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RESEARCH ARTICLE

Integrating clients' religion and spirituality within psychotherapy: A comprehensive meta-analysis

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Abstract

Some religious or spiritual (R/S) clients seek psychotherapy that integrates R/S values, while others may be reticent to disclose R/S-related aspects of struggles in a presumably secular setting. We meta-analyzed 97 outcome studies ($N = 7{,}181$) examining the efficacy of tailoring treatment to patients' R/S beliefs and values. We compared the effectiveness of R/S-tailored psychotherapy with no-treatment controls, alternate secular treatments, and additive secular treatments. R/S-adapted psychotherapy resulted in greater improvement in clients' psychological ($g = 0.74$, $p < 0.000$) and spiritual ($g = 0.74$, $p < 0.000$) functioning compared with no treatment and non R/S psychotherapies (psychological: $g = 0.33$, $p < 0.001$; spiritual: $g = 0.43$, $p < 0.001$). In more rigorous additive studies, R/S-accommodated psychotherapies were equally effective to standard approaches in reducing psychological distress ($g = 0.13$, $p = 0.258$), but resulted in greater spiritual well-being ($g = 0.34$, $p < 0.000$). We feature several clinical examples and conclude with evidence-based therapeutic practices.

KEYWORDS

adaptations, meta-analysis, psychotherapy, psychotherapy relationships, religion, spirituality

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1 | INTRODUCTION

Religious or spiritual (R/S) beliefs and practices are woven into the fabric of many people's lives. About 68% of the world's population view religion as an important aspect of their day-to-day experience (Diener, Tay, & Myers, 2011). In the United States, 89% believe in "God or a universal spirit," 75% describe religion as either "somewhat" or "very" important to them, 80% pray regularly, and 50% belong to a local house of worship (Pew Research, 2016).

An extensive body of research has documented a positive relation between R/S and physical and mental health (Koenig, King, & Carson, 2012). Specifically, R/S can foster increased social belonging, connection, and support; adjustment to stressors through meaning-making, coping, and resilience; and grounding of one's identity through salient beliefs and values (e.g., Paloutzian & Park, 2014). However, for some individuals, R/S can be a source of struggle and confusion, or serve as a defense against unresolved psychological conflicts (e.g., Exline & Rose, 2014). Incorporating clients' R/S identity within psychotherapy has the potential to impact both change processes and treatment outcomes. "When people walk into the therapist's office," Pargament (2011), writes, "they do not leave their spirituality behind in the waiting room (p. 4). They bring their spiritual beliefs, practices, experiences, values, relationships, and struggles along with them."

Many patients who experience R/S as a salient part of their identity hope that their therapist will integrate these beliefs and values within psychotherapy (Vieten et al., 2013). Although some individuals forthrightly state this, others do not. Such clients may be reticent to disclose R/S-related aspects of their struggles in a setting they presume to be limited to secular considerations, potentially hampering therapeutic outcomes. A number of patients stand to benefit through secular psychotherapy, but may experience additional gains if treatment were contextualized within their R/S values. For others, R/S struggles play a significant role in their psychological and emotional distress, making it vital to address such topics in therapy.

In addition to patients' unique needs, R/S adaptations in psychotherapy may be complicated by several clinician characteristics. Notably, psychotherapists as a whole are less likely to identify as R/S compared with the general population. In one survey, 35% of psychologists—in contrast with 75% of the public—described their approach to life as significantly influenced by R/S (Delaney, Miller, & Bisonó, 2007). Furthermore, relatively few psychotherapists receive explicit training and supervision in how to ethically and sensitively address patients' R/S beliefs in assessment and treatment (Schafer, Handal, Brawer, & Ubinger, 2011). Thus, although R/S is increasingly recognized as an important aspect of multicultural competency, psychotherapists may be unsure how and in what way to best facilitate integration of such concerns, which can result in "spiritually avoidant care" (Saunders, Miller, & Bright, 2010, p. 355).

In this study, we examine the effectiveness of R/S accommodation in psychotherapy. We begin by defining R/S and discussing common measures of these constructs. We also offer clinical examples illustrating treatment accommodations in psychotherapy, considering the patient's R/S beliefs and worldview. Next, we present the results of a meta-analysis examining the efficacy of R/S-adapted psychotherapies and explore patient, study, and treatment characteristics that may moderate therapeutic effects. We also consider patient contributions, research limitations, and diversity considerations. We conclude with therapeutic practices based on the research evidence.

2 | DEFINITIONS AND MEASURES

Historically, the terms *religion* and *spirituality* were closely linked, and at times, used interchangeably. *Religion* can be defined as adherence to common beliefs, behaviors, and practices associated with a particular faith tradition and community, which provides guidance and oversight (Hill et al., 2000). In contrast, *spirituality* is a broader concept describing the subjective, embodied, emotional experience of closeness and connection with what is viewed as sacred or transcendent. This often constitutes either (a) a divine being or object or (b) a sense of ultimate reality or truth, and can be understood within the framework of implicit relational knowledge.

