The Spirituality Augmented Cognitive Behavioural Therapy- *evidence based meaning therapy for depression and demoralisation*

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Abstract

Objective: To explore and describe the Spiritually Augmented Cognitive Behaviour Therapy and its applications

Method: The background on the need for incorporating spirituality in to therapy is considered. The SACBT, A meaning therapy for sustaining mental health and functional recovery is described with the cognitive components and behavioural components including the use of existential techniques in discovering meaning. The use of meditation, together with the validation and incorporation of the appropriate belief system of patients into their treatment is described. The use of rituals that are practised are incorporated in to the treatment in the form of a ritual monitoring sheet

Result: Open randomised controlled studies have demonstrated the 16 session SACBT to be significantly beneficial in not only extinguishing hopelessness and despair, but are also found to improve treatment collaboration and reduce relapse thus increasing time to next relapse and improving functional recovery

Conclusion:
This meaning based therapy that incorporates appropriately a person belief system, which often might be the core that helps the patient and family cope, is an adjunct therapy that has been shown to improve function outcomes. Thus this evidence based adjunct therapy has an important and useful role in enhancing functional recovery and whole person care – an area that has had less attention given to in conventional psychiatric treatment.

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INTRODUCTION

Much of the world is becoming a truly post-modern society, a place where we are learning to incorporate uncertainty in our view of the world. The absolute is giving way to the relative; objectivity to subjectivity; function to form. In the modern view of the 20th century, seeing was believing; in the post-modern world of the turn of the century, believing is seeing. Conviction yields to speculation; prejudice to a new open-mindedness; religious dogma to a more intuitive, inclusive spirituality. Even the concept of God receives a changed emphasis, from the materialist's 'out-there' being, to a spirit that is more intimately part of us [1].

The historical split between "facts" and "values"; science and religion is being reconsidered. There has been the recent shift away from dichotomies such as therapy/ spirituality, science/religion towards a both/ and syntheses in the "New Science" and spirituality. The "Cartesian anxiety" and dualism that has dominated western thought in the last 300 years is now less apparent, and science is more inclusive of different paradigms [2].

BACKGROUND

Spirituality is a concept globally acknowledged. However, attempts to reach a consensus regarding its nature have not met with success. In discussing spirituality, one is really discussing the ways in which people fulfil what they hold to be the purpose of their lives. Spirituality can encompass belief in a higher being, the search for meaning and a sense of purpose and connectedness. There can also be a wide over lap between religiosity and spirituality.

There is now awareness across multi disciplines of the importance that spirituality and religiosity has for many patients. This has lead to suggestions and research in relation to validating the incorporation of aspects of spirituality and religiosity into multi-disciplinary assessments and interventions for patients with psychological and physical illness [3]. In an Australian survey a large majority of patients wanted their therapist to be aware of their spiritual beliefs and needs. About two thirds (68.7%) of respondents believed that their spiritual beliefs helped them to cope with psychological pain [4].

Demoralisation, originally described by Jerome Frank, [5] is the experience under stressful circumstances of being unable to cope, characterised by feelings of distress, apprehension, helplessness, subjective incompetence, hopelessness, diminished esteem and confidence, isolation and alienation, and a loss of personal meaning and purpose in life [5, 6]. Frank explicitly described psychotherapy as the treatment for demoralisation, effective across different cultures. This is particularly important in the medically ill, where the treatment of depression with antidepressants, while effective, is complicated by drug interactions and adverse effects [7].

Folkman and Greer [8] elaborated the idea of meaning based coping. In their therapy there is an emphasis on exploring meaning and purpose and identifying meaningful and realistic goals within whatever limitations life and illness brings. Further work by Breitbart et al [9] looked at a group therapy intervention explicitly looking at existential issues based on the work of Victor Frankl's work and existential therapy. Earlier work by Moorey and Greer [10] using an "Adjuvant Psychological Therapy" based predominantly on "techniques of cognitive restructuring which included reality testing, challenging negative automatic thoughts and assumptions", demonstrated in a randomised controlled trial that it was able to diminish levels of hopelessness [11].

A study by Cole and Brenda [12] testing the efficacy of a spiritually focussed therapy group (SFT) and a no treatment centred group of people confronting cancer, where the SFT was formulated around four existential themes relevant to this population: control, meaning, identity and relationships. The results suggested that the SFT group tended to improve in functioning, while the control group tended to decrease in functioning across almost all of the dependent variables. The treatment group's level of depression reduced across time while the control group's

level of depression increased. Specifically, surrendering control was predictive of lower levels of depression, anxiety and pain severity. The same group compared a CBT without spiritual issues and resources and SFT. The results suggested that the CBT was superior to the SFT in decreasing anxiety but not in its effect on other dependent variables. Propst et al [13] studied the comparative efficacy of a religious CBT (RCBT) and non religious CBT (NRCBT) in a cohort of 59 patients who considered religious and spiritual issues important or very important, and who met Research Diagnostic Criteria (RDC) for non-psychotic, non-bipolar depression, and were treated with 18-20 one hour sessions over three months. The RCBT patients reported significantly lower post treatment depression and adjustment scores than did the NRCBT group. Pargament, Koenig & Perez [25] completed a study assessing the full range of religious coping methods, including potential helpful and harmful religious expressions. Results of regression analyses showed that religious coping accounted for significant unique variance in measures of adjustment (stress-related growth, religious outcome, physical health, mental health and emotional distress) after controlling for the effects of demographics and global religious measures.

