the spiritual component appeared to have a unique additive effect that enhanced the ability of meditation to decrease negative affect and trait anxiety, both of which are aspects of MDD.

Not only is meditation convenient and able to be done almost anywhere, it is also comparatively brief, cost effective, and can potentially be applied to a range of chronic pain disorders and mental illnesses (Grossman et al., 2004). Studies like the present one will add to this body of knowledge on the use of Christian-based mindfulness for the treatment of MDD. The next section will define SFMM used in the present study, present a single-case study using SFMM to treat recurrent depression, and offer a rationale for the need to study this methodology.

Christian Mindfulness Meditation

In a single-case study using a Christian version of MBCT with a client suffering from MDD, Hathaway and Tan (2009) reported the individual's recurrent depression included feelings of rejection by God. The participant relayed feeling like "God was displeased with her for numerous life failures" (p. 164). Following the diagnostic interview, the patient received individual therapy for 18 weeks. Features of CBT and MBCT were combined throughout her treatment. Although MBCT is most often done in a group setting, the basic tenets of MBCT were employed in the individual therapy. After exercising the nonjudgment and acceptance skills and the practice of mindful breathing for four weeks, she presented with brighter affect and a more positive mood in both the fourth and fifth sessions. She reported to the researchers her feelings of relief from guilt and shame so often connected to her own experiences. Therapy emphasized her acceptance of herself through her times of meditation, and by the ninth session her anxiety and depression decreased dramatically (Hathaway & Tan, 2009).

As reported by Hathaway and Tan (2009), at the beginning of her treatment, adaptive functioning was rated with a Global Assessment of Functioning score of 55. This indicated significant difficulty in her significant relationships and her home life. Her Global Assessment of Functioning score at termination was 80. At her initial intake, her subjective unit of distress

ratings for anxiety and depression were 80 and hopelessness was 60 on a 100-point subjective unit of distress scale with 100 meaning “most severe ever.” When she finished her treatment, her subjective unit of distress ratings had reduced to 5 for depression, 10 for anxiety, and 1 for hopelessness. The patient reported “feeling closer with God . . . [and] able to be in God’s presence without the feelings of shame or guilt she previously felt constantly.” The patient, according to Hathaway and Tan (2009), acknowledged that this change was the result of the insight she gained into what grace means and a deepening knowledge of God’s acceptance of her. The authors emphasized mindfulness meditation as a variety of strategies easily adapted to an individual’s personal belief system. For example, through Christian mindfulness meditation, this individual was taught and encouraged to experience her thoughts, feelings, and sensations in an accepting manner, void of judgment, guilt, or shame of any kind (Hathaway & Tan, 2009).

Two studies revealed that individuals experiencing recurrent depression tend to have maladaptive mental processes characteristic of sad moods triggered or reactivated by the reoccurrence of the sad mood (Barnhofer et al., 2007; Segal et al., 2002). Furthermore, Webb, Heisler, Call, Chickering, and Colburn (2007) found positive correlation between both shame and guilt and symptoms of depression. An important aspect of SFMM is teaching the individual acceptance of feelings and thoughts without the added dimension of guilt and shame. Garzon and Ford (2016) emphasized the need to provide religiously accommodative treatments such as SFMM not only for conservative Christian clients, but also for spiritually minded individuals seeking to overcome perceived obstacles to their relationship with or closeness to God (Hathaway & Tan, 2009).

The following section will present a rationale for using IPA as the chosen methodology for this qualitative study and three qualitative studies using semistructured interviews to explore

the lived experience of individuals using mindfulness-based meditation to mitigate the effects of depression.

Methodology of Study

Qualitative research, per Kazdin (2011), offers the investigator the means for studying “individuals and human experience much more intensively” (p. 398) than other research modalities. The all-pervading personal characteristics of depression render an IPA a valid choice to explore the details of how participants make sense of their experience with SFMM to mitigate the effects of depression (Bloomberg & Volpe, 2012; Smith & Osborn, 2008; Williams et al., 2011). The important role that patients play in research today and the personal contribution they make toward finding effective treatments make this type of study important for treating MDD (Hodgetts & Wright, 2007).

A systematic and epistemologically coherent framework, IPA offers a unique way to look at the phenomena of depression by facilitating exploration of the experiential world of the individual participant suffering from depression (Hodgetts & Wright, 2007; Kazdin, 2011). As qualitative inquiry has the potential to engender new insights into existing problems and produce distinct descriptions of explicit experiences, IPA offers an opportunity to assess the added element of spirituality to the TAU modality being offered to Christians diagnosed with MDD (McLeod, 2011; Ponterotto, 2005). This will offer deeper scrutiny of the experience of the presenting problem of depression and the effect meditation does or does not have on the depressed mood (McLeod, 2011; Morrow, 2005; Moustakas, 1994). Consequently, to expand an

understanding of depression and gain perspective from the individual dealing with MDD, IPA as the research methodology is well suited for this investigation.

In Sorajjakool et al.'s (2008) qualitative study, the researchers explored the role of spirituality and meaning among 15 participants suffering from severe depression. Using semistructured interviews to explore the role of spirituality and meaning, this study focused on understanding the place of spirituality and meaning in the lives of individuals who struggle with chronic depression. The authors emphasized the importance and value of having descriptive narratives and listening to individuals struggling with chronic depression to offer more complete care for these patients. This emphasis is one reason a qualitative study like the present one is a valuable and necessary endeavor. Most of the participants reported that depression made them feel disconnected from their spirituality, God, and their community (Sorajjakool et al., 2008). A common thread, however, was that although depression left them feeling disconnected, their spirituality also “offered hope, brought comfort, prevented suicide, and provided sustenance during these dark and cold periods in their lives” (p. 527). Additionally, 13 of the 15 participants found a close connection between their spirituality and their meaning and purpose in life.

In Wachholtz and Pargament's (2008) study, not only was the frequency of migraine headaches reduced, but the participants using spiritual meditation also reported a greater sense of meaning and self-purpose in their lives, suggesting that meditation focuses meditators on the more positive aspects of their spiritual lives and connection with God. Similarly, in Wachholtz and Pargament's (2005) study, the spiritual component of the meditation was reported to be correlated with increased sense of meaning and purpose in participants' lives, suggesting that individuals with strengthened spiritual lives may have more positive affect and less anxiety, and

may find an advantage from use of the spiritual techniques as coping mechanisms for various life stressors.

Allen, Bromley, Kuyken, and Sonnenberg (2009) conducted a qualitative interview study with 54 participants and selecting 20 interviews for analysis to determine the efficacy and acceptability of MBCT relapse prevention for depression. The research question was, “How do people describe and evaluate their experience of MBCT as a treatment for recurrent depression?” (p. 415). Four overarching themes emerged from the data: “an increased sense of control over depression; an acceptance of depression-related thoughts and feelings; expressing and meeting personal needs in relationships;” (p. 423) and a range of struggles with MBCT. These four themes are consistent with those noted in previous studies (Finucane & Mercer, 2006; Ma & Teasdale, 2004; Mason & Hargreaves, 2001). Concerning the overarching theme of acceptance, Allen et al. (2009) found participants described feelings of being understood an ability to let go of the stigma attached to depression by identifying with other individuals suffering from depression. They found a measure of empowerment enabling them to “become aware of, express and accept thoughts and feelings, including difficult experiences” (Allen et al., 2009, p. 425). This transformative aspect of meditation was emphasized as important to counteract imbalanced affective functioning by promoting interpersonal skills like the ability to discern between thoughts and reality for the development of affective balance (Wallace & Shapiro, 2006). The need for more integrative stress-reducing techniques not only to mitigate mood disorders including MDD, physical ailments, and pain associated with chronic illness, but also to regulate interpersonal harmony and emotional and spiritual needs, is evident in the literature, making this

present study an important addition to the body of research, especially considering the personal and pervasive impact of MDD.

Summary

Chapter Two presented research findings currently found in the literature relating to the *DSM-5* (APA, 2013) conceptualization of MDD and evidence-based treatments for MDD, including ADMs and CBT. Available research on mindfulness-based treatments for mitigating the symptoms of depression was presented. Additionally, research examining empirical studies for integrating spirituality into treatment and a rationale for focusing the present study on Christian mindfulness-based meditation for treating Christians with MDD were presented. Lastly, in order to provide a rationale for the research method, a brief overview of three qualitative studies using semistructured interviews to explore the effect of mindfulness-based meditation to mitigate the effect of depression was presented.

Stronger study designs are needed to determine the effects of Christian meditation programs in improving the positive dimensions of mental health as well as stress-related behavioral outcomes. Since there was no evidence of a qualitative study that supports the use of a spiritually-focused devotional meditation with a clinical population as a component of therapy to mitigate the effects of depression, the present study was conducted.

CHAPTER THREE: METHODS

The purpose of this qualitative IPA was to explore in detail the lived experience of a select clinical sample presently suffering from MDD, using SFMM as an adjunct to their present treatment. The phenomenological design was chosen because it affords the researcher the opportunity to conduct a comprehensive exploration of how an individual can learn and use a spiritual form of mindfulness meditation to lessen the effects of MDD and how each participant can reveal something about his or her experience that will allow for charting the similarities and differences of the experience.

An important aspect of all research is the presentation of the research design, its suitability for the study, and the procedures used to conduct the study (Bloomberg & Volpe, 2012). This chapter presents a comprehensive summary of IPA, which is comprised of the three primary theoretical elements: phenomenology, hermeneutics, and idiography (Bloomberg & Volpe, 2012). Additionally, the research question and the context for the study are described. Methods used to select the individual participants for the study and details about the initial workshop; individual in-depth, semistructured interviews; the reflective journal, and the ethical protection of the participants are presented. Also, pertinent information about the role of the researcher, methodology for selecting participants, and data collection procedures follows. The chapter concludes with data analysis procedures and the methods used to ensure validity and trustworthiness of the findings.

Research Design

Although the individual terms used to make up IPA have a long history in the human sciences, they were first linked together to form a method of study by Jonathan A. Smith (2004). IPA has three broad fundamentals: (a) the epistemological position, (b) a set of guidelines for

conducting the investigation, and (c) a measure of the empirical research (Smith, 2004). As a methodology, it involves a highly concentrated and exhaustive analysis of the personal accounting produced by a comparatively small number of participants (Larkin, Watts, & Clifton, 2006). IPA entails a two-stage interpretation process: the detailed examination of the lived experience of the individual and the researcher's endeavor to interpret how the participants make sense of their experience (Smith et al., 2009). This gives the researcher the added advantage of exploring the individual experience with the phenomenon in specific detail, considering fully the experiential claims and concerns of those individuals involved in the study. Essentially, it includes comprehensive descriptions of the lived experience of the individual, which then become the foundation for a reflective structural analysis that describes the importance of the experience (Moustakas, 1994).

Qualitative research, per Kazdin (2011), offers the investigator the means for studying “individuals and human experience much more intensively” (p. 398) than other research modalities. The important role that patients play in research today and the personal contribution they make toward finding effective treatments make this type of study an important one for treating MDD (Hodgetts & Wright, 2007). Through this systematic and epistemologically coherent framework, IPA offers a unique way to look at the phenomena of depression by facilitating exploration of the experiential world of the individual participant suffering from it (Hodgetts & Wright, 2007; Kazdin, 2011). While all qualitative inquiry has the potential to engender new insights into existing problems and produce distinct descriptions of explicit experiences, IPA extends an opportunity to assess the added element of spirituality to the TAU modality being offered to Christians diagnosed with MDD (McLeod, 2011; Ponterotto, 2005). It allows for a deep scrutiny of the experience of the presenting problem of depression and the

effect meditation does or does not have on depressed mood (McLeod, 2011; Morrow, 2005; Moustakas, 1994). IPA developed as a means of deeply exploring human experience and meanings, thus enhancing the counselor's ability to understand clients' experiences and providing much-needed insight into what may work and how change is effected (Hodgetts & Wright, 2007). Consequently, to expand our understanding of depression, IPA as the research methodology is well suited for this investigation. The following three subsections describe the three features of IPA: phenomenology, hermeneutics, and idiography.

Phenomenology

Phenomenological researchers seek to understand the lived experience of the individuals participating in the study (Larkin et al., 2005). IPA is a phenomenological methodology. Phenomenological analysis is a scientific examination of an individual's perceptions of his or her experience through inductive exploration using, for example, interviews and discussions to gather comprehensive information from that person's experience. Although flexible in its approach to research, it is no less rigorous or complex when compared to more epistemological qualitative methods when it is done with essential care and commitment (Larkin et al., 2005). As such, an essential aspect of IPA is the central role of the analyst in making sense of, or interpreting, the data (Smith, 2004). Furthermore, it is important to recognize that IPA, on a methodological level, offers an opportunity for the researcher to properly examine, understand, and convey the experiences and perspectives offered by a small number of participants (Alase, 2017). IPA is a distinctive approach to qualitative research.

A phenomenological approach requires the focus to be centered on the phenomenon as it is experienced by the participant, not the phenomenon as a material reality. However, in IPA it is essential not to separate description from interpretation but to continually draw from insights

offered by the participants and the hermeneutic tradition, keeping in mind that all description of the phenomenon constitutes a form of interpretation (Willig, 2013). Van Manen (2016) stressed that phenomenological research explores the complexity of human experience. The basis for phenomenological research is to gain a more thorough understanding of the nature or meaning of everyday experiences. Phenomenology asks, “What is this or that experience like?” (van Manen, 2016, p. 9). Simply put, it is an in-depth inquiry of the lived experience of individual subjects to gain an insightful accounting, offering deeper understanding of the human experience (van Manen, 2016).

According to Clark Moustakas (1994), human science perspective models have many similarities. First, human experiences are best captured through qualitative methods. Second, the phenomenological perspective concentrates on the entirety of the experience, not simply a piece under inspection. Instead of quantifying the experience, qualitative methods explore the meaning and characterization of the individual’s experience. This is accomplished through first-person accounts obtained through journaling, informal conversations, and semistructured interviews. As a final point, the data collected are vital to acquiring an in-depth understanding of human behavior and as verification for further scientific investigations (Hodgetts & Wright, 2007; Moustakas, 1994).

Because of the intense personal characteristics of depression, especially for a Christian population, in whom depression is so often coupled with guilt and shame (see Clinton & Ohlschlager, 2002), a phenomenological methodology is ideal to explore the individual perceptions of how each research participant makes sense of their experience using SFMM as an adjunct to evidence-based treatment for depression (Bloomberg & Volpe, 2012; Smith & Osborn, 2008). Although there is a surfeit of quantitative research studying the effects of and

treatments for depression, studies investigating the lived experience of individuals with depression with a personal perspective and interpretation are minimal (Propst et al., 2009), and for the Christian segment of society, almost nonexistent (Hathaway & Tan, 2009). The flexibility of IPA was important to this study given the purpose of this research.

Hermeneutics

Hermeneutics is the theory of interpretation of highly specialized for texts or transcribed meanings developed by the German philosopher Dilthey (1833–1911; Bloomberg & Volpe, 2012). However, its history is far older, as it began as the central theory used to interpret texts of the Bible (Smith, 2011). This science of interpretation is used to gain in-depth understanding of an experience to reveal greater meaning and is accomplished by revisiting the data over and over again in order to derive deeper meaning and understanding as the experience is increasingly understood (Bloomberg & Volpe, 2012). Conducting hermeneutic science involves adopting a willingness to understand and find intention and meaning behind appearances in the lived experience of an individual (Moustakas, 1994). It requires an interrelationship, or a listening for the underlying dynamics that account for the experience, to find the fundamental meaning that enables one to comprehend or identify the substance and essence of the experience. Thus, a central emphasis in hermeneutics is consciousness and inner experience (Moustakas, 1994). Principally, the researcher is trying to make sense of the participant as they try to make sense of their personal experience with the phenomenon (Smith, 2004).

As a modality, engaging in hermeneutics requires that the researcher not presume upon what the individual is sharing, but, instead, listen emphatically and carefully to gain deeper understanding of what that individual has experienced. Subsequently, hermeneutic analysis is a vital part of gaining a correct understanding of the text (Moustakas, 1994). According to

Gadamer (1976), “The hermeneutic process involves a circle through which scientific understanding occurs, through which we correct our prejudices or set them aside and hear ‘what the text says to us’” (p. 18). As such, the journals and semistructured interview protocol provide a crucial description of the conscious experience of each individual. Reflective interpretation using the hermeneutic process is necessary to attain a fuller, more meaningful understanding and bring to light what might otherwise remain hidden behind the words.

For interpretation of the data, allowing for a more thorough critique, going beyond what was said or written, and uncovering fundamental inner meanings of which even the individual may be unaware are essential. Before understanding can be gained, interpretation is required. In short, hermeneutic science adds the ability to gain deeper understanding and uncover meanings hidden behind appearances (Moustakas, 1994; Willig, 2013). Thus, it is not an interpretation of what the person meant but an articulation of what is expressed in the individual’s accounting. This interrelationship is the candid accounting of the experience and the underlying dynamics that account for the experience, which can reveal the fundamental meaning that enables one to comprehend or identify the substance and essence of the experience (Moustakas, 1994). This methodology is closely related to the original concern of scientific exploration, finding meaning and meaning-making of the vast depth of human behavior (Smith & Osborn, 2008).

Idiography

As a methodology, IPA is clearly idiographic (Smith, 2004). The idiographic view recognizes that each individual has a distinct psychological framework that includes specific traits unique to that individual (Smith & Osborn, 2008). Whereas hermeneutics is the study of an individual’s written content, in short, idiography is the dedicated study of the individual, bringing the personal experience into scientific psychology. The uniqueness of the individual

lifestyle, history, personality traits, choices, and all that sets that person apart is the core of the idiographic approach. The detailed examination of each case, one at a time, until a measure of closure is achieved before moving on to the next aligns with the idiographic nature of IPA. This can only be achieved when utilizing a small sample; for a student it is suggested to use three, but for others five to 10 (Smith, 2004).

As the purpose of this study is to gain a greater understanding of how a spiritually minded individual experiences MDD and how using a spiritually focused meditation impacts the symptoms, the traditional nomothetic approach to research would be less effective because of the generality of the investigation, which gives no attention to the actual individual's experience (Smith & Osborn, 2008). This approach gives the investigator the ability to make specific statements about the individuals taking part in the study, whereas quantitative analysis of groups of people makes probabilistic claims about the individuals used in the research based on percentages rather than individual experiences (Smith & Osborn, 2008).

For this IPA, a purposeful rather than random sample is used, which ensured that the research question was addressed meaningfully. The idiographic approach entails looking in detail at the transcript of each interview and journal before moving on to examine the others. This is done case by case, pulling out particular meanings and slowly working toward a more general categorization of the experiential details (Smith & Osborn, 2008).

Research Question

To conduct a thorough inquiry, the right questions, directly tied to the research purpose, must be asked (Bloomberg & Volpe, 2012). Thus, the primary research question was: How does a clinical sample of research participants describe the experience and effectiveness of SFMM as a component of therapy to mitigate the effects of depression? To best answer the research

question in phenomenological research, it is important to keep the questions posed to the participant nondirective and open-ended (Willig, 2013). For the semistructured interview questions, see Appendix A.

Context for the Study

Depression is a deeply personal experience often accompanied by a sense of worthlessness or guilt (Clinton & Straub, 2010). For Christians, this experience is strongly contrasted with a life of faith and praise, often leaving them with feelings of hopelessness (Breitbart, 2001). IPA explores the depth of personal experience from the client's perception of that experience, making this methodology appropriate for this study (Smith et al., 2009; Smith & Osborn, 2008). The necessary strategy of inquiry includes a workshop, individual in-depth interviews, and a reflective journal.