Spirituality has been further defined within four main categories, based on the sacred/transcendent object (Davis et al., 2015). First, *religious spirituality* involves a felt sense of closeness and connection with a higher power

or worship tradition as described by a specific religion (e.g., Christianity, Islam, Judaism, and Buddhism). Second, *humanistic spirituality* involves a sense of closeness and connection with other human beings, including feeling compassion, lovingkindness, or altruism. Third, *nature spirituality* involves a sense of closeness and connection with the environment or aspects of nature, such being awestruck at a beautiful sunset or the grandeur of a mountain landscape. Fourth, *cosmos spirituality* involves a sense of closeness and connection with the universe, such as contemplating the vastness of outer space or one's sense of being within the cosmos.

Adapting psychotherapy to a patient's R/S framework may influence the treatment in several ways: conceptualization, treatment goals, intervention, and interpersonal process. First, understanding the patient's R/S aids in conceptualizing causes of psychological distress and identifying key risk and protective factors. This might include exploring the role of R/S in the patient's history, identity, and current functioning, as well as any areas of difficulty (e.g., spiritual struggles, spiritual bypass). Second, R/S-tailored psychotherapy provides a broader context within which to understand the patient's reasons for attending psychotherapy. In addition to symptom reduction and self-development, R/S clients may identify additional goals, like developing a closer relationship with Jesus Christ, faithfulness to Allah, following the teachings of Buddha, or greater connection with the transcendent. Psychotherapeutic outcomes such as increased spiritual well-being and positive religious coping may prove important considerations when patients' goals extend beyond the psychological to the R/S aspects of their lives.

Third, the patient's R/S can be integrated within traditional interventions (e.g., behavior activation, challenging negative thoughts, distress tolerance, and mindfulness skills) aimed at reaching treatment goals. R/S interventions might incorporate methods consistent with a client's R/S culture (e.g., prayer, meditation, religious imagery, sacred scriptures, religious rituals, or services) that may be positive coping resources, or could explore and address underlying R/S issues (e.g., anger at God, existential doubts, or spiritual abuse) contributing to psychological distress. Finally, R/S integration may occur implicitly in the "being with" process of psychotherapy, as a patient experiences and internalizes the consistent, attuned, and caring presence of the psychotherapist. Helping R/S patients reflect on the ways in which the psychotherapy relationship mirrors or challenges their perceived relationship with the sacred may positively impact how they relate to God or their higher power.

For the purposes of the present meta-analysis, we examined treatment outcome via two patient dimensions: *Psychological outcomes* and *spiritual outcomes*. Nearly every treatment study in our meta-analysis included at least one psychological outcome measure. For example, studies evaluating R/S-adapted psychotherapy for depression often administered the Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996), whereas those examining R/S treatments for anxiety often used the Hamilton Anxiety Rating Scale (HAM-A; Hamilton, 1959).

Patients' R/S was typically measured as a single demographic question, but some studies also assessed R/S outcomes of accommodated psychotherapy. The Multidimensional Measure Of Religiousness/Spirituality (MMRS; 88 items; Fetzer Institute, 1999) was often used, assessing 12 domains, including daily spiritual experiences, private religious practices, and organizational religiousness. Other researchers used the Spiritual Well-Being Questionnaire (SWBQ; 20 items; Gomez & Fisher, 2003), which measures personal, communal, environmental, and transcendental well-being, and some studies used the Brief Religious Coping Scale (BRCOPE; 14 items; Pargament, Feuille, & Burdzy, 2011), which assesses aspects of negative religious coping (e.g., spiritual discontent, reappraisals of God's punishment) and positive religious coping (e.g., spiritual surrender, reappraisals of God's protection and care).

3 | CLINICAL EXAMPLES

R/S adaptations of psychotherapy are as unique as each patient who walks through the door. The following case examples illustrate several of the complex ways that R/S can intersect with other cultural identities and influence the course of treatment. We focus especially on the systematic ways that researchers have formally integrated R/S within treatments.

3.1 | Case 1: Religiously integrated CBT for depression

Religiously integrated cognitive behavior therapy (RCBT) is founded on the cognitive model while contextualizing interventions within the patient's religious framework. The psychotherapist makes "explicit use of the client's own religious tradition as a major foundation to identify and replace unhelpful thoughts and behaviors to reduce depressive symptoms" (Pearce et al., 2015, p. 58). Some of the major tools of RCBT include (a) renewing the mind by replacing negative self-talk with sacred scriptures; (b) meditating on sacred writings and engaging in contemplative prayer; (c) considering religious beliefs and resources; (d) cultivating forgiveness, hope, gratitude, and generosity through daily religious practices; (e) identifying and making use of R/S resources in line with one's faith tradition; and (f) altruistic involvement in one's religious community. Treatment manuals and patient workbooks have been developed to guide RCBT with Christian, Muslim, Jewish, Buddhist, and Hindu patients.

