1-1-1981

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Recommended Citation

Propst, L. Rebecca (1981) "The Comparative Efficacy of Religious and Nonreligious Imagery for the Treatment of Mild Depression in Religious Individuals," *Issues in Religion and Psychotherapy*. Vol. 7 : No. 1 , Article 6.

Available at: <https://scholarsarchive.byu.edu/irp/vol7/iss1/6>

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THE COMPARATIVE EFFICACY OF RELIGIOUS AND NONRELIGIOUS IMAGERY FOR THE TREATMENT OF MILD DEPRESSION IN RELIGIOUS INDIVIDUALS¹

L. Rebecca Propst²
Ohio University

The cognitive model of depression is based on the assumption that "the affective response is determined by the way an individual structures his experiences" (Beck, 1963). The therapeutic efficacy of cognitive therapy has repeatedly been demonstrated in case reports (Rush, Khatami, & Beck, 1975), clinical outcome studies (Rush, Beck, Kovacs & Hollon, 1977), and studies with depressed volunteers (Taylor & Marshall, 1977; Fuchs & Rehm, 1977). The present report focuses on a unique variant of cognitive restructuring for religiously oriented depressives, the modification of depressive imagery using religious content.

One cognitive strategy that has been used to help individuals restructure their experiences is imagery modification (Lazarus, 1977). It has been used most frequently for pain (e.g., Horan, 1973) and anxiety control. In the case of anxiety, a cognitive self-control version of systematic desensitization is usually used in which the individuals are instructed to stay with anxiety-provoking imagery and imagine themselves coping (Goldfried, 1971). Other than Lazarus's (1971) case reports and Schultz's (Note 1) study, however, there have been no controlled clinical outcome studies reported using imagery-based cognitive restructuring techniques for depression control.

Modifying mental images, however, may be an alternative channel for modifying one's assumptions about the world, as Lang (1977) contends that images are not mere pictorial representations but rather the individual's verbalizations and assumptions about the world.

The use of the imagery modality for cognitive restructuring may be particularly useful for depressives as Beck (1976) has contended that negative masochistic imagery plays an important role in the maintenance of depression, and Starker and Singer (1975) found a relationship between depressive symptomatology and negative fantasies in daydreaming. Depression, in that study, was the only type of psychopathology to relate significantly to imagery types. The present study hypothesized that using imagery content more familiar to the client should facilitate the modification of images via at least two mechanisms. First, the therapist's serious use of the client's values in therapy will improve the client-therapist relationship by improving the client's trust of the therapist. Indeed, the psychotherapy

literature suggests that highly religious clients are more likely to terminate or less likely to benefit from therapy when the counselor does not share their religious belief system, or does not encourage it or make use of it in therapy (Rogers & Dymond, 1954; Rosenbaum, Friedlander, & Kaplan, 1956).

The use of religious imagery for clients who hold to a religious conceptualization of the world would also aid in the actual "working through" or cognitive restructuring phase of the treatment. Using religious categories would allow the clients to use cognitive categories with which they were comfortable and to make use of their own assumptive worlds (Franks, 1974). Indeed, Worthington (1978) found that subjects who were free to choose their own imagery in a pain-coping treatment showed a greater increase in coping capacity than those whose imagery was chosen for them.

The present analogue study (mildly depressed volunteers were used) assesses (a) the therapeutic efficacy of imagery modification for the self-control of depression by comparing two different imagery modification treatments (also containing self-monitoring) to self-monitoring plus therapist contact and self-monitoring only; and (b) the contribution of actual religious content by comparing two treatments: one in which participants were invited to use imagery consonant with their religious value system, and one in which they were encouraged to use nonreligious imagery.

Method Participants

Three hundred university students in an introductory psychology course were administered the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), $M = 10.79$, $SD = 9.66$; and the belief and experiential dimensions of the King and Hunt (1972) religiosity scale, $M = 33.61$, $SD = 11.82$. Students who scored in the mild or moderate range of the depression scale (greater than 15) and at least moderately high on the religiosity scale were invited to participate in the study. (Scoring moderately high on the King and Hunt scale means that students indicated that statements such as "I pray frequently" were, on the average, "somewhat true of

¹The author wishes to thank J. T. Reagan and Russell Dern for their valuable help in the execution of the study.

