

## Cognitive Behavioral Therapy With Religious and Spiritual Clients: A Critical Perspective

Kathryn M. Carlson and A. Antonio González-Prendes

School of Social Work, Wayne State University, Detroit, Michigan, USA

### ABSTRACT

Religion and spirituality (R/S) are important factors in the lives of many individuals. Yet, R/S and their impact on mental health are topics that are often overlooked in clinical practice. We offer a critical perspective on the integration of R/S in cognitive-behavioral therapy (CBT). We discuss factors that have contributed to the relative lack of attention to R/S in mainstream psychotherapies in general and CBT in particular, and examine the use of CBT with R/S clients. We suggest ways to conceptualize and adapt CBT strategies, including mindfulness, so that they can be effectively used with R/S clients.

### KEYWORDS

Cognitive behavioral therapy; counseling and psychotherapy; mindfulness; religion; spirituality

Religion and spirituality (R/S) are important factors in people's lives, and often have a significant impact on physical and psychological health. According to the Pew Research Center (2015), 89% of adult Americans report that they believe in God; 63% report "absolute certainty that God exists;" 53% report that religion is very important in their lives; and 37% attend religious services at least once a week. At the same time, a number of studies have suggested a positive relationship between R/S involvement and health outcomes (Carmody, Reed, Kristeller, & Merriam, 2008; Contrada et al., 2004; Hill, Angel, Ellison, & Angel, 2005; Hill, Burdette, Angel, & Angel, 2006; Ironson, Stuetzle, & Fletcher, 2006; la Cour, Avlund, & Schultz-Larsen, 2006; Leigh, Bowen, & Marlatt, 2005; Litwin, 2007; Reyes-Ortiz et al., 2006; Tully et al., 2006; Yakir, Anaki, Binns, & Freedman, 2007). A review of 3,300 studies conducted between 1872 and 2010 concluded that R/S can lead to better mental health, increased adaptability to problems, and a lower risk for physical problems (Koenig, 2012). For many individuals, R/S beliefs have the potential to reduce stress, increase positive emotions, give meaning to adversity and enhance one's sense of purpose (Koenig, 2012).

The growing evidence on the relationship between R/S and health outcomes suggests that clinicians must attend to their clients' R/S beliefs in psychotherapy. According to Weisman De Mamani, Tuchman, and Duarte (2009), spirituality and therapy have similar goals: "both religion/spirituality

and therapy aim to increase a sense of identity, to answer questions about life's meaning, and to encourage social support networks" (p. 349). Therapy seeks to build on clients' strengths and resources, and R/S are often a source of strength for many clients (Van Wormer & Davis, 2013). Indeed, a study of mental health centers across the United States found that more than half of clients seeking counseling wished to incorporate spirituality into their treatment (Rose, Westefeld, & Ansely, 2001).

The importance of R/S in clinical practice is reflected in the standards of various professional organizations in the fields of social work, psychology and counseling. For instance, the Council for Social Work Education (CSWE) added religion to its key characteristics of diversity in 1994, and later added spiritual development as a central aspect of human behavior (Van Wormer & Davis, 2013). To promote cultural competency in this area, the CSWE established a Religion and Spirituality Work Group in 2011. According to the CSWE (2014):

Social workers need to understand religion and spirituality to develop a holistic view of the person in environment and to support the professional mission of promoting satisfaction of basic needs, well-being, and justice for all individuals and communities around the world.

The American Psychological Association (APA) has a similar division, the Society for the Psychology of Religion and Spirituality, which is dedicated to promoting research and practice in nonsectarian religion/spirituality (APA, 2014). Similarly, the American Counseling Association (ACA) has the Association for Spiritual, Ethical, and Religious Values in Counseling, which is "devoted to professionals who believe that spiritual, ethical, religious, and other human values are essential to the full development of the person and to the discipline of counseling" (ACA, 2015). The importance of assessing the role of R/S in a client's life has also been underscored by assessment models such as RESPECTFUL (Ivey, D'Andrea, & Ivey, 2012) and ADDRESSING (Hays, 2008). Both models emphasize the need to explore the client's R/S identity. However, despite the prevalence of R/S among clients and the recognition of its importance by professionals, R/S often goes unaddressed in therapy.

In this article we explore and discuss ways to integrate R/S in clinical practice within the framework of cognitive behavioral therapy (CBT). CBT encompasses a number of therapeutic approaches that hold rooted in the fundamental principle that one's thoughts and beliefs are the prime determinant of one's emotional and/or behavioral responses to life events (A. T. Beck, 1976; Ellis, 1962). In essence, CBT is an information-processing model that maintains that our reactions to situations are influenced by how we cognitively process and interpret (i.e., meanings, attributions, judgments, etc.) those situations. Moreover, those immediate

and fluid interpretations of life events are influenced by a set of core beliefs (J. Beck, 2011) that represent the more central, stable, fundamental, and definitive views the individual has about the self, others, and the world at large. These fundamental core beliefs start to develop early in life and often reflect the views and mental representations that the person has internalized from early interactions with parents, families, caretakers, school, and society among others. A significant influence on the formation of one's beliefs and values is one's culture, including the possible influence of R/S views. Given the central importance that one's belief system has in shaping responses within the framework of CBT, we suggest that, for a sensitive and accurate assessment of such beliefs, these must be assessed against the framework of the client's cultural background including R/S views.

CBT is one of the most widely practiced therapy modalities partly because it has garnered extensive empirical support. Butler, Chapman, Forman, and Beck (2006) conducted a review of meta-analyses which included 16 meta-analytic studies published between 1967 and July 2004, encompassing 332 clinical trials with 9,995 participants and covering 16 disorders or populations. The authors concluded that the evidence from the 16 meta-analyses supports the efficacy of CBT across many disorders with particularly large effect size for unipolar depression, generalized anxiety disorder, panic disorder with or without agoraphobia, social phobia, posttraumatic stress disorder, and childhood depressive and anxiety disorders. In another review of 269 meta-analyses (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012) the authors evaluated a representative sample of 106 studies published between 2000 and January 2012 covering 17 disorders or populations and concluded that the "the evidence-base of CBT is very strong, and especially for treating anxiety disorders" (p. 436). The results of this study also suggest strong support for the use of CBT with somatoform disorders, bulimia, anger control problems, and general stress. In addition, varied levels of effectiveness were reported for the use of CBT in the treatment of schizophrenia and other psychotic disorders, substance abuse disorders, depression and dysthymia, and bipolar disorders. However, the authors pointed out that "except for children and elderly populations, no meta-analytic studies of CBT have been reported on particular subgroups, such as ethnic minorities and low income samples" (p. 436). Other empirical studies have also provided support for the use of CBT with depressed and anxious youth (Chu & Harrison, 2007); schizophrenia and schizoaffective disorders (Wykes, Steel, Everitt, & Tarrier, 2008); acute and chronic posttraumatic stress disorders in adults, children, and adolescents (Kar, 2011); and alcohol and drug use disorders (McHugh, Hearon, & Otto, 2010). In a comparison of CBT with other psychotherapies, Tolin (2010) reviewed 26 randomized controlled studies with 1,981 participants and suggested that CBT demonstrated superior

effectiveness in the treatment of anxiety, and should be considered as a first-line approach with such conditions.

At the same time, numerous surveys of mental health professionals have indicated that CBT is their preferred and most widely used theoretical orientation. The 2008 Survey of Psychology Health Service Providers revealed that, out of 5,051 psychologists surveyed, 1,964 cited CBT as their primary theoretical orientation—more than twice the total of the next largest orientation (Center for Workforce Studies, 2010). In addition, another 257 participants cited “cognitive therapy” and 148 cited “behavior therapy” as their primary theoretical orientations. In another study by Pignotti and Thyer (2009) exploring the use of empirically supported therapies favored by clinical social workers, CBT was cited as the most frequently used intervention by 43% of participants (with an additional 18.5% citing cognitive therapy and 12.6 % behavior modification), and 72.9% named CBT as their most currently used intervention in the past year. Given the popularity of CBT among mental health care providers, the increased focus placed on R/S matters by professional organizations, and the importance of R/S among the general population, there seems to be a need to explore how mental health practitioners using a CBT model can integrate R/S in their work with clients—a subject that has received relatively little attention in the literature.

However, the question of when or how R/S should be utilized in therapy is a sensitive one, particularly when it comes to CBT. CBT is based on logical positivism, which traces knowledge to tangible outcomes (Rosmarin, Green, Pirutinsky, & McKay, 2013). While CBT’s focus on empiricism has served it well when it comes to gaining respect from the scientific community and promoting evidence-based practices, it raises questions about how CBT can be used to address the less-tangible aspects of life such as R/S. The challenge for CBT practitioners delving into the areas of R/S is how to integrate strategies that address these issues while staying true to the evidence-based, problem-solving focus of CBT. Recent years have seen increased attention and empirical support for adaptations of CBT that focus on mindfulness-based interventions. One such approach is mindfulness-based cognitive therapy (MBCT) (Segal, Williams, & Teasdale, 2013). Mindfulness represents a shift away from outcomes that can be explicitly measured by research and it offers exciting possibilities for incorporating R/S into therapy (Birnbaum & Birnbaum, 2008).

Although the relationship between R/S and clinical practice has been discussed elsewhere (see Koenig, 2012), we narrow the focus to a critical discussion on the use of CBT in general, and mindfulness in particular, with R/S clients. We briefly explore reasons behind the apparent lack of attention to R/S issues in traditional psychotherapy. Then R/S CBT is reviewed, with regards to efficacy and philosophical similarities/differences with religious traditions. We talk about mindfulness-based interventions and their potential

to make treatment more relevant for R/S clients. Finally, we discuss implications for practice and directions for future research.

