TEXT BOOK OF

SPIRITUALITY & MENTAL HEALTH: REFLECTIONS OF THE PAST, APPLICATIONS IN THE PRESENT; PROJECTION FOR THE FUTURE

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Fostering Spirituality and Well-being in clinical Practice:
Part-I : Spirituality Religion and Psychiatry: Its application to clinical practice
Part-II: Spiritually Augmented Cognitive Behaviour Therapy- A meaning therapy for sustaining mental health and functional recovery.

Dr. Russell D'Souza

Health professionals and patients are increasingly aware of the basic need of all human beings for a source of meaning that is greater than one's self. The growth in awareness is driven by professional's practical goal of reducing disability from mental disorders and by the wishes of the patients for their therapists to recognise the need for self transcendence. As a result mental health professionals and the general public are growing in awareness of the need to foster spirituality and well-being in clinical practice. There is now a groundswell of professional work that suggest from evidence that this domain has an important role in caring for patients. In fact the word psychiatry is derived from Greek and literally means "the healing of the psyche" The "psyche" is the Greek word for soul or spirit, which is the immaterial but intelligent aspect of the consciousness of a human being. The great mystery of neurosciences is the human consciousness cannot be explained or reduced to materialistic process. I will work through this important area which will be addressed in three parts, part one will discuss spirituality, religion and psychiatry and its application to Clinical practice the second part will consider Spirituality and Religiosity -*Has it a Place in Psychiatric Assessment and Management?* And the third part will describe the evidence based spiritually augmented cognitive behaviour therapy.

Part 1

Spirituality, Religion and Psychiatry: Its Application to Clinical Practice

Russell D'Souza

'Nothing in life is more wonderful than faith- the one great moving force which we can neither weigh in the balance nor test in the crucible…Faith has always been an essential factor in the practice of medicine…Not a psychologist but an ordinary clinical physician concerned in making strong the weak in mind and body, the whole subject is of interest to me'

William Osler [1]

WHAT IS SPIRITUALITY/RELIGIOSITY?

Spirituality is a globally acknowledged concept [2]. However, attempts to reach a consensus regarding its nature have not been met with success [3]. In discussing spirituality, one is fundamentally discussing the ways in which people fulfil what they consider to comprise the purpose of their lives. Therefore, it is possible to see why many different definitions of spirituality have been proposed.

Human beings are considered to have two realms of existence, the outer and inner realms [4]. The outer realm consists of a person's interaction with the world, whereas the inner realm has been defined as the individual's interaction with the transcendental. This may be a divine being or ideals hinted at through experiences such as beauty, awe, and love [4]. These realms may arise from different contexts. For example, in the monotheistic faiths one acts justly to know God, whereas in Buddhism one acts justly to be released from suffering [5].

In addition, some patients may define their problems as spiritual rather than religious. By 'spiritual' they generally mean a transcendent relationship between the person and the higher being – 'a quality that goes beyond a specific religious affiliation' [6]. By contrast, the term religion refers to adherence to and beliefs and practices of an organised church or religious institution [7].

SPIRITUALITY IN PSYCHIATRY

It has long been agreed that the mind, body, and spirit are integrally connected [8]. Western medicine has dichotomised the mind, body, and spirit/soul in comparison to the eastern system [8]. Traditionally, psychiatrists and psychologists have underemphasised religious issues in their work. Religion is often regarded by mental health professionals in western societies as irrational, outdated, and dependency forming. This view is derived from Freud who saw religion as a 'universal obsessional neurosis' [6].

Historically it has been acknowledged that psychiatry has had three revolutions. The first of which was the middle ages, when mental illness was accepted as an illness, rather than the earlier held belief that it was a curse of God. Subsequently, mental illness moved from the realms of religion to medicine. This period was also known as the 'age of enlightenment'. The second revolution was the 'age of psychoanalysis'. The fear of a return to the dark ages may explain partly the stance that Freud took towards religion. The third revolution is considered the 'age of deinstitutionalisation', which was heralded by the advent of the neuroleptic Chlorpromazine. From this flowed the end of the paternalistic model that was the realm of management for patients with mental illness. It is now believed that we are heralding the fourth

revolution, the ‘age of empowerment of the consumer’. This has been a force that is currently seeing the need for re-evaluating and changing our practises.

