

Spirituality, religiousness and psychotherapy

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Abstract

Religious/spiritual beliefs and practices constitute an important part of culture and principles clients use to shape judgments and process information. Psychotherapists may use knowledge of these belief systems and appreciation of their potential to leverage client adherence and achieve better outcomes. However, many approaches have yet to do so and the variety of concepts of religiosity/spirituality may place obstacles to this important interface. This article raises certain concepts that we see as consistent, accessible, and capable of facilitating professional dialogue in the therapeutic sphere. We discuss the impact of subjectivity, states of consciousness and perceptions influenced by religiosity/spirituality, on mental health as well as the importance of psychotherapists actually focusing clients and their belief systems, developing models to mobilize hope, and boosting coping abilities. Despite the current distance between controlled studies and clinical practice, we discuss the integration of spiritual/religious dimensions in psychotherapy with ethical professionalism, knowledge, and the ability to align the collected information so as to benefit clients. Since only 7.3% of Brazilians have no religion, and very few psychotherapeutic approaches or practitioners do actually engage religiosity/spirituality, we point to the relevance of research on this issue and the importance of testing related psychotherapeutic proposals in clinical trials.

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Introduction

Interest in spirituality and religiousness has been a constant feature of human history at all times and in all different cultures. However, science has only recently shown interest in investigating this subject. The first specialized journals emerged in the early 1960s, with the *Journal of Religion and Health*, but research was still dispersed at that time. Since then, more research on spirituality and religiousness in specific situations (e.g. serious illnesses, depression, anxiety disorders) has proved pertinent to the task of examining the impact of such practices on mental health and quality of life (Propst, 1992; Azhar et al., 1995; Pargament, 1997; Koenig, 2001; Berry, 2002).

Religious belief is an important part of culture, principles and values used by clients to shape judgments and process information. Confirming their beliefs and

perceptive leanings may boost the ability to organize or comprehend painful, chaotic, or unexpected events (Carone and Barone, 2001). Several studies have shown that knowing clients' belief systems and valorizing them assists adherence to psychotherapy and helps to achieve better outcomes (Giglio, 1993; Razali et al. 1998; Sperry and Sharfranske, 2004). However, very little research on religiousness, spirituality, and psychotherapy has been done in Brazil. We conducted a review of the literature based on articles published prior to January 2007 by searching Medline/PubMed and PsycINFO using the descriptors *religiousness - spirituality - psychotherapy*. Articles, books, and theories we saw as pertinent to the aims of this article were selected as a basis for analyzing and discussing research findings in this field, the clinical implications, and the relevance of the theme for further research in Brazil.

Spirituality and religion - concepts

There is currently growing emphasis on the theme of spirituality in the psychological literature (Crossley and Salter, 2005). A recent study showed that the main domains discussed by Americans in individual psychotherapy included work, family, friends and sexuality. Religion and spirituality were seen as equally important subjects and clients thought that therapists were open to discussing these domains (Miovic et al., 2006). However, not all approaches found a way of adjusting the subject to their therapeutic interventions. Qualitative methods with semi-structured interviews were used to examine the way in which clinical psychologists understood and approached spirituality during psychotherapy; they saw spirituality as a subject capable of providing balance and harmony for their clients. However, the wide range of concepts relating to spirituality was noted as a crucial aspect of the difficulty in working with this field during psychotherapy. The study pointed to the importance of making religion and spirituality concepts more coherent and accessible in order to facilitate professional dialogue in the therapeutic context (Miovic et al., 2006; Crossley and Salter, 2005). In this article, therefore, we have used the definitions suggested by Koenig (2001), who conceptualizes *religion* as an organized system of beliefs, practices, rituals and symbols designed to help the individual with sacred and/or transcendent aspects, and *spirituality* as a personal quest for answers in relation to the meaning of life and relationships with sacred and/or transcendent aspects.

Psychotherapy, its basis and validation

Humanity has always reflected on itself and on our lives, feelings, and the reasons we exist, are born and die, thus giving rise to philosophy, which is recognized as the cradle of psychology. The roots of psychology go back to Ancient Greece, when the philosopher Aristotle (384-322 B.C.) wrote *De Anima*, often referred to as the first handbook of psychology (Aristotle, 1956). "Psychology", from the etymological root *psyche* (soul) plus the suffix *logos* (reason, study), emerged in the late 16th century with Rodolfo Goalenio and the publication of *Psychologia, hoc est de hominis perfectione, animo et in primis ortu eius, commentationes ad disputationes*, its original purpose to study and understand the spirit—from the Latin *spiritus*, literally 'breathing'. The limitations of scientific method in ancient times favored psychology's remoteness in relation to the study of the "intangible", while medicine developed methods to investigate the body (from the Latin *corpus*: essential part) (Finger, 1994).

