The Cognitive Behaviour Therapist, 2010, **3**, 95–106
doi:10.1017/S1754470X10000073

PRACTICE ARTICLE

Addressing spirituality in CBT

Rob Waller[1]*, Chris Trepka[2], Daniel Collerton[3] and James Hawkins[4]

[1]*NHS Lothian – Psychiatry, Livingston, UK*
[2]*Bradford District Care Trust – Psychology, Bradford, UK*
[3]*Northumberland Tyne and Wear NHS Trust, Gateshead, UK*
[4]*Edinburgh, UK*

Received 24 November 2009; Accepted 24 June 2010; First published online 27 July 2010

Abstract. Mental health policy places a requirement on clinicians to address matters of religion and belief, yet practice falls far behind. This paper summarizes a Panel Discussion at the 2008 BABCP Annual Conference attended by over 50 people. The five speakers each presented their experience of working with particular faith groups (Orthodox Jewish, Christian, Muslim) and from an agnostic viewpoint. Common themes are given, as well as practical advice to therapists who find themselves working with people who hold strong faith beliefs they may not share.

Key words: Belief, faith, formulation, policy, religion, spirituality.

Introduction

NHS guidance requires all health professionals to demonstrate that they have considered spiritual issues when working with a client, just as they would other issues of diversity like race and age [Department of Health (DoH), 2007; Scottish Government, 2008]. Although it is often said that the UK is 'post-Christian', census data shows that 86% of people say they have a faith [Office of National Statistics (ONS), 2001].

But what does this mean for a therapist offering cognitive behavioural therapy (CBT) to a committed Muslim, Christian or Jew? Within any faith group, there are a wide range of behaviours, beliefs and emotions seen as part of the faith. Furthermore, how should therapists approach working with people who are spiritually minded but who do not follow an established spiritual tradition – who 'believe without belonging' (Davie, 1994)? For the therapist and the a client, it is necessary to decide if the spiritual issue being raised is a source of mental distress, a resource for good mental health or a red herring that is not for addressing in therapy.

*Author for correspondence: Dr R. Waller, NHS Lothian, OPD5 Psychiatry, St John's Hospital, Howden Road, West Livingston, West Lothian EH54 6PP, UK. (email: rob.waller@nhslothian.scot.nhs.uk)

Is spirituality relevant to CBT?

For thousands of years, humans have looked to faith and religious belief for answers to their emotional problems. The majority of studies show that having a faith or belief is, in general, good for your mental health (Koenig, 2009). Religions have initiated charities specifically to help mental health problems, such as the Samaritans (for other examples see Porterfield, 2005). However, religion can also be seen as being bad for your mental health (see Ellis, 1980, for an example).

CBT was developed from empirical studies that did not initially consider faith as a variable. However, as investigations on the role of religious belief and practice have grown in popularity, evidence has been gathered in various religious groups: randomized controlled trials of CBT adapted for Judaism (Paradis *et al.* 1996), Taoism (Zhang *et al.* 2002) and, most commonly, Christianity (Propst, 1980; Pecheur & Edwards, 1984; Johnson & Ridley, 1992; Propst *et al.* 1992; Johnson *et al.* 1994; Hawkins *et al.* 1999; Small, 2003) have been published. Some authors have developed models of how to include it in CBT formulations (e.g. Williams *et al.* 2002; Hebblethwaite, 2005), although these have not been the subject of trials. Concepts drawn from Buddhism have influenced the development of several newer forms of CBT such as Dialectical Behaviour Therapy, Mindfulness-Based Cognitive Therapy, Spirituality-Based CBT and Compassion Focused Therapy (for examples see Gilbert, 2009). Generic spiritual concepts (such as hope and well-being) and the importance of virtues (e.g. fortitude and humility) have been researched by D'Souza & Rodrigo (2004) and Tan & Johnson (2005), and reviewed by Hodge (2006, 2008).

