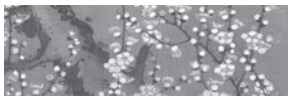

CHAPTER 1

Foundations of Spirituality, Religion, and CBT

As discussed in the Introduction, the practice of spirituality and religion is common in the general population. They are also often clinically relevant to mental health, and many patients wish to broach the subject in the context of their mental health care. The primary objective of this book is therefore to provide an evidence-based and theoretically rigorous practical guide for addressing spirituality and religion in the practice of CBT. Needless to say, developing core competencies in this or any other area of life is a multistaged process. To this end, this chapter establishes basic foundations, starting with the definitions of spirituality and religion, followed by a discussion of pertinent ethical issues (e.g., *Should* CBT clinicians be involved with promoting or discouraging spirituality and religion?), and concluding with a general approach to spiritual and religious diversity.

DEFINING SPIRITUALITY AND RELIGION

Spirituality refers to any way of relating to that which is regarded as sacred.[1] The operative word in this definition is *sacred,* which is synonymous with sanctified, holy, or consecrated. In contradistinction from the concepts of meaning and flow and other concepts of positive psychology,

[1]These definitions are adapted from those of my mentor, Kenneth I. Pargament, PhD (Pargament, Mahoney, Exline, Jones, & Shafranske, 2013).

spirituality involves behavior that is aimed at connecting with a higher reality. Another important, though secondary, feature of this definition is that spirituality is subjective and is based on unique personal experiences. In this regard, the term *spirituality* not only refers to concepts of God, but also to diverse aspects of life that are perceived to be mystical (e.g., God-like qualities or experiences, higher states of being). Spirituality may encompass both positive and negative aspects of inner life that relate sacredness to experience. By contrast, *religion is defined as institutionalized or culturally bound ways of relating to that which is perceived to be sacred*. Here, too, the primary operative word is *sacred,* but religion is less subjective than spirituality because it occurs within a social context that defines and facilitates spiritual connections to a greater reality. In this respect, religion is a subset of spirituality (see Figure 1.1), and the only difference between spirituality and religion is that the latter is part of an established culture or institution that informs one's perceptions of the sacred.

Spirituality and religion have considerable empirical overlap, at least in the United States. According to most estimates, 59–74% of Americans identify as both spiritual and religious and only 3–11% identify as neither spiritual nor religious (Marler & Hadaway, 2002), representing a weighty 63–85% concordance (i.e., 63–85% of the population is either spiritual *and* religious, or neither). This is a substantial portion of the population to endorse any sociological phenomenon. Another 14–20% of Americans identify as spiritual but not religious, suggesting that spirituality and religion do not always coexist. A very small minority of individuals (3–4%) identify as religious but not spiritual (Zinnbauer et al., 1997). This latter finding may appear to conflict with the definitions of these concepts, which postulate that religion is a subset of spirituality. Misunderstanding of survey items and sampling error could contribute

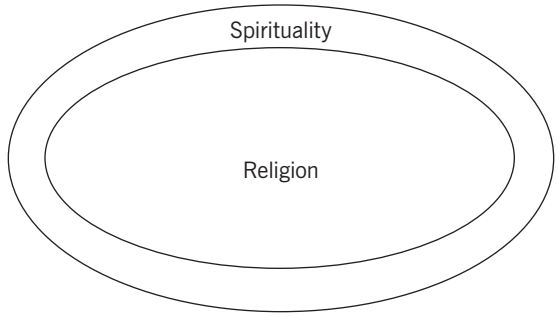

FIGURE 1.1. The relationship between spirituality and religion.

to these response patterns. Alternatively, this group also may identify as "religious" because they are members of a religious community but they lack inner faith. Regretfully, a comprehensive study contrasting spiritual and religious life has not been conducted in over a decade, so many questions concerning Americans' thoughts on the subject remain unanswered.

