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Collaborative Efforts in Cognitive Therapy with Religious Clients

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Cognitive therapy requires an understanding of and tolerance for the religious views of clients. Collaborative techniques in cognitive therapy are described and ideological obstacles in doing cognitive therapy with religious clients are considered. It is suggested that confronting clients' religious beliefs as pathological or absolutistic is clinically inappropriate. Beck's and Meichenbaum's collaborative techniques are endorsed as important clinical strategies in working with religious clients.

Outcome studies of the usefulness of cognitive therapy have proliferated in recent years, reflecting the popularity of the cognitive approaches. Numerous studies have demonstrated the effectiveness of cognitive therapy with unipolar depression (Beck, Hollon, Young, Bedrosian, & Budenz, 1985; Blackburn, Bishop, Glenn, Whalley, & Christie, 1981; Dobson & Shaw, 1986; McNamara & Horan, 1986; Murphy, Simons, Wetzel, & Lustman, 1984; Reynolds & Coats, 1986; Rush, Beck, Kovacs, & Hollon, 1977; Shaw, 1977; Simons, Lustman, Wetzel, & Murphy, 1985; Simons, Murphy, Levine, & Wetzel, 1986; Taylor & Marshall, 1977; Teasdale, Fennell, Hibbert, & Amies, 1984). Other effective uses of cognitive therapies have also been documented, in-

cluding cognitive-behavioral therapy for hypochondriasis (Salkovskis & Warwick, 1986), postdivorce adjustment (Graff, Whitehead, & LeCompte, 1986), childhood disorders (Meador & Ollendick, 1984; Swanson, 1985), test anxiety (Dendata & Diener, 1986), and reduction of Type A tendencies (Thurman, 1985a, 1985b).

The effectiveness of cognitive therapy for a variety of problems has been established. Attention can now be turned to the questions of specific effectiveness addressed by outcome researchers of other forms of psychotherapy (e.g., Strupp, 1978). Which cognitive therapists work best with which clients using which techniques? After reviewing the literature on cognitive-behavioral treatment of depression, Williams (1984) concluded that an area requiring further investigation is "specifying which technique works for which patient and at what stage in the time-course of the disorder" (p. 259). Although Williams was not referring to religious variables, it seems clear that an open consideration of client and therapist religious values is essential when considering client-therapist matching (Beit-Hallahmi, 1975; McMinn, 1984).

Because psychologists tend to be non-religious and sometimes lack sophistication in understanding religious thought, Bergin (1980) suggested that religious values of clients need more consideration in the practice and evaluation of psychotherapy. A similar argument has recently emerged in the psychiatric literature (Larson, Pattison, Blazer, Omran, & Kaplan, 1986). A compelling reason to better understand religious values is that nonreligious therapists tend to view religious clients as more responsible for their problems than nonreligious clients (Houts &

Graham, 1986). Petee (1981), Sacks (1985), and Stovich (1985) correctly concluded that sensitivity to and awareness of clients' religious traditions is an important element of effective treatment.

Moreover, clients with religious values expect their values to be respected in therapy. A recent survey showed that 79% of respondents believed religious values were important to discuss in therapy. Over half of the respondents preferred to seek therapy at a pastoral counseling center (Quackenbos, Privette, & Klentz, 1985).

Collaborative Empiricism in Cognitive Therapy

Although the cognitive therapies have certain commonalities, they also have distinctions. For example, Albert Ellis (1962) attempts to identify and dispute irrational beliefs quite immediately in the process of rational-emotive therapy (RET). In contrast, Aaron Beck's (1976) cognitive therapy for depression is first oriented toward discovering internal communications and automatic thoughts. In order to evaluate these internal communications and automatic thoughts, Beck suggested the therapist and client collaborate by deriving appropriate "experiments." Those automatic thoughts eventually do lead the therapist to the maladaptive underlying assumptions which are similar to Ellis's irrational beliefs. Donald Meichenbaum's (1977) cognitive-behavior therapy differs from both Beck and Ellis in that Meichenbaum does not search for a single scheme or irrational belief. Rather, he collaborates with clients in creating a fiction to explain behavior. That fiction then becomes a guide to more effective behavior and control of emotions (Meichenbaum, 1987).

Both Beck and Meichenbaum emphasized the need for therapist and client to collaborate whereas RET tends to be more teaching oriented and may involve more direct confrontation. As a hypothetical example, consider a 25-year-old depressed woman who feels she is failing in her career because she was recently passed over for promotion. A rational-emotive therapist would teach her that her emotions are not as much related to

loss of promotion as to her beliefs. For example, she may believe that if she is not the very best employee then she is a total failure. By teaching her to dispute the irrational belief, a rational-emotive therapist would help her realize that the loss of one promotion does not mean she is failing.