Much of this research has been conducted *by* people of faith *for* people of faith in areas of high religious adherence such as the southern United States. However, the picture in the UK is one of a range of beliefs among clients and therapists with a range of attitudes as to how important and relevant the faith/health interaction is. In the remainder of this article we summarize a recent Panel Discussion which took place at the 2008 Annual Conference of the British Association of Behavioural and Cognitive Psychotherapy. The 50 attendees were mainly practising cognitive therapists from a range of professional backgrounds with a self-declared interest in the topic. The session was interactive with plenty of discussion and here the panel members present a number of useful pointers for therapists when spirituality is relevant to an item on the agenda.

> THERAPIST POINTER: *Do not make assumptions about peoples' faith beliefs based on ethnicity or background, or whether spiritual factors relate to their current problem. There is wide variation.*

Religious models of the mind

The world's major religions all have models of the human psyche, and a recognition of the interaction between mind and spirit. It is not possible to give an exhaustive list of such models and neither is it necessary (see below regarding joint working), but it may pay dividends to find out about the relevant models for the community in which you work. These models can often be used to engage a person's faith in a constructive manner and in a way not dissimilar from CBT, especially if they have latched onto just one tenet of their faith and are using this negatively in their formulation. Here are two examples out of many that could have been

chosen, and it should be noted that these are not held by *all* Muslims or *all* Christians, respectively: as well as systematic differences in beliefs across subgroups (e.g. between Catholics and Pentecostals within Christianity) there are also significant variations in interpretation within groups (e.g. between traditionalists and liberals). Other faiths have their equivalents.

Islam

Islamic psychology within the Sufi tradition was established as far back as the 11th century by Al Ghazali, who described the self as made up of four elements: heart, spirit, soul, and intellect. These can be respectively linked to CBT domains like emotions, behaviours, thoughts, and the capacity for reflection (Haque, 2004). This may enable the CBT therapist to make the seemingly western CBT concepts more acceptable.

Christianity

Pentecostal Christians often talk about three levels of body, soul, and spirit – the former is earthly and the latter holy, with the soul somewhere in between (Porterfield, 2005). Used unhelpfully, this can result in a dualist approach where a depressed person believes they have committed a sin of some kind that has killed any spirit and tied their soul for ever to their earthly and sinning body. Used more helpfully, the therapist can encourage such persons to think that (like the body) the mind/brain can become ill and make them feel depressed, but the soul can still be there – enabled to retain a degree of objectivity because it *is* still in touch with the spirit.

Cultural factors commonly modify religious or spiritual expression and can be powerful contributions to patients' perceptions and emotions. It is beyond the scope of this paper to cover all ways in which spiritual and cultural factors relate to mental health but the topic has recently been reviewed by Cook *et al*. (2009)

Many religions also contain a holistic model of the person and society that means the therapist is on safe ground when recommending behavioural interventions like exercise and diet, and systemic interventions like sorting-out family problems or conflicts with neighbours. This is illustrated in Maori culture by Elders (2008). Similarly, most faiths share with CBT the practice of reflection, the search for meaning and the journey of self and societal improvement.

In the UK, with many nominal adherents, the client may not have an in-depth knowledge of what their faith group thinks about the mind, but Socratic questioning helps here. It will not only find out what they know, but show where it links into any formulation and may yield dissonances and opportunities for change. Padesky (1993) states that in good questioning, both therapist and client may be surprised at what is discovered, and that is often possible in this area. Lack of knowledge can be an aid to good Socratic dialogue. As one speaker (D.C.) at the panel discussion said, 'People are complex and so are religions. CBT has tools that help us understand those complexities.'

> THERAPIST POINTER: *Working within clients' faiths and worldviews can enhance the degree to which they understand formulations. Socratic questioning will aid collaborative formulation*.