Given that spirituality and religion are so closely related, I do not distinguish between these two constructs in this book. Instead, I either conflate these terms by referring to the broader of the two constructs—*spirituality*—or I combine them as *spirituality–religion* (S-R). This is a utilitarian compromise that has considerable, albeit not complete empirical support. I ask that readers who are devoutly egalitarian, religiously fundamentalist, or aficionados of linguistics forgive my technically inaccurate use of these terms.

ETHICAL ISSUES

Ethical questions are a key reason for most clinicians to shy away from addressing S-R in treatment. The first critical, but basic, question is: Should S-R be introduced at all in the context of CBT, which is fundamentally a secular school of thought? Other related ethical questions are also important. Is it appropriate to promote or discourage S-R beliefs and practices in the context of treatment? How can this be done without coming off as proselytizing? Does raising the topic blur the important distinction between health care and spiritual life? If so, what separates the roles of licensed mental health practitioners from clergy in pastoral care? Must practitioners necessarily share patients' beliefs to incorporate S-R in treatment? What should be done when conflicts arise between clinicians and patients concerning S-R? For example, how should treatment proceed if a clinician deems that addressing S-R would be beneficial but a patient refuses, or vice versa? Does conceptualizing the psychological functions of S-R invalidate a spiritual worldview by taking a reductionist and/or materialist approach to S-R? I discuss these issues in this chapter, and, more important, I explicate guidelines on how to address each of them in the clinical practice of CBT.

Should CBT Clinicians Seek to Address S-R in Treatment at All?

When I started presenting on this topic several years ago, practitioners routinely and sometimes zealously challenged my assertion that it is often appropriate for clinicians to address S-R in treatment. At one conference,

I was aggressively confronted by an attendee who decried S-R as having no place in CBT, and stated it should be "checked at the door of the therapy room." I remember similar sentiments being expressed, or at least implied, by several professors in the course of my undergraduate and graduate work in psychology.

My response to these sentiments, based on data reviewed in the book's introduction, is that (1) S-R beliefs and practices are very common, (2) S-R is tied to mental health functioning in both positive and negative ways, and (3) more than 50% of psychotherapy patients in national studies report a desire to address S-R issues in treatment. Considering these findings, the question of whether S-R *should* be addressed in mental health services falls to the wayside. Given the significance of S-R in mental health, the greater question is whether it is ethical *not to* address S-R in treatment, and, quite frankly, the answer seems to be a resounding no! Given the centrality of S-R to the lives of most patients, ignoring this domain represents a failure to uphold the ethical directives to "strive to benefit" patients, "respect the dignity and worth of all people," and "respect cultural, individual and role differences, including those based on . . . religion" (American Psychological Association, 2002). Consider as well that in one recent study over 85% of patients (but less than 70% of physicians) rated the ability to pray and be at peace with God as "very important" attributes to have at the end of life (Steinhauser et al., 2000). Would our field ever consider ignoring other aspects of diversity, such as culture, race, ethnicity, or sexual orientation? Why, therefore, would we consider ignoring S-R? We have an obligation to address this domain with all patients.

Should CBT Clinicians Seek to Promote or Discourage S-R?

Ultimately, CBT is a conglomeration of clinical methods that reduce emotional distress and improve psychosocial functioning, predicated upon the principles of cognitive theory and behaviorism and verified by scientific methods. In this regard, the promotion of psychologically adaptive S-R beliefs (cognitions) and practices (behaviors) and the discouragement of maladaptive aspects of S-R fall squarely within the purview of CBT. The fact that S-R is a sensitive and significant topic for many people should not preclude it from being used in treatment. Sexuality and finances are similarly personal topics, yet they are frequently and constructively addressed in many cognitive behavioral treatments (e.g., Hurlbert, White, Powell & Apt, 1993; Roemer, Salters-Pedneault, & Orsillo, 2006). The widespread practice of effectively banishing religious concerns from the therapy room by refusing to discuss them with

patients (Allport, 1950) is therefore outdated, as there is nothing inherently unethical in directly engaging in S-R as a subject matter. Thus, promoting attendance of religious services (e.g., church), or even praying with patients in-session to harness spiritual activity as an emotion-regulation strategy, may be bona fide behavioral interventions if they are clinically appropriate for select patients.

