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Religiously Integrated Cognitive Behavioral Therapy: A New Method of Treatment for Major Depression in Patients With Chronic Medical Illness

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Abstract

Intervention studies have found that psychotherapeutic interventions that explicitly integrate clients' spiritual and religious beliefs in therapy are as effective, if not more so, in reducing depression than those that do not for religious clients. However, few empirical studies have examined the effectiveness of religiously (vs. spiritually) integrated psychotherapy, and no manualized mental health intervention had been developed for the medically ill with religious beliefs. To address this gap, we developed and implemented a novel religiously integrated adaptation of cognitive–behavioral therapy (CBT) for the treatment of depression in individuals with chronic medical illness. This article describes the development and implementation of the intervention. First, we provide a brief overview of CBT. Next, we describe how religious beliefs and behaviors can be integrated into a CBT framework. Finally, we describe Religiously

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Integrated Cognitive Behavioral Therapy (RCBT), a manualized therapeutic approach designed to assist depressed individuals to develop depression-reducing thoughts and behaviors informed by their own religious beliefs, practices, and resources. This treatment approach has been developed for 5 major world religions (Christianity, Judaism, Islam, Buddhism, and Hinduism), increasing its potential to aid the depressed medically ill from a variety of religious backgrounds.

Keywords

depression; religion; spirituality; medical illness; psychotherapy

Depression is a significant public health problem and is one of the major causes of disability worldwide (World Health Organization, 2008). Depression is associated with higher rates of morbidity, mortality, and medical costs, especially among those with a medical illness, whose risk of mortality is up to twice that of the general population (Covinsky et al., 1999; Davydow et al., 2011; Hedayati et al., 2010; Katon, 2003; Sheeran, Byers, & Bruce, 2010). Medications used to treat depression are effective for only about 60% of individuals (Gartlehner et al., 2007) and appear to be minimally effective for those with mild to moderate depression (Fournier et al., 2010). Response rates drop further in those with comorbid medical illness (Simon, Von Korff, & Lin, 2005; Sinyor, Schaffer, & Levitt, 2010).

Two resources that are widely used by people suffering from mental and physical illness are psychotherapy and religion/spirituality. One of the most evidenced based forms of psychotherapy is cognitive–behavioral therapy (CBT; Chambless & Ollendick, 2001). Randomized controlled trials (RCTs) generally indicate that CBT is an effective treatment for depression in the setting of medical comorbidity (e.g., Lustman, Griffith, Freedland, Kissel, & Clouse, 1998; Savard et al., 2006), although a systematic review of 23 RCTs concluded that the quality of many of these studies was questionable (van Straten, Geraedts, Verdonck-de Leew, Andersson, & Cuijpers 2010). CBT may have disorder-specific effects, such that depression associated with some medical conditions (e.g., cancer) may respond better than depression associated with other medical conditions (e.g., HIV/AIDS; van Straten et al., 2010). Those with medical illness also frequently report turning to religion to find strength and comfort and derive meaning (Koenig, Shelp, Goli, Cohen, & Blazer, 1989; Pargament, 1997). Numerous empirical studies have revealed inverse relationships between religious beliefs and practices and depression (see Koenig, King, & Carson, 2012).

A number of theoretical and empirical articles emphasize the need to integrate religion/spirituality into treatment (see Hodge, 2006; Hook et al., 2010; McCullough, 1999; Pargament, 2007; Rose, Westefeld, & Ansely, 2001; Smith, Bartz, & Richards, 2007; Worthington, Hook, Davis, & McDaniel, 2011). Several *spirituality*-based therapies have also been developed. These include Spiritual Self-Schema therapy for treatment of addiction and HIV risk behavior (Avants & Margolin, 2004); mindfulness, an integration of Buddhist and Western psychological principles and practices used for the amelioration of psychological problems (e.g., Epstein, 1995; Rubin, 1996); mindfulness-based cognitive therapy for depression (Segal, Williams, & Teasdale, 2002); and spiritual coping groups for

those with HIV (Tarakeshwar, Pearce, & Sikkema, 2005), sexual abuse (Murray-Swank & Pargament, 2005), and cancer (Cole & Pargament, 1999). Spiritual interventions have been used for the treatment of generalized anxiety (Koszycki, Bilodeau, Raab-Mayo, & Bradwejn, in press; Koszycki, Raab, Aldosary, & Bradwein, 2010) and posttraumatic stress disorder (Bormann et al., 2006; Bormann, Thorp, Wetherell, Golshan, & Lang, 2013).

Intervention studies have found that integrating religious clients' spiritual and religious beliefs in therapy is at least as effective in reducing depression than secular treatments (Azhar & Varma, 1995; Azhar, Varma, & Dharap, 1994; Berry, 2002; Hodge, 2006; Hook et al., 2010; McCullough, 1999; Pargament, 1997; Propst, 1980; Propst, Ostrom, Watkins, Dean, & Mashburn, 1992; Razali, Hasanah, Aminah, & Subramaniam, 1998; Smith et al., 2007; Tan & Johnson, 2005; Wade, Worthington, & Vogel, 2007; Worthington & Sandage, 2001). Worthington and colleagues' (2011) meta-analytic review of 46 spiritual intervention studies concluded that patients with spiritual beliefs in spiritually integrated psychotherapies showed greater improvement than patients treated with other psychotherapies. When compared with the same type of therapy in secular form, spiritually integrated therapies showed greater improvement on spiritual outcomes and similar improvement on psychological outcomes. Furthermore, 77% to 83% of patients over age 55 wish to have their religious beliefs integrated into therapy (Stanley et al., 2011).

