

# Religion and Spirituality

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Many clients highly value religious and spiritual (R/S) commitments, and many psychotherapists have accommodated secular treatments to R/S perspectives. We meta-analyzed 51 samples from 46 studies ( $N = 3,290$ ) that examined the outcomes of religious accommodative therapies and nonreligious spirituality therapies. Comparisons on psychological and spiritual outcomes were made to a control condition, an alternate treatment, or a subset of those studies that used a dismantling design (similar in theory and duration of treatment, but including religious contents). Patients in R/S psychotherapies showed greater improvement than those in alternate secular psychotherapies both on psychological ( $d = .26$ ) and on spiritual ( $d = .41$ ) outcomes. Religiously accommodated treatments outperformed dismantling-design alternative treatments on spiritual ( $d = .33$ ) but not on psychological outcomes. Clinical examples are provided and therapeutic practices are recommended. © 2010 Wiley Periodicals, Inc. *J Clin Psychol: In Session* 67:204–214, 2011.

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One relationship factor that can potentially affect the outcome of psychotherapy is the match or mismatch between a client's religious or spiritual (R/S) beliefs and the type of psychotherapy. Some R/S clients want R/S accommodated treatment. Others can accept secular treatment. Even for those who do not demand R/S treatment, some might benefit from treatment in their R/S framework (Pargament & Saunders, 2007; Worthington & Aten, 2009).

There has been an increase in outcome studies examining psychotherapies that incorporate R/S (Hook et al., 2010; Post & Wade, 2009; Smith, Bartz, & Richards, 2007). At the time of the first edition of *Psychotherapy Relationships That Work* (Norcross, 2002), there were only 11 outcome studies examining an R/S psychotherapy, making conclusions based on this set of studies necessarily tenuous (Worthington & Sandage, 2001). Furthermore, these studies were limited to mainly Christian-accommodative or Muslim-accommodative cognitive-behavioral interventions. Thus, it was difficult to generalize to other R/S psychotherapies. Thus, tailoring psychotherapy to the R/S beliefs of clients was judged to have promising empirical support, but more research was needed (Norcross, 2002). The increase in number, variety, and rigor of outcome studies evaluating R/S psychotherapies allows for a far more rigorous evaluation of the effectiveness of tailoring psychotherapy to a patient's R/S convictions.

In this article, we first define R/S and discuss how these constructs are generally measured. We offer clinical examples that illustrate how psychotherapy might be accommodated for one's R/S beliefs. Then, we present data from an original meta-analysis that examine the effectiveness of R/S psychotherapy. Thereafter, we discuss patient contributions to the effectiveness of R/S psychotherapy and note several limitations of the present body of research. Finally, we advance practice recommendations based on the present research evidence.

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## Definitions and Measures

Although the terms religion and spirituality have historically been closely linked, current conceptualizations make important distinctions between religion and spirituality. *Religion* can be defined as adherence to a belief system and practices associated with a tradition in which there is agreement about what is believed and practiced (Hill et al., 2000). *Spirituality*, in contrast, can be defined as a more general feeling of closeness and connectedness to the sacred. What one views as sacred is often a socially influenced perception of either (a) a divine being or object or (b) a sense of ultimate reality or truth (Hill et al., 2000). Many people experience their spirituality in the context of religion, but not all do.

Four types of spirituality have been identified on the basis of the type of sacred object (Davis, Hook, & Worthington, 2008; Worthington & Aten, 2009). First, *religious spirituality* involves a sense of closeness and connection to the sacred as described by a specific religion (e.g., Christianity, Islam, Buddhism). This type of spirituality fosters a sense of closeness to a particular God or Higher Power. Second, *humanistic spirituality* involves a sense of closeness and connection to humankind. This type of spirituality develops a sense of connection to a general group of people, often involving feelings of love, altruism, or reflection. Third, *nature spirituality* involves a sense of closeness and connection to the environment or to nature. For example, one might experience wonder by witnessing a sunset or experiencing a natural wonder such as the Grand Canyon. Fourth, *cosmos spirituality* involves a sense of closeness and connection with the whole of creation. This type of spirituality might be experienced by meditating on the magnificence of creation, or by looking into the night sky and contemplating the vastness of the universe.

