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Incorporating Religion/Spirituality Into Treatment for Serious Mental Illness

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This paper examines whether religion and spirituality (R/S) should be incorporated into treatment for patients with serious mental illness. This question merits attention, especially in light of the strong presence of R/S in the United States and, in particular, among members of ethnic minorities. While the literature is somewhat mixed, prior research supports the view that incorporating adaptive R/S elements into treatment for patients with serious mental illness is beneficial, particularly for patients who do not exhibit severe psychotic symptoms. Drawing from our experiences in developing a family-focused Culturally-Informed Therapy for Schizophrenia (CIT-S), we will also highlight the importance of addressing spiritual issues within minority populations. In the second half of this paper, we will present several case illustrations of how R/S issues were used in CIT-S to help patients make sense of adverse situations and obtain much-needed support and coping resources outside the treatment room. Findings from this study indicate that religion and spirituality can often be incorporated into treatment in a way that coalesces with patients' values and enhances treatment gains. Future research should investigate how therapists' own R/S values interact with those of their clients, and whether congruency in R/S values has any impact on treatment efficacy.

The question of whether or not to incorporate religious/spiritual (R/S) approaches into treatment for serious mental illness has received a great deal of attention in the literature (Borras et al., 2007; Phillips & Stein, 2007; Pieper, 2004). At the heart of the debate resides a conflict over whether discussing religious or spiritual issues provides beneficial or adverse effects for individuals suffering from serious mental illness. As will be discussed in detail below, the nature of this debate is based on the differential effects of different forms of religious coping and the potential for religion to be a poor prognostic indicator when religious themes are infused into positive psychotic symptoms (i.e., religious delusions). One purpose of this paper is to review the evidence for and against incorporating R/S issues into treatment for serious mental illness. This issue is particularly salient in the treatment of ethnic minority populations, as they tend to use religion heavily to cope with life events (Pargament, 1997). In addition, we will describe how the current literature has informed the development and implementation of the Spiritual Coping module of a new family-focused intervention for mental illness: Culturally-Informed Therapy for Schizophrenia (CIT-S). Case examples from CIT-S will be provided that illustrate how R/S techniques can be used to strengthen support and coping strategies in patients and family members. We will also offer examples of when clients have demonstrated potentially detrimental uses of R/S during CIT-S and will discuss how we have attempted to intervene to reframe these uses.

Following Weisman (2005), the terms *religion* and *spirituality* will be used interchangeably in this paper, and the symbol R/S will be substituted for these terms and their derivatives (e.g., religion, spiritual, religiousness). It is important to note that the term "religion" often refers to the dogma and rituals associated with R/S, whereas "spirituality" is more often used to refer to one's quest for meaning and belonging and to the core values that influence one's behavior (Sperry, 2001). In this paper, however, we make no distinctions in terms, mainly because, until recently, these constructs were measured by global indices (e.g., frequency of prayer, self-report of strength of faith) and most of the research reviewed in this article and in developing CIT-S did not formally distinguish between these constructs. Thus, it would be beyond the scope of this paper to tease apart one from the other when making sense of the findings.

Why Incorporate Spirituality Into Psychotherapy?

Despite the diversity of religious beliefs and traditions in the United States, one fact is difficult to overlook: individuals in this country are religious. As cited in the introduction to this special issue, results from a Gallup Poll taken in 2007 confirm that religion is alive and well in

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the American consciousness (Rosmarin, Pargament, & Robb, 2010). The religious landscape of this country thus makes R/S issues difficult to ignore in therapeutic settings because many if not most clients served in therapy look towards faith for solutions and guidance (Pargament, Magyar-Russell, & Murray-Swank, 2005). For this reason, ignoring R/S in mental health care may be akin to ignoring personal meaning systems that could offer important resources for social and personal strength and self-understanding (Fallot, 1998b).

One factor to consider when determining the relevance of R/S in treatment is that the goals of R/S and the goals of psychotherapy are often quite similar. For example, both R/S and psychotherapy aim to increase a sense of identity, to answer questions about life's meaning, and to encourage social support networks (Stander, Piercy, MacKinnon, & Helmeke, 1994; Wiggins Frame, 1996). In fact, R/S values may bolster the effects of psychotherapy because they incorporate themes of gratitude, forgiveness, and empathy, which are essential in the therapeutic process. A number of qualitative studies have explored the contribution of R/S in the healing process by examining the content of recovery narratives. Findings suggest that R/S helps to engender hope and optimism (Fallot, 1998a), acts as a coping and problem-solving strategy, and provides an overarching framework that helps individuals make sense of their lives and experiences (Sullivan, 1993).

