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Abstract

Depression is one of the most prevalent mental disorders. Cognitive behavioral therapy (CBT) is a common treatment option for depression. Often, CBT is only effective at masking the symptoms of depression without helping the person overcome depression altogether; thus, it may benefit CBT patients if alternative therapies are combined with CBT. Incorporating the patient's religion into therapy is an alternative that may help many people. A large percentage of Americans are still religious or spiritual. This literature review discusses methods of building a personalized version of CBT that incorporates the patient's religion, or religiously integrated CBT (RCBT), and the effects of religion on fighting depression. Some of the unique tools RCBT uses are the power of prayer, involvement in a religious community, and the opportunity for gratitude. RCBT does not offer positive outcomes for depression with every patient, and often its success is dependent on the patient's religious social support. Nevertheless, RCBT has been shown to help religious people cope with depression more effectively than more standard treatments.

Depression is one of the most prevalent mental disorders. Major depressive disorder (MDD) affects 10–15% of the American population and can be life-crippling for those who develop it (Al-Harbi, 2012). Due to how common it is, MDD has amassed a large array of treatment options. The most common treatment for MDD is medication in the form of antidepressants such as selective serotonin re-uptake inhibitors and tricyclic antidepressants (Al-Harbi, 2012). However, only 60–70% of MDD cases respond to antidepressants; the other 21–31% and 9% are resistant to treatment or not at all responsive to psychopharmacological treatment, respectively (Al-Harbi, 2012). There is a clear need for treatments outside of medication for MDD.

Cognitive behavioral therapy (CBT) provides one other treatment option for MDD. In many cases, CBT effectively reduced the effects of MDD (Pearce et al., 2015). CBT trains people to ward off their depression through cognitive reframing (Pearce et al., 2015). However, the same common problem arises in CBT as medication: Far too often, CBT is only effective at masking or subduing the symptoms of depression without helping the person overcome MDD altogether. CBT needs a reevaluation of its methods to see if it adequately treats all kinds of people with all versions of depression. CBT needs to become more personalized to individual patients by utilizing each's existing support systems. One way CBT can accomplish the needed change is by incorporating religion.

Some assume there is no place for religion in psychological therapy sessions. It is often assumed that the two are not compatible because most current models of therapy do not account for a client's religion. Dein (2018) noted a "religious gap" where mental health professionals themselves seem to be a rather non-religious group in general when compared to their non-professional patients, which is probably why they typically eschew religious methods when treating their patients.

However, those views are misguided. Despite the common reports of declining religious activity in the American population, religion and spirituality are still very much alive and thriving in the lives of most people. Using religious service attendance as a measure, religious commitment has been stable in the U.S. since at least 1990 (Presser &

Chaves, 2007). Using a different measure of religious commitment, as of 2018 more than 89% of people in America believe in a higher power (Ramos, Erkanli, & Koenig, 2018). A Gallup poll (2020) shows that nearly 70% or more of every generation (i.e., millennials, baby boomers, etc.) claim a religious preference. The Pew Research Center (2015) also found that at least 70% of Americans have some sort of religious affiliation. Religion and spirituality provide comfort, support, and relief for when challenging times arise (Pevey, Jones, & Yarber, 2009). Mental disorders, especially one as debilitating as depression, can be challenging, but people may be helped through them by their religion. To think that religion is dying out due to secularism and that people do not rely on it as they once did would be a gross oversight of the psychological community (Achterberg et al., 2009). Rather than ignore it, psychologists should seek to appropriately incorporate religion into therapy.

Religion can be an effective treatment tool for depression (Koenig et al., 2015). Religious coping is unofficially used by many and is associated with not only reducing depression but also faster recovery from depression (Koenig, 2007). A religious patient could already have a background support system of belief; using that background, therapists can build a personalized version of CBT that incorporates the patient's religion, known as religiously integrated CBT (RCBT) (Pearce et al., 2015). The techniques of RCBT can be applied to any religious patient and has many unique tools for fighting depression. Of course, RCBT will not work for everybody, but it still has much to offer in way of therapy.

Techniques of RCBT

RCBT is built upon the same foundation as CBT but with techniques added from religion. CBT is a form of talk therapy where the therapist helps the depressed patient to identify negative or false thoughts and then to replace those thoughts with more realistic ones. It follows a basic ABC model that all therapists can use and adapt for their needs. The "A" stands for adverse event, meaning the event that is causing the cognitive disturbance for someone, such as a loss of employment. The "B" stands for the person's beliefs surrounding the event, such

as the belief that one is a failure in all things because of being fired form a job. The "C" stands for the emotional consequences people suffer due to their beliefs surrounding the adverse event, such as the emotional impact of negative beliefs on self-esteem. The therapist's goal is to (A) reframe the adverse event and (B) change irrational beliefs to rational ones, which (C) help produce positive emotions rather than negative ones (Malkinson, 2010). For someone with depression, the simple task of being aware of the untruthfulness of their thoughts can be nearly impossible, hence the need for a trained therapist to assist in developing healthy thinking habits.