A therapist employing Beck's cognitive therapy might collaborate with this client by constructing an experiment. Since she believes she is failing in her work, she would be instructed to interview ten co-workers and two supervisors about their opinions of her work performance. This experiment might help modify her automatic thoughts that she is a failure.

A therapist employing Meichenbaum's cognitive-behavior therapy might use collaboration to develop a "healthy thinking script." For example, using what Meichenbaum (1987) called a "Columbo technique," a therapist might verbally note the paradox that this client is telling herself things that make her feel bad and yet seems to want to improve, as evidenced by her willingness to participate in therapy. The woman might then decide to explore alternate ways of talking to herself in order to change her feelings.

Although all cognitive therapies focus on rational, logical intervention, participants at the 1984 World Congress on Behavior Therapy noted that, despite the assumptions of cognitive therapies, emotions can cause distorted thinking and emotions and cognitions can occur simultaneously (Cordes, 1984). Thus, it is important to find ways to broaden cognitive therapies beyond the assumptions on which they were founded. Beck (Beck & Padesky, 1987) and Meichenbaum (1987) appear to be using collaboration to better include affective elements in their therapies. Rather than being limited to a linear perspective (such as Ellis's A-B-C model) where irrational beliefs cause negative emotions, Beck's and Meichenbaum's emphasis on collaboration allows for an interactional view of emotions and cognitions. With such an interactional view, emotions serve an important role in identifying specific cognitions. Cognitions evoked by certain emotional states can then be reevaluated in

therapy using collaborative methods.

Cognitive Therapy with Religious Clients

Understanding clients' religious values may be especially important in cognitive therapy where beliefs and schemas are routinely evaluated and systematically changed. Marzillier (1987) concluded that "there has always been a danger that the rational or cognitive therapies have underplayed the role played by values in the urge to stress the importance of rationality and logic" (p. 150). The role of religious values in cognitive therapy has received little research attention, perhaps because of the relative newness of the cognitive therapies. A few empirical studies and theoretical works have been published.

Bruun (1985) reported a case study where cognitive therapy was combined with religious strategies for effective outcome. It illustrated the positive potential of matching a religious client with a religious therapist but doesn't address broader issues of client-therapist matching.

Pecheur and Edwards (1984) compared secular and religious versions of cognitive therapy for depression. They found both versions of cognitive therapy to be more effective than a waiting list control condition. No outcome difference between secular and religious versions was found. However, the study is limited by two problems. First, Christian therapists were used for both groups. The only difference in therapy was the explicit use of their belief system in cognitive restructuring. Second, subjects were Christians in both treatment conditions. Although the study yields interesting results, it does not address questions of client-therapist matching.

Propst (1980a) reported use of religious cognitive imagery to be superior to nonreligious imagery in treating mild depression. Therapists in her study were nonreligious but understanding of religious value systems. Clients in the religious imagery group were religious, matched with clients in the standard imagery group. Propst's study suggests that at least some forms of cognitive therapy

can be modified to be more effective with religious clients, even when the therapy is delivered by nonreligious therapists who are understanding of their clients' values.

In addition to the empirical studies reported above, two authors have compared spiritual and cognitive treatment approaches theoretically. Propst (1980b) suggested a parallel between cognitive restructuring and evangelical approaches, especially with regard to the uses of imagery. Tan (1987) used principles from Scripture to construct a biblical approach to therapy that is largely cognitive-behavioral in orientation and practice, but more broad-based and comprehensive than secular cognitive-behavior therapy. He also pointed out many limitations and criticisms of cognitive therapies. These works may be useful for religious therapists interested in using cognitive-behavior interventions incorporating spiritual dimensions with religious clients.

Matching techniques to specific clients may require more than additional research. Existing research methodologies result in global assessments rather than yielding specific technique variations that might be attempted in response to ideological differences of religious clients. For example, we know that religious imagery is more effective than nonreligious imagery in dealing with religious clients (Propst, 1980a), but we do not know which specific religious ideologies make the imagery technique most advisable. Some religious clients will reject any kind of imagery technique because of recent Christian writings opposed to imagery of all kinds (Hunt, 1987; Hunt & McMahan, 1985). Until our research methodologies are sufficiently refined to address more specific effectiveness questions, these questions must be addressed by reporting experience-based observations. Below, we outline specific areas of ideological conflict observed in doing cognitive therapy with religious clients and suggest appropriate technique modification. In each case, we conclude the collaborative elements of cognitive therapy (Beck, Rush, Shaw, & Emery, 1979; Meichenbaum, 1977) to be preferable over more confrontive approaches, such as rational-emotive therapy.

Ideological Obstacles with Religious Clients

Self-Interest and Self-Direction

Ellis (1971) asserted that self-interest and self-direction are qualities of emotionally healthy individuals. Because religious clients have neither, according to Ellis (1971), they are not emotionally healthy. One goal of rational-emotive therapy is to help the client become healthier by acting more upon personal interests (Ellis, 1980).