Spirituality-based interventions, however, may or may not include religious elements. In contrast, religious psychotherapy focuses specifically on including and using patients' religious resources. *Religious* psychotherapy, specifically religiously integrated CBT, which uses the religious resources of patients in the treatment of depression, may boost the effects of conventional CBT in religious patients with medical illness (Koenig, 2012; Pearce & Koenig, 2013). Several studies have examined the effectiveness of Christian CBT among college students and clinical samples (e.g., Hawkins, Tan, & Turk, 1999; Pecheur & Edwards, 1984; Propst, 1980; Propst et al., 1992; Tarakeshwar et al., 2005) and Muslim CBT-like approaches (Azhar & Varma, 1995; Azhar, Varma, & Dharap, 1994; Razali et al., 1998) for the treatment of depression and anxiety. As with the other spiritually integrated therapies, these religiously integrated therapies were found to be as or more effective than conventional or control treatments for depression. However, many of these studies were small and of debatable quality. There are also few "religiously"-based manual-guided interventions available.

What remains to be determined is the effectiveness of religiously integrated CBT for the treatment of depression in the medically ill. To explore this important question, we designed and implemented a multisite, randomized controlled trial of religiously integrated CBT compared with conventional CBT for the treatment of depression in individuals with a chronic medical illness (Koenig, 2012). The randomized controlled trial of this intervention is now drawing to a close with patient follow-up to end December 2013; results will be reported soon thereafter.

The goal of the present article is to describe the development and implementation of the manualized intervention used in the above trial. First, we provide a brief overview of CBT. Next, we describe how clients' religious beliefs and behaviors can be integrated into a CBT

framework. Finally, we describe Religiously Integrated Cognitive Behavioral Therapy (RCBT), a manualized therapeutic approach designed to assist depressed individuals to develop depression-reducing thoughts and behaviors informed by their religious beliefs and resources.

One of the major challenges of designing and implementing a religiously integrated treatment is how to be both specific to a religious tradition, but also broad enough to be applicable to a number of world religions, as well as to the diversity of beliefs within one religious tradition. Our RCBT intervention was developed for five of the major world religions: Christianity, Judaism, Islam, Buddhism, and Hinduism. The challenges we encountered with integrating each of these religious traditions in treatment will be discussed.

Brief CBT Review

CBT is a psychotherapeutic approach that integrates behavioral and cognitive principles and research with behavioral therapy, cognitive therapy (based on the work of Aaron and Judy Beck), and rational emotive therapy (based on the work of Albert Ellis). The central premise of CBT is that thought patterns and beliefs, emotional state, and behavior are all interconnected. When a person suffers an emotional state such as depression, CBT emphasizes two effective ways to modify emotions. First is to identify, challenge, and change cognitive processes (i.e., how one views a situation), and second is to change behavior. How individuals perceive a situation and interpret it often determines how they feel and what they do. Research has shown that the perceptions and interpretations of depressed persons are usually not accurate (Beck, Rush, Shaw, & Emery, 1979; Beck, 2005) and can initiate a vicious cycle. Those who are depressed have a greater tendency to engage in “cognitive errors,” such as jumping to conclusions, using a negative mental filter, all-or-nothing thinking, or catastrophizing. CBT teaches individuals to identify, challenge, and replace maladaptive thoughts and distorted thinking styles with healthy thoughts and behaviors. CBT is characterized by a collaborative therapeutic style, agenda-setting, frequent eliciting and responding to client feedback, empathic communication, Socratic questioning, guided discovery, homework assignments, and attention to difficulties in the therapeutic relationship.

Integrating Religious Beliefs Into CBT

Religiously integrated CBT adheres to the same principles and style of conventional CBT and uses many of the same tools. What is unique to religiously integrated CBT is the explicit use of the client’s own religious tradition as a major foundation to identify and replace unhelpful thoughts and behaviors to reduce depressive symptoms. When a client discusses symptoms and reactions to symptoms, therapists frame this material in terms of traditional CBT models and listen with a “third ear” for how this material can also be framed within a religiously integrative CBT model. The following section will review some of the major tools of RCBT (Table 1).

Renewing of the Mind

The idea that our thoughts and interpretations play an important role in influencing our emotions and our behaviors is common to many world religions. For example, in the Jewish tradition, King Solomon wrote " … for as he thinks in his heart, so is he" (Proverbs 23:7). In the Christian tradition, "metanoia" literally means "change your mind" or "change how you think," which the Bible translated as "repent" (Matthew 4:17). Islam teaches this notion as well: "Surely Allah does not change the condition of a people until they change their own condition" (Qur'an 13:11). Religious individuals' worldviews and value systems are often founded on their sacred scriptures. For these individuals, sacred scriptures can be used to help form more adaptive and accurate thinking, inconsistent with depression. In RCBT, clients are taught to use their religious teachings to replace negative and inaccurate thoughts with positive principles found in scripture that promote mental health.

