

## CHAPTER 5

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# The Assessment, Diagnosis, and Treatment of Psychiatric Disorders in Religiously Diverse Clients

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For many people seeking treatment, religion is an important and permanent component of life. For others, a change in feelings about faith may be the driving force in seeking treatment. Still other clients may not possess strong religious beliefs that impact their daily life. As clinicians, each of us may have our own beliefs and values with regard to religion. It is important as clinicians that we allow our clients to express their religious beliefs and incorporate them into the therapeutic milieu to the degree they wish.

This chapter will address how religion plays a role in the assessment, diagnosis, and treatment of mental illness. We will discuss issues of both religion and spirituality. Research in this area has not provided a single definition of either of these concepts; rather definitions vary from study to study.<sup>1</sup> Hill and colleagues<sup>2</sup> attempt to conceptually integrate the concepts of religion and spirituality, and suggest that the two concepts are by no means incompatible. In support of this approach are findings that individuals' self-descriptions tend to include labels of both "religious" and "spiritual".<sup>1</sup> Thus many individuals who think of themselves as "religious" also think of themselves as "spiritual" (and vice versa). However, many researchers (and many of the studies described in this chapter) explicitly distinguish between the constructs of religion and spirituality, and many authors recommend making this distinction.<sup>3</sup> Definitions of spirituality often define the spiritual domain as the aspects of life involving transcendental or existential concerns (e.g., reference 4), the search for meaning, purpose, truth, and values (e.g., reference 3), and containing either secular or religious content (e.g., reference 5). Spirituality may be found in diverse domains – through religion; a relationship with a divine being, nature, music, and the arts; a set of values or principles; or a pursuit of scientific knowledge.<sup>3</sup> Although not holding in all circumstances, religious expressions tend to be public, whereas spiritual expressions tend to be private.<sup>4</sup> In this manner, spirituality is often defined

as an attribute of individuals, while religion (and religiosity) is defined as the beliefs, rituals, and practices of an institution.<sup>6</sup> As religion may be one avenue for spiritual expression, Richards and Bergin<sup>4</sup> conceptualize religion as a subset of spirituality. In this chapter, we use Richards and Bergin's<sup>4</sup> conceptualization of religion and spirituality as related concepts. For convenience, we use the term "religion" to refer to both spiritual expressions and religious practices (unless noted otherwise).

Should spiritual and religious issues be assessed by mental health professionals? Psychotherapy clients in the United States are likely to be involved in religious organizations. However, the wide variety of religious groups in the United States means that a diverse range of beliefs and practices will be brought to therapy.<sup>7</sup> D'Souza<sup>8</sup> provides data that clients believe that spirituality and religious issues do have a place in mental health treatment: in a survey of Australian psychiatric patients, 82% reported that their therapists should be aware of their spiritual beliefs and needs. A national survey of American adults with mental illness found that 50% of respondents reported that they engaged in religious or spiritual activities that they believed were beneficial to their mental health, such as prayer, attending worship services, and religious/spiritual reading.<sup>9</sup> Client perception that religion/spirituality was a source of motivation for change in drug misuse treatment programs was one dimension that discriminated between groups of recovered versus nonrecovered outpatient methadone treatment clients.<sup>10</sup> Despite indications that clients may desire to discuss religious/spiritual concerns in therapy, Lindgren and Coursey<sup>11</sup> present data that these discussions may not frequently occur: they found that only half of the clients in their sample who reported a desire to discuss religious and spiritual beliefs in therapy also reported perceptions that they were free to do so.

Current data suggest that a large proportion of clients in the United States believe that their therapists should be aware of religious and spiritual concerns (e.g., reference 8), and believe that religious/spiritual activities are beneficial to their mental health (e.g., reference 9). Yet, these issues may not be raised in therapy due to clients' perceptions that the discussions are unwelcome (*cf.* data presented by Lindgren and Coursey<sup>11</sup>) or due to religious clients' distrust in mental health professionals or the process of psychotherapy.<sup>12</sup> Thus, beliefs and behaviors of both the therapist and the client may make it less likely that religion will be discussed in therapy or used in treatment planning. Consideration of religion is a necessary component of culturally sensitive treatments, as it is ultimately an exercise in dynamic sizing, yet religion is not often considered in the assessment, diagnosis, and treatment of mental illness. Thus, one goal of this chapter is to provide a model for incorporating religion into assessment, diagnosis, and treatment in a culturally sensitive manner. To accomplish this, we first discuss how religion may be relevant for assessment, diagnosis, and treatment using case examples from our own community clinic. Next, we provide a brief review of the scientific literature on the role of religion in mental health services. We then discuss a comprehensive case example that brings together the main points in each of the earlier sections.

Finally, we conclude with suggestions for future directions for research and clinical practice.

## CLINICAL OBSERVATIONS

### Assessment

During the intake assessment, it is important to allow clients to discuss their religious beliefs, and how these beliefs may or may not be relevant to the therapeutic experience. It may be useful to simply ask about religion during the interview, saying something such as “Tell me about your religious beliefs” or “Tell me how spirituality relates to your life”. For some people, religion may be a sensitive subject and being asked openly and nonjudgmentally about it by their therapist may make them feel much more comfortable in discussing it.