As Ellis (1971) suggested, some religious clients are opposed to concepts of self-interest. Biblical passages such as the following seem to counter goals of self-interest: "Whoever finds his life will lose it, and whoever loses his life for my sake will find it" (Matt. 10:39); "Whatever was to my profit I now consider loss for the sake of Christ" (Phil. 3:7).

Many religious clients see self-sacrifice as a higher calling than self-interest. Rather than disputing this belief, it is most useful to focus on locus of control and issues of choice. Clients who *choose* to give up a right or privilege in order to help another will feel differently than those who believe they *must* give up a right or privilege. The former will engage in reinforcing self-talk while the latter will feel deprived.

Ellis (1971) is misguided in describing religious clients as less self-directed, accepting less responsibility for themselves. While some studies have shown no relation between locus of control and religiosity (Benson & Spilka, 1973; Berman & Hays, 1973; Friedberg & Friedberg, 1985; Sexton, Leak, & Toenies, 1980), some have shown religious individuals to be more internal (Shrauger & Silverman, 1971; Silvestri, 1979; Strickland & Shaffer, 1971), indicating that religious individuals expect to have at least as much control over themselves as nonreligious individuals. Thus, it is unreasonable to conclude, as Ellis does, that religious individuals accept less responsibility.

Overtly trying to change a religious client to be more self-interested and self-directed will probably result in resistance. Christian clients often come to therapy with concerns

that their values will be attacked or challenged (Worthington, 1986). Rather than confronting or challenging their values, using clients' belief systems and trying to help them focus on locus of control will be more useful. Clients will be more likely to abandon unreasonable expectations of constant self-sacrifice if therapists focus on internality and choice rather than directly confronting values.

Beck's (Beck et al., 1979) use of collaborative empiricism is useful here. Clients who believe they need to always be selfless can test their assumptions by experimentation. For example, they might watch closely a pastor or religious leader to see if he or she is always selfless. Their beliefs will gradually become more reasonable as they collect data indicating that complete selflessness is a hopeless ideal and as those data are considered in a supportive therapeutic environment.

When doing collaborative empiricism with religious clients, it is often important that the data collection occur within the context of the client's religious environment. Murphy (1985) indicated that the authority for changing cognitions may reside in oneself, group consensus, or expert authority. Since the beliefs of religious clients often come from expert authority (pastor, Bible, God, etc.), it is important to involve that authority in collaborative empirical efforts. Having religious clients verify thoughts by observing the behaviors of Christian leaders or finding appropriate Scripture passages is often useful because these sources are held in authority.

Rigid Thinking

Both rational-emotive therapy (Ellis, 1962) and cognitive therapy for depression (Beck, 1976) postulate that self-statements involving dichotomous thinking or arbitrary "shoulds" are emotionally disruptive. Changing "should statements" involves teaching clients to become more scientific in their thinking. This often involves confrontation in rational-emotive therapy and collaborative empiricism in cognitive therapy for depression. With religious clients, should statements are often difficult to modify because of the authority on which they are based, especially since beliefs of depressed individuals are likely to be

based on illogical justification (Cook & Peterson, 1986). Illogic and high authority for beliefs is a difficult combination to counter.

Confronting should statements in a threatening way may present problems for the nonreligious therapist working with religious clients. This is especially true early in therapy since initial responses to cognitive therapy seem to play an important role in outcome. Fennell & Teasdale (1987) found that those slow responders to cognitive therapy who began with skepticism about the role of thoughts in overcoming depression had poorer long-term treatment outcome. Confronting skeptical clients might easily be perceived as criticism, preventing the necessary therapeutic alliance. This is especially likely since religious clients often bring irrational beliefs about psychology into therapy (Rayburn, 1985). These beliefs require accepting attitudes on the part of therapists.

Some "shoulds" of religious clients represent unrealistic demands for perfection. For example, "I should always be nice to everyone I meet" or "I should never be angry" are unrealistic self-demands. Perfection demands, in turn, are likely to precipitate depression (Hewitt & Dyck, 1986), anxiety and anger (Zwemer & Deffenbacher, 1984). Rossi (1985) suggested that successful therapy for religious clients often involves an examination of their perfectionistic tendencies.

Collaborative empiricism can also be used with should statements and the tendency toward religious perfectionism. For example, a Christian client might agree to find biblical evidence that he or she should never be angry. The client might also look for biblical evidence that anger is acceptable under some circumstances. Alternatively, the client might interview religious leaders to get their views and experiences.

