

The effectiveness of spiritual/ religious interventions in psychotherapy and counselling:

a review of the recent
literature.

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Foreword

This document is a literature review of research into the effectiveness of spiritual/religious interventions in psychotherapy and counselling, intended as a resource for counsellors and psychotherapists. It demonstrates the effectiveness of spiritual/religious interventions for a range of physical and psychological conditions.

The PACFA Research Committee recognises that it is important to counsellors and psychotherapists that they have access to recent research evidence that demonstrates the effectiveness of different therapeutic approaches, to assist them in their practice. This review is one of a series of reviews that has been commissioned by the PACFA Research Committee to support its Member Associations in their work. It was written on behalf of the PACFA Research Committee. However, this does not imply that PACFA or its Member Associations endorses any of the particular treatment approaches described.

The Committee endorses the American Psychological Association's definition of evidence-based practice as 'the integration of the best available research evidence with clinical expertise in the context of patient characteristics, culture and preferences'- although we refer to a client or consumer rather than 'patient' – and the Common Factors research that has shown the centrality of the therapeutic relationship to therapeutic effectiveness, and the relatively minimal relevance of specific techniques.

The Committee recognises that there is significant research evidence to indicate the effectiveness of counselling and psychotherapy and that different methods and approaches show broadly equivalent effectiveness. The strength of evidence for effectiveness of any specific counselling and psychotherapy intervention or approach is a function of the number, independence and quality of available effectiveness studies, and the quality of these studies is a function of study design, measurements used and the ecological validity (i.e. its approximation to real life conditions) of the research.

The Committee acknowledges that an absence of evidence for a particular counselling or psychotherapy intervention does not mean that it is ineffective or inappropriate. Rather, the evidence showing equivalence of effect for different counselling and psychotherapy interventions justifies a starting point assumption of effectiveness.

It should be noted that this review is necessarily limited in its scope and investigates the evidence for the effectiveness of outcomes in interventions for common mental health issues, focussing on six main types of presenting issues as well as interventions for couples and groups. The review also investigates assessment of spiritual/religious issues.

The Committee is committed to supporting PACFA Member Associations and Registrants to develop research protocols that will help the profession to build the evidence-base to support the known effectiveness of counselling and psychotherapy. We hope that you will find this document, and others in this series, useful. We would welcome your feedback.

Dr John Meteyard, Chair of the PACFA Research Committee, 2015

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Abstract

Research shows that spirituality and religion/religious (S/R) beliefs are factors that have both positive and negative influence on psychological and physical health. This article presents an overview of recent investigations of the effectiveness of S/R interventions in psychotherapy and counselling, with a focus on studies published post-2010. Positive outcomes of S/R accommodative interventions have been reported for a variety of client concerns including depression, anxiety, schizophrenia and coping with physical illness. The literature presents arguments and evidence for why and how issues of S/R may be considered in therapy. Issues of assessment and methods by which to incorporate S/R interventions are presented. However, small sample sizes and homogenous groups of participants limit the generalizability of some findings. More scientifically rigorous investigations would help to identify the most effective S/R interventions and methods by which to incorporate in psychotherapy and counselling.

Literature Review

Introduction

Issues of spirituality and religion may strongly influence one's self-perception and worldview, interpretations of experience, and behaviour (Cornish, Wade, Tucker, & Post, 2014). There is increasing recognition of the impact spiritual and/or religious (S/R) beliefs and practices can have on an individual's mental and physical health, with evidence of both positive and negative influences. Numerous studies have reported significant relationships between S/R factors and positive mental health characteristics such as wellbeing, hope and optimism, meaning and purpose, reduced levels of depression and anxiety, and positive coping skills (Koenig, 2012; Mohr, Perroud, Gillieron, Brandt, Rieben, Borrás, & Huguelet, 2011; Smith, Bartz & Richards, 2007; Zenkert, Brabender & Slater, 2014). Studies have also shown an association between S/R doubts or struggles with depression, anxiety, drug use, and suicide (Agorastos, Metscher, Huber, Jelinek, Vitzthum, & Muhtz; Moritz, 2012; Ellison, Fang, Flannelly & Steckler, 2013; Koenig, 2012). Furthermore, research suggests that S/R beliefs and practices may impact physiological outcomes including an individual's recovery outcomes, health behaviours, pain, and immune and cardiovascular functions (Koenig, 2012; Mohr et al., 2011; Pargament, Koenig, Tarakeshwar & Hahn, 2004; Rosmarin, Bigda-Peyton, Kertz, Smith, Rauch, & Björgevinnsson, 2013).

Koenig (2012) conducted a review of over 3,300 studies that researched the relationship of S/R issues with mental and physical health, health behaviours and outcomes. He presented theoretical models illustrating the multiple pathways by which S/R may influence both mental and physical health. He concluded that, in view of the research evidence, issues of S/R should be integrated into health care practice. Rosmarin et al. (2013) reported results of a study investigating the relevance of spirituality to psychiatric treatment outcomes. Participants were 159 patients receiving treatment at a psychiatric hospital and participating in a cognitive behavioural therapy (CBT) day treatment program. Results showed that a belief in God was significantly associated with reduced levels of depression and increased psychological well-being, higher levels of clients' treatment expectancies and perceptions of treatment credibility, and improved psychiatric care outcomes. Mohr et al. (2011) referred to a number of studies that reported lower negative symptoms and improved life quality, maintained at a three year follow up, for patients with schizophrenia for whom religious beliefs were an important part of their coping strategies.