R/S psychotherapy shares many methods and goals as secular psychotherapy but also incorporates methods or goals that are R/S in nature. For example, in addition to using cognitive or behavioral techniques to alleviate depression, a clinician practicing R/S psychotherapy might conceptualize using an R/S framework and, within that framework, use methods such as prayer or religious imagery. Besides pursuing goals that are psychological, a client in R/S psychotherapy might also work toward spiritual goals, such as becoming more like Jesus Christ or adhering more closely to the teachings of Buddha. R/S outcome variables, such as spiritual well-being, might be important in psychotherapy when clients' reasons for attending therapy and criteria for evaluating therapy include spiritual goals.

Accordingly, the outcome measures used in the subsequent review and meta-analysis fall into two categories. First, almost all studies use a psychological outcome variable. A study examining R/S psychotherapy for depression, for example, might use the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). Second, many studies also use a measure of spirituality. For example, a study examining R/S psychotherapy for unforgiveness might use a primary psychological measure of forgiveness but also a secondary measure of spiritual well-being (Ellison, 1983).

The majority of studies in the present review measured R/S beliefs simply by identification (i.e., the participant self-identified as Christian). Some studies used a measure of R/S beliefs or commitments (e.g., Religious Orientations Scale, Allport & Ross, 1967; Religious Commitment Inventory-10, Worthington et al., 2003) and employed a minimum cutoff score as a criterion for inclusion in the study. This ensured that the participants in the study were at least moderately engaged with their R/S beliefs. A few studies (e.g., Razali, Aminah, & Kahn, 2002) used a measure of R/S beliefs or commitments and measured the extent to which R/S treatments had different effects for participants who were more (or less) committed.

## Clinical Examples

### *Case 1: Christian-Accommodative Cognitive Therapy for Depression*

The cognitive model of depression emphasizes the role of maladaptive cognition in causes and treatment (Beck, Rush, Shaw, & Emery, 1979). Christian-accommodative cognitive therapy for depression retains the features of the secular theory, yet places the psychotherapy

in a religious context. For example, the rationale for psychotherapy, the homework assignments, the challenging of negative automatic thoughts, and core beliefs are integrated with and based on biblical teachings regarding the self, world, and future (Pecheur & Edwards, 1984).

Dana (aged 31 years) was a Christian female who presented to psychotherapy with several symptoms of depression. As psychotherapy progressed, Dana explored negative beliefs about herself. Her most problematic core belief was that she was worthless and no one would ever love and accept her as she was. These beliefs seemed related to childhood physical abuse by her mother, who eventually abandoned her. Dana was a committed Christian. At intake she asked to incorporate issues of R/S in her psychotherapy. As Dana and her therapist explored and modified her negative core beliefs, they discussed how Dana thought God viewed her. Several passages of the Bible comforted Dana and helped her realize that although she viewed herself negatively, God and other people loved and accepted her as she was.

### *Case 2: Spiritual Self-Schema Therapy for Addiction*

Spiritual self-schema therapy integrates cognitive-behavioral techniques with Buddhist psychological principles (Avants & Margolin, 2004). The goal of this psychotherapy is to modify a person's self-schema. When a self-schema is activated, beliefs about the self energize specific behaviors. This psychotherapy attempts to facilitate a shift from an "addict" self-schema to a "spiritual" self-schema that fosters mindfulness, compassion, and doing no harm to self or others (Margolin et al., 2007). Psychotherapy sessions focus on aspects of the Buddhist Noble Eightfold Path, which include training in mindfulness, morality, and wisdom.

Dave (aged 47 years) did not profess a religion. He considered himself to be spiritual. After he lost his job because he failed a drug test, he checked into a rehabilitation facility. He had been dependent on drugs and alcohol on and off for 30 years. During psychotherapy, Dave was taught about the wandering nature of the mind and how this contributed to his addict self-schema. When Dave did not work to control his mind, he thought of using drugs. He practiced a meditation technique called *anapanasati*, which involved sitting silently with eyes closed and focusing on the sensations experienced while breathing naturally. Dave improved his concentration and mindfulness with practice and began to discipline his maladaptive thoughts.