Psychological models of spirituality

It is also possible to model religious belief in a manner that is familiar to CBT therapists and allows them to work effectively with faiths that they may have no personal knowledge of. There are many psychological models of faith, but few are clinically orientated. One shared at the panel discussion was developed by the Spiritual Care Committee of Bradford District Care Trust (2006) and divides spirituality into three domains:

(1) Behavioural – what are the behaviours associated with the spirituality, such as attending a place of worship, prayer or reading a sacred text? These may be problematic, or have benefits like behavioural activation helping with isolation.
(2) Cognitive – what are the associated beliefs, such as strongly held cultural beliefs or thoughts around shame and guilt? The beliefs may be conceptualized as negative automatic thoughts as part of a formulation, or they may be used as evidence to challenge such thoughts.
(3) Existential – what does the person feel their spirituality 'adds' to their life? This domain taps into emotions, but also into more deeply held ideas that resonate with Acceptance and Commitment Therapy (ACT) and approaches based on compassion and healing (Gilbert, 2009).

Working with someone from a very different religious and spiritual background can be challenging for both client and therapist. A small minority of clients will not consider seeing someone outside their faith, but most will be happy with this. Enoch (2008) gives a balanced view of the debate in his book *I Want a Christian Psychiatrist.* However, such differences can be opportunities for growth as the client is required to explain his/her spirituality to someone who does not share their background, sub-subculture and religious shorthand. This can expose important assumptions that can be cognitively explored (Cutland, 2005).

To work like this, the therapist will also have to examine the client's assumptions and almost encourage their spirituality. This may go beyond taking a respectful or agnostic stance seeing the client's faith not only as valuable and 'real for them', especially where it helps meet the goals of therapy, and may require taking a pluralist stance, i.e. being willing to see truth within any client's spiritual framework. The therapist does not personally need to regard the client's beliefs as being literally true, but may choose to hold them 'lightly' to facilitate therapeutic discussion, recognizing that the religious client may view those beliefs literally. There will also be a challenge not to impose our world-view on the client, and indeed those at the panel discussion remarked that often the spiritual client may well be better thought through in these matters than the therapist!

For example, an agnostic therapist can appreciate that a committed Christian, Muslim or Jew is following traditions that have helped many people to live spiritually developed lives that are beneficial to themselves and others. However, holding particular beliefs, e.g. about the existence of God and the authority of scripture, is an integral part of those traditions and hence can be regarded as functionally true as far as the therapeutic relationship is concerned. This relationship may be better served where the therapist is curiously engaged in the discussion and learns from the client about the value of their beliefs, rather than examining them from a distance of an already-worked-out world-view.

Case example

Jackie was a committed Buddhist and had been talking through her beliefs with her therapist. She felt respected but also felt that the therapist was disinterested in the core of her faith, merely encouraging her to socialize with other Buddhists to increase activity levels. However, they then began to explore her upbringing and touched on Buddhist perspectives on community and sharing suffering, which she was able to help the therapist understand. The therapist was genuinely interested in this, and was challenged by the individualistic western culture she was used to. Appropriate disclosure of feelings by the therapist enabled therapy to progress much more effectively.

Therapists wishing to take a pluralistic stance may find it useful to read writers such as Karen Armstrong (2007) and Joseph Campbell (1949). Armstrong, for example, outlines a history of the world's major religious traditions that communicates with great appreciation the depth and transformative power of each of them, while noting some of the historical and cultural contexts that influenced their development. In works like these it is possible to identify a common core to spirituality. Themes like facing suffering and developing the self to cultivate compassion, non-violence and self-knowledge can be found within all the traditions (Armstrong, 2007).

These are aspects of human experience frequently encountered in the therapy room too, whether spirituality is 'on the agenda' or not. There is therefore likely to be an ongoing tension between wanting to use therapy as a space for collaborative enquiry and an organizational need to deliver evidence-based therapies that seem not to deal with these areas.

> THERAPIST POINTER: *Using a simple three-domain model* (*Behavioural, Cognitive, Existential*)*, most spiritual practices and beliefs can be attended to within familiar formulation models*.