In the mid-19th Century, psychotherapies emerged in the West for the purpose of treating, removing or modifying symptoms of an emotional nature, and to promote growth or development of personality, their contents varying with the philosophical schools, epis-

temological perspectives, theories and methods underlying their practical interventions. Rosenzweig's 1936 article "*Some implicit common factors in diverse methods of psychotherapy*" was a point of departure for discussing different psychotherapies in terms of their differences, similarities, and effectiveness. This article published 70 years ago (Samstag, 2002, p. 58) foreshadowed the more general finding that there were little or no differences between the main schools of psychotherapy in terms of global efficacy, and Goldfried's discussion (1999) revisited the issue. Areas of agreement between psychotherapeutic approaches are currently more substantial than differences, especially in relation to four aspects: (i) objectives are similar, (ii) the therapist-client relationship plays a central role in the processes, (iii) the client assumes responsibility for choices, and (iv) they aim to have clients understand their "ego" (Duncan, 2002). Indeed, after examining 17 meta-analyses in comparative studies of several modalities of psychotherapies, Luborsky et al. (2002) found no significant differences in outcomes, but admitted that "non-significant outcomes do not indicate that the treatments compared have the same effects for all patients." On the other hand, Bohart (2000) suggested that the client should be seen as the most important common factor in psychotherapy and posed the concept of "resilience" - the ability to go through difficulties and regain satisfactory quality of life - to argue that clients rather than therapists are the agents of curing. Previous studies of resilience concluded that human psychological development is highly refined and self-correcting (Prochaska et al., 1998; Masten et al., 1998). The types of treatment therapists provide are self-healing processes and take place naturally in humans, although in a more refined and systematic manner (Neno, 2005). Psychotherapy should therefore look to clients and their respective belief systems in the sense of potentiating their capabilities, since therapy functions to the extent that a client accepts involvement and learning as pre-conditions. Moreover, it is crucial for psychotherapy to develop collaborative models based on this relationship, that emphasize the mobilization of hope and optimism, with active involvement of clients and helping them mobilize their intrinsic intelligence to find solutions (Bohart, 2000, p.145). In that sense, one may reasonably suppose that religiousness and spirituality should be part of therapists' approaches and that psychotherapeutic strategies valorizing the role of belief systems should be formulated and investigated for efficacy of treatment.

Latest-generation research on the effectiveness of psychotherapy has been influenced by the financing policy of the National Institute of Mental Health, in which the medical model consolidated in pharmacological studies is prescribed for evaluating psychotherapies (Goldfried and Wolfe, 1998, p. 144). Methodological innovations included: a) use of the DSM-IV (American Psychiatric Association, 1994) for defining problems

and measuring outcomes; b) selecting patients on the basis of their strictly fitting into a certain diagnosis; c) randomly distributing participants among groups; d) refining guidelines for intervention (detailed manuals); e) training therapists to follow manuals and f) creating mechanisms for verifying correspondence between therapist performance and manuals prescribed. Seligman (1995) also draws attention to the importance of evaluating aspects referred to as “non-specific”, such as the therapist’s personality traits that may sensitize rapport in the therapeutic alliance, adherence and client confidence in relation to the professional and the treatment concerned. Evidence-based psychotherapies call for standardization with a manual; efficacy must be shown in at least two randomized clinical studies with significant samples of patients properly characterized under DSM-IV criteria (American Psychiatric Association, 1994), and must use carefully selected control groups – wait list, placebo, medication, and/or other predetermined interventions (Weissman et al., 2006). The concepts of internal validity (level of confidence with which changes observed may be attributed to experimental factors that are part of treatment) and external validity (evidence that treatment works in actual clinical practice) have also been proposed for examining psychotherapy efficacy (Chambless and Ollendick, 2001). However, although certain approaches aimed at specific disorders have been empirically validated (Chambless et al., 2006), Weissman et al. (2006) found that little evidence-based psychotherapy is taught in psychology and psychiatry programs credited by the American government. The considerable distance between controlled studies and current clinical practices prevails, but we would emphasize that psychotherapeutic proposals in the area of religiousness and spirituality, as in other areas, should be standardized and tested in clinical trials. Making more efforts in this respect aligns with providing ethical assistance for individuals seeking psychotherapy.