²Address all correspondence to L. Rebecca Propst, Department of Psychology, Ohio University, Athens, Ohio 45701.

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them" on a 4-point scale ranging from "always untrue" to "always true.")

Finally, selected participants were also instructed to record their mood five times daily (upon waking up, lunch, dinner, midevening, and bedtime) on individual daily cards for a period of 2 weeks. Those individuals who showed the lowest mood scores for the baseline period of 2 weeks were chosen for the program and assigned by a within-sample matching technique (Goldstein, Heller, & Sechrest, 1966) to religious imagery ($N = 9$), nonreligious imagery ($N = 11$), therapist contact plus self-monitoring ($N = 13$), and self-monitoring ($N = 11$) conditions. Participants ranged in age from 18 to 20 years (mean age = 19.1 years) and were not being seen in therapy elsewhere. Of the 47 subjects who originally began the study, 3 were eliminated for failure to complete the treatment. Two dropped out of the religious imagery treatment and 1 dropped out of the nonreligious imagery treatment. The mean BDI scores for participants was 15.4 ($SD = 6.95$) and the mean religiosity score was 37.

Procedure

Therapy was administered in groups (two groups per condition) and standardized across the three treatment conditions. Therapists (two) and treatments were completely crossed.

Participants were reassessed within the week following the termination of therapy and at a 6-week follow-up.

Measures

Two classes of measures were used in evaluating the results of the treatment procedures: a questionnaire battery and a behavioral observation of subject participation in a group.

The questionnaire battery consisted of a short form of the MMPI (Overall, Butcher, & Hunter, 1975) for use as a measure of global psychopathology (sum of K-corrected T scores) and as a measure of depression (D scale). Butcher and Tellegen (1978) suggest such short forms of the MMPI are valid research instruments as long as code types are not desired.

In addition to the Beck Depression Inventory, participants also completed a pleasant events schedule designed by Lewinsohn (MacPhillamy & Lewinsohn, 1974). This measure assessed the frequency and enjoyability of the individual's activities for a measure of total perceived reinforcement.

After completing the questionnaires, participants were asked to take part in a discussion, ostensibly to allow them to get acquainted. Two observers, who were stationed behind a one-way mirror, coded all interactional behaviors in the group (initiations and responses to conversations) using a variant of Lewinsohn's procedures (Lewinsohn, Weinstein, & Alper, 1970). The observers

¹The present study used a simplification of Lewinsohn's procedure in that all the categories of behavior proposed by Lewinsohn were not coded, but only those mentioned in the text. Otherwise, Lewinsohn's basic procedure was followed.

placed themselves with an automatic timer, which delivered an auditory signal every 10 seconds. After a period of observer training, the interrater agreement for the major scoring categories was virtually 100%. (Conversation initiations, responses to others, responses toward participant, and range of participants' interactions were the data recorded.)

Participants were randomly assigned to these assessment groups such that subjects in the same assessment groups were not necessarily in the same treatment condition.

After completion of the first treatment session, all participants responded to a questionnaire measuring their assessment of the therapist and the treatment, and their expectations for improvement.

An identical battery of tests (also including the treatment evaluation measure) was administered at posttreatment and follow-up assessments.

Therapy⁴

Therapy sessions were conducted in groups that met twice weekly for eight 1-hour sessions.

Nonreligious Imagery. The actual treatments were a combination of restructuring and systematic desensitization techniques (Meichenbaum, Note 2). Clients were asked to recall depressive episodes and to analyze their thoughts and feelings during that period. The "restructuring of thoughts" phase of the treatment resembled somewhat Meichenbaum's (Note 2) and Goldfried's (1971) use of systematic desensitization in that clients were asked to modify their depressogenic images and thoughts while actually visualizing the depressive situation.

The actual treatment sequence was as follows: Participants first relived depressive episodes and described their accompanying images. Such examples were then used to reinforce the rationale that thoughts and images influence affect and to make group members aware of depression-engendering images. Group members were also instructed to record moods and accompanying mental images five times daily between sessions as added self-awareness practice.