Spirituality and CBT in practice

Raising matters of faith

When people visit a therapist, they may not see their faith as something they can bring up – even if it is very relevant to their case. This is due in part to a belief that therapists are 'secular' (Neeleman & Persaud, 1995) and in part to therapists not being sure how to ask the opening question. It could be argued that good guided discovery will raise any necessary issues, but if there is a reluctance of patients to talk of spiritual concerns a more direct approach may be helpful.

Professionals have learnt how to ask sensitively about issues like sexual abuse (Nelson & Hampson, 2008) and the same can be done with spiritual matters. As increasing numbers of people 'believe without belonging' (to an organized religion), so asking questions about behaviours like church attendance may not be that helpful. However, there are a number of suggested ways of raising the issue.

Vaughan (2008) helpfully reviews the new guidance from the General Medical Council (2008) on how personal beliefs and medical practice interact. The guidance states that 'You should not normally discuss your personal beliefs with patients unless those beliefs are

directly relevant to the patient's care' but in doing so makes it clear that there are situations where it *is* relevant. Vaughan quotes from Murray *et al.* (2004) who found that 'many patients expect that doctors will not be interested in spiritual issues, even though they themselves would like to talk about them' and 'many patients and carers were uneasy about turning to health and social services for spiritual support, although, if they did find professionals who were willing to discuss such needs, this was much valued'. Vaughan further suggests asking a simple question in the consultation such as 'Do you have a faith that helps you at a time like this' which can be taken up by the patient if they wish to discuss this further, but passed over without offence if they do not. Vaughan (2008) and Murray *et al.* (2004) both say that taking a spiritual history can be a very empowering experience for the patient and the therapist.

Similar issues were covered in a report by the Mental Health Foundation (2007) based on a literature review and examples of good practice and included 'What gives your life meaning?', 'What gives you hope?' and 'How can we help you to feel connected to these things whilst you are with us?'. The report recommended that managers should actively collect data on faith needs and that clinicians should consider the mental health implications of a spiritual perspective.

> THERAPIST POINTER: *Asking a simple question like 'Do you have a faith that helps you at a time like this' can open up the area for discussion, but not cause offence.*

Joint working

It was the experience of panel members that faith groups want to seek help as they feel *clinically* out of their depth, but the audience were also clear that mental health professionals can feel *spiritually* out of their depth. Hence, there will be times when these sources of support need to talk to each other. Consultation can, for example, clarify whether beliefs or behaviours are common within a specific faith group, or idiosyncratic to a distressed individual. It is not unusual for patients' distress to be influenced by real or perceived conflicts between religious principles. Exploration of how conflicts are generally managed may be useful. Guidance on acceptable behaviour may be useful when devising behavioural experiments; for example, therapeutic rupture may come from suggesting exposure to spiritually distressing stimuli like unclean foods.

Some people at the panel discussion thought that mental health professionals should leave the topic of spirituality well alone and stick to doing CBT. Therefore one common response is to ask for chaplaincy to be involved. This can be a good first step, and examples were shared of joint sessions with chaplains where both professionals learnt a great deal as well as the client benefitting.

However, there are also a number of problems with relying on chaplaincy for *all* spiritual problems. Hospitals vary considerable in the number of chaplains they employ, and they will never be able to see all people with a spiritual component to their care. They also tend to focus on in-patients over outpatients, so the individual worker must have some basic skills in this area. Further, the person may already be part of a faith community and not want to see a different chaplain who they may not share beliefs with. Chaplains can work generically, meaning they will work with people of any faith, but not all patients are agreeable to this and want to see someone of their own faith.

An alternative is direct joint working between the health professional and the local faith community. A number of examples were shared, including one situation where the therapist (D.C.) working in a highly ethnic area met with a number of community elders, enabling him to be 'recognized' as a person who would be sensitive to religious concerns. In Hull, there is an extensive local network of churches in regular consultation with the mental health provider; and the churches are seen by the provider as voluntary sector providers, rather than faith communities, to reflect their role in this area (Meesam, 2009). This means the churches that offer services have to conform to more rigorous standards but also means they have an official position in discussions.