Discussing religion with a client may also help to build rapport and help the clinician to see the client as a whole person, rather than just someone with a psychological disorder. For some individuals, religion plays a significant role in their life and will come up frequently throughout the therapeutic process. By introducing this issue during the assessment phase, the client can lay the groundwork for discussing religion in future sessions. It also gives the clinician an opportunity to indicate how much he or she knows about the client’s religion, and to demonstrate an openness to learning about the client’s beliefs. The following case example helps to illustrate this point.

*Therapist (T):* Mark, please tell me how spirituality relates to your life.

*Mark:* Well, I consider myself to be a very religious person. I am Jewish . . . Do you know much about Judaism?

*T:* No, not very much. But I would like to learn more. Could you tell me about the role of Judaism in your life?

The client then goes on to tell the therapist a bit more about his feelings regarding his faith. They also come to an understanding that the clinician should feel free to ask questions about anything the client brings up that is unclear. As the therapy progresses, the client at times will even explain some of the religious practices that he talks about even before the clinician can ask. In this manner, the clinician is able to get a fuller picture of who the client is as an individual and how religion fits into his life. Additionally, religiosity may influence scores on assessment measures such as the Minnesota Multiphasic Personality Inventory-2 (MMPI-2). Research on this topic is discussed later in this chapter.

### Diagnosis

Perhaps the most important point to make regarding religious sensitivity in diagnosis is that one should not diagnose as abnormal something that is considered a part of the client’s religious practice and does not cause that individual functional impairment. A thorough assessment of the client’s religion and typical religious

practices will help to make this distinction. In addition, further research into the client's religion may be necessary to confirm what practices are considered normal within that religion, a process akin to Sue's<sup>13</sup> principles of scientific mindedness and dynamic sizing. This will help clinicians make the distinction between whether or not behaviors and beliefs are symptoms of clinical disorders or normal religious practices. This point is so important that the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision (DSM-IV-TR) makes a statement regarding the issue:<sup>14</sup> (p. xxxiv)

“A clinician who is unfamiliar with the nuances of an individual's cultural frame of reference may incorrectly judge as psychopathology those normal variations in behavior, belief, or experience that are particular to the individual's culture. For example, certain religious practices or beliefs (e.g. hearing or seeing a deceased relative during bereavement) may be misdiagnosed as manifestation of a Psychotic Disorder.”

Once a clinician has identified potential symptoms, another means of resolving the issue of whether they are normal religious practice or mental illness is to ask the client how distressing and impairing these behaviors or beliefs are. As is noted throughout DSM-IV, full criteria for a disorder are not met unless the client is experiencing clinically significant distress or impairment.<sup>14</sup> If the symptoms being experienced by the client are not distressing or impairing, it is likely that a diagnosis is not warranted. However, it is important to keep in mind that behaviors or beliefs that *are* part of normal religious experience for a client may still cause that client some distress or impairment. For example, consider the case of the individual who hears or sees a deceased relative during bereavement. Although this experience may be normative according to his or her religious practices, it may also cause extreme sadness and grief (i.e., distress) regarding the lost loved one. Therefore, just because a potential symptom causes distress or impairment does not mean that it is not a normative religious experience.

Another situation that may arise during the diagnostic phase is nonacceptance of the diagnosis on the part of the client or the client's family due to religious beliefs. Some religions, such as Roman Catholicism, believe that spirits or the devil may be the cause of abnormal behavior. Therefore, members of these religious groups may be reluctant to accept that a mental illness is the cause of problematic behaviors and thoughts. A young man named Sam with very religious parents presented at our community-based clinic. Given symptoms such as tactile hallucinations, delusions of reference, and inappropriate affect, Sam was diagnosed as having schizophrenia. He had also experienced several suicide attempts and inpatient hospitalizations, but Sam's parents were still reluctant to accept the diagnosis of schizophrenia. His delusions and hallucinations had no religious content or meaning to them, and his parents believed that these thoughts and behaviors were abnormal. However, they did not believe that he was suffering from a mental illness; rather that he had been possessed by the devil and if they prayed enough, he would recover. It was

very difficult for the parents to accept that their son was suffering from a severe mental illness and that he needed extensive care. Although it is understandable, perhaps even normative, for parents to have difficulty accepting that their child has a severe mental illness, this family's religious beliefs presented an extra barrier preventing them from coming to terms with their son's diagnosis.

## Treatment

First and foremost, treatment should not interfere with faith whenever possible. This statement does not mean that treatment should ignore faith, rather, that the treatment provided should not conflict with the client's faith. A number of therapies meet this requirement. For example, the Cognitive Behavioral Analysis System of Psychotherapy<sup>15</sup> (CBASP) is designed to help clients by having them evaluate situations that occur in their daily lives and determine how to be more successful at achieving their desired outcome in each situation. The client generates his or her own desired outcome for each situation, making this therapy compatible with any religious viewpoint. By allowing the client to set his or her own goals for how situations should be resolved, this treatment ensures that the goals the client is working toward will be compatible with his or her own religious beliefs. In this manner, CBASP is value-free, as the therapist does not make any judgments regarding what outcomes or goals the client works toward.