An area of importance is the consideration and validation of the spiritual dimension of the patient, and the need for ‘whole person therapy’. Recent attempts at empirical assessments of the relationships between religion, spirituality and mental health have suggested that religion may promote better mental health [6]. To date, medical training in the western world has been strongly concerned with the more easily measured physical aspects. Therefore, education surrounding the spiritual aspects of medical care have not typically been included in the medical school or college curriculum. However, the accumulating evidence suggests that it is emerging as something that our patients want and expect as part of our caring for them.

Several Australian studies [9, 28] have validated these findings, and have replicated results of similar studies in the United States of America and New Zealand [10]. Importantly, in a patients’ interaction with clinicians/psychiatrists they do not cease to be human beings with deep and wide ranging needs. Indeed, in times of illness, questions surrounding life and death may loom all the more strongly within a patient’s consciousness and subsequently spiritual issues are likely to come to the fore of human awareness for both patients and professionals. Therefore, recognising patients’ spiritual concerns may be viewed as an essential part of ‘patient-centred medicine’, increasingly seen as crucial to high-quality patient care[11]. Additionally, studies have shown that religious individuals are less satisfied with a non-religious clinician than with a religious one[12]. There are signs that things may be slowly changing. Numerous authors are beginning to underscore the importance of mental health professionals

taking into account patients' religious and spiritual lives during the psychiatric consultation [6].

ARE DOCTORS, PSYCHIATRISTS AND CLINICIANS HEALERS?

Doctors, Psychiatrists and Clinicians are healers primarily through the caring relationships they form with patients. Caring includes calling on an individual's inner strengths. These strengths amongst others include spiritual resources, which support integration or wholeness of body, mind, and spirit. By addressing the spiritual and religious dimensions in patient care, clinicians can truly be holistic - the need of the day. Thus, it appears that spiritual and/or religious care that is ethical and sensitive is an invaluable dimension of total patient care. Attending to the spiritual dimensions of the patient can provide the physician with a more in-depth understanding of the patient and his or her needs. Therefore, it makes sense that clinicians use a variety of spiritually informed therapeutic tools to facilitate the patient's coping ability, thus enhancing well-being and recovery.

Clinicians' own religious or spiritual practices, or non-practices, may impact upon their ability to function effectively in this area of clinical practice. Thus, this is an area we must take cognisance of. As doctors, we have been trained to be objective and to keep our beliefs and practices out of therapy. Unfortunately, we have also over time strayed into keeping our patients' spiritual beliefs, needs, and supports out of clinical practice. We have thus potentially ignored an important aspect of their lives that might be integral to their ability to cope, which is vital not only for recovery but also for their 'well being'. This is the objective of medical practice.

SPIRITUALITY AND RELIGIOSITY FOR THE PATIENT

The World Health Organisation defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Patients want to be seen and treated as whole persons, not as diseases. A whole person is someone who has physical, emotional, social, and spiritual dimensions. Ignoring any of these aspects of humanity leaves the patient feeling incomplete and may even interfere with healing. For many patients spirituality is an important part of wholeness and when addressing psychosocial aspects in psychiatry this dimension of their personhood cannot be ignored.

There is evidence to suggest that many seriously ill patients use religious beliefs to cope with their illness[13]. Religious and/or spiritual involvement is a widespread practice that predicts successful coping with physical illness[14]. Numerous studies by Koenig [13-16] suggest that high intrinsic religiousness predicts more rapid remission in depression, an association that is particularly strong in patients whose physical function is not improving [15]. A meta-analysis [16] examining the relationship between religious involvement and various aspects of mental health found that the majority of people experience better mental health and adapt more successfully to stress if they are religious. Another meta-analysis examining religious involvement and health found that compared to non-religious individuals, religious people are physically healthier, lead healthier life styles, and require fewer health services[17].

Despite the above rementioned evidence, it is important that religious practices do not replace psychiatric treatments. While many people find that illness spurs them to metaphysical questions and helps them rediscover religion, thus far no studies have

shown that people who become religious only in anticipation of health benefits experience better health.

ADDRESSING PATIENTS' SPIRITUAL NEEDS

Patients spiritual needs can be addressed at a variety of levels including research, training, and practice. In academia, relatively little attention has been paid to spirituality (a search of the Medline 1966 database, in February 2000 yielded 19301 out of 10074921 articles, less than 0.2%). Given the importance of spiritual considerations for patients, this is remarkable. There is a need for future research to examine the prevalence and clinical presentations of major mental disorders and their relationship to religious and spiritual problems. With regards to training, with the exception of texts on palliative care [18] and ethics courses, spirituality is not directly considered in medical teaching, even though spiritual considerations will be present whenever patients' rights and needs are discussed. Doctors and clinicians should be required to learn about the ways in which religion and culture can influence a patient's needs.

