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ORIGINAL PAPER

Effects of the HeartSync Intervention on Depression, Anxiety, and Life Satisfaction in the USA

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Abstract

HeartSync is an Inner Healing Prayer intervention that has been used mostly in Christian lay ministry since 2010. The purpose of this study was to examine the effectiveness of this inner healing approach for the treatment of symptoms of depression/anxiety in clinical settings in the United States. In this quasi-experimental study, participants (n = 31) were assessed for depressive symptoms before, during, at the end, and 90 days after 10 sessions of HeartSync treatment. The PHQ-9, CES-D, Satisfaction with Life Scale, and GAD-7 were administered at each time point. The results indicated that (1) the average PHQ-9 score decreased by 65%, with 77% of participants having symptoms that decreased by 50%; (2) the mean CES-D score decreased by 60%, with 68% of participants having symptoms that decreased by 50%; (3) the mean GAD-7 score decreased by 55%, with 61% of participants having symptoms that decreased by 50%; and (4) the mean Satisfaction with Life Scale score increased by 123%, with 68% of participants indicating improvements of 50% or more in life satisfaction. Patient-reported outcomes (PROs) were also assessed, yielding an effectiveness rating of 8.4 out of 10. These findings provide preliminary support for HeartSync as an effective intervention for the treatment of depressive and anxiety symptoms and warrants further testing in a randomized controlled trial against other standard treatments for emotional disorders.

Keywords Spirituality · HeartSync · Inner healing prayer · Depression · Satisfaction with life · Anxiety

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Introduction

Over the past several decades, the integration of spirituality into psychotherapy has become an increasingly recognized topic in clinical research. Research suggests that many clients desire spiritual or religious components in their treatment (e.g., Currier et al., 2020; Rosmarin et al., 2015), particularly when addressing depression, anxiety, trauma, and addictions. Spiritually or religiously adapted psychotherapy can be both acceptable to clients and clinically effective. In a meta-analysis of 97 studies (N = 7,181), Captari et al. (2018) reported that compared with no treatment, psychotherapy tailored to clients' spiritual or religious beliefs produced significantly greater improvement in psychological and spiritual functioning and had modest but significant advantages over secular psychotherapy. Similarly, in a meta-analysis of randomized controlled trials, Bouwhuis-Van Keulen et al. (2024) reported that spiritually or religiously adapted psychotherapy demonstrated higher efficacy than standard treatments did, with a Hedges' g of 0.52 at posttreatment.

These findings align with broader evidence concerning the effectiveness of incorporating spirituality into mental health treatment, such as that described in the Handbook of Religion and Health by Koenig et al. (2024). Greater levels of spirituality and religiosity are associated with lower levels of depression, suicidality, substance use, and other psychiatric disorders (Koenig et al., 2024; Lucchetti et al., 2021). Within this context, inner-healing prayer (IHP) models appear well suited for addressing Christian clients' desire for spiritually grounded interventions while enhancing their potential for increased treatment effectiveness through the inclusion of IHP as a spiritual or religious intervention. However, there is a lack of empirical research on IHP models which may detract from their use in clinical settings.

Inner Healing as a Spiritually Integrated Intervention

IHP is a form of Christian prayer ministry that invites the Holy Spirit to bring emotional, spiritual, and relational healing to wounds caused by past experiences, trauma, sin, or distorted beliefs by encountering Jesus within those memories, where the truth is revealed. Historically, inner healing movements have been used since the mid-twentieth century (e.g., Payne, 1995; Sandford & Sandford, 1982; Smith, 2005). Wilder et al. (2020) and others describe the emergence of multiple models—often independently developed outside of formal psychological institutions—as a notable spiritual and historical development. IHP models such as HeartSync (Miller, 2010) have been utilized by clergy and lay ministers for decades, and clinicians have also begun to incorporate IHP techniques more informally into their work, mostly within faith-based counseling settings.

Many evangelical Christians report dissatisfaction with their level of spiritual and emotional growth (Hawkins & Parkinson, 2016). Porter et al. (2017) documented similar concerns among licensed Christian therapists who reported limited spiritual transformation in their clients. Additional research has indicated that Christian clients in secular therapy desire an approach that is consistent with their religious or spiritual background and addresses their mental health and spiritual health needs

(Lloyd et al., 2026), which indicates an opportunity for more spiritually integrated interventions, including IHP and other faith-based experiential modalities such as HeartSync to address these needs.

For many clients, the expectation of encountering God—rather than relying solely on secular and religious coping strategies—can enhance motivation and therapeutic engagement. Christian clients may experience this relational engagement with God as more impactful than cognitive coping strategies alone, particularly in terms of increasing hope, perceived support, and openness to change. This perspective aligns with research demonstrating the clinical importance of relational spirituality and models that utilize this concept of experiencing greater power as an important aspect of mental health treatment. According to Sandage et al. (2020), relational spirituality is defined as follows: "a broad range of clinical approaches that intentionally engage spiritual and religious dynamics in psychotherapy in ways that are theoretically and clinically coherent" (p. 4).

