Why Address Spirituality in Cognitive Behavior Therapy?

- Eric Bellows[1] is a 36-year old man who has experienced over 10 depressive episodes accompanied by significant worry and anxious apprehension over the past fifteen years. He is interested in exploring the ways in which spirituality and religion may help him to cope with his symptoms, but does not know where to begin.
- Elizabeth Carmen is a 24-year old Roman Catholic. She recently presented to an outpatient therapist with a first major depressive episode, following the voluntary termination of a pregnancy. Elizabeth's religious guilt is pronounced, but she is reluctant to raise the topic for discussion with her secular therapist, out of concern that her moral struggle will be dismissed as irrelevant or even viewed as pathological.
- Michelle Santos is a 56-year old devoutly religious Latina woman who has experienced panic symptoms throughout her entire adult life without adequate diagnosis or treatment. A recent divorcee, she entered psychotherapy last month at the behest of her priest. She would like spirituality to be addressed in her treatment, but her therapist has not yet asked her about this essential aspect of her life.

In these cases – and countless others – practitioners of Cognitive Behavior Therapy (CBT) face a conundrum: Despite years of education and practice in the methods of evidence-based psychotherapy, the overwhelming majority lack even elementary training in how to address spirituality and religion in treatment (Rosmarin, Green, Pirutinsky & McKay, 2013). This being the case, most CBT clinicians are ill equipped to handle even the most elementary intersections of spirituality, religion and mental health, such as those described above.

This concern is not inconsequential. It is widely apparent that spirituality and religion[2] are powerful forces that shape economics, politics, and social behavior in all cultures around the world. Particularly in the United States, where every bill and coin brought into circulation by the US Bureau of Engraving and Printing bares the phrase "In God We Trust," it is clear that spiritual life has broad societal relevance. However, it is less commonly recognized and acknowledged that this domain often has personal and psychological relevance to many individuals as well. Consider the following:

- 73% of Americans profess "certain" belief in God, and 56% report that religion is "very important" in their lives (Gallup, 2011).
- 58% of Americans pray at least once per day, and 39% attend religious services at least once per week (Pew Research Center, 2009).

[1] All of the patients described throughout this text are composite clinical examples based on a number of patients. In addition, all names and other identifying details have been thoroughly changed to protect patient privacy and confidentiality.

[2] See Chapter 1 for definitions of these terms and a description of their use throughout this text.

- More than 20% of residents in New Hampshire and Vermont (the least religious American States) attend religious services weekly (Pew Research Center, 2014).
- 83.7% of the world population is affiliated with a religious group, and only 27% of all people live as religious minorities (Pew Research Center, 2012).
- Up to 68% of religiously unaffiliated individuals around the world profess one or more religious beliefs and up to 44% have some form of yearly religious practice (Pew Research Center, 2012)

In other words – even in this ostensibly secular age – for the majority of people, spirituality and religion are not simply abstract, macro-level constructs or perfunctory yearly engagements, but part and parcel of consciousness, identity, and daily life. A lack of competence to deal with spirituality and religion among clinicians is therefore a significant barrier to understanding and relating to patients[3].

Much more importantly for practicing clinicians, spirituality and religion are often relevant to psychological functioning and mental health. In fact, nearly 30 years of psychological science has linked spirituality and religion – broadly defined – to psychological functioning. Consistent research from hundreds of studies suggests that spiritual and religious beliefs and practices buffer against substance abuse (Kendler, Gardner, & Prescott, 1997) and depressive symptoms (Smith, McCullough & Poll, 2003) in the general population, although effect sizes on the former are greater than those on the latter. Furthermore, a rich literature now describes the many methods of religious coping – a myriad of ways in which spirituality and religion serves as a resource to people in times of distress (Pargament, 1997). Religious coping is extremely common – it has been reported by more than 80% of psychotherapy patients (Tepper, Rogers, Coleman, & Maloney, 2001), up to 73% of cancer patients (Thuné-Boyle, Stygall, Keshtgar, Davidson, & Newman, 2011), and by 90% of a national sample in the wake of the September 11th, 2001 terrorist attacks (Schuster, Stein, Jaycox, Collins, Marshall, Elliott, Zhou, Kanouse, Morrison, & Berry, 2001). More importantly, positive religious coping tends to be associated with lower levels of emotional distress and more emotional wellbeing, even after controlling for secular coping methods (Harrison, Koenig, Hays, Eme-Akwari & Pargament, 2001). Positive religious coping is particularly helpful in the context of high stress professions (Prati, Pietrantoni & Cicognani, 2011), trauma (McIntosh, Poulin, Silver & Holman, 2011), and terminal illness (Vallurupalli, Lauderdale, Balboni, Phelps, Block, Ng, Kachnic, VanderWeele, & Balboni,