"Katina" presented to psychotherapy with depression. She identified as a 42-year-old African American, cisgender woman, and her most salient identity was her Christian faith. Katina was somewhat reticent about how traditional psychotherapy could help her. Picking up on this, her therapist explored Katina's religious history and the role that R/S played in her life. They discussed ways she desired to incorporate this into treatment. Katina reported growing up in a strict religious family, where she felt she could never be good enough. She recounted episodes of physical and emotional abuse by her father throughout childhood, and the untimely death of her mother from cancer when she was a teenager. Katina identified her Christian faith as a source of coping and hope in the midst of this loss, but as psychotherapy progressed, she also became more aware of her anger toward God because she believed that God took her mother away or (at best) allowed bad things to happen.

Katina identified her most problematic core beliefs as (a) I am worthless and no one can ever love and accept me as I am, and (b) bad things keep happening to me and God does not stop them, so I cannot fully trust him. As Katina and her therapist modified these negative core beliefs in the context of her faith, she found comfort in meditating on Scripture passages about God's presence and unconditional love. Katina identified that listening to Christian music, journaling, taking reflective prayer walks, and attending a small group at her church were all ways she could incorporate daily spiritual practices, rather than being controlled by negative self-talk.

3.2 | Case 2: Spiritual self-schema therapy for addiction

Spiritual self-schema therapy integrates CBT with Buddhist psychological principles, guided by a 12-session treatment manual (Avants & Margolin, 2004). The goal is to decrease impulsive behavior through modifying a client's habitual self-schema, described as a "highly automatized system of knowledge or beliefs about one's intentions or capacities, stored in long-term memory, that mediates the environment and interpersonal behavior" (Margolin et al., 2007, p. 982). When a habitual self-schema is activated, negative beliefs about the self can motivate self-destructive behaviors, such as drug use. This psychotherapy attempts to facilitate a shift from an addict self-schema to a spiritual self-schema by fostering mindfulness, self-compassion, and commitment to do no harm to self or others. Spiritual self-affirmations, meditation, prayer, and self-schema check-ins are used to foster spiritual awareness. Each session also focuses on the development of a spiritual quality, including generosity, lovingkindness, and truth.

"Tom" sought treatment at an inpatient drug rehabilitation facility at the urging of his parents. He identified as a 28-year-old White, cisgender man for whom spirituality was a salient personal identity. He grew up in a family with a Jewish cultural heritage but had explored other perspectives and worldviews. Tom recently lost his job after testing positive for cocaine on a drug screening. He had begun experimenting with alcohol and drugs in middle school, and soon began dealing to other athletes on his sports team. Tom had hopes of playing football in college, but received drug charges as a high school senior that forced him to forfeit his scholarship. Though Tom tried to "get clean" and start fresh, he did not maintain sobriety. He was shaken by losing several friends to drug overdoses and expressed a desire to change, but was resistant to acknowledging the full impact of his addiction.

During psychotherapy, Tom was taught about the wandering nature of the mind, what his psychotherapist called "monkey mind," and how this contributed to his addict self-schema. If Tom did not work to control his mind, he usually thought about using drugs. Tom's therapist introduced him to a meditation technique called anapanasati, which involves sitting silently with eyes closed and practicing nonjudgmental awareness of thoughts, feelings, and sensations while breathing naturally. Tom practiced this coping strategy whenever he felt the overwhelming urge to use drugs. As treatment progressed, Tom became more aware of the ways in which he turned anger and hatred toward his parents inward, leading to impulsive behavior that put him in harm's way. Tom began to notice moments throughout his day when his cravings subsided, and he felt more inner peace and calm. Over time, he came to understand this as his core spiritual self, which offered him wisdom, groundedness, and lovingkindness.

3.3 | Case 3: Religious cultural psychotherapy for anxiety

Religious cultural psychotherapy retains Beck's cognitive model and accommodates treatment for working with Muslim clients (Razali, Hasanah, Aminah, & Subramaniam, 1998). This approach draws on passages from the *Holy Koran* and *Hadith* (sayings and customs of the prophet Muhammad) to (a) examine the evidence for and modify automatic negative thoughts, (b) facilitate the development of positive religious coping skills, including prayer, acceptance, and adherence to Islamic customs, and (c) help clients understand symptoms within the context of their cultural and religious beliefs to reduce mental health stigma. Clients are encouraged to cultivate feelings of closeness to Allah, reflect on truths from the Koran, and express their worries and fears in prayer.

"Abdul" sought psychotherapy after being diagnosed with generalized anxiety disorder by his physician and resisting a referral for medication. He identified as a 50-year-old Palestinian American, cisgender man. His Muslim faith was his most salient identity. Within his religious tradition, taking medication for psychological difficulties was discouraged, so he sought psychotherapy to learn to manage his symptoms. Although a successful businessman, Abdul was constantly tense, consumed with racing thoughts and fears that made it difficult to concentrate at work and home. Even during daily prayer, he could not focus. This compounded his fears that Allah would punish him for his lack of faithfulness.