Therapy can be a long and difficult process for the patient, and for some it is never effective. For the religious population, another factor is in play: their own religious commitment. Higher religious commitment has been linked with less depression, faster recovery rates, lower suicide rates, and overall better mental health (Dein, 2018). Religious people may experience a strong feeling of support from a higher power, daily positive thought input from routines (e.g., prayer, studying religious tests, or symbolic rituals), and external help from his or her religious community. These are just a few examples of the material a therapist trained in RCBT can draw upon to help sculpt a treatment personalized to the patient.

RCBT works on the same theories and principles of CBT but adds the patient's personal religion into the treatment, thereby creating a more personalized and effective treatment. It does this by following the ABCDE model created by Ellis (1962). The "D" stands for disputing, or challenging, the patient's unhelpful thinking. The "E" is short for effective new beliefs that lead to positive emotional results. The therapist frames all RCBT practices in relatable terms to the patient's religion. For example, when combating negative thoughts, the patient might be taught to dispute them with positive messages from his or her personal religious text, resulting in an effective new belief that helps the patient better cope with depression. As part of the therapist's training, he or she would become familiar with each of the major religious organizations of the world and would have a specialized RCBT manual to follow for each one, (Pearce et al., 2015). These guide manuals, with a corresponding workbook for the patient,

gives general guidelines for effectively implementing religion into a CBT-based treatment for depression. A study in Nigeria suggested that religion is an effective conduit for channeling positive, more effective coping measures when fighting depression (Amadi et al., 2015); this study showed that the higher the religious commitment of the person, the more effective his or her coping style was with depression and the more positive the outcome in therapy for depression. While this study was merely measuring the correlation between an individual's religious commitment and his or her outcome using the typical treatment methods for depression, RCBT provides the next step by deliberately including religion as part of the treatment.

Tools from RCBT for Fighting Depression

RCBT offers uniquely religious tools for a therapist to use that are not applicable in the traditional CBT method. These include contemplative prayer, community involvement, and gratitude (Pearce et al., 2015). This list, of course, is not exhaustive; the nature of religion is that it provides a framework for people to guide their actions and lives. Rather than replacing or ignoring that framework, RCBT seeks to incorporate the framework into the treatment process.

Contemplative Prayer

Prayer is probably the most common tool found throughout the major religions and can take many forms. There are prayers of thanksgiving, prayers of supplication, confessional prayers, meditative prayers, and so forth. Approximately 70% of Americans still pray daily (Johnson, 2018). For religious individuals, prayer represents an already well-established coping mechanism for the challenges of life. Strongly religious people who have depression, whether they are receiving treatment or not, are already utilizing prayer as a means of coping with depression (Johnson, 2018). RCBT introduces another type of prayer, contemplative prayer, into the patient's treatment (Ciarrocchi, Schechter, & Pearce, 2013b). The patient is asked to ponder a scripture that is relevant to the challenges he or she is facing, something to counter the negative thoughts of depression. The patient is instructed to sit in a relaxed manner and

simply focus their thoughts on the scripture's comforting words, like meditation. If his or her mind wanders or they start to have negative thoughts, they do not fight off the thoughts; they simply return their focus to the scripture they chose (Ciarrocchi, et al., 2013b). Patients are encouraged to make this a personal moment between them and a higher power. Through this method, patients develop greater mindfulness of both their thoughts and emotions. Contemplative prayer can help patients find deep relaxation, reducing stress and helping them cope with depression (Johnson, 2018). They become more enabled to separate negative thoughts from positive thoughts and irrational thoughts from rational thoughts (Johnson, 2018). This way, patients can learn how to exercise control over their depressive thoughts and replace them with positive thoughts.

Involvement in a Religious Community

Strong social support systems have been directly linked to more positive outcomes of depression. This may be because social support systems can also lead to a host of positive traits such as higher gratitude, optimism, resilience, and a sense of positive well-being (Norton et al., 2008). Each of these positive traits are linked to lower depression rates, reduced symptoms, and speedier recovery (McCanlies, Gu, Andrew, & Violanti, 2018). Another feature of religious commitment is the inherent social life it brings. Most major world religions have a social framework (Koenig et al., 2014). Religious communities provide an opportunity for necessary social connection for one suffering from depression. Perhaps that is why regular church attendance is associated with more feelings of optimism and having a greater purpose in life (Koenig et al., 2014). Being involved in a religious community may lead to more affection given and received, greater respect for others and oneself, and refocused attention beyond the world of depression (Norton et al., 2008). The more involved in the religious community one is, the lower the risk may become for an episode of depression (Koenig et al., 2014).

RCBT seeks to incorporate involvement with the religious community by using it as an opportunity for service. One RCBT manual suggests that clients should seek out someone in their

religious community to support who seems more distressed than the clients. (Pearce et al., 2015). This manual suggests that this other person be from the client's religious community so that there will already be shared experiences and feelings between the client and the other person. It also suggests finding someone worse off than the client so that the client will have the chance to forget him- or herself and focus outward on helping someone else. After all, as the manual points out, other "people are usually great distractions from our own troubles" (Ciarrocchi, et al., 2013a, p. 20). Giving the clients an opportunity to serve others can be effective in dispelling consistent negative thoughts. A client may also be the recipient of help and service from other community members, giving the client a sense of belonging and value.