Holistic conceptions of healthy personality and functioning theorize that spiritual and psychological well-being and wholeness are interconnected. In an inpatient group of clinically depressed Christian adults aged 19–70 yrs, this study compared the effectiveness of Christian cognitive-behavior therapy (CCBT; $n = 18$) to that of traditional cognitive-behavioral therapy ($n = 11$). There was a significant correlation between a reduction in depression and an improvement in spiritual well-being (SWB; $p < .0005$). Both groups demonstrated significant reductions in levels of depression ($p < .0005$) and improvements in SWB ($p < .0005$). Furthermore, there were significantly higher overall SWB scores for those in the CCBT program ($p < .01$). This provides encouragement for the use of therapy that matches and utilizes religious values. [26]

DESCRIPTION OF THE SPIRITUALLY AUGMENTED COGNITIVE BEHAVIOUR THERAPY

Background

The Spiritually Augmented Cognitive Behaviour Therapy was developed and tested for efficacy and effectiveness at the Sydney University's Centre for Excellence in Remote and Rural Psychological Medicine, Broken Hill. A multidisciplinary team of professionals, including members of the hospital pastoral team and the indigenous elder under the leadership of the psychiatrist, took part in developing and testing this therapeutic intervention. This is a meaning therapy that has been found to be significantly beneficial over control groups in a number of outcome measures. These benefits were demonstrated in three randomised controlled trials in patients with depression and or demoralisation.

Principals

This psychotherapeutic intervention uses the principals of Cognitive Behaviour Therapy with an added focus on existential issues, using techniques to find meaning and incorporates and validates the individuals belief system into the treatment. Thus the use of meditation, prayer/ritual together with monitoring the effects of these beliefs and or rituals on their symptoms, and their acceptance of treatment including medications, form the behavioural components of this therapy.

Method

The therapy and method of execution and supervision is informed by our previous work; D'Souza et al [14, 15, 16, 17, 23], and that of Moorey & Greer [10], and Breitbart et al [9]. It is semi-structured and explores a range of issues and the use of a range of therapeutic techniques. The techniques emphasised are empathic listening, facilitation of emotional expression, problem solving, emphasising self-efficacy, exploring meaning and purpose and ultimately enabling self-therapy. Exploring meaning includes the specific meaning of the situation – the appraisal of the current situation and its significance for the future, and where relevant, global meaning. Finding meaning by the use of approaches such as **experiential values**- by experiencing something, or someone we value, **creative values** –'doing a deed' providing oneself with meaning by becoming involved in the project of one's life [18], and **attitudinal values**- which include such virtues as compassion, bravery, a good sense of humour, and even achieving meaning, as Frankl suggested, in one's suffering [19]. When there is much negativity and cognitive distortions, cognitive restructuring is employed together with the conventional principals and techniques of Cognitive Behavioural Therapy.

In this intervention there is an important emphasis on the respect for, and maintenance of patient autonomy and empowerment. Thus the 16 sessions might not aim to achieve radical change to personality or the instilling of values never held, but the rekindling of values and resilience perhaps forgotten or lost in illness, and set backs in the form of trauma, and loss of meaningfulness that was never fully expressed before – thus we would aim to encourage a purposeful engagement with the dimensions that life has to offer.

This intervention is semi structured, used in a manualised form, and is end focussed with the end directions being patient as self-therapist, empowerment and coping enhancement. It is bi-directional in that lists of useful catalogues of issues are offered for work with, and the patient returns with possible solutions. The therapist initially takes on the role of Captain – offering direction and leadership but then moves sidewards during therapy to the role of a Coach – offering support from the side. Thus a gradual positive shift takes place. It is expected that the objective of empowerment with the patient becoming the self-therapist, will be achieved.

New issues in this therapy

What is new in the therapy is its focus on meaning, purpose, and sense of connectedness in the context of the patient's belief system. Thus validating and appropriately including their belief and rituals, that often might be the core that gives the patient and his/her family's life meaning and hope. This aspect of this therapy offers to the patient comfort in the clinician supporting this core area of possible importance to them and their families. An area that many patients miss in their encounters with care-givers [20].

In this therapy attention is focussed in the meaning of illness, of relationships, of one's self and one's role, even of suffering, the purpose of life and of everyday activities. In loss, meaning is created by searching and finding the redeeming value [21]. This area may not be dealt with or may even be avoided in the traditional cognitive behaviour therapy. The use of problem solving is important to reduce existential anxiety and to increase mastery. The encouragement of social connectedness, an aspect of spirituality, can help reduce isolation and anxiety and give meaning that is associated with being part of a family and community.