Scripture Memorization and Contemplative Prayer

In RCBT, therapists provide clients with a passage from scripture that is relevant to a particular session's topic. For example, the third session focuses on meditation for the purpose of managing feelings of distress. In our Hindu CBT manual, clients are asked to memorize the following passage: "Let him a (wise man) sit intent on Me (God) …" (Bhagavad Gita ch 2, v 61). Similarly in the Buddhist CBT manual, clients memorize this passage "Meditation brings wisdom; lack of meditation leaves ignorance. Know well what leads you forward and what holds you back, and choose the path that leads to wisdom" (Dhammapada 282). Clients are asked to memorize the passage and therapists suggest that the more positive teachings of their religious tradition they have stored away in their memories, the easier it will be to challenge and help them change their negative thinking. Clients can also be taught to meditate on these passages, called Contemplative Prayer, which helps them to remember and apply this type of thinking (Table 2).

Challenging Thoughts Using One's Religious Resources

A common strategy for identifying and challenging negative thinking, and the central approach used in RCBT, is the ABCDE method developed by Albert Ellis (Ellis, 1962). We add step R for religious beliefs and resources (Table 3). This is a practical approach to help clients see how their thoughts, feelings, and behaviors are linked. Clients are instructed on how to be scientists, examining their thoughts carefully and objectively, before automatically accepting them as truth.

The first step, "A," stands for the Activating event and is used to describe the situation that occurred around the time the negative emotions began. The second step, "B," stands for Beliefs, and involves identifying the thoughts that went through the clients' minds as a result of the activating event. The third step, "C," stands for Consequences, of which there are two types: emotional and behavioral. This ABC process is the basic premise of conventional CBT. Several additions are made at this point to integrate the client's religious beliefs and practices to help them challenge dysfunctional beliefs and thinking patterns. First, clients are introduced to categories of unhelpful thinking styles, such as magnification, all-or-nothing thinking, and should statements (Table 4). What makes this different from conventional CBT is that a theological reflection for each style of thinking is provided and discussed. The

theological reflections ground this exercise in the client's religious tradition, which is different from conventional CBT. It also helps clients to focus their minds on the truths taught by their religious tradition. Contrasting the maladaptive thinking style with their religious teaching provides another source of motivation to change negative thoughts. This method can also address distorted religious beliefs, such as a distorted view of a punishing God.

After the client identifies the unhelpful thinking style involved in their thought process, they are ready to implement steps "D" and "E" of the ABCDE approach to change negative beliefs. These steps explicitly call upon the client's religious beliefs and practices as resources to help confront and change dysfunctional beliefs. Step "D" stands for Disputing and is used to challenge unhelpful and negative thinking. An essential part of step D is having clients examine their religious beliefs and resources to see how these might help them dispute their negative thoughts. For example, clients can turn to the way they believe the world works from a religious viewpoint, their sacred scriptures and religious writings, spiritual wisdom, and other sources for evidence to challenge their negative beliefs. Clients are asked questions like the following: "When you look at your original belief, expectation, or your way of thinking about the situation, are there any beliefs or attitudes from your religious tradition that strike you as helping to generate an alternative viewpoint?" The answers clients derive from these disputing questions, such as supporting or negating evidence, will result in step "E," which is an Effective new belief and new Emotional and behavioral consequences.

Religious Practices

RCBT not only addresses cognitions that contribute to depression, but also behaviors. In terms of the behavioral arm of RCBT, like traditional CBT, religious beliefs can be effective motivators that may support clients in their striving to build positive behavioral patterns to combat depression. For example, most world religions encourage forgiveness, gratitude, generosity, and altruism, each of which is addressed in RCBT. Other behavioral practices in RCBT include praying for self and others, regular social contact with members of their religious community, writing a gratitude letter, and engaging in hope-promoting, stress-reducing activities based on the spiritual concept of "walking by faith" and not by feelings. For example in the Jewish tradition, the notion that a person can use freewill to engage in positive behaviors despite conflicting emotions is reinforced in the Torah. The Talmud writes: "one who seeks to improve, the way is opened for him."

Clients are instructed to engage in several specific religious practices daily, namely contemplative prayer, scripture memorization, and prayer for others. These daily practices have the potential to impact psychological skill agility and spiritual growth where spiritual growth represents an understanding of one's self that empowers the person to overcome depression. One of the strengths of RCBT is that it integrates CBT skills into the structure of daily spiritual activities, daily devotional practice, and daily ritual. In religious traditions, daily practices are typically regarded as important ingredients of spiritual growth (e.g., prayer, keeping scripture at the forefront of one's mind). In RCBT, they are used to support

the development of psychological skill agility (e.g., ability to readily access learned emotional regulation, thought challenging, support seeking skills).

Religious/Spiritual Resources

RCBT encourages clients to make use of the many religious/spiritual resources they have available to them. These may include meditation, social support from members of their house of worship, conversations with religious leaders, participating in religious study groups, reading religious literature, watching religious programming, engaging in charity, and attending religious services or activities sponsored by religious groups, such as Swadhyaya (Hinduism) activities or activities in mosques (Islam), or meditation retreats/ sessions (Buddhism).