### **Why do religion and spirituality go unaddressed in therapy?**

R/S are abstract concepts that do not easily lend themselves to hard scientific inquiry. They can be understood as separate but overlapping constructs. Pargament, Mahoney, Exline, Jones, and Shafranske (2013a) suggested that religion is “the search for significance that occurs within the context of established institutions that are designed to facilitate spirituality” (p. 15), whereas spirituality is the “search for the sacred,” with the sacred meaning God or a divine power (p. 14). Historically, R/S have been marginalized from the fields of psychology and social work in order to give these disciplines more scientific credibility (Dwyer, 2010; Pargament et al., 2013a). Some have suggested that the secularization of therapy has helped it gain recognition as objective “hard science” (Pargament, Mahoney, Exline, Jones, & Shafranske, 2013b), whereas spiritual therapy techniques such as meditation, praying with a client, or utilizing spiritual texts are by nature difficult to study objectively (Gause & Coholic, 2010). Also, the views of influential thinkers have contributed to the historically adversarial relationship between psychology and R/S. For instance, Sigmund Freud and Albert Ellis have seen religion as a contributor to neuroticism (Koenig, McCullough, & Larson, 2001). Freud viewed religious practice as akin to obsessive neuroticism, and he suggested that psychological maturity necessitated renouncing one’s religious beliefs. Similarly, Ellis (1980) wrote:

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 view-point. (p. 2)

To this end, Ellis (as cited in Koenig et al., 2001) offered that, “the elegant therapeutic solution to emotional problems is to be quite unreligious and have no degree of dogmatic faith that is unfounded or ungrounded in fact” (p. 62). Such views have contributed to an attitude in which the importance of R/S is marginalized or even seen as an impediment to psychotherapy.

Moreover, when considering why R/S are often unaddressed in therapy one must consider the personal beliefs of mental health professionals. Clinicians who have their own positive experiences with R/S are more likely to integrate these concepts into therapy than are those who have had negative experiences with R/S or are inexperienced in addressing clients’ R/S issues in psychotherapy (Daniels & Fitzpatrick, 2013). In the *Handbook of Religion and Health* (Koenig et al., 2001), the authors cited data that shows that the

proportion of mental health professionals who reported being unaffiliated with any religion or who saw themselves as atheist or agnostics far surpasses the proportion in the general population. The same seems to be true of academia. In a random survey of 1,500 college professors, Gross and Simmons (2009) found out that, among psychology professors, 59% saw themselves as atheist and 11% as agnostics. In the field of social sciences in general, 39% saw themselves as firmly atheist or agnostic while only 25% affirmed the existence of God without doubt. In another study, Curlin et al. (2007) suggested that psychiatrists are the least religious of all physicians. Given the prevalence of atheistic or agnostic beliefs in academia, it could very well be that these matters are not deemed to be important and, consequently, are not addressed in the academic preparation of mental health practitioners.

Indeed, a lack of training in how to utilize R/S in therapy may also contribute to practitioners' reluctance to incorporate R/S techniques. In a study conducted by Rosmarin et al. (2013) with members of the Association for Behavioral and Cognitive Therapies, over 70% of the sample reported little to no clinical training in how to assess and address R/S issues in treatment. Additionally, 36% indicated a fair degree of discomfort in addressing these issues, and 19% reported rarely/never inquiring into these issues in treatment. Another survey of 126 practicing master's-level social workers found that, while 35% of the sample agreed that R/S were woven into their graduate course work, less than 5% had actually taken a class on R/S or had received significant training in this area (Dwyer, 2010).

In addition, ethical concerns contribute to practitioners' reluctance to utilize R/S techniques. Practitioners are rightfully cautious about blurring professional boundaries or imposing their own religious views on clients (Gause & Coholic, 2010). R/S are highly personal issues, and they highlight the importance of respecting client autonomy (Hodge & Bonifas, 2010). Practitioners who encounter clients from diverse and unfamiliar religious backgrounds may feel uncomfortable addressing R/S with those clients. Yet, Dwyer (2010) suggested that this comes at a cost, because by failing to address these issues, practitioners can inadvertently communicate a tacit opposition to the client's fundamental core beliefs. This can lessen the effectiveness of therapy, or even make it harmful to the client (Hodge, 2008). Furthermore, Hodge and Bonifas (2010) argued that ignoring R/S when the client wishes to incorporate it into therapy could be considered a breach of self-determination.

### **Cognitive-behavioral therapy and religion/spirituality**

R/S beliefs have the potential to influence how people interpret important events in their lives and the meaning they attach to those events (Koenig, 2012). Those interpretations may lead to decreased stress, increased

adaptability and functionality, or to increased stress and coping difficulties. Consequently, it would seem that CBT, with its focus on beliefs, would be a compatible approach to address issues of R/S that are deeply entrenched in belief systems. Although a historical account of the evolving relationship between CBT and R/S is beyond the scope of this article, it is important to note that in recent years CBT has become more open towards issues of R/S. For instance, in an article addressing the use of rational emotive behavior therapy (REBT) with clients who have devout beliefs in God and religion, Albert Ellis (2000) reassessed some of his earlier views about religion being antithetical to good mental health. Instead, Ellis posited that religious and nonreligious beliefs in themselves do not help people to be emotionally “healthy” or “unhealthy” but rather it is the absolute, dogmatic devotion to beliefs that helps to create emotional disturbance. Furthermore, Ellis went on to delineate 12 REBT philosophical principles and their compatibility with religion-based precepts (see Ellis, 2000).

In 2005, the relationship between CBT and spirituality was the centerpiece of a conversation between Aaron Beck and the 14th Dalai Lama at the International Congress of Cognitive Psychotherapy in Göteborg, Sweden. Beck and the Dalai Lama discussed areas of overlap between CBT and the spirituality of Buddhism thus underscoring the possibility for better integration between the two. Beck suggested that many negative thoughts and emotions are grounded in self-centeredness. Egocentricity can lead to unhappiness, because it makes people feel isolated and caught up in their negative emotions. When people learn to see life from a more holistic perspective and feel as if they are part of the larger human structure, then pain, discomfort, and conflict are more easily managed. This egoism that Beck speaks of runs counter to spirituality, which is about connecting with something greater than oneself. It seems then that CBT and spirituality could potentially have the same goal of promoting a sense of interconnectedness. In the conversation the Dalai Lama made reference to Beck’s 1999 book *Prisoners of Hate: The Cognitive Basis of Anger, Hostility, and Violence*, and described it as “almost like Buddhist literature” (ICCP, 2005). The Dalai Lama referred to the process of reflecting on one’s life in order to gain insight into the object of the meditation, reprioritize, and act accordingly as *analytical meditation* (2014). Moreover, the Dalai Lama drew a parallel between analytical meditation and the cognitive restructuring found in CBT where clients are invited to examine their beliefs in order to evaluate their validity and functionality. At its core CBT is a belief-focused system of psychotherapy where the emphasis of treatment is on the evaluation and reframing of (a) client’s immediate evaluative beliefs about events, or (b) the more foundational set of core beliefs the person has about the self, the world, and others.

### **Empirical support for R/S CBT**

The empirical support for R/S CBT has yielded mixed results. For instance, Smith, Bartz, and Scott (2007) conducted a meta-analysis of 31 outcome studies of spiritual therapies and concluded that there is empirical evidence that spiritual-oriented intervention may be beneficial to individuals with psychological problems of depression, anxiety, stress, and eating disorders. In this case, CBT-based interventions comprised 52% of those included in the analysis. However, the study did not focus exclusively on CBT interventions and the analysis included different modalities; moreover, the summary data was not specific to one particular approach. Similarly, Worthington, Hook, Davis, and McDaniel (2011) conducted a meta-analysis of 46 studies ( $n = 3,290$ ) that compared outcomes on therapies that accommodated R/S elements versus therapies that did not have such accommodations. The authors did not indicate how many of the studies used R/S-oriented CBT and the conclusions did not specify the efficacy of particular theoretical models. Nonetheless, the results were mixed. The authors reported that R/S-accommodated therapies outperformed control conditions (i.e., no treatment) and secular treatments on both spiritual and psychological measures. However, when the R/S therapies were compared with non-R/S of the same theoretical orientation and length of treatment, the R/S-accommodated approach outperformed the secular approach on spiritual measures but not on psychological measures. This suggests that R/S-accommodated therapies might be more efficacious with clients who are religiously or spiritually committed. However, the authors did not differentiate outcomes according to specific disorders (i.e., depression, anxiety, etc.) or theoretical orientations of the interventions.

With a more specific focus on CBT interventions, Hodge (2006b) reviewed 14 outcome studies on the use of R/S CBT with a variety of psychological problems including depression, anxiety disorders, and schizophrenia, and concluded that R/S CBT is “a well-established intervention for treating depression among Christians,” as well as “a probably efficacious intervention for depression among Muslims” (p. 162). Propst, Ostrom, Watkins, Dean, and Mashburn (1992) compared religious-oriented CBT with standard CBT on a sample of 59 Christian adults with depression randomly assigned to one of the two treatment conditions. Participants receiving religious-oriented CBT seemed to improve slightly more than the others, indicating “cautious support for the increased efficacy of CBT adapted to the beliefs of a religious subpopulation” (Propst et al., 1992, p. 101). Johnson and Ridley (1992) compared Christian and secular versions of REBT with 10 depressed clients and reported that both treatments were effective in reducing self-reported depression and negative thoughts, although only the Christian version led to a significant reduction of irrational beliefs. Another study comparing

Christian versus secular REBT with 32 depressed individuals concluded that although both therapies were effective in reducing depression, there were no significant differences between treatment conditions (Johnson, Devries, Ridley, Pettorini, & Peterson, 1994). After reviewing studies that incorporated the use of R/S-oriented CBT with older adults, Paukert et al. (2009) suggested that clinicians should consider integrating R/S into psychotherapy for older adults with depression or anxiety. Other studies evaluated the effects of religious versus standard CBT on generosity (Pearce, Koenig, Robbins, Daher et al. 2015) and optimism (Koenig, Pearce, Nelson, & Daher, 2015) on persons with major depression and medical illness. Both studies demonstrated positive changes in the targeted variables. However, the researchers found no significant differences between the religious and standard forms of CBT. In both studies the authors indicated that higher religiosity at baseline predicted an increase of both generosity and optimism regardless of treatment conditions. Other studies have reported benefits in the use of R/S CBT for anxiety (Barrera, Zeno, Bush, Barber, & Stanley, 2012; Ramos, Barrera, & Stanley, 2014; Razali, Aminah, & Khan, 2002). Although the evidence for the efficacy of R/S CBT with severe mental illness is scant, Tabak and Weisman de Mamani (2014) suggested that cognitive restructuring perhaps could be useful in addressing meaning-making and improving the quality of life in patients with schizophrenia. However, the authors suggested that this would be more applicable to patients in recovery and caution about generalizing to individuals in acute stages of schizophrenia or with severe symptoms. They suggest that more empirical investigation is needed to generate additional evidence.