Spiritually oriented meditation as a component of therapy makes sense for those who are Christians, as they strive to live according to biblical premises (Hathaway & Tan, 2009). In the Bible, meditation is rooted in God's counsel to man based on the need to reorient man's mindset. Biblical meditation is presented as the key to personal success, prosperity, and victory over physiological, psychological, and spiritual difficulties (see, for example, the following biblical references: Josh. 1:7–9, Ps. 1:1–3, 1 Tim. 4:15, Phil. 4:6–9, New King James Version). It is reasonable to say that from a Christian perspective, meditation is God's method of renewing the immaterial and energizing it to overcome the material (Eph. 5:26). Therefore, this phenomenological analysis is conceptually founded on the basis that alternative treatments, including meditation, have been found as or more effective than placebo, cognitive, pharmacological, and behavioral treatments for diminishing the effects of anxiety, stress, and

major depression (Srivastava et al., 2011). The following section provides the ethical basis for the protection of the participants.

Ethical Protection of Participants

A critical piece of any study is the ethical considerations. Respect and personal boundaries when it comes to the process, the role of the researcher, and continual sensitivity to the vulnerability of and minimizing the risks for the participants, are essential ethical issues that must be well thought-out (Creswell, 2013). Differing ethical concerns arise at each phase of the study. Before any study can be fully developed, federal regulations for the protection of human subjects in research require that Institutional Review Board approval be obtained to ensure compliance and minimize any risks involved (Protection of Human Subjects, 45 C.F.R. § 46, 2018). This includes: initial contact with the site and the individuals used for recruitment or voluntary participation (see Appendixes B and C); informed consent forms (see Appendix F); sensitivity to differing cultural, religious, gender, or other specific differences in participants that need to be respected; a clear awareness of potential power imbalances and exploitation of participants (e.g., interviews, observation); protecting confidentiality and anonymity; sensitivity to the topic and personal vulnerabilities of the participants; and falsifying or disclosing information that could adversely affect the participants in any way (APA, 2013; Creswell, 2013; Roberts, 2010; Rovai, Baker, & Ponton, 2014; Smith et al., 2009).

For this inquiry, avoidance of harm to participants is of utmost importance (Smith et al., 2009). Although the risks of participating in this study would not be considered more than may be experienced in a person's daily life, ethical standards require specific care be taken to ensure the individual participant's rights are clearly protected. However, there are some risks that participants were made aware of prior to their consent to take part in this study, including, but

not limited to, feeling uncomfortable or anxious or having self-doubt about having to share their experience with depression and the personal details of meditation with a stranger. Some may even feel a sense of shame or exposure, and some could experience heightened feelings of depression resulting from the experience. As a final point, some might feel uncomfortable sharing intimate details or openly reflecting on those experiences.

Additional measures to minimize these risks include an informed consent and confidentiality agreement between participant and their clinical therapist and the researcher conducting the study. The informed consent included an overview of what would be expected from the participant, possible risks, possible benefits, and the limits of confidentiality associated with qualitative studies (see Appendix F). Participants were also given an opportunity to scrutinize the experiment and the researcher conducting the study in a pre-interview and to ask as many questions as needed to feel at ease with the process and their possible participation (Smith et al., 2009). This time was not rushed in any way, and adequate time was provided for the researcher to explain in detail what was to be expected from the actual meditation, journaling, and the subsequent semistructured interview, as well as the likely outcomes of data analysis (i.e., the verbatim extracts in the published work). I took the necessary time to answer questions and established a sensitive and working rapport with the individuals taking part in this study. During the actual interview, the confidentiality and consent information was restated, enabling the participant to voice any emerging sensitive issues or questions that may have developed in their minds since the initial interview.

The very nature of this type of inquiry requires checks and balances. The collaboration between researcher and participant included feedback from participants on how they felt about what shared and wrote and how the researcher interpreted their meaning-making and experience

with the phenomenon (Williams & Morrow, 2009). If any participant had become emotionally overwhelmed during the research process, I was prepared to refer them to the therapist currently treating them for MDD. As a final step to minimize risk, the participant were given the opportunity to pull out of the study at any time. The next two sections will discuss confidentiality and its limits.

Confidentiality

Necessary steps to inform, protect, and gain consent from participants included a limited measure of confidentiality and absolute anonymity (Bloomberg & Volpe, 2012). All recordings, journals, and semistructured interview data will be kept private and safely locked in an appropriate safe in the researcher's private office. Any personal information, including specific demographics that could be used by anyone to identify the participant, is omitted or changed specifically to protect the individual's identity. Each participant was given the opportunity to choose a pseudonym (a false identity) by which they would be addressed throughout the study, as Creswell (2013) suggested this would allow them to be more fully invested in the study. All transcribed and video-recorded data were coded in such a way as to remove any and all personally identifying information. Additionally, the coding sheets will be stored separately and locked and protected in the researcher's private office. All interview and research records (journals) will be stored on a secure, encrypted laptop that remains in the constant possession of the researcher, and backup devices (i.e., portable USB) will be stored and locked in a safe in the researcher's private office.

All videos recorded during the semistructured interviews will be deleted immediately upon completion of this study, and all other transcribed data, notes, and identifying information (stored separately) will be destroyed within three years of completion of the study. Until that

time, data will be stored in the private office of the researcher and in a coded format inaccessible to outsiders. Before the submission of the dissertation, the three individuals participating in the study were given the option of reviewing those data extracts from their individual semistructured interviews and had an opportunity to delete any portion they did not want to appear in the public domain (Smith et al., 2009).

Limits of Confidentiality

Although the theoretical nature of a qualitative study often means complete confidentiality is not possible because of the integral role of the personal data (i.e., excerpts and descriptions from participants' interviews and journals), confidentiality was maintained by inviting participants, as mentioned previously, to choose pseudonyms and review all information included in the study and written report. The participants had an opportunity to read the draft before it was submitted, and if something had been included in the draft that made the participant uncomfortable and it could be explained to their satisfaction, it would have been removed. Each participant had the opportunity to disallow specific information that they felt would expose them or make them feel vulnerable to exposure. The next section covers the role of the researcher and the unique qualifications of this author for this inquiry.

Role of the Researcher

Perspective is an essential aspect of qualitative research, and any insights acquired from analysis of the data are the result of interpretation (Bloomberg & Volpe, 2012; Maxwell, 2012; Willig, 2013). Not only does the perspective of the researcher impact the study, but the background and experience of the researcher also plays a key role in phenomenological inquiry (Creswell, 2013). With this understanding, a vital aspect of qualitative writing is to distinguish

between personal influences and focused research in order to achieve intellectual goals not subjected to the researcher's personal perspective (Creswell, 2013; Maxwell, 2012).

Personal experience on the part of the researcher is also a benchmark for the motivation for the study, which often results from personal investment and interest, increasing the richness and depth of the study (Maxwell, 2012). I have worked as a family therapist for the last 30 years, and depression has been a common presenting problem for many of my clients. For Christian families, there was added complexity to their suffering. On top of dysfunctional family life, tragic loss, defeat and failure, and the world around them becoming increasingly unpredictable and overwhelming them, they were often unable to utilize their faith as a resource to effectively address their hopelessness and depression. Instead, in addition to the depression, guilt and a sense of worthlessness for not trusting God and having hope in Him complicated the depression and made recovery even more difficult. In other words, although the Bible exhorts Christians to rejoice, be glad, trust in God, and cast all care on Him, they suffered silently with feelings of emptiness or sadness, inexplicable feelings of loss and sorrow, even fear and a diminished interest in life itself. They often found themselves without a safe place to articulate these experiences due to the fear of being seen as not trusting God enough. Some were so stressed and anxious, feeling defeated so much of the time, that thoughts of suicide, the "ultimate betrayal" of their faith, impinged on their daily lives. In my clinical work, it became apparent to me that assessing and addressing spiritual concerns in counseling was vitally important.

In addition to the value of ethically and effectively integrating faith into counseling, the benefit of using mindfulness practices also become salient. Currently, I am working in an adult drug and alcohol rehabilitation center, and depression is a critical aspect of addiction and recovery. For most with substance disorders, depression is a constant underlying aspect of their

attempts at recovery. It is one of the reasons relapse rates are so high for substance addiction (Curran, Flynn, Kirchner, & Booth, 2000; Hasin et al., 2002; Witkiewitz & Bowen, 2012).

Teaching mindfulness techniques to the patients to help them choose alternative responses to the emotional distress of depression has been rewarding as they learn to resist their usual, learned response of craving the substance to mitigate their feelings (Teasdale et al., 2000; Witkiewitz, Bowen, 2012).

As I engage with these patients on a daily basis and listen to them share in group sessions, I am encouraged by their accounting of using the mindfulness techniques on a daily basis and am motivated to explore the lived experience with the selected sample to more clearly define the impact of mindfulness meditation and the effect it may have on a clinical sample diagnosed with MDD. For the population interested in spirituality as a part of their treatment, this study utilized a form of spiritually focused mindfulness that considers the patient's belief in God, adding significance to the literature on treatments for the spiritually minded. By adding spirituality and their understanding of God to meditation, it may be possible to increase the hope for recovery in individuals suffering from MDD. The following section offers an overview of how the participants for this study were selected.

Selection of Participants

Methodologically, IPA requires a small, purposive, and homogeneous selection of participants that have a distinctive or unique experience with the phenomenon. Smaller samples enable the researcher to examine, understand, and convey the experiences and perspectives of the participants with depth and critical analysis (Creswell, 2013; Larkin, 2017; Smith et al., 2009; Willig, 2013). Although this methodology limits generalizability, it fosters a detailed

representation of an individual's experience with the phenomenon of study (Hefferon & Gil-Rodriguez, 2011; Smith et al., 2009; Willig, 2013).

Consequently, participants for this inquiry were selected from a particular group of people, specifically interested in a spiritually focused form of meditation, who have each experienced MDD and been diagnosed by a clinical professional. According to Creswell (2013), qualitative research entails the individual's experience with and perception of the phenomenon, so a purposive selection of participants is central to this study. Consistent with this focus, three individuals, diagnosed with MDD, presently in treatment with a mental health professional, and willing to add a spiritual element, were selected to participate in the present study. Screening procedures included the administration of the demographic questionnaire (see Appendix D) to verify if the individual was eligible for the study. The therapist gave the questionnaire to the possible participant and gave each participant my phone number so they could call me if they were interested in participating. Three main questions were used to clarify eligibility of the individual: (a) Have you been diagnosed for MDD? (b) Do you consider yourself to be a Christian? and (c) Do you agree to meditate for 10 to 20 minutes a day using SFMM for three weeks? After receiving an introduction to me and the study, each participant had opportunity to ask any questions they felt relevant to the study. From that point, I asked them for a brief overview of their diagnosis, and they were given a date and time for the workshop.

Participants for this inquiry were selected from a particular spiritually minded group of people, at least 18 years old, who have each experienced MDD, have been diagnosed, have relapsed one or more times, and are currently being treated by a clinical professional. Participant criteria included the stipulation that they speak English and agreed to journal about their experiences, thus requiring a measure of ability to record purposeful notes. Additionally, the

semistructured interview required the individual to be capable of honest, open reflection and be willing to share their experiences with the mediation as well as the depression without excessive difficulties with recall or articulation (Hodgetts & Wright, 2007; Smith, 2004; Smith et al., 2009; Willig, 2013). Male and female adults willing to add a Christian element and recommended by the therapist were interviewed for the study.

Following Institutional Review Board approval, an overview of the study (see Appendix A) and a recruitment letter (see Appendix B) were hand-delivered to selected mental health professionals prequalified by phone. A recruitment letter (see Appendix C) was distributed by mental health professionals once they determined which patients would be a good fit for the study. The patients interested in more information were given my phone number; when they called, they were invited to be in the research study and given an overview of what that entailed, including a description of the two-hour SFMM group workshop they were asked to attend. Then they had an opportunity to have any initial questions answered. As an incentive to participate in all phases of this study, each of the three participants received a \$50 Visa gift card. The following section provides an overview of the data collection and analysis methods used in this study.

Data Collection and Analysis

Although the qualitative methodology allowed for flexibility for unanticipated topics or themes to emerge during the semistructured interview and analysis of data collected, it is important to fully divulge how the data were collected and analyzed. The following subsections offer an overview of each aspect of collection, organization, and analysis of the data.

Data Collection

Potential participants who agreed were contacted by the researcher. During this call, they were invited to be in the research study and given an overview of what that entailed (see Appendix A), including a description of the two-hour group workshop they were asked to attend. They then had opportunity to have any initial questions answered. Three individuals who accepted the offer to take part in the study were scheduled for the SFMM workshop, held within 10 days of this initial phone interview. During this pre-interview, participants were asked: (a) if they have ever tried meditating to lessen the symptoms of their depression, (b) if they have ever been involved in a study previously, (c) what aspect of spirituality are they interested in using for meditation, and (d) if they had any questions for me concerning the study or what would be asked of them. When they agreed to be in the study, their therapist gave them the informed consent form (see Appendix F) and a demographic survey to fill out (see Appendix D). These forms were picked up by the researcher prior to the workshop.

The SFMM workshop was held as a group training for those volunteering for the study. This training took place in my private counseling office. After an initial introduction of myself and the study, which included the importance of confidentiality and privacy for the participants, participants had an opportunity to ask any questions concerning their involvement. If any of them wished for an opportunity to talk privately, that was also made available. The workshop included detailed instructions about SFMM and how the meditation is done. The participants received two handouts describing the meditation (see Appendixes H & I). The training included a 20-minute meditation exercise using a characteristic of God (Appendix I) led by the researcher. An introduction to the experiential journals was given, and each of them received a journal to be used for the study.

During the experimental period of SFMM meditation, participants reflected about their experiences using SFMM with the experiential journal. They were instructed to write down their thoughts about the meditation (e.g., their mood before and after; their thoughts during the meditation; if their mood improved; how long the mood improvement, if any, lasted through the day). Participants were also asked to record what type of meditation they chose (e.g., a scripture verse, a characteristic of God, or perhaps a line from a Christian song). Journals were collected at time of interview and were combined with the interview data for analysis.

The individual interviews were scheduled to take place at my local counseling office. They were scheduled for within one week of the end of the three-week period of meditation. During the interview, I attempted to enter the experiential world of participants by allowing the individual participants to describe their experience with SFMM in any way they chose at the beginning. Throughout the interview, probing and/or specific questions (see Appendix G) were posed so I could gain insight and/or encourage the participant to elaborate on something he or she said or agree/disagree with particular claims of statements offered by the researcher (Smith et al., 2009; Willig, 2013). This was accomplished by encouraging the participants to speak freely and reflectively, share stories, develop ideas, and express their experience at length.

The interview was semistructured to allow the participants to lead the discussion rather than answer specific questions that may limit their freedom to share details of their experience with the phenomenon (Smith et al., 2009). Although I used the interview guide, the goal was to encourage and allow the participant to share the details of their experience with SFMM and its impact on their depressive symptoms with ease and comfort. The entire interview was video recorded.

Organization and Analysis of the Data

Once the data were collected, the next step was to manage, arrange, and draw meaning from the accumulated information. The goal was to summarize the collected data as accurately as possible. This process began with induction as the researcher progressively narrowed the plethora of data into more focused groups of key data using the following sequential phases: organizing the data, creating categories, identifying patterns/themes, and coding the data (Bloomberg & Volpe, 2012).

Organizing the data began with a careful transcription immediately following the recorded interview and assignment of identification codes to each of the transcripts (Bloomberg & Volpe, 2012; Smith et al., 2009). For this study, I did the transcribing personally to become immersed and intimately involved with the data, allowing careful consideration of the experience, including nonverbal communication (e.g., pauses, laughter, interruptions, or audible sounds like sighing) to be noted in the transcription within parentheses (Bloomberg & Volpe, 2012). Data from the journals were used to add to and triangulate (confirm) thematic selection (Creswell, 2013; McLeod, 2011; Ponterotto, 2005).

The primary focus in IPA is to direct the analytic attention to the participant's attempts to make sense of their experiences. Throughout the analyzing process, I moved between the particular details and the shared feelings and from the descriptive to the interpretative (Smith et al., 2009). This was accomplished by a genuine commitment to understanding the participants' point of view and a psychological focus on what the individuals were trying to express within the particular context of their experience with depression and with the meditation, as well as trying to sort out how they feel as a result of taking the time to meditate. I used a reflective journal to

“bracket” off my own experiences, ideas, and thoughts about depression, SFMM, and mindfulness to differentiate them from those of the participants (Moustakas, 1994).

Using a heuristic framework for analysis of the data, the structure was understandably flexible, but it was clear enough to gain a thorough understanding of the experience (Smith et al., 2009). Following the step-by-step guide to IPA analysis developed by Smith et al. (2009), data analysis involved the following steps:

Step one involved *immersing* in the original data, reading it again and again, and producing wide-ranging and mostly unfocused notes reflecting initial thoughts and observations (Smith et al., 2009; Willig, 2013). While reading the written data, I listened to the audio recording to get a sense of the emotions and feelings behind the participants’ words, the nonverbal communication mentioned above.

Step two, *initial noting*, was the most detailed and time-consuming of the stages. During this step, anything of interest was noted as the transcript became more fully understood. This process involved exploratory commenting that consisted of comprehensive and detailed notes using descriptive comments (i.e., describing content of what participant said), linguistic comments (i.e., concentrating on specific language), and conceptual comments (i.e., a more interrogative and conceptual level; Smith et al., 2009).

During the third step, *developing emergent themes*, the focus was on identifying central themes that kept showing up throughout the reading and listening. It was important at this stage to keep in mind that the whole experience is interpreted through the understanding that every statement has value, adds meaning, and provides an increasing portrayal of how SFMM impacted the individual’s depressive symptomology (Smith et al., 2009; Willig, 2013). Themes emerged that reflect the participants’ words and thoughts and my interpretation of their words,

feelings, and emotions. Each of these themes was ordered chronologically according to the order they showed up in the text.

Step four, *searching for connections across emergent themes*, involved the development of charts, maps, and the hierarchical relationship the themes have to one another (Willig, 2013). Although some could be discarded, at first each emergent theme was put into list form in chronological order to look for patterns and connections between them (Smith et al., 2009).

This process was repeated for each participant, and when each analysis was completed, a graphic representation (master table) of the structure of the emergent themes was developed with quotations that illustrate each theme (Smith et al., 2009; Willig, 2013). A master table was created for each case, and this table of themes reflected the patterns and possible similarities from case to case that emerged during step four. For each emergent theme, a new Word file was be opened and identified with a number (e.g., 10.6 – page 10, line 6). From these files, the master table listed theme, page/line, and key words. I looked for patterns that appeared across the cases, looking for connections, repeating feelings or thoughts, similar responses from the experience with the phenomenon and the revealing of consistent themes (Smith et al., 2009).

Trustworthiness

Trustworthiness, or the ability to assess validity of the research, is an essential element of qualitative methodology, as it demonstrates that the research is grounded on meticulous adherence to methodological rules and principles. An essential aspect of trustworthiness is minimizing researcher bias; to minimize researcher input and maximize results coming from the participant data, bracketing (fully explained in Chapter Four) as utilized throughout the data collection and analysis phases (Angen, 2000; Brocki & Wearden, 2006; Smith et al., 2009). Validity also includes how well a study is conducted and the production of accurate conclusions,

which, for the IPA study, involves precise and sensitive insights in response to the research question. Yardley (2000) offered four principles used for assessing the quality/trustworthiness of qualitative research: including sensitivity to context, commitment and rigor, transparency and coherence, and impact and importance. These open-ended principles were employed to ensure trustworthiness for this study (Smith et al., 2009).