Ethics, psychotherapy, and religiousness

Should doctors or psychologists discuss spiritual themes with their clients? What limits apply to doctors or psychologists and client when religious or spiritual themes are addressed? Where are the professional boundaries between doctors or psychologists and chaplains spiritual advisors? Those are some of the questions posed in recent ethical discussions of the issue (Post et al., 2000). The inclusion of “religious or spiritual problems” as a diagnostic category in the DSM-IV (American Psychiatric Association, 1994) recognizes that religious and spiritual themes may be the focus for psychiatric / psychological consultation and treatment (Lukoff et al., 1995). Some educators suggest that doctors should routinely ask about spirituality and religion on compiling patients’ medical histories (Ehman, 1999). However, integrating spiritual and religious dimensions of clients’

lives during psychotherapy requires professionalism in terms of ethics, high quality of knowledge and capabilities for aligning information collected on beliefs and values for the benefit of the therapeutic process. Some empirical findings show that clients adopt (are converted to) their psychotherapists’ values (especially moral, religious and political values) revealing serious ethical problems such as diminishing the client’s freedom, violation of the therapeutic contract, lack of therapist competence, loss of therapist neutrality (Tjeltveit, 1986). The American Psychiatric Association produced a guide encouraging therapists to understand and emphatically maintain respect in approaching patients’ religious beliefs (Giglio, 1993), and emphasized that appropriate therapist training, therapist-client compatibility, paying attention to the person and not just the disorder, and emphatic understanding may reduce the occurrence of value conversions and minimize the associated ethical problems (Tjeltveit, 1986; Giglio, 1993; Post et al., 2000). Lomax et al. (2002) appraised psychologists that seek to integrate psychotherapy and religion or psychotherapy and spirituality, and found that the former is difficult, whereas integrating non-religious psychotherapy and spirituality is possible and achieves good results. These researchers point out that there are certain ethical observations worthy of attention such as: (1) the ability to inquire about the patients’ religious and spiritual life is an important element of psychotherapeutic competence; (2) asking about patients’ religious and spiritual lives frequently reveals data that may be extremely important for them in coping with difficulties; (3) the process of inquiry on this domain should be respectful; and (4) there is significant potential for ethical faults when a therapist exaggerates personal convictions and abandons the principle of neutrality.

Confidence in the therapist has a key role for the efficacy of the treatment. This means that clients having a relationship of empathy and confidence with their doctors or psychologists will benefit more than others. This need for confidence cannot be rejected by professionals, but there has to be caution in ethical terms (Peres et al. 2007a). The American Psychiatric Association convention, Shafranske (The American Psychiatric Association, 2006) recommend procedures for psychotherapists working with the question of spirituality and religiousness: a) determine whether religious and spiritual variables are clinical characteristics relevant to the complaints and symptoms presented; b) examine the role of religion and spirituality in the belief system; c) see whether religious idealizations and representations of God are relevant and approach this idealization clinically; d) demonstrate the use of religious and spiritual resources in psychological treatment; e) use interview procedures to access history and involvement of religion and spirituality; f) train appropriate interventions for religious and spiritual subjects and update knowledge of ethics in relation to religious and spiritual themes in clinical practice.

Psychotherapists should be comfortable with clients raising existential or spiritual issues (Shaw et al., 2007a). While exploring religious or spiritual beliefs may be useful in the psychotherapeutic process (Sparr and Fergusson, 2000), there is both a therapeutic need and an ethical duty to respect these opinions and achieve empathy, while showing restraint in relation to the client's reality, even if therapists do not share the same religious beliefs (Shafranske, 1996).