Another strategy, consistent with Meichenbaum's cognitive-behavioral therapy, is to review a client's religious script. For example, one of us worked with a client whose depression seemed directly connected to her beliefs that she was an inadequate Christian. One productive session was spend collaboratively reviewing the internal script she used when sitting in church. Her pastor, who ap-

parently was quite negative and critical in most sermons, evoked many negative self-statements in her. She told herself, "Other Christians are more committed than I am," "If I was really a Christian I would do more things for the church," and so on. Several subsequent sessions were spent looking at emotional consequences of the thoughts and eventually she decided she wanted to learn another script. In her new script, she internally challenged the words of her pastor rather than automatically feeling guilty for her inadequacy. She learned the script quickly, generalized it to other self-statements, and showed significant gains in therapy. The key was collaborating in evaluating the self-talk rather than immediately confronting it as irrational.

Need for Philosophical Change

Ellis (1987) recently argued that most cognitive therapies miss the important element of identifying and altering the absolutistic demands clients place on themselves. He then concluded that rational-emotive therapy is more satisfactory than other cognitive therapies because it allows clients to have deeper philosophical changes in their thinking. Earlier, Ellis (1971) argued that religious individuals are not emotionally healthy individuals. He himself is a probabilistic atheist and he believes these religious values to be the most satisfactory for good emotional health (Ellis, 1980).

Ellis' suggestion is antithetical to the point of this article. In fact, this is precisely the point of contention we have with Ellis. Whereas he argues that devout religious values need to be changed in order for mental health to be attained, we believe the philosophical beliefs of religious clients can often be maintained throughout effective cognitive therapy by using appropriate collaboration. For example, Ellis (1980) argued that blaming oneself is irrational and can only come from unhealthy absolute standards of right and wrong. But many religious clients have absolute standards of right and wrong, based on written authority or religious leaders, and blame themselves for violating those standards. To argue that one cannot be emotion-

ally healthy within the context of absolute standards of right and wrong is to overlook the millions of emotionally healthy religious individuals who never seek psychological help. There have been differing opinions about whether religious thinking contributes to psychopathology (Bergin, 1980; Ellis, 1971; London, 1976; McLemore & Court, 1977; Walls, 1980), but the most definitive empirical study is Bergin's (1983) critical evaluation and meta-analysis demonstrating that religious individuals have no more psychopathology than do nonreligious individuals. Moreover, Donahue's (1985) review indicates that intrinsic religiousness is unrelated to negative personality characteristics.

The goal of cognitive therapy is to implement some philosophical changes in the way clients view their world. However, Ellis' assumptions that devout religious philosophies need to be altered (Ellis, 1984) is not consistent with pastoral or Christian therapy (Wessler, 1984).

Helping clients determine which philosophical changes to pursue needs to be a collaborative effort. One can test whether or not an absolutistic belief system requires change. If a belief system necessitates depression, then everyone with that belief system will be depressed. Otherwise, individual cognitive differences or some noncognitive factors account for the client's depression.

Beck's cognitive therapy and Meichenbaum's cognitive-behavioral therapy do not ignore philosophical realities. But rather than searching for a global form of absolutistic thinking, Beck and Meichenbaum advocate searching for individualized scripts or schema, beliefs about the world based upon past learning. Although these schema may sometimes relate to religious views, effective treatment doesn't necessarily require the client to abandon absolutistic thinking altogether.

Conclusion

The empirical data on cognitive therapy with religious clients are sparse. It appears that religious imagery is useful for some religious clients and that cognitive therapy remains effective when modified into a religious form. However, two best-selling

Christian books (Hunt, 1987; Hunt & McMahon, 1985) have recently criticized psychologists' use of imagery, so skepticism toward imagery, even religious imagery, may be a factor in working with some clients.

Regardless of lacking empirical data, the subtle dimensions of doing cognitive therapy with religious clients cannot be fully explored with current research methodologies. Thus, we have observed, based on clinical experience, some ideological obstacles in doing cognitive therapy with religious clients. With each obstacle we have pointed to the importance of using collaborative strategies in therapy. By using Beck's technique of collaborative empiricism or Meichenbaum's collaborative therapeutic style, clients can be motivated to evaluate their beliefs in a supportive way. Excessive confrontation, especially from a nonreligious therapist, may produce resistance rather than progress. We tend to agree with Marzillier (1987):

A frontal attack on highly cherished beliefs will, I believe, tend to lead to greater resistance to change or, in response to the overwhelming barrage from the RET therapist, a token surrender that does not lead to a true or substantive belief change. (p. 150)

Cognitive therapy is an effective treatment for depression, anxiety, and other disorders—that has been determined. We now need to turn our attention to more specific questions of applying cognitive techniques to our clients, many of whom have religious orientations. Beck's and Meichenbaum's emphasis on collaboration in therapy seems to be more promising than the directive and confrontive approaches of rational-emotive therapy.

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