Overall, the literature provides ample evidence to support the integration of a client's S/R beliefs and practices as part of good counselling and psychotherapy practice. Furthermore, research suggests that a majority of clients believe it is appropriate and important for issues of S/R to be discussed in therapy (D'Souza & Rodrigo, 2004; Post & Wade, 2009; Zenkert et al., 2014).

Data from the Pew Research Center showed that in 2010 only 16.4% the world's population did not identify with any religion (Pew Research, 2012). A majority of Americans identify themselves as being religious and/or spiritual (Cornish, Wade & Post, 2012; Hook, Worthington, Davis, & Atkins, 2010). In the 2011 Australian census 69% of the total population, and 81% of those of 65

years, reported some form of spirituality and/or religious practice (Australian Bureau of Statistics [ABS], 2014). In view of these statistics, it would follow that issues of spirituality and/or religion may be relevant to many clients who present for therapy. Post and Wade (2009) suggested that ‘...the practical question for clinicians is no longer whether to address the sacred in psychotherapy with religious and spiritual clients, but rather, the questions are when and how to address the sacred’ (p.131).

Reviews of research relevant to the questions of when and how to integrate S/R in therapy have been conducted by a number of authors, covering studies from 1984 to 2010 (Bonelli & Koenig, 2013; Hook, et al., 2010; Richards & Worthington, 2010; Worthington, Hook, Davis & McDaniel, 2011). The purpose of the present article is to provide an overview of some of the more recent studies that have explored the effectiveness of incorporating religious- and/or spirituality-based interventions into counselling and psychotherapy treatments.

Method

Using PsychINFO, PsycARTICLES and Medline databases, a search was conducted by entering the terms [spiri* OR religio*] AND [counsel* OR therapy], AND [outcome OR effectiveness]. Results returned a total of 3,023 peer-reviewed articles. Refining the publishing date to post-2010 reduced the number of results to 435. Articles were then reviewed to identify those that reported statistical outcomes of studies into the effectiveness of S/R interventions in psychotherapy, delivered by counsellors, psychologists or psychotherapists. Relevant articles cited in reference lists of articles were also considered. Exclusion criteria included non-English studies; RCTs with less than 10 participants; editorials, and non-peer reviewed articles. Studies reporting outcomes of mindfulness interventions were also excluded, since mindfulness is often incorporated as an exercise in developing attention, without any overt spiritual/religious content. (For readers who are interested in a review of mindfulness as an intervention, Keng, Smoski and Robins (2011) reviewed a number of empirical studies of Dialectic Behavior Therapy, Mindfulness-Based Cognitive Therapy and Mindfulness-Based Stress Reduction.)

In an attempt to locate studies conducted in Australia, a search was conducted with the additional term Australia* and the scope of the publication date was extended to include studies published since 2004. Only one Australian study met the majority of criteria for the current review. An article by D’Souza and Rodrigo (2004) discussed spiritually-augmented CBT treatment outcomes. However these studies were reported in 2002/3, dates outside the scope of this review. Recently, Snider and McPhedran (2014) conducted a review that sought to investigate reports of treatment outcomes in the context of relationship between religiosity/spirituality and psychiatric/psychological health in Australia. Of the total 948 articles that met their search terms, the authors of that study identified only 13 articles as relevant. Only seven of those articles provided original data, and none directly examined outcomes of the use of S/R interventions in psychotherapy. These findings suggest that there is a lack of published research of S/R issues in relation to psychotherapy and counselling in Australia.

Table 1 Outcome studies included in the present review of effectiveness of Spiritual/Religious interventions