### *Case 3: Christian-Accommodative Forgiveness Therapy*

REACH is a model of promoting forgiveness that involves five steps: Recall the hurt, develop Empathy toward the offender, give an Altruistic gift of forgiveness, Commit to forgive, and Hold on to the forgiveness (Lampton, Oliver, Worthington, & Berry, 2005). Christian versions of REACH actively encourage clients to access their religious beliefs while moving toward forgiveness (Rye et al., 2005). Clients are encouraged to view forgiveness as a collaborative process with God and to consider prayer or use of Scripture in forgiving.

Lisa (aged 20 years) was a Christian who struggled to forgive her father, who had extramarital affairs when Lisa was younger, which precipitated her parents' divorce. Lisa's father was unreliable when Lisa was growing up. Lisa harbored resentment and anger toward him. At college, she concluded that her unforgiveness was a problem. Even though her father was not a part of her life, most days Lisa woke up angry, stressed, and upset towards her father. She attended a group psychoeducational workshop for people struggling with forgiveness. During the workshop, the group leader led the group through the steps to promote forgiveness. Group members shared how they had been hurt and tried to develop empathy for their offender. The group discussed God's role in forgiveness, which helped Lisa realize the extent that God and others had forgiven her. Lisa's gratitude to God for forgiving her helped her forgive her father.

#### *Case 4: Muslim-Accommodative Cognitive Therapy for Anxiety*

Similar to Christian-accommodative cognitive therapy for depression, Muslim-accommodative cognitive therapy for anxiety supplements a cognitive model (Beck, Rush, Shaw, & Emery, 1979) with spiritual strategies and interventions. For example, psychotherapists work with clients to identify and challenge negative thoughts and beliefs using the Koran and Hadith (sayings and customs of the Prophet) as guidance (Razali, Aminah, & Khan, 2002). Clients are encouraged to cultivate feelings of closeness to Allah, pray regularly, and read the Koran.

Hasan (aged 35 years) was a highly committed Muslim male, diagnosed with generalized anxiety disorder. His anxiety interfered with his marriage and job. In psychotherapy, Hasan said that he did not believe the world was a safe place, and he felt as if he had to worry or else something terrible might happen. The psychotherapist helped Hasan examine the evidence for and against his thoughts. Hasan and his psychotherapist worked together to develop religious coping strategies and discover religious truths to counteract his anxious thoughts. For example, it helped Hasan to remember that he believed that Allah was always in control and that he could trust in Allah to be with him and comfort him.

#### Meta-Analytic Review

Past research assessing the efficacy and specificity of R/S psychotherapies has been mixed. Hook and colleagues (2010) reviewed R/S psychotherapies for empirically supported status. They found that some R/S psychotherapies performed better than control groups and equal to established secular psychotherapies but did not consistently outperform established secular psychotherapies. However, in a recent meta-analysis, Smith and associates (2007) found evidence that R/S psychotherapies typically performed better than alternate treatments.

In the present meta-analytic study, we sought to determine the extent to which tailoring the psychotherapy relationship to the client's R/S is efficacious. We address this goal at three levels. First, we compare outcomes of clients in R/S psychotherapy with clients in no treatment control groups. Studies using comparative designs control for possible confounding variables present in less rigorous designs. The use of control groups provides for credible inference concerning the efficacy of R/S psychotherapies. Second, we compare outcomes of clients in R/S psychotherapy with clients in alternate psychotherapies. These types of studies not only control for possible confounding variables but also provide some evidence for the specificity of R/S psychotherapies. Third, we compare outcomes of clients in R/S psychotherapy with clients in alternate psychotherapies that use a dismantling design. In these studies, the R/S psychotherapy and the comparison treatment are equivalent in regard to theoretical orientation and duration of treatment but differ in whether they are accommodated to R/S clients. Comparison conditions may differ in strength, so these studies most rigorously test whether it is helpful to tailor psychotherapy to a client's R/S.