Counted et al. (2018) reported that relational spirituality was associated with health benefits and increased quality of life in 12 of the 20 studies that they reviewed. IHP models that are integrated into clinical psychotherapy, such as HeartSync, (Miller, 2010), may operationalize relational spirituality in a structured therapeutic format within the mental health field to provide a standardized and clinically oriented process for patients to relate to the sacred in their lives (Sandage, 2020).

IHP may be described not only in terms of relational spirituality but also in terms of being an "experiential intervention" that is well documented as effective and evidence based in the psychological literature (Duffy et al., 2023). Contemporary experiential therapies such as Dialectical Behavioral Therapy, Eye Movement Desensitization and Reprocessing, and Internal Family Systems share mechanisms with IHP, emphasizing emotional processing, present-moment experience, imagery, and relational attunement. These elements are central features of experiential therapy (Cain et al., 2016; Greenberg & Pascual-Leone, 2006). However, while most experiential models are grounded in humanistic or neuropsychological frameworks, IHP explicitly orients the experiential encounter toward God as a healer.

Rationale for the Present Study

Despite the growing familiarity and popularity of IHP as a type of spiritually integrated psychotherapy, little empirical research has directly examined IHP models, and no peer-reviewed studies to date have evaluated the HeartSync (Miller, 2010) model specifically. Scholarly reviews have repeatedly noted this gap. Sperry (2025) observes that there is "no consensus, guidelines, or professional standard for integrating 'inner healing prayer' into licensed psychotherapy," classifying it as "experimental" rather than "empirically supported" (p. 195). This lack of empirical evidence regarding IHP has contributed to a general uncertainty concerning how and when to utilize it in clinical practice and has likely constrained broader clinical application, despite reports of benefits (Ritchey, 2013). Despite extensive research on the associations between religiosity/spirituality and health, Gonçalves et al. (2015) noted that "few studies have investigated the clinical applicability of this

evidence" (p. 1). With the empirical evaluation of IHP models remaining limited, additional studies are needed to keep pace with their increasingly widespread use, particularly in faith-based clinical psychotherapy.

Traditionally, IHP movements have relied primarily on testimony and ministry practice rather than empirical evaluation to validate their effectiveness. Thus, both pastoral and psychological communities have contributed to the lack of formal research: the former, due to its reliance on experiential knowledge, and the latter, due to the traditional separation between psychology and lay healing ministries. As noted, future progress depends on subjecting these models to rigorous empirical evaluation. The present study aims to address that need by examining HeartSync, an intervention that is conceptually grounded in clinical theory, structured in an experiential format, consistent with inner healing traditions, and standardized to support empirical investigation. By evaluating its effectiveness, this study seeks to take the next step in a longer journey towards securing empirical support, or the lack thereof, for the use of IHP in clinical counseling. By evaluating a structured intervention associated with reductions in depression and anxiety symptoms and improvements in life satisfaction, this research contributes to the broader aims of enhancing the effectiveness of the mental health field in general and the United Nations Sustainable Development Goal 3, particularly Target 3.4 to promote mental health and well-being.

Description of HeartSync

HeartSync Healing Prayer was developed by Bishop Andrew Miller in 2010, informed by his clinical training as a social worker and his Christian theological context as an Anglican Bishop. HeartSync is presented as a neuroscience-informed, attachment-based intervention that integrates prayer and mindfulness to attend to emotional and spiritual contributors to psychological symptoms. The model focuses not only on the individual's global emotional or spiritual experience but also on what Miller conceptualizes as distinct "parts" or "core aspects" of the heart.

These core aspects are described as loosely corresponding to hierarchically organized neural systems, drawing conceptually on affective neuroscience and attachment theory, particularly the work of Schore (1994). Schore's work was later synthesized into a layered framework within the Life Model literature (Wilder et al., 2000), which describes a "five-level control system" of brain functioning. Within this conceptualization, the core aspects of the heart are identified as follows: (a) emotion (right-hemisphere cingulate cortex), (b) guardian (amygdala), (c) function (left-hemisphere executive processes), and (d) true self (right orbitofrontal and prefrontal systems associated with identity).

The HeartSync process begins with the establishment of emotional safety and grounding, including the use of what Miller terms "divine encounters," often facilitated through guided experiential prayer practices, such as the "Immanuel Approach to IHP". This approach, originally developed by Lehman (2016), uses a Holy Spirit-led thankfulness exercise to identify a memory that serves as a foundational place of grounding that clients are encouraged to return to in HeartSync if they become

emotionally overwhelmed. The HeartSync process follows a structure described in Miller's HeartSync in a Nutshell worksheet (www.heartsynchealing.org), intentionally attune to the core aspects of the heart, and in the process, participants often release somatic and emotional pain through what Miller calls "trauma release prayers".