Study	Design	Participants	Intervention	Control	Outcome measures	Results	Comments
Barrera et al., 2012 - GAD	Case studies	N = 3 Females Mean age 64.	Calmer Life program: Incorporating S/R components (inc. focus on S/R values of forgiveness, gratitude; S/R imagery in relaxation; daily S/R behaviours) in manualised CBT for GAD. Language tailored to align with clients' beliefs.	NA	Penn State Worry Questionnaire-Abbreviated (PSWQ-A); Geriatric Anxiety Inventory (GAI); Geriatric Depression Scale (GDS) ; Geriatric Depression Scale Short form (GDS-SF); Insomnia Severity Index (ISI); Satisfaction With Life Scale (SWLS).	Substantial reductions in worry & decrease in anxiety; increase in life satisfaction; improvement in insomnia symptoms; outcomes maintained at 6 month follow up for 2 clients. Client with least S/R had lowest improvement scores: client with most S/R had greatest improvement. A variety of secondary outcomes.	Client able to choose interventions. Lack of generalizability. Small n. No comparison treatment to allow the outcomes to be attributed to the S/R interventions specifically.
Breitbart et al., 2010 -- patients with terminal cancer intended	Randomised controlled trial, group therapy 8 weekly sessions.	Average age 60.1; 48.9% male; 63.3% at Stage IV cancer; groups of 8-10 participants; n(MCGP) = 49; n(SGP) = 41.	Meaning Centered Group Psychotherapy (MCGP) incorporating didactic, experiential exercise focused on concepts and sources of meaning and purpose.	Supportive psychotherapy (SGP), manualized; discussions of experiences and emotions, around coping with cancer.	Functional Assessment of Chronic Illness Therapy – Spiritual Well-being (FACIT SWB)	Results included SWB total scores, $t(36) = 4.38, p < 0.0001$, and meaning/peace subscales scores, $t(36) = 4.51, p < 0.0001$. At 2-month follow up: SWB total score $t(25) = 4.98, p < 0.0001$, and meaning/peace subscale, $t(25) = 2.73, p = 0.006$.	High attrition. Larger RTC being undertaken.
Garlick et al., 2011 - women with primary breast cancer	Within subject quasi-experimental	N = 24; female; (M Age 53; diagnosed with primary breast cancer (stages 0-3).	Psycho-Spiritual Integrative Therapy: 8 session group therapy.	NA	Functional Assessment of Cancer Therapy-Breast (FACT-B); Profile of Mood States (POMS); Functional Assessment of Chronic Illness Therapy-Spiritual (FACIT-Sp-Ex); Posttraumatic Growth Inventory (PTGI).	FACT-B total score $F(1.5) = 9.46, p = .002$, with significant improvement between pre and post, and follow up: effect for time on Depression subscale POMS, $F(2) = 3.84, p = .031$ & Anger subscale $F(2) = 3.52, p = .041$; & FACIT-Sp-Ex Spiritual Wellbeing $F(2) = 6.17, p = .005$	Lack of control group; small sample size/low power; convenience sampling.
Harris et al., 2011 - trauma	Random controlled trial	N = 54; 6 females, veterans with exposure to traumatic events; mean age 45 years. n(BSS) = 26; n(control) = 28.	Building Spiritual Strength (BSS): 8 session spiritually integrated group intervention	Non-active	PTSD Checklist (PCL); Traumatic Life Events Questionnaire (TLEQ).	No statistical differences; significant reduction in PTSD symptoms in BSS group	Small sample size, non-active control group; ambiguous results.

Study	Design	Participants	Intervention	Control	Outcome measures	Results	Comments
Jafari et al., 2013. -- women with breast cancer:	A randomized controlled trial	Iranian women breast cancer patients in radiotherapy clinic; n = 34 spiritual therapy group; n = 31 control group. Age 24 – 64,	Spiritual group therapy. “Some aspects of program were inspired from “Re- Creating Your Life: During and After Cancer” program which designed by Cole and Pargament (1999).”	Standard medical care, interaction with oncologists, brief education on health and radiation therapy.	Quality of Life Questionnaire -Cancer (QLQ-C30).	QOL from baseline 44.37 (SD = 13.03) indicating poor QOL to post intervention 68.63 (SD=10.86), effect size 2.15, indicating improvement in all symptoms except four biological symptoms	Spiritual therapy provided by “three spiritual healers with great experience in this field”. Lack of psychological component in control group, and homogenous group limits evaluation of efficacy of treatment and generalisability.
Koszycki et al., 2014 - Generalized Anxiety Disorder (GAD)	Randomized control trial – pilot study	Mean age 40; Spiritually Based intervention (SBI) n = 11 (82% female); Supportive Psychotherapy (SP) n = 12 (50% female). Participants with GAD diagnosis based on SCID-PV, ≥ 15 on Hamilton Anxiety Rating Scale (HAM-A) and ≥ 4 on Clinical Global Impression-Severity (CGI-S).	SBI:- manualised multicomponent therapy (based on Walsh, 1999); 12 X 50 minute individual sessions weekly inc. discussion of spiritual framework and themes, prayer, meditation, and other spiritual practices. Weekly readings and homework.	Standardized SP (Markowitz, Manber, & Rosen, 2008); 12 X 50 minute individual unstructured sessions weekly inc. common psychotherapeutic factors e.g. reflective listening, empathy. No homework.	HAM-A; PSWQ; Beck Anxiety Inventory BAI;, Beck Depression Inventory; BDI; CGI-S, and others	At endpoint SD scores for SBI v SP - HAM-A: 4.8 v 9.4, F(1,17)=11.37, p = .004, Cohen’s d = 1.40; PSWQ: 49.1 v 59.7, F(1,17) =9.92, p = .006, Cohen’s d = 0.83; CGI-S: 1.7 v 2.7, F(1,17) = 12.09, p = .003, Cohen’s d = 1.39. No significant difference for BAI, BDI-II	Small sample size, majority female, Caucasian, and from Christian backgrounds, therefore limited generalizability; therapists not blind to study. Structure and homework components variables.
Ramos et al., 2014 – GAD	Case Study	53-year-old male with symptoms that met criteria for GAD according to SDI DSM-IV. Nontheistic Unitarian Universalist beliefs.	Calmer Life program: Incorporating R/S components in manualised CBT for GAD. The language used in interventions tailored to align with client’s beliefs. i.e. nontheistic words, imagery and statements	NA	GAD-7 (Total score range 0-21): Patient Health Questionnaire-8 (PHQ-8: total score range 0-24): ISI (total score range 0-28); SWLS (total scores range 5-35)	GAD-7: Pre=17, Post=9; PHQ-8 Pre=19, Post=5; ISI Pre=21, Post=16; SWLS Pre=19, Post=16.	Single case; demonstrates flexibility of Calmer Life program across multiple faiths; No comparison treatment to allow the outcomes to be attributed to the S/R interventions.
Ripley et al., 2014 - couples therapy	Randomised assignment	N = 184 (92 couples); (nRA = 55; nS = 42) mean age 43.78 years; mean length of current marriage 8.96 years, 94% Christian.	Hope Focused Couples Approach Religion-Accommodative (RA)	Hope Focused Couples Approach Standard (S)	Primary outcome measure the Revised Dyadic Adjustment Scale, score range from 0-70 with 48 criterion for distress	RA couples baseline score 42.17, posttreatment 46.87, 6 month follow-up 50.69: S couples baseline 42.70, posttreatment 49.51, 6 month follow-up 46.98	Results indicated religious components did not improve or impair outcomes for HFCA.
Weisman de Mamai et al. 2014 - schizophrenia	Randomized controlled trial	N = 69; 28Female, 41Male; mean age 42.59. n(CIT-S) = 38; predominantly Hispanic/Latino	Family focused, culturally informed treatment for schizophrenia (CIT-S); 15 weekly sessions	PSY-ED, same as psychoed units of intervention;3 sessions.	Brief Psychiatric Rating Scale (BPRS); SCID-I/P	Symptom severity total BRPS score CIT-S M = 43.44, SD = 14.77, PSY-ED M = 53.71, SD = 17.77, F(1,41) = 45.3, p = .039 (no significant difference on cluster scores.	Drop out rate approximately 33% with rates same between conditions. CIT-S 12 weeks more than PSY-ED.