In psychotherapy, Abdul acknowledged that he did not believe the world was a safe place. He felt that he must constantly prepare himself and his family for the worst-case scenario. He also worried about how rising political tensions and Islamophobia in the United States might impact his safety and that of his wife and three children. The psychotherapist validated Abdul's fears while working with him to identify how his faith could be a positive source of support. Abdul found that it eased his worries to meditate on the beliefs that Allah was always in control and that he could trust Allah to take care of him and his family. As Abdul's shame over his symptoms subsided, he attended the mosque more frequently and gained comfort from connection with others in his faith community.

4 | META-ANALYTIC REVIEW

4.1 | Inclusion criteria

We included outcome studies of psychotherapy broadly defined (Norcross, 1990), published in the English language, which explicitly integrated R/S throughout the psychotherapeutic process, either through incorporation of R/S content within a standard technique (e.g., Christian cognitive therapy) or the addition of R/S practices (e.g., prayer, meditation, and reading sacred texts) as an adjunctive to sessions. Additionally, all studies that we considered for inclusion compared an R/S-accommodated treatment with either (a) a no-treatment control condition or (b) an alternate treatment. Although the vast majority of studies used an experimental (randomized) research design, a small group of studies used a quasiexperimental (nonrandomized) design due to limitations arising from the treatment setting.

We excluded studies of peer-led support groups (e.g., Alcoholics Anonymous, Celebrate Recovery) as well as standalone self-help interventions (e.g., meditation, intercessory prayer) that were not psychological treatment. Because we were interested primarily in psychological and spiritual outcomes of psychotherapy, we did not consider studies that examined physical health as the primary outcome measure. However, we did include outcome studies in which psychological intervention was provided to individuals with a medical problem (e.g., cancer, hypertension) who sought psychotherapy for associated psychological (e.g., depression, anxiety) or spiritual (e.g., meaningless, feeling far from God) difficulties.

4.2 | Literature search

We identified studies for analysis using a comprehensive approach of both backward and forward search. First, we identified relevant psychotherapy outcome studies through database searches of PsycINFO, PsycArticles, Psychology and Behavioral Sciences Collection, SocINDEX, and Dissertation Abstracts International, as of May 15, 2017, using the key terms (counseling OR therapy) AND (religio* OR spiritu*) to define our search criteria. Second, we used previous meta-analyses and systematic reviews of the literature to identify additional outcome studies that met the aforementioned criteria. Finally, we reviewed all issues to date of *Spirituality in Clinical Practice* because this journal focuses on R/S-oriented interventions.

Subsequently, we contacted the corresponding author for each study identified through the previous methods to inquire about additional investigations they had conducted or were aware of, including unpublished file-drawer studies. Compared with findings supporting the null hypothesis, findings that support differences in treatments have been found to be several times more likely to be published. Furthermore, effect sizes tend to be significantly larger in published compared with unpublished studies. To minimize the risk of overestimating population effects and account for publication bias, we included both published and unpublished findings.

Overall, we identified 102 independent samples from 97 studies with data available for inclusion. Among these, 45 samples (44 studies) compared R/S psychotherapy to a no-treatment control condition only, 43 samples (40 studies) compared R/S psychotherapy to a comparison treatment only, and 14 samples (13 studies) compared R/S psychotherapy to both no-treatment control and other treatments. Among the 57 samples (53 studies) with a comparison condition, 24 samples (23 studies) used an additive design, in which R/S was added to a standard treatment and then compared with the standard treatment. Considered together, we examined a total of 116 comparisons in our analyses.

4.3 | Effect size

For each study, we report *g*, which is a statistic that reflects the posttest difference between the R/S condition and the comparison (or no-treatment control) condition in standard deviation (*SD*) units. Mean differences were reversed for negatively valenced outcome measures (e.g., depression, anxiety) so that positive values of effect sizes indicate more favorable outcomes for the R/S condition relative to the comparison or control condition. Some published studies did not include sufficient data to classify the study and calculate effect sizes. In these situations, we contacted the corresponding author to request the missing data. In situations where the data were not available, we excluded the studies from the meta-analysis.

4.4 | Study coding

We extracted the sample size and associated statistical information (e.g., means, *SD*s) necessary to determine the effect direction and to calculate effect sizes. For potential moderators, we coded a number of study, treatment, and patient characteristics. Study characteristics involved data source (e.g., published or unpublished), use of randomization, time lapse to follow-up data collection point, outcomes measured (coded as either religious or spiritual), and whether or not

the study used an additive design. Treatment characteristics included therapeutic approach (e.g., CBT, psychospiritual), intervention format (e.g., group, individual), accommodative focus (e.g., Christian, Muslim), number of sessions, use of a treatment manual, and psychotherapy fidelity checks. Patient characteristics included age, gender, race or ethnicity, presenting problem, use of psychotropic medication, and religious affiliation.

4.5 | Data analysis

We used Comprehensive Meta-Analysis Version 3.0 (Borenstein, Hedges, Higgins, & Rothstein, 2012). Random effects models were used because effects were considered to be sampled from a population of effects. Consistent with random effects models, studies were weighted by the sum of the inverse sampling variance plus tau-squared.