Sensitivity to Context

Larkin et al. (2006) purported that sensitivity to context and responsiveness to the participant is central to trustworthiness in IPA. Sensitivity to context involves the researcher's sensitivity to, for example, the individual's social-cultural environment, the collected journal's contents, and the current literature on the topic (Alase, 2017; Larkin et al., 2006; Rodham, Fox, & Doran, 2015; Smith et al., 2009). This sensitivity begins from the initial interview and continues for the length of the inquiry. The idiographic nature of the interpretative study requires establishing an alliance with the participants in which they feel validated, understood, and a legitimate part of what is happening, creating access to the individuals' more thoughtful feelings and any meaning they may have gained from the phenomenon under examination (Alase, 2017; Larkin et al., 2006; Yardley, 2000). The meaningful, interactional nature of the data collection (i.e., journals, initial interview, semistructured interview) requires an ability to discern the various nuances of an individual's interactive style. For example, showing empathy, helping the participants to feel comfortable sharing sensitive aspects of their experience, and even recognizing interactional difficulties they may be experiencing are essential aspects of sensitivity to context (Alase, 2017; Larkin et al., 2006; Rodham et al., 2015; Yardley, 2000).

Subsequently, for the researcher to accurately perceive how the participants make sense of their experience with the phenomenon, immersive and disciplined sensitivity and attention to

the unfolding accounting is critical (Alase, 2017; Larkin et al., 2006; Rodham et al., 2015; Yardley, 2000). This ability to detect and/or respond to slight changes like body language, signals like sighing, or influences like culture is essential for not only the interactive interview session but also the written data (i.e., participant's journal) used for a full accounting in the written report (Alase, 2017; Larkin et al., 2006; Rodham et al., 2015; Smith et al., 2009; Yardley, 2000). The evidence of this sensitivity is found in the numerous verbatim extracts, giving true voice to the participant and allowing readers to discern the validity of the researcher's interpretation of the content (Smith et al., 2009; Yardley, 2000).

As a final note, sensitivity to current literature, whether substantive or theoretically focused on IPA, is another aspect of showing sensitivity to context (Brocki & Wearden, 2006; Smith et al., 2009; Yardley, 2000). Awareness of relevant substantive research not only orients the study and findings but provides a context for discussing the findings (Angen, 2000; Brocki & Wearden, 2006; Smith et al., 2009; Yardley, 2000).

Commitment and Rigor

An in-depth, meaningful IPA inquiry requires a considerable investment, personal commitment, and high degree of assiduous attention from the investigator (Angen, 2000; Brocki & Wearden, 2006; Smith et al., 2009; Yardley, 2000). Throughout the data collection process, the investigator is required to remain attentive and connected to the participant, ensuring a comfortable place to share subjective experiences and possible feelings of vulnerability and exposure (Brocki & Wearden, 2006; Smith et al., 2009; Yardley, 2000). Additionally, a sincere interest in what the participants are sharing and specific skills (e.g., motivational interviewing, an empathetic alliance) are an important part of connecting with and being committed to the participant (Yardley, 2000).

Rigor involves attention to detail throughout the study and can be demonstrated in numerous ways. One is a purposive sample appropriate for the research question (Smith et al., 2009; Yardley, 2000). Thus, the specific boundaries of the inquiry require that this sample be chosen judiciously, considering the phenomenon under investigation. Furthermore, it entails a homogeneous sample (i.e., they have been diagnosed for MDD, they are currently in treatment, how many times they have relapsed, types of treatment have they had), as the participants shared personal meaning and how they made sense of SFMM and the impact it has on the depressive symptomology (Brocki & Wearden, 2006; Smith et al., 2009; Yardley, 2000). This facet of rigor is the criterion used to recruit purposive participants (Smith et al., 2009).

Another aspect of rigor is the quality of the semistructured interview and the diligence to prepare an exhaustive list of secondary questions to guide the researcher in obtaining a detailed accounting of the participants' experience with the phenomenon (Brocki & Wearden, 2006; Smith et al., 2009; Yardley, 2000). Brocki and Wearden (2006) even suggested, for enhanced trustworthiness, to include the prompt questions as a part of the description of the interview process. An additional piece here includes the skill on the part of the researcher to call attention to important cues, probe deeper into what is being shared, and ascertain how the participant is experiencing the phenomenon at a more in-depth level than what was initially shared in answer to a question posed (Angen, 2000; Brocki & Wearden, 2006; Smith et al., 2009; Yardley, 2000). Additionally, rigor is sustained by the idiographic engagement piece for a thorough analysis; participants all have their own voice, experience, personal accounting, and meaning-making relating directly to how they understand and describe this lived experience with the phenomenon (Brocki & Wearden, 2006; Smith, 2011; Smith et al., 2009). For an extensive analysis of the participants' experience, it is important to allow their voice to be heard and be vigilant to

consider every nuance of their responses—not just what they say, but the interpretation of the meaning behind the words (Brocki & Wearden, 2006; Smith et al., 2009).

Finally, like sensitivity to context mentioned earlier, the small number of participants means the researcher has the responsibility to record verbatim extracts from each individual to illustrate each of the major themes found for each of the three participants (Brocki & Wearden, 2006; Smith, 2011; Smith et al., 2009). Although the goal here is to tell the readers something important, the interpretative facet of this methodology requires of the researcher thoroughness, precision, and accuracy in those reflections (Brocki & Wearden, 2006).

Transparency and Coherence

Transparency comprises the clear and concise write-up of the research process, including a description of the process of selecting the sample, how the interview was structured and conducted, and the specific steps involved in the analysis (Rodham et al., 2015; Smith et al., 2009; Yardley, 2000). This would also include creating charts or tables detailing different aspects of the inquiry (Yardley, 2000). Rodham et al. (2015) added to this discourse the inclusion of reflective notes from the investigator (or possibly making them available online in a forum attached to the journal article). Coherence is, as they say, in the eyes of the beholder, so it important to show the reader a coherent argument, themes that are connected logically, and that any ambiguities or contradictions are clearly enunciated and explained (Rodham et al., 2015; Smith et al., 2009; Yardley, 2000).

Considerable drafting and redrafting is a critical aspect of coherence (Smith et al., 2009). Additionally, Yardley (2000) emphasized the importance of keeping the research and the underlying theoretical assumptions of the methodology (IPA) closely aligned throughout the report. For this inquiry, that requires the phenomenological and hermeneutic aspect (i.e., the

experiential domain for the participant and the commitment of the investigator to remain focused on the phenomenon under study) to be apparent in the written report (Brocki & Wearden, 2006; Smith et al., 2009; Yardley, 2000).

Impact and Importance

The real test, according to Yardley (2000), is found in whether the report reveals to the readers something important, interesting, or useful. Various factors included in the study should be able to not only identify and inform the particular aspects of the participant's experience, but also create for the reader a more universal understanding of the phenomenon under examination (Brocki & Wearden, 2006; Smith et al., 2009) as well as the ability to meaningfully apply it to the field (McLeod, 2011).

Summary

This IPA study was predicated on a desire for a deeper understanding of how SFMM impacts depressed persons. It is my hope that an in-depth understanding of how SFMM does or does not mitigate depressive symptoms will make a significant contribution to the clinical and empirical literature.

This chapter offered an overview of IPA as the methodology selected for this study. It included a definition of the individual elements of IPA: phenomenology, hermeneutics, and ideography. The research question was presented and the context for the study explained. An explication of ethical considerations, including Institutional Review Board approval, confidentiality, and the limits of confidentiality in qualitative studies followed. An overview of the role of the researcher was explained. Participant selection and data collection and analysis methods were described. The chapter ended with an explanation of trustworthiness of the research findings, including sensitivity to context, commitment and rigor, transparency and

coherence, and impact and importance. Chapter Four will present the findings of this phenomenological inquiry.

CHAPTER FOUR: RESULTS

The epistemological and coherent framework of IPA qualitative design offered a unique way to investigate the phenomenon of depression from the perspective of the research participants to gain an in-depth understanding of their subjective experience with depression. Moreover, IPA presented an opportunity to assess the added element of spirituality to the participants' current treatment. Three individuals attended a two-hour workshop together for an introduction to the study to: (a) learn how to use SFMM, (b) be taught how to journal their experiences, (c) receive an explanation about the individual in-depth interviews, and (d) ask any questions they had concerning the study. The semistructured interviews were audio recorded and transcribed verbatim. Finally, data from three individuals were coded for patterns of essential core meaning to gain a deeper understanding of the participants' subjective and behavioral experiences using SFMM to moderate depressive symptoms.

To satisfy the hermeneutic, or interpretative, aspect, the data were revisited again and again to reveal deeper meaning; this enabled a greater sensitivity of comprehension of the underlying dynamics of participants' experiences (Bloomberg & Volpe, 2012; Moustakas, 1994). Furthermore, the idiographic aspect of the IPA design required a detailed examination and analysis of each individual's data as though they were the only participant until a measure of closure or understanding was achieved before continuing to the next (Smith, 2004). Thus, a detailed exploration of how each participant experienced meditating with SFMM and how their individual lives were impacted is delineated in this chapter. As a final note, when the verbatim quotes are exceptionally lengthy, ellipses are used to eliminate unnecessary, less relevant sections of the data.

Participants

Methodologically, IPA requires a small, purposive, and homogeneous sample; therefore, three individuals meeting the proposed criteria were chosen for this study. The criteria required that each participant be diagnosed by a clinical professional, be in treatment for MDD, and be interested in a spiritually focused form of meditation. All three individuals spoke English; desired to add a spiritual element to their current treatment; were willing to journal about their experience and were capable of doing so; presented as capable of honest, open reflection; and were willing to share their experiences with the meditation as well as the depression. Additionally, although not in the previous criteria, each of the participants had suffered from alcohol or drug addiction and had experienced more than two depressive relapses.

Demographic Information

The participants were homogeneous in terms of race/ethnicity, religious affiliation, clinical diagnosis of MDD, and experience of two or more depressive relapses. Each participant was female; the median age was 54, with ages ranging from 47 to 59. All three were Caucasian. Rose and Tracee were unemployed, and Angela was employed full-time. Years of education ranged from 12 to 16 (Karen received a college degree, Tracee completed some college), one was divorced, and two were married. Rose had one child, Angela had two children, and one had no children. Gross family income at the time of the study ranged from \$25,000 to over \$75,000.

At the time of the demographic questionnaire, participants reported severity of depression on a 10-point scale (0 = no depression, 10 = severe depression) at 1, 2, and 7, respectively. Moreover, all three participants indicated current treatment for MDD by a professional clinical therapist, and each one was currently taking at least one prescribed medication for depression. The participants' duration of depression was reported as 14 years, 30 years, and lifetime. None

of the three reported exercising regularly. In terms of spirituality, Angela and Rose reported being Christians, Tracee reported “spiritual but not religious,” and all reported that faith was very important to them. Rose and Tracee reported no church attendance, while Angela reported attending two to three times a month. One participant indicated she prays three to four times a day, and two indicated they pray twice a day. Each participant indicated belief in a higher power, and all engaged, or had engaged, in some form of meditation.

The intention of this study was to discover how SFMM affects depression symptomology; therefore, the participants’ prior involvement with meditation was significant. Angela and Tracee had a vague understanding of mindfulness meditation, and Rose was more familiar with mindfulness meditation. Rose had limited experience with doing meditation, and none had ever meditated to mitigate the symptoms of depression. When asked about their interest in SFMM, Angela and Rose reported being on a “spiritual journey” and looking for something like SFMM as an alternative form of meditation. Tracee had no history of seeking God as part of her solution, but related that AA introduced her to a higher power as a part of sobriety and freedom from depression.

Table one provides a summary of demographic information for each participant. In conclusion, to offer the reader the opportunity to gain a deeper understanding of the content analysis, the following section provides a narrative of the individual participants’ life experiences and circumstances (Moustakas, 1994; van Manen, 2016).

Table 1

Demographic Information

Demographic	Angela	Rose	Tracee
Gender	Female	Female	Female
Age	59	58	47
Ethnicity	Caucasian	Caucasian	Caucasian
Education	College	High School	Some College
Gross income	\$75k+	\$25k+	\$25–45k
Employment	Employed	Unemployed	Unemployed
Marital status	Married	Divorced	Married
Years married	28	2 and 6	15
Children	2 [23,18]	1 [32]	0
Religious affiliation	Christian	Spiritual not religious	Christian
Present severity of depression	7	1	2
Duration of depression	30 years	Lifetime	15 years
Presently being treated for MDD	Yes	Yes	Yes
Medication	Abilify, Pristiq	Zoloft, Abilify	Elavil, Trazodone
Diagnosed with MDD	Yes	Yes	Yes
Regular exercise	No	No	No
Prayer frequency	3 to 4x a day	2x a day	2x a day
Church attendance	Yes – 2 to 3x month	No	No
Belief in a higher power	Yes	Yes	Yes
Presently engagement in any form of meditation	Yes	Yes	Yes
Form of meditation?	Psalms meditation CD	Manifesting grace through gratitude	Deepak Chopra
Yoga	No	Yes, 1x a week	No
Familiarity with mindfulness meditation	Very	Somewhat	Somewhat

Note. Fictitious names are used throughout.

Individual Participants Narratives

Rose. Rose, age 58, grew up in Massachusetts on Cape Ann, a fishing community, which she described as “breathtakingly stunning.” Believing she was “born an alcoholic,” she left her small village in 2004 at the age of 44, finding she “couldn’t stand it anymore,” claiming alcohol and drugs were too accessible. Rose started drinking at 12 years of age, and by 13 she drank

continually. She asserted that she was “depressed most of the time throughout her childhood” and mentioned that “there are a bunch of pictures of me as a child, not smiling, always pouting.” She remembered being “discontent from a very early age.” Her parents were “entrepreneurial,” never having much time for their children, leaving them feeling like they “weren’t really a priority, making me feel like they were unavailable to me, and I don’t feel like I ever had a good sense of self-worth.” Rose related that throughout her childhood she bore the emotional stress of feeling “abandoned and irrelevant.”

Rose attended Catholic school and reported, “They were always telling me that I was bad, and I was different than my ‘perfect’ sister.” She was sexually abused by an uncle at seven years of age and lost her virginity at 13 to date rape. After graduation, she lived a “sexually promiscuous” life of alcohol and drug addiction with increased periods of depression until she became pregnant with her son. Her first experience with sobriety was during her pregnancy and for four years following his birth. Drugs, alcohol, and sex became a “way to feel better about myself” and fight the “dark feelings of depression that followed me around.” Rose attempted suicide several times: “First time I was about 20, and I went to a treatment place for two weeks.” She had been in and out of four rehabilitation treatment facilities. She could not recall the second attempt, but the third one was two years ago, when she was 56. She “overdosed on pills and woke up in a hospital.”

Rose was first diagnosed with MDD at 17 or 18 years of age. She was prescribed antidepressants and saw a psychiatrist weekly. She described the depression as being “so dark that it caused me to want to die; I just didn’t want to live anymore. I was relieved when I thought it was going to be over, and I wouldn’t wake up again.” Although the medication helped her feel better most days, she reported, “My mind still can take me to a dark place.”

At the time of the interview, Rose had been sober for six months. She had found a program (AA) and meetings that “worked” for her. When asked what changed from the previous experiences with AA, she stated, “I had a spiritual experience, it was just shockingly unbelievable.” She reflected that God “opened my heart and showed me how my choices have affected my family, and that I was, in fact, a deeply depressed alcoholic.” Rose gave an account of her sobriety as, “Oh God, I so love Him. I’m so happy, so relieved, and so grateful for that moment; I tell Him every day, thank You for saving my life.” When asked why she wanted to take part in this study, she said, “What motivated me was my experience with lifelong clinical depression and the opportunity to learn a spiritually based meditation to combat it.”

At the time of the study, Rose was on anti-depressant medication, resided in South Florida, and worked through the AA program as a sponsor to others seeking the sobriety that she had found. She was unmarried and had one son in his early 30s.

Tracee. Tracee, age 47, was born in Indiana and taken to Florida by her biological mother as a toddler. Although her recollection was unclear, she believed she was around the age of three when her mother “began selling my little body to men to use as they pleased for sexual pleasures” so her mother could buy drugs. She recalled being “tied to a lawn chair in the ghetto for most of my first eight years.” She sadly reported, “I was handcuffed to that lawn chair and sold for drugs and alcohol until my uncle Harold stepped in and basically kidnapped me.” He took her to her grandparents, who got emergency custody of her and later adopted her as their child. Tracee then experienced reconstructive surgery on her young body to repair the damage that resulted from the sexual abuse. She moved back to Indiana, where she lived until her family moved to Florida when she was 16 years old.

After graduating from high school, Tracee moved back to Indiana for college and remained there until she was 19. At that time, her mother gave birth to another baby girl, and she moved to California to adopt her sister. Two years later, she returned to Indiana to finish college. After the 9/11 tragedy, she moved back to Florida to “live near family and raise my daughter [sister].” She met and married her husband at 33, and they raised her sister “as their own daughter.” Tracee was never able to conceive as a result of the sexual trauma and damage done to her physically. Her father (grandfather) died when she was 35, and she began drinking to “numb my feelings of loss” and the deep ache of a lifetime of rejection and pain.

Although Tracee bore the physical and emotional scars of her mother’s chronic addiction and subsequent sexual, emotional, and violent physical abuse, she had never confronted her own feelings of depression, “seeking to be an overachiever rather than face them.” However, after her grandfather’s death, “the depression became an angry monster that wouldn’t be silenced.” At first, she “would binge drink once a month or so just to numb out.” But that led to drinking all the time to try to

dull the pain of losing my father and the continual feelings of rejection. I always felt like a mistake and had low self-esteem. My mother (grandmother) was extremely abusive, mentally and physically, and I think I’d been depressed most of my life; in fact, it really was a way of life for me. My grandfather, who was my dad, he was always that saving person in my life—when my mom (my grandmother) would get too out of hand, he always stepped in. When I got bad reports from school, she [her grandmother] would photocopy them at work, come home, and take all the pictures off the wall and put these bad reports all over the house.

Tracee was diagnosed with MDD at age 36. She had been in and out of rehabilitation treatment centers, involuntarily committed to hospitals under the Baker Act, and jailed, and she had also checked herself into a psych ward “because the depression had gotten out of hand, and I was suicidal. I tend to get suicidal when the depression gets too bad.”

At the time of the study, Tracee had been sober for eight months, she had found an AA group that worked well for her, and she worked through the 12-step program with her sponsor. However, she still struggled with depression daily, saying, “It just swirls around in my head, the depression, my mood just goes up and down.” She reported the changes from using SFMM: “The meditation is great, it gets me grounded and ready for my day. I am able to know God is in control and I just have to stop trying to run my own life.” She also stated her desire to “remain sober and start living a life worth living.” When asked why she wanted to take part in this study, she stated, “I wanted to do it for my continual growth with God, I wanted to see for myself that if I meditate on scriptures how much it will help me with my depression and my negative thinking.”

At the time of the interview, Tracee was on antidepressant medication, and lived with her husband of 14 years and their dog in South Florida. She found ways to give back to her community through volunteer work and worked with others going through the AA program.

Angela. Angela, age 59, grew up in a little suburb of Houston, Texas. She lived there until she married her high school sweetheart at 17 and moved to Galveston, then four years later moved to Little Rock, Arkansas. She shared, “he came home one day and just said I can’t be married anymore; I’m getting someone to commit adultery.” They had been married ten years. She completed her education to be a registered nurse, and during that time she met her present husband, who was then studying medicine.

Angela started drinking when she was 45 after the death of her father to release the tension she felt constantly from running her home and her husband's busy medical practice. She drank heavily for about two years and then checked herself into a rehabilitation center. She stated:

My husband, he just got so scared. He called the medical director of that treatment program because he didn't know what to do with me. And he's always stood by with me. I mean I've never gone totally to the bottom but being irresponsible not cooking or throwing together some at the last minute you know; I was just neglecting the atmosphere at home and my children. I was there physically for them, and I wasn't there emotionally. You know I was just shut down, just really shut down mentally.

Depression began in her early 20s. She was diagnosed with premenstrual dysphoric disorder and given Prozac for the symptoms. Angela also suffered from "super bad migraines with my periods, almost to where it would shut me down." She was diagnosed with MDD in her early 30s. Furthermore, she discontinued the medications for four years when she found out she was pregnant with her son. She also reported having "postpartum depression because of my hormones." Because of that, she was prescribed ADM in the last month of her pregnancy with her daughter, which, she related, "really helped." She reported, "I had a lot of depression when I was pregnant with each of them, and I felt so guilty about it."