CBT Cognitive Behavior Therapy; RET Rational-Emotive Therapy; SDI Structured Diagnostic Interview; NA Not applicable

The nine articles that met criteria for the current study are summarised in Table 1. These articles reported outcomes for a variety of treatments across a range of diagnoses: depression, anxiety, trauma and Post-traumatic Stress Disorder PTSD, schizophrenia, and breast cancer.

While the number of studies that presented outcomes for the effectiveness of S/R interventions according to the current article's criteria may be few, there is a wealth of literature that discusses various aspects of S/R issues in therapy. Prior to discussion of the nine studies this article provides a brief overview of these issues. These include definitions of the terms, discussion of the relevance and importance of S/R in assessment, types of S/R interventions, and the use of S/R in group therapy, and couples counselling. Findings of two recent literature reviews of studies into S/R interventions in treatments of depression and anxiety are outlined.

Definitions of Terms

Although the terms spirituality/spiritual and religion/religious are often used interchangeably, and both have been used to refer to an individual's sense of meaning, purpose and connectedness, there is agreement that the terms each refer to distinct concepts (D'Souza & Rodrigo, 2004; Hill, Pargament, Hood, McCullough, Swyers, Larson, & Zinnbauer, 2000; Hodge, 2011; Piedmont, Ciarrochi, Dy-Liacco & Williams, 2009). The term religion has generally been used to refer to more theistic, ritualised and communal expressions of belief that are often maintained in accordance with a theology or doctrine with reference to a supreme being (Decker, 2007; Hill et al.; Paukert, Phillips, Cully, Romero & Stanley, 2011). The term spirituality is generally used to refer to less formal and more experiential, individual and personalised beliefs and practices (Hill et al.; Paukert et al.; Shah, Kulhara, Grover, Kumar, Malhotra, & Tyagi, 2011). While belief in a supreme being may or may not be part of spirituality, the sacred and/or transcendent in some form is often a factor. The element of transcendence, that which is beyond the physical and separate from the ordinary and everyday, may be without any particular religious associations (Decker, 2007; Pargament, Lomax, McGee & Fang, 2014).

Worthington et al. (2011) identified four spirituality types: religious (involving sense of connection with a God or Higher Power); humanistic (connection to a people group, attitudes of altruism, feelings of love); nature spirituality (closeness to nature/environment); and cosmos spirituality (connection to creation). Richards (2012) provided an informative summary of the various definitions and descriptions of the concept of spirituality found in the literature (pp. 245-246), together with outlines of the characteristics of major world religions (p. 244).

Hodge (2013) suggested that maintaining a distinction between the two constructs is useful for the therapist in gaining a respectful and accurate understanding of a client's perspectives on these issues, particularly during the assessment stage of therapy.

Assessment of Spiritual/Religious Issues

Hodge (2013) discussed the importance of routinely including issues of spirituality and religion in assessment, and how this would contribute to the development of a comprehensive understanding of a client. Even when issues around S/R are not a focus of therapy, they can be important background factors (Shafranske & Sperry, 2005, p. 20).

Hodge (2013) also suggested that a biopsychosocial-spiritual assessment of every client could optimise treatment effectiveness, and proposed a two-stage assessment model. A brief

preliminary screening could be used to determine if spirituality and religion are meaningful to the client and indicate whether a more extensive assessment of the issues would be relevant. If so, a more comprehensive assessment can then be made of the client's S/R history, making use of tools such as genograms, and mapping S/R relevant life experiences and relationships.