Spiritual discernment is incorporated into this model to explore spiritual factors that may contribute to symptoms or resistance to healing and change. The intervention culminates in fostering connection and synchronization among the individual's internal parts with each other, with other interpersonal relationships, and with their relationship to God (if desired). HeartSync shares certain structural and conceptual features with established clinical interventions that are similar to HeartSync, such as internal family systems (IFSs). Please refer to Table 1 for commonalities and differences between HeartSync and Internal Family Systems. HeartSync Healing Prayer is further described at www.heartsynchealing.org, and the orientation video provided to clinical participants in this study is available at www.clinicalheartsync.com.

Study Aims

This study was designed to provide a quantitative evaluation of HeartSync as a clinical intervention for treating depression and anxiety and increasing satisfaction with life. Specifically, the investigation examined changes in standardized measures of these outcomes to (a) test the effectiveness of HeartSync as an intervention for depression/anxiety, (b) contribute to the limited empirical literature on IHP in general, (c) explore whether a structured IHP intervention might perform comparably to established evidence-based treatments, and (d) provide a foundation for future randomized controlled trials.

Materials and Methods

Participants and Procedures

The study was approved by the Institutional Review Boards at a Christian University in central Virginia (IRB# FY24-25-455) prior to data collection. A minimum sample size of 30 participants was predetermined to balance the need for statistical analysis with the clinical and research demands placed on the participating clinicians. Participants were recruited from the clients who expressed interest in the study by contacting the organizations where participating HeartSync-trained, state-licensed mental health practitioners were practicing. Of the 36 individuals who expressed interest and received complete information about the study, three did not meet preliminary eligibility criteria, two declined to participate, and 31 proceeded to enrollment, representing 86.1% of those who received complete study information. Enrolled participants were screened for the presence of a DSM-5 depressive disorder, agreed to participate in 10 one-hour sessions using a clinical adaptation of HeartSync Prayer Ministry (Miller, 2010), and paid the same fees as clients receiving regular clinical

Table 1 HeartSync and internal family system commonalities and differences

Commonalities	Differences	
	Internal Family Systems	HeartSync
Doing parts work	Healing comes from connecting to Self	Healing comes from connecting to God
Builds internal awareness, compassion, and fosters internal connection	Psychotherapy framework	Spiritually integrated inner healing framework
Supports trauma-informed emotional regulation	Emphasizes Self-leadership	Emphasizes prayer & encounter

services. Participants were asked to refrain from additional or external interventions and to make no significant medication changes during their participation in the study.

Participants completed four standardized assessments of depression, anxiety, and life satisfaction before treatment, at the end of the fifth session, at the conclusion of treatment, and 90 days following completion of the 10 HeartSync sessions (See Fig. 1). Assessments were administered at each time point through a secure client portal, with scores stored under confidential client identification numbers.

Measures

Satisfaction with Life

Satisfaction with life was measured with the Satisfaction with Life Scale (SWLS; Diener et al., 1985). The SWLS is a five-item self-report measure rated on a Likert-type scale ranging from strongly disagree (1) to strongly agree (7). The scores on items are summed, with higher scores indicating higher satisfaction with life. Sample items include "In most ways, my life is close to my ideal" and "The conditions of my life are excellent." Diener et al. (1985) reported strong psychometric properties during the initial validation of this instrument in older adults, supporting internal consistency ($\alpha = .87$), temporal stability (test–retest $r = .82$ over 2 months), and criterion validity and correlated with an interviewer life-satisfaction composite ($r = .43$).

Anxiety

Anxiety was measured with the Generalized Anxiety Disorder-7 (GAD-7; Spitzer et al., 2006). The GAD-7 consists of seven items that are rated on a Likert-type scale ranging from not at all (0) to nearly every day (3). Sample items include "Not being able to stop or control worrying" and "Being so restless that it is hard to sit still." All seven items are totaled, with higher scores reflecting higher levels of anxiety. Clinical categorizations for levels of anxiety include minimal (0–4), mild (5–9), moderate (10–14), and severe (15–21). Spitzer et al. (2006) reported that the scale demonstrated good internal consistency ($\alpha = .92$), test–retest reliability (intraclass correlation $= .83$), and convergent validity with the Beck Anxiety Inventory ($r = .72$).