Therefore, encouraging religious patients and relatives to engage in religious activities that interest them, including attending services or volunteering with religious groups, may provide an important bridge for applying some of the values and skills discussed in therapy to real-life situations. Specific religious interventions in therapy have already been shown to increase clinical benefits among religiously oriented individuals with depression and anxiety. As depression and anxiety are common clinical correlates of serious mental illness, these interventions are directly applicable to the treatment of schizophrenia. For example, depressive symptoms can be found in approximately one-third of patients with schizophrenia (Siris et al., 2001) and the overall lifetime prevalence of meeting criteria for major depressive disorder is approximately 17% among schizophrenia patients (Blazer, Kessler, McGonagle, & Swartz, 1994). In addition, comorbid anxiety disorder is present in up to 45% of patients with schizophrenia (Braga, Mendlowicz, Marrocos, & Figueira, 2005; Cosoff & Hafner, 1998).

One clinical trial has examined the efficacy of a religious cognitive therapy for treatment of religiously oriented individuals with clinical depression (Propst, Ostrom, Watkins, Dean, & Mashburn, 1992). The religious cognitive therapy (RCT) was adapted from traditional cognitive-behavioral approaches to include Christian religious rationales, religious arguments for cognitive restructuring, and religious imagery. When compared to a standard nonreligious cognitive therapy (NRCT), a wait-list control (WLC), and a pastoral counseling treatment-as-usual (PCT) condition, patients in the RCT and PCT conditions reported significantly lower scores on depression and adjustment after treatment than patients in the NRCT and WLC (Propst et al., 1992). In another study that focused on religious patients with generalized anxiety disorder, Azhar, Varma, and Dharap (1994) found that patients who received a religious psychotherapy showed a more rapid improvement in anxiety symptoms than patients in two control conditions (supportive psychotherapy only and medication only). One important limitation of this study is that it did not compare the religious psychotherapy to a standard evidence-based treatment. Nonetheless, findings from these two clinical trials highlight the potential benefits that can be afforded by incorporating R/S into treatments for anxiety and depression, which represent two of the most common manifestations of psychological distress in individuals with and without serious mental illness.

A number of psychospiritual interventions have also been developed specifically for people with serious mental illness. Phillips, Lakin, and Pargament (2002), for example, created a semistructured group intervention, which explored the spiritual journey of members with serious mental illness. Specific topics included spiritual resources, spiritual strivings, spiritual struggles, forgiveness, and hope. The authors presented some qualitative outcome data on their intervention, reporting that group members enjoyed and appreciated the opportunity to discuss spiritual issues in a mental health setting. They also mentioned that discussing spiritual issues in the group did not appear to have any adverse effects on participants. Similarly, drawing from 16 years of experience, Kehoe (1998) reported that her Spiritual Beliefs and Values Group for patients with serious mental illness has been a predominantly positive experience for patients and the author reports no instances of it triggering religious delusions in members. This paper is largely qualitative, however, and the author did not cite any empirical outcome data from her group work. Nonetheless, these two examples of psychospiritual groups for people with serious mental illness offer hope that R/S can be incorporated into treatments in a sensitive and beneficial manner.

Beneficial Versus Detrimental Aspects of R/S in Serious Mental Illness

There is some controversy over whether R/S provides beneficial or adverse effects for individuals with serious mental illness. The evidence for beneficial effects of

religion on general mental health is compelling. Fairly strong correlations between religious participation and positive outcomes emerge throughout the literature in samples with both medical and psychiatric illness (Koenig, Larson, & Weaver, 1998). Some of these positive outcomes include lower rates of depression, anxiety disorder, smoking, and alcohol abuse (Kendler, Gardner, & Prescott, 1997; Koenig, Ford, George, Blazer & Meador, 1993; Koenig, Larson, et al., 1998). Empirical support also exists linking greater religiosity with less substance abuse and more symptomatic remission in an outpatient sample of patients with schizophrenia and other psychotic disorders (Borras et al., 2007).

