Integrating Faith and Cognitive Behavioral Therapy to Treat Depression in Adults

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Major Depressive Disorder (MDD) is the most often diagnosed psychiatric illness worldwide, with prevalence rates indicating that as many as 25% of the population during their lifetimes will experience symptoms of MDD (Holmes, 1997). Therapies that focus on restructuring the client's cognitions have been shown to be effective in the treatment of this disorder. For some clients, however, reoccurring depressive episodes are common and symptom reduction is infrequent. The research of Worthington (1988) suggests that the highly religious client may actually see the world in a uniquely differently way than does the non-religious. These individuals utilize more religious schema and as a consequence of this distinct perspective may experience more favorable treatment outcomes when the therapeutic approach supports their strongly held religious views (Worthington, 1988; Worthington & Sandage, 2001). This single case study will utilize archival data and a manualized approach that focuses on spiritual growth and symptom reduction through an integrated cognitive behavioral therapy approach. The findings of this study confirm the work of many integrative researches that suggest symptom reduction is more apparent when an integrative approach is applied rather than a non-integrative approach.

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Prevalence of Major Depressive Disorder

The National Institute of Mental Health describes Major Depressive Disorder (MDD) as an invisible disease, with lifetime prevalence rates falling between five and twenty-five percent (NIMH, 2003; APA, 2000). Approximately ten percent of adults over the age of 18 will be diagnosed with depression during any given year. This equals approximately 18.8 million people annually. According to NIMH more people are hospitalized for Major Depressive Disorder than for any other psychiatric diagnosis (2003). As a consequence of the vast prevalence of this disorder there are significant fiscal implications affecting both the individual and society. The annual loss of worker productivity is estimated to be forty-four billion dollars (Druss & Rosenbeck, 1999). Decreases in productivity are also observed in employee turnover, in work-related absences, as well as in workers negligence. Beyond these actual deficits are the noted increases in medical expenditures for psychiatric and health illnesses (Druss & Rosenheck). Recurrent depression, when compared to single episode depression, does...
tend to magnify the costs and the far-reaching implications of this disorder.

The Frequency of Recurring Symptoms

A formal psychotherapy treatment model for chronic, recurring depression would be difficult to locate prior to the 1980's. This is due in part to an absence of a treatable chronic affective category in the publication of the Diagnostic and Statistical Manual of Mental Disorders 3rd edition (DSM-III, American Psychiatric Association, 1980). In spite of the lack of official categorizing, the chronicity of this disorder was nonetheless greatly evident among the psychiatrically diagnosed population (McCullough, 2003). It is important to recognize that 2 recurrent depression, although not formally acknowledged in past research, is nonetheless very present.

It has been shown that recurrent depression is likely to be the experience for many clients that are diagnosed with Major Depressive Disorder (McCullough, 2003). In one investigation it was found that only 22% of those clients diagnosed with MDD reported experiencing only one depressive episode. Lewinsohn's research confirms the recurrence of depressive episodes when he found that 45% of the individuals investigated had experienced at least two distinct depressive episodes. Multiple, recurrent episodes appear to be somewhat the norm according to Lewinsohn's research. Furthermore, it has also been found that 33% of the clients diagnosed with Major Depressive Disorder reported having at least three distinct episodes (Lewinsohn et al., 1989). These, as well as other studies suggest that for many, depression is a lifelong disorder that requires close monitoring coupled with effective treatment. Although there remain numerous treatments for recurrent depression, the current trend of psychotherapy emphasizes empirically supported outcome oriented approaches. Perhaps the most highly investigated therapeutic orientation encompasses Cognitive Behavioral Therapy (CBT) and has emerged as the one of the most effective approaches.

CBT as a First Line Treatment Approach

Propst and associates (1992) note that CBT has been an effective treatment for depression but suggested that traditional CBT, although useful for the general psychiatric population, may not be equally successful with the religious client. The reason for this lack of effectiveness is complex and the studies addressing this issue are somewhat limited. However, it has been hypothesized that the answer lies in what this researcher describes as value incongruence. Value incongruence proposes that the general ideals held by secular, non-religious, cognitive behavioral therapists might actually be in conflict with the values esteemed by numerous religions and individuals of faith orientation. For example, some of the more firmly held CBT ideals such as personal autonomy and self-efficacy are incongruent with the religious values of humility and corporate dependence. There are numerous additional values that are incongruent, thus creating a dissonance between secular and sacred CBT. The recommendation of Propst and associates is to create skillfully a commonality between the treatment approach of the clinician and the clients firmly held religious beliefs. The objective of effective integration is evident in the emerging research. Within the last 25 years religiously oriented studies have mushroomed, adding insight and effective treatment for those who esteem faith to be an important part of their life experiences (McMullough, 1999; Worthington & Sandage, 2002).
The Growth of Religious Interest in Psychology