In England and Wales, and increasingly elsewhere in the UK, joint working is enshrined in the Care Programme Approach (CPA; DoH, 1990) with regular meetings to which significant people are invited. The CPA may enable therapists to set up joint-working meetings using structures they are used to working within.

> THERAPIST POINTER: *Both therapists and local faith leaders can greatly benefit from joint working. Consider using the CPA or similar multidisciplinary process as well as or instead of referring to chaplaincy.*

What can you believe together? (or what is 'helpful spirituality'?)

As therapists, our role is not to state what is true or not, but it can be to help clients see if their beliefs fit with the evidence and if their thoughts, emotions and behaviours are part of a maintaining formulation or part of helping them achieve their therapy goals. So, if a person is engaged in a religious behaviour like attending church, how do we know if this is 'helpful' for their depression or not, and can we encourage it or not?

The studies of christianized CBT above typically recommend church attendance, bible reading or prayer as part of the therapy, but (as with many manualized approaches) there is no attempt to formulate these behaviours. They are seen as *de facto* good and the more the better. However, we will all have seen people who read the bible a lot because of their OCD, pray a lot because of their worry and attend church a lot because of their health anxiety! The advantage of CBT is that this is all grist to the Socratic mill.

The issue is not about the 'form' of their behaviour, as helpful churchgoing looks much like unhelpful churchgoing, but about the 'function' they perceive it to have. Are they praying vague prayers because a specific prayer might not be answered? Are they attending church because of a magical (not 'faithful'!) link with health? Are they reading the bible in a search for yet more verses that prove they are sinners? The trick is to do this curiously and collaboratively and without undermining their faith. A clear paper that helps differentiate form from function is by Thwaites & Freeston (2005).

The point about form is crucial as it is not the form that is the problem. There will be many other followers of that faith with seemingly unhelpful beliefs/practices that could be seen to be causative of depression, yet they are not depressed. The discipline of silence is a good example. People vary greatly within religious groupings, but careful formulation enables the helpful and unhelpful aspects of their beliefs and behaviours to be picked apart. Thought experiments ('What are other people doing?', 'What would you suggest to someone else who felt or thought as you do?') and testing alternative behaviours ('Are you better

off praying more, or less?') can both be useful. Many formal religions have recognized the potential for spiritual practices to be unhelpful and distressing and have developed their own treatment approaches. Scrupulosity – an excessive preoccupation with spiritual doubt – is one example that is often addressed. Less, rather than more, religious practice is the usual recommendation, which fits well with CBT concepts of recognizing and reducing safety behaviours.

> THERAPIST POINTER: *When there is seemingly relevant spiritual material to discuss, do not forget to do good basic CBT, where form can be differentiated from function, and so formulated only if needed.*

An ACT approach to CBT also has something to offer the spiritual or religious client. ACT originated from a behavioural analysis of spirituality (Hayes, 1984) and its methods include ways of helping people develop capacities to accept and forgive, increase contact with a transcendent sense of being and become clearer about and more able to live in accordance with their fundamental values. All of these elements can readily be related to a person's own spiritual framework since they do not themselves come from a particular spiritual tradition.

Another useful aspect of ACT in this area is the emphasis on reducing the influence of concepts and self-conceptualizations on behaviour. For instance, the concept of 'defusion' or 'deliteralization', which involves 'holding thoughts and beliefs lightly' (Hayes & Strosahl, 2005) can be useful in situations where cognitions constrain psychological flexibility and engender psychological dysfunction. Such an approach could also address relevant faith and belief issues without being seen to undermine them or imply abandonment of a person's heritage. There are often a variety of styles within any given faith and even within a denomination that could allow the therapist and client to consider whether a particular belief or spiritual practice needs to be followed in exactly the way they are following it.