These findings may present an overly optimistic picture of religion, as they focus on general measures of religiosity. It is important to note that some researchers insist that how one uses his or her religion may be more relevant than whether or not one is religious (Pargament et al., 1988). For example, a religious coping style that emphasizes collaboration with God in solving life's problems is generally associated with a greater sense of personal control and self-esteem, while a religious coping style that involves deferring problem-solving responsibilities to God is associated with a greater sense of control by chance and lower self-esteem (Pargament et al., 1988). Similarly, in numerous studies, using religious reappraisals to highlight the spiritual benefits that come from stressful life events (benevolent religious reappraisals) has been shown to have a positive influence on quality of life, whereas using religious reappraisals to view stressful life events as punishment from God (punishing God reappraisals) has been associated with negative outcomes, such as depression (Koenig, Pargament, & Nielsen, 1998; Pargament, Koenig, & Perez, 2000). These differential contributions from certain aspects of R/S are also evident in mentally ill populations. For example, in an empirical study focusing on a sample of young adults with mental illness, benevolent religious reappraisals were associated with positive adjustment, whereas punishing God reappraisals were associated with negative adjustment, including greater psychological distress and lower levels of psychological well-being (Phillips & Stein, 2007).

In addition, Pieper (2004) studied a group of religious inpatients on measures of both problem-focused and emotion-focused methods of religious coping. In this sample, it was determined that religious coping was very helpful in dealing with mental health problems. Specifically, intrinsic religiosity (which is present in those who hold religion as a master motive and framework for living) and especially having a positive relationship with God, was found to correlate most closely with positive religious coping. In turn, religious coping was significantly related to both existential and psychological well-being (Pieper, 2004). The author also highlighted that being religiously active (praying, reading the Bible) led to higher anxiety levels in this sample. This may be because these activities represent an obsessive ritual in the absence of having a positive relationship with God (Pieper, 2004).

Other findings from the literature on religion and serious mental illness stress the beneficial functions that religious coping may serve. For example, research suggests that patients with a diagnosis of schizophrenia, schizoaffective disorder, and bipolar disorder reported that they had used religious coping for a significantly greater number of years and found religious coping to be significantly more helpful than those diagnosed with depression. No differences were noted among diagnoses in regards to the type or total number of religious coping strategies that were used (Reger & Rogers, 2002). Similarly, Tepper and colleagues (2001) found that patients who increased their religious involvement when their symptoms worsened were hospitalized less frequently over the previous year than patients who downgraded the importance of religion in their lives after symptom exacerbation. In addition, years of religious coping and percentage of coping time related to religious coping were associated with less severe symptoms and better functioning in this sample (Tepper, Rogers, Coleman, & Malony, 2001). Taken together, findings suggest that positive forms of religious coping among individuals with serious mental illness are perceived as especially beneficial, can help reduce symptoms and can contribute to psychological well-being.

A major source of the controversy over incorporating R/S into treatment for serious mental illness stems from the fact that psychiatric patients frequently experience delusions of a religious nature (Brewerton, 1994; Neeleman & Lewis, 1994). Siddle, Haddock, Tarrier, and Faragher (2002) found that patients with schizophrenia whose delusions were of a religious nature had higher symptom scores on the Positive and Negative Syndrome Scale for Schizophrenia (PANSS), lower functioning levels on the Global Assessment of Functioning (GAF), were prescribed more medications and tended to have longer histories of mental health problems. The group with religious delusions also appeared to hold more conviction in their delusions and to be more certain that their auditory hallucinations stemmed from an external cause (Siddle et al., 2002).

Findings suggest that while religious delusions may be a poor prognostic indicator, there is not much evidence linking religion per se to detrimental outcomes. For example, several researchers found no differences in religious involvement, importance or affiliation between patients with and without religious delusions (Huguelet, Mohr, Borras, Gillieron, & Brandt, 2006). However, in a

study which examined the influence of religious activity on the severity of religious delusions, researchers found that religious activity prior to hospitalization was a strong predictor of religious delusions during hospitalization. In the same study, however, religious affiliation did not seem to affect the severity of religious delusions (Getz, Fleck, & Strakowski, 2001). In this regard, the research appears to be mixed on whether or not religious patients have more religious delusions.