Another example of a treatment that may effectively work without interfering with religious beliefs is exposure-based treatment for anxiety disorders. In this type of treatment, the therapist and client work together to generate a list of feared situations that the client would like to be able to experience without impairing or distressing levels of anxiety. The client is able to set the parameters of the situations and the therapist does not force the client to complete any specific exposures that he or she is unwilling to complete. Take, for example, a client diagnosed with obsessive compulsive disorder (OCD) who spends 8–10 hours each day praying. Although praying is an important part of this individual's religion, it is also interfering with her ability to be successful in life – to hold down a job and to have friendships and romantic relationships. This client expressed to her therapist that she would like to be able to pray less frequently, yet still pray daily. The client and therapist worked together using the techniques of exposure with response prevention<sup>16</sup> to gradually decrease the amount of time spent in prayer each day and increase the time spent in social activities.

Alternatively, a therapist may have a client diagnosed with OCD who is more concerned with other rituals such as cleaning or checking and not distressed about the time that they spend praying. With this client, exposure treatment could focus on the other rituals and not target the prayer rituals, again illustrating the role of dynamic sizing. If the client is not distressed or impaired by their prayer rituals, there is no therapeutic reason to try to change them. Just like CBASP, exposure treatments may have heightened success with people from diverse religious backgrounds, as they allow the clients to set their own goals and work toward them in a way that is compatible with their religious beliefs. They also ensure that the

clinician does not have to place a value judgment on the client's actions.

Although it is important that treatment does not conflict with faith, at times treatment may be focused on issues of faith. Clients may seek treatment to help deal with conflicts of faith, such as personal disagreement with general church doctrines or questions about their own faith-based belief systems. In those cases, therapy can be helpful as an opportunity for the client to discuss these issues freely and work out a way to reconcile personal values with religious values. For these clients, it is important to provide a supportive, nonjudgmental environment to allow them to explore their own feelings. Therapies such as Interpersonal Psychotherapy<sup>17</sup> (IPT) may be useful in these circumstances. IPT has four areas of focus, one of which is role transition. For a client who has been a strong believer in a specific organized religion but is shifting to creating his or her own system of spirituality and values, IPT role transition is a useful tool to help facilitate that transition. However, it is also important for a therapist to not force a focus on faith when the client is presenting in treatment primarily to seek help with other issues. The therapist must be careful to allow clients to discuss spirituality when desired but not bring it up repeatedly if the client does not identify it as a focal point of therapy.

Finally, the therapist's own religious viewpoints should be taken into consideration during treatment. It is important for the therapist to not force his or her own views onto the client and to not make pronouncements about the client's behavior based on the perspective of the therapist's religion. Clients, particularly those who are very spiritual themselves, may ask about a therapist's own religious background or knowledge of a specific religion. The therapist should address these issues openly and honestly, but not discuss them at length, as the client's situation is the primary focus of therapy. Lengthy discussion of the therapist's religious views may serve to make the client feel that he or she will be judged by the therapist. Consider the case of a lesbian woman who seeks therapy to work through problems with her long-time partner. If she asks her therapist about his religion and he talks at length about how he is a strict Catholic, she may feel much less comfortable discussing her sexual orientation with him. Once again, therapists must focus on working toward the client's goals rather than the goals that they think may be appropriate for their client. The following case example illustrates how a therapist may wish to respond to questions regarding his or her own religious views.

*Sarah (S):* So, Tom, what religion do you adhere to?

*Therapist (T):* Sarah, I'm willing to talk with you about my spirituality if you really want to know about it, but I think that it is important for us to remember that I'm here to help you to explore the issues that you are interested in overcoming.

*S:* Well, I was just wondering.

*T:* Why were you wondering?

*S:* In the past I've found that people of certain religious groups tended to be

judgmental about things. So I guess I'm wondering about how you might judge me.

T: I see. That's certainly a valid concern. But let me assure you that I feel my role as your therapist is to help you reach whatever goals you have, and my own personal feelings or value judgments are irrelevant to that process. Is there something in particular that is bothering you that people have been judgmental about in the past?

In this example, the therapist was able to explain to Sarah that his chief concern as her therapist was to help her to improve herself and that he intended to be nonjudgmental. He was also able to get Sarah talking about something else that was bothering her, namely, the issue of being judged by others. Whereas sometimes clients ask personal questions of their therapists out of mere curiosity, at other times the client has a larger issue in mind. Finding out why the client is asking the question may open up an important avenue of discussion.