Other studies have yielded mixed results. For instance, Anderson et al. (2015) reviewed 16 studies that used CBT as the basis for their faith-adapted therapies and concluded that even though they found statistically significant benefits of using faith-adapted therapies, the substantial methodological limitations of the studies pre-empted any firm recommendations about the efficacy of these faith-adapted treatments. Similarly, in a detailed evaluation of the efficacy of R/S therapies for mental health problems such as depression, anxiety, unforgiveness, eating disorders, schizophrenia, alcoholism, anger, and marital issues, Hook et al. (2010) reviewed 28 outcome studies. The studies included cognitive therapy adaptations as well as other treatment modalities, and encompassed various R/S traditions (i.e., Christianity, Islam, Taoism, Buddhism,  $n = 1$  and other forms of generic spirituality). Although the authors concluded that Christian-accommodated cognitive therapy should be viewed as an efficacious treatment for depression, they add that not enough empirical evidence exists to suggest that R/S therapies are superior to comparable secular therapies, and “the decision to use an R/S therapy may be an issue of (a) client preference and (b) therapist comfort” (p. 69). In another systematic review, Lim, Sim, Renjan, Sam., and Quah (2014)

evaluated adapted CBT for religious individuals with depressive disorders, generalized anxiety disorders, and schizophrenia and concluded that there were no differences between the R/S-CBT and standard CBT. The authors state that R/S CBT cannot be considered a well-established intervention for the treatment of the aforementioned disorders.

It is important to note that the current empirical support for R/S-oriented therapies in general and R/S-oriented CBT in particular is limited and underscored with methodological shortcomings. The methodological limitations of the current research seem to cluster around (a) small sample of participants, (b) inconsistent use of random assignment, (c) lack of evidence of the efficacy of the specific R/S components of treatment, (c) few comparisons of R/S versus secular versions of the same theoretical approach, (d) disparities in the implementation of treatments (e.g., manualized vs. non-manualized, fidelity issues, frequency of session, length of treatment), (e) lack of controlling for client demographic variables that could affect outcomes, and (f) publication bias that may ignore studies with nonsignificant findings (Hodge, 2006b; Lim et al., 2014; Smith et al., 2007; Worthington et al., 2011).

Notwithstanding the aforementioned limitations, the available literature suggests that for spiritual clients in general, and Christian clients in particular, R/S CBT seems to be more effective than control conditions, and at least as effective as secular interventions in the treatment of depression (Hook et al., 2010; Koenig, 2012; Pargament et al., 2013b; Rosmarin, Pargament, & Robb, 2010; Tan, 2013). As Lim et al. (2014) pointed out, R/S-oriented CBT has not been found to be inferior to other treatment comparisons and that “incorporating religious dimensions in therapy may be more important for persons with a religious bent” (p. 11). Other authors have discussed the areas of concurrence between CBT and Islam, as well as the efficacious potential of CBT to treat depression in Muslim clients (Beshai, Clark, & Dobson, 2013; Razali et al., 2002; Thomas & Ashraf, 2011). According to Tan (2013), practitioners have also begun to adapt CBT for use with other religious groups, including Jewish, Taoist, and Buddhist clients, and to conduct research to examine the efficacy of these adaptations.

## ***Characteristics of R/S-Oriented CBT***

### ***The therapeutic relationship***

In CBT the therapeutic relationship is defined by the concept of “collaborative empiricism” (J. Beck, 2011). This implies a joint approach to the assessment, exploration, and solution of the problem. During the assessment process the clinician should incorporate questions that help to assess the client’s R/S identification and the role, if any, that R/S may play in how the person copes with stress and adversity. However, the therapist should not assume that if the client professes R/S orientation that R/S interventions

should be automatically integrated in treatment, or if the client is not a R/S person that such interventions should then be discounted (Post & Wade, 2009). Instead, the clinician should explore the client's preference for and openness to the use of R/S interventions in treatment (Hodge, 2011). Tan (2013) suggested, when practicing spiritually oriented CBT, the therapist needs to discern the client's level of interest in these matters, as well as the client's individual beliefs, as these form the foundation of the client's worldview and coping skills. During this process the therapist must be sensitive, respectful, competent, and congruent with the client's cultural, religious and spiritual background. As Wade, Worthington, and Vogel (2007) suggest, the quality of the therapeutic relationship with the R/S client is influenced not so much by the matching of the client-therapist along a R/S commitment, but rather it is the client's perception of the degree of respect shown by the therapist towards the client's R/S, and the therapist's openness to the use of R/S interventions as needed. When working with R/S clients, such an attitude may foster a nonjudgmental, accepting, and understanding atmosphere that increases the probability of positive outcomes. Rosmarin et al. (2010) indicated that spiritually oriented CBT differs from standard CBT in that the rationale for change is presented in the context of the client's spiritual belief system. Therefore, it is not the practitioner's role to determine the validity of the client's spiritual beliefs, but rather to promote mental health in that context (Edwards, 2006; Robb, 2001).

### *Cognitive reframing*

Because the focus of CBT is often on the beliefs, meanings, interpretations, and behaviors of the client, it is important for the therapist to evaluate such beliefs and behaviors against the framework of the client's culture, religion and spiritual background. Doing so allows the culturally competent practitioner to avoid pathologizing beliefs and behaviors that may not be pathological and to tailor interventions that are congruent with the client's culture, R/S (González-Prendes, 2013). Consequently, the exploration of personal meaning is critical in assessing the impact of R/S on a person's life in general as well as on the presenting problem in particular. This personal meaning that the individual attaches to specific events are what CBT calls "automatic thoughts" (J. Beck, 2011; Newman, 2013). It is important to draw a distinction between these automatic thoughts and the more central, fundamental, and absolute core beliefs the person has about the self, others and the world-at-large. For instance, if a person feels depressed because he believes that he has committed a sin by violating a religious precept, the CBT clinician rather than focusing on the validity of the religious precept itself, would want to explore the personal meaning that the client attaches to such action; this meaning is usually imbued with self-deprecatory ("I am a terrible person") or catastrophizing ("I am condemned to eternal damnation") implications. It is

that meaning that can be targeted, evaluated, and reframed in order to engender a healthy course of action and bring relief to the individual. The challenge for the CBT clinician is to not tell the client how they should think, but rather to engage the client in a collaborative dialogue and ask questions that help the client consider various aspects of the issue at hand (e.g., perhaps some that had been previously overlooked) in order to formulate a more balanced perspective. In CBT this is done through the use of what is known as “guided discovery” or “Socratic questioning” (J. Beck, 2011; Newman, 2013). After considering various, and at times opposing, aspects of a problem the therapist may use synthesizing questions (e.g., “On the one hand you have *A* and on the other hand you have *B*. What does that tell you? What do you make of that?”) that invite the client to consider all the identified evidence to reassess and reframe the original interpretation into a more balanced perspective. It has been suggested (Nielsen, 2001; Robb, 2001) that religious doctrines generally include material that can be used in this manner to help the client challenge and reframe their own individual absolutistic evaluations. Nonetheless, we suggest that clinicians must be cautious by carefully differentiating between a client’s core foundational religious beliefs from the more immediate evaluative beliefs (i.e., automatic thoughts), which reflect a more personal and idiosyncratic meaning.

Clients often misinterpret or distort the meaning of events by engaging in the process of “selective abstraction.” In cognitive theory, selective abstraction refers to the process of selectively attending only to elements of one’s experience (e.g., religion) that are congruent with one’s idiosyncratic perspectives, while discounting other elements that are contrary or do not support such perspectives (J. Beck, 2011). DiGiuseppe, Robin, and Dryden (1990) argued that religious clients may selectively focus on teachings or precepts of their religion that support their perspectives and exclude other aspects/teachings of the same religion that may provide a counterbalance. In such cases, Johnson (2001) suggested that the culturally competent and aware clinician may use teachings from the client’s religion to engage the client in “more elegant disputations that attempt to correct doctrinal and/or scriptural misunderstandings” (p. 45). A key point here is that the competent clinician is not arguing against religious doctrine per se, but is attempting to help the client reframe the misunderstanding or misinterpretation of the point in question in order to broaden the client’s perspective and promote a healthier solution.

### ***Behavioral activation***

Behavioral activation is often prescribed by CBT clinicians as an essential element in the treatment of depression (J. Beck, 2011; Greenberger & Padesky, 2016). Behavioral activation serves to counterbalance the depressed client’s tendency towards inertia and inactivity by helping the individual

become engaged in activities that bring pleasure and a sense of purpose and accomplishment. A number of tools such as activity records, activities scheduling, and activities rating can be used to gradually help clients become more active (see Greenberger & Padesky, 2016). Some authors have suggested that behavioral activation can be accommodated to serve the needs of R/S clients with depression. Pearce et al. (Pearce, Koenig, Robins, Nelson et al., 2015) included behavioral activation as an integral aspect of their 10-week R/S-oriented CBT to treat depression in individuals with chronic medical illness. Similarly, Paukert et al. (2009) argued for the inclusion of behavioral activation (i.e., participation in religious activities) in R/S-oriented CBT treatment of geriatric anxiety and depression. However, Paukert and colleagues suggested that the benefits of religious behavioral activation may take place only for those clients who are intrinsically religious and who derive a sense of personal fulfillment from their beliefs, as opposed to individuals who may engage in religious activities as a way of eliciting praise or some other form of external reward. As is the case in standard CBT, the purpose of any intervention should be fully explained to the client and implemented in a collaborative fashion to ensure not only that the client has the physical abilities to engage in the activity, but also that the activity is congruent with the client's culture, religious, and spiritual beliefs. Behavioral activation with R/S clients may include attending religious services, volunteering, and reading sacred texts (Paukert et al., 2009), as well as engaging with supportive persons from the client's religious community (Pearce, Koenig, Robins, Nelson et al., 2015).