In session 3, or whenever group members had facility in recalling images and were reasonably convinced of the relationship between their mental images and their moods, they were given lists of coping statements and images directed toward each of the three components of Beck's (1976) cognitive trial of depression (negative self, environment, and future) and were instructed that they could select statements and images from this list to reduce their depression. Clients then relived their depressive images and attempted to modify them using the coping imagery and statements. An example of a nonreligious coping image aimed at the participant's negative expectations about the future would be: "I see myself in the future coping with that particular situation."

⁴Copies of the therapist manual are available from the author.

Religious Imagery. This procedure was identical to the procedure in the nonreligious group, except that religious imagery was used. Participants modified their depressive images using religious images (e.g., "I can visualize Christ going with me into that difficult situation in the future as I try to cope"). Again, participants were given a list of coping statements and images directed at Beck's cognitive triad. The content, however, was religious.

Therapist Contact plus Self-Monitoring. Participants in this condition simply met for a discussion group and kept track of their daily mood. For homework they were to record items for group discussion on their mood cards. The content of the discussion was up to the participants, as the therapists participated as little as possible.

Self-Monitoring. Participants in this condition were informed that they were in a control condition that was a very important part of the project. They simply filled out daily mood cards and received the same pretest, posttest, and follow-up assessments as were administered to individuals in the other conditions.

Therapists

A 1st-year and a 2nd-year graduate student served as therapists. A detailed therapy manual was used (see footnote 4). Both therapists ran a three-session training group in cognitive imagery observed and supervised via an intercom system by the author. Neither therapist was religious and reported feeling less comfortable though not antagonistic to the religious treatment. The use of nonreligious therapists controlled for therapists' expectancies regarding the religious treatment. The author met with both therapists after each session to discuss difficulties and outline the subsequent session.

Results

The average number of sessions attended in each condition were not significantly different (nondirective = 6.6, nonreligious imagery = 6.0, and religious imagery = 6.1).

Separate univariate analyses of variance conducted on each dependent variable indicated no significant pretest treatment differences, or therapist effects on any of the depression measures used in the study.

Posttest Treatment Effects

Questionnaire Battery. The results of one-way analyses of covariance on each of the questionnaire variables are presented in Table 1. There were significant treatment effects only for the MMPI-D Scale. Tests for differences between adjusted means revealed that individuals in the self-monitoring-only condition reported a significantly higher score on this MMPI scale (indicating greater depression) than individuals in the religious imagery condition or the self-monitoring plus therapist contact conditions, $t(39) = 1.96, p < .06$ and $t(39) = 2.44, p < .01$, respectively. A simple investigation of relative proportions of subjects who still scored in the depression range on the BDI (greater than 9), however, indicated that the religious imagery

Table 1. One-Way Analyses of Covariance and Adjusted Means at Posttesting

Measure	Adjusted treatment M			
	F	Religious imagery	Non-religious imagery	Therapist contact and self-monitoring only
Self-report				
Beck depression inventory	.87	7.35	9.88	7.06
Pleasant events total reinforcement	1.66	1.31	1.29	1.02
MMPI-D	3.02 ^a	19.97 _a	22.76 _{a,b}	19.37 _a
MMPI-total pathology	1.14	163.83	179.91	161.71
Group interaction (behavioral)				
Initiations	1.91	6.55	5.58	3.59
Reactions	3.19 ^c	29.49 _a	25.08 _{a,b}	17.68 _b
Actions + reactions (total conversation)	4.00 ^d	36.44 _a	30.40 _{a,b}	21.11 _b
Behavior toward subject	4.12 ^d	36.44 _a	29.73 _{a,b}	19.85 _b
Range	.34	3.52	3.51	3.39

^aMeans in the same row with different subscripts different from each other at least at the .05 level.

^bFor analyses of covariance, $df = 3,33, 3,34$, or $3,35$.

^c $p < .05$.

^d $p < .02$.

group (at 14%) showed a significantly lower proportion of depressed individuals ($p < .05$) than either the wait list group (60%)¹ or the nonreligious imagery group (60%).² The nondirective group showed 27% still depressed.

At follow-up, an analysis of covariance (with pretest scores as covariate) revealed a trend at the .10 level indicating less general pathology and less depression on the MMPI for the religious imagery group as compared to the other conditions. A reinspection of the relative proportions of subjects who still scored in the depression range on the BDI indicated that all groups except the wait list condition had an equally low proportion of depressed individuals. There were no significant differences in the proportions, however.