Based on the literature cited here, it seems that there is more generalizable evidence in favor of incorporating spiritual issues into treatment for serious mental illness than against it. More specifically, drawing from the research, the beneficial effects of R/S seem to be more far-reaching, whereas the adverse effects are relatively confined to patients with actively psychotic religious delusions and patients who use maladaptive forms of religious coping. With this in mind, incorporating R/S into treatment is a delicate line of work and researchers and clinicians must be particularly sensitive to the nature and severity of the patient's delusions as well as the ways in which a particular patient may use religious themes in an adaptive or maladaptive fashion. Because schizophrenia has an episodic course and the type and nature of symptoms vary throughout the course of the illness, when doing R/S based interventions it is important to assess the severity and content of delusions at the first intake and to carefully monitor delusions to rule out the development of religious delusions over time.

R/S With Underserved Mentally Ill Populations

Encouraging R/S gains through psychotherapy may be particularly beneficial when working with underserved mentally ill populations, such as ethnic minorities or families from the lower socioeconomic strata. Research has shown that religious coping is more common among Blacks, poor people, the elderly, and women than among the general population (Ferraro & Koch, 1994; Gurin, Veroff, & Feld, 1960; Koenig et al., 1992; Pargament, 1997). This may be because groups with a disadvantaged or minority status tend to place greater importance on their religious faith or because R/S resources may be more accessible for individuals with limited resources (Fallot, 1998b).

In support of the first possibility, Hispanics have frequently been observed to base their conceptualization of physical and mental illness on their religious faith (Musgrave, Allen, & Allen, 2002). In one study conducted by Weisman, Gomes, and Lopez (2003), researchers found that 40% of a relatively unacculturated sample of Hispanics living in the Los Angeles area made reference to religion in describing their relative with schizophrenia. Furthermore, almost all of these religious references were framed in a positive or adaptive light. Therefore, for Hispanics, there is some evidence suggesting that families dealing with schizophrenia turn to their religious beliefs to find answers and comfort when confronted with difficult life issues. Secondly, religious communities often act as safe havens for individuals who have experienced stigma and other negative effects as a consequence of living with serious mental illness (Fallot, 1998b; Sullivan, 1993). In many minority cultures, churches and religious communities play a central role in the lives and coping processes of their members. Furthermore, where access to mental health care is limited, as it is for many minorities of lower socioeconomic status, individuals often turn to religious coping for strength and support (Lincoln & Mamiya, 1990; Pargament, 1997).

Based on the literature reviewed here, we feel that incorporating R/S issues into treatment for serious mental illness provides an important avenue for discussing topics that are often at the core of how people perceive and interact with the world. We believe that psychotherapy is an appropriate and important place to address these issues, especially when dealing with religious populations, such as ethnic minorities. For this reason, we have included a Spiritual Coping module in our Culturally-Informed Therapy for Schizophrenia, which will now be reviewed in detail.

Culturally-Informed Therapy for Schizophrenia (CIT-S)

CIT-S was created to tailor existing family-focused treatments to better serve minority populations. The treatment consists of five modules, each of which is composed of three sessions. The modules, in order of presentation, are: Family Collectivism, Psychoeducation, Spiritual Coping, Communication Training, and Problem Solving. Three of these modules (Psychoeducation, Communication Training, and Problem Solving) have been adapted from the work of colleagues and are explained extensively in the literature (Falloon, Boyd, & McGill, 1984; Goldstein & Miklowitz, 1995). The other two modules (Family Collectivism and Spiritual Coping) are unique to CIT-S and are specifically thought to be culturally sanctioned for minority families. The Family Collectivism module aims to foster a strong sense of family cohesion and to help relatives view themselves as a team working towards a mutual goal (e.g., helping the patient get better). Within this segment, specific focus is placed on deflecting the blame away from any one person in the family. The Spiritual Coping module is at the heart of this paper and therefore will be described in detail below.