Depression

Two instruments were used to measure depression. First, depression was measured with the Patient Health Questionnaire − 9 (PHQ-9; Kroenke et al., 2001). The PHQ-9 consists of nine self-report questions, which are rated on a Likert-type scale. Responses can range from not at all (0) to nearly every day (3). Scoring consists of summing all nine items, with higher scores reflecting higher levels of depression. Sample items include "Little interest or pleasure in doing things" and "Feeling tired or having very little energy." The clinical categorizations for levels of depression

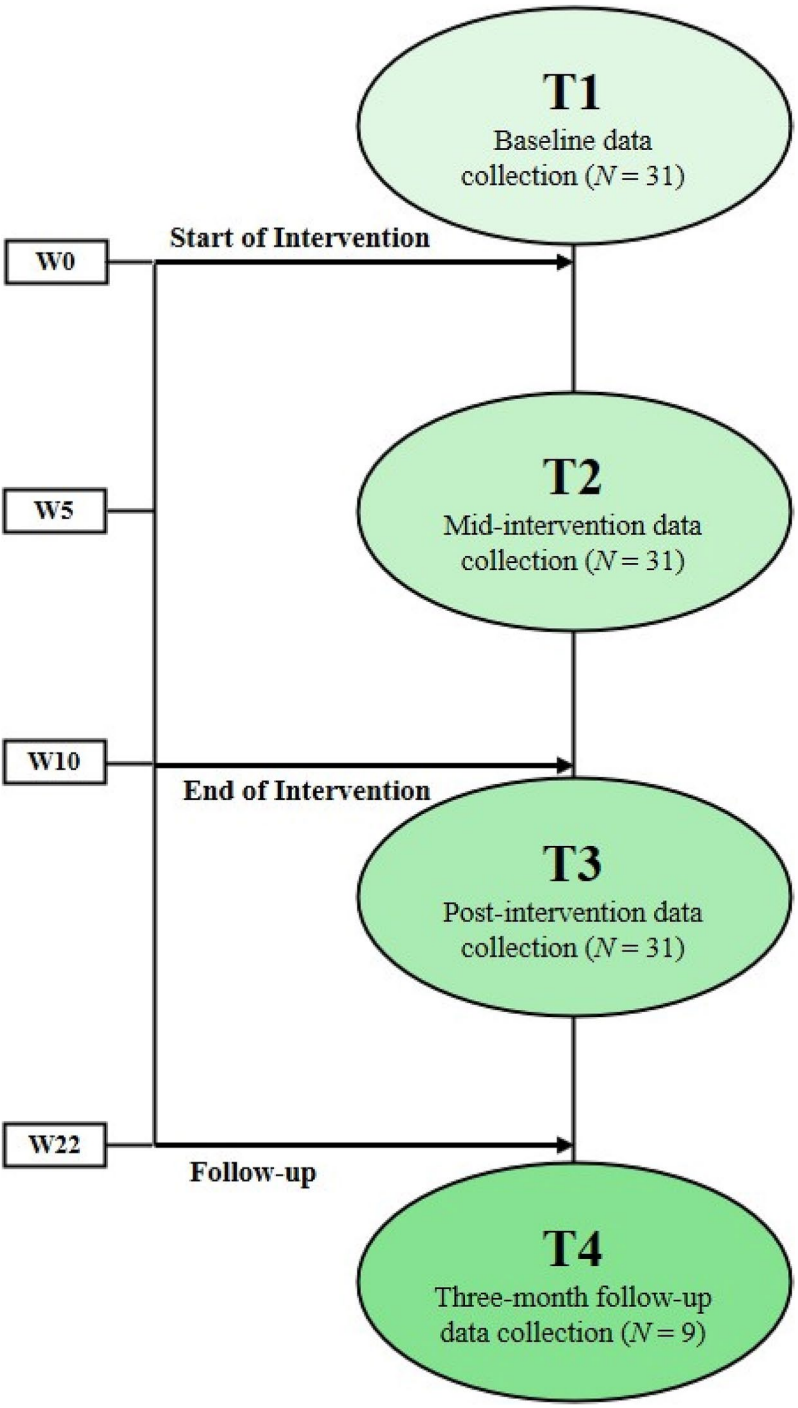

Fig. 1 Participant Flow

are minimal (0–4), mild (5–9), moderate (10–14), moderately severe (15–19), and severe (20–27). In Kroenke et al.'s (2001) validation studies, the PHQ-9 showed strong internal consistency (Cronbach's $\alpha = .89$), strong short-interval stability (test–retest $r = .84$ over 48 h, clinic self-administered vs. telephone administration), and strong construct validity via correlation with SF-20 mental health subscale ($r = .73$).

Depression was also measured with the Center for Epidemiological Studies Depression Scale (CES-D; Radloff, 1977). The CES-D contains 20 self-report questions, rated on a 5-point Likert-type scale ranging from rarely or none of the time (0) to all of the time (4). Sample items include "I felt depressed" and "I felt fearful." The total score is summed, with higher scores indicating higher levels of depression. With respect to development, internal consistency was high in general population samples ($\alpha \approx .85$), test–retest stability was moderate under "no negative life events" conditions ($r = .54$ across 3–12 months, and criterion-related validity was supported by a correlation with a nurse-clinician depression severity rating ($r = .56$; Radloff, 1977).