WHAT DOES THIS MEAN FOR CLINICAL PRACTICE?

The first and foremost step is for doctors to acknowledge the importance of spirituality and religious beliefs in the lives of their patients. Therefore, all medical students and graduates should be trained to take a spiritual history as part of history taking. Knowledge of a patient's spiritual history is as important, and should come as naturally as asking patients about their inter-personal relationships, marital history, hobbies, and interests. Cox [19] argues that 'if mental health services in a multicultural society are to become more sensitive to user needs then eliciting religious history with any linked spiritual meanings should be a routine component of a psychiatric

assessment, and of preparing a more culturally sensitive care plan'. It may therefore, be beneficial to adapt existing therapies to the patient's spiritual perspective.

There is evidence that cognitive therapies may be more effective if they take a patient's religious beliefs into account [20, 29]. Spiritually Augmented Cognitive Behaviour Therapy, developed by our team, has shown efficacy in randomised controlled studies in patients who rated spirituality as important or very important in the patients' spiritual needs survey [21, 22, 23, 29]. Spiritually Augmented Cognitive Behaviour Therapy has been shown to be associated with improved treatment adherence and higher satisfaction, than the control arm, in patients with schizophrenia who had recovered from psychosis [24]. Furthermore, patient centred approaches, as a whole, help to maintain patient dignity and ensure that the interventions offered are appropriate. This has resulted in positive outcomes including compliance with medication, a major barrier to outcomes in psychiatry, and greater patient overall satisfaction [25].

We have included some thoughts in these regards, based on clinical experience, outcome studies, and common sense.

What doctors and clinicians should <u>not</u> do

Doctors should not 'prescribe' religious beliefs or activities for health reasons. In addition, doctors should not impose their own religious or spiritual beliefs on patients. Furthermore initiation of prayer without knowledge of the patient's religious background and the likely appreciation of such activity is strongly discouraged.

Psychiatrists should not provide in-depth religious counselling to patients, something that is best done by trained clergy.

What doctors and clinicians should do

Doctors should acknowledge and respect the spiritual lives of patients and always keep interventions patient-centred. Acknowledging the spiritual dimensions of patients involves taking a spiritual history [26]. A consensus panel of the American College of Physicians have suggested four simple questions that physicians may ask ill or seriously ill patients [27]: (i) "Is faith (religion, spirituality) important to you?", (ii) "Has faith been important to you at other times in your life?" (iii) "Do you have someone to talk to about religious matters?", and (iv) "Would you like to explore religious, spiritual matters with someone?". Taking a spiritual history is often a powerful intervention in itself [25]. The doctor may then consider whether supporting the patients' spiritual religious beliefs will aid in coping. It is acknowledged that religious and spiritual patients', whose beliefs often form the core of their system of meaning, almost always appreciate the doctor's sensitivity to these issues. The doctor can thus send an important message that he or she is concerned with the whole person, a message that enhances the patient-physician relationship, the corner stone in medical care, which may increase the therapeutic impact of the intervention.

At times it may be necessary to enlist the help of a religious professional such as a chaplain or someone influential in a religious organisation [6]. Chaplains are increasingly becoming a pivotal part of the multi-disciplinary team in the United Kingdom, justified on the basis that religious and spiritual needs are prevalent among patients with acute and chronic mental illness. Religious professionals may be the first

'port of call' for those with mental health problems, and there is a need for collaboration between religious and mental health professionals [6].

Our calling as physicians and clinicians is to cure sometimes, relieve often, and comfort always. The comfort conveyed when a psychiatrist or mental health clinician supports the core that gives the patient's life meaning and hope is what many patients miss in their encounters with mental health professionals. Finally, considering these issues and approaching questions of spirituality and religiosity of patients will not only improve patient care and the patient-doctor relationship, but in time may well come to be seen as the salvation of biomedicine.

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Part 2

Spirituality and Religiosity -*Has it a Place in Psychiatric Assessment and Management?*

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Background

Spirituality in recent times has become an area that has been discussed at important professional

meetings and conferences. This area has in the past, been alienated by the world of psychiatry.

There is increasing awareness across professions in regards to the importance that the areas of spirituality and religiosity hold to many patients. Thus there have been suggestions and research validating the incorporation of aspects of spirituality and religiosity into multidisciplinary assessments, and interventions for patients with psychological and physical illness.