Does Inclusion of S-R Blur Important Distinctions between Health Care and Spirituality?

Promotion of S-R beliefs and practices by health care practitioners can potentially obscure distinctions between spiritual and mental health domains, which raises ethical concerns. Contrasts must be drawn between pastoral counseling and CBT. While both are health care services, the former has the dual goals of promoting S-R growth and physical and mental health, whereas the latter is solely aimed at reducing symptoms and improved functioning. This distinction is key, because it lays the foundation for a variety of clinical decisions that pertain to broaching the subject of S-R with patients. In a CBT context, S-R is valued only inasmuch as it plays a psychologically functional role to facilitate treatment outcomes. Of course, this does not preclude CBT practitioners from placing a personal value on S-R in any way. But, ways of integrating S-R into CBT, such as providing S-R explanations for treatment strategies (see Chapter 6), using S-R verses or stories from religious texts to counter maladaptive conditions (see Chapter 7), or promoting patient engagement in religious ritual (see Chapter 8), are *only* carried out after a functional analysis has revealed that such methods have the potential of yielding tangible benefits. Furthermore, the decision to continue or terminate integration of S-R in CBT must be determined empirically. If continued assessment reveals that S-R integration is advantageous, then it should remain part of the treatment process, and be employed to its greatest effectiveness. However, if no clinical benefit is indicated, S-R aspects of treatment should be either modified or discontinued. These clinical judgments are difficult to quantify, but in the context of health care practice there must be reasonable clinical justification for the inclusion of S-R in treatment. In contrast, pastoral counseling has an inherent S-R ideological locus, which typically leads to advocacy of spiritual perspectives and activities without functional analysis, ongoing assessment, or clinical indication.

Several types of spiritually integrated psychotherapies have emerged in recent years that seek to focus on spiritual targets as well as on emotional and behavioral concerns (Hook et al., 2010). Increasing S-R engagement is a core stated goal of these treatments, along with traditional clinical

targets, such as reduced depressive symptoms or increased psychosocial functioning. These approaches may be useful in some contexts, and they have gained some popularity among patients, but seeking specifically to promote spiritual change in the context of a health care intervention raises ethical concerns. Chiefly, delivering such treatments to patients who are legally mandated to receive treatment or living in government-supported care facilities may constitute religious coercion. Furthermore, billing insurance companies for such services is questionable when their intended purpose—primary or otherwise—is not exclusively related to health care. And finally, while S-R is closely tied to improved mental functioning for many individuals, mental health services whose sole aim is to increase patient S-R and not to improve their mental health may be construed as misrepresentation when licensed health care practitioners deliver such treatments.

In short, there is nothing inherently unethical in utilizing S-R concepts and practices in the course of CBT, *but it must be done for the purpose of addressing clinical mental health targets.* The role of the CBT therapist in the context of S-R also must be clarified from the outset of treatment. At a minimum, this requires conveying that the intervention being provided is a health care intervention, and S-R will be addressed inasmuch as it relates to presenting mental health problems. As long as patients understand that their CBT therapists are not pastoral care providers, and as long as spiritually inclined CBT therapists do not wander beyond the bounds of good treatment, S-R can be ethically and effectively included in any treatment protocol.

Do CBT Practitioners Need to Share Patients' Faith to Address Their S-R in Treatment?

