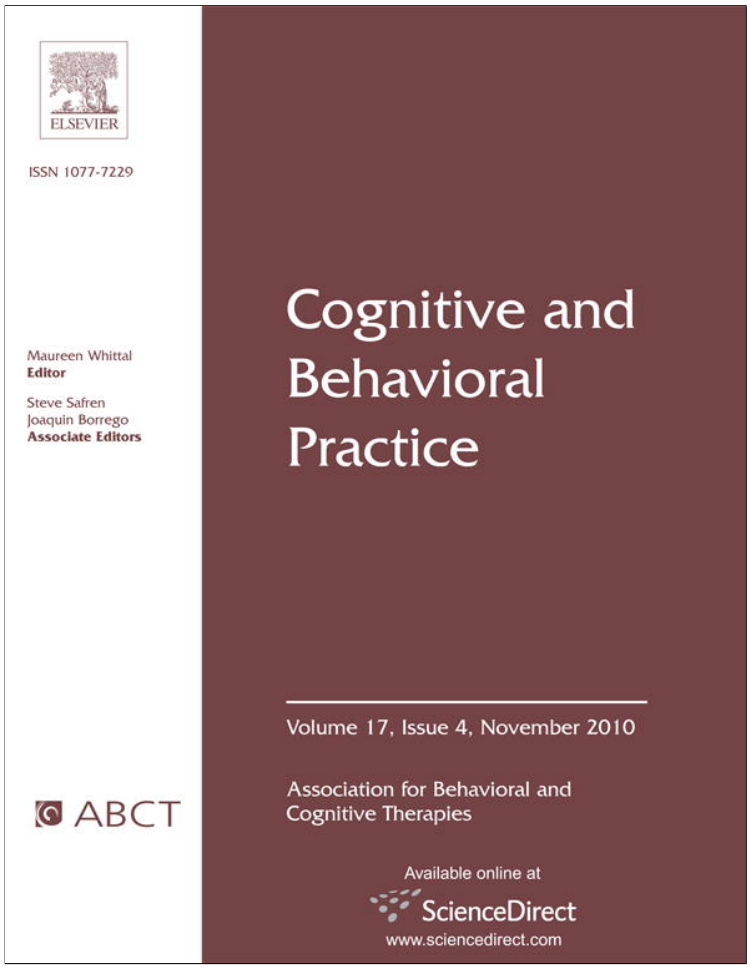

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SPECIAL SERIES
Spiritual and Religious Issues in Behavior Change

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Introduction

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Spiritual and religious beliefs and practices are commonplace in the general population of North America today. In recognition of this fact, research on the interplay of spirituality, religion, and psychological variables increased substantially over the past 3 decades; a recent PsycInfo search identified over 28,000 scientific contributions to this area. However, the relevance of spirituality and religion to clinical practice remains poorly understood. As a result, many practitioners of empirically supported treatments may be reticent to address spirituality and religion in the course of their work. The intent of this special series is to help demystify this topic with the hope of increasing dissemination of spiritually sensitive, empirically supported treatments. The authors in this series cast some light on this understudied topic by highlighting several salient spiritual and religious issues in behavior change. Moreover, based on case material, the authors illustrate how to assess for and address both adaptive and maladaptive utilizations of spirituality and religion in the practice of cognitive behavior therapy. This introductory paper presents a rationale for why it is important to address this topic, and provides an overview of recent research developments in the creation of spiritually integrated psychosocial treatments.

Recent findings from surveys conducted with nationally representative samples in the United States indicate that spiritual and religious beliefs and practices are highly prevalent in the general population. Specifically, 93% of Americans report a belief in God or a higher power, 76% report believing that the Bible is the actual or inspired word of God (Gallup Poll, May 8–11, 2008), 59% report believing that religion can answer "all or most" of today's problems, and more than 50% indicate that religion is *very important* to them in their lives (Gallup Poll, May 10–13, 2007). Accordingly, it appears that the vast majority of individuals seeking psychological treatments in North America profess some form of spiritual or religious belief (Robb, 2001; Rose, Westefeld, & Ansley, 2001). For practitioners of empirically supported psychological treatments, these facts raise some important questions. For example, how are spiritual and religious factors relevant to symptom presentation and treatment outcome? Which specific factors are most salient, and how can we identify, quantify, and address them? Can and should client spirituality be integrated into treatment? If so, what are the ethical issues that this raises and how should these be dealt with? Moreover, when should this be facilitated, how should this be accomplished, and how might this impact treatment efficacy? The papers in this special series provide empirically based answers to these and other questions relevant to this topic area. Collectively, they offer rich, clinically relevant, and empirically informed recommendations for how to address some of the many spiritual and religious issues that arise in the practice of cognitive-behavioral therapy. By way of introduction to these contributions, the present paper will attempt to illustrate why it is important to address spiritual and religious issues in behavior change. Furthermore, an overview of recent advances in the development of spiritually integrated treatments and an Appendix containing suggestions for further reading is provided.