#### *Inclusion Criteria*

Studies included in the present meta-analysis met a definition of psychotherapy (Norcross, 1990), and all studies explicitly integrated R/S into psychotherapy. All studies included in the present review used random assignment and compared an R/S treatment with either (a) a no-treatment control condition or (b) an alternate treatment. We excluded studies of (a) 12-step groups such as Alcoholics Anonymous, (b) meditation or mindfulness interventions that were not explicitly R/S, (c) R/S interventions such as intercessory prayer that were not contextualized in psychotherapy, and (d) one session "workshop-type" interventions.

#### *Literature Search*

We conducted our literature search by (a) using two or more computer databases (listed below), (b) manually searching the references of previous meta-analyses and reviews, and (c) contacting relevant researchers for file-drawer studies. We included both published and unpublished studies. Effect sizes from published studies tend to be larger than effect sizes from

Table 1  
Overall Results for Psychological and Spiritual Outcomes

Comparison	Posttest					Follow-up				
	<i>N</i>	<i>k</i>	<i>d</i>	95% CI	<i>F</i> <sup>2</sup>	<i>N</i>	<i>k</i>	<i>d</i>	95% CI	<i>F</i> <sup>2</sup>
<i>Psychological outcomes</i>										
Control	1,280	22	.45	.15 to .75	83.84	602	8	.21	-.43 to .86	92.62
Alternate	1,718	29	.26	.10 to .41	57.47	610	13	.25	-.05 to .45	28.74
Dismantling	387	11	.13	-.26 to .52	67.87	277	8	.22	-.09 to .52	30.34
<i>Spiritual outcomes</i>										
Control	600	8	.51	.19 to .84	71.18	317	4	.25	-.03 to .52	25.87
Alternate	707	14	.41	.18 to .65	53.95	222	6	.32	-.10 to .74	56.62
Dismantling	235	7	.33	.07 to .59	0	126	4	.38	-.16 to .91	51.96

Note. The symbol *N* is the sample size summed across studies. The *k* is the number of effect sizes summarized. The *d* is the weighted mean *d* across samples. The 95% CI is the confidence interval for the mean *d*. The *F*<sup>2</sup> is the percentage of the observed variance that reflects real differences in effect sizes.

unpublished studies, so limiting the review to published studies may exacerbate publication bias (Lipsey & Wilson, 2001).

First, we identified studies by searching the PsycINFO, Social Sciences Citation Index, and Dissertation Abstracts International databases up until December 1, 2009. The search used the key terms [*counseling* OR *therapy*] AND [*religio*\* OR *spiritu*\*] AND [*outcome*]. Second, we used previous reviews of the literature (Harris, Thoresen, McCullough, & Larson, 1999; Hodge, 2006; Hook et al., 2010; McCullough, 1999; Smith et al., 2007; Worthington, Kuru, McCullough, & Sandage, 1996; Worthington & Sandage, 2001) to identify relevant studies. Third, we contacted the corresponding author from each study identified to inquire about studies we may have missed, including unpublished file-drawer studies.

Overall, a total of 51 samples from 46 separate studies evaluated R/S psychotherapy. Each of these studies is described in Table 1 in Worthington, Hook, Davis, and McDaniel (2011), from which this article is digested. Eleven samples employed both a control condition and an alternate treatment, resulting in 62 total comparisons. Of these comparisons, five did not have sufficient information to calculate the effect size, and six did not come from a study that employed random assignment to condition, leaving 51 valid comparisons for analysis. Of these comparisons, 22 compared R/S psychotherapy with a control condition, and 29 compared R/S psychotherapy with an alternate treatment. Of these 29 comparisons, 11 comparisons were identified that used a dismantling design in which the R/S condition and the comparison condition were identical in theoretical orientation and duration of treatment.

The total number of participants from the 51 samples was 3,290 (1,524 from R/S psychotherapies, 921 from alternate psychotherapies, and 845 from no treatment control conditions). R/S psychotherapies addressed a variety of problems. Also, many R/S perspectives were represented, although the most common perspectives were Christianity, Islam, and general spirituality. Many theoretical orientations were represented; the most common were cognitive, cognitive-behavioral, and mind-body-spirit.