The Spiritual Coping module of CIT-S consists of three sessions, which are aimed at helping the family members tap into their spiritual or existential beliefs in adaptive

ways. As addressed above, incorporating R/S issues into family treatments for serious mental illness necessitates a careful and slow beginning. We therefore begin the Spiritual Coping module by providing a rationale for including R/S issues into treatment with a particular emphasis on the evidence pointing to the beneficial effects of religious interventions. That is, we talk to clients about the research pointing to positive links between religion and psychological adjustment, and we engage them in a conversation about the potentially beneficial role of religion and spirituality in their own lives as a means of coping with adversity. After the module is introduced and questions about its relevance are addressed, we move onto a detailed assessment of each family member's beliefs and practices in order to better understand which aspects of R/S are most salient and deserve more detailed attention.

As mentioned earlier in this paper, ongoing assessment of religious delusions is an important component of treatments that incorporate spiritual themes, as religious delusions may be a poor prognostic indicator. For this reason, we formally assess the severity of religiously based delusions at each assessment point of CIT-S (baseline, termination of treatment, 6-month and 12-month follow-ups). This assessment, drawn from items from the Positive and Negative Syndrome Scale for Schizophrenia (Kay, 1991) includes asking patients if they believe that God has assigned them a special role or purpose, whether they can be considered one of God's messengers or angels, and whether they have heard the voice of God or the Devil. We ask patients to provide more information if they respond "yes" to any of these questions. Therapists also monitor the presence and functions of religious themes in treatment and use this information to tailor the specific treatment plan for each family.

Each CIT-S module is accompanied by a series of handouts that are aimed at helping the family and the therapist to organize conversations around particular themes. To facilitate conversation, we introduce the "Exploring Your Spirituality" handout. The questions on this handout were largely drawn from the work of Sperry (2001). Family members are encouraged to discuss their beliefs or disbeliefs about God, their notions of morality, and the meaning or purpose that they attribute to life. They are also prompted to discuss their participation in religious groups or communities, their personal use of prayer or meditation and the extent to which they utilize spiritual supports (such as rabbis or priests).

Another important issue to consider when offering a treatment for serious mental illness that includes a religious component is how to modify the treatment for patients who are not religious. One way that clinicians may approach this issue is to address spiritual topics in more general terms, so that the conversation focuses on existential beliefs about meaning and purpose rather than on beliefs in supreme beings or on any particular religious tradition. In CIT-S, we offer a complimentary handout for families that are not religiously oriented. This handout, also called "Exploring Your Spirituality," mirrors the handout that we offer to our more religious families, but the questions are tailored to address existential concerns. For example, rather than asking, "What is your main religious or spiritual identity?" we ask, "What are your ideas about morality and the concepts of right and wrong?" In this way, we hope to include individuals with varying degrees of religious convictions.

Once the exploration of beliefs and practices has progressed, we distribute a "Spiritual Pillars" handout and begin to discuss forgiveness, empathy, appreciation, and peace. These are concepts that patients and family members frequently identify as important principles in their lives yet often find difficult to apply to their own struggles with mental illness. To this end, we engage in conversations about how clients can make use of their R/S principles and practices more directly in coping with the illness. For instance, we discuss ways that the patient's loved ones can show greater appreciation of the real struggles the illness presents to the patient, greater empathy for the patient in light of his/her difficulties adjusting to limits imposed by the illness, and greater forgiveness of the patient's occasional withdrawal, silence, or "unusual" behavior. Likewise, patients are encouraged to show greater empathy for their loved ones' difficulties in accepting and comprehending their illness, greater appreciation of the ways in which family members have been affected by the illness or their caregiving roles, and greater forgiveness for family members' occasional lapses in their own understanding, acceptance, and empathy towards the patient. Relatedly, family members and patients are encouraged to show greater forgiveness for themselves. Family members and patients can often blame themselves for having caused the illness (e.g., by not having given the patient enough attention as a child; by failing to recognize the symptoms earlier and not seeking treatment "soon enough" for the patient; and/or, as the patient, by having engaged in risky behaviors as a child or adolescent that likely "activated" the patient's predisposition to schizophrenia; etc.). Thus, it is important for therapists to actively invite participants to discuss, explore, and challenge these guilt-inducing thoughts. To this end, therapists can find it useful to refer back to insight gained from the Psychoeducation module (i.e., "Families do not cause schizophrenia").