An assessment of S/R issues may be particularly relevant to a number of specific presentations. Dein (2013) argued that the consideration of S/R issues may be an essential part of therapy for depression and anxiety, since questions of meaning and control in life are relevant to both disorders. Serious health problems, grief, loss, and relationship conflict, struggles for meaning, or experiences that trigger doubt in one's worldview, may also require direct consideration of spiritual issues in therapy (Pargament & Saunders, 2007; Sperry, 2012).

Interventions

Spiritual/religious interventions have been integrated in a variety of psychotherapy treatments including CBT (Barrera, Zeno, Bush, Barber, & Stanley, 2012; McMinn, Snow, & Orton, 2012; Pearce, Koenig, Robins, Nelson, Shaw, Cohen, & King, 2014), and trauma focused therapy (Decker, 2007). A S/R intervention may include discussion around specific issues such as faith, purpose, and meaning (Pargament & Saunders, 2007), and exercises relevant to client's beliefs and practices. For example, imagery congruent with a client's beliefs can be introduced in relaxation exercises (Barrera et al., 2012). Music therapy, bibliography, and prayer have also been used to incorporate spirituality in therapy (Dyer & Hagedorn, 2013). Life maps were recommended in Nichols and Hunt's (2011) review of literature supporting the incorporation of spirituality in therapy for clients with chronic illness. Other interventions included assisting the client to develop personalised spirituality-related activities and rituals to incorporate into their daily management of their illness.

The effectiveness of Spiritual/Religious interventions in treatment

Studies investigating the application of religion-accommodative therapy for the treatment of anxiety and depression were discussed in a review conducted by Paukert, Phillips, Cull, Romero, and Stanley (2011). Their review targeted four aspects for investigation: (1) efficacy of religion-accommodative therapy; (2) effectiveness compared to traditional treatment; (3) indications of the most effective ways for interventions to be delivered; and (4) the scientific merit of the studies. Criteria required that the studies reported empirical results of outcomes of treatment for adults with anxiety and/or depression; that interventions included religious content integrated into traditional psychotherapy approaches; and that results of outcomes of a control group were provided. In addition, the research was to be original, published in English, and reporting outcomes for studies with 20 or more adult participants. A total of 11 articles (published by seven different research teams) between 1992 and 2008 met the criteria.

Cognitive therapy (CT) was the secular control intervention in nine of those 11 studies. A Christian based religious-accommodative treatment was the intervention used in six studies, and the other five studies incorporated interventions with an Islamic perspective. Each study reported results that indicated religion-accommodative therapy to be an effective treatment for clients with anxiety or depression, with outcomes equivalent, although not superior, to the control CT interventions. However, there was evidence that suggested that religious-accommodative cognitive therapy was more effective than secular CT for highly religious individuals.

Paukert et al. (2011) examined the methods of the studies and found that all were of acceptable scientific quality. However, with the exception of one study, power to detect a medium effect

was below 70%. The authors identified a number of other areas for criticism including inconsistency in how religion was incorporated into therapy and restricted sample characteristics, limiting generalisation of results to broader populations. The majority of participants were females from university or hospital psychiatric clinics. Paukert et al. concluded that the studies indicated that religious-accommodative interventions are as effective as secular cognitive therapy in treatment of anxiety and depression for populations that view religion as important. Paukert et al. recommended that therapists enquire directly about the value of religion to each of their clients, rather than waiting for the client to raise the issue. If S/R issues are of relevance, the decision as to whether S/R interventions be included in psychotherapy should be made by the client (p.106).

In a review, Pearce and Koenig (2013) considered the theoretical and empirical evidence that had been reported in support of Christian-CBT as an effective treatment for depression. The authors presented a theoretical argument that CBT for treatment of depression in Christian clients experiencing an illness would be enhanced by integration of S/R issues. References were provided to numerous studies that had identified an inverse correlation between levels of depression and S/R. They cited research linking spirituality and religion with reduced depressive symptoms; improved medical outcomes; positive emotions; higher rates of social support; higher levels of optimism; and enhancement of therapeutic alliance. Following on from these studies, Pearce et al. (2014) described the development of a religiously integrated CBT intervention, which included a manual as well as a client workbook. The intervention incorporated teachings of Judaism, Christianity, Hinduism, Buddhism and Islam within a CBT framework. The authors stated that results of a randomized controlled trial to determine effectiveness of the intervention for treatment of depression in clients with medical illness would soon be reported.

Generalised Anxiety Disorder (GAD)

Barrera, Zeno, Bush, Barber, and Stanley (2012) reported the results of treatment for GAD using an S/R intervention in three clinical case studies. The Calmer Life program is a manualised treatment developed on evidence-based CBT treatment for late-life GAD, with patient preference directing the selection of S/R elements that were incorporated into the program modules. Examples of S/R interventions included the use of religious images or words during relaxation exercises.