Angela has been on ADM for MDD for most of her adult life. She mentioned she still battled depression daily, although the medications helped her to feel more level most of the time. She noted, "Well, yeah, I've been on Viibryd for like four years and I've been doing great. I was doing great and then it started back. I started feeling really sad and unmotivated again." She

talked about the depression being coupled with guilt and shame for feeling like she was “letting God down” by not being able to “beat” the depression.

At the time of the study, Angela attended AA meetings that worked for her, had connected with a great sponsor, and had developed a strong support group. Although Angela was seeking counseling and using prescribed ADM, she “struggles daily with depression.” She was married and had two children, one son in his late 20s and one daughter who was 18. She reported being sober for 16 months. When asked why she wanted to take part in this study, she said, “I was hoping to have improvement with my depression and anxiety, learn a new tool to use.”

As per Smith et al. (2009), the first principle of a well-done IPA study is sensitivity to context. Accordingly, this section offered insight into the lives of the three individuals who took part in this study. Evident from their history, each faced significant life stressors including alcoholism, addiction, sexual abuse, and/or neglect. Depression appeared to be part of their lives from childhood. The next section presents the themes revealed through the comprehensive examination and analysis of each individual’s data (Smith, 2004).

Findings

This research explored the subjective experience of three participants diagnosed with MDD who used SFMM. The research question was: How does a clinical sample of research participants describe the experience and effectiveness of spiritually focused mindfulness meditation as a component of therapy to mitigate the effects of their depression? Participants used SFMM 15 to 20 minutes a day for three weeks and made entries in their journals daily to describe their experience with SFMM, their moods and challenges, and any other features they

considered important to record. Two of the participants completed the daily journaling, and one did not journal her experience.

Primary Themes

The primary themes that emerged from a content analysis of the perspectives of the research participants fit into four categories of overall effect of SFMM: biological, psychological, social, and spiritual. To clearly answer the research question, the findings are organized according to the primary themes found in the four categories.

Biological Effects of SFMM on Depression

The biological symptoms of depression include changes in appetite, sleep patterns, daily activities, and libido; fluctuating moods based on daily events (often including worsening of mood in the morning); lethargy; panic attacks; tension headaches; and increased heart rate (APA, 2013). The study participants reported that SFMM had an impact on their biological symptoms in the following areas: change in sleep patterns, sustained good/better mood, increased energy and motivation, and noticeable control over the effects of anxiety and/or stress.

Change in sleep patterns. A significant biological effect experienced by each of the three participants was a change in sleep patterns. Each reported sleeping longer without interruption, sleeping deeper, waking rested, and having the ability to go back to sleep if they did awake in the night.

Angela reported that before using SFMM, she could fall asleep most nights initially but would then awaken numerous times throughout the night. When asked if she slept any better through the three weeks of meditation, she answered, “You know, initially I would look at my clock and count on my fingers, but after I did my meditation and deep breathing, I fell into such

a deep sleep and didn't wake until morning." A little later in the interview she readdressed this issue and said:

When I first get in bed, and I just meditate a little bit, I'd feel like butter, my whole body relaxes into my bed, my whole body, and the next thing I knew it was five o'clock; I slept. My whole body was just so relaxed.

Tracee was surprised by the change in her sleep patterns:

I forgot to take my medication several times, when I woke up in the morning, I was just able to be with God and be calm [meditating]; I was calm enough to sleep without them. I never slept without medication before.

When asked to explain this she related:

Even in the mornings, waking up in the mornings, doing this [SFMM] before I would even get out of bed. I would start my day with such a great thing; you know, I'd get my shower, put my hair up, go to my meeting, and be able to go through the day and not even think about it. That's huge! It is huge because my medication has been a crutch for me, but sleeping all night made such a difference, then meditating in the morning and I'm off.

Rose reported she had struggled throughout her lifetime with poor sleeping habits. She revealed how SFMM affected her sleep:

Once I had quite a stretch of sleeping very poorly. I was okay during the day; it's not like I was, you know, dragging during the day, but I just wasn't sleeping more than, sometimes four hours, or whatever. I'd wake up a lot in the night. One night I meditated . . . and I slept through the whole night that night! So yes! It helps my rest; so much, more peaceful.

Sustained good/better mood. Research participants reported improvements in mood characterized by an ability to more fully manage their moods, reduced mood swings, and better mood overall. Angela recounted, “For a few days my mood has been getting better and better; I think the meditation has been a big part of my good mood lately.” Tracee articulated how meditating helped her manage her mood swings: “My mood is more manageable, it [meditating] hasn’t taken it away, but [it is] definitely more manageable, definitely more manageable.” Rose shared how she was able to extend the feelings of calm she experienced by recalling aspects of the meditation throughout the day:

After the three weeks, I would have to say that my mood is better because the meditation has been a daily part of my life. And it’s like during the day I sort of refer back to it, so it brings me peace. Like part of my consciousness, I just take a deep breath and calm myself.

Increased energy and motivation. Participants reported that energy and motivation improved as a result of SFMM, enabling them to complete previously challenging daily tasks like grocery shopping, cleaning house, and fixing food for family. Tracee had been on ADMs for 10 years and had lost motivation for most of her normal daily activities before taking part in the study. Tracee reported the SFMM impacted her energy. She found herself motivated and able to do the things she liked to do again, like cooking and cleaning house. She explained:

I think that I was able to focus on my task that I wanted to do, you know, like I wanted to get into the kitchen and I wanted to cook. I didn’t want to cook like normal things; I wanted to get in the kitchen and play, and I haven’t played in my kitchen in a long time. But I went in and I made all kinds of things; I made cream puffs, I made eclairs, I made this pumpkin spice cake, I took it to our early meeting. I made blueberry banana and

banana bread. I mean I was just in the kitchen excited to make lasagna and ziti for him [her husband] and his favorite burger.

Tracee attributed this surge back to self-hood to the depression lifting as a result of engaging in SFMM. In her journal, she wrote, “I meditated four times today! My day got so much better, and I was active all day!”

Rose also reported increased energy. She shared, “I had more energy for the day, and I didn’t feel dragged out. I also felt so calm and relaxed, more peaceful, not so anxious or stressed.” Furthermore, Angela had been experiencing recurring episodes of depressive sadness and lethargy before she began the study. As she explained, “In the evenings I was just so lonely and sad, I was just letting things pile up.” Later in the interview, when asked how meditating with SFMM affected her, she emphasized, “Oh, I’m much better now, even if he [her husband] calls to tell me he’s not coming home till later, I just do a load of laundry, I read some, and I’m good.” Angela found that SFMM resulted in a shift from negative, self-destructive thinking to becoming motivated and focused on the tasks ahead.

Noticeable control over the effects of anxiety and/or stress. The final effect reported by each participant in the biological category was a noticeable awareness of and shifts in negative thinking, anxiety, and emotional stress. Tracee summarized the change: “My experience was, how would I describe it? I would describe it as a calming effect. It helped me be more focused, you know, centered, able to control what was flowing through my mind, like anxiety.” Rose shared how she had become more sensitive to the depressive symptoms and how she could use the SFMM as a skill to change how she felt: “I can feel it [depression] coming on now, and sometimes in the afternoon, sometimes at night, I would just sit down and meditate. I would always feel so much better, like peaceful and calm.” Likewise, Angela shared,

I feel lost sometimes to myself, so I would meditate, and it works, and I can start focusing. But it works. I could just feel the stress being lifted from me. All that pressure and stress was just gone. It was really good for that.

As can be seen from the data reported, each research participant reported improved sleeping and mood, increased energy and motivation, and more control over the effects of anxiety and stress. Participants attributed these improvements in functioning directly to the use of SFMM.

Psychological Effects of SFMM on Depression

Psychological symptoms of clinical depression include sad and irritable mood for most of the day, almost every day, loss of interest or pleasure, feelings of emptiness, hopelessness, and negative self-perceptions (APA, 2013). Several cognitive shifts were reported by the participants as a result of practicing SFMM daily. They reported greater control over their low moods and increased good mood, a return of laughter and renewed interest and pleasure in daily activities, a sense of hope coming back, and an ability to self-soothe through feelings of calm and peace.

Ability to control low mood and increase positive mood. The first psychological impact of SFMM reported by participants was an ability to control low mood and increase positive mood. Each woman reported struggling with the sad and dark mood of depression during the three weeks, but, as they chose to meditate with SFMM, their mood noticeably lightened and the sadness lifted. As the three weeks continued, their moods improved significantly.

Admittedly plagued with depression for most of her life, which led to several suicide attempts, Rose shared how her experience with SFMM gave her a measure of control:

I can use it [SFMM] to calm my mood. Even if I woke up in a foul mood, I would meditate, and my mood got lighter. . . . One day I was in such a low mood all day, you know, a funk, and when I got home, I realized I didn't meditate today. After I did it, my mood lifted off!

Although Tracee had been sober for more than six months leading up to the study, her clinical depression was a daily struggle. She described how she had benefited from using SFMM:

[The depression is] different now. It's more manageable, definitely more manageable. Like I said, sometimes I have to do it more than once. . . . And sometimes I woke up in the mornings, or sometimes I didn't sleep. When I would meditate, I would feel so much better, you know, more motivation to do the day. You know I do think though, because I'm going to continue this, this is something that won't stop for me. I love it for me because I'm also dealing with pain issues. I'm dealing with those types of serious things; it really helps me.

At the time of the study, Tracee reported suffering with physical pain for almost a year. She shared that the SFMM helped manage not only her depression but the physical pain as well.

Tracee reported that SFMM also helped calm her moods, change negative thinking patterns, and realign her thinking to something more helpful or positive:

After I meditated, I was usually very serene. It sort of changed my thinking from where I was before I meditated. . . . After I meditated, I was usually very serene. It sort of changed my thinking from where I was before I meditated to knowing God is with me. There is a God and that is big for me, really big for me because I always thought if there was a God, where was He when I was being abused? But now I know there is a God.

The daily practice of SFMM offered Angela a measure of control she had not experienced previously. She stated, “I think the meditation has been a big part of my good mood lately. . . . I now have a skill that helps me not just live with my low moods.”

Increased interest/pleasure. Loss of interest in the daily activities of living and an inability to find pleasure and enjoyment are psychological impacts of clinical depression. Research participants found that SFMM led to improvements in mood, including increased gratitude, feelings of happiness, returned pleasure from daily activities, and a returning of laughter to their lives. Tracee reported:

The one thing I find interesting too, through all of this also, is when I laugh now it feels good. Like I realize I know how to laugh the way I used to laugh. That’s back in my life. And that in itself is like “Wow! I’m actually happy.” . . . I had more motivation to do things, to be around people, get myself in the middle of what’s going on, and not isolate myself.

Mornings are often difficult for people suffering from clinical depression. This was true for Angela. For years, most mornings she would awake under a dark cloud of depression that would linger throughout her day. She shared the changes to her mood:

Yes, I may be just sad a little bit in the morning, but soon as I meditate and focus on the Scripture and deep breathing [SFMM], it goes away and lifts right off. Sometimes I don’t know where it came from, but I just felt really sad, and after meditating, then it was gone. It’s almost like it’s boosting my enhanced mood, you know, me boosting my mood, just feeling better about life and me in the future.

Similarly, Rose reported changes: “I often find myself smiling during my meditation. When I feel that serenity that comes over me, it makes me happy. I never used to be happy; no one ever saw me smile. I always feel so good after meditation.”

Return of hope. A psychological aspect of clinical depression is hopelessness. After using SFMM , participants reported a return of hope and a renewed hopefulness for their lives and the future. Rose shared:

It’s very centering. And it’s you know, it gives me peace and hope. It really does. And hope is an important thing for people that suffer from addiction and depression. . . . Hope is like (whistles), you know, without it, wow, just doing it you can set those goals with God, you know one more month Lord, help me make it a year. I’m smiling now, even laughing out loud. It’s new; it’s good. I don’t remember ever thinking that a year was even possible. It’s great.

Likewise, Angela shared, “It’s almost like it’s boosting my enhanced mood, you know me boosting just feeling better about life and me in the future. I have hope for a better way of living.” Tracee echoed this sentiment, saying,

There are a few women that are in my meetings [AA] that I go to, and they’ve just noticed that I’m more calm. . . . I share about where I am, that my strength my hope are coming back, and what things are going on.

Feelings of calm and peace. Each of the participants reported an effect of calm and peace as they meditated. Even if beforehand they were anxious or troubled, they affirmed how SFMM emotionally soothed them. For example, Rose explained:

As a drunk I just was incredibly self-absorbed. . . . I even tried to kill myself a couple of times. . . . The ultimate act of selfishness . . . I mean there was actually, there was a

pretty big change. . . . And I am definitely a different person. I mean, I'm not a thousand percent different, but I'm so, so much better than I was. It [SFMM] makes me so calm. Rose reported, "It was very helpful. I always felt better after my meditation. Just more peace, you know, I mean more conscious of what I'm doing." When asked specifically how the meditation affected her depression, Rose answered:

Well, it brings me more peace, and so if I get depressed and then I meditate, it brings me out of it, really brings me peace and hope, certainly. Yeah. Coming from somewhere else besides me. . . . Not leaving me up to my own devices.

Later during the interview, when asked how her mood was after meditating with SFMM, Rose explained:

After the three weeks I would have to say, better. Because the meditation has been a daily part of my life except for maybe one or two days I didn't meditate. But aside from that I did. And it's like during the day, I sort of refer back to it. So, it brings me peace. It's like part of my consciousness. It's beautiful, yeah. I've really felt good for these three weeks.

Tracee recounted a similar effect: "Through this process, I've learned a lot about myself from this mindful meditation. . . . And I allowed myself to have that time . . . in a quiet space that was just mine, I felt so peaceful, so calm." Finally, Angela conveyed, "I'm feeling better about myself. In fact, I've gotten lots of more compliments as far as why I'm looking so good. That means I'm looking peaceful, not the way I've been looking like."

The psychological effect of using SFMM could be seen in improved ability to control low mood, increased positive mood, and a renewed ability to enjoy pleasurable activities, including

laughing again. Each participant shared how hope had returned to her life and along with feeling calmer and more peaceful.

Social Effects of SFMM on Depression

Clinically significant distress or impairment in social, occupational, or other important areas of functioning are the social symptoms of MDD (APA, 2013). Social withdrawal (i.e., dysfunctional social behavior; pulling away from family, friends, and activities) is also an effect of clinical depression. Additionally, socially triggered stress leading to frequent deleterious social interactions and an amplified reaction to people or situations (e.g., hypersensitivity to negative feelings and interactions) are probable effects of major depression. The research participants reported that SFMM decreased these symptoms, as evidenced by increased patience and tolerance of others and a renewed desire to mix with people.

Increased patience and tolerance. Participants linked SFMM-related improvements in mood to increased social capacities. Participants reported noticeable increases in patience and tolerance when dealing with people at home, work, and outside their homes. Angela reported that previous to using SFMM, helping her husband in his busy medical practice often taxed her emotions and patience level, especially when she dealt with coworkers. She shared how this had improved as a result of meditating with scripture:

I think it [SFMM] helped me with my patience and tolerance of other people. Because sometimes I can get so rude, impatient, irritable, and zone into what's wrong with the other person. But, oh my goodness, it helped me realize that they are human and if I'm going to hold them to a higher standard then what about me? I should have to have that same standard or higher.

Angela also shared how SFMM affected her patience level when she was out shopping:

I felt more calmness after I would meditate. For the whole day, I would have more patience for people, and I could sense God helping me with it. I can get irritable with people, like even a slow cashier, or people complaining in line. But I had more clarity and understanding for people.

Tracee believed that SFMM helped her come out of isolation, comparing the experience to “a mask coming off.” She described it as a “mask of manipulation, a mask of lying,” and explained how she isolated, not wanting others to see how depressed and hurting she was:

I think the depression has always been there. But I also think that in my earlier years I was able to mask it. During these weeks of meditating, I find that as I’m walking through my days, like I said, even if I’m not feeling great, I don’t need the mask anymore. I’m able to walk through my days as who I am. I can make space for what they need. It makes me feel better, more tolerant. I don’t need people to give me things to feel better anymore. I am enough. I’ve been a big isolator, a loner. Not anymore.

Similarly, Rose attributed SFMM to helping her become more focused on others, their needs, and how her behavior affected them, when previously: “I was always so self-involved, it was always all about me.” She summarized, “Now I go to my meetings [AA] and find the ones who need encouragement. I have become a sponsor and helping others is now what I focus on.”

More outgoing and engaged with people. The last social theme participants emphasized was an increased ability to engage with people in social settings and the desire to once again become more outgoing. Angela shared how isolated she had become at home and how she resisted spending time with her neighbors: “I just didn’t want to be around anyone after I left my office, nothing left over for them.” Later during the interview when asked if the meditation had

affected her social life, she described an experience she had with her neighbor during the three-week meditation trial:

My neighbor down the street knows my struggles with depression; she can look at me and see I'm struggling. But the other day I saw her and stopped to talk to her she asked, "What's going on? You look so good, better." I told her about the spiritual meditation and she asked me for information so she could pass it to her son who is suffering from alcoholism and drug addiction and in a treatment center.

After using SFMM, Angela began to see herself as someone who could help another who suffered from depression and alcoholism rather than the one who always needed help for herself: "It's been a long time since I didn't feel like the helpless one." She summarized her perspective change:

I was just really flat, could not feel happiness or joy [leading up to the study]. I didn't even want to be around it. People having or being happy or joyous kind of just intensified this feeling that something's wrong with me and gave me a hopeless and helpless feeling. After using SFMM for three weeks, now I'm enjoying being around people, I'm laughing again, I'm happy more than not. It's nice.

Tracee reported similar effects. After spending years "caught up in [her] own story," she found that SFMM was breaking through a history of isolation:

I had more motivation to do things, to be around people, to get myself in the middle and not isolate myself. I'm a big isolator, a loner. Even though people don't believe that of

me, that is who I am when depressed. But now [through SFMM] it seems it's changing and I'm getting involved.

Although Rose had shared during the semistructured interview how she had isolated herself from “family and friends for years,” she, like the other participants, related noticeable changes resulting from SFMM: “I’m more engaged and outgoing, able to help others. . . . I used to be so isolated; I had nothing to offer.”

During the semistructured interview following the three weeks of meditation with SFMM, each of the participants reported noticeable improvement interacting with people socially. This included an increase in an ability to show patience and tolerance of others, consideration of the needs of others, and feeling more engaged when they were around people.

Spiritual Effects of SFMM on Depression

As previously noted, spirituality was important to the research participants, and they were interested in this study, in part, because SFMM included a spiritual component congruent with their spiritual beliefs. After using SFMM over the course of the study, participants reported meaningful spiritual impacts in the following areas: increased awareness of God, renewed relationship with God, and expanded spiritual connection.

Awareness of God

Participants reported that using SFMM increased their awareness of God’s help and interest in them. For example, Tracee shared, “I never thought God was interested in me,” but in her journal, on day 13, she related:

God is working in me now, and others can even see a difference, I’m so grateful. I’m really getting in touch with a [spiritual] side of myself I didn’t know I had. I love it

though, and it makes my days much better. I still get mad, sad, and angry; however, I can reel it in much faster; I look at my part in it much easier.

To this end, Tracee began to derive meaning from the entire experience and was not limited to how particular circumstances affected her. On day 19, she was struggling with extreme pain in her teeth and jaws (she is waiting for surgery to remove some rotten and injured teeth); however, she was able to actively make choices that were for her benefit and not her destruction. She wrote:

So, I haven't been feeling well. My teeth are killing me. I have my time with God [SFMM] however, and I'm looking forward to being out of pain. It's been a struggle for me. Normally, I sit in my own self-pity. I am still a bit depressed over it, ok, more than a bit. My health, my pain, my sobriety is all I think about. Usually, I would have lost this battle by now and I would have given in to self-medicating, but I haven't. God is here with me, it's just not time for things to be taken care of. Life is about ups and down so I'm just riding the wave for now!