> THERAPIST POINTER: *Acceptance and commitment approaches can be used to enhance fundamental values; and to accept, forgive and make contact with a sense of self without undermining faith.*

Conclusion

This article demonstrates how exploring a complex issue can enhance therapists' skills in therapy and overall care. The wider professional and political agenda around spirituality and mental health will capture increasing attention from clients and managers.

It captured the thoughts of the panel and audience at a recent symposium on the topic at a major CBT conference, and as such is in part personal opinion. However, it can be seen that there is a large body of research supporting these views and the importance of the topic in day-to-day practice.

The research also suggests considerable need for developments in the future and these mirror the three learning objectives for this article.

Awareness raising

In many ways, things are still at this stage and not the two stages beyond. There are increasing numbers of articles appearing on this topic. Koenig (2004) completed an online literature search in the PsycINFO database using the words 'religion' and 'spirituality' and found '6774 articles published since 2000, about 50% being research studies'. Professional bodies are increasingly placing spirituality on their agendas with varying degrees of success. For example the National Institute of Mental Health for England (NIMHE) has produced resources on spirituality and mental health (DoH, 2003*a*). However, a recent government publication (DoH, 2003*b*) emphasized the importance of faith groups in the provision of holistic care, but highlighted the failure of health providers to use this resource.

Equality and diversity legislation is also increasingly focusing on religion and belief alongside other themes like race and gender. A Single Equality Bill is currently being considered by Parliament (Government Equalities Office, 2009), and as part of the Department of Health's response to this, NIMHE resources are being given a fresh launch.

Knowledge of good practice

Hitherto, training courses have not dealt with this topic consistently and knowledge is patchy (Cutland, 2005). This paper offers a number of 'helpful tips' to CBT therapists; however, more profound changes need to be embedded in the way therapists and other professionals are trained. Over one third of medical schools in the USA in 1998 offered at least one course in the role of spiritual and religious factors in health and medical practice (Puchalski & Larson, 1988) and this number is increasing and is permeating into the UK. The Royal College of Psychiatrists' Spirituality Special Interest Group have made a submission to the new psychiatry training curriculum saying that average trainee should 'be able to demonstrate awareness and have a working knowledge of spiritual aspects of psychiatric care' (Royal College of Psychiatrists, 2002), but this has yet to be implemented. With competing demands on curricula, educators still need to be convinced of the healthcare benefits of taking spirituality and mental health seriously. Research is advancing and this debate has been helpfully reviewed by Cook *et al.* (2009).

Developing skills

Among other measures, the proposed Single Equality Bill (Government Equalities Office, 2009), would require healthcare providers to proactively consider how a person's stated religion and belief would impact on their treatment and make reasonable adjustments. This would mean asking all people referred for CBT whether faith beliefs were relevant and therefore skills in asking about this (and in dealing with the answers!) are needed.

As the prevalence of people with stated spiritual beliefs is high (ONS, 2001) the audience at the panel discussion felt this indicated at least one training case to consider this aspect of therapy, either practically or in an essay. Training of established therapists is more challenging and it is hoped that future conferences will continue to address this topic, maybe as pre-conference workshops with more time to learn.

Declaration of Interest

Rob Waller writes as a practising Christian and a Director of Mind and Soul, a national network equipping the church to deal with mental health issues. Chris Trepka starts from an agnostic view of spirituality with an interest in 'third-wave' CBT approaches. Daniel Collerton is a consultant psychologist in Newcastle, whose clients include the Orthodox Jewish community. James Hawkins is a scientific humanist who believes there is a growing evidence base in this area.

Recommended follow-up reading

Mental Health Foundation (2007). *Keeping the Faith. Spirituality and Recovery from Mental Health Problems.* London: Mental Health Foundation.

References

Armstrong K (2007). *The Great Transformation: The World in the Time of Buddha, Socrates, Confucius and Jeremiah*. London: Atlantic Books.