Belief, subjectivity and perception

Most psychotherapeutic approaches articulate perception, memory and individuals' belief systems during the therapeutic process (Peres et al., 2005b). Neuroscience has shown that the world an individual perceives is not a precise reflection of the physical world; indeed certain key aspects and characteristics of the perceived world are not actually present in the physical world (Ramachandran et al., 1998). Studies of visual perception show that information assimilated by the brain as we observe the world is very limited in relation to the abundance of information it supplies. Discussions of these findings point to the rich variety of subjective individual experiences. Everyday behaviors depend much less on what is seen or perceived than on learning-based projections (Ramachandran and Gregory, 1991; Yarrow et al., 2001). Qualities of perception, emotional valences, and interpretations relating to events experienced do not have a single or unique counterpart corresponding to physical events. In other words, perception of the world is subject to individual beliefs and life histories affecting sensibility to specific *stimuli*, criteria of selection and threshold of observation (Metzger, 1974). Moreover, subjective experiences alter synaptic arrangement in neural circuits (Kandel et al., 2000, p. 34) and percepts constituted by objective and subjective experiences may determine which *stimuli* an individual will respond to (Metzger, 1974). An example of the important impact of subjectivity in psychological suffering was shown in a work by Creamer et al. (2005). In accordance with DSM-IV criteria, the definition of Post-Traumatic Stress Disorder (PTSD) includes objective (A1) and subjective (A2) components (American Psychiatric Association, 1994). The authors studied the prevalence of the A2 criterion and its association with traumatic and psychopathologic memories in the aftermath of traumatic events in 6,104 adults. Most individuals (76%) met criterion A2, with greater prevalence in women (81%) than men (69%). Only 3% of the individuals that did not meet criterion A2 presented persistent traumatic memories. Creamer et al. suggest that subjective processing involving traumatic memories may be the decisive mediator for post-trauma psychopathology. The study reinforces the importance of psychotherapeutic treatment involving subjective dialogues and the corresponding internal belief systems (Peres et al., 2005a).

Other neuroscience findings suggest that the neurophysiologic value of the imagination is similar to that of faculties mobilized in objective behavior (Williamson et al., 2001). Kraemer et al. (2005) and other researchers have shown that an imaginary audition and visualization situation follows neural reciprocities similar to a real situation involving hearing and seeing the same events. Active visualization techniques have been used in psychotherapy with satisfactory results, although the treatment is not effective for all patients (Menziés et al., 2004). Mobilizing the subjective nature of human perception, the ability to emotionally reconstruct and reinterpret painful events may also be effectively used in psychotherapy (Peres et al., 2005b; Peres et al., 2007b). Experimental designs could ask whether religiousness and spirituality comprise a cognitive-imaginative framework providing support when coping with or overcoming psychological difficulties.

Religion, health and spiritual well-being

Some researchers have suggested that religion arose as a means of dealing with death (Malinowski, 1954 for instance). The first discussions on religion within the scope of psychology were posed by Freud, who saw religion as an illusory remedy against feelings of helplessness. Belief in life after death would be based on fear of dying; analogous to fear of castration, and the situation the ego would be reacting to was feeling helpless (Freud, 1926/1980, p. 153). In our own time, religious experience is no longer seen as a source of pathology; indeed in certain circumstances it is recognized as capable of leading to equilibrium being regained and a state of health in terms of personality (Levin et al., 1996; Koenig, 2001). Current sociological theories see belief in life after death as a central component in many religious systems and one that lends significance to life through continuity in the next life (Stark and Bainbridge, 1996). Indeed, the existence of life after death is a belief found in most broadly based religions (Obayashi, 1992). Census data show that over three-quarters of Americans believe in life after death (Greeley and Hout, 1999; Klenow and Bolin, 1989-1990) as do approximately 92% of Brazilians, since only 7.3% profess no religion (IBGE Demographic Censuses 2000). Although belief in life after death is widespread, little research on this topic has emerged in psychological and psychiatric literature (Exline, 2002), and most existing studies focus on the effects of this belief in relation to fear of dying (Alvarado et al., 1995; Templer, 1972; Templer and Dotson, 1970). Certain studies suggest there is evidence for continuity of life after death (Stevenson, 1983; Stevenson and Samararatne, 1988; van Lommel et al., 2001). Although the question remains unanswered by science, belief in life after death in a nationwide sample of 1,403 Americans was associated with less severe levels of six sets of symptoms (anxiety, depression, compulsion, paranoia, phobia and somatization). The same study

showed that this belief also has a positive influence on quality of life (Flannelly et al., 2006).