In a study in New Zealand, a "Practical Gap' was confirmed between patients and their therapists[1]. This study found that while two thirds of the sample of patients reported beliefs in "God", Atheism and agnosticism were more frequently reported in the sample of psychiatrists, suggesting the presence of a religiosity gap, thus replicating similar studies in the UK and USA. This study further found that only 11% of the sample of patients reported a spiritual history being taken in their psychiatric assessments. This study also found that 94% of psychiatrists surveyed had not received formal or informal training in this area in their postgraduate training. The alienation that has existed between the mental health professions and religion for most of the 20th century is ending. There is now more spiritual awareness, referred to

as “spirit of the times”. During the 1990’s many articles on religious and spiritual issues in mental health and psychotherapy were published in mainstream journals [2], this area is one which has been of focus at many conventions of mental health organizations. Topics included attitudes and skills of spiritually sensitive and competent therapists, and a call for greater competency in religious and spiritual diversity in managing patient’s psychiatric problems.

Controlled studies on interventions promise a better understanding of the relationship between spiritual and religious factors, and health [18,19]. Evidence from studies examining spiritually augmented cognitive-behavioural therapies, using forgiveness interventions, different meditation approaches, and prayer, suggest efficacy in improving health under specific conditions [3]. While there are potential moderating and mediating variables such as extent of religious commitment, intrinsic religiousness and specific religious coping strategies that may influence efficacy, the positive effect in enhancing recovery and psychological wellbeing with the inclusion of spiritual and religious factors must not be overlooked. To this extent studies are needed to demonstrate that spiritual and religious interventions independently influence treatment efficacy.

In patients with a history of psychological trauma there are suggestions that the addressing of spiritual and religious issues of these patients have an important place. Grame CJ et al suggest four theories that highlight the body-soul connection involved in psychological trauma, these are attachment theory, self-psychology theory, Thomas Aquinas theology of embodiment, and object relations’ theory. Further suggesting the need for cross-professional training such as the psychotherapist and clergy [4].

In the family therapist’s clinical training, spirituality is considered as an important dimension. Being more cognizant of both patients’ and therapists spiritual and/or

religious beliefs can make them more available, when appropriate, as part of the therapy process [5]. Haug defines spirituality as attributions of a personal nature, which give meaning to life events, help transcend difficult experiences, maintain hopefulness, and lead to behaviours which honour connectedness. He proposes a rationale for including the spiritual dimension in therapy and therapy training, with graduate training programs to raise therapists' spiritual understandings [6].

In the area of therapy in a multicultural setting, there is a need to integrate multicultural issues, counselling, and spirituality. There is also need for the integration of spiritual, and multicultural competencies, clarifying healthy and unhealthy expressions of spirituality and exploring spiritual issues expressed through pain and loss. As well as needs for power and creativity, understanding counselling process issues, including ethical concerns, and integrating spiritual interventions into one's own counselling style [7]. Further there is a perception that psychiatry and psychiatrists often forget the value and role of spirituality in the life of their patients. Wig and Narendra used illustrations from Hinduism, to show the inter-relationship of mental health and spirituality in India. The Indian system does not follow the Western concepts of the mind-body dichotomy. There needs to be an awareness of the dangers of ethno-centricity in reaching clinical diagnosis, and managing patients with mental illness across cultures. These authors highlight the need for the clinician to be aware of scientific progress, but without giving up the role of religion [8].

Research has suggested a relationship between the therapist's spirituality and their beliefs about healing. There is growing evidence of the importance of spirituality as a key component of the healing relationship. While this relationship is uncharted territory, and outside the present scope of western medicine practice, a study in this area found that spirituality in healers was associated with their own use of self-healing

practices. This may influence healing methods with patients, and result in a belief in a positive health outcome. This study found that incorporating concepts of spirituality in undergraduate medical curricula, continuing medical education, and thus in active clinical practice, could have an important place in the health of the healer as well as the patient[11]. In the area of rehabilitation, there is data on the positive associations of spirituality and religiousness, with measures of physical and mental health and wellbeing, in people with disabilities [12]. The role of religion-spirituality in the lives of caregivers for people with disabilities has been studied, suggesting again a positive association, as are professional's attitudes towards considering patients religious and spiritual involvement in the course of rehabilitation.