S-R is inherently diverse (Pew Research Center, 2012), and differences in S-R between clinicians and patients are quite common. Most often, patients report greater levels of S-R than clinicians do (Delaney, Miller, & Bisonó, 2007). From an ethical standpoint, however, shared S-R is not necessary for the provision of spiritually integrated CBT, as long as practitioners have a healthy respect for patient S-R and take reasonable steps to become familiar with patients' belief systems to effectively utilize S-R in treatment. In cases in which practitioner knowledge is lacking, clinicians can work with patients to identify clinically relevant facets of S-R. This will typically remediate any problematic deficiency in clinicians' knowledge of patients' traditions, but in some cases it can also be helpful to collaborate with S-R leaders, such as clergy, to obtain additional perspectives. Interestingly, one randomized controlled trial

found that nonreligious therapists providing religion-accommodative CBT were actually *more* effective than religious therapists in providing the same treatment (Propst et al., 1992). Having said this, in some cases patients may prefer to see a clinician who practices the same faith. One consideration is that additional explanations and consultation can extend the course and cost of treatment in some cases. However, as long as all parties are informed and give consent, there are no clear ethical concerns with using S-R in treatment when clinicians and patients are of different faiths.

Thus, it is perfectly acceptable for a nonreligious CBT clinician to address S-R with a patient who desires to do so in session. Similarly, there is no reason why a CBT clinician who identifies with a specific religious group cannot provide spiritually integrated treatment to a patient of another faith. In general, S-R differences between clinicians and patients need not be addressed explicitly in treatment unless a patient makes a specific inquiry. The following sample dialogue illustrates how to respond when a patient raises questions about S-R differences in a session.

CLINICIAN: Last session, we started to speak about your spiritual–religious life and how it's relevant to your depression and anxiety. Would you like to revisit that discussion?

PATIENT: Yes, I was grateful last week when you asked me about religion, as it is very important in my life. At the same time, I was wondering if you have faith of your own and, if not, how you intend to discuss this topic with me.

CLINICIAN: I'm glad you asked. Personally, religion is not a big part of my life, but I readily appreciate that it is for many of my patients. My hope in raising this subject is to learn more about you so I can do a better job addressing your clinical concerns.

PATIENT: Thank you. That means a lot to me. So, do you believe in God?

CLINICIAN: I'd be happy to speak more about my personal beliefs if you like, but I think it would be more fruitful to discuss what *you* believe and how it's relevant to your symptoms and treatment. My goal is to help you—not just to exchange ideas about faith.

PATIENT: I see. I guess that makes sense. It sounds to me like you just genuinely want to help me, and you're going to respect my beliefs so I guess that's all that really matters.

What Should Be Done When Clinicians and Patients Disagree about S-R Issues?

An entirely different set of ethical issues can surface when conflicts occur between clinicians and patients about S-R issues as they relate to treatment. Chiefly, patients may profess that their S-R beliefs and practices are psychologically adaptive, whereas clinicians may view them as problematic, or vice versa. For example, some patients may insufficiently commit to the treatment process by invoking nonpsychological explanations for their symptoms that include spiritual etiologies (e.g., demonic possession) and by viewing engagement with S-R as an attempt to ameliorate such spiritual causes (e.g., warding off evil spirits). One such patient of mine—a 27-year-old man—presented to McLean Hospital with recurrent major depression and a brief psychotic disorder. His pathology included religious persecutory delusions that his depressed mood was caused by a spiritual "disease" that he had contracted from not being sufficiently humble. His associated behaviors included groveling and excessive petitionary prayer, which I determined was only serving to increase his stress level as well as his sense of worthlessness and guilt and other depressive symptoms. In other cases (e.g., bipolar disorder), patients may express overenthusiasm about S-R in the hope that this domain will provide a panacea for all psychological maladies. Furthermore, spiritual healing remains widespread throughout the Western world and is surprisingly not associated with socioeconomic or racial/ethnic status, state of health, or lack of health care options (Levin, Chatters & Taylor, 2011). In Chapter 3, other psychologically maladaptive S-R mechanisms (e.g., with obsessive– compulsive disorder [OCD]), such as engaging in rituals to avoid negative emotions, are discussed in detail.