Spiritual well-being is a dimension of state of health along with bodily, psychic and social dimensions (World Health Organization, 1998). Taking mystic and meditative experiences as measurable and quantifiable processes based on evidence accumulated in the literature and in medical practice, the World Health Organization included the domain of Religiousness, Spirituality, and Personal Beliefs in 100 items in its generic instrument for evaluation of quality life. That instrument collaborated with other studies that identified correlations of importance to health professionals. Myers (2000) investigated the relationship between state of happiness and religious practice in 34,000 participants and found a positive correlation between these variables. Mueller (2001) reviewed published studies and meta-analyses that examined the association between religious/spiritual involvement and physical and mental health and quality of life. Most of the studies showed that religious involvement and spirituality are associated with better health, including longevity, coping skills, and quality of life, as well as lower levels of anxiety, depression, and suicide. A recent meta-analysis of 49 studies involving a total of 13,512 participants investigated the association between religious coping and psychological adjustment (Ano and Vasconcelles, 2005). Positive religious coping showed a moderate positive relationship ($r=.33$) with positive psychological adjustment and a modest inverse correlation ($r=-.12$) with negative psychological adjustment, while negative religious coping showed a positive correlation ($r=.22$) with negative psychological adjustment. Most studies investigating the relationship between religiousness/spirituality and the mental health have shown that higher levels of religious participation are associated with better well-being and mental health (Moreira-Almeida et al., 2006).

Trauma, helplessness, and hope

Helplessness is a word often used by traumatized or PTSD individuals attempting to express their emotional states (Scher and Resick, 2005). Studies suggest that feeling more hopeful and less despairing and helpless may be important factors making for better health and longevity (Kubzansky et al., 2001, pp. 913-914). Traumatized individuals often seek new meaning or significance for their lives (Peres et al., 2007a). A decisive factor in the development of resilient responses has to do with the way individuals perceive and process experiences (Peres et al., 2005). Those who develop interpretations able to deal with the present and attempt to positively modify it can overcome traumas more easily (Bonanno, 2004). Spiritual and religious beliefs and practices are strongly based on a personal quest to understand the meaning of life and relations with sacred and transcendental subjects (Moreira-Almeida and Koenig, 2006). Religious practices may have an important effect on the way people interpret

traumatic events and deal with them, promoting resilient perceptions and behaviors such as positive learning from experience, help to cope with psychological pain, and feel confident about facing adversities. A study that evaluated possible correlations between religion and psychological trauma involved 1,385 veterans being treated for PTSD. Their experiences of witnessing their fellow soldiers being killed and being unable to prevent their deaths had weakened their religious faith, and this was found to be a significant predictor of continuing use of mental health services. Surprisingly, severity of PTSD symptoms and difficulties in interpersonal relations were not predictors for continuing use of these services, but weakened faith was. The authors posed the possibility that veterans' preliminary motivation for continually seeking treatment may be the search for meaning and purpose around their traumatic experiences. This suggests that working with spirituality may be more central to treatment of PTSD than previously thought (Fontana and Rosenheck, 2004). In another review of 11 empirical studies of the associations between religion, spirituality and psychological traumas, Shaw et al. (2005) presented three main findings: (i) religion and spirituality are usually but not always beneficial in post-trauma treatment, (ii) traumatic experiences may lead to religiousness or spirituality being deepened, and (iii) positive religious coping, openness to religious experience, readiness to confront existential questions, and intrinsic religiousness was associated with post-trauma coping. Pargament et al. (2004) suggest that religious coping may have something special to offer: it may provide individuals with exceptional ability to respond to situations in which they find themselves face-to-face with the limits of human power and control on being confronted with their weaknesses. The same author also notes that religious beliefs and practices may reduce loss of control and helplessness, providing a cognitive structure that may reduce suffering and develop a purposeful and meaningful response in the face of trauma.

There are multiple and sometimes unexpected ways of attaining resilience (Bonanno, 2004). Since helplessness is a risk factor for PTSD, as well as psychological trauma, vulnerability and high levels of despair (Scher and Resick, 2005), assistance, support and hope may be sources of protection against traumatic events for individuals exposed to them, as well as helping recovery (Peres et al., 2007a). Supporting this hypothesis, some studies have shown that religiousness may have a preventive effect in relation to mental disorder and operate as a positive factor when dealing with stressor situations (Grzmala, 1996, Mallony, 1991, Martins 2000).