The importance of spirituality in the lives of patients/clients has been acknowledged in the most recent curriculum policy statement of the council on Social Work Education, and the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. A number of studies in professional literature have advocated the inclusion of spirituality in both social work practice and education [13]. This area, which has importance to psychiatry, mental health and wellbeing of patients, has been relatively under researched. It is important for those concerned with patient's psychological wellbeing and positive mental health outcomes, to be able to draw on every aspect of knowledge and appropriate interventions that utilise supports and strengths that are available to the patient. These will ensure that all avenues are fully utilised to enhance recovery, global health and wellbeing of the psychiatric patient. Thus a survey of patient's spiritual needs and attitudes would be a starting point to address this issue.

Objective

To carry out a quality assurance survey of the spiritual attitudes and needs of rural patients with a psychiatric illness attending the Centre of Excellence in Remote Psychological Medicine, (CERPM) Broken Hill Base Hospital.

Method

Seventy-nine patients that included both inpatients and outpatients, of the Department of Psychiatry of the Broken Hill Base Hospital, took part in this survey.

This survey used a questionnaire developed and tested for reliability at the CERPM. The test re-test reliability studies, using the questionnaire on a sample of ten patients, which was repeated after eight days, achieved a correlation of .83, suggesting good reliability with the questionnaire. Case managers of patients, and the duty member of the Department of Psychiatry, gave the instrument to the patients for completion.

Results

The results of the survey found that 79% of the patients surveyed rated spirituality as very important, 7.6% were neutral, and 13.4% considered it as not important.

When asked if they thought their therapist should be aware of the spiritual beliefs and needs – 82% said it was necessary, 4.3% were neutral while 13.7% said it was not necessary.

When asked if they felt their spiritual needs should be considered in their treatment plan, 68.7% said they wanted their spiritual needs to be considered in their treatment plan, while 11.6% were neutral, and 19.7% did not want their spiritual needs included in their treatment plan.

With regards to the question on the need for their spiritual supports such as their elders, pastors, priests etc to be included in their treatment plans, 36.3% said it was

necessary, 16.8% were neutral, while 46.9% said it was not necessary. On the question of their spirituality helping them to cope with their psychological problems, 67.2% felt it helped, 14.5% were neutral, while 18.3% said it did not help.

Discussion

These results suggest that in this cohort, spirituality was an important issue for the majority of the patients. There was an even stronger mention for the need of the patient's therapist to be aware of their spiritual beliefs and needs. A somewhat lower, but certainly a strong need, was

expressed by these patients for their spiritual needs to be taken into consideration when treatment was being planned. This suggested that in a majority of these patients a spiritual intervention would not only be accepted but also desired. The outcome of this type of an intervention on enhanced recovery and or coping with their psychological problems is likely to be positive. While there are several variables, further research into the type of intervention, and the outcomes of not only incorporating aspects of spirituality into the assessment, but also offering or supporting the spiritual beliefs of the patient will be an important and interesting exercise. The current evidence certainly suggests that the place of spirituality for the individual patient needs to be considered in their psychiatric assessment and management [15, 16]. To this end, incorporating spirituality, and the taking of a spiritual history, into the training of psychiatrists and mental health professionals will be a step in the right direction [17].

Spiritual issues encompass what is most meaningful and central in human existence. In times of crisis, illness and transition, spiritual issues are likely to come to the fore

of human awareness for both patients and professionals. All health care professionals, in different disciplines, have distinct contributions to make in the way they use their training to assess the religious and spiritual issues of patients. All health care professionals need to include the spiritual dimension in the assessment and treatment of patients. There is thus a need for inter-professional dialogue and collaboration in order to understand each other's perspective on the spiritual dimensions of care [10].

Conclusion

Therapists might utilise the patient's beliefs to complement and facilitate the process of psychotherapy. Where appropriate the patient's spiritual resources can be used to enhance mental and emotional healing. While admittedly this can be difficult ground for the Psychiatrist and other mental health specialists, addressing spiritual issues with patients is becoming an increasingly accepted part of whole person care in psychiatry. While clinicians will differ in the extent to which they decide to utilise and delve into religious issues with their patients, there is a minimal standard that has emerged in this area [9].

Finally, the evidence suggests that the integration of spirituality into treatment can have an enhancing effect on recovery. Spirituality based interventions and collaborations that can enhance successful treatment must be used, thus improving positive health outcomes. The trans-theoretical aspects of spirituality such as acceptance, forgiveness, hope, prayer and meditation, can be incorporated into the treatment of patients [14].