Situations such as these underscore the importance of clinicians obtaining informed consent from patients to prevent any potential S-R-related conflicts. Expressing negative views about the fundamental tenets of a patient's faith undermines the treatment process, but even lightly challenging or calling such tenets into question, or discussing them in a critical tone, can derail the process as well. As one of my patients remarked to me recently about her prior experience in psychotherapy, "I felt judged by my previous psychologist when I mentioned my religious beliefs, and from that point I just had no desire to continue treatment with her." CBT conceptualizes informed consent as a continuous process (Persons, 2012) involving formal provision of agreement by patients prior to treatment, as well as ongoing consent as the treatment plan progresses. In addition to giving patients the option of introducing S-R issues at the outset of treatment, clinicians who practice spiritually integrated CBT must effectively convey the purpose and potential outcomes

of any S-R-related interventions that are used during its course. The clinician and patient must agree to all parts of an intervention. If they have a fundamental disagreement over an S-R issue to the point of impasse, such conflicts must be discussed openly and respectfully so patients have the option to either resolve them or to choose another therapist for their mental health services.

Fortunately, in my experience, resolution is usually the chosen course. CBT has a rich framework already in place for addressing potentially thorny S-R conflicts: It is called collaborative empiricism, which refers to therapist and patient working together making clinical observations, testing hypotheses, collecting data, and drawing conclusions based on the results obtained (Kuyken, Padesky, & Dudley, 2009). CBT therapists and patients jointly assume responsibility to notice clinically relevant information, share observations in treatment, and evaluate the effects of treatment processes on treatment targets. This collaborative process helps create and maintain a straightforward and open therapeutic engagement in which therapist and patient work cooperatively and in unison. Collaborative empiricism creates an environment in which therapists and patients are on a level playing field, jointly yoked to outcomes; opinions are collectively scrutinized and ratified or discarded in light of the evidence. Thus, when conflicts about the psychological functions of S-R arise, they can be addressed amicably and put forth as standing questions, rather than as points of contention.

For example, a CBT clinician might initiate the collaborative process by directly conveying in a nonjudgmental manner an observation that the patient is voicing spiritual (as opposed to psychological) explanations for symptoms, which might be undermining the patient's motivation for treatment. Supposing the patient disagrees with the clinician's perspective, the pair should collaboratively test whether psychological explanations for symptoms are valid. The following sample dialogue illustrates this approach.

CLINICIAN: You've mentioned that you think the reason you're depressed is because God is angry with you. Do you still feel that way?

PATIENT: Yes. I feel like I'm doing my best now, but God just isn't letting up on me. It's so unfair!

CLINICIAN: It must be really hard on you to feel that way.

PATIENT: Yes, I feel terrible!

CLINICIAN: I've also noticed that you're not particularly motivated in being treated. You've struggled to do your homework in each of the last few weeks.

PATIENT: It's true. I am struggling with motivation. I just feel like no matter what I do, God won't let up on me, so there's no point.

CLINICIAN: I can understand that. If I felt that an omnipotent Being were going to thwart my efforts to get out of depression, I wouldn't be motivated either.

PATIENT: Hmmm. I never thought about it that way.

CLINICIAN: Would you be willing to do an experiment with me?

PATIENT: Depends. What do you have in mind?

CLINICIAN: I wonder what would happen if you were to get dressed and get out of bed every day over the next week. Maybe God won't let up on you and you'll remain hopelessly depressed? Or maybe you'll feel even a tiny a bit better?

PATIENT: I guess I could do that. I don't have much to lose!

In subsequent sessions, the clinician and patient should jointly review results of this experiment until a consensus is reached. The patient may observe some lift in depressive symptoms and agree that treatment may be beneficial. Alternatively, the patient's efforts (at behavioral activation, in this case) may not be successful, in which case the therapist should postulate alternative explanations or agree to disagree with the patient.

Does a Clinical Approach to S-R Invalidate an S-R Worldview?