Campbell J (1949). *The Hero with a Thousand Faces*. Novato, Canada: New World Library

Cook CH, Powell A, Sims A (2009). *Spirituality and Psychiatry*. London: Gaskell.

Cutland T (2005). Intrinsic Christianity, psychological distress and help seeking (http://www.psuche.co.uk/founder-of-psuche.htm). Accessed 30 April 2010.

Davie G (1994). *Religion in Britain since 1945: Believing without Belonging*. Oxford: Wiley/Blackwell.

Department of Health (1990). Caring for People. The CPA for people with a mental illness referred to specialist mental health services. Joint Health/Social Services Circular C(90)23/LASSL(90)11.

Department of Health (2003*a*). Inspiring hope: recognizing the importance of a whole person approach to mental health. London: HMSO.

Department of Health (2003*b*). Delivering race equality: a framework for action. London: HMSO.

Department of Health (2007). Single equality scheme 2007–2010. London, Crown Copyright.

D'Souza R, Rodrigo A (2004). Spiritually augumented cognitive behavioural therapy. *Australas Psychiatry* **12**: 148–152.

Elders A (2008). Is therapy paying enough attention to spirituality? *CBT Today*, December 2008.

Ellis A (1980). *The Case Against Religion: A Psychotherapists View and the Case Against Religiosity*. Austin: American Atheist Press.

Enoch D (2006). *I Want a Christian Psychiatrist – Finding a Path Back to Mental and Spiritual Well-being*. Oxford: Monarch Books.

General Medical Council (2008). *Personal Beliefs and Medical Practice*. London: General Medical Council.

Gilbert P (2009). *The Compassionate Mind*. London: Constable.

Government Equalities Office (2009). Equality Bill. London: HMSO (http://services.parliament.uk/bills/2009–10/equality.html).

Haque A (2004). Psychology from Islamic perspective: contributions of early Muslim scholars and challenges to contemporary Muslim psychologists. *Journal of Religion and Health* **43**, 357–377.

Hawkins RS, Tan RS, Tan S, Turk AA (1999). Secular versus Christian inpatient cognitive-behavioral therapy programs: impact on depression and spiritual well-being *Journal of Psychology and Theology* **27**, 309–319.

Hayes SC (1984). Making sense of spirituality. *Behaviorism* **12**, 99–110.

Hayes SC, Strosahl KD (2005). *A Practical Guide to Acceptance and Commitment Therapy*. New York: Springer-Verlag.

Hebblethwaite P (2005). Helping people change! Part 3 – a new Christian model for CBT. *ACCORD* **46**, 4–6.

Hodge D (2006). Spiritually modified cognitive behavioural therapy: a review of the literature. *Social Work* **51**, 157–166.

Hodge D (2008). Constructing spiritually modified interventions. *International Social Work* **51**, 178–192.

Johnson W, DeVries R, Ridley CR, Pettorini D, Peterson D (1994). The comparative efficacy of Christian and secular rational-emotive therapy with Christian clients. *Journal of Psychology & Theology* **22**, 130–140.

Johnson W, Ridley CR (1992). Brief Christian and non-Christian rational-emotive therapy with depressed Christian clients: an exploratory study. *Counseling and Values* **36**, 220–229.

Koenig H (2004). Religion and mental health: what should psychiatrists do? *Psychiatric Bulletin* **34**, 204.

Koenig HG (2009). Research on religion, spirituality and mental health: a review. *Canadian Journal of Psychiatry* **54**, 283–291.

Meesam M (2009). Spirituality and the NHS. Seminar delivered at the 2009 Mind and Soul Northern Conference.

Mental Health Foundation (2007). *Keeping the Faith. Spirituality and Recovery from Mental Health Problems*. London: Mental Health Foundation.

Murray S, Boyd K, Kendall M, Worth A, Benton TF, Claus H (2004). Exploring the spiritual needs of people dying of lung cancer or heart failure: a prospective qualitative interview study of patients and their carers. *Palliative Medicine* **18**, 39–45.