The case studies reported outcomes of treatment using the program for three females in their mid-sixties who met criteria for GAD, one with co-morbid dysthymia and one with comorbid panic disorder (without agoraphobia). Each client completed at least nine of the 12 weeks of individual 40-minute sessions with interventions tailored to incorporate the client's S/R beliefs. Outcomes were measured by the Penn State Worry Questionnaire–Abbreviated, the Geriatric Anxiety Inventory, the Geriatric Depression Scale–Short Form, the Insomnia Severity Index, and the Satisfaction With Life Scale. At the conclusion of treatment all three clients experienced substantial reduction in symptoms of worry, and improved sleep patterns. Three-month follow-up scores on the anxiety scale and depression scale for one client had decreased from baseline scores of 17 and 12 respectively to zero, and these results were maintained at the six-month follow-up. Interestingly, the participant with the least improvement had chosen to limit S/R elements in only two of the eight modules completed. However, since these cases involved clients the same religious background (Roman Catholic) and age group, and lacked any experimental control group, it was not possible to conclude that the S/R elements had been the effective components of the treatment.

More recently, Ramos, Barrera and Stanley (2014) reported a case study of the effectiveness of the same program (Calmer Life) for treatment of a 53-year-old male diagnosed with GAD. This client identified as an agnostic with strong spiritual beliefs around Universalist principles. He had presented with severe scores on measures of anxiety, worry, and depression. At completion of a nine-session program, the client's anxiety and depression levels showed significant reductions. The authors suggested that the results indicated that the treatment could be used for clients of multiple faiths. However, as in the study by Barrera et al. (2012), the lack of a control prevented any evaluation of the extent to which the S/R elements may have contributed to the effectiveness of the treatment.

A study by Koszycki, Raab, Aldosary and Bradwejn (2010) indicated the efficacy of a multifaith spiritually based intervention (SBI) as comparable to that gained by using CBT as a treatment for GAD. In an effort to determine whether the SBI interventions could contribute more to outcomes than other psychotherapies, Koszycki, Bilodeau, Raab-Mayo and Bradwejn (2014) conducted a randomized control trial. Eleven participants with a primary diagnosis of GAD were allocated to the SBI treatment and 12 were allocated to supportive psychotherapy (SP). The SBI intervention was based on a multifaith program developed by Walsh (1999, cited in Koszycki et al. 2014). Spiritual components of the SBI intervention included contemplative practices; developing a spiritual wisdom framework that recognised sacred aspects of people, self and things; and cultivating attitudes such as forgiveness, compassion and gratitude. A manualised guide to psychotherapy was used in the SP treatment. It included common components of interpersonal, psychodynamic and cognitive behaviour therapies such as reflective listening and empathy. Measures of primary outcomes included the Hamilton Anxiety Rating Scale (HAM-A; Hamilton, 1959), the Penn State Worry Questionnaire (PSWQ) as a measure of worry symptoms, and the Beck Anxiety Inventory (BAI). A number of secondary outcome measures, including the Beck Depression Inventory (BDI-II), were also applied. Baseline scores were similar on all measures, with improvements in outcomes for both treatments. All outcomes for the SBI showed large ($d > 0.80$) within-group effect sizes, and for the SP on the HAM-A, CGI-S and BDI. The results of an ANCOVA were superior for the SBI compared to the SP, and large between group effect sizes were reported. At a 3-month follow up treatment gains had been maintained. The retention rate for the SBI was 100%, and compliance satisfactory. The authors concluded that the study presented evidence of the superior efficacy of the brief spiritually-focused intervention for the treatment of GAD compared to nonspecific therapy factors. However, homogenous client characteristics, with a majority being of Christian background, Caucasian and female, limit the generalizability of results. There were also variables between treatments such as homework for SBI but not for SP that may have contributed to outcomes apart from any specific S/R interventions.

Coping with breast cancer

A study investigating spiritual well-being as a mechanism by which posttraumatic growth may be aroused was reported by Garlick, Wall, Corwin and Koopman (2011). In their study, 24 women who had received a diagnosis of primary breast cancer participated in group therapy based on Psycho-Spiritual Integrative Therapy (PSIT). The focus of treatment and its activities addressed psychological, spiritual, and existential issues. Activities included meditation practice; discussion of disruption to values and worldview; identification of emotions and cognitions; learning stress reduction practices; and addressing issues of meaning and purpose. The intervention was delivered over eight weeks. Outcome measures included the Functional Assessment of Cancer Therapy-Breast (FACT-B) which measures areas of quality of life such as physical, emotion and social/family well-being for patients with breast cancer; and the Profile of Mood States (POMS) which includes subscales for tension, depression, anger, vigour, fatigue and confusion. Results indicated significant improvement across the psychological, physical and spiritual well-being

measures, suggesting efficacy of the PSIT program and integration of psycho-spiritual interventions for cancer patients. However, as for many of the studies, an evaluation of effectiveness of the treatment is limited by the lack of a control group and the small number of participants.

Jafari, Zamani, Farajzadegan, Bahrami, Emami, and Loghmani (2013) reported an investigation of the quality of life in a group of women with breast cancer undergoing radiation treatment in a hospital in Iran. The authors pointed out that the great majority of Iranian populations are Muslims who hold a strong belief in God, and spiritual beliefs are a common and major coping strategy for Iranian women with breast cancer. Furthermore, many hold the perspective that illness is both sent from and cured by God. The authors cited a number of previous studies, published from 1999 – 2010, that reported a positive contribution of S/R interventions in areas of symptom management, maintaining functional well-being and quality of life, coping, and adjustment in patients with cancer.