## THE CURRENT STATE OF THE LITERATURE

As mentioned above, spirituality is an important dimension of culturally sensitive therapies.<sup>18</sup> The following section briefly reviews the literature on religion and mental health. Our goal is to answer (at least in part) what is involved in culturally sensitive treatment with regard to diversity in religion and spirituality. This review is by no means exhaustive: a selective emphasis is placed on empirical contributions to the literature. In addition, although we do not mean to suggest that treatment considerations are necessarily the same for those of all religious and spiritual beliefs and practices, the present review does not attempt to comprehensively address specific treatment considerations for particular religions. Instead we use selective examples to illustrate general principles. Readers interested in treatment considerations and recommendations for specific religious affiliations may wish to consult Koenig<sup>19</sup> as well as Richards and Bergin.<sup>20</sup> The latter text dedicates individual chapters to the major religions represented in America, including breakdowns by denominations, (e.g., there are separate chapters for Roman Catholicism and Eastern Orthodox Christianity). Each chapter begins with an overview of the beliefs and practices of the religion for readers who desire general information about religious groups in addition to specific treatment guidelines, as a way to help build up culture-specific expertise.

### Assessment

The finding presented above that clients often do not discuss religion with therapists despite a desire to do so suggests that methods of assessing religious/spiritual issues and concerns need to facilitate client acceptability and trust as well as provide information that will aid in treatment. A common recommendation in the literature is for therapists to take a *spiritual history* (e.g., references 21 and 22) or

*spiritual assessment* (e.g., reference 3) with clients during the intake or assessment phase of treatment. General areas to assess include clients' levels of identification and involvement with the religious or spiritual tradition. Another goal of spiritual assessment or spiritual history is to assess whether religious/spiritual practices are normative (relative to others who share the same beliefs and practices) and whether they are used in a healthy or unhealthy manner.<sup>12</sup> In some cases, the influence of religious/spiritual beliefs and practices may be apparent during the development of psychopathology (e.g., symptoms with religious content), whereas in others the influence of religious/spiritual beliefs may be apparent during the prevention or treatment of psychopathology. An assessment of religious/spiritual beliefs and practices is thus part of a thorough assessment which may aid in a therapist's understanding of the client's problems as well as the identification of potential client resources that may facilitate treatment.<sup>22</sup>

Koenig and Weaver<sup>23</sup> provide a general framework to use in a spiritual history that is based on a list of psychological and spiritual needs of clients, each of which may be addressed. The framework includes three categories, "needs related to self" (e.g., a need for meaning and purpose), "needs related to God" (e.g., a need to experience the presence of God), and "needs related to others" (e.g., a need for fellowship with others). Baez and Hernandez<sup>24</sup> suggest that assessments of spiritual belief systems need to be dynamic and include a range of beliefs and practices. Including the assessment of a range of spiritual beliefs would prevent simplistic categorizations of individuals into "believes" or "does not believe" groups.

More specific recommendations and assessment tools are available to guide therapists in taking a spiritual history. For example, Puchalski and Romer<sup>21</sup> suggest completing four steps when completing a spiritual history. The steps can be remembered with the acronym, "FICA." The first step ("F" for *faith*) involves asking questions related to the client's faith and beliefs, such as whether they consider themselves spiritual or religious and if they have spiritual beliefs that aid in coping with stress. The second step ("I" for *importance*) involves questions related to the importance of faith and beliefs in the client's life, such as what role beliefs play in the client's actions toward recovery. The third step ("C" for *communities*) involves questions about the clients' involvement in spiritual or religious communities. The final step ("A" for *address*) involves questions about how clients would like their therapist to address the issues they described in treatment. Anandarajah and Hight<sup>3</sup> provide a similar set of questions for a spiritual assessment, denoted by the acronym "HOPE." The first set of questions ("H" for *hope*) addresses sources of hope, comfort, and strength for clients. The second set ("O" for *organized*) address clients' level of participation in organized religion. The third set ("P" for *personal practices*) addresses personal spiritual practices. The fourth set ("E" for *effects*) addresses the effects of spirituality on treatment. We are not aware of research demonstrating that the use of these spiritual assessment tools directly improves accuracy of diagnosis or treatment outcomes. Our recommendation on the use of these assessment tools therefore remains tentative, though it appears that the use of these tools may help clinicians to implement dynamic sizing more appropriately.

Over 100 standardized measures of religiousness and spirituality are available. A review of all of these measures is not possible here; interested readers are referred to Hill and Hood,<sup>25</sup> and Slater *et al.*,<sup>26</sup> both of which provide information on measures of religiousness and spirituality. Some of these measures assess parts of the religiousness or spirituality (as opposed to the global frameworks discussed above, such as “FICA” and “HOPE”). For example, the Spiritual Transcendence Scale<sup>27</sup> (STS) assesses the capacity of individuals to engage in “spiritual transcendence” – a behavior that involves three parts – universality, connectedness, and prayer fulfillment. The STS has been shown to predict such psychological variables as wellbeing, stress experience, and psychological growth.<sup>6</sup> These variables may be relevant to treatment outcome. For example, diagnoses or symptom counts are often used as outcomes in studies of psychological treatments; however, an individual’s wellbeing at the end of treatment may also represent a relevant outcome variable (e.g., see reference 28). In addition, an individual’s response to psychotherapy might depend on his or her experiences of stress or levels of psychological growth, both of which may be influenced by religion and spirituality.