Why Address Spirituality and Religion?

Clinical and counseling psychologists tend to demonstrate markedly lower levels of religiousness than the population at large. In one study conducted with a random sampling of members from Division 12 (Clinical Psychology) of the American Psychological Association (APA), Shafranske and Malony (1990) found that less than 30% of respondents endorsed belief in a "personal God of transcendental existence," and 58% reported very limited or no involvement or identification with religion, or disdain for religion. In a more recent study with a

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random sampling of all APA members, almost half (48%) of respondents described religion as unimportant in their lives (Delaney, Miller, & Bisonó, 2007). By virtue of their own stance toward religion and spirituality, many practitioners may not be sensitive to the religiousness and spirituality of their clients, and the need to address spiritual and religious issues in behavior change. More fundamentally, though, there are deeply seated assumptions within the field of mental health that spirituality and religion are generally unimportant, largely unrelated to human psychological functioning, and at most, a side issue in psychotherapy (Pargament, 2007). These assumptions appear to be unfounded, however. The past three decades of psychological research on religion and spirituality have yielded substantial evidence to suggest that spirituality and religiousness are indeed salient to psychological functioning. Furthermore, spiritual and religious factors are at times inextricable from clients' presenting symptoms.

Perhaps the best researched construct in this area involves the utilization of religious resources during times of stress in a process known as religious coping (Pargament, 1997). Religious coping is highly prevalent. After the September 11, 2001, terrorist attacks, for example, 90% of a sample drawn from across the United States reported turning to religion in some way (Schuster et al., 2001). A number of studies show that religious coping is predictive of lower rates of depressive symptoms, anxiety, and increased levels of self-esteem and life satisfaction (see Harrison, Koenig, Hays, Eme-Akwari, & Pargament, 2001, for a review). In addition to religious coping, a rich literature ties simple behavioral markers of spirituality and religion such as prayer, meditation, and Bible study to decreased depression (Smith, McCullough & Poll, 2003), anxiety (Koenig, Ford, George, Blazer, & Meador, 1993), and reductions in the consequences of stressful life events (Williams, Larson, Buckler, Heckmann, & Pyle, 1991), as well as higher levels of life satisfaction (see Koenig, McCullough, & Larson, 2001, for a review). Other studies link cognitive facets of spirituality such as religious beliefs to a lower incidence of depression (e.g., Koenig, George, & Peterson, 1998) and anxiety (Rosmarin, Krumrei, & Andersson, 2009).

Not all utilizations of spirituality and religion appear to be psychologically beneficial, however. Recent research on the topic of spiritual struggle suggests that some facets of faith can also be a source of distress. Spiritual struggle, which is sometimes referred to as negative religious coping, involves strain and tension relating to spiritual matters. Three primary types of struggle have been identified (Exline & Rose, 2005; Pargament, Murray-Swank, Magyar, & Ano, 2005): (a) interpersonal spiritual struggle, which involves conflict with others in a spiritual context, such as disagreements with fellow congregants, or a falling out with clergy; (b) intrapersonal spiritual struggle, which involves existential crises resulting from questions/doubts about spiritual and religious issues; and (c) divine spiritual struggle, which involves emotional tension in one's relationship with God (e.g., feeling anger towards God, feeling abandoned by God). While less common in occurrence than positive religious coping (McConnell, Pargament, Ellison, & Flannelly, 2006), spiritual struggle is tied to poor recovery from physical illness (Fitchett, Rybarczyk, DeMarco, & Nicholas, 1999), declines in health and illness-related mortality (Pargament, Koenig, Tarakeshwar, & Hahn, 2004), and psychological difficulties (Ano & Vasconcelles, 2005), and therefore presents a significant risk factor for religious individuals. The relationship of spiritual struggle to well-being underscores the importance of assessing for potentially deleterious spiritual and religious factors across cognitive (e.g., beliefs that one is being punished by God), behavioral (e.g., arguing with God), and/or emotional (e.g., feelings of anger towards God) domains in the course of treatment (Exline, Yali, & Sanderson, 2000).