[3] I will use "patients" as opposed to "clients" throughout this text by virtue of my academic affiliation with a medical school.

2012), and recent research suggests that it can even buffer against the progression of AIDS (Trevino, Pargament, Cotton, Leonard, Hahn, Caprini-Faigin & Tsevat, 2010).

However, as one of my mentors[4] regularly says, "All things in life can be used for their primary purpose, or the opposite." It is therefore no surprise that spirituality and religion can have negative effects on human emotion as well. For example, spiritual struggles such as negative beliefs about God or feeling disconnected from one's spirituality or faith community robustly predict greater emotional distress in the general population (McConnell, Pargament, Ellison, & Flannelly, 2006), and are even associated with illness-related decline (Ai, Pargament, Kronfol, Tice & Appel, 2010) and mortality (Pargament, Koenig, Tarakeshwar, & Hahn, 2001). Further, recent research in clinical psychiatric samples suggests that spiritual struggles are a significant risk factor for suicidality (Rosmarin, Bigda-Peyton, Öngur, Pargament, & Björgvinsson, 2013), and predict greater severity of mood symptoms even among those who are otherwise not religious (Rosmarin, Malloy, & Forester, 2014). Perhaps for all of these reasons, many patients wish to address spiritual and religious issues in the context of psychotherapy.

Anecdotally, for my doctoral dissertation I conducted a randomized clinical trial of a spiritually-integrated treatment for sub-clinical symptoms of Generalized Anxiety Disorder in the Jewish community (Rosmarin, 2009). Despite lacking any formal training or experience in recruitment for research, a remarkable 486 individuals from around the globe – more than three times as many as I expected – signed up to participate during the study period. Even more remarkable, I continued to receive a steady stream of interest from prospective participants through the end of 2011 – long after the study had been published – and even today I occasionally receive requests from individuals to participate in my study from time to time! My personal experiences witnessing marked interest in spiritually-integrated treatment is corroborated by current data.

In a 2010 study of six mental health clinics across various regions of the United States, over 55% of outpatients reported a desire to address spiritual matters in treatment (Rose, Westefeld, & Ansley, 2001). More recently, my colleagues and I at McLean Hospital in Eastern Massachusetts (not exactly a hotbed of religious fundamentalism) found that 58.2% of our patients reported "fairly" or greater interest in integrating spirituality into their mental health treatment, and 17.4% reported "very much" interest (top anchor on a 5-point scale; Rosmarin,

[4] Rabbi Lawrence Kelemen

Forester, Shassian, Webb & Björgvinsson, 2015). It is also worth noting that Americans are considerably more likely to seek support from clergy (25%) than mental health professionals (16.7%) even for impairing mental disorders (Wang, Berglund & Kessler, 2003).

Furthermore, and perhaps most important for CBT practitioners, it is not inconceivable that the recent popularity of third-wave CBT approaches, including Acceptance and Commitment Therapy (ACT) and Dialectical Behavior Therapy (DBT) may be in part due to latent and/or explicit spiritual themes that emerge in the context of mindfulness practice. Indeed, one recent study found that 49% of Mindfulness Based Stress Reduction (MBSR) participants reported that their #1 reason for commencing treatment was none other than "spiritual growth." (Greeson, Webber, Smoski, Brantley, Ekblad, Suarez & Quillian-Wolever, 2011).

Collectively, everything stated above can be summarized as follows:

- Spirituality and religion are highly prevalent, particularly in the United States.
- Spirituality and religion can impact emotional functioning in positive and negative ways.
- Many patients wish to address spiritual issues in the context of their mental health care.