There is also evidence that religion and spirituality may impact clients’ responses to standard assessment measures (i.e., those designed to measure mental health symptoms, not religion or spirituality). For example, one study found religious participation and spirituality were associated with responses on the MMPI-2.<sup>29</sup> These researchers found that individuals who reported religious involvement obtained lower clinical scale scores than individuals who reported no religious involvement. These results indicate that religious individuals responded to the questions on the MMPI-2 in a way that suggests lower levels of psychopathology. These data suggest that clinicians may need to consider religion and spirituality when interpreting standard assessment measures.

## Diagnosis

Many researchers suggest that religiosity/spirituality should be considered when diagnosing psychopathology in clients: beliefs and practices may be used in either adaptive or maladaptive ways (e.g., references 12, 30, and 31). Therefore, therapists must determine whether maladaptive religious/spiritual beliefs and practices may be contributing to the development or maintenance of a disorder (e.g., reference 32) or may be influencing the content of symptoms (e.g., reference 33). Sahlein<sup>30</sup> suggests that therapists use their scientific mindedness and begin by hypothesizing about whether religious/spiritual beliefs and practices are promoting or impeding mental health.

Research supports the hypothesis that religious/spiritual beliefs and practices may influence the content and expression of a disorder, rather than directly contributing to the development or maintenance of a disorder. For example, level of religiosity was not predictive of the presence of religious obsessions in a sample of individuals with OCD. This finding suggests that higher levels of religiosity did not lead to the development of symptoms.<sup>34</sup> However, in the same sample, in individuals who did present with a variety of obsessions, religious obsessions were

common. The authors suggest that religion is one domain in which OCD manifests itself rather than religion being a cause of the disorder. Greenberg and Witztum<sup>31</sup> suggest two domains in which religion may contribute to the content of OCD symptoms – cleanliness and purity, and liturgy. The religious theme of cleanliness and purity may appear in the content of obsessions such as dirt and contamination, or compulsive behaviors such as washing. Religious liturgy, especially prayer and confession, may also appear in the content of obsessions and compulsions (e.g., guilt association with confession among Roman Catholic individuals with OCD). Religious content also appears in the content of bipolar I symptoms; for example, Jerrell and Shugart<sup>35</sup> found that hyper-religiosity was found in 18.5% of a sample of adults with bipolar I disorder. Finally, Wilson<sup>33</sup> suggests that religion may “color the expression of symptoms” in both schizophrenia and affective disorders, but that religion is unlikely to serve as a causal mechanism in the development of a disorder (p. 172).

The literature reviewed above suggests that religious content may appear in the symptoms of disorders such as OCD, bipolar I disorder, and schizophrenia. When are religious practices better described as expressions of faith and belief and when are they better described as symptoms of a disorder? Greenberg and Witztum<sup>31</sup> suggest that religious content which is repetitive in nature and handled pedantically is most likely to appear as a focus of symptoms. Based on their observations (not empirical data), they suggest that the practice of religious rituals is likely to be symptomatic of a disorder when the following conditions are present: the behavior exceeds the requirements of religious law, the behavior is concentrated solely on one particular area (not an overall concern for religious practice), a narrow focus leads to neglect of other features of religious life, or rituals are repeated solely due to fear that a ritual was omitted.

Religion or spirituality has also been found to relate to the number and severity of mental health symptoms with which a client presents. For example, Murphy and colleagues<sup>36</sup> found that stronger religious beliefs predicted lower levels of depressive symptoms in clients with clinical depression; this effect was due to lower levels of hopelessness among religious individuals. Thus, religious individuals reported less depression and this relationship was explained by the fact that religious individuals were less hopeless. The authors suggest that one interpretation of their findings is that the presence of religious beliefs may counteract negative thoughts that lead to hopelessness and depression. However, this study used a cross-sectional design; thus, we cannot conclude that religiosity caused less hopelessness or less depression. In a similar study, Baetz and colleagues<sup>37</sup> investigated the relation of frequency of worship attendance to mental health outcomes in a sample of psychiatric inpatients. More frequent worship attendance was related to less severe depressive symptoms, shorter hospitalization stays, higher satisfaction with life, and lower current and lifetime alcohol misuse. In addition, involvement in a religious community was found to be associated with lowered rates of antisocial behavior (i.e., lifetime violence, delinquency, and status offenses) in a sample of adolescents.<sup>38</sup> Thus, the likelihood of obtaining a diagnosis may depend on a

client's level of religious or spiritual involvement.

Why might religious and spiritual variables relate to mental health outcomes? One process suggested in the literature is religious coping – the use of religious beliefs and practices to provide comfort, hope, and meaning in times of distress.<sup>39</sup> In a cross-sectional examination of religious coping in a sample of psychiatric inpatients, increased time spent on religious coping (e.g., prayer or reading the Bible) was related to lower levels of frustration and less severe symptomatology.<sup>40</sup> Identification of processes such as religious coping provides a potential explanation for the relation between religion/spirituality and mental health outcomes.

A final area relevant to formulating a diagnosis involves the issues or concerns about religion or spirituality that clients bring to therapy as a potential focus of therapy. The DSM-IV-TR includes codes for conditions or problems that may be a focus of clinical attention but that are not considered disorders; these conditions and problems are coded on axis I. The DSM-IV-TR provides a specific code for religious or spiritual problems (V62.89). Examples of concerns that may fall under this category include distress concerning loss or questioning of faith, problems associated with the conversion to a new faith, or questioning of spiritual values that may not be related to a religious institution.