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Part 3

The Spiritually Augmented Cognitive Behaviour Therapy - *A meaning therapy for sustaining mental health and functional recovery.*

Dr. Russell D'Souza

INTRODUCTION

Most of the world is becoming a truly post-modern society, a place where we are learning to incorporate uncertainty in our view of the world. The absolute is giving way to the relative; objectivity to subjectivity; function to form. In the modern view of the 20th century, seeing was believing; in the post-modern world of the turn of the century, believing is seeing. Conviction yields to speculation; prejudice to a new

open-mindedness; religious dogma to a more intuitive, inclusive spirituality. Even the concept of God receives a changed emphasis, from the materialist's 'out-there' being, to a spirit that is more intimately part of us [1].

The historical split between "facts" and "values"; science and religion is being reconsidered. There has been the recent shift away from dichotomies such as therapy/spirituality, science/religion towards a both/and syntheses in the "New Science" and spirituality. The "Cartesian anxiety" and dualism that has dominated western thought in the last 300 years is now less apparent, and science is more inclusive of different paradigms [2].

BACKGROUND

Spirituality is a concept globally acknowledged. However, attempts to reach a consensus regarding its nature have not met with success. In discussing spirituality, one is really discussing the ways in which people fulfil what they hold to be the purpose of their lives. Spirituality can encompass belief in a higher being, the search for meaning and a sense of purpose and connectedness. There can also be a wide over lap between religiosity and spirituality.

There is now awareness across multi disciplines of the importance that spirituality and religiosity has for many patients. This has lead to suggestions and research in relation to validating the incorporation of aspects of spirituality and religiosity into multi-disciplinary assessments and interventions for patients with psychological and physical illness [3]. In an Australian survey a large majority of patients wanted their therapist to be aware of their spiritual beliefs and needs. About two thirds (68.7%) of

respondents believed that their spiritual beliefs helped them to cope with psychological pain [4].

Demoralisation, originally described by Jerome Frank, [5] is the experience under stressful circumstances of being unable to cope, characterised by feelings of distress, apprehension, helplessness, subjective incompetence, hopelessness, diminished esteem and confidence, isolation and alienation, and a loss of personal meaning and purpose in life [5, 6]. Frank explicitly described psychotherapy as the treatment for demoralisation, effective across different cultures. This is particularly important in the medically ill, where the treatment of depression with antidepressants, while effective, is complicated by drug interactions and adverse effects [7].

Folkman and Greer [8] elaborated the idea of meaning based coping. In their therapy there is an emphasis on exploring meaning and purpose and identifying meaningful and realistic goals within whatever limitations life and illness brings. Further work by Breitbart et al [9] looked at a group therapy intervention explicitly looking at existential issues based on the work of Victor Frankl's work and existential therapy. Earlier work by Moorey and Greer [10] using an "Adjuvant Psychological Therapy" based predominantly on "techniques of cognitive restructuring which included reality testing, challenging negative automatic thoughts and assumptions", demonstrated in a randomised controlled trial that it was able to diminish levels of hopelessness [11].

A study by Cole and Brenda [12] testing the efficacy of a spiritually focussed therapy group (SFT) and a no treatment centred group of people confronting cancer, where the SFT was formulated around four existential themes relevant to this population: control, meaning, identity and relationships. The results suggested that the SFT group

tended to improve in functioning, while the control group tended to decrease in functioning across almost all of the dependent variables. The treatment group's level of depression reduced across time while the control group's level of depression increased. Specifically, surrendering control was predictive of lower levels of depression, anxiety and pain severity. The same group compared a CBT without spiritual issues and resources and SFT. The results suggested that the CBT was superior to the SFT in decreasing anxiety but not in its effect on other dependent variables. Propst et al [13] studied the comparative efficacy of a religious CBT (RCBT) and non religious CBT (NRCBT) in a cohort of 59 patients who considered religious and spiritual issues important or very important, and who met Research Diagnostic Criteria (RDC) for non-psychotic, non-bipolar depression, and were treated with 18-20 one hour sessions over three months. The RCBT patients reported significantly lower post treatment depression and adjustment scores than did the NRCBT group. Pargament, Koenig & Perez [25] completed a study assessing the full range of religious coping methods, including potential helpful and harmful religious expressions. Results of regression analyses showed that religious coping accounted for significant unique variance in measures of adjustment (stress-related growth, religious outcome, physical health, mental health and emotional distress) after controlling for the effects of demographics and global religious measures.