Some studies reported more than one outcome measure. We calculated the effect size for the one psychological outcome and one spiritual outcome that best assessed the goal of the specific psychotherapy. For example, if a study purported to examine R/S cognitive behavioral therapy for depression, a measure such as the BDI-II (Beck et al., 1996) was chosen to account for psychological outcomes and a measure such as the SWBQ (Gomez & Fisher, 2003) was chosen to represent spiritual outcomes.

4.6 | The studies and patients

We analyzed data from 7,181 patients (3,495 from R/S interventions, 1,634 from alternate interventions, and 2,052 from no treatment or control conditions), which was gathered from 102 independent samples. Most participants were diagnosed with a primary mental health disorder ($k = 50$), such as depression, anxiety, or posttraumatic stress disorder. Other participants received psychotherapy targeting psychological symptom distress and/or spiritual well-being following the diagnosis of a medication condition ($k = 29$), such as cancer or human immunodeficiency virus. Still other participants reported couple conflicts, spiritual problems, unforgiveness, or similar life challenges ($k = 23$).

Across studies, a number of diverse R/S perspectives were integrated in psychotherapy, with the majority being Christianity ($k = 28$), Islam ($k = 18$), and general spirituality ($k = 51$). Treatment was provided in individual ($k = 38$), group ($k = 57$), individual + group ($k = 2$), and couple or family ($k = 4$) formats. Psychotherapists utilized a variety of approaches, which we categorized into six broad areas: Cognitive and/or behavioral ($k = 33$), existential and/or narrative ($k = 7$), general psychospiritual ($k = 33$), mind-body ($k = 17$), REACH forgiveness ($k = 4$), and supportive and/or pastoral ($k = 8$). Follow-up time ranged from 1–6 months for R/S treatment-control studies ($M = 3.10$; $SD = 2.28$), and from 1–12 months for R/S treatment-alternate studies ($M = 3.10$; $SD = 2.28$).

5 | RESULTS

Meta-analytic results for psychological and spiritual outcomes are summarized in Table 1, which reports separate effect sizes by outcome type (psychological or spiritual) and comparison type (no-treatment controls, alternative treatment comparisons, or additive-treatment comparisons). The statistics reported are for the 90 studies that used an experimental design.

Our first analysis examined whether or not patients who received R/S-integrated treatment showed greater improvement compared with patients in a no-treatment control condition. R/S-adapted psychotherapy outperformed no-treatment control conditions on both psychological ($g = 0.74$, $p < 0.000$) and spiritual ($g = 0.74$, $p < 0.000$) outcomes. These gains were similar at follow-up (psychological: $g = 0.81$, $p = 0.002$; spiritual: $g = 0.71$, $p = 0.006$). Treated participants were better off than no-treatment control patients by about 0.7 *SD*s on average for both sets of outcomes—a large effect that is typical of treatment-control effect sizes for many forms of psychotherapy (Wampold & Imel, 2015). We encourage caution when interpreting this result—something almost always works better than nothing.

TABLE 1 Results for psychological and spiritual outcomes of all randomized studies

	Posttest					Follow-up				
Comparison	***N***	***k***	***g***	**95% CI**	I^2	***N***	***k***	***g***	**95% CI**	I^2
Psychological outcomes										
Control	3664	50	0.74***	0.52, 0.96	89.92	1522	17	0.81**	0.30, 1.31	95.10
Alternate	2283	31	0.33***	0.20, 0.47	60.49	896	14	0.33**	0.09, 0.57	66.92
Additive	805	19	0.13	−0.09, 0.34	53.79	465	14	0.22	−0.01, 0.44	30.33
Spiritual outcomes										
Control	2373	29	0.74***	0.48, 0.99	88.34	1112	11	0.71**	0.20, 1.21	93.56
Alternate	817	13	0.43***	0.19, 0.66	63.45	404	7	0.21	−0.14, 0.56	66.98
Additive	601	13	0.34***	0.18, 0.50	0	268	8	0.32*	0.02, 0.62	30.70

Note. CI: confidence interval for *g*; *g*: Hedge's *g*, a measure of effect size, which corrects for potential bias in Cohen's *d*; I^2: percentage of the observed variance that reflects real differences in effect sizes; *k*: number of effect sizes summarized; *N*: sample size summed across studies.

*$p < 0.05$.

**$p < 0.01$.

***$p < 0.001$.

Second, we examined whether patients who received R/S-integrated treatment displayed greater improvement on psychological and spiritual outcomes compared with patients receiving any alternate (e.g., secular) form of psychotherapy. Studies that used an identical theoretical orientation and therapy duration to isolate the impact of R/S accommodation were examined separately (see next analysis). R/S-adapted psychotherapy out-performed alternate treatments on both psychological ($g = 0.33$, $p < 0.001$) and spiritual ($g = 0.43$, $p < 0.001$) measures. Psychological gains were maintained at follow-up ($g = 0.33$, $p = 0.007$), but spiritual gains were not ($g = 0.21$, $p = 0.245$). At termination, participants who received R/S accommodative psychotherapy were better off than those who received an alternate secular treatment by about 0.3 *SD*s on average for both sets of outcomes, which is a small–medium effect. At follow-up, these participants continued to report less psychological symptoms by about 0.3 *SD*s.

