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Review

Adapted cognitive-behavioral therapy for religious individuals with mental disorder: A systematic review

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ABSTRACT

Cognitive-behavioral therapy (CBT) is considered an evidence-based psychological intervention for various mental disorders. However, mental health clinicians should be cognizant of the population that was used to validate the intervention and assess its acceptability to a target group that is culturally different. We systematically reviewed published empirical studies of CBT adapted for religious individuals with mental disorder to determine the extent to which religiously modified CBT can be considered an empirically supported treatment following the criteria delineated by the American Psychological Association Task Force on Promotion and Dissemination of Psychological Procedures. Overall, nine randomized controlled trials and one quasi-experimental study were included that compared the effectiveness of religiously modified CBT to standard CBT or other treatment modalities for the treatment of depressive disorders, generalized anxiety disorder, and schizophrenia. The majority of these studies either found no difference in effectiveness between religiously modified CBT compared to standard CBT or other treatment modalities, or early effects that were not sustained. Considering the methodological limitations of the reviewed studies, religiously modified CBT cannot be considered a well-established psychological intervention for the treatment of the foregoing mental disorders following the a priori set criteria at this juncture. Nevertheless, melding religious content with CBT may be an acceptable treatment modality for individuals with strong religious convictions.

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1. Introduction

Cognitive-behavioral therapy (CBT) is considered an evidence-based psychological intervention for various mental illnesses. Randomized controlled trials show that CBT is a promising adjunctive psychosocial treatment for refractory schizophrenia (Dixon et al., 2010; Tandon et al., 2008; Turkington et al., 2008).

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Findings from meta-analyses indicate strong evidence for CBT in the treatment of other disorders including depression (Gloaguen et al., 1998), adult anxiety disorders (Stewart and Chambless, 2009), pediatric posttraumatic stress disorder (Kowalik et al., 2011), and obsessive-compulsive disorder (Watson and Rees, 2008). However, mental health clinicians should to be cognizant of the population that was used to validate CBT and assess the acceptability of this intervention to target groups that are culturally different.

Culture refers to the way of life for a particular group of people. The term emphasizes the transmission of traditions, ways of living, coping behaviors, values, norms, and beliefs (Whaley and Davis, 2007). It considers the influences of age, developmental disabilities, socioeconomic status, sexual orientation, national origin, gender, and religious orientation (Hays, 2009). Although practitioners and researchers from various disciplines are increasingly cognizant of the need to adapt evidence-based psychosocial interventions to be more compatible with the culture of ethnically diverse populations (Bernal et al., 2009; Castro et al., 2004), less attention has been directed at adapting psychosocial interventions to be more congruent with the religious beliefs of individuals with mental illness (Hodge, 2004).

According to the cultural compatibility hypothesis, evidence-based psychological treatments are more effective when the intervention complements the client's culture (Tharp, 1991). Adapting interventions to improve congruence between components of the intervention and the client's culture could increase adherence to the intervention and lead to better outcomes (Fraser et al., 2009). Cultural adaptation is predicated on two circumstances. First, adaptation is warranted when the client does not find the proposed intervention meaningful or useful, hence declining to engage in the intervention (Fraser et al., 2009). Indeed, studies have found an underutilization of mental health services by Protestants (Larson et al., 1986, 1989) and individuals with religious affiliations (Borras et al., 2007; Ng et al., 2011). This discrepancy in service utilization could be attributed to the conflict in values that mental health interventions encompass, and those endorsed by individuals with certain religious affiliation (Koenig, 2005; Propst et al., 1992). Second, interventions should be adapted to be more culturally sensitive when the known risk and protective factors related to the problem of interest vary according to culture. Indeed, individuals with mental illness often engage in religious practices to cope with persistent symptoms and stressful life events (Mohr et al., 2012; Russinova et al., 2002; Tepper et al., 2001). Moreover, the use of religious coping methods has been found to be associated with better mental health outcomes among individuals with medical and psychiatric illnesses (Koenig, 2007, 2012; Koenig et al., 1992; Tepper et al., 2001). The foregoing empirical evidences provide the scientific rationale to adapt existing evidence-based psychological interventions to be more congruent with the culture of religious individuals with mental illness in facilitating recovery.

We reviewed empirical studies of CBT adapted for religious individuals with mental illness and use the criteria proposed by the Task Force on Promotion and Dissemination of Psychological Procedures (1995) to determine the extent to which this intervention, henceforth referred to as religiously modified CBT, can be considered an empirically supported treatment (see Table 1). These criteria were developed to facilitate the evaluation of psychotherapies to determine whether adequate empirical evidence exist to warrant widespread dissemination in training and implementation. In addition, we described how CBT was culturally adapted in some of the reviewed studies using the framework of the ecological validity model (Bernal et al., 1995). This model is the first known framework for cultural adaptation of psychosocial treatments published in the literature and the most widely referenced (Castro et al., 2004). Although several reviews have been conducted on religiously modified psychotherapies (Griner and Smith, 2006; Hodge, 2006; Hook et al., 2010; Paukert et al., 2011; Post and Wade, 2009), the majority of previous reviews have tended to focus on psychotherapies in general rather than on CBT. Moreover, the majority did not use established criteria to examine the level of empirical support for religiously modified CBT. Nor has previous reviews use a framework for cultural adaptation to describe how religiously modified CBT was adapted; it would seem, therefore, that a description of the adaptation approach might facilitate the process for mental health practitioners who are considering modifying CBT to be more consonant with the religious beliefs of their clients.

Table 1
Task force's criteria for empirically validated treatments.

Category I: well-established treatments
1. At least two group design experiments with methodological rigor and adequate statistical power ($n = 30$ per group) conducted by independent investigators demonstrating that the intervention is either superior to another treatment, and/or the intervention is equivalent to an established treatment in studies.
OR
2. A sizable number of singe-case design studies that have demonstrated efficacy by using good experimental design and comparing the intervention to another treatment.
AND
3. The intervention was delivered according to a treatment manual or according to clear descriptions of the treatment.
AND
4. The characteristics of the study sample were specified.
Category II: Probably Efficacious Treatments
1. Two experiments must show that the treatment is superior to waiting-list control group.
OR
2. One or more experiments must meet the criteria for well-established treatments, but are conducted by the same investigator.
OR
3. At least two good studies demonstrating effectiveness but with a heterogeneous sample.
OR
4. A small number of single-case design studies demonstrating efficacy using good experimental design with a comparison group that comprise another treatment, treatment manuals, and clear specification of the sample characteristics.
Category III: Experimental Treatments
1. Treatments that have not been established as at least probably efficacious.

2. Methods

A search for published empirical studies through June 2013 that examined the effectiveness of religiously modified CBT was performed (see Fig. 1). Relevant research articles were searched in the National Center for Biotechnology Information (NCBI) PubMed (MEDLINE) and PsycINFO databases using the following keywords: religion; cognitive-behavioral therapy or modified cognitive behavioral therapy; cultural adaptation; and mental illness or mental disorders. Titles and abstracts of the shortlisted articles were screened. In addition, reference sections of relevant articles and systematic reviews were examined to extract germane articles. Articles that met the following criteria were included in the review: (1) the paper was published in English; (2) participants included in the studies were diagnosed with an Axis I mental disorder that includes major depressive disorder, bipolar disorder, generalized anxiety disorder, obsessive compulsive disorder, panic disorder, post-traumatic stress disorder, or schizophrenia per the diagnostic criteria specified in the Diagnostic and Statistical Manual of Mental Disorders (DSM), the International Classification