She attributed relevant meaning to her suffering rather than using it as an excuse to become depressed and drink to offset the pain. Additionally, she became proactive and made her own choice about the day on how she would respond to the pain in a healthier, better way for herself and her family. She made the decision not to succumb to the darkness of depression. Tracee also shared:

After I meditated, I was usually very serene. It sort of changed my thinking from where I was before I meditated to knowing God is with me. There is a God and that is big for me, really big for me because I always thought if there was a God, where was He when I was being abused? But now I know there is a God.

A lifetime of bad choices brought Rose to the edge of death several times. She lived her life depressed, isolated, and angry, using drugs and alcohol to sedate her feelings. She related how “God has opened the door for a new life for me; I’m helping people and making a difference.” In the journal record of her meditation experience, she shared:

I want to live a sober life for the rest of my life, and I never want to walk in that darkness of depression again, or live my life without the Lord. When I meditate, He brings me peace and hope. I’m using it to practice gratitude and humility every day in order to maintain my spiritual health. I now believe that with God, all things are possible for me. These are choices I am making for myself.

Angela reported that as she used SFMM, she experienced a renewal of her understanding of God’s love and care for her. She shared:

I don’t feel like I have to work so hard. I don’t have to earn His attention or help. I can just be me. He loves me as I am. And I have a lot that I reflect back on, you know in my younger years, how I thought I had to earn His love. Like if I missed church and didn’t read my Bible for that day. I didn’t pray as much as I used to, then I was out of His help. Now, I know He loves me whether I do that or not. It’s just a concept that amazes me now. And once I accepted that, I want to do more. . . . It comes naturally to sit with Him, to meditate with His Word.

Renewed relationship with God. As noted in the literature review, Christians with MDD often report feeling alienated from God, as though He was somehow disappointed in them. The participants’ experiences prior to using SFMM were congruent with this idea. However, after using SFMM, the participants reported believing that they had grown closer to God as they meditated using the scripture as their focus. Rose shared that SFMM

brought Him closer. I think I remember almost every time that I meditated that He was part of my consciousness. Doing the three steps, making the scripture personal, definitely made it more, satisfying is the word I'm looking for. The scripture reminds me that I'm not alone, actively reminds me that there is a God, my God and He is there for me, and always has my back. When I ask, He is there.

Furthermore, she related how using SFMM had a greater impact on the depression than her previous meditation style: "I've been close with God since I got sober, and I had been using meditation that's not spiritually based. . . . So long as I ask, He is there, He is more tangible to me. Somehow, more available." Rose also wrote in her journal, "I hesitated to meditate today. I don't know why! I kept putting it off. When I finally did, I was filled with gratitude for the love and care of God."

Angela found that SFMM expanded her understanding of the faith she had known since childhood. She explained:

I know now; He's never going to stop loving me the same way always. No condemnation. I condemn myself, which hurts Him. Yes, I'm His child; it [SFMM] has opened up a whole different side of how I see God, and Jesus, and the Holy Spirit.

Tracee also reported a spiritual shift and renewal after using SFMM:

Depression, you know, makes you unmotivated, and you don't care about living. You don't have any desire to go do things you know, from real depressive symptoms. Well for me, my depressive symptoms came in when I wasn't feeling well, so, having the meditation, the mindful meditation, for me was a lifesaver through the three weeks, because I could have easily gone somewhere else into the dark. So, even though I was dealing with this extraordinary pain, I felt like instead of doing what I would have

normally done with that kind of pain, the meditation helped me stay above it. I called on God to help me. I mean there's no doubt about it because I did it. Normally, I don't have motivation. Normally, when the depression comes, and I don't feel like doing anything, I don't want to cook, I don't want to clean. I don't want to do anything, period. God helped me. I was able to be above it.

Although Tracee had tried meditation before the study, she had used a silent form of meditation with music, which she did not find very helpful. She shared that often "it just made the depression worse." She also expressed how her mind would sometimes just "swirl." At this point, she found it difficult to avoid becoming deeply depressed. When her mind would begin to swirl during the three-week trial, she said, "I would meditate." When asked, "Then what would happen?" She answered:

He's [God's] there, and He sometimes is telling me you have to sit through it for a minute. And then once I was out of it, I would meditate. As the process went at the beginning, I wasn't too good. Once the process kept going, I was better; I could understand. I was able to sit calmly and listen for an answer. And sometimes the answer didn't come to me until a little while later maybe. But I was able to sit and pray on it and just say "I'm here waiting." I want an answer when You're ready. But I was able to patiently listen, and I'm not good at that. . . . The depression never came.

An expanded spiritual connection. Participants reported that using the scripture as a baseline for the spiritually focused meditation expanded their spiritual connection with God. Although turning to God for support or guidance was a foreign concept to Tracee, following the three weeks of mediation using SFMM, she shared:

I really had no concept of God. I mean, I knew He was out there somewhere, but He didn't know or care about me. But this mindfulness meditation gave me a relationship with God. This is so impacting my relationship with Him. I think that I thought I was being spiritual. I think that I thought I had turned it over to God. I think I was questioning what that was. I was always just calling it my higher power because I couldn't name Him. I couldn't. I didn't know. I did feel connected, but I didn't call it God. And now I have God, God is in me. He is working magic on me, as long as I just take my time and sit with Him. I know He wants to help me. He cares about me.

Tracee summed up the impact of SFMM on her spiritual experience like this:

This concept of God just amazes me now. He's never going to stop loving me the same way, no condemnation. I can forgive myself for what I do that hurts Him. Yes, I'm His child; He will help me. It has opened up a whole different side of how I see God and Jesus and the Holy Spirit. When I feel the darkness flooding in, I can ask for His help. He is there helping me.

Rose reported on how meditating with SFMM increased her positive thoughts and feelings about herself and impacted her relationship with God:

I've been close with God since I got sober and I had been using meditation that's not spiritually based. For me, it's always nature inspired while meditating. Serene places in nature, beautiful places in nature. And to me God and nature were kind of one thing. But the scripture I used in SFMM reminds me that I'm not alone, actively reminds me that there is a God, my God, and that He is there for me and always has my back.

Despite feeling forsaken by God during traumatic times in their lives, following the three weeks of meditation with SFMM, Tracee declared she was "learning to forgive and let go,"

Angela said, “I now know I have a relationship with God,” and Rose stated, “Now I have peace and hope for my future because God is with me.”

Each of the participants in this study acknowledged changes in their understanding of and connection to God. They shared how they became aware that God wanted to help them, loved them, and desired to be involved in the details of their struggles with depression and addiction. Additionally, each of them shared that they gained new understanding of His love for them, a change from their previously held beliefs that He was angry with them and condemned their behavior.

This overview of the primary themes included the biological, psychological, social, and spiritual effects of using SFMM to mitigate the impact of the symptoms of clinical depression. All the themes included verbatim data from each of the research participants. A summary of the primary themes for each of the participants is provided in Figures 3, 4, and 5 below.

Overview of Verbatim Responses

Figures 3, 4, and 5 depict an overview of the verbatim responses for each of the four categories of effects of using SFMM for each participant: biological, psychological, social, and spiritual.

Rose

As a result of using SFMM consistently, Rose reported enjoying more restful and extended sleep and awaking with more energy than she had previous to the meditation. Rose believed that SFMM helped her have more control over her dark moods and that her overall mood was improved during the three-week research period. She shared that she was smiling again and had become more motivated to spend time with people. In conclusion, Rose explained how God had become a real and valid part of her recovery from addiction and depression.

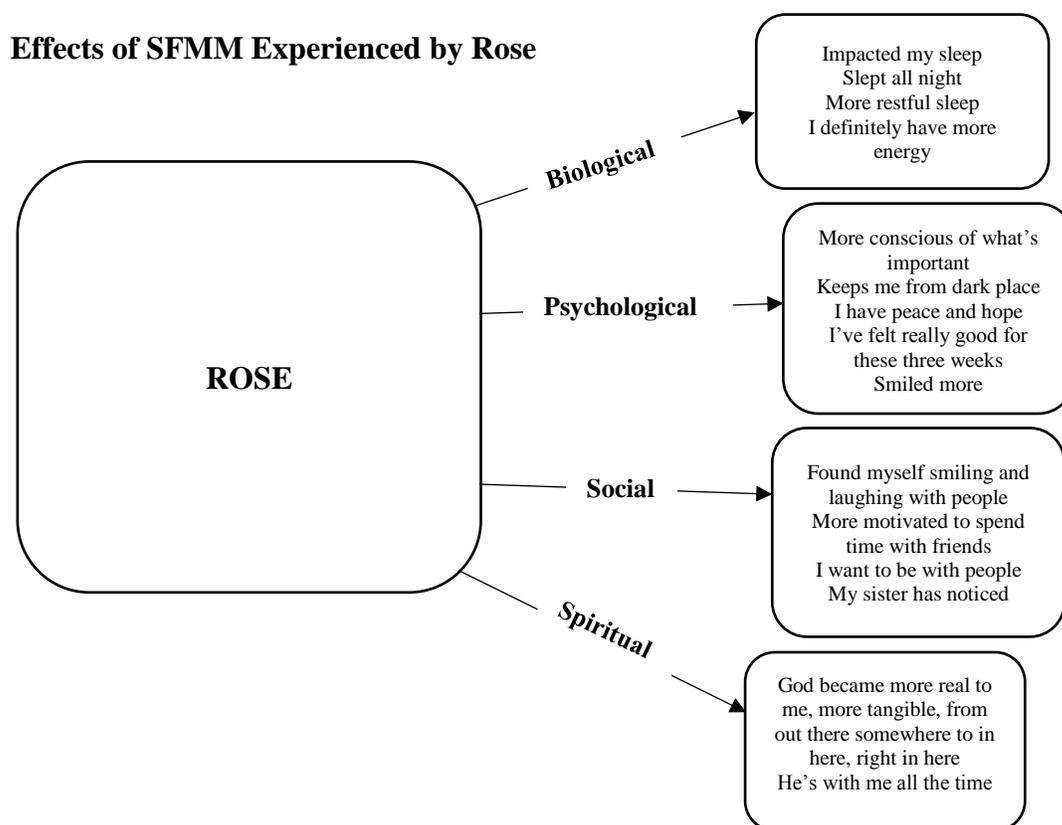


Figure 3. Rose.

Tracee

Tracee believed that SFMM brought a measure of peace and calm to her anxieties along with the ability to sleep through the night and wake with energy that lasted all day. She found herself motivated to cook again and try new recipes. Additionally, she could change her mood by meditating and could see herself in a more positive light. She also found that laughter returned to her life, and she felt more centered and focused throughout her day. Tracee reported wanting to spend time with people again, and she felt a connection with God she had not previously experienced.

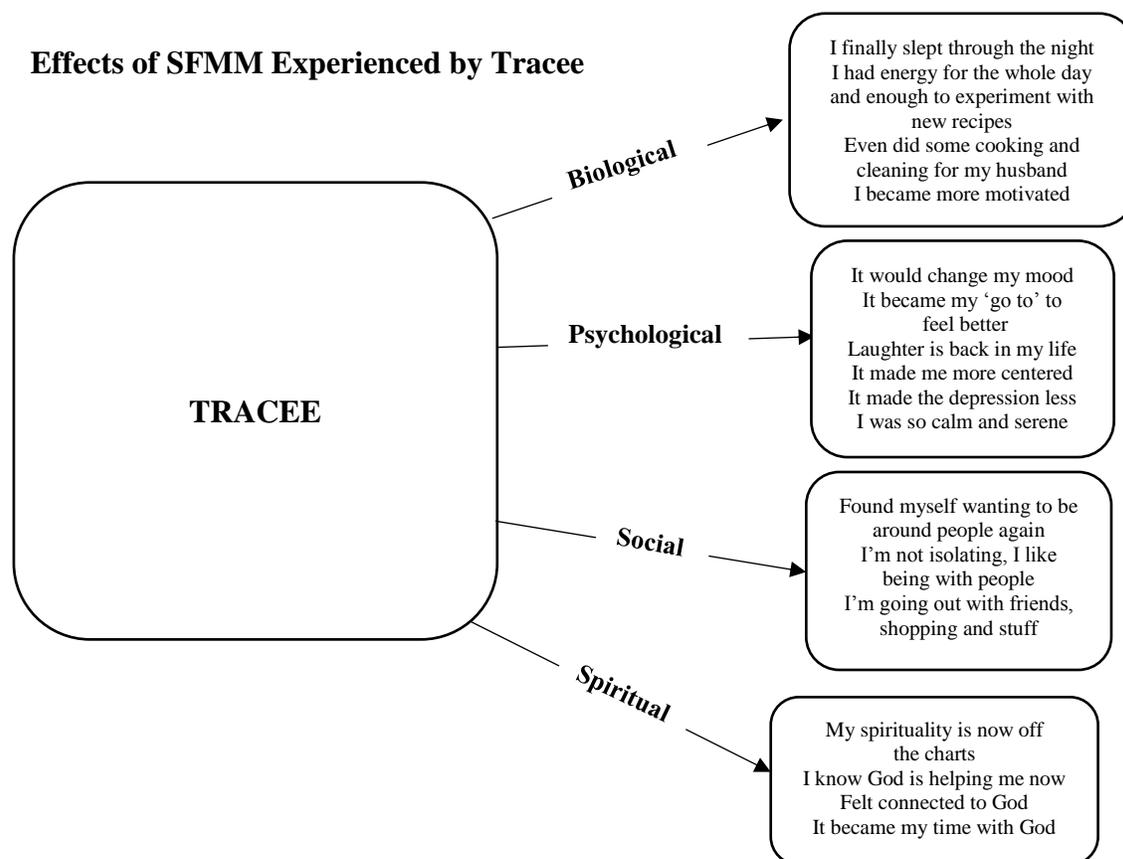


Figure 4. Tracee

Angela

Angela experienced calm and more focus during times when she normally would have been anxious or stressed. She related how when sadness tried to overwhelm her, she meditated and the sadness just lifted. Additionally, she felt her good moods increased throughout the trial, and the pressures she usually felt were not there. Angela also shared how she enjoyed a lessening of depressive symptoms as she meditated. For her, there was a new ability to be patient and tolerant with people at work, home, and in public. She experienced a spiritual renewal grounded in the belief that God was not judging or condemning her, but loving and helping her.

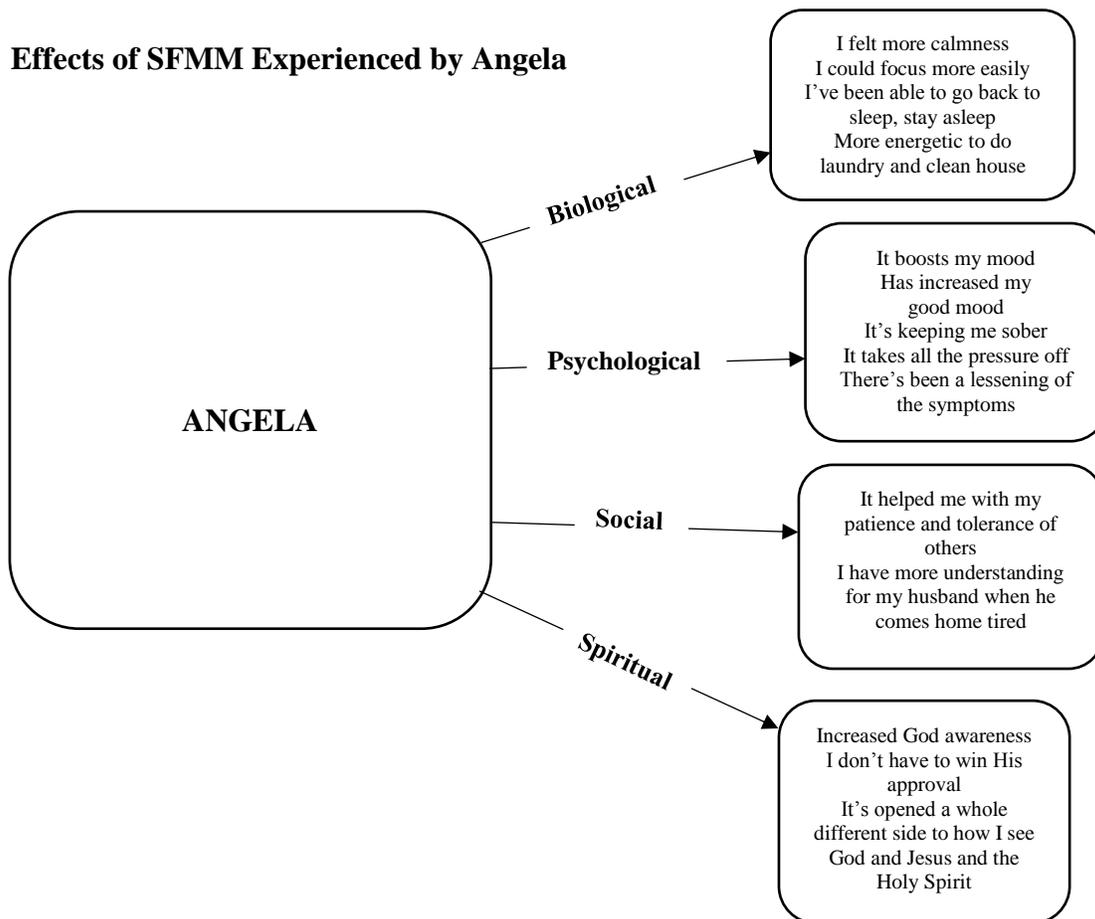


Figure 5. Angela.

Table 2 presents a synthesis of the findings as answers to the interview questions, followed by a presentation of the themes with verbatim excerpts.

Table 2

Summary of Findings: Themes Found in the Data and Sample Verbatim Quotes

Interview question	Theme	Sample Corresponding Quotes
Physical effects of SFMM	Changes in sleep patterns	<p>“Slept better, longer, deeper”</p> <p>“I could fall asleep easier”</p> <p>“Found myself sleeping better”</p> <p>“I slept all night long”</p>
	Increased energy and motivation	<p>“I found I had energy all day and a desire to clean my house”</p> <p>“Noticed the difference in my energy when I didn’t do it”</p> <p>“I feel like I’m living again”</p>
	Sustained good/better mood	<p>“My mood has been getting better and better”</p> <p>“My mood is more manageable”</p> <p>“My mood is better”</p>
	Increased control over the effects of anxiety and/or stress	<p>“I was able to control what was flowing through my mind”</p> <p>“I would meditate and could feel so much better”</p> <p>“I could just feel the stress being lifted from me”</p>
Psychological (mental and emotional) effects of SFMM	Ability to control low moods and increase positive moods	<p>“It’s very centering, it gives me peace and hope”</p> <p>“I can use it to calm my mood”</p> <p>“I now have a skill that helps me not to just live with my low moods”</p> <p>“Even if I woke up in the morning in a foul mood, I would meditate, and my mood got lighter”</p>
	Increased interest/pleasure	<p>“I enjoyed getting outside and going shopping with my friend”</p> <p>“I awoke refreshed and ready to enjoy my day”</p> <p>“I often find myself smiling during my meditation.”</p>
	Return of hope	<p>“I have hope for a better way of living”</p> <p>“It gives me peace and hope”</p>
	Feelings of calm and peace	<p>“It makes me so calm”</p> <p>“After I feel so peaceful”</p> <p>“I’m more centered, you know, calm”</p>

Social effects of SFMM	Increased patience and tolerance	“I’m not so easily provoked or frustrated with people” ----- “I have more patience for people” ----- “It helps me be more tolerant of other people”
	More engaged and outgoing with people	“I’m mixing with people again in a new and fresh way” ----- “I’m more motivated to go out and spend time with people” ----- “I’m more engaged and outgoing”
Spiritual effects of SFMM	Increased God awareness	“I now know God cares about me, the personal me that needs Him” ----- “God is part of my daily struggle” ----- “I pray now, I know He hears me”
	New level of relationship with God	“I was feeling disconnected from Him, now I’m connected” ----- “I definitely feel closer to Him” ----- “I could hear Him speaking to me, in my heart”
	Trusting God to help	“I felt like God was helping me” ----- “I can more easily rely on Him for help” ----- “I feel connected to God all day; I know God is helping me”

Summary

This chapter presented an overview of the demographic information of each of the participants and the findings of this IPA study, which examined how SFMM affected the depressive symptoms of a purposive sample. To give context for the study, a narrative synopsis of each of the three participants’ lives and experience with depression was offered. The remainder of the chapter presented the primary themes extrapolated from the data collected during the semistructured interviews and from participants’ personal journals. One participant did not journal; however, her verbatim responses to the semistructured interview questions were included. Chapter Five presents an overview of why the study was done with a review of the questions used and a summary of the findings, an interpretation of the findings, implications for

social change, recommendations for action, and recommendations for further study. Chapter Five ends with a reflection on the researcher's experience with the research process and a description of possible biases, preconceived ideas and values, the possible effects of the researcher on the participants, and changes in the researcher's thinking as a result of the study.