For homework, participants are asked to create spiritual or philosophical genograms. Working together, they are asked to create a "family tree" illustrating the ancestral history of their R/S traditions. When

indicated, we also invite clients to read spiritual bibliotherapy (i.e., personally meaningful excerpts from Scripture or other sources with religious/spiritual meaning) and bring them into the next session so they can share with the group the meaning such readings hold for them. Lastly, family members are encouraged to engage in spiritual practices that are considered meaningful and therapeutic (e.g., church attendance, prayer, scripture-reading, etc.), particularly when there has been a significant lapse of time since they engaged in such behaviors. Rather than encouraging families to seek particular religious resources, we stress the importance of finding readings and spiritual practices that hold personal significance.

Perhaps the most directive aspect of the Spiritual Coping module is the therapist's role in helping family members to reframe maladaptive uses of religion. This part of treatment is likely to vary depending on the particular family's R/S fabric, but in our experience, a number of broad themes have emerged. These include deferring problem-solving responsibility to God (as described in Pargament et al., 1988) and holding blaming attributions, such as believing that mental illness is God's punishment for wrongdoing or sin. At times, therapists may evoke passages from the Bible to help family members reframe these maladaptive thoughts, such as, "I have learned to find resources in myself whatever my circumstances" (Phil. 4:11) or "Blessed are the merciful..." (Matt. 5:7). Some of these maladaptive themes and ways in which therapists have intervened are depicted in the following case studies.

Case Studies

Case Study One

In many of our cases, generational and personal differences arise during the R/S assessment and provide valuable information about how the therapist can best tailor the treatment to individuals and the family unit at once. This issue was particularly salient with one family we treated, which consisted of a middle-aged patient and his mother. Although the patient was raised in a Catholic home and still went to church on religious holidays, he reported that religion had little influence in his life. His mother, by contrast, attended church regularly and also subscribed to some Eastern and New-Age spiritual beliefs, such as reincarnation and parapsychology. She stated that organized religion is "like kindergarten," but it is an individual's responsibility to study and come to a personal conclusion about his or her own spirituality. For her, this meant coming to an understanding of why she was "reborn" as the mother of a son with mental illness. In one session, the mother relayed an experience she had had with a psychic, who had told her that she and the patient had encountered each other in a previous life. The mother was working in an orphanage and the man who is now her son was a small boy that was brought to her, but he would not talk and he only faced the wall. The mother reported that this story helped her to realize that this incarnation of her son was given to her "to help him speak and to grow."

The question "Why do bad things happen to good people?" is one that comes up often in religious texts and sermons. For this mother of an adult with mental illness, the answer to this question was that humans are challenged because when they meet their challenges and are able to overcome, they build virtue. In sum, she was able to use her beliefs about reincarnation and life's purpose to explain her son's illness as well as her role in his recovery. While beliefs in reincarnation are not falsifiable, we can verify that this mother reported belief in reincarnation. Working with beliefs is a primary objective of evidence-based treatments: clinicians must work with the beliefs that patients report (regardless of their veracity) to help them adopt more psychologically functional beliefs that are beneficial to mental health.

Although this mother was already using an adaptive form of spiritual coping in understanding her own situation, she had difficulty applying the same acceptance and adaptive coping style towards her son. She would make comments about her son's stunted spiritual development and often blamed him for his thoughts and behaviors. Therefore, the therapist's role as facilitator was essential in guiding the conversation and steering the mother away from philosophical conjecture without relation to coping. In doing so, he helped the mother articulate how she had applied her ideals of acceptance and building virtue to the relationship between mother and son. The therapist also frequently checked in with the patient's perceptions of his mother's beliefs and validated the patient's lack of religious conviction so that he did not feel isolated or ashamed. Finally, it was important for the therapist to allow for flexible definitions of prayer and meditation so that the patient felt involved in the conversation; this definition included spending time alone, listening to music, thinking (or slowing down and clearing the mind), and relaxing.

Case Study Two

Another important aspect of religion that contributes to spiritual coping is the cultural and social support that religious communities provide. In many families, religion plays a primarily traditional or cultural role that strengthens family ties, especially during holiday seasons. With one of our Jewish families, this was a dominant theme that emerged when the Spiritual Coping module of CIT-S overlapped with the High Holidays and the start of the

Jewish New Year. This family entered therapy without the identified patient, who was resistant to attending treatment. A common thread throughout all five CIT-S modules was how the family could come to terms with the loss of their former "healthy" relative, while accepting and supporting the patient as he was living with and suffering from schizophrenia.

