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Review

Faith-adapted psychological therapies for depression and anxiety: Systematic review and meta-analysis

Naomi Anderson [a], Suzanne Heywood-Everett [b,c], Najma Siddiqi [b,c], Judy Wright [c], Jodi Meredith [d], Dean McMillan [a,d,*]

[a] Hull York Medical School, University of York, Heslington, York YO10 5DD, United Kingdom
[b] Bradford District Care Trust, New Mill, Victoria Road, Saltaire, West Yorkshire BD18 3LD, United Kingdom
[c] Institute of Health Sciences, University of Leeds, 101 Clarendon Road, Leeds LS2 9LJ, United Kingdom
[d] Department of Health Sciences, University of York, Heslington, York YO10 5DD, United Kingdom

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ABSTRACT

Background: Incorporating faith (religious or spiritual) perspectives into psychological treatments has attracted significant interest in recent years. However, previous suggestion that good psychiatric care should include spiritual components has provoked controversy. To try to address ongoing uncertainty in this field we present a systematic review and meta-analysis to assess the efficacy of faith-based adaptations of bona fide psychological therapies for depression or anxiety.
Methods: A systematic review and meta-analysis of randomised controlled trials were performed.
Results: The literature search yielded 2274 citations of which 16 studies were eligible for inclusion. All studies used cognitive or cognitive behavioural models as the basis for their faith-adapted treatment (F-CBT). We identified statistically significant benefits of using F-CBT. However, quality assessment using the Cochrane risk of bias tool revealed methodological limitations that reduce the apparent strength of these findings.
Limitations: Whilst the effect sizes identified here were statistically significant, there were relatively a few relevant RCTs available, and those included were typically small and susceptible to significant biases. Biases associated with researcher or therapist allegiance were identified as a particular concern.
Conclusions: Despite some suggestion that faith-adapted CBT may out-perform both standard CBT and control conditions (waiting list or "treatment as usual"), the effect sizes identified in this meta-analysis must be considered in the light of the substantial methodological limitations that affect the primary research data. Before firm recommendations about the value of faith-adapted treatments can be made, further large-scale, rigorously performed trials are required.

Contents

Abbreviations: CBT, Cognitive behavioural therapy; F-CBT, Faith-adapted therapy (based on cognitive or cognitive behavioural models)

* Correspondence to: Mental Health and Addiction Research Group, Department of Health Sciences and Hull York Medical School, University of York, Room 205, Area 4, ARRC Building, Heslington YO10 5DD, United Kingdom. Tel.: +44 1904 321359; fax: +44 1904 321651.
E-mail address: dean.mcmillan@york.ac.uk (D. McMillan).

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1. Introduction

The Pew Research Center estimates that 84% of the global population self-identify with a religious group, whilst only 16% report no religious affiliation (Hackett and Grim, 2012). Religious involvement has been associated with better mental health (Koenig, 2008b, 2001; Moreira-Almeida et al., 2006). Further, religious service attendance is believed to be a protective factor against completed suicide (Kleiman and Liu, 2014).

Many studies have reported that people with mental health problems are more likely to be religious. A US study reported that over 80% of people with persistent mental illness use religious beliefs or activities to help them cope (Tepper et al., 2001), and other studies report that clients are both willing and want to discuss religious concerns in psychotherapy (Baetz et al., 2004; Rose et al., 2008).

Psychiatrists and psychologists, however, are less likely to be religious than the general population (Baetz et al., 2004; Koenig, 2009; Pargament, 2011). Since the time of Freud, there have been widespread negative views about religion within the psychiatric community, perhaps linked to the pathological expression of religious delusions (Koenig, 2008b; Moreira-Almeida et al., 2006). Previous suggestion that good psychiatric care should include spiritual components (Koenig, 2008b) provoked controversy (Cook, 2011). Despite these barriers, a wealth of literature explores the inclusion of religion in counselling and psychotherapy. Pastors and psychologists alike have published case studies to explain or promote "cognitive–theological" approaches (see for example, Bingaman (2007) or Cole (2008)), and in the past decade a number of randomised controlled trials have evaluated faith-adapted psychological treatments.

Previous reviews (Hook et al., 2010; McCullough, 1999; Smith et al., 2007; Worthington et al., 2011b) have produced somewhat contradictory conclusions about the value of incorporating religion into psychological treatment. A meta-analysis (Smith et al., 2007) of mixed study designs identified "moderately strong" evidence that faith-adapted treatments outperform standard psychological treatments (effect size 0.56), but more recent reviews of randomised controlled trials (Hook et al., 2010; Worthington et al., 2011b) found insufficient evidence to identify differential outcomes. One review (Hook et al., 2010) identified that "methodological problems… make it difficult to make strong conclusions about the specificity of therapies". However, neither this, nor subsequent reviews have formally analysed the quality of individual studies nor the impact of biases on review findings. Further, previous meta-analyses have typically combined results of interventions for different mental health problems and different faith groups, resulting in meta-analysis of highly heterogeneous studies.

Culture and religion are highly interlinked, and the National Institute for Health and Care Excellence (NICE) now recommend that clinicians should be competent to provide a "culturally sensitive" assessment and treatment (National Institute for Health and Clinical Excellence, 2010), including "seeking the advice and support of an appropriate religious or community leader to support the therapeutic process" (National Institute for Health and Clinical Excellence, 2006) where necessary (for example, in treating obsessions with religious content).

1.1. Definitions

There has been some controversy over the definition of the terms "religion" and "spirituality" (Koenig, 2008a). In line with other researchers (Koenig, 2009; Moreira-Almeida et al., 2006) we use "religious" to refer to an allegiance to the beliefs, teachings or traditions of an organised religion, arising from a group of people with common beliefs and practises concerning the sacred. By contrast, we use the term "spiritual" to refer to a more personal relationship with or belief in the transcendent, which may or may not coincide with the recognised beliefs of an organised religion.