Post-Treatment Questionnaire

About half of the participants ($n = 16$) also completed a survey at the end of their tenth session regarding their perception of the intervention. This instrument included 10 open-ended questions about their experiences, whether the intervention helped them, and comparisons with other interventions. Participants also rated the intervention's perceived effectiveness on a scale of 1–10. The questionnaire was given to the clients after their last session and returned by email.

Data Management and Analysis

Clinical assessments were tracked in Google Sheets over the course of treatment, with participants completing each of the measures three times over the span of 12 weeks (Schmidt, 2025). The resulting data were exported from Excel to IBM SPSS Statistics (v. 30.0) for analysis. Prior to conducting inferential statistics, the data assumptions were tested. For the planned repeated measures analyses, the data met the key assumptions of normality and lacked multivariate outliers. For each of the planned outcomes (SWLS, GAD-7, PHQ-9, and CES-D), the assumption of sphericity was met, as indicated by a nonsignificant result for Mauchly's test of sphericity.

Quantitative data were analyzed using descriptive statistics and repeated measures analysis of variance (RM ANOVA). Repeated contrasts were used to compare each level with the one immediately preceding it, providing insight into the trends over time. Qualitative data from the open-ended questions were analyzed with thematic analysis, assisted by ChatGPT (OpenAI, 2026). Preliminary insights from the ChatGPT included human verification and debriefing with the clinician involved, ensuring human oversight throughout the interpretive process (Goyanes et al., 2025).

Results

A total of 31 individuals participated in the intervention and completed three assessments (baseline, mid-intervention, and postintervention). Of these, nine also completed the three-month follow-up assessment. In addition, 16 of the participants provided responses to the open-ended questionnaire after completing their treatment. One participant did not provide any demographic information (3.2%). The majority of participants were female (80.6%), with only five males (16.1%). The sample was predominantly white (77.4%), followed by Asian (9.7%), African American (6.5%), and Hispanic (3.2%).

The ages of the participants ranged from 22 to 77 years, with an average of 49.13 years (SD = 15.18). Most participants reported being married (61.3%), followed by single (25.8%), widowed (6.4%), and divorced (3.2%). Additionally, most participants indicated some level of faith-based orientation (90.3%), with two participants indicating that they did not have any faith-based orientation (6.5%). Additional demographic information is summarized in Table 2.

Preliminary correlation analysis indicated that at Time 1, satisfaction with life significantly negatively correlated with both measures of depression. Additionally, anxiety positively correlated with depression, as measured with the CES-D but not with the PHQ-9 (p = .056). Both measures of depression were positively correlated with each other (see Table 3). These correlations were largely consistent at each time of assessment.

Satisfaction with Life

Descriptive statistics of the variables over time are provided in Table 4. All 31 participants increased in Satisfaction with Life from Time 1 to Time 3. On average, participants' scores increased by 10.3 points (SD = 6.9). Additionally, 67.7% (n = 21) increased by 50% or more. The results of the RM ANOVAs for each of the variables are shown in Table 4. For Satisfaction with Life, there was a significant effect of time. Post hoc contrasts further indicated that there was a significant increase from Time 1 to Time 2 ($p < .001$) and Time 2 to Time 3 ($p = .001$) (See Fig. 2, Panel A). This finding indicates that participants involved in HeartSync increased in life satisfaction steadily over time.

Anxiety

Among the 31 participants, 29 had decreased GAD-7 scores from Time 1 to Time 3. One participant's score did not change, and one participant's GAD-7 score increased by one point. On average, the score of each participant decreased by 7.8 points (SD = 5.4). The score of 19 participants (61.3%) decreased by 50% or more. The patterns in the GAD-7 scores are provided in Fig. 2 (Panel B). The RM ANOVA was significant ($F(2, 60) = 39.88$, $p < .001$, $\eta_p^2 = .57$, Hedge's g = 2.24).

Table 2 Participant Demographic Characteristics (N = 31)

	N	%
Gender		
Female	25	80.6
Male	5	16.1
Missing	1	3.2
Race		
Black/African American	2	6.5
Asian	3	9.7
Hispanic/Latino	1	3.2
White/Caucasian	24	77.4
Missing	1	3.2
Age		
20–29	3	9.7
30–39	7	22.6
40–49	4	12.9
50–59	7	22.6
60–69	7	22.6
70 +	2	6.5
Missing	1	3.2
Marital Status		
Married	19	61.3
Single	8	25.8
Divorced	1	3.2
Widow	2	6.5
Missing	1	3.2
Faith-Based Orientation		
Yes	28	90.3
No	2	6.5
Missing	1	3.2