Other strategies have been suggested for use with religious and spiritual clients, including gratitude exercises, prayer, and reading of religious texts (Rosmarin et al., 2010; Tan, 2013). Hodge and Bonifas (2010) also suggested encouraging clients to incorporate healthy self-statements into their prayer and meditation exercises outside therapy. For instance, when praying or meditating, clients may incorporate self-statements that underscore unconditional self-acceptance or reinforce their intrinsic worth as human beings in order to counterbalance the client's self-downing tendencies. The challenge for the clinician is to help the client develop self-statements that are congruent with the client's own spiritual, religious, and cultural values. Hodge (2008) presented a three-step model for constructing spiritually modified statements. Because most mainstream therapies are rooted in Western European values that promote individualism, secularism, and self-determination, Hodge suggested that the first step in constructing spiritually sensitive self-statements is to identify the basic concept or message embedded in the statement (i.e., Is the statement promoting assertiveness, self-worth, etc.?). The second step is to assess whether the message is congruent with the client's own values. For instance, messages that promote assertiveness, individualism, or self-determination may not be fully congruent with certain individuals whose cultural, spiritual, or religious values are influenced by a

more collective and egalitarian orientation or who may look to a “higher power” as a source of strength. The third step is to frame the message congruent with the client’s values. Spiritually modified interventions do not necessarily have to be drawn from religious texts, nor do they have to be provided by the practitioner directly. In true collaborative fashion they can be uncovered through a dialectical process, with the therapist engaging clients to articulate their spiritual values (Hodge, 2008).

Next we describe two vignettes that illustrate some of the strategies described previously. The first vignette focuses on a collaborative approach to use the client’s own religious beliefs to help address and reframe self-downing and perfectionistic demands that fueled depression. In the second vignette we illustrate the use of sacred scriptures to promote behavioral activation to counteract the inertia and inactivity in a client with depression.

### *Vignette: The case of John*

John, a 42 year-old, unemployed, self-described religious man with obsessive-compulsive personality disorder traits, came to therapy to address his depressed mood, which seemed rooted in rigid perfectionistic demands that he placed upon himself. The problem was that when John failed to live up to his own rigid perfectionistic expectations, he would condemn himself and label himself as a failure in the eyes of both his family and God. This intense self-downing would not only engender a depressed mood, but would also result in John feeling high anxiety at the prospect of “failure,” which to him was anything short of being “perfect.” Using John’s own strong religious beliefs, the therapist suggested that John identify passages in the Bible where the imperfection of humans was apparent and where there was evidence of forgiveness of such imperfections. This provided John with food for therapy and put a chink in John’s perfectionistic armor. However, he continued to struggle with issues of self-deprecation whenever he failed to be perfect. The therapist then explored John’s concept of God. John described a compassionate and loving being who embodied total perfection. Using a Socratic line of questioning, the therapist helped shift the focus to helping John see the incongruence that existed between his concept of God as the one and only totally perfect being, and his own self-demands for perfection. Through this process John confronted ideas such as:

If God is the only true perfect being, wasn’t he [John], whenever he put himself down for making a mistake and not being perfect, in fact demanding perfection of himself? And, if he was demanding perfection of himself, and God was the only true perfect being according to John, wasn’t John indeed demanding to be God-like?

As John worked on this issue in subsequent visits, he began to see the irrationality of his demanding perspective, reframe his original self-views,

and eventually begin to accept himself as an imperfect and fallible human being.

In the case of John, the therapist was not a particularly religious person, but he was open to and accepting of John's religious views. Instead of confronting such views as detrimental, he was able to explore John's perspectives, using a collaborative approach to form the basis for a cognitive reframing that was congruent with John's religious beliefs.

John also derived a strong sense of purpose and meaning from providing for his family (a collective orientation); consequently messages that promoted self-worth through individual achievements would not be congruent with his values. Instead, John and his therapist were able to construct messages that underscored his value and contributions to his family, even though he remained unemployed. These messages allowed John to begin to regain a sense of meaning and purpose in his life. Consequently his mood began to lift and he adopted a more proactive approach to address his unemployment situation, which was eventually resolved.

### *Vignette: The case of Mary*

Another example is the case of Mary, who was referred to treatment due to depression. Mary considered herself a religious person who believed that God would help her overcome her state of depression. When asked what she did to combat depression she indicated that she "prayed about it." Meanwhile, the depression kept her mired in inactivity, which in turn exacerbated her mood. Knowing that behavioral activation is a recommended CBT strategy to counteract depression, the therapist's challenge was how to motivate Mary to take a more proactive approach (vs. solely relying on divine intervention), within the context of her R/S beliefs, to help herself overcome her depression. The therapist recognized that for Mary to change her current behavior and inactivity she would need to modify her perspective that praying about it would help lift her depression. The therapist's task was not to challenge Mary's foundational belief in the power of prayer, but rather to supplement her praying with increased purposeful activity. In this case the therapist searched for religious texts that promoted "initiative" and "action" and presented them to Mary. The introduction of this religious material was preceded by seeking permission from Mary to do so. The therapist asked Mary, "Is it okay with you if we look at some readings from the scriptures that may be appropriate to what you are going through?" This request had the intent of eliciting Mary's input in a collaborative fashion and respect for Mary's wishes to include (or not) religious text into treatment. Mary agreed, and two religious-based statements from the New Testament were introduced:

But be doers of the word and not hearers only ... for if any be a hearer of the word, not a doer, he is like unto a man beholding his natural face in the a mirror ... and

goes away and forgets what kind of man he was...but a doer of the work, this man shall be blessed in his deed. (1 James, 22–25)

My children let us not love in word, neither in tongue; but in deeds and in truth. (3 John, 18)

Using a Socratic approach, the therapist helped Mary to identify and reflect upon the underlying messages of taking initiative and action presented in these statements and the meaning that she derived from them. This helped Mary to gradually modify her perspective from passively waiting for God to resolve her problem to taking more direct action to help herself. The next task was to work collaboratively with Mary to identify meaningful behavioral activities congruent with her religious views. Mary decided to start by attending Bible studies once a week on Wednesday evenings. This led to increased social interactions with and support from members of her religious community and eventually led her to volunteer to help in her church on Sundays. The therapist encouraged Mary to use activities scheduling and rating forms (Greenberger & Padesky, 2016) in order to monitor, rate, and process her activities in terms of the sense of purpose, fulfillment, and gratitude that she derived from them. Gradually her behavioral activities increased counteracting the inactivity of her depression and she began to feel better.

As illustrated in the cases of John and Mary, when practicing within a CBT framework, the goal is to help clients to challenge and reframe maladaptive beliefs that are fueling debilitating emotions and behaviors, and become more proactive in helping themselves improve their moods. Moreover, when working within a religious or spiritual framework, the practitioner's task is not to resolve spiritual or theological issues, but rather it is to help the client develop the cognitive and behavioral skills to either eliminate or learn to manage the problem effectively. It has been suggested that, if the therapist feels compelled to consult with clergy about the client's R/S concerns, the client's permission should be sought (Hodge & Bonifas, 2010; Plante, 2013). Furthermore, if the presenting issue seems to be primarily spiritual, the therapist should consider a referral to clergy.

## **Mindfulness**

Mindfulness practice represents another avenue by which R/S can be introduced into the practice of psychotherapy in general, and CBT in particular. An oft-quoted definition offered by Kabat-Zinn (2011) states that mindfulness is a present state of awareness that develops from "paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally" (p. 291). Keng, Smoski, and Robins (2011) went on to emphasize that this nonjudgmental approach is accompanied by an equally important element of acceptance. Keng et al. (2011) underscored that

acceptance, far from a passive state, represents the full experience of the moment, without extreme responses such as preoccupation with or suppression of the experience. Sherman and Siporin (2008) indicated that mindfulness can be viewed as both a specific practice and a general way of being. As a therapeutic technique, mindfulness has certain expected results (e.g., reduction in symptoms of depression); while as a way of being it is more a philosophical approach to life, unattached to expectations (Gause & Coholic, 2010).

The concept of mindfulness was introduced to Western clinical practice by Jon Kabat-Zinn, who founded the Mindfulness-Based Stress Reduction (MBSR) Clinic at the University of Massachusetts Medical Center in 1979 (Bergemann, Siegel, Belzer, Siegel, & Feuille, 2013; Kabat-Zinn, 2011). Influenced by the work of Kabat-Zinn, Segal and his colleagues (2013) subsequently developed MBCT as a strategy to help reduce the risk of relapse for individuals suffering from depression. Although MBCT is not outwardly spiritual, and the treatment manual contains no references to R/S, the meditative aspects integral to MBCT draw from Eastern spiritual traditions such as Buddhism. Hathaway and Tan (2009) drew a distinction between R/S-modified standard CBT and MBCT. They explained this by stating that, “the accommodative forms of CBT emerged as an iteration of standard secular treatments [whereas] ... the mindfulness-based strategies emerged from spiritual and religious soil” (p. 160).

Mindfulness, a form of meditation, has often been associated with spirituality and spiritual development (Carmody et al., 2008; Hathaway & Tan, 2009; Leigh et al., 2005). Meditation is an important aspect of many religious practices. At the same time, from a nonreligious perspective, meditation has been suggested as a tool to promote spiritual and existential growth (Marlatt & Kristeller, 1999). According to Marlatt and Kristeller: “To the extent that spiritual experience is a universal human capacity, meditation has been proposed and experienced by many, as a way to cultivate a sense of inner calm, harmony and transcendence often associated with spiritual growth” (p. 74). In the 1990s, the field of CBT began to see an increase in the popularity of mindfulness meditation and acceptance as critical factors in psychotherapy. The therapeutic uses of “mindfulness meditation” and “radical acceptance” have garnered significant interest leading to an increase in the number of research studies evaluating the effectiveness of these interventions for a variety of issues. Shonin, Van Gordon, and Griffiths (2014) indicated that research on the use of mindfulness to treat a wide range of issues including depression, anxiety, substance use, chronic pain, and cancer, among others has increased from 10 papers published in 2002 to 500 scientific papers published in 2012.