For all three family members, the religious community had served as an important support system during life transitions or difficult times. In fact, in their own ways, each family member's life narrative was punctuated by happy memories of attending synagogue, singing prayers, and hearing stories from the Torah (sacred Jewish text, i.e. the Old Testament) while surrounded by family and friends. In their faith, the family had found the company of "good" people who shared their cultural and religious beliefs and traditions. In this way, the family was able to use the Jewish High Holidays as a time to reflect on their actions and ways of caring for their relative, while asking for forgiveness and health in the upcoming year.

The Jewish New Year (Rosh Hashanah) is a day of judgment in the Jewish tradition that is dedicated to asking God to forgive us for the sins committed over the past year. During services, a *shofar* (ram's horn) is sounded a number of times to awaken listeners from their "slumber" and to alert them that the day of judgment is here. After services, a traditional practice on this day is to visit a moving body of water. As the congregation prays, each individual throws pieces of bread into the water to symbolically cast away their sins from the previous year. In treatment, the family reflected that attending services this year was especially meaningful for them. At the sound of the *shofar*, they reflected that they had been inpatient with the patient and critical of his odd behaviors. At the riverside, they symbolically cast away their old patterns of caregiving and asked God for forgiveness. Together, this family made a pledge to provide a more accepting and low-key environment for the patient.

As an additional therapeutic reward, the patient was encouraged to attend religious services with his family. Family members later reported that the patient had enjoyed the services because they made him feel like a valued member of his society. The family recognized how involving the patient in low-stress activities in supportive environments could improve family functioning and the patient's sense of belonging.

Case Study Three

At times, the benefits that religion provides may be behavioral in nature. One of our patients, who attended treatment with his elderly mother, was socially isolated. He lived at home with his mother and sister and worked a night shift at a call center, where he had little engagement with coworkers. Although he had a strong desire to meet new people and make friends outside of his workplace, he experienced a great deal of anxiety surrounding social situations and reported that he often felt like an outsider. Throughout treatment, a primary goal was increasing the patient's self-esteem through positive interactions with others.

In the Spiritual Coping phase, it became clear that both the patient and his mother had strong Christian values. The patient's mother shared that she used to be very shy and had a difficult time meeting new people, but her prayer group helped her to feel accepted by her community and increased her confidence to make new friends. The patient suggested that going to church with his mother would be a good opportunity for him to interact with others in a supportive environment.

The following week, the patient stated that he had attended church services with his mother twice over the past week. He had also picked up a brochure on church-sponsored community service projects that he was interested in joining. As a future goal, the patient decided that he would like to become a part of one of these service projects. This was the first time in therapy that he was able to set a goal for himself that involved a significant social component. Although he was very anxious about other activities that require interacting with people, such as finding a new job or socializing with his brother's friends, the patient reported that he felt surprisingly little anxiety about socializing at church, because people there were very understanding and shared his core values.

Ongoing Research

These case studies provide a snapshot of the spiritual coping work we have done with families thus far. While the study is still underway, approximately 20 families have already completed CIT-S. For this paper, we have analyzed some preliminary data on consumer satisfaction with the Spiritual Coping module of CIT-S. At present, for patients, the average satisfaction rating on a 7 point Likert-type scale (1 = *very dissatisfied*, 7 = *very satisfied*) was 5.58 (SD = 1.52). Family members' average satisfaction with the Spiritual Coping module was 6.42 (SD = .64). While preliminary, we interpret these findings as suggesting that patients and families appear to be quite satisfied with the Spiritual Coping module of CIT-S.