## Treatment

A large number of studies on the relation between religion and physical health conducted with diverse samples, differing designs and methods, different measures, and diverse types of health outcomes, converge on the finding that religious involvement and affiliation are associated with positive physical outcomes, including lowered risk for cardiovascular disease, hypertension, and stroke.<sup>41,42</sup> Studies generally also find a positive relation between religion and mental health outcomes.<sup>42</sup> One review of the relation between religion and mental health outcomes with over 200 studies found a positive relation between religion and mental health outcomes in approximately half of the studies and a negative association in fewer than a quarter of the studies.<sup>43</sup> The data thus far indicate that religion and spirituality are related to mental health outcomes. Religion and spirituality most likely function as moderator variables; this means that mental health outcomes may be different depending on an individual's level of religious/spiritual involvement. Religion and spirituality have been found to protect against the development of psychological symptoms and to aid recovery and treatment.<sup>42</sup> Below we provide some examples of the role of religion in mental health outcomes and then review two studies directly investigating the role of religion in treatment.

Spirituality was found to relate to treatment outcomes in an outpatient substance misuse program.<sup>6</sup> Higher levels of spirituality before entering a substance misuse treatment predicted better treatment outcome over and above effects due to personality. However, the analyses did not control for scores on the outcome measures at the start of treatment, thus spirituality cannot be said to relate to change that occurred during treatment. In addition, findings that pretreatment scores on measures of religion or spirituality predict treatment outcomes do not

directly address whether it would be beneficial for psychological treatments to be modified to target individuals for whom religion or spirituality is particularly important (or unimportant). Below we describe two studies that directly address this question.

Azhar *et al.*<sup>44</sup> investigated the incremental efficacy of adding religious psychotherapy to a combination of supportive psychotherapy and anxiolytic medications for a sample of religious individuals with generalized anxiety disorder. Half of the participants received the additional component of religious psychotherapy, which consisted of discussions of specific religious issues. Participants who received religious psychotherapy showed greater reductions in anxiety symptoms after treatment. We would like to note, however, that neither supportive psychotherapy nor discussions of religious issues are considered front-line empirically supported treatments (ESTs) for anxiety disorders (e.g., see reference 45 for a discussion of ESTs). Thus, future work is needed to see if supportive psychotherapy plus discussion of religious issues is a better treatment for anxiety disorders in religious individuals than front-line empirically supported treatments such as exposure and cognitive-behavioral therapy (CBT).

Propst and colleagues<sup>46</sup> suggested that the emphasis on personal autonomy and self-efficacy in traditional CBT may not fit with the cultural values of some religious individuals with worldviews centered around dependence on God. They tested whether a religiously framed modification of CBT (RCT) would be more efficacious for self-identified Christian individuals than a standard CBT protocol (NRCT). These researchers also included a pastoral counseling condition (PCT), which contained all of the nonspecific factors of religious counseling without the active components of CBT. The study additionally included a wait-list control. The study also investigated whether nonreligious therapists could implement the religious modification of CBT by including an equal number of religious and nonreligious therapists in both CBT conditions. All participants believed that the treatment program was religious to a certain extent: they were told that some therapists would be explicitly religious, whereas others would not, but that all therapists would be respectful of and encouraging toward their religious beliefs and relationship to God. The religious CBT protocol (RCT) included Christian religious rationales for the procedures, religious arguments to counter irrational thoughts, and religious imagery.

Post-treatment results indicated that participants in RCT reported greater reductions in depressive symptoms and greater improvements in social adjustment and general symptomatology than participants in a waiting list control, whereas patients in standard CBT did not report greater reductions than waiting list control participants. The finding that standard CBT was not better than a wait-list control is not consistent with a robust finding in the literature that CBT is an effective treatment for depression and better than wait-list control (e.g., reference 45). This finding suggests two possibilities: first, that the standard CBT used in this study was not a “full dose” of CBT. This possibility could explain why standard CBT was not better than wait-list control in this sample. It would also suggest that the

RCT may have outperformed standard CBT in this sample because it contained additional “ingredients” of CBT (e.g., rationale) that gave patients a “full dose” of the treatment. In this case, the religious modification may have been more effective because additional content was used, not necessarily because that content was religious in nature. The use of a treatment group with additional nonreligious components was not used, thus this hypothesis was not tested.

Propst and colleagues<sup>46</sup> provided a different interpretation of their findings. They reported that traditional CBT and pastoral counseling performed similarly in this population (though direct statistical tests of this claim were not performed). They suggested that in a religious population, consideration of clients’ religious worldviews may be as efficacious as the active ingredients of CBT. Thus, the fact that traditional CBT did not do better than a wait-list control in this sample may be due to differences between religious samples and the samples normally used to test the efficacy of CBT.