Thus, the extant literature has clearly demonstrated that many aspects of spirituality and religion are salient predictors of psychological functioning. More specifically, spirituality and religiousness can be utilized in positive or negative ways, which divergently relate to mental health and distress. Based on these observations, some have proposed that spirituality/religion neither causes nor ameliorates symptoms of mental illness in and of itself (Ellis, 2000). In this vein, spirituality and religion are no different from other human contexts, such as culture. However, the domains of spirituality and religion appear to exert a more potent and extensive influence than many other areas of human life. This influence is not limited to human affect and behavior; it is widely apparent in large-scale social efforts, including war and peace (McCullough & Willoughby, 2009). While it remains unclear why, exactly, religion and spirituality have such a powerful impact on humanity, it has been suggested that sanctification plays a key role. Sanctification is the process by which aspects of life are perceived as having Divine or sacred character and significance (Pargament, 2007). While virtually any aspect of life (e.g., values, beliefs, objects, people) can be sanctified, that which is perceived to be sacred exerts a robust influence on emotions and behaviors, including increasing investments of time and effort with sacred matters, taking on responsibility and risk to preserve and protect that which is sacred, and the elicitation of both positive and negative emotions with a strong valence (see Pargament & Mahoney, 2005, for a review). Thus, while perhaps not intrinsically connected to psychological functioning, the use of spirituality and religiousness in a positive and adaptive manner may be

particularly helpful to individuals in times of psychological distress. Conversely, as described throughout this special series, spirituality and religiousness can exert a profound influence on how psychopathology manifests. Given the widespread significance of religion and spirituality to members of our society, and evidence suggesting that these factors have an impact on psychological functioning, it is necessary to provide a clinically useful analysis of how to deal with spiritual and religious issues in behavior change.

Integrating Spirituality Into Treatment

Unfortunately, the "religion gap" between psychologists and general public compromises our field's ability to disseminate treatments in the general population (Delaney et al., 2007). Recently, only 13% of training directors in clinical psychology graduate programs in North America reported that their curriculum offered a course on religion or spirituality (Schulte, Skinner, & Claiborn, 2002). As a result, the majority of clinicians lack training on how to grapple with spiritual and religious issues in treatment. Furthermore, some may be concerned that approaching this subject oversteps professional bounds (Pargament, 2007). This is unfortunate, as there is evidence to suggest that many clients would appreciate a spiritually sensitive approach to treatment.

It has been established that conventional psychological services are underutilized by religious populations as religious individuals tend to prefer spiritually integrated care (Puchalski, Larson, & Lu 2001). However, preference for spiritually integrated treatment does not appear to be limited to cloistered religious communities. A recent survey of over 31,000 adults by the National Center for Complementary and Alternative Medicine indicated that 43% of respondents prayed for their own health, 25% recruited others to pray for them, and 10% joined a prayer group for their health (U.S. Department of Health and Human Services, 2005). In another national study, 45% of medical patients stated that too little attention was paid to spiritual and religious concerns and 48% indicated that they would like their physicians to pray with them (Post, Puchalski, & Larson, 2000). While not much research in this area has been conducted with regards to psychotherapy, it has been noted that, historically, North Americans are more likely to seek help from clergy and religious communities than mental health providers when experiencing psychological problems (Norris, Kaniasty, & Scheer, 1990). Additionally, one large-scale study involving six mental health facilities found that 55% of psychotherapy clients would like to talk about spiritual and religious issues in the course of treatment (Rose et al., 2001). Addressing spirituality and religion may therefore be an important step towards the dissemination of cognitive behavior therapy (CBT). It is not inconceivable that one of the reasons for the recent popularization of third-wave CBT, including mindfulness-based treatments and Acceptance and Commitment Therapy (ACT), is the willingness of proponents to link treatment to spirituality and transcendence (e.g., Hayes, 2002).