In our third and most important analysis, we examined studies in which the R/S and alternate (e.g., secular) psychotherapy conditions used the same theoretical approach and treatment duration (thus constituting an additive design). The goal here was to isolate the additive effects of R/S-specific intervention elements. There was not a significant effect of R/S integration on psychological outcomes directly following treatment ($g = 0.13$, $p = 0.258$) or at follow-up ($g = 0.22$, $p = 0.062$). This means that R/S-accommodated treatments were as effective, but not more effective, than standard psychotherapy. However, R/S-adapted psychotherapy did outperform standard psychotherapy on spiritual outcomes, both directly following treatment ($g = 0.34$, $p < 0.000$) and at follow-up ($g = 0.33$, $p = 0.037$). Participants who received R/S-accommodative psychotherapy reported greater spiritual well-being by about 0.3 *SD*s on average, which is a small-medium effect.

These meta-analytic results provide substantial empirical support for incorporating R/S into psychological treatment. Consistent with previous meta-analyses, R/S-adapted psychotherapy resulted in greater improvement in patients' psychological and spiritual functioning compared with alternative non-R/S psychotherapies. With more stringent criteria, R/S treatments were equivalent to secular treatments on psychological outcomes and were superior to secular treatments on spiritual outcomes, both at posttest and follow-up.

5.1 | Publication bias

The file-drawer problem refers to the possibility that there may be unpublished studies that we were unable to retrieve and include in the meta-analysis. Thus, we conducted a fail-safe *N* analysis to estimate the number of

TABLE 2 Results for fail-safe *N* analyses

Comparison	Posttest			Follow-up		
	Rosenthal's *K*+	*z* for observed studies	Orwin's *K*+	Rosenthal's *K*+	*z* for observed studies	Orwin's *K*+
Psychological outcomes						
Control	4133	17.26***	224	486	10.36***	64
Alternate	460	7.47***	69	67	4.71***	32
Additive	122	4.91***	57	32	3.45***	30
Spiritual outcomes						
Control	1851	15.52***	166	224	9.05***	46
Alternate	136	6.02***	47	0	1.95*	4
Additive	71	4.81***	39	7	2.64**	17

Note. Orwin's *K*+: the number of missing studies with a non-existent or trivial *g* (in this case <0.10) that would need to be added to the analyses to bring the overall *g* under 0.10; Rosenthal's *K*+: the number of missing studies with a mean effect of zero that would need to be added to the analyses to bring the $p < 0.05$; *z* = the overall *z*-score for observed studies.
*$p < 0.05$.
**$p < 0.01$.
***$p < 0.001$.

additional studies with nonsignificant results that would need to be added to the meta-analysis to change the overall conclusions. Results (see Table 2) suggest minimal impact of the file-drawer problem, with the exception of follow-up analyses, which may be more modestly prone to bias because of small sample sizes. If all existent file-drawer studies were retrievable, effect sizes for follow-up analyses of spiritual outcomes, in particular, could be weakened or become nonsignificant. We also conducted the trim and fill procedure to estimate the number of missing studies due to publication bias and statistically impute these studies, recalculating the overall effect size. Results suggested minor over or underestimation of some effects, but overall conclusions remain unchanged.

5.2 | Moderators

We categorized moderator variables into three groups: (a) Patient characteristics, (b) study characteristics, and (c) treatment characteristics. Potential moderators were tested on the within-group effect sizes, because we were interested in assessing how these variables might impact response to treatment. We conducted metaregression to control for potential confounding among variables and allow examination of unique effects. We dummy coded polychotomous categorical moderators, indicating our reference groups as Christian (accommodative focus), cognitive behavioral (treatment approach), and individual therapy (modality).

The findings of the moderator analyses on the within-group effect sizes are reported in Table 3. Unpublished studies trended toward smaller effects in symptom reduction compared with those published ($p = 0.093$). Treatments including psychotropic medication predicted larger effects than those not including medication on both psychological ($p < 0.001$) and spiritual ($p = 0.001$) outcomes. General spiritual accommodated psychotherapy was significantly less effective than Christian accommodated psychotherapy on spiritual outcomes ($p = 0.050$), but not on psychological outcomes. In terms of treatment approach, supportive and pastoral therapy showed weaker effects than CBT on symptom reduction ($p = 0.016$) and spiritual outcomes ($p = 0.012$). Mind-body psychotherapies predicted slightly smaller reductions in psychological distress compared with CBT ($p = 0.051$). Finally, group formats trended toward weaker effects than individual psychotherapy on psychological outcomes ($p = 0.067$).