Propst and colleagues<sup>46</sup> also reported that at three-month and two-year follow-up, no differences in depressive symptoms were found between the treatment conditions. Thus, the superiority of the religious modification of CBT was not maintained over time. The authors also reported that tests of effects due to therapists’ religious orientations indicate that the treatment group showing the greatest reduction in depressive symptoms was the religious modification of CBT conducted by nonreligious therapists. This suggests that modifying a treatment to include religious content is sufficient for therapeutic enhancement – particular therapists are not necessary to implement the treatment. This study suggests that modifying the content of traditional CBT for depression to better match the worldviews of religious clients may be relatively more efficacious for religious clients. However, the lack of a comparison group of nonreligious clients as well as a lack of differences at follow-up precludes drawing conclusions about the efficacy of matching clients to religious or nonreligious treatments based on pretreatment religious beliefs or practices. Additional research is needed to understand whether religious modifications of existing ESTs lead to better treatment outcomes for religious individuals.

## COMPREHENSIVE CASE EXAMPLE

Monica was a 30-year-old married woman who presented with symptoms of OCD and depression. During the intake interview, she explained that she was a devout Catholic and that many of her rituals involved prayer. She reported that she married her husband when she was 23 and did not have sex until her wedding night. One year ago Monica had an affair with a man she met through friends. The relationship lasted for about two months, at which point she ended it, as guilt regarding the affair was causing her great distress. She had not told her husband about the affair and many of her rituals involved repenting and spiritual cleansing to “erase the sin of the affair”.

During the intake process, Monica was encouraged to explain her religious

views, and she expressed great conflict with regard to her religion. She reported that she was raised as a devout Catholic, and that she endorsed the belief that premarital sex is wrong and that having an affair is a sin. Her husband was also a strongly religious individual and she worried that telling him of her affair would not only hurt him emotionally but would cause him to see her as a sinner. She felt that she had no one to talk to about this because all of her friends were also religious and she believed they would condemn her for what she had done. She expressed hope that by praying and repenting daily she could cleanse her soul and make amends for the sin she had committed.

Monica reported spending two to three hours daily engaged in her prayer rituals. She also indicated spending another one to two hours engaged in cleansing rituals, including two showers daily and multiple hand-washings. She additionally reported that she had been feeling very guilty regarding her affair and that having had the affair meant she was a weak person morally. She had difficulty sleeping at night and had lost weight over the past few months. Monica insisted that she was not suicidal, as she believed that suicide was a sin.

Monica and her therapist initially decided to focus on her symptoms of depression, as she indicated that those symptoms were more distressing than her OCD symptoms. The initial treatment plan consisted of IPT role transition to help Monica come to terms with the fact that she could not be a “perfect Catholic” as she had struggled to be for so long. Using the techniques of IPT, Monica’s therapist was able to remain nonjudgmental by allowing Monica to talk through her feelings and work on transitioning to a role that was more comfortable for her. In addition, the therapist provided support and understanding when Monica told of her affair so that Monica would not feel judged. Below is a transcript of an example session between Monica and her therapist.

*Therapist (T):* So, Monica, tell me how you have been feeling since I saw you last.

*Monica (M):* I’ve been feeling like such a failure. All my life I have tried to be a perfect Catholic but I’m really not. I had an affair! That is so wrong!

*T:* It sounds like you are holding yourself to a very high standard. Are all other Catholics perfect?

*M:* No, I guess not. But I have always tried to be perfect and I just keep failing. I feel like I am not worthy.

*T:* What are you not worthy of?

*M:* I’m not worthy of . . . God’s love, I guess. And my husband’s love too. He made a commitment to be with me and then when I had my affair I just totally abandoned him and abandoned my faith.

*T:* Was that what you were thinking when you had your affair? That you were abandoning your husband and your faith?

M: No, not really. I think I was just really unhappy with how my relationship with my husband was and I sort of acted impulsively. I really liked this guy and he liked me, he seemed to understand me more than my husband does and that was appealing to me. I didn't think about how it would impact my marriage or my faith until later.

T: So you weren't trying to abandon your husband or your faith.

M: No. But that doesn't really matter, does it? I mean, the bottom line is that I committed a sin whether I meant to or not.

T: Is that really the bottom line? Do your religious traditions mandate that you must never make mistakes or act impulsively?

M: Well, I don't know. I guess it is okay to make mistakes. Maybe if you confess your sins then it will be okay.

T: That makes sense. Because a lot of people make mistakes.

M: Yeah, that's true. I guess everyone makes mistakes sometimes, but not all of them are sins. It's worse when it is a sin. I don't think perfect Catholics ever sin, even by mistake.

T: Really? Perfect Catholics don't sin at all? That's pretty impressive. It must be really hard not to ever sin.

M: Well, if the Lord is really with you, that makes it a lot easier. He helps you so that you don't sin.

T: I see. So let's say, for the moment, that perfect Catholics are people who don't ever sin. What does this mean for you, that you are no longer a perfect Catholic?

M: Well, I . . . I'm not really sure. I feel like a failure. I feel like God is disappointed in me.

T: That must be difficult. A few minutes ago, though, you said that maybe if you confessed it would be okay.

M: Yeah, I keep thinking that I should go to confession but I am really embarrassed. I don't want my priest to know about my affair. I'm afraid that he would look down on me.