Practical issues

The therapy is given individually at the bedside or in a room that has a healing environment, such as the quiet room, a non-denominational prayer room or the chapel. The SACBT manual uses a bridging session work sheet, which lets the patient prepare for each session, and helps with returning to areas to be focussed on in the therapy session. These include areas that are found to be difficult to contend with and other areas that bring wholeness and satisfaction. An opportunity to disclose reasons for not being able to complete the homework, including the daily and/or weekly meditation, and prayer/ritual monitoring forms, is made available in this bridging work sheet. Thus reducing the drop out from patients who have not completed the homework.

The cognitive focus takes place in four key areas, those being: Acceptance, Hope, Achieving meaning and purpose, and the Dimensions of Forgiveness. The behavioural focus is on Relaxation, Medication and Prayer/Ritual exercises, together with record keeping soon after these exercises. This is achieved by reflecting on the benefits of these exercises (meditation and prayer) on the patients symptoms and dysfunction domain. These would include the impact of the exercises of meditation, prayer and ritual in bringing hope, extinguishing helplessness and existential despair, accepting of medication, and reduction of side-effects if these are being experienced. There is the validation of the belief in a force greater than the self, be it the supernatural or for some "God". This serves in part to achieve **dereflection-** a technique in achieving meaning by moving beyond and away from the self on to others and for some a supernatural [18].

The patient reflects and then records the effects of these exercises (meditation, rituals – including prayer) on improving sleep, appetite, energy, function and positive well-being. The patient marks a score of 1 to 5 for each of these areas on the daily work sheet. After Day 7 the patient is encouraged to spend a short period reviewing the daily record sheet, and then fill in a weekly score for each of the domains on the weekly monitoring record sheet. Based on the evidence that the patient has from these work sheets, together with the subjective experience, they are encouraged to write a comment in the weekly record sheet that reflects the true situation. This is discussed and examined during therapy sessions. The intersession of self-therapy sessions can be planned as early as the 3rd week to take place in-between therapy sessions.

Each of the four cognitive areas of Acceptance, Hope, Meaning and Purpose, and Forgiveness are considered from the catalogue of issues, surrounding each of the areas from the manual. Reflection on developmental history, and life experiences that have contributed to, or negatively impacted on each of these areas are considered and dealt with in the sessions.

Achieving meaning and purpose

The area of meaning and purpose takes an important focus. There are five phases through which the patient is guided to work through towards achieving meaning and purpose. This starts with confronting the inevitabilities of life such as birth and death – confronting and desensitising oneself with mortality then moving to the phase – the letting go of fear and turmoil in one's life. Exercises around achieving the letting go of fear and turmoil are built in, with the aim of mastery accomplishment in this phase. The next phase encourages examining one's lifestyle – centring on lifestyle areas that avoid confronting mortality, and perpetuate fear and turmoil. Lifestyle changes are planned that

will be adaptive to achieving desensitisation of one's mortality together with the realistic removal of fear and turmoil in one's life. Moving to the next phase involves focuses on seeking divine purpose, after examining and accepting one's journey in life between the two inevitabilities of birth and death. Finally meaning is sought by seeking meaning for each day. This is achieved by identifying meaningful and realistic goals within whatever limitation life and illness brings. The use of experiential values, creative values and attitudinal values discussed earlier can be drawn on in helping the patient achieve meaning.

Structure of sessions

Generally the therapy takes place over 10 to 16 sessions for about 60 minutes duration, with flexibility to allow for between 45 to 70 minutes. The initial two weeks might allow for two sessions per week, if necessary and where possible. This will aid engagement and is appropriate to the level of distress patients generally are experiencing. Further, this could positively influence the building of trust and therapeutic alliance – a key component in achieving successful outcomes in most psychological interventions. Thereafter sessions follow on a weekly basis. The assessment of termination needs and relapse prevention needs in the form of scheduling booster sessions must start early in the therapy. This ensures the place in predicting and planning for the patient's needs later in therapy and further down. For ethical reasons the therapy may continue past the 10 to 16 sessions if the patient desires this and there is mutual agreement with the patient and therapist with regards to this need.

Efficacy, Effectiveness and Efficiency

Three randomised controlled trials comparing SACBT and case management, SACBT and supportive therapy, and SACBT and equal clinical contacts have been completed. The results have not only shown significant benefits over controls in reducing hopelessness, despair, depression and improving quality of life [15, 16] but importantly has achieved significantly better treatment adherence, lower adverse effects of treatment and lower relapses compared to controls followed for 12 months [17, 23].

CONCLUSION

This meaning based therapy that incorporates appropriately a person belief system, which often might be the core that helps the patient and family cope, is an adjunct therapy that has been shown to improve function and quality of life. This is an important part of caring for the whole person, an area that has been found wanting in the bio-medical model [22].

The results of trials [17,23] have shown a reduction in relapse and re-hospitalisation in the group of patients that received this therapy. There is also evidence, that reducing relapses and increasing time to next relapse in psychiatric illness, will offer benefits in psychosocial functioning such as work and relationships, including the marital relationship [24]. Thus this adjunct therapy has an important and useful role in enhancing functional recovery and whole person care – an area that has had less attention given to in conventional psychiatric treatment.

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