### ***Mindfulness practice with religious and/or spiritual clients***

Despite being secular in nature, therapies such as MBCT offer increased opportunities to incorporate R/S into therapy. With roots in Buddhism, mindfulness-based techniques seem to be a natural fit for clients from Eastern religious traditions (Hathaway & Tan, 2009). Mindfulness can also be appropriate for clients from Western religions. Although there is a misconception among some that meditation is in some way contraindicated for Christians and/or individuals from other religious groups, it is possible for clients of varying religious persuasions to practice Buddhist-derived techniques without identifying as Buddhist (Hathaway & Tan, 2009). As Bergemann et al. explained:

Secularization of many core Buddhist practices is possible because of the non-theistic orientation of Buddhism in which little emphasis is given to endorsement of an abstract creed. It is highly possible to practice Buddhist-derived meditation and subscribe to the psychological view from this perspective while maintaining one's beliefs and membership in other religious traditions, or in no religious tradition at all. (p. 208)

Beside Buddhism, contemplative practice is also encouraged in other traditions such as monastic Christianity, Judaism, Sufi Islam, and Confucianism (Sherman & Siporin, 2008).

As Symington and Symington (2012) suggested, for clients who wish to incorporate spirituality into therapy, mindfulness can easily be adapted to include spiritual values such as “attuning to God’s presence and appreciating the sacredness of the present moment” (p. 76). Writing from a Christian perspective, Symington and Symington (2012) suggested that mindfulness can be used to help clients become more aware of miracles in ordinary life, and to focus on one’s values, even in the midst of hardship. Also from a Christian perspective, Tan (2011) recommended thinking of mindfulness as releasing one’s thoughts to God, rather than passively letting them go. Self-acceptance in mindfulness can be connected to God’s unconditional acceptance, both in Christianity and other religious traditions (Hathaway & Tan, 2009).

Knabb (2012) suggested that mindfulness has some similarities with centering prayer, which is drawn from Catholicism. In centering prayer, the individual sits quietly and repeats a word or phrase in the mind such as “love” or “God.” This helps the individual to connect with the sacred by facilitating an experiential rather than intellectual knowing of God. As in mindfulness, centering prayer encourages the individual to shift attention from negative cognitions, in order to attend to one’s present experience nonjudgmentally. However, the purpose of centering prayer is connecting with God’s presence, rather than mood regulation. According to Knabb (2012), despite this difference, the benefits of centering prayer may be similar

to the benefits of MBCT in preventing depressive relapse. The author claimed that centering prayer may be preferred to MBCT by some Christian clients; however, he also noted the need for systematic research to determine the effectiveness of centering prayer as a psychotherapeutic alternative for treating chronic depression.

Another perspective is offered by Mirdal (2012), who connected the practice of mindfulness to Islamic mysticism. He specifically drew on the work of Rumi, an Islamic theologian, mystic, and poet, underscoring:

Acceptance and acknowledgement of both positive and negative experiences; unlearning of old habits and looking at the world with new eyes; decentering, changing one's focus from Self to Other; and attunement of body and mind through mediation, music and dance" (Mirdal, 2012, p. 1206)

Mirdal went on to highlight the apparent commonalities between these teachings and mindfulness practice, and encouraged therapists to cultivate a curiosity for clients' non-Western spiritual experiences.

### ***Mindfulness and spirituality***

A number of studies have suggested a positive relationship between mindfulness and spirituality (Carmody et al., 2008; Chiesa & Serretti, 2009; Daniels & Fitzpatrick, 2013; Greeson et al., 2011; Watmough, 2013). Chiesa and Serretti (2009) conducted a meta-analytic review of 10 studies that evaluated the impact of MBSR on healthy people and concluded that, despite methodological limitations (i.e., small samples, nonrandomization, and self-selection) the results suggested that MBSR was effective in reducing stress and enhancing spirituality, compared to waitlist and inactive controls. In another study, Carmody et al. (2008) evaluated 44 adults to ascertain whether participation in the MBSR program was associated with increases in mindfulness and spirituality, and to examine the associations between mindfulness, spirituality, and medical and psychological symptoms. The authors reported that there were significant improvements in spirituality, state and trait mindfulness, psychological distress, and reported medical symptoms. Moreover, the authors also found that increases in mindfulness were associated with increased spirituality. They concluded that, "spiritual well-being, particularly the cultivation of a sense of inner meaning and peace, may occur as a function of mindfulness meditation, even when presented entirely within a secular context" (pp. 401–402).

Gause and Coholic (2010) offered further evidence that mindfulness has the potential to enhance spirituality. Reporting on their study of a mindfulness group for women designed to improve self-awareness and self-esteem, the authors noted that spiritual discussions emerged naturally. Moreover, group members indicated that they were able to use mindfulness time to

connect with a “higher power” or “the universe” (p. 13). Reporting on further individual discussions with the participants, the authors stated that some expressed how mindfulness could promote a deeper sense of spirituality, including greater awareness of the purpose and goals of life. Though these examples are anecdotal, they suggest that mindfulness-based interventions can create the space necessary for clients to find meaning in their experiences (McCown, 2013). In many of these instances there are recurrent themes that underscore what spirituality means to the participants: a deeper sense of self-awareness or insight, increased compassion, inner peace and calmness, interconnectedness with others, a connection with a transcendent entity (i.e., God, nature, etc.), and a sense of purpose and meaning.

### ***Towards a more holistic view of mindfulness***

Although mindfulness has its roots in Buddhist spirituality, in psychotherapy mindfulness it is most often used as a secular technique (Falb & Pargament, 2012; Gause & Coholic, 2010). This is because mindfulness was intentionally separated from its spiritual roots to make it accessible to people of any religious or spiritual persuasion (Gause & Coholic, 2010; Kabat-Zinn, 2011). When developing MBSR, Kabat-Zinn (2011) sought to preserve the fundamentals of Buddhist teachings, but was cautious not to present his ideas in overly spiritual terms. He wanted to avoid MBSR being perceived as “Buddhist, New Age, Eastern Mysticism, or just plain flakey” (p. 282). He wrote, “To my mind this was a constant and serious risk that would have undermined our attempts to present it as commonsensical, evidence-based, and ordinary, and ultimately a legitimate element of mainstream medical care” (p. 282). A similar theme has emerged in the development of CBT and other psychotherapies: in order to be accepted as scientific, spiritual connotations have largely been avoided.

Ironically, some have suggested that the spiritual potential of mindfulness is actually part of its popularity (Rosmarin et al., 2010). Even if it is not presented in an overtly spiritual way in therapy, mindfulness still has a spiritual flavor to it. Sherman and Siporin (2008) explained:

Beyond the instrumental and pragmatic value of mindfulness training and practice there is the spiritual potential. Clearing the mind of all cognitive and affective content and attuning it to the consciousness that is in and around us can be spiritual and transcendent. (p. 268)

In fact, mindfulness may be more effective as a therapy technique if this spiritual potential is realized (Falb & Pargament, 2012; Weber & Pargament, 2014). Dimidjian and Linehan (as cited in Gause & Coholic, 2010, p. 8) agreed, stating that, “something is lost in the separation of mindfulness from its spiritual roots.” Similarly, Nilsson (2014) advocated for a holistic view of

mindfulness that incorporates its physical, mental, social, and existential aspects. He contended that health and well-being are best promoted through the integration of all these aspects (Nilsson, 2014). Taking a broader view of mindfulness as a holistic philosophy promotes integration on a deeper level, and sets the stage for life-long practice (Gause & Coholic, 2010).

Many CBT practitioners are familiar with mindfulness techniques and already use them in therapy. These same practitioners should also be interested in incorporating R/S into therapy when this is of therapeutic benefit to the client. Mindfulness is one way to incorporate R/S into therapy that is nonsectarian, adaptable, and has already been established as an evidence-based practice for a variety of issues.

## **Practice implications and future directions**

### ***Practice implications***

Practitioners need to be aware that the current research on the efficacy of R/S-oriented therapies in general and R/S-oriented CBT in particular is limited, underscored with methodological shortcomings, and has yielded mixed results. Given this, practitioners should be cautious when drawing conclusions from and generalizing the research findings to practice situations. Most of this research has focused on testing the use of R/S CBT with depression. Some studies looking at R/S CBT for anxiety have shown some promise, but these are few and more research is needed to establish the empirical basis of R/S CBT for anxiety. Very little work has been done on the use of R/S CBT with severe mental illness (i.e., schizophrenia). Practitioners should take note of Weisman de Mamani et al.'s (2009) call for caution when incorporating R/S themes with patients with active delusions as there is the risk that doing so may exacerbate delusional beliefs, increase symptom severity and reduce functional levels.

Nonetheless, some themes emerge from the research evidence with implications for practitioners on the use of R/S CBT for mental health treatment. The available evidence suggests: (a) R/S-CBT is efficacious for R/S clients particularly those with intrinsic religiosity; and (b) R/S CBT is more effective than control conditions, and at least as effective as secular interventions in the treatment of depression. Most of the R/S CBT treatments follow the traditional CBT models of Beck's cognitive therapy (see J. Beck, 2011) or Ellis' rational-emotive behavior therapy (see Dryden, DiGiuseppe, & Neena, 2010) with adaptations to conform to the clients' R/S background. Throughout this discussion we have suggested ways to integrate CBT strategies (i.e., Socratic questions, cognitive reframing, self-statements, and behavioral activation) to help address R/S concerns presented by clients. However, practitioners wanting to incorporate R/S into their practice may also want to review R/S CBT

models that have been developed for anxiety (Barrera et al., 2012; Ramos et al., 2014) and depression (Pearce, Koenig, Robins, Daher et al., 2015).

Another significant practice implication that emerges from the current literature is the importance of conducting a R/S history during the initial assessment (Hays, 2006; Ivey et al., 2012; Koenig, 2012). From a CBT perspective, this initial assessment should include questions to evaluate the importance or meaning of R/S in the person's life, and to determine whether there may be R/S explanations for the client's beliefs or behaviors. For example, the CBT practitioner may want to ask about R/S messages that the person has internalized in order to get a clearer idea as to whether those messages promote well-being or distress. This information would be useful when formulating a cognitive-behavioral conceptualization of the presenting problem. In collaboration with the client, the practitioner can then determine whether these factors need to be integrated into a comprehensive treatment plan.