Involvement in Religious Community

RCBT encourages involvement in the religious community and identification of someone whom the patient can support; for example, someone whom they can spend time with and pray for. This is different than simply seeking support from others within the religious community, as religious traditions typically encourage their adherents to live out their religion by supporting and caring for others. This community engagement is likely to lead to both increased social support (Hill & Pargament, 2003) and increased altruistic activities that help to neutralize negative emotions (Krause, 2009; Seligman, Steen, Park, & Peterson, 2005; Shariff & Norenzayan, 2007).

Development and Implementation of RCBT

In this section, we discuss the study's development and implementation of RCBT, including a description of the content and format of the 10 sessions, use of the workbook, therapy delivery methods, training and supervision of RCBT therapists, and challenges involving the application to five world religions. The RCBT we developed is a variant of the treatment protocol originally designed by Beck et al. (1979) and is based on theory and empirical research on the important role that religious beliefs play in the lives of religious clients in psychotherapy. We adapted the intervention to apply to individuals who are depressed in the setting of chronic medical illness. This design is present across the five manuals corresponding to the religious traditions of the major five world religions.

We use the following scriptures in the five religiously integrated treatments: In the Jewish treatment manual, the Torah and Talmud are used as the main sacred scriptures; in the Christian manual, the Holy Bible; in the Hindu manual, the Bhagavad Gita (containing the essence of all four Vedas that were revealed through Brahman); in the Buddhist manual, the Dhammapada (a collection of several hundred short wise sayings or verses attributed to the Buddha); and in the Muslim manual, the Holy Qur'an.

Session Length

We chose a 10-session protocol for a number of reasons. First, many insurance companies allow only a limited number of sessions for psychotherapy, requiring that this therapy be relatively brief. Second, our patients were those who had situational depression related to

their medical condition and disability. They were not psychiatric patients with long-standing mental disorders. Finally, a systematic review indicates that depression can be treated efficaciously by psychotherapy, particularly CBT, with >10 session (Nieuwsma et al., 2012). Therefore, we followed protocols designed for either Internet- (Kessler et al., 2009) or telephone-based CBT (Simon, Ludman, & Rutter, 2009; Simon, Ludman, Tutty, Operskalski, & Von Korff, 2004) used previously in primary care patients. We acknowledge that in clinical practice some patients may need >10 sessions and/or may need more time spent on specific sessions, such as the session on spiritual struggles. Long-term follow-up may also be necessary, depending on how deep seated the patient's problems are.

Session Content

Each session was 50 to 60 min in length and followed a similar format.

Session 1: Assessment and Introduction to RCBT

In the first session, clients are introduced to the basic format of treatment and the therapist begins to establish rapport by allowing the client to discuss his or her emotional and medical problems, life circumstances, and religious beliefs. The rationale for the treatment is presented, and the nature of religiously integrated CBT is described in detail. Clients are then taught how to monitor their activities and mood during the upcoming week using an activity monitor. Scripture/sacred writing memorization is introduced. Clients are taught that a key way to begin to change their thoughts and perspectives is by replacing negative thoughts with what is said in their sacred scriptures. For example, in the Christian manual, patients learn that the Bible is self-described as "alive and powerful" and that as they meditate on scripture, God's words become alive in them and change them from the inside out. Christian patients are then assigned the following verse to memorize that week: "Finally, whatever is true, whatever is noble, whatever is right, whatever is pure, whatever is lovely, whatever is admirable—if anything is excellent or praiseworthy—think about such things" (Philippians 4:8). In all sessions across all manuals, a verse from scripture relevant to the session material is given to memorize and meditate on for the following week (see Table 5 for examples).

Session 2: Behavioral Activation

In the second session, therapists reinforce clients' basic understanding of the treatment rationale and further refine their ability to self-monitor their mood and activities. Clients are taught the importance of participating in pleasant activities for improving their moods and are asked to schedule several pleasant activities for that week. For clients who are monotheistic in their belief, therapists emphasize that there are many things God asks people to do that they don't necessarily feel like doing. People do these things because they believe that a loving God would only ask them to do things that are ultimately for their benefit. In the same way, clients may not feel like engaging in activities, but they can draw upon this principle to do so and have faith that their feelings will change. In the Jewish manual this concept is explained as follows: *An effective way to change our mood is to engage in pleasant activities. One of the first steps in changing our perceptions and negative thoughts is to begin to see the good things in our environment and to make some of them a part of our*

daily activity. This idea is consistent with Torah thought. The 13th Century work "Sefer HaChinuch" writes, "Know that a man is influenced in accordance with his actions. His heart and thoughts follow after his deeds in which he is occupied … Therefore, look carefully at what you do, for after your actions your heart will be drawn." We cannot always remove the source of the negative events—in your case, for example, your medical condition—but things can be improved by increasing the number of positive events. Finally, clients are asked to identify a supportive person from their religious community with whom they can interact, support, and pray for during the coming weeks. The goal is not only to increase their social support, but to provide them with ways to care for others, increase a sense of purpose, and evoke gratitude for what is going well in their lives.

