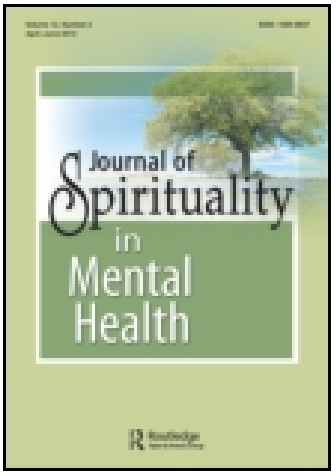

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Psychologists and Clergy Working Together: A Collaborative Treatment Approach for Religious Clients

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Positive religious engagement has numerous benefits for individuals struggling with mental health difficulties. There is, however, a dearth of literature addressing ways that secular psychologists can engage a client's religious belief system in a manner that allows the positive benefits of the client's religious and/or spiritual involvement to be experienced within therapy without requiring religious knowledge or theological training by the psychologist. The following article proposes a collaborative treatment model composed of distinct interventions functioning in a cooperative, coordinated manner. Discussion is also given to principles that aid psychologists in coordinating psychological and spiritual interventions into a coherent and cooperative treatment process.

KEYWORDS collaboration, clergy, psychological interventions, integration, spirituality

Historically, the relationship between psychology and religion has been contentious. Attempting to establish itself as a legitimate empirical science, psychology frequently disregarded religious belief as irrational. Religious

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expression was even considered a form of neurosis or emotional disturbance by some prominent psychologists (e.g., Freud, 1961; Skinner, 1953). As a result, clergy became reticent to refer congregants for psychological services, fearing that psychological constructs and interventions would contradict religious beliefs. Over the past 20 years, however, the need for effective collaboration between psychologists and spiritual leaders[1] has became increasingly evident for three primary reasons: the extent to which religious affiliation is espoused by clients, continually emerging literature detailing the benefits of positive religious coping and religious/spiritual (R/S) engagement, and the American Psychological Association's (APA) formal recognition of religion as an area of diversity requiring clinical competence. Capitalizing upon this recognition, the following article details a collaborative model of treatment, presenting secular psychologists with principles that will allow their client's faith to be utilized in such a way that it has the possibility of positively influencing therapy.

FACTORS INDICATING A NEED FOR COLLABORATION

Religious engagement and practice is still an important aspect in the lives of many Americans. The 2008 American Religious Identification Survey (Kosmin & Keysar, 2009) reported that approximately 70% of Americans believe in a personal God. According to data from a 2012 Pew forum survey (Funk & Greg, 2012), approximately 79% of Americans consider themselves religiously "affiliated." When viewed by denomination 73% consider themselves Christian (Protestant, Catholic, Mormon, Orthodox) and the remaining 6% are comprised of Islam, Judaism, Buddhism and Hinduism. The survey also showed that approximately 65% of Americans consider themselves "religious." Furthermore, 37% of Americans stated that they attended religious services at least once a week or more, while 33% stated that they attend a religious worship service monthly. A study by Rose, Westefeld, and Ansley (2001) found that 63% of clients sampled from across nine different counseling centers believed that discussion of R/S concerns was appropriate. They further found that of these individuals 55% desired to talk about R/S issues. These numbers speak to the relative significance that religious affiliation plays in the lives of the general American public.

Regarding the advantages of religious coping, convincing literature has emerged detailing the positive benefits of religious coping and engagement for individuals in inpatient psychiatric facilities as well as among psychotherapy clients. A study of 400 patients treated by mental health organizations in L.A. County (Tepper, Rogers, Coleman, & Maloney, 2001) revealed that of the 80% of individuals that utilized a religious belief or activity to deal with their symptoms, 65% stated that their faith helped either to a large or moderate degree in coping with their symptoms. Furthermore, the number of years