In recognition of the widespread general interest in spirituality and the need to provide religious communities with culturally appropriate care, numerous spiritually integrated interventions have been created in recent years. Spiritually integrated treatments (SITs) are psychosocial interventions that draw on spiritual resources and address spiritual concerns (Pargament, 2007). Much like conventional treatments, SITs target various presenting problems, including addictions (Margolin et al., 2007), sexual abuse (Murray-Swank & Pargament, 2005), social anxiety (McCorkle, Bohn, Hughes, & Kim, 2005), physical and psychological well-being among cancer patients (Cole, 2005), and migraines (Wachholtz & Pargament, 2008). SITs have been integrated with several modalities of psychotherapy (Worthington & Sandage, 2001). Perhaps most significant for practitioners of empirically supported treatments, several attempts to integrate spirituality and religion into cognitive behavioral and rational-emotive behavioral therapy have been successful (e.g., Johnson & Ridley, 1992; Johnson, DeVries, Ridley, Pettorini, & Peterson, 1994; Pecheur & Edwards, 1984; Propst, 1980). Spiritually integrated forms of CBT are similar to conventional CBT except that the rationale for treatment is presented in a spiritual framework, and religious arguments are utilized to counter maladaptive beliefs (Nielsen, 2001; Nielsen, Johnson, & Ellis, 2001; Robb, 1988). Furthermore, spiritual/religious practices (e.g., gratitude exercises, blessings, prayer) can be purposefully included in treatment as behavioral activation strategies, with the intention of increasing positive emotions such as gratitude and hope.

While research in this area is still in its early stages, we located 34 open and controlled clinical trials of SITs in a recent literature search. One meta-analysis of investigations comparing religion-accommodative CBT with standard CBT for depression indicated that both treatments were equally effective in reducing depressive symptomatology at 1-week follow-up (McCullough, 1999). On this basis, it has been suggested that SITs can be offered to clients without compromising treatment efficacy, and that choice of SITs is a matter of availability and client preference. However, a more recent meta-analysis may indicate that SITs are more efficacious than other treatments. Smith, Bartz, and Richards (2007) found an overall effect size of 0.51 among 24 studies comparing SITs to established treatments; that is, SITs produced a 0.51 standard deviation change in post-study measures over and above comparison treatments. Furthermore, of studies evaluating positive psychological variables such as

happiness and well-being, the effect size of SITs increased to 0.96. It should be noted, though, that the majority of studies reviewed in this meta-analysis did not use manualized treatments or employ fidelity checks, and therefore these findings should be interpreted with some caution. Nevertheless, there is evidence to suggest that SITs are equally and perhaps more effective than non-spiritually-integrated treatment approaches for some presenting problems. It should also be noted that one particularly well-designed study in this area found that nonreligious therapists obtained somewhat better results than religious therapists in treating clients with spiritually-integrated CBT for depression (Propst, Ostrom, Watkins, Dean, & Mashburn, 1992). This suggests that a lack of religiousness on the part of a therapist is not a barrier to the implementation of spirituality in treatment. It therefore appears that SITs are within our capabilities to master and are deserving of our attention.

This Series

For this special series, we collected the work of several empirically oriented practitioners and researchers on the subject of spiritual and religious issues in behavior change. These papers provide readers with valuable practical guidelines for how to (a) assess for and address salient spiritual and religious factors in the course of treatment, (b) determine when and how it may be appropriate to integrate spirituality into treatment, and (c) better understand some of the unique issues that can arise in the practice of empirically supported treatments with religious individuals.

First, Weisman de Mamani, Tuchman, and Duarte (2010) examine whether religion and spirituality should be incorporated into treatment for patients with severe mental illness. In doing so, they provide invaluable case examples of both adaptive and maladaptive uses of spirituality in patients with schizophrenia from an ongoing study evaluating a culturally informed therapy in this population. Second, Spangler (2010) has written a rich clinical description of how religious doctrines about the body and religiously based eating practices can operate within the context of eating disorders. Based on case material, she provides a theoretical basis to inform case formulations involving client spirituality and religion within a CBT framework, in the treatment of eating disorder symptoms. Next, Karekla and Constantinou (2010) provide an overview of the processes of religious coping and spiritual struggles in cancer patients. This contribution further describes how to assess for these factors and approach spiritual and religious issues within this population using an ACT approach. Finally, Huppert and Siev (2010) provide a theoretical framework for differentiating religiousness from scrupulosity among Orthodox Jews. They further illustrate how exposure and response prevention can be used in a culturally sensitive manner to treat obsessive-compulsive disorder in religious individuals.

It is hoped that this special series will help practitioners of empirically supported treatments to appreciate the importance of spirituality and religion to clients' lives. Moreover, it is hoped that the contributions in this series will provide practical guidelines for practitioners who wish to gain knowledge in this understudied area. Perhaps most of all, it is hoped that this series will spawn the development of greater sensitivity and skill in confronting spiritual and religious issues in behavior change.

Appendix Suggested Readings

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