Session 3: Identifying Unhelpful Thoughts

In the third session, cognitive processing is introduced. Clients are taught to identify their mood and the thoughts accompanying changes in mood. Categories of distorted thinking styles are introduced and discussed. For each category, theological reasons are presented for why these types of thinking are unhelpful and unscriptural (Table 4). The ABC method of challenging beliefs that lead to negative emotions is taught and practiced (Table 3). Finally, clients are introduced to contemplative prayer (Table 2). Contemplative prayer involves meditating on a passage of scripture, repeating it silently to oneself, saying it as a prayer, and focusing one's attention on the words. This leads to a contemplative, prayerful state and also helps clients to memorize key passages of scripture that can be used to challenge negative thoughts.

Session 4: Challenging Unhelpful Thoughts

In the fourth session, therapists help clients to reinforce and refine their ability to monitor thoughts and to clarify their understanding of the thought distortion categories. They are introduced to how one's interpretation of an event leads to a change in mood. Finally, they are taught how to dispute negative automatic thoughts and develop alternative ways of responding to negative beliefs and expectations based on their personal value systems and goals (steps D and E of the ABCDE method). Therapists emphasize that clients' religious beliefs can help them formulate more effective ways of looking at a situation and that religious practices can aid them in generating coping responses to negative events. In the Muslim manual, clients are instructed as follows: *As a Muslim, you are not just challenging unhelpful thoughts and replacing them with more positive thoughts. You also have the added power of being able to replace your negative thoughts with the true words of God, which, according to the Holy Koran, "guides to the straightest way" (17:9).*

Session 5: Dealing With Loss

In session five, clients identify the losses they are suffering as a result of physical illness and depression. They also identify sacred losses, which in clients who are monotheistic are defined as losses that are related to their religious orientation and relationship with God, such as the loss of relationships with members of their religious community, feeling abandoned by God, and the loss of specific religious beliefs (e.g., A good God doesn't let his children suffer). The difference between control and active surrender is explained, and

active surrender is offered as one potentially effective tool for dealing with loss. Active surrender involves a conscious decision to release or let go of those things that one does not have the power to change. Clients are taught that when people surrender to God they demonstrate their faith that God will take care of things in God's own way. Paradoxically, people often report feeling more in control after surrendering. The Buddhist manual instructs clients in a similar manner: *Surrendering the need to have things be a certain way helps us begin the process of letting go. It is important to remember that active surrender is different from giving up. Notably, surrender is paradoxical—the Buddha said that much dukkha or stress has to do our need for things to happen in a certain way. In Buddhist terms, "surrender" is not surrendering the "will" to God, but rather surrendering or letting go of identity with the core of the ego, or the identification of the self with a source of pain or a source of desire.* Therapists also emphasize the use of religious resources to understand and giving meaning to their losses.

Session 6: Coping With Spiritual Struggles and Negative Emotions

In the sixth session, clients discuss various spiritual struggles as a result of their depression and/or medical illness. Therapists help clients to explore core experiences that may have contributed to a change in the client's religious beliefs, such as feeling abandoned or punished by God (if monotheistic). Clients are given time and permission to voice their hurts, doubts, and questions. Therapist and client discuss the meaning of forgiveness and repentance and explore how these tools can help to cope with spiritual struggles and negative emotions. Research on the relationship between negative emotions and physical/mental health is shared with the client. The ABCDE method is used to help the client see the situation from the offender's perspective, aiding in the development of empathy and the alignment of feelings with the decision to forgive. In the Christian manual, if clients desire to forgive themselves or someone else, they are given the option of praying the following prayer or one similar to this: *Heavenly Father, I purpose and choose to forgive ___ (the person) for ___ (the action). I release him/her and cancel their debt to me completely. I will no longer hold any accusation against them. Even now I release them from this sin. I ask that you would forgive them for this sin and separate the sin from them forever. Please forgive me for the unforgiveness/bitterness (or other feelings against this person) that I have stored in my heart. I give you all my feelings of ____ and ask that You would cause my feelings to line up with my decision to forgive ___ (the person). I also purpose and choose to forgive myself. Thank you for forgiving me and making me righteous in your sight. Holy Spirit, please heal my heart and tell me your truth about the situation.*

Session 7: Gratitude

Clients are first introduced to the benefits of gratitude. Therapists help clients explore what it means to be a grateful person and how their feelings of gratitude may have been reduced or even destroyed by experiences with illness. Cognitive restructuring is then practiced from a gratitude framework. Special focus is given to religious gratitude, including the importance of gratitude in the client's religious tradition and being grateful to God and the things, people, and experiences God has provided (again, if monotheistic). The concept of giving thanks in all situations is explored. In the Jewish manual, therapists share the following: *The Torah has a lot to say about being thankful. In fact, it's hard to find a section*

of the Torah or even a single Psalm that does not mention gratitude, praise, or thankfulness. We are instructed in Psalms to thank God for the fact that He is good and that His goodness extends to the entire world without ceasing. God wants us to be thankful at all times. Indeed, many times the word "thanksgiving" is paired with the words "sacrifice" and "offering." This suggests that giving thanks to God is seen as a pleasing sacrifice of our wills and desires to God. Clients across all religious traditions are led in an exercise of identifying the things they are grateful for in their lives. They are also directed to engage in grateful behavior by writing a thank you letter to someone significant.