Neuroimaging of religiousness and altered states of consciousness

William James (1890) was one of the first psychologists to draw attention to states of consciousness other than

wakefulness. Metzner (1995) defines Altered State of Consciousness (ASC) as a temporary change in thinking, feeling, and perception, in relation to the ordinary state of consciousness, and one that has a beginning, middle, and end. Weil (1995) suggests that the perception of reality depends on the state of the individual's consciousness. In addition, ASC induced by prayer and meditation have been studied using functional neuroimaging methods. Experts on meditation subjected to painful *stimuli* during meditation did not experience pain in the same way as in a state of wakefulness. They showed predominantly alpha frequencies during ASC with 10Hz peaks in the occipital, parietal and temporal lobes, suggesting a state of deep relaxation not characterized as sleep. As in previous findings on the representation of sensory/emotional perception of pain (Rainville et al., 2002), the meditation state showed significantly decreased activity in the thalamus, secondary somatosensory cortex, insula and cingulate cortex compared with the non-meditation state. Pain is a complex sensory and emotional experience and this and other studies using electrophysiological and neuroimaging methods have shown that altered ASC may generate altered activity in circuits related to perception of pain (Kakigi et al., 2005; Rainville et al., 2002). Changes in cerebral blood flow were also observed in Franciscan nuns when praying (oral and repetitive). In comparison with baseline, ASC during prayers showed higher activity levels in the prefrontal cortex, and inferior parietal and frontal lobes (Newberg et al., 2003). Similar findings were reported by Azari et al. (2001), who studied the neural reciprocities of religious experience investigated as a cognitive attribution phenomenon. While reciting religious items there was increased activity of the frontal-parietal circuit, comprising the frontal parietal cortex and medial prefrontal and dorsolateral cortex. Previous studies indicate that these areas underlay reflection and sustentation of thought and the authors argue that the religious experience may be a cognitive process rather than just an immediate emotional experience. Lans (1996) confirms that religiousness may be a rich source for finding purpose in life, and for formulating cognitive guidelines for appraisals or generating appropriate behaviors in crucial or traumatic situations. Spontaneous or voluntary evocation of traumatic memories occurs during ASC with significant sensory and emotional manifestation (Peres et al., 2005b). Traumatized individuals subjected to exposure therapy and cognitive restructuring built resilient narratives, with new meanings and attributions for the traumatic event, and attenuated emotional responses mediated by greater activity of the prefrontal cortex and left hippocampus as shown by post-psychotherapy neuroimaging exams (Peres et al., 2007b).

Tart et al. (1990) and Metzner (1995), studied ASC and their use in psychotherapy to show that experience of such states may influence changes in behavior. Several authors show that using ASC in the perception of

mental images may be an effective tool for forming new patterns of thinking, feeling and behaving (Kaspro and Scotton, 1999). Different states of consciousness may lead to new perceptions of the same phenomenon, and so to new more favorable emotional states for coping with or overcoming difficulties and suffering in the psychological ambit (Dietrich, 2003). Theoretically, subjective religious/spiritual practices such as praying, contemplation, or meditation may alter states of consciousness and affect changed perceptions of an event that triggers suffering. Hypnosis has been used to induce ASC for therapeutic purposes (Eslinger, 2000), and use of ASC may be one way of approaching the integration of spirituality and religiousness with psychotherapy in order to assist persons whose belief systems and values are aligned with this subjective instance. Transpersonal psychotherapy, to take one example, works with subjects such as the importance of spirituality for regaining health and well-being, as well as the use of ASC to promote relaxation and visualization to obtain therapeutic impact (Walach et al., 2005).

Psychotherapy, religiousness, and spirituality

Interest in the study of the role of religiousness, spirituality and psychotherapeutic practices in healthcare has developed for a number of socioeconomic and clinical reasons. In an industrialized country such as America, 96% believe in a God or universal spirit, 75% pray regularly, 42% attend religious services regularly, 67% are member of a local religious body, 67% say religion is very important in their lives, and 63% believe doctors should talk to their patients about spiritual beliefs (Gallup, 1995). Initiatives associating religiousness and spirituality with psychotherapy have gained ground in the last 25 years. To take one example, religious psychotherapy seeks to recognize and use clients' religious beliefs to reduce symptoms and difficulties in the mental health ambit (Berry, 2002). From the standpoint of social psychology and personality psychology, Emmons and Paloutzian (2003) reviewed the empirical and conceptual development of this approach with emphasis on the cognitive and affective foundations of religious experience, and found that the basis for it was that religion and spirituality are important processes in human experience. However, although spirituality and religiousness are important and sometimes fundamental to human life, Schultz-Ross and Guthcil (1997) argue that the difficulty in integrating this theme with psychotherapy resides in certain factors such as the traditional line taken in psychotherapy schools that spirituality is outside the sphere of investigation and knowledge, the absence of supervision and training programs the and educators and professionals feeling uncomfortable about working with spiritual and religious themes. However, regardless of psychotherapeutic approach used, persons profes-

sing religious beliefs benefited in terms of outcome of psychotherapy (Muller, 2004).