All of this is bad news for CBT clinicians. After all, some of the foremost thinkers in the CBT world were vehemently anti-religious. For example, Albert Ellis – the father of Rational Emotive Behavior Therapy – penned an entire text dubbed "The Case Against Religiosity" in which he unapologetically and directly attacks a spiritual worldview. Here is one excerpt:

> If religion is defined as man's dependence on a power above and beyond the human, then, as a psychotherapist, I find it to be exceptionally pernicious. For the psychotherapist is normally dedicated to helping human beings in general, and his patients in particular, to achieve certain goals of mental health, and virtually all of these goals are antithetical to a truly religious viewpoint. (Ellis & Murray, 1980, p. 2)

Although Skinner, Watson and other behaviorists were not as overtly antagonistic towards religion – at least not in their writings – Mowrer[5] did argue that spirituality was simply an extrinsically motivated method of facilitating interpersonal relations (Mowrer, 1961). While Ellis and Mowrer both tempered their views on religion later in their lives (Ellis, 1992; Mowrer, 1967), they appear to have left an impression on the field. In a recent survey of over 250 CBT practitioners, participants reported substantially lower levels of religious belief and involvement than the general population and lower levels of religious practice than a general sample of

[5] A lesser known but nevertheless important behaviorist

psychotherapy practitioners; more importantly, 71% reported little-to-no previous training in how to address spiritual issues in treatment (Rosmarin, Green, et al., 2013).

Perhaps due to the anti-religious currents described above, the CBT world was almost entirely devoid of any methods for addressing patient spirituality until the early 1990s when a handful of laboratories adapted CBT methods to accommodate Christian religious beliefs and practices in the practice of Cognitive Therapy and Rational Emotive Behavior Therapy (e.g., Johnson & Ridley, 1992a; Johnson, DeVries, Ridley, Pettorini, & Peterson, 1994; Propst, Ostrom, Watkins, Dean, & Mashburn, 1992). These approaches included religious as well as bio-psycho-social explanations of distress in psychoeducation, provided Christian rationales for treatment procedures, used religious arguments to counter maladaptive cognitions, and used religious imagery procedures. Since that time, several other randomized controlled trials of religion-based CBT have been conducted with promising results (e.g., Armento, McNulty & Hopko, 2012; Combs, Bufford, Campbell, & Halter, 2000; Koenig, Pearce, Nelson, Shaw, Robins, Daher, Cohen, Berk, Belinger, Pargament, Rosmarin, Vasegh, Kristeller, Juthani, Nies, & King, 2015; Koszycki, Bilodeau, Raab-Mayo, & Bradwejn, 2014; Nohr, 2001; Tonkin, 2005; Vannoy & Hoyt, 2004; Zhang, Young, Lee, Zhang, Xiao, Hao, Feng, Zhou, & Chang, 2002). On the whole the integration of spirituality/religion into CBT appears to be as effective as standard CBT (McCullough, 1999), and possibly more effective for some patients (Hook, Worthington, Davis, Jennings, Gartner & Hook, 2010; Smith, Bartz & Richards, 2007). Alongside the growing empirical foundations for integrating spirituality and religion into CBT over the past few decades, a number of fine clinical papers and case studies have been published describing clinical processes of addressing patient spirituality in the practice of CBT for geriatric anxiety (Paukert, Phillips, Cully, Loboprabhu, Lomax, & Stanley, 2009), eating disorders (Spangler, 2010), schizophrenia (Weisman de Mamani, Tuchman, & Duarte, 2010), and acute psychiatric distress (Rosmarin, Auerbach, Bigda-Peyton, Björgvinsson & Levendusky, 2011). Other contributions have delineated methods for integrating religious content into mindfulness-based cognitive therapy (Hathaway & Tan, 2009), and the use of Exposure and Response Prevention for religious OCD symptoms (e.g., Huppert & Siev, 2010; Abramowitz & Jacoby, 2014).