On a more general perspective, there are matters of ethical issues and cultural competence that practitioners should consider when working with R/S clients. CBT is rooted in a collaborative approach and this collaboration becomes more critical when working with R/S clients. The decision to incorporate R/S strategies into the treatment should come from the client. Although CBT practitioners may help their clients weigh the pros and cons of such interventions, the ultimate decision is the client's. Consequently, practitioners need to be cognizant to not impose their personal views on clients, or of dismissing clients' concerns because they are not congruent with the practitioner's beliefs. CBT practitioners should be aware of their own beliefs and values and the possible preferences and biases inherent in those values. Given the importance of meaning-making in CBT, in order to gain a more accurate perspective of the meaning clients attach to events in their lives, practitioners should strive to evaluate the clients' presenting issue against the framework of client's R/S beliefs. Although Plante (2013) suggested that practitioners should have a basic working knowledge of the religious groups related to the clients they work with in practice, a theme that emerged out of the current literature is that the religiosity of the practitioner did not seem to have an effect on the outcomes of therapy, and that the lack of religiosity in the practitioner is not necessarily a barrier in delivering religious treatment models (Propst et al., 1992). For instance, Hook et al. (2010) indicated that nonreligious therapists were effective at delivering Christian accommodative cognitive therapy. Nonetheless, practitioners should recognize that all clients have different lived experiences, and even clients from the same religious group may have very different beliefs and consequently attach different meaning to their lived experiences (Tan, 2013). Lastly, if a practitioner cannot adequately address a client's concerns because of a conflict in beliefs and/or values, then again, a referral should be considered (Hodge, 2006a).

### **Future directions**

The literature clearly shows that there is a need for more empirically controlled studies evaluating the efficacy of traditional R/S CBT and MBCT for R/S-oriented clients. We suggest that this needs to happen along two lines of inquiry: (a) explore how effective are various CBT strategies in addressing and reframing the R/S views that may contribute to emotional or behavioral dysfunction; and (b) what might be the specific treatment variables and client characteristics (i.e., gender, age, race, culture, etc.) that may contribute to a more favorable prognosis when using CBT with R/S individuals. Furthermore, contributing to the current state of the relationship between psychotherapy and spirituality is the fact that spiritual therapy techniques are, by nature, difficult to study (Gause & Coholic, 2010). Variables such as spirituality and mindfulness are experiential and deeply personal, so they are difficult to operationalize in the context of a research study (Gause & Coholic, 2010; Shonin et al., 2014). Also, studies have typically relied on self-report measures, making them more prone to participant bias. When it comes to mindfulness many studies are not well-controlled, making it difficult to isolate the effects of mindfulness from other variables. Also discrepancies between the levels of experience among mindfulness instructors could impact the external validity of the research (Shonin et al., 2014).

Nonetheless, so far, studies have suggested that spiritually modified CBT is an effective intervention for Christians with depression; however, research with other populations is scant at best. Consequently, future researchers will need to examine not only the effectiveness of specific spiritual interventions, but also the effectiveness of such interventions with racial, ethnic, cultural and other diverse populations.

The need for better training on how practitioners can incorporate R/S CBT into therapy is also an important issue. Studies have shown that most clinicians receive very little training in how to incorporate R/S into their practice (Hodge, 2006a). So given the importance of R/S in people's lives, it is important for social workers, psychologists, counselors and other mental-health professionals to receive formal training in this area, so they are better prepared to address their clients' R/S concerns relative to mental health; this is "a real need and serious challenge" to the mental health field (Tan, 2013, p. 183). For instance, Hathaway (2013) recommends systematic training addressing the relationship between R/S and mental health, and suggests that, at the very least, R/S be incorporated into graduate courses on cultural competency. More specifically, given the aforementioned discussion of CBT and religion/spirituality, individuals training in CBT would benefit from recognizing the role that R/S beliefs play in the coping processes and overall mental health of individuals.

## Conclusion

R/S are highly prevalent among clients, and play an important role in health and well-being. They are salient issues for CBT practitioners, and present both an ethical challenge and an opportunity for growth. Historically, there have been tensions between CBT and R/S because of the emphasis that CBT places on rationality, empiricism, and the scientific method. Nonetheless, CBT, with its focus on clients' beliefs, meanings, and practices seems to be well-positioned to work with religious and/or spiritual individuals. Recent developments in R/S-oriented CBT have shown potential for increasing cultural competency by tailoring interventions to fit clients' spiritual beliefs and worldviews. We suggest that a hallmark of culturally competent practitioners is that they strive to tailor their interventions to fit the client's cultural background, which includes their religious beliefs (González-Prendes, 2013; Griner & Smith, 2006) and that R/S-oriented CBT is one way that practitioners can address the therapeutic concerns of clients who identify with R/S. At the same time, mindfulness-based cognitive therapy has added a new dimension to traditional CBT. Although mindfulness has been separated from its spiritual roots to make it accessible to a wide variety of clients, it is important to consider the spiritual potential of mindfulness and how this can be further developed as a way to incorporate spirituality in an open and accepting manner. Ultimately, integrating R/S CBT in the treatment of clients who are open to it can make therapy more effective by increasing client buy-in and by drawing on existing strengths (Hathaway, 2013; Hodge, 2008).

## References

- American Counseling Association. (2015). *Association for Spiritual, Ethical and Religious Values in Counseling*. Retrieved from [www.aservic.org](http://www.aservic.org)
- American Psychological Association. (2014). *Division 36: Society for the Psychology of Religion and Spirituality*. Retrieved from <http://www.apa.org/about/division/div36.aspx>
- Anderson, N., Heywood-Everett, S., Siddiqi, N., Wright, J., Meredith, J., & McMillan, D. (2015). Faith-adapted psychological therapies for depression and anxiety: Systematic review and meta-analysis. *Journal of Affective Disorders, 176*, 183–196. doi:10.1016/j.jad.2015.01.019.
- Barrera, T., Zeno, D., Bush, A. L., Barber, C. R., & Stanley, M. A. (2012). Integrating religion and spirituality into treatment for late-life anxiety: Three case studies. *Cognitive and Behavioral Practice, 19*(2), 346–358. doi:10.1016/j.cbpra.2011.05.007
- Beck, A. T. (1976). *Cognitive therapy of the emotional disorders*. New York, NY: International University Press.
- Beck, J. (2011). *Cognitive Behavioral Therapy: Basics and beyond* (2nd ed.). New York, NY: Guilford Press.
- Bergemann, E. R., Siegel, M. W., Belzer, M. G., Siegel, D. J., & Feuille, M. (2013). Mindful awareness, spirituality, and psychotherapy. In K. I. Pargament, A. Mahoney, & E. P. Shafranske (Eds.), *APA handbook of psychology, religion, and spirituality (Vol. 2): An*

- applied psychology of religion and spirituality* (pp. 207–222). Washington, DC: American Psychological Association.
- Beshai, S., Clark, C. M., & Dobson, K. S. (2013). Conceptual and pragmatic considerations in the use of cognitive-behavioral therapy with Muslim clients. *Cognitive Therapy and Research*, 37(1), 197–206. doi:10.1007/s10608-012-9450-y
- Birnbaum, L., & Birnbaum, A. (2008). Mindful social work: From theory to practice. *Journal of Religion and Spirituality in Social Work: Social Thought*, 27(1/2), 87–104. doi:10.1080/15426430802113913
- Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-behavioral therapy: A review of meta-analyses. *Clinical Psychology Review*, 26(1), 17–31. doi:10.1016/j.cpr.2005.07.003
- Carmody, J., Reed, G., Kristeller, J., & Merriam, P. (2008). Mindfulness, spirituality, and health-related symptoms. *Journal of Psychosomatic Research*, 64(4), 393–403. doi:10.1016/j.jpsychores.2007.06.015
- Center for Workforce Studies. (2010). *2008 APA survey of psychology health service providers*. Washington, DC: American Psychological Association.
- Chiesa, A., & Serretti, A. (2009). Mindfulness-based stress reduction for stress management in health people: A review and meta-analysis. *The Journal of Alternative and Complementary Medicine*, 15(5), 593–600. doi:10.1089/acm.2008.0495
- Chu, B. C., & Harrison, T. L. (2007). Disorder-specific effects of CBT for anxious and depressed youth: A meta-analysis of candidate mediators of change. *Clinical Child and Family Psychology Review*, 10(4), 352–372. doi:10.1007/s10567-007-0028-2.
- Contrada, R. J., Goyal, T. M., Cather, C., Rafalson, L., Idler, E. L., & Krause, T. J. (2004). Psychosocial factors in outcomes of heart surgery: The impact of religious involvement and depressive symptoms. *Health Psychology*, 23(3), 227–238. doi:10.1037/0278-6133.23.3.227.
- Council on Social Work Education. (2014). *Religion and spirituality clearinghouse*. Retrieved from <http://www.cswe.org/CentersInitiatives/CurriculumResources/50777.aspx>
- Curlin, F. A., Odell, S. V., Lawrence, R. E., Chin, M. H., Lantos, J. D., Meador, K. G., & Koenig, H. G. (2007). The relationship between psychiatry and religion among U.S. physicians. *Psychiatric Services*, 58(9), 1193–1198. doi:10.1176/ps.2007.58.9.1193
- Daniels, C., & Fitzpatrick, M. (2013). Integrating spirituality into counselling and psychotherapy: Theoretical and clinical perspectives. *Canadian Journal of Counselling and Psychotherapy*, 47(3), 315–341.
- DiGiuseppe, R., Robin, M. W., & Dryden, W. (1990). Rational-emotive therapy and the Judeo-Christian tradition: A focus on clinical strategies. *Journal of Cognitive Psychotherapy: An international Quarterly*, 4(4), 355–368.
- Dryden, W., DiGiuseppe, R., & Neena, M. (2010). *Primer on rational-emotive behavior therapy*. Champaign, IL: Research Press.
- Dwyer, M. (2010). Religion, spirituality, and social work: A quantitative and qualitative study on the behaviors of social workers conducting individual therapy. *Smith College Studies in Social Work*, 80(2), 139–158. doi:10.1080/00377317.2010.486359
- Edwards, A. (2006). Cognitive and cognitive-behavioral therapy with religiously oriented clients: Two case studies. *Social Work & Christianity*, 33(1), 36–57.
- Ellis, A. (1962). *Reason and emotion in psychotherapy*. New York, NY: Citadel Press.
- Ellis, A. (1980). *The case against religion: A psychotherapist's view and the case against religiosity*. Austin, TX: American Atheist Press.
- Ellis, A. (2000). Can rational-emotive behavior therapy (REBT) be effectively used with people who have devout beliefs in God and religion? *Professional Psychology: Research and Practice*, 31, 29–33. doi:10.1037/0735-7028.31.1.29