T: Really? I thought that priests were supposed to be understanding and to help us to forgive ourselves.

M: Yes, they are, but he's human too!

T: What do you mean by that?

M: He's supposed to be all nice and forgiving because he's a priest but he's also a human and humans judge others.

T: You are right, humans do judge others, but they are also understanding and forgiving. People tend to be especially forgiving when the person who made the mistake is really sorry.

M: And I am really sorry!

T: I know you are. These last few sessions, as you've been telling me about your affair and how you feel about it, has it made you feel better at all?

M: It has, actually. I was really nervous to tell you about it at first but now it is kind of a relief to be able to talk about it.

T: Maybe going to confession would also be a relief?

M: I think so. Maybe it won't be as bad as I think. I mean, I was afraid that you would judge me but I feel like you haven't, so maybe my priest wouldn't judge me either. I had a time of weakness but now I am very sorry about it and I want to do whatever I can to make amends and not ever let this happen again.

At her next appointment, Monica reported that she had gone to confession. She said that it was very difficult for her but she felt that her priest was understanding. However, she continued to report feelings of guilt and distress. The following session, she admitted that she had been considering leaving her husband, but that she also felt leaving the marriage would be another failure on her part. She reported dissatisfaction with the marriage and a desire to experience life on her own. However, these feelings were also causing her great distress as she believed that divorce was wrong and that she had made a lifelong commitment to her husband the day they were married. At this point, treatment switched to Motivational Interviewing<sup>47</sup> so that Monica could explore her feelings of ambivalence regarding her marriage.

After several sessions of Motivational Interviewing, Monica decided that it was very important to her to remain in her marriage and work on improving it. She generated a list of things that she and her husband could do to improve their relationship. Her symptoms of depression began to decrease but she still reported significant feelings of guilt regarding her affair. Treatment at this time switched back to IPT role transition and several sessions were spent discussing what makes a "perfect Catholic" and what makes a "good Catholic." Monica was able to recognize that being a "good Catholic" might be enough to make her feel happy and that making mistakes is part of being human. As her symptoms of depression continued to decrease, Monica found that her symptoms of OCD also began to decrease.

In later sessions, exposure with response prevention was used to help Monica further reduce the time spent on her ritualized behaviors that stemmed from her OCD diagnosis. She maintained that it was still important to her that she pray daily but she was able to reduce her amount of time spent in prayer to 30 minutes. She was also able to eliminate all of her cleansing rituals. After the final sessions spent discussing the gains Monica had made and suggestions to help her in the

future, therapy was terminated, in keeping with our clinic's practice of continuing treatment for 8–12 sessions following symptom remission.

By being nonjudgmental and open, the therapist was able to create an environment in which Monica felt comfortable discussing her affair as well as her thoughts regarding divorce. In particular, Monica's fears of being judged were alleviated by the therapist's nonjudgmental stance. The therapist was able to remain impartial, offering no advice regarding whether or not Monica should divorce her husband, allowing Monica to come to a decision herself. Using the techniques of Motivational Interviewing, the therapist simply encouraged Monica to talk through her reasons for and against divorce until she was able to make a decision. When they turned to the symptoms of OCD, the therapist allowed Monica to set her own goals regarding the amount of prayer that she was comfortable engaging in and the therapist simply helped Monica to achieve her goals. They worked on slowly confining prayer to a certain time of day and reducing the amount of time spent on prayer until Monica reached her goal of 30 minutes per day. The therapist did not force Monica to eliminate prayer completely, as Monica emphasized that it was important to her to spend some time praying each day.

## CONCLUSIONS AND FUTURE DIRECTIONS

Two studies have suggested that modifications of existing treatments to include religious components may be efficacious for religious individuals.<sup>44,46</sup> However, neither of these studies allows for inferences about the causal mechanisms contributing to the efficacy of the religious components of treatment. Therefore, it is difficult to generalize these results to other treatments in terms of suggesting the form of potential treatment modifications. Propst and colleagues<sup>46</sup> found that a modification of traditional CBT based on Beck and colleagues<sup>48</sup> model was effective for individuals who identify as Christian. However, it is unclear to what extent similar modifications in terms of rationale for treatment would be incrementally useful for the type of CBT presented in this chapter. To address this issue, future research investigating the efficacy of CBASP for highly religious and spiritual individuals is needed as well as research investigating potentially differential mechanisms of treatment effects or client experiences in CBT based on Beck and colleagues<sup>48</sup> framework compared with CBASP.

In closing, Richards and Bergin<sup>4</sup> call for an increase in spiritual sensitivity and competency among mental health professionals. We suggested that treatments which use clients' personal goals and formulations of success as the framework for intervention may be especially acceptable to – and helpful for – individuals with strongly held religious and spiritual beliefs. Future research specifically addressing this hypothesis is needed before strong recommendations can be made; however, consistent with the need for culture-specific expertise, we suggest (with an air of hopeful caution) that spiritual sensitivity and competency may be increased (at least in part) by familiarization with common religious/spiritual beliefs and practices as well as familiarization with the techniques of a spiritually sensitive treatment.