### Effect Size

The effect size used in this study was the standardized mean difference (*d*). The *d* is a standard deviation metric with zero indicating no mean group difference. The value of *d* summarizes the posttest difference between the R/S condition and the comparison condition. A positive *d* indicates that the R/S condition performed better, on average, than the comparison; a negative *d* indicates that the comparison condition performed better.

Some studies did not contain sufficient data for the calculation of effect sizes. For each study with insufficient data to calculate the effect size, we requested missing data from the

corresponding author. If the necessary data could not be obtained, we excluded the study from the analysis.

### *Study Coding*

We coded studies for sample size and information necessary to calculate the  $d$  and standard error of the  $d$  (e.g., means, standard deviations). Also coded were three potential moderators: (a) study design characteristics involved source of data (published or unpublished). An effect for source of data would suggest that publication bias could be present, which might limit the conclusions that could be drawn; (b) treatment characteristics included treatment format (e.g., group, individual), problem rated (e.g., depression, anxiety), theoretical orientation (e.g., cognitive, behavioral), and type of R/S (e.g., Christian, Muslim, general Spirituality); and (c) measurement characteristics were type of measure (e.g., psychological, spiritual).

### *Data Analysis*

To analyze data, we used Comprehensive Meta-Analysis Version 2.2 (Borenstein, Hedges, Higgins, & Rothstein, 2005). Random effects models were used because we had no reason to believe that the population effect sizes were invariant. Consistent with random effects models, studies were weighted by the sum of the inverse sampling variance plus tau-squared (Borenstein, Hedges, Higgins, & Rothstein, 2009). Separate analyses were conducted for psychological and spiritual outcomes. For studies that reported more than one effect size, we used the measure that best assessed the goal of the specific psychotherapy. For example, if a study purported to examine R/S cognitive-behavioral therapy for depression, a measure such as the BDI was chosen and other measures, such as anxiety or general distress, were ignored. In addition, measures that had been subjected to peer-review were chosen over nonpeer-reviewed measures.

### *Results*

The meta-analytic results for psychological and spiritual outcomes are summarized in Table 1. The first column lists the level of comparison. Columns two through six list the posttest results. The second and third columns list the number of participants ( $N$ ) and studies ( $k$ ). The fourth and fifth columns list the mean  $d$  and 95% confidence interval for the observed  $d$ . The sixth column lists  $I^2$ , the ratio of true heterogeneity to total variation in observed effect sizes. Columns seven through eleven list the follow-up results using the same format.

Our first analysis examined whether patients in R/S psychotherapies showed greater improvement than would patients in no-treatment control conditions on both psychological and spiritual outcomes. This was largely the case (psychological  $d = .45$ ; spiritual  $d = .51$ ). Participants in R/S psychotherapies outperformed no-treatment control conditions on psychological and spiritual outcomes. These differences in outcomes were maintained at a smaller magnitude at follow-up, although these results should be treated with caution because of the small number of studies reporting such data.

Our second analysis examined whether patients in R/S psychotherapies showed greater improvement than those in alternate psychotherapies on both psychological and spiritual outcomes. This was largely the case (psychological  $d = .26$ ; spiritual  $d = .41$ ). Participants in R/S psychotherapies outperformed secular alternate treatments on psychological and spiritual outcomes. These differences in outcomes were largely maintained at follow-up, although again these results should be treated cautiously because of the low number of studies reporting such data.

In our third analysis, we compared treatments in studies that used a dismantling design (R/S and alternate treatment had the same theoretical orientation and duration of treatment). For psychological outcomes, there is no practical or statistical difference between conditions ( $d = .13$ ). For spiritual outcomes, participants in R/S psychotherapies outperformed

participants in alternate psychotherapies at posttest ( $d = .33$ ). This difference was maintained at follow-up, although again few studies reported such data.