- Falb, M. D., & Pargament, K. I. (2012). Relational mindfulness, spirituality, and the therapeutic bond. *Asian Journal of Psychiatry*, 5(4), 351–354. doi:10.1016/j.ajp.2012.07.008
- Gause, R., & Coholic, D. (2010). Mindfulness-based practices as a holistic philosophy and method. *Currents*, 9(2), 1–23.
- González-PrenDES, A. A. (2013). Culture sensitive regulation of anger. In E. Fernández (Ed.), *Treatments for anger in specific populations: Theory, application, and outcome* (pp. 236–254). New York, NY: Oxford University Press.
- Greenberger, D., & Padesky, C. A. (2016). *Mind over mood: Change the way you feel by changing the way you think* (2nd ed.). New York, NY: Guilford Press.
- Greeson, J. M., Webber, D. M., Smoski, M. J., Brantley, J. G., Ekblad, A. G., Suarez, E. C., & Wolever, R. (2011). Changes in spirituality partly explain health-related quality of life outcomes after mindfulness-based stress reduction. *Journal of Behavioral Medicine*, 34(6), 508–518. doi:10.1007/s10865-011-9332-x
- Griner, D., & Smith, T. B. (2006). Culturally adapted mental health interventions: A meta-analytic review. *Psychotherapy: Theory, Research, Practice, Training*, 43(4), 531–548. doi:10.1037/0033-3204.43.4.531
- Gross, N., & Simmons, S. (2009). The religiosity of American college and university professors. *Sociology of Religion*, 70(2), 101–129. doi:10.1093/socrel/srp026
- Hathaway, W. (2013). Pathways toward graduate training in the clinical psychology of religion and spirituality: A spiritual competencies model. In K. I. Pargament, A. Mahoney, & E. P. Shafranske (Eds.), *APA handbook of psychology, religion, and spirituality: Volume II* (pp. 635–649). Washington, DC: APA.
- Hathaway, W., & Tan, E. (2009). Religiously oriented mindfulness-based cognitive therapy. *Journal of Clinical Psychology*, 65(2), 158–171. doi:10.1002/jclp.v65:2
- Hays, P. A. (2006). Developing culturally responsive cognitive-behavioral therapies. In P. A. Hays, & G. Y. Iwamasa (Eds.), *Culturally-responsive cognitive-behavioral therapy: Assessment, practice, and supervision* (pp. 3–19). Washington, DC: American Psychological Association.
- Hays, P. A. (2008). *Addressing cultural complexities in practice: Assessment, diagnosis, and therapy*. Washington, DC: American Psychological Association.
- Hill, T. D., Angel, J. L., Ellison, C. G., & Angel, R. J. (2005). *Journal of Gerontology: Social Sciences*, 60B(2), S102–S109. doi:10.1093/geronb/60.2.S102
- Hill, T. D., Burdette, A. M., Angel, J. L., & Angel, R. J. (2006). Religious attendance and cognitive functioning among older Mexican-Americans. *Journal of Gerontology: Psychological Sciences*, 61B(1), P3–P9. doi:10.1093/geronb/61.1.P3
- Hodge, D. (2011). Using spiritual interventions in practice: Developing Some Guidelines from evidence-based practice. *Social Work*, 56(2), 149–158. doi:10.1093/sw/56.2.149
- Hodge, D. R. (2006a). A template for spiritual assessment: A review of the JCAHO requirements and guidelines for implementation. *Social Work*, 51(4), 317–326. doi:10.1093/sw/51.4.317
- Hodge, D. R. (2006b). Spiritually-modified cognitive therapy: A review of the literature. *Social Work*, 15(2), 157–166. doi:10.1093/sw/51.2.157
- Hodge, D. R. (2008). Constructing spiritually-modified interventions: Cognitive therapy with diverse populations. *International Social Work*, 51(2), 178–192. doi:10.1177/0020872807085857
- Hodge, D. R., & Bonifas, R. P. (2010). Using spiritually-modified cognitive behavioral therapy to help clients wrestling with depression: A promising intervention for some older adults. *Journal of Religion & Spirituality in Social Work*, 29(3), 185–206. doi:10.1080/15426432.2010.495598

- Hofmann, S. G., Asnaani, A., Vonk, I. J. J., Sawyer, A. T., & Fang, A. (2012). The efficacy of cognitive behavioral therapy: A review of meta-analyses. *Cognitive Therapy and Research*, 36, 427–440. doi:10.1007/s10608-012-9476-1
- Hook, J. N., Worthington, E. L., Jr., Davis, D. E., Jennings, D. J., II, Gartner, A. L., & Hook, J. P. (2010). Empirically supported religious and spiritual therapies. *Journal of Clinical Psychology*, 66, 46–72.
- International Congress of Cognitive Psychotherapy. (2005). *A meeting of the minds*. Retrieved from <http://www.tpccpg.com/beck/MeetingOfTheMinds.html>
- Ironson, G., Stuetzle, R., & Fletcher, M. A. (2006). An increase in religiousness and spirituality occurs after HIV diagnosis and predicts slower disease progression over 4 years in people with HIV. *Journal of General Internal Medicine*, 21, S62–S68. doi:10.1111/j.1525-1497.2006.00648.x
- Ivey, A. E., D'Andrea, M. J., & Ivey, M. B. (2012). *Theories of counseling and psychotherapy: A multicultural perspective*. Thousand Oaks, CA: Sage.
- Johnson, W. B. (2001). To dispute or not to dispute: Ethical REBT with religious clients. *Cognitive and Behavioral Practice*, 8(1), 39–47. doi:10.1016/S1077-7229(01)80042-0
- Johnson, W. B., Devries, R., Ridley, C. R., Pettorini, D., & Peterson, D. R. (1994). The comparative efficacy of Christian and secular rational-emotive therapy with Christian clients. *Journal of Psychology and Theology*, 22(2), 130–140.
- Johnson, W. B., & Ridley, C. R. (1992). Brief Christian and non-Christian rational-emotive therapy with depressed Christian clients: An exploratory study. *Counseling and Values*, 36, 220–229. doi:10.1002/cvj.1992.36.issue-3
- Kabat-Zinn, J. (2011). Some reflections on the origins of MBSR, skillful means, and the trouble with maps. *Contemporary Buddhism*, 12(1), 281–306. doi:10.1080/14639947.2011.564844
- Kar, N. (2011). Cognitive behavioral therapy for the treatment of post-traumatic stress disorder: A review. *Neuropsychiatric Disease and Treatment*, 7, 167–181. doi:10.2147/NDT.S10389.
- Keng, S. L., Smoski, M. J., & Robins, C. J. (2011). Effects of mindfulness on psychological health: A review of empirical studies. *Clinical Psychology Review*, 31(6), 1041–1056. doi:10.1016/j.cpr.2011.04.006.
- Knabb, J. J. (2012). Centering prayer as an alternative to mindfulness-based cognitive therapy for depression relapse prevention. *Journal of Religion and Health*, 51(3), 908–924. doi:10.1007/s10943-010-9404-1
- Koenig, H. G. (2012). Religion, spirituality, and health: The research and clinical implications. *International Scholarly Research Network*, 2012, 1–33. doi:10.5402/2012/278730.
- Koenig, H. G., McCullough, M. F., & Larson, D. B. (2001). *Handbook of Religion and Health*. New York, NY: Oxford University Press.
- Koenig, H. G., Pearce, M. J., Nelson, B., & Daher, N. (2015). Effects of religious versus standard cognitive-behavioral therapy on optimism in persons with major depression and chronic medical illness. *Depression and Anxiety*, 32, 835–842. doi:10.1002/da.22398.
- la Cour, P., Avlund, K., & Schultz-Larsen, K. (2006). Religion and survival in a secular region. A twenty year follow-up of 734 Danish adults born in 1914. *Social Science and Medicine*, 62, 157–164. doi:10.1016/j.socscimed.2005.05.029
- Lama, D. (2014). Symposium: Pursuit of happiness in interreligious perspective: Happiness from the Buddhist perspective. *Journal of Law and Religion*, 29(1), 5–13. doi:10.1017/jlr.2013.13
- Leigh, J., Bowen, S., & Marlatt, G. A. (2005). Spirituality, mindfulness and substance abuse. *Addictive Behaviors*, 30, 1335–1341. doi:10.1016/j.addbeh.2005.01.010