DESCRIPTION OF THE SPIRITUALLY AUGMENTED COGNITIVE BEHAVIOUR THERAPY

Background

The Spiritually Augmented Cognitive Behaviour Therapy was developed and tested for efficacy and effectiveness at the Sydney University's Centre for Excellence in Remote and Rural Psychological Medicine, Broken Hill. A multidisciplinary team of

professionals, including members of the hospital pastoral team and the indigenous elder under the leadership of the psychiatrist, took part in developing and testing this therapeutic intervention. This is a meaning therapy that has been found to be significantly beneficial over control groups in a number of outcome measures. These benefits were demonstrated in three randomised controlled trials in patients with depression and or demoralisation.

Principals

This psychotherapeutic intervention uses the principals of Cognitive Behaviour Therapy with an added focus on existential issues, using techniques to find meaning and incorporates and validates the individuals belief system into the treatment. Thus the use of meditation, prayer/ritual together with monitoring the effects of these beliefs and or rituals on their symptoms, and their acceptance of treatment including medications, form the behavioural components of this therapy.

Method

The therapy and method of execution and supervision is informed by our previous work; D'Souza et al [14, 15, 16, 17, 23], and that of Moorey & Greer [10], and Breitbart et al [9]. It is semi-structured and explores a range of issues and the use of a range of therapeutic techniques. The techniques emphasised are empathic listening, facilitation of emotional expression, problem solving, emphasising self-efficacy, exploring meaning and purpose and ultimately enabling self-therapy. Exploring meaning includes the specific meaning of the situation – the appraisal of the current situation and its significance for the future, and where relevant, global meaning. Finding meaning by the use of approaches such as **experiential values**- by experiencing

something, or someone we value, **creative values** –'doing a deed' providing oneself with meaning by becoming involved in the project of one's life [18], and **attitudinal values**- which include such virtues as compassion, bravery, a good sense of humour, and even achieving meaning, as Frankl suggested, in one's suffering [19]. When there is much negativity and cognitive distortions, cognitive restructuring is employed together with the conventional principals and techniques of Cognitive Behavioural Therapy.

In this intervention there is an important emphasis on the respect for, and maintenance of patient autonomy and empowerment. Thus the 16 sessions might not aim to achieve radical change to personality or the instilling of values never held, but the rekindling of values and resilience perhaps forgotten or lost in illness, and set backs in the form of trauma, and loss of meaningfulness that was never fully expressed before – thus we would aim to encourage a purposeful engagement with the dimensions that life has to offer.

This intervention is semi structured, used in a manualised form, and is end focussed with the end directions being patient as self-therapist, empowerment and coping enhancement. It is bi-directional in that lists of useful catalogues of issues are offered for work with, and the patient returns with possible solutions. The therapist initially takes on the role of Captain – offering direction and leadership but then moves sidewards during therapy to the role of a Coach – offering support from the side. Thus a gradual positive shift takes place. It is expected that the objective of empowerment with the patient becoming the self-therapist, will be achieved.

New issues in this therapy

What is new in the therapy is its focus on meaning, purpose, and sense of connectedness in the context of the patient's belief system. Thus validating and appropriately including their belief and rituals, that often might be the core that gives the patient and his/her family's life meaning and hope. This aspect of this therapy offers to the patient comfort in the clinician supporting this core area of possible importance to them and their families. An area that many patients miss in their encounters with care-givers [20].

In this therapy attention is focussed in the meaning of illness, of relationships, of one's self and one's role, even of suffering, the purpose of life and of everyday activities. In loss, meaning is created by searching and finding the redeeming value [21]. This area may not be dealt with or may even be avoided in the traditional cognitive behaviour therapy. The use of problem solving is important to reduce existential anxiety and to increase mastery. The encouragement of social connectedness, an aspect of spirituality, can help reduce isolation and anxiety and give meaning that is associated with being part of a family and community.

Practical issues

The therapy is given individually at the bedside or in a room that has a healing environment, such as the quiet room, a non-denominational prayer room or the chapel. The SACBT manual uses a bridging session work sheet, which lets the patient prepare for each session, and helps with returning to areas to be focussed on in the therapy session. These include areas that are found to be difficult to contend with and other areas that bring wholeness and satisfaction. An opportunity to disclose reasons

for not being able to complete the homework, including the daily and/or weekly meditation, and prayer/ritual monitoring forms, is made available in this bridging work sheet. Thus reducing the drop out from patients who have not completed the homework.