Session 8: Altruism and Generosity

Here the client is introduced to the notion of expressing religious gratitude by being generous and engaging in altruistic acts. A religious motivation is provided for helping others (e.g., the great commandment of doing unto others as you would have them do unto you). In the Hindu manual, therapists share the following religious rationale for altruism: *Research tells us that if we pay even a little attention to giving to others that, over time, we end up feeling better ourselves. We also know that no behavioral feature characterizes Hinduism more than its focus on doing your duty, caring for and loving other people. Compassion toward the less fortunate, giving alms to the needy, building temples for prayers, and giving a certain portion of one's wealth is a highly desired virtue.* Clients are led in an exercise to plan several altruistic acts they can perform that week.

Session 9: Stress-Related and Spiritual Growth

The concept of stress-related growth, particularly from a spiritual perspective, is discussed. Clients explore ways they may have experienced positive growth through their illness experience, including positive changes in their personal relationships, character, and abilities. A series of exercises are completed in which clients look for the positives in their lives in the midst of the current challenges. Clients are encouraged to look to their religion to help them find meaning and purpose in their suffering. Therapists revisit the importance of one's interpretation of life events as a means to achieve stress-related and spiritual growth through discussing several stories in scripture illustrating this point. In the Muslim manual, therapists share the following with clients to show how a prophet found meaning and purpose in his suffering: *A Koranic example is prophet Yusuf, who was thrown into the well and spent many years innocent in the jail, but these unfortunate events led him to become a high authority in the land and to be an example of morality among the people. So as is said in Surah Yusuf: "certainly those who keep from evil and are patient, Allah does not let the wage of the good doers go to waste" (12:90).*

Session 10: Hope and Relapse Prevention

In the final session, hope is introduced as a positive state of being that results from using religious cognitive and behavioral strategies. When discussing hope with Buddhist clients, therapists state the following: *According to the words of the Buddha: "Insight into change teaches us to embrace our experiences without clinging to them—to get the most out of them in the present moment by fully appreciating their intensity, in full knowledge that we will soon have to let them go to embrace whatever comes next. Insight into change teaches us*

hope. Because change is built into the nature of things, nothing is inherently fixed, not even our own identity. No matter how bad the situation, anything is possible (Thanissaru Bhikkhu). Clients discuss their dreams and goals, their spiritual resources, and what they have learned over the course of therapy. Therapist and client review the key skills the client learned over the 10 weeks of therapy and explore how to maintain the gains achieved, such as continued involvement in their religious community (receiving and giving support), monitoring and challenging thoughts, and making use of spiritual resources.

Despite the differences across the five major world religions, the religious themes included in treatment were those that were similar across all five religious traditions. There were, however, a few themes or concepts that differed between religions and these are noted in the manuals. For example, a fundamental difference in theology between Buddhism and monotheistic religions is that the Buddha was not considered a manifestation of a transcendent God. There is no concept of being "saved" by God, or of intercessory action by a god. At the same time, there are many Buddhist stories that depict Buddha as a god and that refer to miraculous powers, reincarnation, a heavenly like paradise, a hell populated by demons. Asian Buddhists are more likely to relate to such images, but they are unlikely to hold the same meaning they would for a Christian. Therefore, in relation to the emphasis and purpose of the Buddhist manual, the focus is brought back over and over to the core teachings of Buddhism: that the power to heal suffering lies within, and relief from suffering lies in using the teachings of the Buddha in a way that he intended.

Workbook and Home Practice Activities

A 10-session patient workbook and corresponding therapist workbook were created to complement the treatment manual. Clients are provided with a copy of the workbook before treatment begins. Each section of the workbook begins with a home practice activities instruction page, which summarizes the assignments the client will complete on their own during the week following the therapy session. At the end of a session, therapists review these assignments with clients. Clients are expected to complete all of the home practice activities, with the expectation that the more effort they put into treatment, the more they will get out of it. At the same time, it is important for therapists to remember that they are working with depressed people, who are limited to some degree by their medical illness and the fatigue caused by their depression. As such, when clients do not complete home practice activities, therapists are instructed to praise clients for what they did accomplish and focus on identifying barriers and engaging in problem solving.

Training and Supervision

Therapists who want to provide RCBT to their clients need first to be well versed in conventional CBT. They then need to learn how to integrate clients' religious beliefs and practices effectively, sensitively, and ethically into the CBT model. Our manuals provide detailed instructions on how to do this; however, additional training and supervision may be necessary for those who do not have prior experience integrating religion into psychotherapy. This is a form of cultural competence and is a lifelong learning and refining process. All therapists who participated in our randomized controlled trial of RCBT received

two days of onsite training followed by regular supervision sessions conducted by telephone throughout the trial.

After a brief refresher course on CBT for depression, including specific examples and modeling, therapists will need specific training in RCBT, including the basic principles of RCBT, how to use the manual and workbook, and ample time to role play each session with a colleague. After the training, it is recommended that therapists participate in regular supervision until they are comfortable delivering the therapy. When treating patients from a religious tradition outside the therapist's familiarity, it is advisable to seek a supervisor within that religious tradition for guidance. In our RCBT clinical trial, supervisors experienced in CBT from each of the religious traditions who developed the manuals helped to supervise therapists. We acknowledge that access to supervisors from other religious traditions may be limited for some clinicians. To address this need, our team is exploring ways to provide therapists with online training, consultation, and supervision. The treatment manuals will be available on the Duke Center for Spirituality, Theology, and Health Web site in early 2014.