Table 3 Correlations and Scale Reliability at Baseline

	α	1	2	3
1. SWLS	0.84	–		
2. GAD7	0.88	− .30	–	
3. PHQ-9	0.68	− .52**	.35	–
4. CESD	0.85	− .51**	.51**	.63**

*$p < .05$. **$p < .01$

SWLS = Satisfaction with Life Scale; GAD-7 = Generalized Anxiety Disorder–7; PHQ-9 = Patient Health Questionnaire–9; CES-D = Center for Epidemiologic Studies Depression Scale

Table 4 Descriptive Statistics and Trends Over Time

	Time 1	Time 2	Time 3	Time 4	RM ANOVA		
	M (SD)	M (SD)	M (SD)	M (SD)	F (2, 60)	*p*	η_p^2
Full Sample (n = 31)							
SWLS	12.10 (5.62)	17.90 (5.80)	22.38 (6.20)		39.94	< .001	.57
GAD7	13.42 (5.42)	8.35 (4.21)	5.61 (3.68)		39.88	< .001	.57
PHQ9	17.45 (4.30)	10.03 (5.53)	6.03 (4.33)		85.35	< .001	.74
CESD	40.48 (9.43)	25.07 (9.98)	16.06(10.58)		81.04	< .001	.73
Subsample (n = 9)							
SWLS	12.00 (7.76)	18.22 (5.81)	20.89 (6.58)	21.44 (8.29)			
GAD7	12.33 (4.58)	7.22 (1.99)	6.44 (3.94)	4.89 (4.81)			
PHQ9	16.00 (4.61)	7.44 (2.88)	6.00 (3.20)	5.78 (6.32)			
CESD	36.56(10.88)	20.78 (6.65)	15.00(11.02)	14.89(12.80)			

SWLS = Satisfaction with Life Scale; GAD-7 = Generalized Anxiety Disorder–7; PHQ-9 = Patient Health Questionnaire–9; CES-D = Center for Epidemiologic Studies Depression Scale

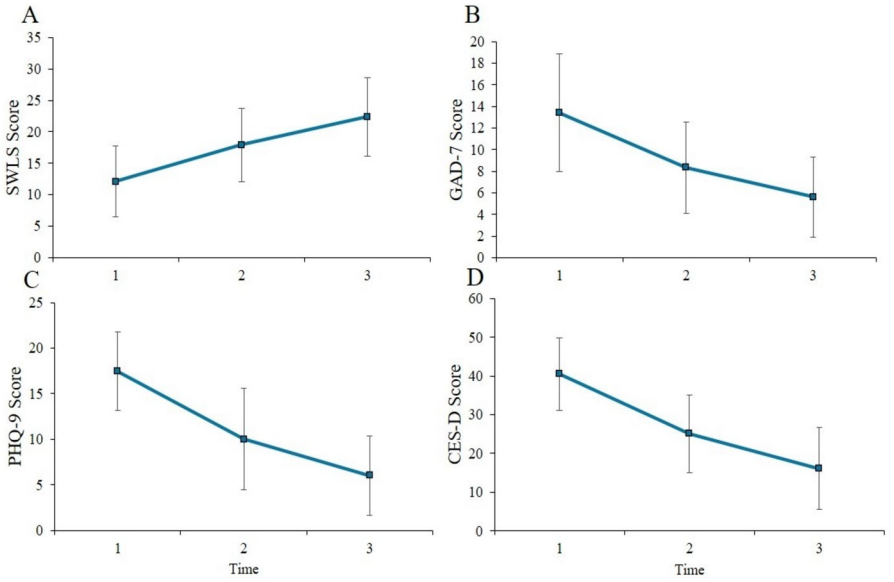

Fig. 2 *Trends over time (N = 31)*. Note. Panel A: SWLS scores at baseline (1), mid-intervention (2), and postintervention (3). Panel B: GAD-7 scores at baseline (1), mid-intervention (2), and postintervention (3). Panel C: PHQ-9 scores at baseline (1), mid-intervention (2), and postintervention (3). Panel D: CES-D scores at baseline (1), mid-intervention (2), and postintervention (3). The error bars represent the standard deviation from the mean. SWLS = Satisfaction with Life Scale; GAD-7 = Generalized Anxiety Disorder–7; PHQ-9 = Patient Health Questionnaire–9; CES-D = Center for Epidemiologic Studies Depression Scale

More specifically, there was a significant decrease from Time 1 to Time 2 ($p <$ .001) and Time 2 to Time 3 ($p <$ .001). These findings indicate that participants' experience of anxiety steadily decreased over time during the trial.

Depression

The PHQ-9 scores of all 31 participants decreased from Time 1 to Time 3, on average, by 11.4 points (SD = 5.1). A total of 24 participants (77.4%) decreased by 50% or more. The patterns in the PHQ-9 scores over time are provided in Fig. 2 (Panel C). The results of the RM ANOVA indicate a significant effect of time, F (2, 60) = 85.35, $p <$ .001, $\eta_p^2 =$ .74, g = 3.29, with a significant decrease from Time 1 to Time 2 ($p <$ .001) as well as Time 2 to Time 3 ($p <$ .001).