### *Publication Bias*

We conducted a series of analyses to determine whether our results were affected by publication bias, that is, the tendency for studies available to the reviewer to systematically differ from studies that were unavailable. In our study, published studies had slightly higher effect sizes than unpublished studies (see Table 2); in no case was this difference significant. We used the trim and fill procedure (Duval & Tweedie, 2000) to estimate the effects of publication bias. The trim and fill procedure estimates the number of missing studies because of publication bias and statistically imputes these studies, recalculating the overall effect size. Effect sizes were somewhat reduced using this procedure, but the overall conclusions did not change (see Table 3). The results of the publication bias analyses indicate that it may be more difficult for studies on R/S psychotherapies with small magnitude or negative results to be published. Caution is warranted. These analyses were conducted with few studies.

### Moderators

We coded and tested three potential moderators—treatment format (individual vs. group), target problem (psychological, forgiveness, or health), and type of R/S (religious vs. spiritual)—in our meta-analyses. All moderator analyses were conducted on psychological outcomes at posttest. None of the moderators were statistically significant. That is, none of

**Table 2**  
*Comparison of Published and Unpublished Studies*

Level of specificity	<i>k</i>	<i>d</i>	95% CI	<i>k</i>	<i>d</i>	95% CI
	Published	Published	published	Unpublished	Unpublished	unpublished
Comparison with control	15	.49	.06 to .92	7	.41	.20 to .62
Comparison with alternate	23	.26	.10 to .41	6	.19	-.34 to .71
Comparison with alternate (dismantling)	7	.18	-.24 to .60	4	-.06	-.91 to .80

*Note.* The symbol *k* refers to the number of effect sizes summarized. The statistic *d* is the weighted mean standardized mean difference across samples. The 95% CI is the confidence interval the weighted mean standardized difference.

**Table 3**  
*Results for Trim and Fill Analyses*

Comparison	Posttest		
	<i>K</i> <sup>+</sup>	<i>d</i> adj	95% CI
<i>Psychological outcomes</i>			
Control	7	.15	-.13 to .44
Alternate	4	.17	.01 to .33
Dismantling	1	.03	-.37 to .43
<i>Spiritual outcomes</i>			
Control	0	.51	.19 to .84
Alternate	3	.25	.03 to .51
Dismantling	1	.26	-.01 to .53

*Note.* CI = confidence interval. The *K*<sup>+</sup> is the number of the studies imputed by the trim and fill procedures. The symbol *d* adj is the weighted mean *d* of the distribution of *d* that contains both the observed and the imputed effects.

these variables accounted for appreciable variance in the effect size estimates in the reviewed studies.

### Patient Contributions

The research reviewed in the present meta-analysis focused on the psychotherapist's contribution to the relationship. Our analysis addressed the question of whether it is helpful to tailor the psychotherapy to the client's religious and spiritual proclivities. However, characteristics of individual clients probably also affect tailoring.

One patient characteristic that might be pertinent is the client's R/S commitment. In the vast majority of studies, the participants identified with a particular religion or spirituality under investigation; for instance, studies on Christian accommodative psychotherapy for depression recruited only Christian participants. However, people differ in their level of R/S commitment. For some, R/S beliefs may be little more than a tradition or demographic characteristic, whereas for others R/S beliefs may be the driving force behind their core values, life goals, and everyday behaviors. Thus, religious commitment is likely more important than beliefs or a religious demographic identification (Worthington, 1988). It therefore follows that including R/S into psychotherapy may be more important for clients that are highly R/S committed than for clients who are less R/S committed.

There is modest support for this hypothesis in a recent effectiveness study (Wade, Worthington, & Vogel, 2007). Unfortunately, this hypothesis has not been addressed frequently enough in RCT studies to be tested in the present review. Almost all studies simply required that participants identify with the particular religion that is integrated with the psychotherapy or indicate that they are open to participate in a psychotherapy that includes spirituality. Two studies (Nohr, 2001; Razali, Aminah, & Khan, 2002) assessed the efficacy of R/S psychotherapies using clients with different levels of religious commitment. But their findings were mixed. Thus, there is not sufficient research on this patient factor to make viable conclusions or clinical recommendations.