Despite these important developments, there remains a consensus in the literature that more research is needed to incorporate spirituality into CBT for religious patients seeking spiritually-integrated treatment. Further, CBT practitioners appear to desire additional training in

this area: In the aforementioned study of CBT practitioners more than 50% of respondents reported a high level of interest in being trained how to assess and address spiritual issues in CBT (Rosmarin, Green, et al., 2013). That is, there is a need for clear instruction in how to address spirituality and religion in the context of evidence-based treatment (Rosmarin, Pargament & Robb, 2010; Tan, 2013; Waller, Trepka, Collerton & Hawkins, 2010). More specifically, the following issues – all of which are seemingly central to the practice of spiritually-sensitive CBT – remain unclear:

- How to respect patients' spiritual beliefs and practices while maintaining fidelity to an empirical framework
- How to identify psychologically relevant facets of spirituality and religion in a clinical context
- How to conceptualize spiritual and religious functioning using CBT language and concepts
- How to initiate a discussion with patients about spirituality and religion
- How to conduct a functional assessment of patient spirituality and religion
- How to frame CBT methods using spiritual/religious concepts in order to enhance motivation for treatment
- How to utilize patient spirituality and religion in the context of behavioral activation
- How spiritual beliefs can be harnessed in cognitive therapy
- How to address clinically maladaptive spirituality and religion in a culturally sensitive manner

The primary objective of this text is to provide an evidence-based and theoretically rigorous, practical guide for practitioners in how to integrate spirituality into CBT. As readers will see, this approach is not fundamentally different from conventional CBT, except that efforts are made to conceptualize the relevance of patient spirituality and religion to presenting problems and this domain is addressed in the treatment process.

This book is divided into two parts: Part I (Chapters 1-4) lays the theoretical and empirical foundations to facilitate case conceptualizations of spirituality within the context of CBT, and Part II (Chapters 5-8) presents an array of CBT techniques to address patient spirituality and religion in clinical practice. More specifically, Chapter 1 reviews definitions of spirituality and religion, discuss some ethical issues in addressing patient spirituality and religion in treatment, and delineate an approach to dealing with religious diversity. Chapter 2 presents a flexible set of principles drawn from learning theory (1st wave CBT), cognitive theory (2nd wave CBT), and emotion regulation theory (3rd wave CBT), to understand spirituality and religion through a CBT lens, in order that clinicians will learn to explain *how* and *why* spiritual/religious life interfaces with mental health. Chapter 3 provides a more focused discussion of how to

conceptualize patient spirituality/religion when it is clinically maladaptive and contributing to distress, including spiritual symptoms (e.g., religious OCD), and spiritual struggles (i.e., religious beliefs or practices that exacerbate guilt, tension and fear, or are a source of interpersonal conflict). As a capstone to Part I of this book, Chapter 4 applies the principles delineated in Chapters 1-3 to a series of five cases involving a wide spectrum of presenting problems including depression, worry, stress, obsessive-compulsive disorder, restricted eating, and chronic pain.

Part II of this book marks a transition point in the text to clinical pragmatics. Chapter 5 presents a step-by-step guide for how to initiate a discussion about spirituality in the context of CBT, and conduct an ideographically-tailored functional assessment of psychologically-relevant spiritual factors to individual patients. The next three chapters (6, 7 & 8) focus more on treatment than assessment, and present methods to utilize patient spirituality in the process of cognitive, behavioral, and affective change. Specifically, Chapter 6 presents "Framing," which involves the use of spiritual and religious concepts, idioms, and language, to describe and explain established CBT techniques to patients. Chapter 7 discusses methods for including spiritual and religious beliefs into Cognitive Therapy techniques. And Chapter 8 presents how to use spirituality and religion in behavioral activation, by directly harnessing common spiritual and religious activities in the treatment process. A brief concluding chapter discusses issues in the implementation of spiritually-integrated CBT and the need for clinical consultation and/or supervision. Finally, an Appendix provides a brief supplementary reading outlining a philosophical approach to the subject of spirituality and CBT. Throughout the entire text, brief summaries are included at the end of each chapter to highlight the most important points. In sum, it is my hope (and prayer!) that this text provides CBT clinicians with some essential principles and tools to address an important yet often overlooked area of their patients' lives.

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