Similarly, the CES-D scores of all 31 participants decreased over the course of the intervention, on average, by 24.4 points (SD = 12.0). The CES-D scores of 21 participants (67.7%) decreased by 50% or more. Trends in CES-D scores are provided in Fig. 2 (Panel D). The RM ANOVA indicated that there was a significant effect of time (F(2, 60) = 81.04, $p <$ .001, $\eta_p^2 =$ .73, g = 3.21). Specifically, there was a significant decrease from Time 1 to Time 2 ($p <$ .001) and Time 2 to Time 3 ($p =$ .001). These findings indicate that participants involved in HeartSync experienced a steady decrease of depressive symptoms over time.

Three-Month Follow-up

A total of nine participants completed three-month follow-up assessments. For these nine participants, scores over time were generally consistent with the larger sample. Satisfaction with life appeared to increase from Time 1 to Time 2, which was then maintained across Time 3 and Time 4. For anxiety, there appeared to be a decrease from Time 1 to Time 2, which was similarly maintained across Time 3 and Time 4. With respect to depression, the two assessments followed a similar pattern, as there was an apparent decrease from Time 1 to Time 2, which was maintained across Time 3 and Time 4. These findings suggest that increases in satisfaction with life and decreases in anxiety and depression that occurred during the participants' involvement in HeartSync were sustained during the three-month post-intervention period, although the small sample is inadequate for inferential statistics.

With respect to depression, a significant effect of time was detected for the PHQ-9 (F(3, 24) = 15.75, $p <$ .001, $\eta_p^2 =$ .66, g = 2.52) and the CES-D (F(3, 24) = 16.75, $p <$ .001, $\eta_p^2 =$ .68, g = 2.64). The two assessments followed a similar pattern, as there was a significant decrease from Time 1 to Time 2 ($p <$ .001), which was maintained across Time 3 (PHQ-9 $p =$ .321; CES-D $p =$ .187) and Time 4 (PHQ-9 $p =$ .892; CES-D $p =$ 958). These findings suggest that decreases in depression that occurred during the time period during which participants were involved in HeartSync were sustained and durable during the three-month post-intervention period.

Patient-Reported Outcomes

For the 16 participants who completed the assessment after the 10-week intervention, patient-reported outcomes (PROs) were assessed, yielding an effectiveness rating of 8.4 out of 10. Thematic analysis of the open-ended questions indicated that participants perceived that they were helped by the intervention and viewed the HeartSync model as more transformative than other kinds of counseling.

The participants perceived many strengths in the program, including the integration of faith, the use of experiential tools, and support from counselors. The respondents described HeartSync as "life-changing" and "deeper than talk therapy." The participants also shed light on some criticisms of the program, as some participants felt that they needed more sessions. Additionally, some raised concerns over psychological terminology.

Discussion

There were several key findings from this study. Most notably, participation in the HeartSync intervention was associated with significant reductions in depressive symptoms. All 31 participants reported decreased depressive symptom severity from baseline to post-treatment, as measured by both depression measures, suggesting improvement over the 10-session treatment period. Likewise, Satisfaction with Life Scale scores increased by 123%, indicating a significant improvement in perceived life satisfaction that may reflect enhanced capacity to cope with ongoing life stressors. While these findings are encouraging, the single-group nature of this study points to the need for continued empirical research into the clinical effectiveness of HeartSync.

Although this HeartSync research project was focused primarily on depressive symptoms, it was notable that participants logged significant reductions in anxiety scores across the intervention period, even though this symptom set was not targeted directly. This pattern suggests that HeartSync may have transdiagnostic relevance for emotional distress, as this tool is relationally oriented and uses experiential approaches that emphasize grounding and affect regulation inherent to the treatment of many mental health diagnostic categories.

Change was also observed relatively early in the treatment episode and continued across sessions. Repeated contrasts indicated significant improvement from T1 → T2 and from T2 → T3, suggesting that benefits could emerge by mid-intervention and continue to accrue through completion of the protocol. Among participants who completed the 3-month follow-up (n = 9), improvements achieved during treatment were generally maintained at T4. These findings provide preliminary support for the durability of treatment gains, although follow-up conclusions are limited by attrition.

The effects of the HeartSync intervention were considerable across all outcomes. Hedges' g was 2.24 for the effect size on anxiety. Note that a recent meta-analysis of the average effect size (Hedges' g) for cognitive behavioral therapy (CBT) in uncontrolled pre–post studies produced a value of 1.18 (95% CI = 1.01–1.34) (Hofmann et al., 2025). Similarly, in a meta-analysis of the pre-post effect size calculations for

the average effect of CBT on depression, Hedges' g was 1.19 (95% CI = 1.14–1.24) for self-reported outcome measures (Rubin & Yu, 2017). This effect size was compared to g = 3.29 for the PHQ-9 and g = 3.21 for the CES-D in the current study for the HeartSync (Miller, 2010) intervention. Note that a Hedges' g value of 0.8 or higher is generally considered a large effect size. Therefore, given that the effect sizes found in this study are 2–4 times that value, it suggests that the clinical benefits from this intervention are quite large. This comparison, however, is intended only as a contextual benchmark to help readers interpret the magnitude of these observed effect sizes, not as establishing full comparative efficacy to modalities like CBT that have been evaluated in numerous controlled studies.