Challenges

We have encountered numerous challenges to implementing RCBT during the clinical trial, some of which are common to administering a manualized treatment (e.g., fidelity to the manual, uniformity of therapist abilities) and others that pertained to the religious nature of the treatment. This section will address those challenges and the lessons learned. One such challenge was the unfamiliarity of therapists with religions traditions outside of their own. When there was a discrepancy in religious orientation between therapist and client, therapists discussed this with their clients during the first session. To assist with this challenge, the manuals include ample dialogue script for the therapists to use, as well as notes and instructions to the therapists regarding religious concepts and resources discussed in the treatment manual. Developers of each of the five religious manuals answered questions posed by either the therapists or their clients pertaining to the particular religious tradition and advised on how best to integrate the patient's religious beliefs and practices into treatment. This approach for working with patients outside of the therapist's religious tradition worked well and has been suggested by others in the field as a way to develop competence in providing religiously/spiritually integrated therapy.

A second challenge was providing treatment for clients who considered themselves spiritual, but not religious. When first recruiting for the study, we enrolled individuals for whom religion *or* spirituality was at least somewhat important. When participants indicated this and were from a Christian religious tradition, they were assigned the Christian manualized treatment. During the initial session, clients who were spiritual but not religious often objected to the liberal use of scripture and a clear focus on Christian teachings and practices. They stated that they considered themselves to be nominal Christians, meaning that while they were raised Christian, they did not follow the teachings of the Bible and were not interested in a treatment that was based on that model. We recognized that continuing in this manner was at odds with the goal of RCBT, which is to integrate the client's religious beliefs and practices into treatment. For those who do not have an active religious tradition,

it is not ethical to try to integrate Christian or any other religious beliefs and practices into treatment. To rectify the problem, we changed the recruitment criteria such that interested participants needed to be practicing within a religious tradition rather than only considering themselves to be spiritual but not religious. Therefore, if clients are spiritual, but not religious, this RCBT treatment would not be a good or ethical choice for therapy.

A third challenge was intrareligious differences. Specifically, each of the religions represented in the RCBT manuals have many different subgroups and sets of beliefs and practices. Take Hinduism, for example. Within Hinduism there are a number of subgroups and belief systems. Based on the theory that God is “Avatar” (rebirth), the Hindu diety is recognized by different names based on the time and era they were born on this earth. There is a misperception among non-Hindus that Hinduism has many gods. In reality, there is one God (Brahman) who is recognized by many different names and forms, such as Rama, Krishna, Ganesh, Buddha, Mahavira (Maha-Vira), Hanuman (Hanuman), and others. In addition, there are a number of gurus or religious leaders who give presentations based on Hindu scriptures. Therefore, when working with a Hindu client, it is important to identify if he or she has chosen a name for God to worship and if he or she listens to presentations given by religious leaders.

Judaism has several major groups, including reconstructionist, reform, conservative, orthodox, and ultraorthodox. For each subgroup, the integration of Judaism into treatment will be different. The same is true for practitioners of Islam: there are major differences between Sunni, Shia, and Sufi subgroups. Significant differences exist among Vipassana, Tibetan, and Zen Buddhist practitioners. Christianity also has many different denominations with varying beliefs and practices. The manuals for each religion would have been much too long and far too complicated to address all the various beliefs and practices within each religion. To meet this challenge, therapists were instructed to learn relevant details from the client about his or her own religious beliefs and practices and were reminded to use the manual as a guide not a prescription. The emphasis was always placed on working with the material provided by the client in terms of their own religious beliefs and practices.

Conclusion

Much has been written about the need for empirically validated, theory-driven spiritually and religiously integrated psychotherapy. Intervention studies have found that integrating clients’ spiritual and religious beliefs in therapy is as or more effective in reducing depression than secular treatments for religious clients. However, few empirical studies have examined the effectiveness of religiously (vs. spiritually) integrated psychotherapy, and no manualized mental health intervention until now has been developed for the medically ill with religious beliefs. We offer RCBT as an approach for treating depressed medically ill individuals with religious beliefs. We believe this is a novel strategy for reducing depressive thoughts and behaviors. The goal of RCBT is to use explicitly a patient’s own religious tradition as a foundation to identify and replace depression-maintaining thoughts and to emphasize that religious beliefs and practices can be used as resources to reduce depressive symptoms and facilitate positive emotions. Some of the major tools of RCBT include scripture memorization to renew one’s mind, contemplative prayer, challenging thoughts

using religious teachings, engaging in religious practices (e.g., gratitude, altruism, forgiveness), and involvement in a religious community. Helping clients to integrate their own religious beliefs, behaviors, and resources in skillful and appropriate ways is the heart and soul of religiously integrative CBT. Depression in those with medical illness knows no cultural or religious bounds. Accordingly, this treatment approach has been developed for five major world religions (Christianity, Judaism, Islam, Buddhism, and Hinduism), increasing its potential to aid the depressed medically ill from a variety of religious backgrounds. RCBT is sensitive to the challenge of being specific to a religious tradition, but also broad enough to be applicable to a number of world religions, as well as to the diversity of beliefs within each religious tradition.