Participants in the randomized controlled trial reported by Jafari et al. were patients who had received a diagnosis within the last year and with radiation therapy scheduled for a minimum of two-weeks. The control group received standard care by oncologists, with specialist referrals if indicated, and a routine health education programme provided by the centre. The intervention group received the same care along with the spiritual therapy course. The course consisted of six sessions of group therapy, with each session of two to three hour duration. Interventions included various imagery, meditation and self-reflective exercises, some two-chair work, attention to schematic representations of relationships, and encouragement in prayer. The treatment group showed significant improvement in overall quality of life scores, with an effect size of 2.15 compared to the control group. Positive effects were indicated for physical, social, emotional and cognitive functioning. No follow up measures were taken.

Terminal illness

In recognition of the positive influences spiritual wellbeing can have on quality of life for terminally ill patients, Breitbart et al. (2010) conducted a pilot study of an intervention designed to enhance spiritual well-being, focusing on the development of a sense of meaning, peace and purpose. Meaning Centered Group Psychotherapy (MCGP) sessions included discussion of themes of meaning and purpose, identity, and reflections on significant relationship and traditions. Outcomes at the end of eight weeks of MCGP sessions were compared with outcomes for patients who had participated in supportive group psychotherapy (SGP). The SGP sessions discussed issues, concerns, emotions and experiences around coping with cancer. Although allocation to groups was randomised (nMCGP = 49, nSGP = 41), participants were asked to indicate their preference for the MCGP versus the SGP intervention. A majority (71.3%) of participants indicated a preference for MCGP. Results post-treatment for MCGP patients indicated substantial and significant increases in spiritual well-being total scores, $t(36) = 4.38$, $p < 0.0001$, and meaning/peace subscales scores, $t(36) = 4.51$, $p < 0.0001$ of the Functional Assessment of Chronic Illness Therapy – Spiritual Well-being (FACIT SWB). Improvements in spiritual well-being had increased at 2-month follow up: SWB total score $t(25) = 4.98$, $p < 0.0001$, and meaning/peace subscale, $t(25) = 2.73$, $p = 0.006$. There was some reduction in psychological distress in the MCGP participants. Results for the SGP participants pre- and post-treatment were small and statistically insignificant. There was a high degree of attrition from both groups. Seventeen (34.7%) participants in the MCGP group attended all sessions, and 40 (81.6%) attended six or more. Nine (21.9%) of the SGP group attended all sessions, and 13 (31.7%) attended six or more. The authors suggested that although reasons were unclear, the severity of illness of participants may have impacted attendance. With the encouraging results of the pilot

study the authors are undertaking a randomized trial to extend the findings and address some of the issues highlighted by the pilot study.

Schizophrenia

In a study of the contribution of S/R to coping skills for individuals with residual schizophrenia, Shah et al. (2011) reported that those patients who considered spirituality to be an important positive factor in their lives had fewer negative symptoms and higher rates of employing adaptive coping strategies. Similar findings were reported by Mohr et al. (2011), who also reported evidence for the negative impact of harmful religious beliefs such as abandonment or judgement by God.

Weisman de Mamani, Weintraub, Gurak and Maura (2014) reported a study into the effectiveness of family focused Culturally Informed Therapy for Schizophrenia (CIT-S) in reducing the severity of symptoms in patients. A spiritual coping module included discussion of beliefs in a supreme being, meaning and purpose, and patients' use of spiritual practices such as meditation and prayer. A comparison group were administered a psycho-educational module. Results supported the hypothesis that the CIT-S intervention would reduce psychiatric symptoms in comparison to the control group, with significant reduction in severity scores compared to baseline for CIT-S group. However, no significant differences were found on positive, negative and affective symptom cluster scores. Although there was a dropout rate of 33%, the authors pointed out that this was no higher than the attrition rate in other research studies looking at treatment for schizophrenia. The study concluded that symptom severity is reduced for schizophrenic patients treated with family interventions using CIT-S, and further investigation of the method as an effective treatment was recommended. A case study was presented as further support of the effectiveness of the intervention. A 27-year-old male of Jewish faith completed the CIT-S with his wife and mother-in-law. At end of therapy the client and his family reported marked improvement in functioning.

Trauma

The inclusion of S/R in therapy may be particularly important for clients who have experienced trauma (Kusner & Pargament, 2012; Zenkert et al., 2014). Religious or spiritual ideas may be shaken by experiences that are incongruous with an existing worldview or violate something held sacred (Kusner & Pargament).

A study by Harris et al. (2011) investigated the outcomes of a treatment using a spiritually integrated intervention for posttraumatic stress symptoms in veterans who had experienced trauma events. A number of previous research studies that had reported positive effects for spiritually integrated interventions were discussed (Decker, 2007; Dyer-Layer et al., 2004; Murray-Swank & Pargament, 2005, 2008, cited by Harris et al., 2011). In the study by Harris et al. veterans who reported having experienced exposure to traumatic events were assigned to either a wait list (n = 28) or eight sessions using the Building Spiritual Strength (BSS) programme (n = 26) delivered in group therapy sessions. Established on the evidence that positive spirituality is a contributing factor to positive adjustment, the BSS programme aimed to enhance spiritual functioning and address areas of an individual's spiritual struggles or conflicts. Discussion, written prayer exercise, and promotion of meditation practices were included together with attention to conflict resolution and forgiveness. Progress on spiritual goals and planning of ongoing spiritual development was addressed in the final session. Symptoms of PTSD were reduced following the intervention, although there were no statistically significant results between groups. It was suggested that by addressing the impact of trauma specifically on spiritual beliefs, BSS may be an appropriate and relevant complement to PTSD focused

treatments. A number of limitations of the study were acknowledged. These included a non-active control group, and a number of participants being involved in concurrent mental health treatments.