Rose, Westefeld and Ansley (2001) surveyed 74 clients at six separate mental health centers. The results of the study reinforce the importance of religion in the treatment process. Most of the participants in the study were white (92%) and female (87%). Nearly 40% of the participants were not affiliated with any current religion. More than half of those interviewed (55%) indicated an interest in discussing spiritual and religious concerns in their counseling. Only 18% stated that they did not want to include religion in therapy. Furthermore, clients who reported higher levels of prior spiritual experiences preferred to discuss spiritual and religious matters. Therefore, based on the aforementioned study, religion and religious dialogue is important to people seeking treatment, not only in their churches or synagogues, but also in therapy offices and mental health clinics.

Integration for the Religiously Oriented

Client A relatively small number of studies have compared standard therapies with integrative therapies for the treatment of depression (McMullough, 1999; Worthington & Sandage, 2002). All of these studies have employed cognitive or cognitive-behavioral therapies specific to the treatment of depression. The researchers, based on their findings, have concluded that the integrative therapies produce better treatment outcomes for the religiously oriented client when compared with standard therapies. They have also shown that the religiously integrative therapies not only reduce depressive symptoms, but also that clients actually have been shown to reply a subjective increase in spiritual well-being (McMullough; WOlihington & Sandage).

Unique Aspects of this Particular Study

For well over a century, scholars have sought to somehow combine psychology and religion (Haque, 2001; Worthington, Kurusu, McCullough, & Sandage, 1996). This interest in mingling these two somewhat opposing approaches has emerged from the sincere interest to better understand the true complexities of human nature. This integrative process has had a slow, steady growth over the last 100 years. However, starting in the early 1970's, a more abrupt and noteworthy change began to transpire. It was during this period that an upsurge of interest in the study of integrating these disciplines began to develop exponentially. The precise reason for that renewed interest of integrating religion in mental health treatment is at best speculative. Hague suggests that this integrative focus began with the resurgence of the growth of religion within the overall population. Because religion is seen a pervasive and infiltrating force, both within the person and within the culture, there is cause for this increased interest in future research. William James, the founder of the first psychology lab at Harvard, considered religion as "an essential organ of our life, performing a function which no other portion of our nature can so successfully fulfill" (1985) (p.49).

Worthington (1996) observes that most of the research in the area of integration has focused on the potential, rather than the actual, client. He went on to observe that relatively few studies have actually investigated the role of religion in the clients' lives during their present counseling experiences. Much of the meta-analysis on the study of this integration process has investigated the specific role of religion in various topics such as mental health or coping with stress, as well as
comparing the highly religious with less religious population (Worthington, Kurusu, McCullough, & Sandage, 1996). The overall limitations of these past studies exist because of this lack of present, controlled research design. Specifically, the individuals under investigation were not actually receiving counseling at the time of the study, but rather were reflective studies in which the researchers looked back at the results and developed conclusions based on these studies. In other cases, the participants were questioned regarding their expectations of counseling prior to the therapy even taking place. Worthington goes on to conclude that in the coming decade, research on religion and the clients who participate in these programs must be more precise in their reporting and recording of results if psychologists are to be able to generalize the data from research (1996). Worthington appropriately determined that research should be based on the actual client during the time of therapy rather than on the posttreatment reporting. This he suggests is critical and should be the priority if further meaningful data is to be extracted for research on the integrative process.

With this in mind, the focus of this single case study was on the client, comparing the current treatment protocol with the client's past, non-integrative counseling. This study has been designed to compare the client with himself or herself. It utilized as an independent variable a 6 manualized treatment approach that integrates faith and cognitive behavioral therapy (ICBT) (Propst, 1992; Beck, 1995; Neilsen, Johnson, & Ellis 2001). This integrative manualized approach was developed referencing the works both of integrative psychologists and of traditional CBT clinicians (Propst; Beck; Neilsen, Johnson, Ellis). Specific to this study, the highly religious adult client who was selected for this study was treated for depression with an integrative model of therapy. The dependent variables were both the levels of depression and religious behaviors. The Beck Depression Inventory-II and the Millon Clinical Multiaxial Inventory (MCMI-III) will serve as an objective score for depressive levels. The Religious Behavior Inventory will measure any change in religious behaviors.