- Lim, C., Sim, K., Renjan, V., Sam., H. F., & Quah, S. L. (2014). Adapted cognitive-behavioral therapy for religious individuals with mental disorder: A systematic review. *Asian Journal of Psychiatry*, 9, 3–12. doi:10.1016/j.ajp.2013.12.011.
- Litwin, H. (2007). What really matters in the social network-mortality association? A multivariate examination among older Jewish-Israelis. *European Journal of Ageing*, 4, 71–82. doi:10.1007/s10433-007-0048-2.
- Marlatt, G. A., & Kristeller, J. A. (1999). Mindfulness and meditation. In W. R. Miller (Ed.), *Integrating spirituality into treatment*. Washington, DC: American Psychological Association.
- McCown, D. (2013). *The ethical space of mindfulness in clinical practice: An exploratory essay*. Retrieved from <http://www.ebilib.com>
- McHugh, R. K., Hearon, B. A., & Otto, M. W. (2010). Cognitive behavioral therapy for substance use disorders. *Psychiatric Clinics of North America*, 33, 511–525. doi:10.1016/j.psc.2010.04.012.
- Mirdal, G. M. (2012). Mevlana Jalāl-ad-Dīn Rumi and mindfulness. *Journal of Religion and Health*, 51(4), 1202–1215. doi:10.1007/s10943-010-9430-z
- Newman, C. F. (2013). *Core competencies in cognitive-behavioral therapy: Becoming highly effective and competent cognitive-behavioral therapist*. New York, NY: Routledge.
- Nielsen, S. L. (2001). Accommodating religion and integrating religious material during rational-emotive behavior therapy. *Cognitive and Behavioral Practice*, 8, 34–39. doi:10.1016/S1077-7229(01)80041-9
- Nilsson, H. (2014). A four-dimensional model of mindfulness and its implications for health. *Psychology of Religion and Spirituality*, 6(2), 162–174. doi:10.1037/a0036067
- Pargament, K. I., Mahoney, A., Exline, J. J., Jones, J. W., & Shafranske, E. P. (2013a). Envisioning an integrative paradigm for the psychology of religion and spirituality. In K. I. Pargament, J. J. Exline, & J. W. Jones (Eds.), *APA handbook of psychology, religion, and spirituality: Volume I* (pp. 3–19). Washington, DC: APA.
- Pargament, K. I., Mahoney, A., Exline, J. J., Jones, J. W., & Shafranske, E. P. (2013b). From research to practice: Toward an applied psychology of religion and spirituality. In K. I. Pargament, A. Mahoney, & E. P. Shafranske (Eds.), *APA handbook of psychology, religion, and spirituality: Volume II* (pp. 3–22). Washington, DC: APA.
- Paukert, A. L., Phillips, L., Cully, J. A., Loboprabhu, S. M., Lomax, J. W., & Stanley, M. A. (2009). Integration of religion into cognitive-behavior therapy for geriatric anxiety and depression. *Journal of Psychiatric Practice*, 15, 103–112. doi:10.1097/01.pra.0000348363.88676.4d
- Pearce, M. J., Koenig, H. G., Robins, C. J., Daher, N., Shaw, S. F., Nelson, B., & ... King, M. B. (2015). Effects of religious versus conventional cognitive-behavioral therapy on generosity in major depression and chronic medical illness: A randomized clinical trial. *Spirituality in Clinical Practice*, 2(3), 202–215. doi:10.1037/scp0000076.
- Pearce, M. J., Koenig, H. G., Robins, C. J., Nelson, B., Shaw, S. F., Cohen, H. J., & King, M. B. (2015). Religiously integrated cognitive behavioral therapy: A new method of treatment for major depression in patients with chronic medical illness. *Psychotherapy*, 52(1), 56–66. doi:10.1037/a0036448.
- Pew Research Center. (2015, November). *U. S. public becoming less religious: Modest drop in overall rates of belief and practice, but religiously affiliated Americans are as observant as before*. Retrieved from [http://www.pewforum.org/files/2015/11/201.11.03\\_RLS\\_II\\_full\\_report.pdf](http://www.pewforum.org/files/2015/11/201.11.03_RLS_II_full_report.pdf)
- Pignotti, M., & Thyer, B. A. (2009). Use of novel unsupported and empirically supported by licensed clinical social workers: An exploratory study. *Social Work Research*, 33, 5–17. doi:10.1093/swr/33.1.5

- Plante, T. G. (2013). Consultation with religious institutions. In K. I. Pargament, A. Mahoney, & E. P. Shafranske (Eds.), *APA Handbook of Psychology, Religion, and Spirituality: Volume II* (pp. 511–526). Washington, DC: APA.
- Post, B. C., & Wade, N. G. (2009). Religion and spirituality in psychotherapy: A practice-friendly review of research. *Journal of Clinical Psychology: In Session*, 65(2), 131–146. doi:10.1002/jclp.20563.
- Propst, L. R., Ostrom, R., Watkins, P., Dean, T., & Mashburn, D. (1992). Comparative efficacy of religious and nonreligious cognitive-behavioral therapy for the treatment of clinical depression in religious individuals. *Journal of Consulting and Clinical Psychology*, 60(1), 94–103. doi:10.1037/0022-006X.60.1.94
- Ramos, K., Barrera, T. L., & Stanley, M. A. (2014). Incorporating nonmainstream spirituality into CBT for anxiety. *Spirituality in Clinical Practice*, 1(4), 269–277. doi:10.1037/scp0000035
- Razali, S. M., Aminah, K., & Khan, U. A. (2002). Religious-cultural psychotherapy in the management of anxiety patients. *Transcultural Psychiatry*, 39, 130–136. doi:10.1177/136346150203900106
- Reyes-Ortiz, C. A., Ayele, H., Mulligan, T., Espino, D. V., Breges, I. M., & Markides, K. S. (2006). Higher church attendance predicts lower fear of falling in older Mexican-Americans. *Aging & Mental Health*, 10(1), 13–18. doi:10.1080/13607860500307787
- Robb, H. B. (2001). Can rational-emotive behavior therapy lead to spiritual transformation? Yes, sometimes! *Journal of Rational-Emotive & Cognitive Behavior Therapy*, 19, 153–161. doi:10.1023/A:1011137432529
- Rose, E. M., Westefeld, J. S., & Ansely, T. N. (2001). Spiritual issue in counseling: Clients' beliefs and preferences. *Journal of Counseling Psychology*, 48, 61–71. doi:10.1037/0022-0167.48.1.61
- Rosmarin, D. H., Green, D., Pirutinsky, S., & McKay, D. (2013). Attitudes toward spirituality/religion among members of the Association for Behavioral and Cognitive Therapies. *Professional Psychology: Research and Practice*, 44(6), 424–433. doi:10.1037/a0035218
- Rosmarin, D. H., Pargament, K. L., & Robb, H. (2010). Spiritual and religious issues in behavior change: Introduction. *Cognitive and Behavioral Practice*, 17(4), 343–347. doi:10.1016/j.cbpra.2009.02.007
- Segal, Z., Williams, J., & Teasdale, J. (2013). *Mindfulness-based cognitive therapy for depression* (2nd ed.). New York, NY: The Guilford Press. Retrieved from <http://www.r2library.com>
- Sherman, E., & Siporin, M. (2008). Contemplative theory and practice for social work. *Journal Of Religion & Spirituality In Social Work: Social Thought*, 27(3), 259–274. doi:10.1080/15426430802202179
- Shonin, E., Van Gordon, W., & Griffiths, M. D. (2014). The emerging role of Buddhism in clinical psychology: Toward effective integration. *Psychology of Religion and Spirituality*, 6(2), 123–137. doi:10.1037/a0035859
- Smith, T. B., Bartz, J., & Scott, R. S. (2007). Outcomes of religious and spiritual adaptations to psychotherapy: A meta-analytic review. *Psychotherapy Research*, 17(1), 643–655. doi:10.1080/10503300701250347
- Symington, S. H., & Symington, M. F. (2012). A Christian model of mindfulness: Using mindfulness principles to support psychological well-being, value-based behavior, and the Christian spiritual journey. *Journal of Psychology and Christianity*, 31(1), 71–77.
- Tabak, N. T., & Weisman De Mamani, A. (2014). Religion's effect on mental health in schizophrenia: Examining the roles of meaning-making and seeking social support. *Clinical Schizophrenia & Related Psychoses*, 8(2), 91–100. doi:10.3371/CSRP.TUWE.021513.

- Tan, S.-Y. (2011). Mindfulness and acceptance-based cognitive behavioral therapies: Empirical evidence and clinical applications from a Christian perspective. *Journal of Psychology and Christianity*, 30(3), 243–249.
- Tan, S.-Y. (2013). Addressing religion and spirituality from a cognitive-behavioral perspective. In K. I. Pargament, A. Mahoney, & E. P. Shafranske (Eds.), *APA handbook of psychology, religion, and spirituality (Vol. 2): An applied psychology of religion and spirituality* (pp. 169–187). Washington, DC: American Psychological Association.
- Thomas, J., & Ashraf, S. (2011). Exploring the Islamic tradition for resonance and dissonance with cognitive therapy for depression. *Mental Health, Religion & Culture*, 14(2), 183–190. doi:10.1080/13674676.2010.517190
- Tolin, D. F. (2010). Is cognitive-behavioral therapy more effective than other therapies? A meta-analytic review. *Clinical Psychology Review*, 30, 710–720. doi:10.1016/j.cpr.2010.05.003
- Tully, J., Viner, R. M., Pietro, G. C., Stuart, J. M., Zambon, M., Peckham, C., & Booy, R. (2006). Risk and protective factors for meningococcal disease in adolescents: Matched cohort study. *BMJ*, 332, 445–450. doi:10.1136/bmj.38725.728472.BE
- Van Wormer, K., & Davis, D. R. (2013). *Addictions treatment: A strengths perspective* (3rd ed.). Belmont, CA: Brooks/Cole, Cengage Learning.
- Wade, N. G., Worthington, E. L., Jr., & Vogel, D. L. (2007). Effectiveness of religiously tailored interventions in Christian therapy. *Psychotherapy Research*, 17, 91–105. doi:10.1080/10503300500497388
- Watmough, R. (2013). *Exploring the relationship between MBCT and spirituality* (Unpublished doctoral thesis). Canterbury Christ Church University, Canterbury, UK.
- Weber, S., & Pargament, K. (2014). The role of religion and spirituality in mental health. *Current Opinions in Psychiatry*, 27(5), 358–363. doi:10.1097/YCO.0000000000000080
- Weisman De Mamani, A. G., Tuchman, N., & Duarte, E. A. (2009). Incorporating religion/spirituality into treatment for serious mental illness. *Cognitive and Behavioral Practice*, 17(4), 348–357. doi:10.1016/j.cbpra.2009.05.003
- Worthington, E. L., Hook, J. N., Davis, D. E., & McDaniel, M. A. (2011). Religion and spirituality. *Journal of Clinical Psychology: In Session*, 67(2), 204–214. doi:10.1002/jclp.20760.
- Wykes, T., Steel, C., Everitt, B., & Tarrier, N. (2008). Cognitive behavior therapy for schizophrenia: Effect sizes, clinical models, and methodological rigor. *Schizophrenia Bulletin*, 34(3), 523–537. doi:10.1093/schbul/sbm114.
- Yakir, K., Anaki, D., Binns, M., & Freedman, M. (2007). Cognitive decline in Alzheimer disease: Impact of spirituality, religiosity, and QOL. *Neurology*, 68(18), 1509–1514. doi:10.1212/01.wnl.0000260697.66617.59.

Copyright of Journal of Spirituality in Mental Health is the property of Taylor & Francis Ltd and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.