TABLE 3 Multiple moderator analyses prepost R/S psychotherapy

Comparisons	*k*	*B*	95% CI	*z*(*B*)	*Q*	*df*	*p*
Psychological outcomes							
Overall model:	64				120.03***	14	0.000
Intercept		2.89	1.85, 3.93	5.43***			0.000
Race/ethnicity		0.00	−0.00, 0.01	0.69			0.487
Published		−0.51	−1.10, 0.09	−1.68^{+}			0.093
Accommodative focus					1.01	2	0.603
General spiritual		0.02	−0.61, 0.64	0.06			0.956
Muslim		0.40	−0.55, 1.36	0.83			0.407
Treatment approach					14.77*	5	0.011
Existential/narrative		−0.70	−1.58, 0.17	−1.58			0.114
General psychospiritual		0.11	−0.57, 0.80	0.33			0.742
Mind-body		−0.79	−1.58, 0.00	−1.95^{+}			0.051
REACH forgiveness		−0.12	−1.11, 0.88	−0.23			0.821
Supportive/pastoral		−1.11	−2.00, −0.21	−2.42*			0.016
Modality					3.52	2	0.172
Group		−0.57	−1.18, 0.04	−1.83^{+}			0.067
Couple or family		−0.64	−1.82, 0.54	−1.07			0.286
Medication included in Tx		−1.55	−2.32, −0.77	−3.93***			0.000
Treatment manual		0.22	−0.37, 0.82	0.73			0.467
Treatment fidelity check		0.22	−0.40, 0.83	0.69			0.491
Spiritual outcomes							
Overall model:	38				41.06***	13	0.000
Intercept		0.64	0.36, 0.92	4.50***			0.000
Race/ethnicity		−0.00	−0.01, 0.00	−1.08			0.278
Published		−0.14	−0.44, 0.16	−0.91			0.365
Accommodative focus					8.33*	2	0.016
General spiritual		−0.26	−0.52, 0.00	−1.96*			0.050
Muslim		0.26	−0.23, 0.75	1.05			0.296
Treatment approach					10.39^{+}	5	0.065
Existential/Narrative		0.07	−0.31, 0.45	0.37			0.713
General psychospiritual		0.30	−0.12, 0.71	1.40			0.162
Mind-body		0.21	−0.21, 0.64	0.98			0.330
REACH forgiveness		0.05	−0.70, 0.80	0.14			0.893
Supportive/pastoral		−0.51	−0.91, −0.11	−2.50*			0.012
Medication included in Tx		−1.63	−2.56, −0.71	−3.46***			0.001
Modality		−0.30	−0.70, 0.11	−1.44			0.150

(Continues)

TABLE 3 (Continued)

Comparisons	k	B	95% CI	z(B)	Q	df	p
Treatment manual		0.12	−0.14, 0.39	0.90			0.366
Treatment fidelity check		−0.18	−0.46, 0.11	−1.24			0.217

Note. Reference groups are as follows: Accommodative focus—Christian, treatment approach—Cognitive Behavioral, modality—individual, medication incorporated in treatment—yes, treatment manual—yes, and treatment fidelity check—yes.
B: slope; CI: confidence interval; *k*: number of studies; *p*: two-sided *p*-value indicating statistical significance for each level of the model; *Q*: homogeneity test; *z*(*B*): *z* statistic for the slope.
$^{+}p < 0.10$.
$^{*}p < 0.05$.
$^{**}p < 0.01$.
$^{***}p < 0.001$.

6 | PATIENT CONTRIBUTIONS

It has been theorized that a client's level of R/S affiliation, practice, and/or commitment may impact the effectiveness of R/S psychotherapeutic accommodations. The majority of outcome studies assessed patient R/S solely as a demographic variable (participants self-identified as Christian, Muslim, Jewish, spiritual, etc.). Thus, in most cases, patient R/S was viewed as a dichotomous rather than continuous variable and used for informational purposes only. We tested religious affiliation (percentage of the sample religiously affiliated) as a potential moderator, but did not find a significant effect. Much is lost by analyzing treatment outcomes of all R/S individuals based on identification alone, because there is tremendous variance in the extent to which people are influenced by their R/S beliefs. More specific measurements of the strength of R/S are needed to better understand the relation between patient R/S and psychotherapy outcome.

Regrettably, we were not able test moderation of the strength of R/S commitment because few studies measured or reported this information. Only a few investigations used a measure of R/S beliefs or commitment in the pretreatment screening process, identifying a minimum cutoff score for inclusion to ensure that all patients in the study were at least moderately R/S. This lack of specificity in research and measurement represents a significant gap for future exploration.

7 | LIMITATIONS OF THE RESEARCH

Despite growing empirical support for R/S-adapted treatments, some shortcomings must be acknowledged. Our results at follow-up should be interpreted more cautiously in light of fewer studies including this data, resulting in a smaller analyzable sample. Generalizability of findings has been limited by the use of relatively homogeneous samples that fail to capture many aspects of diversity evident in "real world" clients. Furthermore, small samples make it difficult to capture a true treatment effect. Many studies did not use a bona fide comparative secular and R/S treatment (e.g., same theoretical orientation and duration). Without isolating the R/S component, it is difficult to tease apart the relative impact of R/S from other features of psychotherapy. Future research can ensure the alternative treatment condition is identical, with the exception of the R/S component. Investigators would also be wise to recognize and control for potential allegiance effects, since many researchers in this area identify as R/S themselves.