Major Depressive Disorder

**Epidemiological Overview**

The World Health Organization estimates that unipolar depression will be the second most prevalent cause of illness-induced disability by the year 2020. Depression has been termed the "common cold of emotional life" (Tan & Ortberg, 1995) and the American Medical Association estimates that one of every five families has a depressed person (1998). Not surprisingly therefore, antidepressants are the third most common group of therapeutic agents distributed worldwide (Calanda, Puig, Bosch, Adell & Artigas, 2004). Depression negatively impacts many aspects of individuals' lives, including their relationships, financial situations, professional lives, and even their physiological functioning; this poses a problem that afflicts a substantial proportion of the population. Estimates of the number of clients diagnosed with depression range from 12% to 17% annually (Kessler et al., 1994). A more critical view of these figures proposes that the problem may be far greater than these statistics suggest. Currently there exists a large percentage of the population who may suffer from undiagnosed dysthymia, a 7 milder, longer-term form of depression. Individuals with this less debilitating disorder may never actually receive a diagnosis and
subsequently never obtain the appropriate treatment. In addition to this population there are those who may actually experience true depression, but for numerous reasons fail to be diagnosed accurately. These individuals may be inaccurately diagnosed, in part due to cultural variation of how mental illness is perceived, experienced and finally treated (Salvador, 1999). Thus, the culture in which the individual is impeded can be crucial to the process by which he or she seeks out and receives treatment.

Depression is a severe problem that has far-reaching implications. Depression influences the individual relationally, financially, professionally as well as physiologically. There are many aspects that directly influence the development and maintenance of clinical depression. The following section will discuss this disorder in a more well-rounded and complete manner.

Sociocultural Factors

Gender Differences: Depression is much more likely to be diagnosed in women than in men. Specifically, females are diagnosed two times more often than males (Smith & Weissman, 1992; Kessler, et al., 1994). This ratio has been consistent in research done in 30 countries over a period of 40 years. Even though depression occurs throughout the life span, there are a number of identified risk factors for the development of this disorder. Research indicates that the rate of depression in males and in females is essentially the same until adolescence. With the onset of adolescence, the rate for females diagnosed with depression tends to increase rather sharply (Kessler, et al., 1994). During adolescence and beyond, the figures stabilize at the 2:1 ratio, with women two times more likely to experience this disorder (Brooks-Gunn & Petersen, 1991).

Depression is also mediated by the life span and by human development. The incidence of depression tends to peak during adolescence and again sometime in the individual's mid 40's. In addition, there is emerging evidence to suggest that there is a third peak occurring in old age (Murphy & Macdonald, 1992). Risk factors that suggest liability for this third peak include loneliness, poor physical health and financial concerns.

Social Class Issues: Social class has been shown to have a negative correlation on the incidence of those diagnosed with major depressive disorder. Research suggests that those in lower socioeconomic levels suffer from depression more than those in higher levels (Smith & Weissman, 1992). A relationship seems to exist between higher rates of depression and lower socioeconomic classes. The connection between depression and socioeconomic levels is more a function of external stressors associated with a general lack of resources than of genetic or biological factors. It has been demonstrated that individuals in this lower financial bracket typically encounter more frequent and severe stressors (Holmes, 1997). These stressors include unemployment, divorce, lack of education, and poor health. A consequence of these socioeconomic adversities is a reported increase in personal stress and difficulties. It may be concluded that when greater socioeconomic difficulties are present, the risk of depression increases. (Smith & Weissman).

Ethnicity: Studies that investigate ethnicity and prevalence rates have been well researched. No clear evidence has emerged from the current data suggesting that ethnic background per se is minimally related to the overall prevalence rates of depression (Weissman et al., 1991). Insignificant differences in rates of those diagnosed with depression have been found when comparing white Americans, African-
Americans, and Hispanic-Americans. Smith and Weissman (1992) note that what is so striking is the "similarities rather than the differences among racial groups in rates of major depression" (p. 121).