One additional ethical concern worth considering is whether exploring S-R from a psychological perspective necessitates being reductionistic, which would in turn discredit a spiritual worldview. The clinical integration of S-R into CBT necessitates identifying and discussing the psychological functions of S-R, that is, the effects of S-R on cognitive, behavioral, and emotional dimensions in a brief and direct fashion. Furthermore, it is critical to treatment that both the positive and negative aspects of S-R are identified, labeled, discussed, and addressed. Some factions may view this approach as religiously problematic, because studying the effects of S-R on the human condition bypasses a discussion about this domain's sacred value. Several years ago, while giving a talk on addressing S-R in treatment, a devoutly religious academic from my hosting institution contended that my clinical approach to S-R was unethical because I was discussing S-R outside of traditional contexts (i.e., theology, philosophy, history, and anthropology). I assured him that I meant no offense, but I also disagreed, since a decidedly clinical approach to S-R does not invalidate S-R beliefs but simply retains an

empirical distance regarding their veracity. I also tried to convey that studying the effects of S-R on human psychology does not require a neutral or negative opinion of S-R beliefs and practices. I added a personal note that the opposite has happened in my case, as the psychological study of S-R has enhanced my personal consideration of this domain.

However, as my mentor Dr. Kenneth Pargament often conveys, it's one thing to discuss the effects of S-R and quite another to try to explain the motivation for *all* S-R behavior in psychological terms. The latter approach *is* reductionistic, as it leaves no place for people to genuinely choose S-R based on faith. Furthermore, attempting to reduce all S-R motivations to self-serving psychological motivations is a gross oversimplification of this inherently complex area of human life (and human motivation in general). The risk for reductionism may be especially problematic for CBT practitioners, because the fundamental tenets of behaviorism are predicated on animal models, which assume self-serving motivations for all behavior (Skinner, 1974). A balanced approach will therefore seek to study the clinical relevance of S-R, without making any assumptions or speculations about the motivations that underlie S-R belief and behavior. Furthermore, this book does not seek to identify why people believe in or practice a particular faith; it is not a social psychology endeavor, nor is my perspective philosophical or religious. My only goals are to (1) discuss the psychological effects of S-R on human emotion and functioning and (2) identify how to understand, address, and harness S-R in the clinical practice of CBT. I hope that readers will find this to be a pragmatic and balanced approach that does not degrade the sacredness or significance of S-R in any way.

AN APPROACH TO S-R DIVERSITY

One thing that is certain about the domain of spirituality is that it is highly diverse! From birth ceremonies to funeral rituals and at all points in between, many if not most S-R practices vary between groups and are culturally bound. This fact raises a potential conundrum for clinicians who wish to address patient S-R: How can we address S-R in treatment if it means something different to each religious group and individual? Is a different S-R approach required for patients from different religious groups? Moreover, given the possibility for intragroup differences in S-R beliefs and practices, does a unique approach need to be delineated for each patient? Furthermore, is it appropriate to introduce S-R with patients who profess no religious affiliations or beliefs? A related issue, which complicates the provision of spiritually sensitive clinical services, is that many clinicians fear they might offend their patients' spiritual

sensitivities (or lack thereof) by discussing S-R in a manner that differs from or even clashes with patients' cultural experience (Bartoli, 2007). Is it possible to approach S-R in a generic way without insulting patients, while simultaneously not stripping this subject of its potential meaning?