### Limitations of the Research

There are limitations of the research on R/S psychotherapies. First, although the quality of studies has improved in the past several years, some studies still suffered from less rigorous study designs and low power. In particular, there were relatively few comparisons ( $k = 11$  with psychological effect sizes;  $k = 7$  with spiritual effect sizes) that met the criteria for a dismantling design. These types of studies are especially important; they best answer the empirical question of whether it improves efficacy to incorporate R/S in an existing psychotherapy for R/S clients. Studies that compare R/S psychotherapy with a completely different type of psychotherapy can be rigorous as well. However, if participants in the R/S psychotherapy outperform participants in the alternate psychotherapy, then it is difficult to discern whether this occurred because (a) the specific R/S elements caused the differential outcomes or (b) something else that was different between the two psychotherapies caused the differential outcomes.

Many studies with comparative designs used random assignment to conditions, but some did not. Random assignment to conditions is the gold standard of psychotherapy research, but it is sometimes difficult to accomplish in studies of R/S psychotherapy. Religion is an emotionally charged topic for many people, and thus both highly religious people and adamantly nonreligious people may be unwilling to be randomized to a treatment not in accord with their beliefs.

Another limitation of this meta-analysis was publication bias. Our analyses indicated that some studies indicating negative or null findings for R/S psychotherapies might have been unpublished, literally sitting in a file-drawer somewhere. There are several possible reasons for publication bias in this literature. First, much of the research on R/S psychotherapy is conducted by researchers who have religious orientations. Author decisions may be a cause of the apparent publication bias. When the results of a study do not support the efficacy of R/S



psychotherapy or yield an estimate of efficacy that is small, some authors might not submit the paper for publication. Second, when the research is published, some of the research has been published in religiously oriented journals, which might accept papers that support R/S psychotherapy more than those that do not. Third, editors may be reluctant to publish comparative studies that report null findings because it is hard to determine whether these results reflect (a) no true difference between conditions or (b) problems in the study design and implementation (e.g., low power).

### Summary and Therapeutic Practices

In summary, the meta-analytic results present clear findings about the effectiveness of religious and spiritual accommodation. Consistent with Smith et al. (2007), there was some evidence that R/S psychotherapies outperformed alternate psychotherapies on both psychological and spiritual outcomes. However, this finding is difficult to interpret because comparison treatments varied in quality. When the analysis was limited to studies that used a dismantling design, patients in R/S psychotherapies outperformed patients in alternate psychotherapies on spiritual outcomes but not on psychological outcomes.

To conclude, we offer several concrete applications for clinical practice based on the findings from our meta-analytic review.

- Religious/spiritually oriented psychotherapy works. The research suggests that R/S psychotherapies can result in better psychological and spiritual outcomes, and some evidence suggests that gains are maintained at follow-up. R/S psychotherapies are a valid treatment option for clients seeking or desiring them.
- The addition of R/S to an established secular psychotherapy does not reliably improve psychological outcomes for R/S clients over and above the effects of the established secular psychotherapy alone. Thus, at this time there is no empirical basis to recommend R/S psychotherapies over established secular psychotherapies when the primary or exclusive treatment outcome is symptom remission.
- R/S psychotherapies offer spiritual benefits to clients that are not present in secular psychotherapies. Patients in R/S psychotherapies improved on spiritual outcomes more than did patients in alternate psychotherapies, even when this analysis was limited to studies that used a dismantling design. Thus, for patients and contexts in which spiritual outcomes are highly valued, R/S psychotherapy can be considered a treatment of choice.
- The incorporation of R/S into psychotherapy should follow the desires and needs of the client. Psychotherapists are encouraged to ask about R/S beliefs and commitment as part of intake and to incorporate R/S into psychotherapy (a) as they feel comfortable and (b) in line with the client's preferences. Research summarized elsewhere in this volume demonstrates that accommodating patient preferences modestly enhances treatment outcomes and decreases premature termination by a third (Swift, Callahan, & Vollmer, this volume).
- We hypothesize that incorporating R/S into psychotherapy might be more efficacious with clients who are highly religiously or spiritually committed. Few studies have addressed this hypothesis, but there is no research or clinical evidence to suggest that R/S psychotherapies produce *worse* outcomes than secular therapies for these patients. Thus, we recommend that practitioners consider offering R/S to highly religious or spiritual patients.

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