CHAPTER FIVE: SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

The goal of this study was to extensively explore the relationship between clinical depression and the use of SFMM to mitigate the depressive symptoms for three participants. There was one main research question: How does a clinical sample of research participants describe the experience and effectiveness of spiritually focused mindfulness meditation as a component of therapy to mitigate the effects of their depression? To answer this question, the semistructured interview used four questions to answer what effect SFMM had on the participant biologically, psychologically, socially, and spiritually. The interview questions were as follows:

1. How would you describe the physical (biological) effects of using spiritually focused mindfulness meditation?
2. How would you describe the psychological (thoughts and feelings) impact spiritually focused mindfulness meditation had on you?
3. Describe how meditating with SFMM affected you socially (around people).
4. Describe how SFMM affected you spiritually (your relationship with God).

Participants recounted their experiences with SFMM through the semistructured, hour-long interview with the researcher and the personal written account from daily journals. This qualitative study followed the analysis process for IPA developed by Smith et al. (2009) for analysis and interpretation of the data: (a) immersing in the original data, (b) initial noting, (c) developing emergent themes, and (d) searching for connections across emergent themes. The process was repeated for each individual participant using verbatim quotations throughout the analysis (a complete explanation can be found in Chapter Four).

Hermeneutical phenomenological studies call attention to an individual's perception of self and the external world as essential factors in comprehending behavior and experience. This

approach requires sober reflection on the accounting of lived experiences reported by participants involved in the phenomenon of study (van Manen, 2014). For proper interpretation of those perceptions, the researcher must listen to the nonverbal and paralinguistic levels of communication (e.g., the intonations, the emphases, the pauses, the tears, etc.). It was vital to the integrity of the results that the researcher used thoughtful reflection without theoretical, prejudicial, or suppositional bias (van Manen, 2014). Greater clarity emerged as more time was spent with the data; this rigor is directly linked to trustworthiness of the results. As Creswell (2013) affirmed, because interpretative orientation occurs throughout the process of qualitative research, the results are an interpretation of how the researcher shapes what is found through background experience, education, and experiences with the phenomenon. These findings can only be seen from the perspective of discourse with tentative conclusions that may, in fact, ebb, flow, and change as it evolves (Creswell, 2013).

This chapter offers a review of the previous chapters and a description of how the findings from this study are related to the extant body of literature on the impact of meditation on depression. Implications of these findings for social change and future research on a spiritually focused form of mindfulness meditation and its impact on clinical depression are presented. Additionally, limitations and recommendations for further study are presented, along with a brief explanation of how the researcher was impacted through the process of conducting the research and interacting with the results. This chapter ends with two summaries: one of the important findings and the conclusions drawn from the study and a final summary giving an overview of the entire dissertation.

Interpretation of Findings

Based on the research, the following sections clarify the findings, contrasting them with the existing literature and showing comparisons and similarities that surround the use of SFMM as adjunct to treatment and prevention of clinical depression. For clarity, the findings are structured by the interview questions listed above, expounding on the existing literature where comparable themes were identified by this study. The organization of this chapter follows the conceptual framework from Chapter One to tie the central purpose to the interpretation of the findings. The first research question examines how the biological effect from using SFMM is compared and can add to existing literature.

Interview Question One

Interview question one asked, “How would you describe the physical (biological) effects of using spiritually focused mindfulness meditation?” The effects of clinical depression go beyond mood or emotional states, often affecting physiology or biology. Biological effects of meditation have been shown to include the release of mood-stabilizing neuro-hormones like serotonin, norepinephrine, and dopamine, the feel-good chemicals naturally released from the brain (Rubia, 2009; Solberg et al., 2004). As a result, the release of these natural hormones has shown evidence of impacting sleep positively, improving energy and mood, and positively affecting anxiety (Rubia, 2009). The first interview question revealed four primary themes: changes in sleep patterns, increased energy and motivation, sustained good/better mood, and increased control over the effects of anxiety and/or stress. The importance of these findings in light of existing research will be discussed.

Primary theme one. Participants expressed significant changes in their sleep patterns, including sleeping better and longer, falling asleep more easily, and sleeping through the night

with no or minimal waking. Howell, Digdon, Buro, and Sheptycki (2008) conducted a study that provides an important parallel for the existing study. Their study used a sample of 305 individuals using mindfulness meditation. Results showed positive emotional, psychological, and social well-being as an effect of the meditation. More specifically, the researchers used path analysis, finding support for mindfulness as a direct predictor of well-being and for mindfulness meditation as an indirect predictor of well-being, mediated by sleep quality. Moreover, a study described in Chapter Two hypothesized that mindfulness, as a marker for mental health, encourages high levels of well-being and serves as an indirect boost to well-being by facilitating healthy self-regulatory behavior like sleep (Brown & Ryan, 2003). In the present study, participants emphasized feeling “energized after sleeping through the night and waking refreshed and ready for the day,” increasing their own sense of well-being. Finally, these results were consistent with those from a study by Larouche, Lorrain, Cote, and Belisle (2015) that evaluated the effectiveness of MBCT to treat chronic insomnia. Using an objective and subjective sleep measurement, they found a negative relationship between practicing mindfulness and insomnia; specifically, results showed significant decrease in insomnia severity.

Primary theme two. Each of the participants experienced an increase in energy levels and motivation to return to daily tasks like cooking, cleaning house, and running errands that had been nonexistent before taking part in the study. These results parallel the findings from a randomized controlled trial by Lengacher et al. (2009), which compared mindfulness meditation to usual care. For the group using mindfulness meditation, the study showed significantly reduced symptoms of depression, higher energy levels, and significant improvement in physical and emotional quality of life by breast cancer survivors experiencing chronic depression. Similar evidence for increased energy and motivation for daily tasks could also be seen in a study

mentioned earlier (Kim et al., 2013). Results in the Kim et al. (2013) study showed an increase in the fatigue level of the control group and a significant decrease in fatigue level in meditation group. This was comparable to the findings of the present study, as revealed by Rose: “I definitely have more energy,” Tracee: “I had energy for the whole day and enough to experiment with new recipes,” and Angela: “I’m more energetic to do laundry and clean house.”

Primary theme three. Each participant reported experiencing a sustained good/better mood for most or all of the day following the meditation. By learning to transfer attention from the negativity of their immediate feelings, the participants found that meditating offered them the choice to focus on something positive, boosting their mood. Baer (2003) reported similar findings wherein significant improvement in mood and anxiety resulted from using mindfulness meditation in the numerous studies examined. In this study, Rose stated: “It [SFMM] boosts my mood, has increased my good mood” and Tracee: “It [SFMM] became my ‘go to’ to feel better; it would change my mood.”

Primary theme four. Each participant conveyed feeling an increase in their ability to control the effects of anxiety and/or stress by using SFMM. This result is similar to those found in the effect-size analysis by Hofmann et al. (2010), who measured the effect of mindfulness-based therapy on anxiety and depression in a clinical sample. They reported significant decreases in anxiety and depression. The findings indicate mindfulness-based therapy as a promising intervention for treatment of anxiety and depression in clinical populations. Each participant in the present study had similar results: “It [SFMM] made me more centered, not so stressed”; “It [SFMM] takes all the pressure off; I can stop worrying about every little thing.” In conclusion, Hoge et al. (2018) conducted the first study to combine hormonal and immunological evidence that MBSR may enhance resilience to stress. Results showed

significant reductions in stress markers for patients with General Anxiety Disorder in the MBSR group compared to the control group.

Interview Question Two

The second interview question examined how the psychological effect from using SFMM is compared to and can inform existing literature: How would you describe the psychological (thoughts and feelings) impact spiritually focused mindfulness meditation had on you? The psychological impact of clinical depression includes feelings, emotions, and moods. Symptoms include sadness, feelings of emptiness, hopelessness, worthlessness, irrational temper flairs, negativity, impatience, and the loss of interest or enjoyment in things that were once enjoyed (APA, 2013). Research indicates that a positive belief system or religious coping is related to higher levels of psychological health and lower levels of depression (Ahrens, Abeling, Ahmad, & Hinman, 2010; Shaw, Joseph, & Linley, 2005). In a review of the empirical studies conducted on the effects of mindfulness meditation on psychological health, Keng, Smoski, and Robins (2011) found a range of positive psychological effects, including increased subjective well-being, reduced psychological symptoms and emotional reactivity, and an improvement in behavioral regulation. Question two generated four primary themes: ability to control low moods and increase good moods, increased interest/pleasure, return of hope, and feelings of calm and peace.

Primary theme one. The participants reported an increase in the ability to control low moods and increase good moods. This was an essential result of this study. In effect, studies show that throughout one's lifetime, intrusive and disturbing thoughts will surface, and unwarranted and sometimes warranted feelings will wrestle for control. However, learning how to manage these thoughts and feelings more positively becomes more difficult and sometimes

impossible for those with clinical depression (Steger & Kashdan, 2009). For Rose, there was a sense of reclaimed power over moods that used to control her: “I was agitated all day and suddenly realized, ‘Hey, I haven’t meditated today,’ so I took the time to do it and wow, the peace just flooded me.”

Galantino, Maguire, Szapary, and Farrar (2005) found similar results in a study that measured how cortisol levels were affected by mindfulness meditation. Although the study showed no significant change in cortisol levels, it found significant secondary results on mood, empathy, and emotional exhaustion. Effectively, participants reported significant improvement in mood and reduction of emotional exhaustion. Parallel results were also found in the Speca et al. (2000) randomized, wait-list controlled trial, comparing a group receiving treatment with MBSR to the wait-list control group for treating mood in cancer patients. This clinical trial showed MBSR effective in decreasing mood disturbance and stress symptoms in both male and female patients. Following the mindfulness treatment, results showed significantly lower scores on Total Mood Disturbance and subscales of depression, anxiety, anger, and confusion. The treatment group reported enhanced feelings of vigor and a significant decrease in stress levels. These results parallel the existing study. Participants stated: “I had more energy, more motivation,” “There’s been a lessening of the symptoms,” and “I now have a skill that helps me not to just live with my low moods.”

Primary theme two. Each participant reported finding a renewed interest and pleasure in the daily tasks of living. As depressed individuals begin to “take charge” of their lives once again, a new appreciation for life, interpersonal relationships, and emotional strength can develop, providing them an opportunity to rebuild their worldview and self-esteem (Ahrens et al., 2010). An example of the return of pleasure and interest was seen in Ruth’s account: “After

trying to take my life and hoping I wouldn't wake up, now I find myself smiling and looking forward to my meetings or meeting with the people I love. My life is good, maybe for the first time." Finding a renewed interest and pleasure in living again can also be seen in Tracee's statement: "Laughter is back in my life; I'm looking forward to the day and not dreading it instead." This ability to cultivate focus involves increased attentional control, leading to the reduction of habitual patterns, not unlike self-recrimination (Farb et al., 2012). This in turn affords the meditator the increased ability to reduce negative self-criticism, leading to finding pleasure in living again.

Primary theme three. Each participant reported a return of feelings of hopefulness. The subjective reporting of feelings of hopelessness is an aspect of the first major criterion for MDD (APA, 2013; Robinson & Alloy, 2003). Robinson and Alloy (2003) found that the greater the feelings of hopelessness, the greater the depressive affect. Principally, to gain the ability to fend off the early signs of depression and prevent a relapse unlocks the possibility for a future that looks brighter. Each participant revealed a cognitive hopefulness returning to their lives (Robinson & Alloy, 2003). Likewise, the participants in this study reflected this move to hopefulness: "I find myself in my meetings sharing about God and the strength and hope of where I'm going. I'm looking forward to it."; "I have hope again; I'm getting better; it feels good."; "I have hope for a better way of living."

In conclusion, parallel results were found in a study by Shapiro, Brown, Thoresen, and Plante (2011), who conducted a study using an MBSR intervention as compared to a wait-list control condition. By means of the Adult Dispositional Hope Scale, the study showed significantly higher levels of hope measured up to one year after the treatment study for the mindfulness meditation group.

Primary theme four. Each participant reported experiencing a reduction in stress levels noted by feelings of calm and peace. Mindfulness helps to anchor an individual in present-moment thinking, reducing negative rumination, which is directly linked to clinical depression, anxiety, and stress (Robinson & Alloy, 2003; Segal et al., 2010; Teasdale, 2004). This direct effect was highlighted in the data. Rose shared, “I can feel it [depression] coming on now, and sometimes in the afternoon, sometimes at night when I get so stressed, I would just sit down and meditate. I would always feel so much better, like peaceful and calm.” Tracee shared, “Connecting to God during meditation calms me and helps me be more aware.” Each of them described feeling more calm or serene, happier, more motivated, and less stressed. Angela shared,

When I feel the fear that I haven’t done something just right or pressure from someone, even if I don’t know where the fear is coming from, I stop and close my eyes for a moment, take a deep breath, like you taught us, and repeat the scripture verse under my breath. I say, “Angela you can take control of this,” and the peace comes; the pressure just lifts off.

An important aspect of mindfulness-based therapies is learning skills to decrease emotional reactivity when faced with negative affect-producing stressors (Britton et al., 2012; Wachholtz & Pargament, 2008). Through SFMM each participant experienced an increased awareness of cognitive and emotional states, learned to accept her own personal vulnerability, and discovered that she could reduce her emotional reactions and stress. These results directly correlate with findings from a 10-week study by Schreiner and Malcom (2008) investigating the influence of mindfulness meditation on affective states of depression, anxiety, and stress. The severity levels of all three affective states decreased significantly, and the decrease was notably

higher for the greatest severity groups. As a treatment consideration, mindfulness meditation research confirms its positive effect on cognitive and emotional states of depression, anxiety, and stress. Similar results were found in a study of recovering cancer patients by Speca et al. (2000). Significant reductions in mood disturbances and stress resulted from participation in a mindfulness-based meditation program. Primary theme four became more apparent as each of the participants referred to a recognition of inner strength and determination they had not tapped into previously. Parallel results were also found in the Wachholtz and Pargament (2005) study as they compared spiritual meditation with secular meditation to examine the benefits of a spiritual intervention. The spiritual meditation group reported lower anxiety, more positive mood, a greater increase in spiritual experiences, and more closeness to God.

Interview Question Three

The third interview question examined how the use of SFMM impacted the participants socially and how the results compare to and can inform existing literature: Describe how meditating with SFMM affected you socially (around people). The effects of clinical depression go beyond mood or emotional states, often affecting psychosocial factors. Understandably, there is often a combination of biological, psychological, and psychosocial elements involved in MDD. Depressed people not only feel socially isolated but also often misread the social cues of acceptance or belonging. The misconstrued perception leaves them feeling out of place or unwanted, adding to their self-imposed isolation (Steger & Kashdan, 2009). Question three generated two primary themes: increased patience and tolerance for others and more outgoing and engaged with people.

Primary theme one. Each participant reported an increase in the ability to be patient and tolerant of others in their daily lives. The destructive thinking associated with clinical depression

is characterized by a lack of empathy for others, self-indulgence, intolerance of others' feelings, limited insight, and a tendency to interpret situations around how they alone are affected (Hjemdal et al., 2017; Papageorgiou & Wells, 2001). Negative experiences can be encountered daily as people move throughout their work and tasks. For those suffering from clinical depression, this can be stressful enough to trigger relapse (Steger & Kashdan, 2009). This kind of thinking is self-destructive and harms relationships that could otherwise be beneficial to the process of healing and growth.

Comparable results to the ones found pertaining to the social impact of SFMM in the present study were found in a study by Beddoe and Murphy (2004) using MBSR to show its impact on stress and empathy levels. They found favorable results on several stress dimensions and two dimensions of empathy. Similarly, Angela shared how helping her husband in his busy medical practice can be very taxing on her emotions and patience level. After meditating with SFMM she reported: "It [SFMM] helped me with my patience and tolerance of others." This can also be seen in what Tracee shared: "I can make space for what they [other people] need. It [SFMM] makes me feel better, more tolerant." Additionally, Britton et al. (2012) examined the effects of mindfulness on emotional reactivity to a laboratory-based social evaluative threat in a sample with partially remitted recurrent depression. Results showed an overall decrease in emotional reactivity and significant decrease in overall anxiety levels to social stressors.

Primary theme two. Each participant reported that she had become more outgoing and engaged with people. Meaning-making for Rose involved recognizing her inability to see herself as others saw her and gaining a new perspective of herself. Her perceptions enlarged to include others and an ability to put their needs above her own. She stated, "I could see what I was doing and how it affected my family. I'm able to help others now." She now sees herself as someone

who cares about others and not just herself. The mindfulness skills learned by the participants during the eight-week study resulted in significant increases in adaptive emotion regulation and a decrease in emotional reactivity in social settings. Pace et al. (2009) examined the effect of compassion meditation on behavioral responses to psychosocial stress. Results showed significant correlations between amount of meditation practice and behavioral responses to psychosocial stress. Tracee stated, “I found myself wanting to be around people again,” and Rose said, “I’m more motivated to go out and spend time with people.”

Interview Question Four

The fourth interview question examined how the spiritual effect from using SFMM is compared to and can inform existing literature: Describe how SFMM affected you spiritually (your relationship with God). Numerous studies can be found on the importance and value of spirituality and its impact on mental health (Baetz & Toews, 2009; Carlson et al., 2001; Garzon & Ford, 2016; Koenig & Larson, 2001; Levin, 2010; Mutter & Neves, 2010). Research indicates that a positive belief system or religious coping is related to higher levels of psychological health and lower levels of depression (Ahrens et al., 2010; Shaw et al., 2005). Furthermore, religious and spiritual orientation is an important aspect of cultural diversity in modern psychology (Daniels & Fitzpatrick, 2013). SFMM offered a holistic element of spirituality to the participants of this study, who used a verse of scripture for the meditative process. The final question generated three primary themes: increased God-awareness, a new level of relationship with God, and an expanded spiritual connection to God.

Primary theme one. Each participant reported experiencing increased awareness of God as a result of meditating with SFMM. In an empirical study comparing the effects of spiritual meditation with the effects of a secular form of meditation and relaxation conducted by

Wachholtz and Pargament (2005), participants in the spiritual meditation group experienced greater decreases in anxiety and more positive mood, spiritual health, and spiritual experiences than the secular meditation or relaxation groups. At the pretest, there was no difference between groups on reported closeness to God. However, at the post hoc test, significant differences were found; when compared to the secular meditation group and the relaxation group, the spiritual group reported feeling significantly closer to God. Also, the spiritual meditation group reported significantly greater daily experiences of a spiritual nature than the secular meditation group or the relaxation group.