Researchers have varying perspectives about what constitutes R/S integration. We have outlined four broad ways treatment can be tailored (conceptualization, treatment goals, intervention, and interpersonal process). We encourage researchers to be specific about how and how much they integrate R/S, and to make treatment manuals available for cross-validation studies. More psychotherapy outcome studies are needed examining therapeutic approaches aside from CBT, as well as adaptations to other major world religions and spiritual traditions besides Christianity.

Particularly in light of the differences noted between psychological and spiritual change trajectories, future research could include measures of spiritual well-being and assess spiritual outcomes. While R/S composition is commonly included as a patient demographic, future studies can gather more extensive data about the client's R/S and evaluate treatment effectiveness based on strength of religious commitment, as well as daily spiritual experiences and practices, such as attendance at religious services, prayer, and reading of sacred texts. Finally, in most cases, only patient R/S has been assessed. Further exploration of the relative importance of value similarity between psychotherapist and client is warranted.

8 | DIVERSITY CONSIDERATIONS

While the majority of studies reported demographic information, these data were rarely integrated in posttreatment analyses. Little research has explored R/S diversity, including religious commitment and daily spiritual practices. As the research base grows on incorporating patients' R/S beliefs and values in treatment, it is vital that psychotherapists better understand what sorts of individuals are most likely to benefit. For example, it may be that older individuals, women, those of lower socioeconomic status, or clients of certain racial or ethnic backgrounds experience a greater or lesser benefit of religious tailoring. Many questions remain to be explored, including diversity aspects of not only the patient, but also the psychotherapist offering treatment. We encourage researchers to examine these diversity variables as moderators when analyzing treatment outcomes.

9 | THERAPEUTIC PRACTICES

The APA Ethics Code (2017, Principle E) affirms religion as a key consideration within diversity, and research has shown that attending to clients' R/S values and beliefs can positively influence treatment outcomes. "To ignore religion as a cultural issue may not only be unethical, but also lead to malpractice" (Plante, 2014, p. 289). R/S-specific ethical competencies have been proposed (Vieten et al., 2013), and can be used to guide therapists' development of relevant attitudes, knowledge, and skills that promote spiritually conscious psychological care.

Taking time to explore and understand a client's R/S values and experiences communicates that this aspect of their identity is welcome and an asset in the therapeutic process. R/S is an important cultural lens that can be creatively applied in conceptualization, treatment goals, intervention, and interpersonal process, remembering that R/S adaptations of psychotherapy are as unique as each patient who walks through the door.

Avoid making assumptions based on religious identification, and instead, explore patients' unique desires, needs, and expectations. What does R/S mean to them? What role does it play in their day-to-day life? How do they perceive and interact with the divine? In what ways do they perceive R/S to be a source of strength? What practices or activities might be powerful coping resources? Conversely, how might R/S be a source of struggle or inner turmoil? Are they experiencing difficulty reconciling previously-held R/S beliefs with their lived experience? Have they been the target of R/S oppression or abuse? How might this have impacted their relationship with the sacred? Throughout treatment, these are just a few of many potentially relevant R/S areas to explore.

To conclude, we offer several clinical applications based on the findings of this meta-analysis. We also recommend several texts detailing evidence-based strategies for R/S integration within clinical practice (Aten, O'Grady, & Worthington, 2012; Pargament, 2011).

- Treat religion and spirituality as a potentially important aspect of the client's identity. Express curiosity about each client's lived experience. Explore R/S history, values, and commitment as part of the intake process, and consider intersectionality with other dimensions of diversity.

- Incorporate a patient's R/S values and worldview in psychotherapy as requested and when clinically indicated. Research shows that accommodative psychotherapies are at least as effective as secular approaches in reducing psychological symptoms, and can be provided by therapists regardless of their personal R/S background.
- Consider R/S adaptations in psychotherapy for their unique benefits to clients' spiritual lives, including greater spiritual well-being and increased connection with the sacred. When a client's treatment goals include not only symptom remission, but also spiritual development, integration of R/S within psychotherapy is a treatment of choice.
- Tailor treatment especially when working with patients whose R/S is an influential force in their day-to-day life. Preliminary findings suggest that accommodative psychotherapies may result in the greatest symptom reduction among clients with a high level of R/S commitment.
- Follow the client's lead when incorporating R/S beliefs and practices into psychotherapy. Avoid making assumptions based on religious identification, and instead, explore their unique desires, needs, and expectations.
- Practice respect and cultural humility when discussing patients' religious worldviews and practices. Be especially sensitive to one's own potential biases about organized religion and to clients' experiences of the sacred.

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