Behavioral Observation. One-way analyses of covariance were carried out separately on posttest scores for the participants' observed initiations of conversations, responses to others' remarks, remarks directed toward participant, and range of individuals each participant engaged in conversation. As can be seen in Table 1, a significant treatment effect was obtained on three of the five measures. *T* tests for differences between adjusted means (two-tailed) revealed that individuals in the religious imagery condition showed more initiations than individuals in the self-monitoring (SM) or self-monitoring plus therapist contact (SMT) conditions, $t(38) = 2.46, p < .01$ and $t(38) = 1.99, p < .06$, respectively; more reactions to others' initiations than subjects in the SM or SMT conditions, $t(38) = 2.10, p < .05$ and $t(38) = 2.55, p < .01$, respectively; and more total conversations than

¹The experimenters were unable to obtain posttest BDI scores for one subject in both the self-monitoring and the nonreligious treatment conditions.

subjects in the SM and SMT conditions, $t(38) = 2.16$, $p < .05$ and $t(38) = 2.91$, $p < .005$, respectively. They also had more remarks directed toward them at posttest than subjects in the SM, SMT, or nonreligious imagery treatments, $t(38) = 2.20$, $p < .05$, $t(38) = 2.96$, $p < .005$, and $t(38) = 1.68$, $p < .10$, respectively. No significant differences were found among the nonreligious imagery, the waiting list, and the placebo conditions on any of the measures. There were no significant differences on any of the behavioral measures at the follow-up evaluation.⁴

Pre/Post Differences

Analyses of pre/post differences for both the questionnaire battery and the behavioral observation by correlated t tests indicated a significant improvement (at least $p < .05$) in the religious imagery condition across all but the pleasant events schedule. In contrast, the placebo and because comparable results were not obtained for the contact-only treatment on the behavioral measures, religious imagery conditions improved significantly on only the BDI.

Discussion

Religious imagery was found to reduce evidence of depression on both self-report and behavioral measures significantly more than nonreligious imagery or a self-monitoring-only treatment. The self-monitoring plus therapist contact treatment was intermediate in the effect, but only on the self-report measures.

The finding that the self-monitoring plus therapist contact treatment was intermediate in its effectiveness is reminiscent of Shaw's (1977) and Fuchs and Rehm's (1977) earlier findings of the intermediate efficacy of non-specific contact control treatments in similar populations. This finding, coupled with the fact that it appeared only on the self-report and not on the behavioral measures, suggests that expectations or demand may play a crucial role in psychotherapy studies of this type. Thus the religious imagery treatment may have increased both subjects' expectations for improvement and the demand for improvement on the self-report measures in a manner analogous to the self-monitoring plus therapist contact (contact-only) treatment. The improvement of the religious imagery group on the behavioral measures, however, is less attributable to expectations or demand because behavioral measures are usually less vulnerable to demand and expectations than are self-report measures and because comparable results were not obtained for the contact-only treatment on the behavioral measures.

At 6 weeks follow-up, the treatment groups were not found to be significantly different in terms of maintenance of treatment gains. This could be due to either (1)

the brevity of the treatments (average sessions attended were six); (2) the mild nature of the original depression, which increases the probability that any experienced dysphoria will dissipate spontaneously regardless of treatment over a longer time range; (3) the presence of a ceiling effect on the MMPI and the BDI in that many participants had already reached the lower limits of the measures at posttest; and (4) the loss of participants' behavioral data for the follow-up analyses.

The present results thus represent unique findings in the psychotherapy research literature in at least two respects. First, they demonstrate that an imagery modification technique bearing some similarities to Goldfried's (1971) conceptualization of systematic desensitization has therapeutic efficacy for depression as well as anxiety. Second, they demonstrate the increased efficacy of a cognitive therapy geared specifically to the individual's value system. To the author's knowledge, the present study is the only controlled outcome study examining the therapeutic viability of the religious component of therapy. Considering the lessened tendency for religious clients to benefit from regular therapy (Rogers & Dymond, 1954) and the growing sophistication regarding the impact of cross-cultural differences on perceptions of reality (Kiev, 1973), this seems an important area for study.

Further research is especially needed extending value-oriented treatments to more severe clinic populations and to other age ranges, as the population of the present study prevents such generalization.

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