Fortunately, with rare exceptions, fears of offending patients' spiritual beliefs remain unrealized as long as clinicians offer the same respect to S-R as they would to any other aspect of patients' personal lives. When CBT clinicians assess patients' beliefs and behaviors related to relationships, finances, professional issues, education, or any other facet of life, we recognize that there are substantial similarities among patients. In therapy, we typically tend to start with generic questions (e.g., Are you in a relationship? Are you employed?), and become iteratively more focused as we learn about the specific details of our patients' lives (e.g., Do you feel close to your spouse? Are you happy at work?) It turns out that S-R is not different from other areas of life; here too we can broach the subject by inquiring about common concepts and practices and becoming more focused incrementally. Furthermore, despite considerable diversity among S-R traditions, many core concepts and practices are strikingly similar, and are shared by multiple S-R traditions and practices. Central facets of S-R can be labeled as *core common spiritual concepts* (*CCSCs*)—beliefs and tenets of central importance that are common to multiple S-R perspectives—or *core common spiritual practices* (*CCSPs*)—centrally important behaviors that are shared by multiple S-R perspectives. In describing beliefs, different faith systems may utilize vastly different terminology and language as informed by their respective religious traditions, but the concepts of God, a soul, and the afterlife and the values of faith, trust, forgiveness, and gratitude, are central to many, if not most, traditions. All of these facets of S-R are CCSCs. With regard to religious practices, many disparate religious perspectives not only encourage prayer, recitation of blessings, study of religious texts, and attendance at religious services, but place a high value on such rituals and consider them to be central parts of their respective traditions. These facets of S-R are therefore CCSPs. To conclude, although religious systems are diverse, myriad points of intersection occur across the board in the S-R world. Thus, it is possible to initiate the assessment process without risking unduly offending patients in spite of a lack of knowledge about a patient's specific tradition.

During my postdoctoral fellowship at McLean Hospital, I met a 35-year-old woman named Susan, who presented with severe depression and relationship difficulties with her husband. Susan was a Mormon (i.e., an adherent of the Church of Jesus Christ of Latter-Day Saints), and in one of our first sessions I asked she if she wanted to discuss her faith and she responded in the affirmative. Not knowing much about the

Mormon tradition, I began by asking her a very basic question: "How is your spirituality related to your symptoms?" Susan quickly explained that her faith meant much to her and how she deeply believed in God. She added that her religious practice had been a source of great solace, but since her current depressive episode it had become difficult for her to engage consistently, and her practice had diminished. I asked Susan some additional questions about her specific practices—how often she actually prayed, attended religious services, engaged in other practices, and how often she would have *liked* to enact these rituals and practices. Susan reported that she desired to pray daily on her own and attend church each week, and she believed that these activities would likely help her out of her depression by reminding her of the uplifting spiritual messages that once helped her a great deal. I then asked more detailed questions about which prayers she would like to recite, the meaning of those prayers, and which messages and ideas she wanted to strengthen in herself. Susan followed up with more details about prayers that were particularly meaningful to her from the Mormon liturgy, and our discussions about S-R and her symptoms continued for the duration of treatment. Despite my lack of knowledge about Susan's faith prior to seeing her for treatment, my openness to discussing S-R with Susan, coupled with some generic questions about CCSCs and CCSPs provided a fertile environment in which to integrate her beliefs into her treatment.

How does the subject of spiritual concepts and practices pertain to patients who do not have a spiritual or religious orienting framework? Addressing CCSCs or CCSPs with such patients may seem undesirable and not clinically indicated. However, a recent study that I conducted with some colleagues at McLean Hospital seems to suggest otherwise (Rosmarin, Forester, et al., 2015). Consistent with previous findings from national studies (e.g., Rose et al., 2001), we found that more than half (58.2%) of a sample of 253 psychiatric patients (99% response rate) reported that they were fairly, moderately, or very much interested in integrating spirituality into their psychotherapy. While affiliation with any religious group and greater general S-R (e.g., belief in God, subjective importance of S-R, frequency of private/public S-R activity) were both associated with a greater interest in spiritually integrated psychotherapy, effect sizes were lower than expected (r^2 = 0.14 for religious affiliation, and r^2 = 0.45 for general spirituality/religion). More important, 37% of patients with *no* religious affiliation reported being at least "fairly" interested in addressing spirituality in treatment, and 8% of unaffiliated patients reported they were "very much" interested; conversely, a sizable number of religiously affiliated patients did *not* endorse interest (14% "not at all"; 28% "slightly"). These findings reflect my clinical experience—many religiously unaffiliated patients welcome the opportunity to