Although not yet part of healthcare professionals' activities, pastoral counseling is attracting growing interest from psychologists (Young, 1989). Studies confirm that pastoral or religious counseling may lead to high scores on well-being, assist rehabilitation and reduce the impact of stressor events (LeFavi, 2003; Josephson, 2004). One study evaluated the role of the social and psychological support religious leaders offer their followers and showed that this kind of support was effective for those motivated to accept it, boosting personal well being, settling conflicts and reducing symptoms (Poon et al., 2003)

Propst (1992) investigated cognitive standard behavioral versus cognitive religious approaches used by religious and non-religious therapists to treat depression patients and compared their interventions with a wait-list control group. Improvement in individuals subjected to psychotherapy was found equally in the therapeutic conditions used and non-religious therapists obtained better results than religious therapists when they used a cognitive religious behavioral approach. A meta-analysis of five studies that compared the effectiveness of standard counseling approaches with others not using religion found no evidence that one approach is better than the other. Findings suggest that the possibility of using a religious approach with religious clients is probably more a question of client preference than differential effectiveness (McCullough, 1999).

In relation to religious psychotherapy being as effective as standard treatment (Berry, 2002), and for ethnic groups with pronounced cultural characteristics psychotherapy with a religious approach showed quicker initial improvement over 3 months than psychotherapy without religious guidance (Azhar et al., 1995). Matching these findings, Razali (1998) studied anxious and depressive patients and found that those subjected to sociocultural and religious psychotherapy showed improvements in their symptoms sooner in the first few weeks than the control group given standard treatment. However, results did not differ after 6 months. The authors highlight the importance of religious psychotherapy in reducing symptoms in the early months of treatment. Spiritually augmented cognitive behavioral therapy showed that use of meditation led to significant benefits when treating hopelessness and despair (D'Souza and Rodrigo, 2004). A review of articles on the effectiveness of spiritually modified cognitive therapy using American Psychiatric Association criteria showed that this modality was only empirically valid for treating depression (Hodge, 2006). Proposals to insert spiritual and religious themes in group therapy and family therapy have also been researched (Jacques, 1998; Patterson, 2000), as well as programs based on semi-structured psycho-education interventions in which patients discuss religious resources, spirituality, forgiveness and hope (Phillips, 2002). Most groups thought that a spiritual life was

relevant to their understanding of personal problems and preferred therapists comfortable with discussing these topics.

Perspectives for new guidelines and investigations

Religions in general advocate the forgiveness and absolution that is often useful in conflict resolution. There may be negative effects in their maintaining conformity and promoting external control, whereas mental-health professionals work for self-development and sensitize their clients as to competences required to achieve change and lead their own lives (Carone and Barone, 2001).

This article has pointed out that a number of international studies have examined the question of spirituality/religiousness and psychotherapy to show the pertinence of this interface to favorable therapeutic results. Brazilians, in particular, show substantial potential in terms of religious beliefs, with syncretism present too; spirituality/religiousness is highly prevalent with only 7.3% saying they do not have a religion (IBGE Demographic Censuses 2000). Given the small number of approaches and psychotherapists focusing these individuals and their belief systems in Brazil, we believe that consistent research based on randomized clinical trials should be designed and carried out to address the needs of this large section of the population.

Professionals ought to recognize spirituality as an essential component of personality and wellness; the concepts of religiousness and spirituality must be explained to professionals; including spirituality as a health resource during their training; spirituality/religiousness scales should be adapted and validated for the Brazilian situation with specific training for the clinical area. Efforts to add discussion of religion and spirituality to the curriculum in medical and psychological schools are underway (Graves, 2002). Discussion with students on differences in concepts, research on the subject, comprehension of proper and unsuitable processes in relation to using religious and spiritual practices will contribute to better quality in meeting clients' needs, reducing prejudice, leading to better informed and well trained professionals. Just as when we seek to tap the entire personal dimension of human experience, integration of clients' spiritual and religious dimensions in their treatment requires high standards of professionalism and ethics, with quality knowledge and skills to align information collected on beliefs and values to therapeutic efficacy.

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