After meditating on a Scripture verse for this Christian version of mindfulness, each of the participants related how effective the meditation was in mitigating the effects of their depression and generally improving their quality of life. Peselow, Pi, Lopez, Besada, & Ishak (2014) found similar results in their study with 84 clinically depressed patients using naturalistic treatment. Results showed a correlation between greater spirituality and significantly lower measures of hopelessness, dysfunctional attitudes, and depressive symptoms. Their findings suggest that greater spirituality is associated with less severe depression, and the degree to which the depression severity, hopelessness, and cognitive distortions improved was significantly greater for those patients who were more spiritual. Likewise, during the semistructured interview, each of the three participants in the present study related how finding God in the midst of their struggle with depression made all the difference for them. They shared: "I'm really getting in touch with a [spiritual] side of myself I didn't know I had. I still get mad, sad, and angry; however, I can reel it in much faster." "I know now that God is with me, I'm OK." "I know now there is a God, and that is big for me." Collectively, they found a greater awareness

of God, resulting in new strength in prayer and a returning sense of hope. Through that connection, they found renewed energy for their recovery.

Primary theme two. Each participant reported experiencing a new level of relationship with God, or greater God attachment, as they continued to meditate each day with SFMM. These results parallel those of the study mentioned in Chapter Two by Kim (2014), in which participants reported overall greater attachment to God as a result of meditating on scripture verses and aspects of God's character (e.g., love, forgiveness, mercy). This is evident in statements from Tracee: "When I meditate [with SFMM] I felt connected to God," Rose: "God became more real to me, more tangible, from out there somewhere to in here, right in here [pointing to her heart]," and Angela: "It [SFMM] has opened a whole different side to how I see God, and Jesus, and the Holy Spirit."

Primary theme three. Each participant in the study shared that as a result of meditating with SFMM, she enjoyed an expanded spiritual connection to God. Sorajakool et al. (2008) conducted a study to explore the role of spirituality and meaning for participants with severe depression. They found that severe depression created a sense of spiritual disconnection, which included a disconnection from God. The presence of the feelings of disconnection during severe depression highlights the feeling of connection the participants of the present study experienced as their depressive symptoms decreased. Additionally, in a single-case study cited in Chapter Two, Hathaway and Tan (2009) used a Christian version of MBCT similar to the one used in the present study. Not only did results show a significant decrease of anxiety and hopelessness, but the patient also reported "feeling closer with God . . . [and being] able to be in God's presence without feelings of shame or guilt," (Hathaway & Tan, 2009, p. 168) which she had reported feeling constantly previous to the study. The effect of being drawn closer to God during the

meditation with SFMM could be seen in Tracee's statement, "I really had no concept of God. But this mindfulness meditation gave me a relationship with God . . . so impacted my relationship with Him." Rose's statement echoed this sentiment:

The Scripture I used in SFMM reminds me that I'm not alone, actively reminds me that there is a God, my God, and that He is there for me and always has my back,. He is more tangible to me.

In conclusion, the participants in this study, two of whom had suffered for most of their lives with the debilitating effects of clinical depression, shared openly about their experience. Through an exploration of their lived experience using SFMM to mitigate the symptoms of depression, the biological, psychological, social, and spiritual effects of the practice were examined. The following section addresses the implications of this study's findings for the field of counseling and counselor education.

Implications for Counselors and Counselor Educators

Because depression is the most common of all mental pathologies and is increasing in prevalence worldwide, using every treatment modality shown to mitigate the symptoms is of great importance for counselors, those in related fields, and counselor educators. In 2015, it was reported that approximately one million people die by suicide, 10–20 million attempt suicide, and 50–120 million are impacted by the loss of someone who committed suicide (Vijayakumar, 2015). Furthermore, by 2020 clinical depression is predicted to become the leading cause of disability and suicide death in young people worldwide (Mathers & Loncar, 2005). Currently, the most readily available treatment for MDD is ADM. However, the literature reveals it to be lacking for many who suffer from clinical depression, and relapse and suicide rates are only increasing (Craighead & Dunlop, 2014; DeRubeis et al., 2008; Hjemdal et al., 2017; Kirsch et

al., 2008; Turner et al., 2008). CBT is an empirically supported treatment for clinical depression with robust results for relapse prevention (DeRubeis, 2016; Strunk et al., 2007). MDD is recurrent and progressive, and impairment can be severe. Regardless of the effectiveness of CT and CBT treatments, some individuals do not obtain substantial and long-lasting relief from the debilitating effects (Cuijpers et al., 2017; Lynch et al., 2010). Moreover, the characteristics of depression change with each patient, increasing the complexity of determining the best course for managing it. For counselors, filling one's arsenal with other ways to treat clinical depression may improve treatment outcome and minimize relapse.

Mindfulness and various forms of meditation have been found to significantly reduce depression symptomology, including, most significantly, relapse (Kabat-Zinn et al., 1992; Miller et al., 1995; Roemer & Orsillo, 2007; Teasdale et al., 2000; Williams et al., 2008). Although the use of different forms of meditation is increasing, mental health professionals tend to overlook it as a viable adjunct to TAU (Hook, Worthington, Davis, Jennings, & Gartner, 2010). However, mindfulness-based therapies teach necessary skills to decrease emotional reactivity when faced with negative affect-producing stressors, giving patients tools they need to positively affect their mood when triggered (Britton et al., 2012; Wachholtz & Pargament, 2008). In this study using SFMM, each participant experienced an increased awareness of cognitive and emotional states, learned to accept her own personal vulnerability, and discovered that she could reduce her emotional reactions and stress. More studies like the current one may inform the literature significantly considering the use of different forms of mindfulness meditation to mitigate the symptoms of depression and decrease relapse rates.

Shapiro et al. (2003) cited a multicenter randomized clinical trial conducted to evaluate if a meditation-based intervention could help prevent relapse of MDD. Of the 145 recurrently

depressed patients, half received MBCT and half received TAU. Relapse/recurrence of MDD was assessed over a 60-week period. Findings indicated that for patients with recurrent MDD who had three or more episodes, MBCT approximately halved rates of relapse and recurrence during the follow-up period compared to TAU. The researchers emphasized the need for current qualitative investigations to expand our understanding of the subjective experience of individuals using meditation as a coping skill against numerous mental and physical challenges (Shapiro et al., 2003). By being educated in and learning to teach various forms of mindfulness meditation like SFMM, professionals could offer depressed individuals a measure of control to help mitigate the disease.

Treating this enervating disease is at the forefront of mental health care and is only increasing in importance. Research indicates mindfulness meditation in its many forms can lower levels of depression (Ahrens et al., 2010), suppress stress reactions (Segal et al., 2010), increase good mood (Galantino et al., 2005; Speca et al., 2000), enhance sleep (Rubia, 2009), decrease emotional reactivity and anxiety (Hofmann et al., 2010), increase energy levels (Lengacher et al., 2009), and improve behavioral regulation (Farb et al., 2012). Additionally, it can renew interest and enjoyment, increase laughter (Keng et al., 2011), increase feelings of hopefulness and peace (Plante, 2011; Robinson & Alloy, 2003; Segal et al., 2010), increase God-awareness (Wachholtz & Pargament, 2005), and even lessen chronic pain (Wachholtz & Pargament, 2005).

Furthermore, spirituality is a viable and important aspect of cultural sensitivity with patients and could prove to be a significant source of strength and comfort for spiritually minded people to assist in their recovery goals. Mental health conferences would do well to consider incorporating specific strategies of various forms (including spiritual) of mindfulness meditation

to their depression prevention programs and teaching the necessary skills to empower patients struggling with depression, offering them hope for a better tomorrow. Accordingly, the American Counseling Association Code of Ethics (2014) stated:

Counselors select and use with caution assessment techniques normed on populations other than that of the client. Counselors recognize the effects of age, color, culture, disability, ethnic group, gender, race, language preference, religion, spirituality, sexual orientation, and socioeconomic status on test administration and interpretation, and they place test results in proper perspective with other relevant factors (p. 12).

Recommendations for Action

This section offers recommendations for action drawn from the findings of this study. For the millions who suffer from clinical depression, the need for CAM treatments like SFMM is increasing. According to Kessler (2001), six out of every 10 patients diagnosed with clinical depression will seek out some type of CAM therapy to treat their depression. Furthermore, Kessler et al. (2001) reported that alternative treatments for depression and self-reported anxiety have become so common that insurance coverage for CAM treatments has been increasing. Therefore, the number people looking for these treatments will also increase. The biological, psychological, social, and spiritual effects of SFMM revealed by this study emphasize the need for clinicians to include consideration of spiritual beliefs as part of the intake process and give support for the use of SFMM to improve treatment outcome of depression. Publication of the relevant findings of using SFMM to mitigate depression symptomology to effect change in the treatment, and therefore relapse rates, of depression would be important. For the participants in this study, meditating with SFMM resulted in improvements in depressive symptoms: physiological changes that counteract those seen in clinical depression, improvement in

psychological health, positive affect in psychosocial factors, and an increase in spiritual sensitivity. Considering that biological, psychological, social, and spiritual impairments found in depression often persist following treatment and increase risk of relapse, the capacity for SFMM to positively effect these changes would provide an important piece of meditation-based treatment and prevention.

Introducing mindfulness during a treatment session (e.g., conducting a five-minute breathing exercise) has the potential of introducing a form of mindfulness meditation as a part of the treatment plan. Furthermore, there are numerous workshops available to mental health professionals offering introductory classes, skill-building, information on how to integrate mindfulness into current treatment, and much more for those who want to expand effective treatment for depression and anxiety (Beck Cognitive Behavior Therapy, 2018). The greater body of research and treatment protocols for treating clinical depression focus on external factors and observable behaviors such as environment and response to triggers rather than the effects of internal mental processes. In conclusion, educating mental health practitioners, supervisors, and educators in this expanding field of research may increase our ability to treat the devastating symptoms of depression and positively affect relapse rates.

Limitations and Recommendations for Further Study

Potential weaknesses are characteristic of any research study. There are limitations specific to qualitative study and delimitations (i.e. conditions) that were chosen in this study to examine the effect of meditation on clinical depression. The following section examines these limitations and offers suggestions for future research in the area of mindfulness meditation to mitigate the symptomology of clinical depression.

Limitations

IPA studies focus on the common meaning of the lived experience of a small purposive sample chosen specifically for the targeted phenomenon. Nevertheless, the findings can be operationalized and examined qualitatively for comparison with similar outcomes in other IPA studies using meditation to mitigate the effects of depression. The use of a three-week mindfulness course limits the ability to speculate on results from longer durations of meditation. Additionally, the use of a spiritually focused meditation limits our understanding of heterogeneity of meditative techniques. Another limitation was the variability of mood disturbance at baseline, which may have increased or decreased the effect of treatment. Because no depression measure was used, it is not possible to know the intensity of the individual's depressive symptomology. Equally important, the comorbidity of addiction/depression in the sample limits the ability to generalize to other depression samples. Comorbidity suggests interactions between the diseases affecting the course of both (National Institute on Drug Abuse, 2014). Finally, although residual depression symptoms improved following SFMM, results are limited to the subjective data received and translated.

The use of diaries to record experience provided some strengths and limitations to the study. A strength of journaling is the immediacy of recording the impact of the meditation. This enabled a more nuanced understanding of the participants' experience using SFMM and limited bias from participants' possible desire to impress or please the researcher during the semistructured interview. However, journaling does present limitations, considering the possibility of the participants' growing weary with journaling and just jotting down a thought or so and the limits it may have on the participants' ability to fully express the impact of their experience.

Recommendations for Further Study

For such a broad subject as MDD, additional qualitative, quantitative, and mixed-methods studies focusing on SFMM to treat clinical depression are needed. Use of a larger sample, and more heterogeneous sample would increase the extent to which current findings generalize to other populations. As the participants continued to meditate, the positive effects increased; thus, studies that followed participants for significantly longer periods of time may prove beneficial. Rubia (2009) reported on preliminary evidence for significant improvement in psycho-emotional balance and the focused attention skills used for meditation in long-term meditators. It will be important in future studies to assess the degree to which findings similar to those reported herein emerge in samples differing considerably from the present ones and to determine whether certain subject attributes facilitate the nature of how SFMM mitigates the symptoms of clinical depression. Another important aspect of further study surrounds specific meditation techniques that underscore emotional stress reduction that may be useful in treating affective pathologies. Lastly, future studies could also examine how adding a spiritual element to various types of meditation techniques may facilitate self-regulation pertaining to clinical depression.

Relocating the Researcher in the Light of the Findings

Throughout the process of conducting the present study, I was reminded of the devastating effects of clinical depression. Examining the accounts of how the participants had lived with such hopelessness and helplessness, even to desiring to end their lives regardless of the pain and sorrow that would be inflicted on their loved ones, was both heartbreaking and empowering for me as a clinician. I gained assurance in the participants' accounts of having more control over their mood swings and that, by choosing to meditate when feeling triggered,

they could achieve a sense of calm and peace. Tan (2011) claimed a spiritually directed form of mindfulness treatment to be invaluable, most specifically for Christian clients that struggle with obsessive or ruminative thinking. Furthermore, he emphasized, results of meditating with mindfulness included a compassionate, loving disposition directed toward self and others and an increased focus on value-based behaviors that line up with Christian core beliefs. The current study showed this to be true for each participant, and as a direct result of this study, I have gained confidence in teaching a skill that can aid my Christian clients struggling with depression in managing the unique symptoms they bring to therapy.

Summary

More than 350 million people currently suffer from the complex symptoms of clinical depression, and sadly, over a million people die by their own hand each year. MDD is recurrent and progressive, and treatment for this devastating mood disorder is often long, arduous, and expensive; oftentimes, it has little sustainable success. Furthermore, symptoms are relentless, and the literature shows relapse is inevitable in most cases, affecting the person's life, family, and work. Each of the women in this study reported clinical depression from their youth as a result of early childhood trauma and addiction. Nevertheless, the participants found hope at the end of their long-lived dark tunnel of depression. Tedeschi and Calhoun (2004) called this type of survival "positive psychological change experienced as a result of the struggle with highly challenging life circumstances" (p. 1). These authors reported that a relationship can be found between post-traumatic growth and an individual's spirituality. Furthermore, studies show that spirituality and religious beliefs can be the result of surviving trauma (Shaw et al., 2005; Tedeschi & Calhoun, 2004).

In summary of the findings of this study, the participants found renewed hope for their future using SFMM to mitigate depressive symptoms. One participant found hope for the first time in her life:

I feel such joy and serenity during and after my meditation. I feel a connection to God that brings me such peace and hope for the first time in my life, it makes me so grateful for my many blessings.

They found a way to calm themselves and enlarge their perspective of others in their lives, and each participant reported an increase in her understanding of how God was there to aid her, support her, and strengthen her in her journey with clinical depression. As one participant shared, “God became more real to me, more tangible, from out there somewhere to in here, right in here.” Additionally, the participants found they had gained a measure of control over the depressive symptoms and began sharing with others in similar circumstances how SFMM could help them as well. Each participant, in conclusion, realized her own personal resilience and perseverance, helping her derive meaning out of what she had suffered for a lifetime. Although this study was small, the results suggest that SFMM would be a low-cost treatment option for patients suffering from the life-altering, invasive symptoms of MDD.

Final Summary

Initially, the thought behind this study was to find out how mindfulness meditation would affect the symptomology of clinical depression. The study began with a brief overview of the basis for the proposed investigation by drawing attention to the exponential growth of clinical depression worldwide. The research modality chosen for the study was also introduced and the rationale for using it explained. Further, the first chapter introduced the purpose and significance of the study, the conceptual framework from which the study was organized, the research

question, assumptions and limitations, theoretical framework, definitions of terms used throughout the study, and an overview of SFMM. Chapter One ended with an introduction to the researcher and why the study was of interest.

Based on the conceptual framework, Chapter Two examined what the current research offered on evidence-based treatments for clinical depression, including mindfulness-based therapies. Additionally, an overview of mindfulness-based treatments available for those who want to add a spiritual element to their therapy was presented, and justification for the methodology chosen for the study was also described.

Chapters One and Two set the stage for the study, and Chapter Three presented a comprehensive summary of IPA as the chosen research design, including the three primary theoretical elements: phenomenology, hermeneutics, and idiography. Following this, the research question and context for the study were tendered. Pertinent information was provided regarding the participants, including methods used to select them. The initial workshop, the individual semistructured interviews, reflective journals, and ethical protections were described fully. Moreover, relevant information about the role of the researcher and data collection procedures were outlined. The chapter concluded with data analysis procedures and the methods used to ensure validity and trustworthiness of the findings.

Following approval from the Institutional Review Board to conduct the study, possible participants were contacted through letters to local therapists currently treating individuals with MDD. Chapter Four presented an overview of the demographic details for each of the participants and the findings of the IPA study examining how SFMM affected the depressive symptoms of the purposive sample. To give context for the study, a narrative synopsis of each of the participants' lives and experience with depression was offered. The remainder of the chapter

presented the primary themes extrapolated from the data collected during the semistructured interviews and from participants' personal journals. Finally, Chapter Five offered evidence for and interpretation of the primary themes that emerged from the analysis of the data and compared those themes to the literature.

The result of using SFMM to mitigate the biological, psychological, social, and spiritual symptoms of clinical depression was significant improvement in depression severity and cognitive distortions. Biologically, the participants experienced positive changes in sleep patterns, increased energy and motivation, sustained good/better mood, and increased control over the effects of anxiety and stress. Psychologically, the participants experienced an ability to control low moods and increase good moods, increased interest/pleasure, renewed hope, and distinct feelings of calm and peace. Socially, the participants experienced increased patience and tolerance for others and became more outgoing and engaged with people. Lastly, spiritually, the participants experienced an increased God-awareness, new level of relationship with God, and an expanded spiritual connection to God. From these results and the literature findings, mental health professionals may well want to consider including various forms of mindfulness meditation and an assessment of spiritual beliefs for a greater understanding of human complexity and how to better serve spiritually minded clientele.

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Appendix A: One-Page Research Summary

Title:

Spiritually-Focused Mindfulness Meditation: An Interpretative Phenomenological Analysis of the Effect of Spiritually-Focused Meditation on Depression with a Clinical Population

Purpose:

The purpose of this qualitative interpretative phenomenological analysis (IPA) is to explore in detail the lived experience of a select clinical sample presently suffering from major depressive disorder (MDD), using Spiritually-Focused Mindfulness Meditation for reduction in depression symptomatology.

Research Question:

How does a clinical sample of research participants describe the experience and effectiveness of Spiritually-Focused Mindfulness Meditation as a component of therapy to mitigate the effects of their depression?

Possible Questions for Semi-Structured Interview:

1. What is your experience with meditation to lessen the effects of depression previous to this study?
2. How was the experience of Spiritually-Focused Mindfulness Meditation for you; how did it make you feel?
3. How would you describe your experience using Spiritually-Focused Devotional Meditation?
4. Specifically describe the physical, psychological (thoughts and feelings), social and spiritual effects of using Spiritually-Focused Mindfulness Meditation.
5. What, if any, changes did Spiritually-Focused Devotional Meditation have on your overall mood?
6. Explain some of the challenges you had with meditating each day, if any?
7. How has your meditation affected the symptoms of depression for you?
8. On completion of the meditation, to what extent did meditation effect your depressive symptoms?
9. In what way was Spiritually-Focused Devotional Meditation helpful?
10. Do you plan to continue to use Spiritually-Focused Devotional Meditation to moderate depressive symptoms?
11. Explain how practicing Spiritually-Focused Mindfulness Meditation made you feel about your life, and/or your relationship to God.
12. Would you recommend Spiritually-Focused Mindfulness Meditation to your friends or family members? If yes, why?
13. Explain to me how your life has changed by engaging in Spiritually-Focused Mindfulness Meditation on a daily basis.