explore the clinical relevance of S-R to their symptoms when presented with the opportunity. In some cases, my patients have spiritual struggles (discussed in Chapter 3), such as wrestling with the question of theodicy (Why do bad things happen to good people?) and exhibit cognitive and emotional distancing from S-R life, which led them to abandon religious affiliation. In other cases, patients were raised without much S-R at all and remained virtually devoid of S-R in their adult lives, but wonder whether personally exploring this subject may be clinically beneficial. Thus, clinical discussions with nonreligious patients about S-R can be important and worthwhile.

Generally, personal levels of S-R practice and a desire to address S-R in treatment are somewhat orthogonal—that is, some individuals who profess S-R beliefs prefer not to discuss their S-R life in treatment, whereas some individuals who do not have strong S-R beliefs are open to exploring S-R in the context of psychotherapy. According to several recent studies, certain facets of S-R—spiritual struggles in particular—can have clinical relevance for patients, irrespective of levels of S-R involvement (Rosmarin, Malloy, et al., 2014; Rosmarin, Pirutinsky, Carp, Appel, & Kor, 2017). These findings suggest that profiling patients for spiritually integrated treatment based on pretreatment levels of S-R is insufficient, and clinicians should directly assess for patient *interest* in discussing S-R matters. Moreover, attending to S-R diversity requires keeping an open mind and allowing patients from varied backgrounds opportunities to discuss S-R should they desire to do so. Therefore, an approach in which assessment of CCSCs and CCSPs are tailored to individual patients can be utilized across S-R traditions and with both religious and nonreligious patients alike.

Since there are so many shared traits among diverse S-R systems, the beliefs and practices of various world religions are not reviewed in this book, although references to specific religious practices and beliefs have been woven throughout. I also avoid giving general recommendations for working with specific religious groups, not because of a failure to recognize important differences between faith systems, or because I am implying that all S-R approaches to life are identical or equivalent. After all, learning to integrate S-R in treatment is essential for developing basic clinical competencies in addressing patient diversity, and therefore requires an appreciation for patients' religious culture. However, as noted earlier, S-R diversity exists both within as well as among S-R faith systems; individual members of a given faith may vary considerably in their beliefs and practices. As such, typecasting individuals based on their S-R beliefs or practices, or providing clinical guidelines based on a patient's affiliation with an S-R group (or lack thereof) falls short of comprehensively addressing this domain. As outlined in Chapter

5, patient assessment commences with a focus on CCSCs and CCSPs that are widely (albeit not universally) applicable, followed by a more ideographical approach. Fortunately, my colleagues and I have been successful with these clinical methods, having utilized them with nearly 1,000 patients in a variety of clinical settings (e.g., inpatient, day treatment, and outpatient services), and to my knowledge we have yet to offend a single patient.

SUMMARY

- Spirituality refers to any way of relating to that which is perceived to be sacred (a greater reality). Religion is a subset of spirituality that involves institutionalized or culturally bound ways of relating to the sacred.
- Given the centrality of S-R to so many patients' lives, it is unethical for clinicians to ignore this domain.
- Actively promoting or discouraging S-R may be appropriate within the context of CBT if the ultimate goal is therapeutic (i.e., reduced distress, improved functioning).
- Practitioners do not need to share patients' faith to successfully address S-R in CBT, as long as the principle of collaborative empiricism is followed throughout treatment.
- This book's approach to addressing S-R in CBT is clinical, not theoretical; no assumptions are made about the motivations behind S-R beliefs and behaviors.
- S-R is inherently diverse, but central concepts and practices are shared by many faith traditions. Core common spiritual concepts (CCSCs) are common beliefs or tenets of central importance shared by multiple S-R perspectives. Core common spiritual practices (CCSPs) are common behaviors of central importance shared by multiple S-R perspectives.

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