Finally, participant feedback supported the quantitative findings, as participants rated HeartSync as highly effective (M = 8.4/10) and frequently described the transformational nature of the program, perceiving it to be "deeper than talk therapy." This finding is consistent with broader findings that spiritually integrated psychotherapy interventions such as HeartSync are generally acceptable and even preferred by many religious clients and may contribute to enhanced psychological improvement (e.g., Captari et al., 2018; Currier et al., 2020). Further empirical investigation will allow for a more accurate assessment of this IHP model's utility as a clinical intervention.

Study Limitations

While the reported results are promising, they should be interpreted in light of the study's limitations, including the absence of a control group and a relatively small sample. Other study limitations include the relatively short-term follow-up of 3 months and the low response rate at the 3-month follow-up (9 of 31). Future research should include larger and more diverse samples, and comparisons with established evidence-based treatments will be necessary to more fully evaluate the efficacy and generalizability of the HeartSync intervention.

Implications for Research and Practice

The current findings support the need for controlled trial studies of HeartSync for depressive and anxiety symptoms as well as life satisfaction. The promising results of this study suggest that the HeartSync modality may benefit these specific symptoms, and further research may eventually be used in broader clinical populations. The findings from the present research may serve to inspire and encourage other IHP interventions and conduct empirical studies on diverse outcomes to build on this emerging evidence that demonstrates the effectiveness of IHP interventions for utilization in the overall clinical field.

Future evidence-based studies that have documented the effectiveness of HeartSync and other IHP interventions may help to ease the tension that faith-based clinicians experience concerning whether IHP can and should be used in the clinical office. This research seems to lay the groundwork for future steps, diminishing the gap between the clinical psychology world and the pastoral world. Through the

utilization of IHP practices such as HeartSync, clinicians and clients will have more in-depth tool sets available for use in spiritually integrated practice. The hope is that spiritually integrated IHP tools such as HeartSync that are experiential and relational in nature and respectful of client and clinician spirituality will be more accessible and accepted as they meet the definition of evidence-based practice through having a sound clinical foundation supported by empirical data.

Conclusions

Findings from this quasi-experimental study provide preliminary empirical support for HeartSync as a structured, experiential, and spiritually integrated approach associated with significant reductions in depressive and anxiety symptoms, as well as significant increases in satisfaction with life over the course of ten sessions. Improvements were observed across multiple validated outcome measures.

These results represent the first known empirical evaluation of a standardized Inner Healing Prayer intervention with psychometrically validated measures in a clinical framework. This research begins to address a longstanding gap in the literature regarding the effectiveness of IHP modalities, which have historically relied on anecdotal evidence and ministry-based testimony rather than systematic outcome research. These findings suggest that HeartSync may offer a viable intervention for clients who desire a spiritually integrated and relationally oriented therapeutic approach, particularly within Christian clinical contexts.

HeartSync's clinical relevance is supported by its coherent theoretical grounding, reproducible protocols, and integration of experiential techniques consistent with contemporary psychotherapy, including attachment-based interventions, parts-oriented approaches, and trauma-informed practices. The model's emphasis on emotional regulation, relational attunement, and experiential processing aligns with established mechanisms of change in other evidence-based therapies, while its explicit incorporation of relational spirituality distinguishes it from secular experiential modalities.

Despite the limitations of not having a control group and its small sample size, the present study makes meaningful contributions to the emerging literature on spiritually integrated psychotherapy by providing initial empirical support for HeartSync as a structured Inner Healing Prayer intervention. This research advances the dialogue between clinical psychology and pastoral healing traditions, laying the groundwork for future investigations aimed at establishing HeartSync—and potentially other IHP interventions—as empirically supported evidence-based interventions within the broader mental health field.

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Declarations

Conflict of interest Financial interests: The authors declare that they have no financial interests in this research, no honorariums, no travel support, and no research funding. Nonfinancial interests: Author Steve Fair, LMSW, has served on the advisory boards for HeartSync Ministry and is not the volunteer Assistant Director.

Ethical Approval This study was performed in accordance with the principles of the Declaration of Helsinki. Approval was granted by the Ethics Committee of Liberty University (Date: 1/2025/IRB#-FY24-25-455).

Consent to Participate Informed consent was obtained from all the individual participants included in the study.

Consent to Publish The authors affirm that this article contains no individual person's private health information or personal data in any form.

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