Group therapy

In a discussion of some of the process, multicultural, and social justice issues around religion in group therapy, Cornish, Wade, Tucker and Post (2014) pointed out a lack of research around addressing religion and the use of S/R interventions in groups. Cornish and Wade (2010) offered guidelines to assist therapists to incorporate spirituality and religion in their counselling groups, including a list of questions that may facilitate discussion of the issues, together with suggestions on group structure.

Wade, Post, Cornish, Vogel and Runyon-Weaver (2014) outlined the progress of a group of seven individuals over 28 group sessions to illustrate integration of S/R issues in the complexity of nonthematic, general process group therapy. They provided excerpts from three sessions during which issues of religion/spirituality had been discussed. These transcripts were selected to highlight three important concerns for therapists facilitating such group work. One concern was the therapist's need to discern how to welcome the sharing and discussion of S/R experiences while maintaining relevance to the group. A second concern was discussed around a transcript that illustrated the management of conflict within the group around S/R issues. The authors stated that effective group psychotherapy would explore topics of importance and of common concern even though doing so may be uncomfortable and arouse conflict and differences between members of the group. The third area of concern raised was the processing of S/R through discussion or structured exercises, supporting members to voice their views, as well as consideration of inclusion of some degree of the therapist's self-disclosure. Wade et al. suggested that attention to these three areas can result in effective treatment for clients by addressing S/R issues through participation in a safe and cohesive group.

Couples

An investigation comparing a religion-accommodative Hope-Focused Couples Approach (HFCA) intervention with standard HFCA treatment for couples was reported by Ripley et al. (2014). Ninety-two couples participated in the study. There were no significant differences in outcomes for the two versions of treatment, indicating that the inclusion of religious elements in therapy for couples in the study neither increased nor impaired treatment effectiveness.

Hook, Worthington, Davis and Atkins (2014) reported outcomes of a naturalistic study of Christian couples participating in therapy that integrated religious elements or techniques. Techniques most often used include discussion about faith, prayer, assigning religious tasks for homework, and forgiveness. Clients reported high satisfaction, a strong working alliance, and improvements in relationship satisfaction over time. However the authors pointed out that due to a number of limitations, including lack of a comparison group and the therapy being conducted by Christian therapists for Christian clients, the findings should not be generalised to other therapies or populations.

Recommendations and conclusion

The association of S/R with physical and psychological health is well established. The studies discussed in this article add to the many previous investigations that have explored the effectiveness of S/R interventions in psychotherapy and counselling. Studies have reported positive outcomes of S/R inclusive treatment across a range of disorders including depression,

anxiety, PTSD, schizophrenia, and trauma, as well as for patients coping with illnesses such as cancer.

While the effectiveness of the integration of S/R in a variety of therapeutic approaches is supported, there is little evidence at this stage to suggest that S/R interventions are superior to secular treatments. This may in part be attributed to a distinct lack of scientific rigour in the studies, and a call for more rigorous research resounds across the literature (Agorastos et al., 2012; Aten & Worthington, 2009; Bonelli & Koenig, 2013; Koszycki et al., 2014; Masters, 2010; Richards, 2012; Richards & Worthington, 2010; Ripley et al., 2014; Worthington, Hook, Davis, Gartner & Jennings, 2013). The sample sizes of studies tend to be small, and there is a lack diversity of populations, as much of the research has involved Christian centred traditions in the context of Western cultures (Richards, 2012; Watts, 2012). Furthermore, many studies lacked a control group.

The lack of Australian based studies is disappointing, particularly since the gap had been identified over eight years ago (Koenig, 2007). In 2003, Passmore discussed the apparent reluctance of Australian psychologists to acknowledge the relevance of religious issues in therapy or to investigate the issue in research. Passmore (2003) suggested that the reason for this lag behind American colleagues may be the lack of training and investigation of S/R issues provided by psychology programs in Australia. That comment was made over a decade ago. The continued scarcity of Australian research in the area of S/R suggests that the issues Passmore identified may still be relevant today. With the international interest and investigation of the contribution of S/R to mental and physical health already substantial and continuing to grow, psychology training institutions in Australia may need to consider allocating more focused consideration of these issues in course work.

In summary, the literature supports the consideration of S/R issues as a standard component of client assessment, and a number of assessment tools are available. Where an assessment indicates that S/R issues are relevant to an individual client, there are a variety of S/R interventions that have been shown to be effective in therapy. Continued research that extends the diversity of population groups, and implements more scientifically rigorous methods in the investigation of treatment and outcomes, together with the inclusion of S/R focused issues in training curricula would take the knowledge of methods for working effectively in this field forward. Meanwhile, research and resources are already available to provide therapists who wish to gain a working understanding of S/R issues and methods of assessment and intervention. Familiarity with and application of this information can only serve to contribute to an increase in the levels of competence and inclusive practice that therapists are able to provide to their clients.

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