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Table 1

The Major Tools of RCBT

Renewing of the mind
Scripture memorization
Contemplative prayer
Challenging thoughts using one's religious resources
Religious practices (e.g., gratitude, altruism, forgiveness)
Religious/Spiritual resources
Involvement in religious community

Table 2

Contemplative Prayer Instructions

1	Choose a scripture. Begin with your memory passage for the week.
2	Sit comfortably, but not too comfortably, back straight, chest open so the breath is free and open.
3	Read the passage slowly. Savor each phrase. What word phrase or idea speaks to you?
4	Read the passage again. Where does this passage touch your life? What do you see, hear, touch, or remember?
5	Read the passage a third time. Listen quietly.
6	Note insights, reflections, and personal response to the reading in your journal.
7	Follow the steps in order or go back and forth between them as you feel moved.
8	Finish by waiting for a few moments in silence.

Table 3

ABCDE Method for Challenging Thoughts

Activating Event: Describe the situation around the time the negative emotion(s) began.
Beliefs: What negative beliefs or expectations automatically went through you mind when you were in that situation?
Consequent Feelings and Behavior: What painful feelings did these beliefs or expectations lead to? Rate each feeling using a scale of 1–10, where 10 is very painful. What behavior did these beliefs and feelings lead to?
Dispute the Beliefs and Deal with the Situation: Is there any evidence that those beliefs or expectations are not totally accurate or true? Describe the contrary evidence. Specify the unhelpful thought category that best describes the error in the belief. Even if the situation can't change, what evidence do you have that you could manage it (based on your talents, past experience, support persons, and/or resources)?
Religious Beliefs and Resources: How can your view of God, your Christian worldview, the Bible and religious writings, spiritual wisdom, and other sources provide evidence that challenge your automatic negative beliefs and beliefs that you can't cope?
Effective New Belief and Consequence: What is a different way to now look at the situation? How did your feelings change after you looked at the situation differently? Rate each feeling using a scale of 1–10, where 10 is very painful.

Table 4

Theological Reflections on an Unhelpful Thinking Style

Should Statements: You try to motivate yourself with shoulds and shouldn'ts, as if you had to be whipped and punished before you could be expected to do anything. "Musts" and "oughts" are also offenders. The emotional consequence is guilt. When you direct should statements toward others, you feel anger, frustration, and resentment. One example is the depressed housewife who says to herself, "I should keep my house cleaner, and I shouldn't complain," or, "I should be able to get my work done during the day."
Theological Reflection from Christianity
One of the central themes of the New Testament is that Christ has given us a spirit of freedom and accepted us, and we should not condemn ourselves by getting upset at ourselves if we do not perform the way we think we should perform (Romans 8: 31), or the way others think we should. Saying, "I shouldn't do that," leads to a spirit of condemnation. Even if we do not do any "shoulds," God still loves us (Romans 5:8). We are made OK with God simply by grace, not by our pressured determination to keep all the "shoulds" in one's life. (Romans 5:1–2).
Theological Reflection from Islam
Several verses in Holy Koran emphasize the concept that, *Allah does not impose upon any soul a duty but to the extent of its ability (2:286, 2:233, 6:152, 23:62, and 7:42).* "Should statements" on the contrary, often expect us or other people to do or feel what they cannot do or feel under those circumstances. Therefore, they cause resentment and despair and are dysfunctional. For example, when you are depressed, if you tell yourself, "I shouldn't be so weak, I shouldn't feel sad like that," you usually feel bad about yourself, and this can lead to more sadness, weakness, and depression. Even prophet Muhammad is also encouraged in the Koran not to be so hard on himself: as God says to him, *we have not sent down the Koran to you for you to be distressed (20:2)*; so we could be taught that being hard on ourselves can sometimes be dysfunctional.
Theological Reflection from Buddhism
When we use the word "should," there is generally little room for self-acceptance or flexibility. The Buddha taught that guidelines for our own behavior can be important, but that these need to come from a place of caring and love for others, and from a place of higher wisdom and caring for ourselves. Such wisdom may reflect the recognition that situations are often complex and that a single mode of action or behavior is not even desirable or useful.

Table 5

Scripture Memorization Examples Across Religious Traditions

Session 1
Christianity
“Finally, whatever is true, whatever is noble, whatever is right, whatever is pure, whatever is lovely, whatever is admirable—if anything is excellent or praiseworthy—think about such things.” (Philippians 4:8)
Judaism
“Think Good and it will be good.” (Tzemach Tzedek)
Islam
“Allah sets forth a parable that a goodly word is like a goodly tree, whose root is firmly fixed, and its branches are in the heaven, giving its fruit at all times by permission of its lord.” (14 (Ibrahim: 24,25)
Hindu
“Those whose mind and intellect are wholly merged in Him, who remain constantly established in identity with Him, finally become one with Him. Their sins are wiped out by wisdom. They reach the supreme goal from where there is no return.” Bhagavad Gita Ch 2, V 17
Buddhism
“Light the lamp within; strive hard to attain wisdom. Become pure and innocent, and live in the world of light.” (Dhammapada 236)