Major Depressive Disorder represents a highly complex, multidimensional psychological phenomenon that requires targeted and effective treatment to address the many components of this disorder (Freeman, Pretzer, Fleming & Simon, 1990). The symptoms of this disorder can be categorized in numerous ways. This paper will focus on essentially four primary domains. The first domain is the mood. The mood is perhaps the paramount or most obvious of all the domains. Mood symptoms of major depressive disorder include feelings of depression, sadness, and a general sense of listlessness. Depression can come both in a vegetative or in an agative presentation. Agitative depression is characterized by an underlying edginess often coupled with a low-grade anxiety. These feelings are not fleeting or insignificant but are deep, unshakable and profound. On the other hand, vegetative depression is characterized by a restricted, somewhat flat affect with a limited overall range of emotionality. Generally speaking, Major Depressive Disorder is unlike the typical everyday sadness, for this disorder tends to be highly pervasive and consistent, profoundly affecting the client on numerous levels (Holmes, 1997).

The second domain that is influenced by significant, clinical depression is the reported subjective physical experience. Depression can cause a variety of distinct somatic complaints (Barlow, 2001). Typically reported changes include an increase or decrease in sleeping or eating, as well as decreases in the sexual drive or libido. Specifically, severe depression may produce sleep disturbances such as hypersomnia or hyposomnia. Hypersomnia is characterized by an increase in sleep. The highly depressed client may sleep as much as 10 to 12 hours per evening. The cause of this increased sleep is both neurological and psychological. Sleep becomes a primary coping skill that is employed as a means to avoid the depression and its associated problems. Unfortunately, this avoidance of stressful situations can actually increase depressive symptoms, creating a reciprocal interaction. In this instance these poor coping strategies, such as 10 avoidance and denial, in effect further facilitate and maintain the depressive symptoms. Avoidance of the painful issues through excessive sleep only increases the likelihood of more negative and depressive mood states. On the contrary, hyposomnia produces intense feelings of agitation so that maintaining consistent sleep beyond 3 to 4 hours per evening is difficult. This decreased sleep affects the amount of REM, thus producing greater levels of psychological and physiological fatigue. This fatigue, due to the decreased sleep, often negatively influences other aspects of physical health. Poor physical health has been to shown to compound the depressive symptoms (Holmes, 1997).

A general disruption in the client's eating pattern is also common in depression. As with sleep, depression will be manifest either by an increase or by a decrease in eating. If depression is so severe that food ceases to have any real flavor or attraction, the client's lack of interest in eating will result in weight loss. (Holmes, 1997). Conversely, depression also can produce overeating. In the midst of their intense mood states, food offers the only little pleasure the patients can control. Consequently, these individuals are likely to report an increase in weight. This
"swallowing" of one's depression becomes a particularly important and problematic issue for women. This weight gain in women may actually worsen the depression and retard the recovery process (Holmes).

A decrease in libido or sex drive is another somatic change. Preliminary studies suggest this limited interest in sexual pleasure is both a psychological and neurological problem. From a psychological perspective, depression produces a greater interest in interpersonal isolation. The notion of close, physical contact is avoided. The depressed client may become myopic, focusing on his or her own concerns and needs. Neurological changes also bear heavily on the overall sexual drive. Neurochemical changes such as decreases in serotonin, dopamine and norepinephrine have all been associated with this decrease in sexual interest. In some way, this disinterest in sex is actually part of a much larger sense of seclusion and isolation.

Finally, it is documented that prolonged, recurrent depression has the potential to create an impairment of the functioning of the immune system (Herbert & Cohen, 1993). Specifically, there is evidence that depressed individuals produce fewer lymphocytes, cells which play an important role in fighting off disease (Holmes, 1997). Clinical depression has been linked to an increase in health problems ranging from colds and flus to more significant physical illnesses (Herbert & Cohen, 1993).

The motor system is the third domain affected by a prolonged depressive state. Psychomotor retardation involves a reduction or a slowing of motor behaviors often manifested during periods of severe, prolonged depression. Highly depressed clients may present with a drooping posture and a blank, expressionless gaze. As a consequence of this retarded motor state, many personal areas have the potential of remaining unkempt and may reflect a lack of appropriate attention. These areas of neglect may include job, personal responsibilities, and grooming. In contrast to psychomotor retardation, others exhibit psychomotor agitation, and report a constant agitation, including the fact that they are often unable to sit still. This agitation may produce random rather than focused behaviors, producing a reduction in a sense of accomplishment. Psychomotor retardation is more common than psychomotor agitation. Both however, negatively influence personal accomplishments and achieved goals (Holmes). The motor inefficiency associated with severe depression, whether retardation or agitation, has the propensity to prolong the depressive state. As a consequence of motor abnormalities; there is a decrease in goal-driven behaviors. This directionless behavior has the potential to increase depressive feelings. This depression therefore becomes a function of unmet goals, which in turn generate negative cognitions about self, thus maintaining the depressive state in a circular, self-feeding, fashion (Holmes).

