Having faith in mind

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According to the 2011 census, more than two thirds of the UK population report having a religion. So is it not time for mental health services to consider how they are meeting the needs of such people? People of faith have reported feeling unable to discuss their mental health within their place of worship (Wiffen, 2014) and being cautious in seeking therapy outside of this due to a fear of judgement (Mayers et al., 2007). A significant number of the population may not be accessing professional support for their mental health – perhaps that gap in care could be bridged by looking at how we can accommodate religious views in therapy.

In 1994 Gutsche described religion as possibly the most unexamined area of diversity in mental health and this still appears to be the case. Whilst mental health services have made adjustments in other areas, such as language and learning difficulties, no significant efforts have been made to consider the place of religion.

Furthermore, despite the high proportion of religious individuals in the UK, existing research on the integration of religion in psychological therapies is minimal. Of the studies available, many have problems with design and overall quality (Lim et al., 2014). Nevertheless, this article will briefly review evidence for and against the integration of religion in therapy, and raise practical suggestions. These will be informed by my current work within Step 2 of IAPT as a Psychological Wellbeing Practitioner (PWP), in which I guide patients through brief psychological interventions for everyday mental health difficulties such as depression, anxiety and panic following the cognitive behavioural model.

I developed an interest in this area through regular church attendance, where I noticed that personal journeys with mental health were sometimes mentioned in an anecdotal manner but practical suggestions were rarely offered. This led me to think about the relationship between mental and spiritual health, and how this could be used in therapy.

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A very brief review of evidence

The evidence for the integration of religion in therapy is mixed. Propst et al. (1992) compared CBT-r (CBT with religious content) with CBT, pastoral care and a wait list condition. Fifty-nine Christian participants experiencing clinically significant depression completed 18–20 sessions of CBT over three months. Whilst all three conditions resulted in remission of depression for participants, those in the CBT-r group had significantly lower scores on the Beck Depression Inventory than all other groups.

A similar study found that

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participants receiving psychotherapy that integrated religion and cultural norms experienced an accelerated reduction in depression symptoms compared with those receiving standard psychotherapy, although end results showed equal efficacy overall (Razali et al., 1998).

Therefore, therapy that integrates religion seems to be at least as effective as their standard counterparts and may result in a quicker reduction in symptomology. This suggests that there is some value in integrating religious values with therapy. Systematic reviews in this area reach a similar conclusion (see Berry, 2002; Lim et al., 2014; Paukert et al., 2011).

Uncomfortable or unskilled?

When Mir et al. (2015) interviewed a variety of mental health practitioners about discussing religion in therapy, all stated that they avoid the topic or talk around it. 'You may not even go into that territory… I don't think I'd have the courage… we ask them questions around faith… when something related to faith comes we avoid it' (p.193). In a separate study, therapists felt they avoided the topic because they lacked the language or knowledge needed to navigate the discussion in the way they'd like to, which could result in their using terms that may not be appropriate for the discussion (Good, 2010). This lack of appropriate language and comfort may be down to inexperience with religion in therapy. If therapists do not feel comfortable discussing religion, this will limit the use of treatments that integrate faith: this needs to be addressed within training.

How can religion be integrated?

Within research the most popular method of integrating religion with CBT is by creating a specialised treatment manual for therapists to follow. Meer et al. (2012) created an 11-session behavioural activation (BA) manual for Muslim patients in Bradford. They reported that service users (across varying levels of religiosity) responded positively to the availability of a treatment that incorporated their faith. To deliver the manual therapists were required to attend specific training and supervision alongside their standard caseload, supervision and case management. In practice the need for additional supervision may deter therapists from using a specialised manual. Furthermore, according to NICE guidelines, patients with mild to moderate depression should be seen for six to eight sessions of therapy within Step 2 of IAPT: the 11-session schedule would not fit that. Perhaps services will need to alter such manuals to fit their current treatment schedules; many already create their own self-help booklets.

Focusing the integration of religious information into materials that are already commonly used could provide a way around barriers like separate supervision, specialised manuals and to some extent therapist discomfort. For example, Wiffen (2014) modified the widely used online CBT programme 'Living Life to the Full' by adding relevant Christian items such as prayers and illustrative stories. In this way, therapists should be able to explain interventions and run the sessions as they would with a secular client but instead make small changes, such as swapping a standard 'worry' timesheet for one with religious examples.

Experts in religious theology and communication, such as rabbis, imams and pastors, could be consulted during the creation of such materials. If patients have queries about the religious content of the worksheets or modified manuals therapists can encourage patients to connect with or build a support network for their faith, which could include joining a study/connect group, speaking to friends who share their faith, reading further in their religious texts or speaking to leaders in their place of worship. If these sources of support are not available, building that network could be achieved via signposting.

For a working example of how religion and CBT can work together, I reached out to a colleague who often incorporates religion with therapy. As a result of this practice she was able to share her experience of incorporating Christianity with worry time. A client requested that her faith be included in therapy as she was finding it difficult to relate her religion to her current difficulties with anxiety. To start the session my colleague explained worry time and completed a maintenance cycle for anxiety. She then asked the patient how the worries she had identified in the maintenance cycle matched up with what she knew of the Bible. The patient felt that her worries did not match what she knew; they discussed this discrepancy and consequently my colleague asked how she could use that information to challenge her worries. Through discussion they agreed to use a focus scripture – Matthew 6:25–34 ('Look at the birds. They don't plant or harvest or store food in barns, for your heavenly Father feeds them. And aren't you far more valuable to him than they are? Can all your worries add a single moment to your life?). They noticed the worry, wrote it down, then read the focus scripture as part of returning to the present moment.

Conclusion

At first glance, it may seem that the integration of religion in therapy is a step backwards in terms of evidence-based practice. However on closer inspection it's clear that the evidence base remains the same as the intervention itself is unaltered. Services can show commitment to the NHS pledge on diversity by developing materials with religious information (e.g. see www.spiritualityandhealth.duke.edu/index.php/13-religious-cbt-study). In addition, training institutions will need to review the content of their religious diversity training to tackle the problem of therapist discomfort, perhaps broadening content from assessment and awareness to case studies on CBT-r and practical assignments. It is only then that we'll be able to see whether therapist discomfort and training quality are linked or separate factors.

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