Neeleman J, Persaud R (1995). Why do psychiatrists neglect religion? *British Journal of Medical Sociology* **68**, 169–178.

Nelson S, Hamson S (2008). *Yes, You Can! Working with Survivors of Childhood Sexual Trauma*. Edinburgh: Scottish Government.

Office of National Statistics (ONS) (2001). Census 2001: Ethnicity and religion. London: HMSO.

Padesky CA (1993). Socratic questioning: changing minds or guiding discovery? [Keynote Address]. European Congress of Behavioural and Cognitive Therapies. London, 24 September 1993.

Paradis CM, Friedman S, Lazar RM, Grubea J (1996). Cognitive behavioral treatment of anxiety disorders in Orthodox Jews. *Cognitive and Behavioral Practice* **3**, 271–288.

Pecheur DR, Edwards KJ (1984). A comparison of secular and religious versions of cognitive therapy with depressed Christian college students. *Journal of Psychology & Theology* **12**, 45–54.

Porterfield A (2005). *Healing in the History of Christianity*. Oxford: Oxford University Press.

Propst LR (1980). The comparative efficacy of religious and nonreligious imagery for the treatment of mild depression in religious individuals. *Cognitive Therapy & Research* **4**, 167–178.

Propst LR, Ostrom R, Watkins E, Dean T, Mashburn D (1992). Comparative efficacy of religious and nonreligious cognitive-behavioral therapy for the treatment of clinical depression in religious individuals. *Journal of Consulting and Clinical Psychology* **60**, 94–103.

Puchalski CM, Larson DB (1998). Developing curricula in spirituality and medicine *Academic Medicine* **73**, 1038.

Royal College of Psychiatrists (2002). Proposed amendments to the curriculum for basic specialist training and the MRCPsych examination. Prepared by the Spirituality Special Interest Group (http://www.rcpsych.ac.uk/pdf/nl10_five.pdf). Accessed 22 April 2009.

Scottish Government (2008). Spiritual care and chaplaincy in NHS Scotland – revised guidance. CEL (Chief Executive's Letter), 49.

Small DK (2003). The development of Christian-oriented computer-assisted cognitive therapy: a pilot study. *Dissertation Abstracts International: Section B: The Sciences and Engineering* **63** (7-B).

Spiritual Care Committee of Bradford District Care Trust (2006). Model of spirituality [unpublished]. Available on request from Dr Rashid Skinner, Chair (rashid.skinner@bdct.nhs.uk).

Tan SY, Johnson WB (2005). Spiritually orientated cognitive behaviour therapy. In: *Spiritually Orientated Psychotherapy* (ed. L. Sperry and E. P. Shafranske), pp. 77–103. Washington, DC: American Psychological Association.

Thwaites R, Freeston MH (2005). Safety-seeking behaviours: fact or function? How can we clinically differentiate between safety behaviours and adaptive coping strategies across anxiety disorders? *Behavioural and Cognitive Psychotherapy* **33**, 177–188.

Vaughan K (2008). Christ in the Consultation. *Triple Helix* (Summer), pp. 12–13.

Williams C, Richards P, Whitton I (2002). *I'm Not Supposed to Feel Like This – A Christian Self-help Approach to Depression and Anxiety*. London: Hodder & Stoughton.

Zhang YD, Young D, Lee S, Li L, Zhang H, Xiao Z, Wei H, Feng Y, Zhou H, Chang DF (2002). Chinese Taoist cognitive psychotherapy in the treatment of generalized anxiety disorder in contemporary China. *Transcultural Psychiatry* **39**, 115–129.

Learning objectives

(1) Awareness of the increasing profile of spirituality as a topic within mental health service policy.
(2) Knowledge of examples of good practice in working with people who have a strong faith.
(3) Skill in addressing spiritual issues when raised by a client, even if you do not share their faith.