The cognitive focus takes place in four key areas, those being: Acceptance, Hope, Achieving meaning and purpose, and the Dimensions of Forgiveness. The behavioural focus is on Relaxation, Medication and Prayer/Ritual exercises, together with record keeping soon after these exercises. This is achieved by reflecting on the benefits of these exercises (meditation and prayer) on the patients symptoms and dysfunction domain. These would include the impact of the exercises of meditation, prayer and ritual in bringing hope, extinguishing helplessness and existential despair, accepting of medication, and reduction of side-effects if these are being experienced. There is the validation of the belief in a force greater than the self, be it the supernatural or for some "God". This serves in part to achieve **dereflection-** a technique in achieving meaning by moving beyond and away from the self on to others and for some a supernatural [18].

The patient reflects and then records the effects of these exercises (meditation, rituals – including prayer) on improving sleep, appetite, energy, function and positive well-being. The patient marks a score of 1 to 5 for each of these areas on the daily work sheet. After Day 7 the patient is encouraged to spend a short period reviewing the daily record sheet, and then fill in a weekly score for each of the domains on the weekly monitoring record sheet. Based on the evidence that the patient has from these work sheets, together with the subjective experience, they are encouraged to write a

comment in the weekly record sheet that reflects the true situation. This is discussed and examined during therapy sessions. The intersession of self-therapy sessions can be planned as early as the 3rd week to take place in-between therapy sessions.

Each of the four cognitive areas of Acceptance, Hope, Meaning and Purpose, and Forgiveness are considered from the catalogue of issues, surrounding each of the areas from the manual. Reflection on developmental history, and life experiences that have contributed to, or negatively impacted on each of these areas are considered and dealt with in the sessions.

Achieving meaning and purpose

The area of meaning and purpose takes an important focus. There are five phases through which the patient is guided to work through towards achieving meaning and purpose. This starts with confronting the inevitabilities of life such as birth and death – confronting and desensitising oneself with mortality then moving to the phase – the letting go of fear and turmoil in one's life. Exercises around achieving the letting go of fear and turmoil are built in, with the aim of mastery accomplishment in this phase. The next phase encourages examining one's lifestyle – centring on lifestyle areas that avoid confronting mortality, and perpetuate fear and turmoil. Lifestyle changes are planned that will be adaptive to achieving desensitisation of one's mortality together with the realistic removal of fear and turmoil in one's life. Moving to the next phase involves focuses on seeking divine purpose, after examining and accepting one's journey in life between the two inevitabilities of birth and death. Finally meaning is sought by seeking meaning for each day. This is achieved by identifying meaningful and realistic goals within whatever limitation life and illness brings. The use of

experiential values, creative values and attitudinal values discussed earlier can be drawn on in helping the patient achieve meaning.

Structure of sessions

Generally the therapy takes place over 10 to 16 sessions for about 60 minutes duration, with flexibility to allow for between 45 to 70 minutes. The initial two weeks might allow for two sessions per week, if necessary and where possible. This will aid engagement and is appropriate to the level of distress patients generally are experiencing. Further, this could positively influence the building of trust and therapeutic alliance – a key component in achieving successful outcomes in most psychological interventions. Thereafter sessions follow on a weekly basis. The assessment of termination needs and relapse prevention needs in the form of scheduling booster sessions must start early in the therapy. This ensures the place in predicting and planning for the patient's needs later in therapy and further down. For ethical reasons the therapy may continue past the 10 to 16 sessions if the patient desires this and there is mutual agreement with the patient and therapist with regards to this need.

Efficacy, Effectiveness and Efficiency

Three randomised controlled trials comparing SACBT and case management, SACBT and supportive therapy, and SACBT and equal clinical contacts have been completed. The results have not only shown significant benefits over controls in reducing hopelessness, despair, depression and improving quality of life [15, 16] but importantly has achieved significantly better treatment adherence, lower adverse effects of treatment and lower relapses compared to controls followed for 12 months [17, 23].

CONCLUSION

This meaning based therapy that incorporates appropriately a person belief system, which often might be the core that helps the patient and family cope, is an adjunct therapy that has been shown to improve function and quality of life. This is an important part of caring for the whole person, an area that has been found wanting in the bio-medical model [22].

The results of trials [17, 23] have shown a reduction in relapse and re-hospitalisation in the group of patients that received this therapy. There is also evidence, that reducing relapses and increasing time to next relapse in psychiatric illness, will offer benefits in psychosocial functioning such as work and relationships, including the marital relationship [24]. Thus this adjunct therapy has an important and useful role in enhancing functional recovery and whole person care – an area that has had less attention given to in conventional psychiatric treatment.

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