Participant Selection:

- (1) Participant has a current diagnosis for Major Depressive Disorder; (2) Participant is currently being treated for depression by a professional mental health counselor; (3) Participant was capable of committing to 10 to 20 minutes of Spiritually-Focused Mindfulness Meditation per day; (4) Participant was capable and willing to share intimate details and reflection of the meditation experience.

Appendix B: Recruitment Letter to Clinician

Re: Spiritually-Focused Mindfulness Meditation: An Interpretative Phenomenological Analysis of the Effect of Spiritually-Focused Meditation on Depression with a Clinical Population

This study is being conducted by Grace L. Bellingham

Dear Clinician,

As a Ph.D. student from the Center for Counseling and Family Studies at Liberty University, I am writing to ask you about potential patients that may be willing to participate in a research study about how a spiritually-focused form of meditation added as an adjunct to treatment as usual (TAU) may potentially mitigate depressive symptomology. The study is for the dissertation work (title mentioned above) required for graduation from Liberty University as a Ph.D. in Philosophy of Counseling: Professional Counseling.

This study may provide a better understanding of the effect of using Spiritually-Focused Mindfulness Meditation to mitigate or lessen the intensity or overall symptoms of Major Depressive Disorder. Specifically, this study seeks to gain a deeper understanding of major depression and the impact mindfulness meditation has on the emotional effects of depression. The primary research question that will guide this study is: How does a clinical sample of research participants describe the experience and effectiveness of Spiritually-Focused Mindfulness Meditation as a component of therapy to mitigate the effects of their depression?

Participants will be asked to complete a demographic survey, attend a workshop, complete three weeks of mindfulness meditation and journaling, and participate in a recorded semi-structured interview. Participants will be provided with consent information and will have the opportunity to review their contributions to the research prior to publication. All data will be kept confidential and locked in my private office. As a token of appreciation, each participant will receive a \$50 Visa gift card.

I sincerely appreciate your help in this matter, and any patients that you recommend will be treated with utmost care and sensitivity.

Thank you very much for your consideration.

Sincerely,

Grace Lynn Bellingham, MA

Appendix C: Recruitment Letter to Participant

Dear Possible Participant,

My name is Grace Bellingham, and I am a Ph.D. student from the Center for Counseling and Family Studies at Liberty University. I am writing to invite you to participate in my research study about the effect of using Spiritually-Focused Mindfulness Meditation (SFMM) to mitigate or lessen the intensity or overall symptoms of Major Depressive Disorder. Specifically, this research seeks to gain a deeper understanding of major depression and the impact SFMM has on the emotional feelings and effects of depression. Participants must be 18 years or older for this study, selected from a particular spiritually-minded group of people who have each experienced Major Depressive Disorder, have been diagnosed, and are currently in treatment by a clinical professional. Participant criterion includes the stipulation that you speak English and agree to journal your experiences, thus requiring a measure of ability to record purposeful notes. Additionally, the semi-structured interview requires the participant to be capable of honest, open reflection, and a willingness to share your experiences with the meditation as well as the depression without excessive difficulties with recall or articulation. Male and female adults willing to add a Christian element, recommended by their therapist will be interviewed for the study. Lastly, you must be willing and capable of meditating for 10–20 minutes per day for the three-week time period. You are receiving this letter because your therapist thought you would be a good choice for this study.

Procedures for the study include an SFMM two-hour workshop to be held as a group training (five participants) in my private counseling office. After an initial introduction of myself and the study, which will include the importance of confidentiality and privacy, each of you will have an opportunity to ask any questions concerning your involvement. If any of you wish for an opportunity to talk privately, that will also be available. The workshop will include detailed instructions about Spiritually-Focused Mindfulness Meditation and how it is done. You will receive two handouts describing the meditation and we will discuss thoroughly how it is done. We will meditate together for twenty minutes and I will lead the meditation on a character of God (e.g., God's faithfulness and love) so that you can experience how it is done, and have any questions answered.

Additionally, an introduction to the experiential journals (i.e., what you will record in them) will be given and each of you will receive a journal to be used for the study. The journals will be used mainly for reflection about your experiences using SFMM (e.g., mood before and then after, thoughts during the meditation, and improvement in mood, etc.). You will be required to schedule a two-hour interview with me the week following your three weeks of meditation. During this interview you will have opportunity to share your experiences using SFMM, and your journals will be collected at this time to be used with the interview data for analysis. Although, I will lead you with questions during the interview, you will have the freedom to share anything you choose to about your experience. Also, during the interview your experience with meditation and the affects you may have experienced will be video-taped. All of the information concerning the research will be kept securely locked away in my private office and I am the only one who will have access to the data collected.

To participate in this study please sign the consent form and fill out the demographic survey that has been given to your therapist and contact me at the number below.

Remember, participation is completely voluntary. You can choose to be in the study or not. If you'd like to participate or have any questions about the study, please email or contact me.

If you choose to participate, you will receive a \$50 Visa gift card as a token of my appreciation.

Thank you very much for your consideration.

Sincerely,

Grace Lynn Bellingham, MA

Appendix D: Demographic Questionnaire

Name: _____

Age: _____ Marital Status: M S Divorced Years Married _____

Number and ages of children _____

Please complete the following questions: (circle response where appropriate)

Gender: M F

Years of Education completed: _____years (e.g., count grade 12 as 12 years)

Employment: Unemployed Part-time Full-time

Please indicate the severity of your depression that you have experienced in the past week:

Please circle the number – 0 meaning no depression – 10 meaning severe depression

0 1 2 3 4 5 6 7 8 9 10

How long have you suffered from depression _____weeks or _____months or _____years?

Do you presently take medication for your depression? No Yes

What medication do you presently take? _____

Have you been diagnosed with Major Depressive Disorder (MDD)? No Yes

Do you exercise regularly? No Yes

Do you pray? No Yes (if yes) how frequently _____times per month.

Do you attend church? No Yes (if yes) how frequently _____times per month.

Do you believe in a higher power? No Yes

Do you presently engage in any form of meditation? No Yes (if yes please list)

Do you practice yoga? No Yes (if yes) how frequently _____times per week.

How familiar are you with mindfulness meditation?

Not at all	Somewhat		Very	Completely familiar	
Religion:	Christian	Muslim	Buddhist	Hindu	Sikh
	Jewish	Atheist	Traditional Aboriginal Spirituality		
	None	Other (please specify) _____			
Income:	\$0 - \$25000	\$25001 - \$45000	\$45001 - \$75000	\$75000+	

Appendix E: Why Spiritually-Focused Mindfulness Meditation?

Thank you for choosing to participate in this study. Your time, energy and commitment are not only appreciated by me, the researcher, but will contribute to our understanding of depression, depression management, and the role that Spiritually-Focused Mindfulness Meditation can play in mitigating or lessening the symptoms of major depression. This study will involve three individuals such as yourself, and training them in the techniques of Spiritually-Focused Mindfulness Meditation as applied to lessening the effects of depression. One particular aspect of spirituality that is of particular interest involves a sense of inner peace and tranquility, a new calmness, and an ability to center yourself in God and His thoughts toward you as His child. It is thought that this sense of inner peace and tranquility will be strongly correlated with reductions in depression symptoms, thereby providing a potential link between Spiritually-Focused Mindfulness Meditation and depression management.

Mindfulness meditation is a practice that is gaining interest in clinical fields around the world, although meditation has been known to human society for centuries. In the Scriptures there are 62 instances where God encourages believers to meditate. As you may already be aware, there are a variety of meditative practices in which you can engage. Mindfulness is one form of meditation. Moreover, current research has found mindfulness meditation showing significant results in a variety of areas including anxiety management, depression management, stress management, and pain management, to name a few. In this study, we are utilizing a new version of mindfulness—Spiritually-Focused Mindfulness Meditation. It is thought that reductions in anxiety, depressive or sad feelings, and stress will also be an aspect of your participation in this study. If you would like to learn more about mindfulness meditation, you will find a couple of sources at the bottom of this page. Additionally, you can contact the researcher, who would be happy to provide additional resources to you. Remember that to maintain the skills you have learned over the past three weeks, you will need to practice them. God bless you in your mindfulness practice, and thank you again for participating in this study.

A Christian Model of Mindfulness: Using Mindfulness Principles to Support Psychological Well-Being, Value-Based Behavior, and the Christian Spiritual Journey, by Scott H. Symington and Melissa F. Symington.

Adapting Mindfulness for Conservative Christians, by Fernando Garzon and Kristy Ford.

Appendix F: Informed Consent Form

CONSENT FORM

Spiritually-Focused Mindfulness Meditation: An Interpretative Phenomenological Analysis of the Effect of Spiritually-Focused Meditation on Depression with a Clinical Population

Grace Lynn Bellingham

Liberty University

Center for Counseling and Family Studies

You are invited to be in a research study that intends to provide a better understanding of the effect of using Spiritually-Focused Mindfulness Meditation to mitigate, or lessen the intensity or overall symptoms of Major Depressive Disorder. You were selected as a possible participant because you have met the following criteria: diagnosed with Major Depressive Disorder, you are currently in treatment for depression, have relapsed one or more times, and you are at least 18 years-old. It has also been determined that you speak English, are capable of meditating for 10–20 minutes per day for the three-week time period, and you have the necessary aptitude to record your experiences with the meditation in a journal. I ask that you read this form carefully and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Grace L. Bellingham
Doctoral student at Liberty University's Center for
Counseling and Family Studies

Background Information: Considering the impact of depression on individuals and society in our world today, the purpose of the present study is to explore the lived experience with and effectiveness of Spiritually-Focused Mindfulness Meditation as a component of therapy to mitigate the effects of depression. Specifically, this research seeks to gain a deeper understanding of major depression and the impact Spiritually-Focused Mindfulness Meditation has on the emotional feelings and effects of depression. The primary research question that will guide this study is: How does a clinical sample of research participants describe the experience and effectiveness of Spiritually-Focused Mindfulness Meditation as a component of therapy to mitigate the effects of their depression?

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

1. Fill out a demographic questionnaire given to you by your therapist (approximately 20 minutes).
2. Attend a one-time, two-hour group Spiritually-Focused Mindfulness Meditation workshop.
3. Meditate using Spiritually-Focused Mindfulness Meditation for 10 to 20 minutes a day and keep an experiential journal to record, for example, your mood before and then after; your thoughts during the meditation; and if your mood improved, how long it lasted through the day.

4. Attend a semi-structured interview (about 2 hours) to be scheduled at the end of the three-week period of meditation, within one week.
5. Review the transcript/data and ask any questions about what you are being quoted as saying. Reviewing the data will take between one or two hours. At this part of the semi-structured interview you will be given opportunity to have any personal information withheld from the report.

Risks and Benefits of Being in the Study: While the risks of participating in this study are not more than would be encountered in everyday life, there are some risks you should be aware of before agreeing to be in this study. Risks may include feeling uncomfortable or anxious, or having self-doubt due to having to share your story and personal details with a stranger. Some people may feel a sense of shame or exposure. There may also be an emotional cost to openly and reflectively sharing your time, emotional resources, and priceless experience. For instance, you may have negative feelings stirred up and brought back to the surface through sharing your experience.

The possible benefits of you participating in this study include renewed hope, increased insight, greater self-awareness, and learning a vital skill you can use easily throughout your lifetime to help mitigate or lessen your depressive symptoms. This study may also inform and help therapists make changes to treatment protocols that could be more effective and may help the research community identify new areas that require attention.

Compensation: Those who participate in all phases of this study will receive a \$50 Visa gift card as compensation for participation in this study.

Confidentiality: The records of this study will be kept private. In the dissertation report or any subsequent journal publications or presentations, I will not include any information that will make it possible to identify a participant. I may share the data I collect from you for use in future research studies or with other researchers; if I share the data that I collect about you, I will remove any information that could identify you, if applicable, before I share the data.

All transcribed and video-taped data or notes will be coded in such a way to remove your name and all other personally identifying information; the code sheet will be stored separately in a locked and protected area in the researcher's office. All interview and research records will be stored on a secure, encrypted laptop that remains in the constant possession of the researcher, as well as being backed up on a portable USB that will be stored in a locked and protected cabinet in the researcher's office. All video tapes will be deleted immediately upon completion of this study. All other transcribed data, notes, and identifying information (stored separately) will be destroyed within three years of completion of the study. Until that time, data will be stored in the office of the researcher in coded format and inaccessible to outsiders.

Limits of Confidentiality: In a qualitative study, complete confidentiality is not possible because excerpts and descriptions from participants' interviews become an integral part of data reporting. However, confidentiality will be upheld by allowing participants to choose pseudonyms and review all information being included.

Further, in accordance with the US Department of Health and Human Services (see https://www.childwelfare.gov/systemwide/laws_policies/statutes/manda.cfm) if the participant states or suggests that he or she (or his or her spouse) is abusing a child (or vulnerable adult), or child (or vulnerable adult) who is in danger of abuse, the researcher is required to report this information to the appropriate social service and/or legal authorities.

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

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

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, you are encouraged to contact the Institutional Review Board, 1971 University Blvd, Green Hall Ste. 1887, Lynchburg, VA 24515 or email at irb@liberty.edu.

You will be given a copy of this information to keep for your records.

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

I understand and agree to be audio- and video-recorded as a part of my participation in this study.

(Approval indicated in check box is required in order to participate in this study)

Signature: _____ Date: _____

Signature of Investigator: _____ Date: _____

Appendix G: Interview Guide

Respondent's opinions about their experience with spiritually-focused mindfulness meditation:

- Could you tell me about your experience with depression?
- How would you describe what was going on in your life when you were first diagnosed?
- What has your experience with depression been like for you?
- What is your opinion of Spiritually-Focused Mindfulness Meditation?
- How would you describe the physical (biological) effects of using spiritually focused mindfulness meditation?
- How would you describe the psychological (thoughts and feelings) impact spiritually focused mindfulness meditation had on you?
- Describe how meditating with SFMM affected you socially (around people).
- Describe how SFMM affected you spiritually (your relationship with God).

Some Probing Questions:

- Detail-orientated Probes: 'When did that happen?' 'Who else was involved?' 'Where were you during that time?'
- Elaboration Probes: 'Could you tell me more about that?' 'Why exactly do you feel that way?'
- Clarification probes: "You said _____ . What did you mean by that?"
- Silent Probe: Remaining silent and waiting for the participant to continue, perhaps with a simple nod.
- Uh-huh Probe: Encouraging the participant to continue by making affirmative but neutral comments, like 'Uh-huh,' or 'Yes, I see.'
- Echo Probe: Simply repeating the last thing the participant said and asking them to continue. Especially good when a process or event is being described. 'I see. So at first you felt like this and now how do you feel?'

Dee Balkissoon, Semi-Structured Interviews. Retrieved from
<http://designresearchtechniques.com/casestudies/semi-structured-interviews/>

Appendix H: Spiritually-Focused Mindfulness Meditation

A Scripture from the Bible

Mindfulness meditation is learning to mind your mind; it's about becoming aware of what are you thinking, feeling, or what is troubling you, without judgement of any kind. The purpose of this Spiritually-Focused Mindfulness Meditation is to focus specifically on a scripture verse from the Bible. This is not to analyze the theology but to receive the truth of it into your thoughts and heart, to deeply meditate on it and fill your whole being with the truth of it. Choose one from the following list or I can help you find one more personally suited to you. This can also be done with a line from a favorite Christian song. The following is for a 10-minute meditation, for a 20-minute meditation just double the minutes suggested below.

To begin:

- Ask God to help you open your heart to Him and to fully cleanse your heart and mind of all judgement, quietly sitting in His presence, soaking in His love for you.
 - Turn off all distractions, TV, phone, computer, radio, etc.
 - Sit comfortably with feet on floor and hands in lap, close your eyes, take a deep cleansing breath and let it out slowly.
- As you begin, become aware of what you are thinking, feeling, things stressing you, and problems distracting you. What is on your mind?

OK...

- What are you feeling? Notice that feeling, stay with it. Are you nervous, tense, in pain, or something else?
- Now, take a moment to clear your mind of these distractions by focusing your thoughts on one thing only; breathing. Breathe in deeply through your nose, hold it for three seconds, and then let it out slowly through your mouth. As you do this several more times, think only about breathing, the sound, the feeling, the act of breathing, your air, your lungs expanding. Do this for **one minute**.

OK...

- Now, direct your focus toward a verse of scripture. Choose from one of these or one of your own: “The Lord is my Shepard, I shall not want (Psalm 23).” or “I can do all things through Christ, who is my strength (Philippians 4:13.” or “Trust in the Lord with all your heart and lean not to your own understanding (Proverbs 3:5a).” or “God will never leave me or forsake me, therefore, I can boldly say, ‘The Lord is my helper; I will not fear; what can man do unto me? (Hebrews 13:5–6)’” or “Come to me, all you who are weary and burdened, and I will give you rest.” or “He that dwells in the secret place of God, shall abide under the shadow of the Almighty...” Choose one to focus on while your breathing becomes normalized. Focus on that for **three minutes**, breathing normally.
- Now, personalize this: “*God will never leave me or forsake me for any reason, because of this I know that God will help me, and I will not fear what will happen next...*” continue to focus on one of these like this for **three minutes**.
- Now, thank God for the truth of that scripture being true in your life...continue to focus on one of these for **three minutes**.

OK...

- Take two or three deep breaths, open your eyes and allow yourself to feel how relaxed you are, how stress free you feel, and how much clarity you have.

It’s important for you to know that throughout the meditation your mind may wander again and again, that is not problem, just redirect it back to the meditation by taking a deep breath through your nose and letting it out through your mouth as you redirect your thoughts back to the step you had just been focusing on.

Appendix I: Spiritually-Focused Mindfulness Meditation

A character trait of God

Mindfulness meditation is learning to mind your mind; it's about becoming aware of what are you thinking, feeling, or what is troubling you, without judgement of any kind. The purpose of this Spiritually-Focused Mindfulness Meditation is to focus specifically on a character of God and Who He is to you, for you, always with you. This is not to analyze the theology but to receive the truth of it into your thoughts and heart, to deeply meditate on it and fill your whole being with the truth of it. The following is for a 10-minute meditation, for a 20-minute meditation just double the minutes suggested below.

To begin:

- Ask God to help you open your heart to Him and to fully cleanse your heart and mind of all judgement, quietly sitting in His presence, soaking in His love for you.
 - Turn off all distractions, TV, phone, computer, radio, etc.
 - Sit comfortably with feet on floor and hands in lap, close your eyes, take a deep cleansing breath and let it out slowly.
- As you begin, become aware of what you are thinking, feeling, things stressing you, and problems distracting you. What is on your mind?

OK...

- What are you feeling? Notice that feeling, stay with it. Are you nervous, tense, in pain, or something else?
- Now, take a moment to clear your mind of these distractions by focusing your thoughts on one thing only; breathing. Breath in deeply through your nose, then let it out slowly through your mouth. As you do this several more times, think only about breathing, the sound, the feeling, the act of breathing, your air, your lungs expanding. Do this for **one minute**.

OK...

- Now, direct your focus toward God. His character, love, mercy, forgiveness, blessing, faithfulness, promises...Choose one to focus on while your breathing becomes normalized. For example, God is love, He loves no matter what, His love is unconditional, never failing, never ending...focus on that for **three minutes**, breathing normally.
- Now, personalize this: *God loves me, God forgives me, God is faithful to me, God is merciful to me, God is good to me, God is in control, Jesus loves me*...continue to focus on one of these for **three minutes**.
- Now, thank God for loving you, forgiving you, being so faithful to you, so merciful to you, so good to you, for being in control of all that is going on in your life...continue to focus on one of these for **three minutes**.

OK...

- Take two or three deep breaths, open your eyes and allow yourself to feel how relaxed you are, how stress free you feel, and how much clarity you have.

It's important for you to know that throughout the meditation your mind may wander again and again, that is not a problem, just redirect it back to the meditation by taking a deep breath through your nose and letting it out through your mouth as you redirect your thoughts back to the step you had just been focusing on.