Depression can also profoundly affect the thinking or cognitive state. This issue of cognitions is the fourth and final domain of depressive symptom. Cognitions refer to thinking abilities, memory and specific belief patterns. (Freeman, et al., 1999). There are numerous cognitive symptoms that play an important role in the development and maintenance of depression. The first is the client's negativistic evaluation of self, also known as low self-worth. Depressed individuals maintain beliefs that they are inadequate, inferior, inept, incompetent and generally worthless. These individuals often feel
guilty regarding past failures. They inappropriately blame themselves for what they have not been able to accomplish. Low self-worth is an example of how the depression impacts the clients' beliefs about themselves. Depression also increases the tendency to be overly pessimistic in the outlook of the future. Negative self-evaluation causes the tendency in depressed individuals to believe that they will never be able to solve their problems, and that the troubling situation will not become better, but will grow only progressively worse. Furthermore, depression influences the way individuals view others. Depressed individuals have a general tendency to look at other people with some contempt, and often perceive them as threats and/or assume they will offer no assistance. The culmination of these negativistic beliefs seems to center around the self, the future and others. This triad of beliefs of self, of others and of the future is the foundation to Beck's Cognitive triad (Beck, 1967).

McCullough introduces a second cognitive deficit present in the chronically depressed client (2003). Individuals who are chronically depressed are often unaware that their primitive verbal thoughts and behavioral patterns actually serve to keep them depressed. Their cognitive I state, as McCullough describes, is being perceptually disconnected. This perceptual disconnection asserts that the client has a real inability to be appropriately responsive to environmental consequences and feedback. These depressed adults tend to think: in a pre-logical and pre-causal manner, thus causing them to form premises inaccurately and to draw conclusions regardless of the environmental feedback. This is done with such impulsivity that it appears, to both the client and outside observers that it is an instantaneous event with no apparent stops in between. Consequently, the conclusions they reach are often inaccurate and not representative of reality. This inaccuracy is a result of not evaluating all the environmental data. For example, consider a client who experiences continued conflict with others in his or her social network. As this individual interacts negatively with these individuals there is little to no value or emphasis on self-reflection or on identifying his or her personal beliefs about the social interaction. This lack of self-reflection limits his or her insight or awareness. This lack of insight only increases the depression and makes cognitive restructuring less likely.

These perceptual and cognitive deficits can be understood in the contexts of Piaget's (1981) construct of "preoperational thinking". According to this conceptualization the chronically depressed client will behave and exhibit self-talk as would a 4 to 6 year old. This inability to extract oneself and look objectively at the environment becomes a vital part of the chronicity of the disorder. Effective treatment then becomes a function of assisting the client in his or her evaluating and concluding processes; this includes teaching skills to actually slow down the rate at which conclusions are drawn. Effective CBT treatment will be evidenced by an overall limiting of the tendency to dichotomizing, over generalizing or other cognitive distortions.

A lack of motivation represents the third cognitive state associated with depression. Freeman and associates (1999) observed that depression causes a heightened sense of personal inadequacy, causing the clients to have a profoundly difficult time believing that self-efficacy is even an option. This negativistic view tends to decrease their motivation to address certain problems specifically. This creates a circular, reinforcing difficulty. These
unresolved problems can create more harmful feelings, resulting in further depression. This increased depression, in turn, reinforces negative self-cognitions, thus hindering future problem resolution. Unfortunately, low self-worth and lack of motivation can spread and encompass more than just the original cause of the depression. The client then can end up with more severe depression.

The propensity towards maintaining negative attitudes is the fourth important cognitive symptom in depression. Research has shown that the severity of depression is related to inaccurate problem evaluation. Further, it has been demonstrated that the degree to which individuals generalize the nature and origin of their problems is related specifically to symptom severity (Carver & Ganellen, 1983). This evaluative process may become so extremely inaccurate that the individual may develop pseudo-psychotic delusions. That is, despite strong evidence to the contrary, the individual develops and maintains totally erroneous beliefs that are inconsistent with reality and that are simply bizarre and clearly absurd (Holmes, 1997).

References