Opportunity for Gratitude

Gratitude could be defined as a perspective or habit of always focusing on the positive, emphasizing what one has versus what one does not have, and appreciating people and things in one's life (Wood, Maltby, Stewart, & Joseph, 2008). Gratitude is an integral part of most religions. Feelings of gratitude are meant to be directed to a higher power for the blessings it bestows; even those in poverty are expected to be grateful for their lives and what they do have. In return, grateful persons are promised happiness and joy. Grateful people tend to be happier than non-grateful people (Froh, 2008).

Within the realm of psychology, gratitude has obvious effects. Gratitude in college students is related to improved sleep, adjustment to chronic diseases, and higher well-being as well as more positive outcomes for those suffering from depression (Sirois & Wood, 2017). Gratitude can lead to having a more positive outlook on life which in turn can lead to further gratitude. In this way, gratitude may create a positive feedback loop.

RCBT can incorporate gratitude by having the patient acknowledge his or her blessings. This involves having the patient list things, people, events, and so forth for which he or she feels grateful (Ciarrocchi, et al., 2013b). If the depression is so severe it is difficult or impossible to feel any gratitude, the therapist should ask for anything

that is remotely positive, or at least not negative, encouraging the patient consciously find something to be grateful for. This is another example of the ABCDE method used by RCBT. If a patient believes he or she has nothing to be grateful for, pressured introspection and deliberate identification from the therapist can lead the patient to discover gratitude. The goal of the therapist is to teach a patient how to identify things to be grateful for. In this way, the negative feedback loop of depression may be slowly countered by the positive feedback loop of gratitude. While this method of producing gratitude may work equally well for religious and non-religious groups, those who express a religious gratitude directed towards a higher power rather than a feeling of gratitude in general have higher levels of well-being in the long run (Pearce et al., 2016). Being religious seems to lead to naturally higher levels of gratitude, especially when patients are reminded of that religious commitment. That is why CBT needs to incorporate the religious commitment of people when trying to promote gratitude. A religious background when incorporated into treatment for depression may amplify the positive effects of the treatment (Pearce et al., 2016). To ignore a religion-based therapy would not only waste resources but could possibly impede recovery from depression in the patient.

Stipulations of RCBT for Depression

RCBT may not offer positive outcomes for depression with every patient. In some cases, it could do more harm than good because sometimes the religious aspect of a patient's life is contributing to his or her depression (Krause, 2014). One reason for a negative outcome is if the patient lacks a strong social support system even if he or she is actively religious. Although positive religion-based relationships may reduce depression, some research has shown that negative religion-based relationships can be detrimental. Negative interactions with religious community can exacerbate depression (Krause, 2014). If the social aspect of religion is part of the reason someone is depressed, it is unlikely that RCBT can help them as much as a non-religious therapy. Religion only tends to dampen depressive symptoms when the social aspect of it is positive (Gao, 2015). Trying

to force a depressed person into a religious community that is not supportive can be harmful. Therapists who employ RCBT should carefully evaluate potential religious communities to ensure that they will give supportive experiences to patients.

A strong, religiously-centered support system may be ineffective if the patient in question is simply not very religious. RCBT is a therapy that is purposefully specialized to people who are strongly religious. For those who do not strongly identify with their religion, RCBT provides no significant benefit for depression (Gao, 2015). It may not be the religion itself that helps with depression but the quality of outside help one receives as a result of the religion. If someone is not religious, he or she will not have as much in common with those in a religious community and could feel unwanted or excluded. One study found that religious therapy had no more improvement on depression than a similar, non-religious therapy; this may be because the patients were not religious (Paukert, Phillips, Cully, Romero, & Stanley, 2010). If therapists are going to recommend religious therapy for depression, they should be fully aware of their patient's religious background, the strength of their patient's religious commitment, and the kind of support system expected from the patient's religious community.

Conclusion

Clearly, RCBT may be an effective treatment for religious people; the stronger the religious commitment, the better chance there may be for a positive outcome of depression. RCBT works by giving patients hope for a better life through prayer, support groups in the form of religious communities, and the benefits of gratitude. Much of the groundwork for incorporating religion into therapy has begun, including RCBT training and material for therapists and patients alike. While in some circumstances religion has a negative correlation with depression, this may be explained by RCBT being applied to patients who have low religious commitment or depression linked to negative religious experiences. Nonetheless, RCBT may provide useful tools for treating depression when used properly, and concepts from RCBT could be adapted to a variety of situations. Most

of the research done on RCBT focuses on those people who belong to an organized religion. Many people do not belong to an organized religion but still consider themselves highly religious. Research on these non-organizational religious people could yield a wider range of results that will better show the results and effectiveness of RCBT. Therapists should be more open-minded to benefits religious therapy could offer, as it may help the religious population with depression more than anything else. By drawing on an individual's religious heritage rather than ignoring it, therapists could begin to see more positive results than ever before. As more therapists use RCBT, better methods of incorporating religion could arise.

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