In CIT-S, we are also interested in the interactions between clients and their therapists. We have begun to examine what happens when therapists have different views on religion than their clients, as therapist-client match on demographic variables has shown clinical relevancy. For instance, Gamst et al. (2000) found that

therapist-client match on ethnicity was related to higher functioning at termination for ethnic minority patients with schizophrenia. Interestingly, in the Propst et al. (1992) study reviewed earlier, findings suggested that therapist-client match on religious values did not relate to symptom improvement in a linear fashion. Furthermore, they found that the group that performed best on outcome measures was the Religious Cognitive Therapy with nonreligious therapists (Propst et al.). For a poster session at the annual conference of the Association for Behavioral and Cognitive Therapies, Dunham and Weisman de Mamani (2008) examined pilot data to explore whether a greater degree of concordance on religious orientation (intrinsic vs. extrinsic religious orientation) between schizophrenia family members and their therapists' own beliefs and values would be related to therapists' ability to competently adhere to the CIT-S guidelines as outlined in the treatment manual. This could be expected to occur because therapists and clients with more similar religious orientations may more readily agree on goals and treatment course, and may both feel more at ease working with one another. Interestingly, however, concordance did not appear to have any impact on therapists' ability to competently adhere to the CIT-S treatment manual. Given the heterogeneity of religious beliefs in the U.S., this finding is encouraging because it suggests that well trained therapists may be able to follow treatment guidelines in a competent manner, even when they hold R/S beliefs and values that are highly discrepant from those of their clients.

Conclusion

Incorporating religion and spirituality into therapy with patients experiencing severe mental illness is a complex issue—both theoretically and technically. In this paper, we examined this issue in the context of prior research as well as with some of our own findings. This question deserves attention in light of the strong presence of religion in the United States and the fact that R/S and psychotherapy often aspire to similar aims—helping individuals gain a sense of identity, find meaning, and obtain support. This relationship between R/S and psychotherapy may be particularly relevant for members of minority populations, who demonstrate high rates of religiosity and utilization of R/S coping resources. The limited research on this topic thus far has broadly indicated that incorporating R/S into treatment may prove beneficial for patients, but with some exceptions.

On the one hand, our review of the research has shown that R/S is largely associated with several indicators of greater well-being, in both nonclinical and psychiatric populations. Yet, for patients exhibiting psychosis, there is some empirical evidence that incorporating R/S themes into their delusions may lead to greater conviction in delusional beliefs, greater symptom severity, and lower functioning levels (Siddle et al., 2002). Furthermore, previous research has shown that there are both adaptive and maladaptive functions of religious coping that deserve attention in the therapeutic context (Pieper, 2004; Phillips & Stein, 2007). We interpret these findings as suggesting that, for severely mentally ill patients who do not evidence significant religiously based delusions, integrating certain forms of R/S coping into treatment may be indicated.

In our own work with schizophrenia patients and their family members, through the development and evaluation of a Culturally Informed Therapy for Schizophrenia (CIT-S), we have found that bringing R/S into the treatment has helped families in making sense of difficult situations they have faced, including that of having a relative with schizophrenia. We have also seen that patients' R/S practices often provide them with support and resources for coping. The case studies and satisfaction data presented in this paper appear to confirm what prior research suggests: that religion and spirituality can serve as meaningful complements to the therapeutic process for patients with serious mental illness and their family members. In light of the limited studies in this area, we encourage future research to investigate possible mediators of the positive relationship between R/S and mental health. Previous research has suggested that religion may impact mental health via its effect on health-promoting behaviors, the social support it provides, and the sense of coherence that it offers (George, Larson, Koenig, & McCullough, 2000). In addition, previous studies have shown that meaning-making coping has mediated the effect of intrinsic religiosity on subjective well-being (Chamberlian & Zika, 1992; Park, 2005), but further research is needed to understand the applicability of this relationship across samples. From the case studies presented in this paper, religion helped our patients and family members cultivate a sense of meaning (Case Study One), a sense of belongingness in familial and cultural systems (Case Study Two), and it provided one of our patients with a safe environment in which to explore future goals (Case Study Three). Building empirical support for these potential mediators will help clarify the adaptive functions of religion. In turn, this line of research will help therapists and mental health consumers continue to use R/S resources in meaningful ways.

We believe that the Spirituality module, with minor modifications, would be relevant to working with families with a variety of other mental disorders and problems. Although our clinical experience suggests that this aspect of treatment works well for patients with

schizophrenia and their families, the content of handouts and therapeutic goals are not specific to this population. As cited above, numerous cross-sectional, longitudinal, and qualitative studies have examined the beneficial effects of spiritual coping on mental health across samples and specific religious interventions have demonstrated efficacy in alleviating symptoms of anxiety and depression. The fundamentals of R/S have implications for sense-making, self-understanding and empathic treatment of others, all of which are at the heart of mental health and well-being.

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