the patient engaged in religious coping and the amount of time that coping was concerned with religious beliefs or practices was related to better overall functioning and less severe symptoms. Another study by Baetz, Larson, Marcoux, Bowen, and Griffin (2002) found a relationship between religious factors and reduced length of hospital stay, reduction in depression symptoms, increased life satisfaction, and reduced risk of alcohol abuse. Kendler, Gardner, and Prescott (1997) found similar results, which pointed to religious practice as a predictor of lower depressive symptoms and reduced risk of alcoholism. Their study also found evidence suggesting that religious practice serves as a buffer against the depressive effects of difficult life events. Active R/S involvement has also been linked with reduced risk for suicide and substance abuse (Benson, 1992; Koenig & Larson, 2001). VandeCreek, Pargament, Belavich, Cowell, and Friedel (1999) determined that after controlling for the effects of general social support, religious support is a significant predictor of psychological adjustment. Ultimately, for religious individuals, R/S involvement frequently functions as a powerful buffer, coping strategy and recovery aid from both physical and mental illness (Larson, Swyers, & McCullough, 1997).

Lastly, the need for collaboration between spiritual leaders and psychologists has recently been highlighted by the APA through their formal recognition of religion as a diversity domain requiring competence. In a section titled "Human Differences," the APA's 1992 ethical code acknowledged religion as an area in which psychologists must be competent or else make appropriate referrals (APA, 1992). This recognition was further bolstered by a task force put together by the APA's Board of Ethnic Minority Affairs (BEMA). The goal of the board was to develop guidelines and principles for those providing services to ethnically and culturally diverse populations. Concerning religion, the guidelines instructed that "Psychologists respect clients' religious and/or spiritual beliefs and values, including attributions and taboos, since they affect world view, psychosocial functioning, and expressions of distress." The document further adds that "Effective psychological intervention may be aided by consultation with and/or inclusion of religious/spiritual leaders/practitioners relevant to the client's cultural and belief systems" (APA, 1990, p. 6). BEMA not only recognized the importance of religious and spiritual belief in the client's psychosocial functioning, but they also acknowledged that clinical treatment interventions may be aided by consultation with and/or inclusion of spiritual and religious leaders. Religious and spiritual issues require more than just passive acceptance on the part of clinicians. BEMA invites practitioners to actively practice competence in these areas, capitalizing on the inherent positive benefits they possess for clients who espouse them. In what can be interpreted as an attempt to further emphasize the importance of this topic as integral to the area of psychologists' overall aptitude, the iteration of the ethical code that went into effect in

June of 2003 moved religious competence from its original location under "Human Differences" to the new heading "Boundaries of Competence" (APA, 2002).

WHY A COLLABORATIVE TREATMENT MODEL?

In light of the evidence indicating the need for collaboration, the past 15 years have seen significant strides in practitioners' attention to issues of religion and spirituality. Significant portions of the literature concerning collaboration have focused on providing detailed narratives of successful and unsuccessful collaboration as well as extrapolating principles for navigating collaborative relationships (Benes, Walsh, McMinn, Dominguez, & Aikins, 2000; Budd, 1999; Budd & Newton, 2003; Chappelle, 2006; Edwards, Lim, McMinn, & Dominguez, 1999; McMinn, Aikins, & Lish, 2003; McMinn & Dominguez, 2005; McMinn, Vogel, & Heyne, 2010; McRay, McMinn, Wrightsman, Burnett, & Ho, 2001; Milstein, Manierre, Susman, & Bruce, 2008; Milstein, Manierre, & Yali, 2010; Plante, 2009; Richards & Bergin, 2005). The overall aim of these collaborative models and principles has been to establish bidirectional relationships between clergy and psychologists for purposes of consultation and referral. There have also been models developed in which therapists integrate spiritual interventions into psychotherapy (or pastors integrate psychology into spiritual direction). The proposed model differs from all of the above mentioned in that it is specifically a collaborative *treatment* model. That is, the collaboration between the psychologist and clergy in this model is for the purpose of developing a single treatment composed of separate, simultaneous interventions functioning cooperatively. Therefore, in this model the term intervention will be used to describe a specific activity ordered toward the client's mental or emotional well-being employed by either the psychologist or the spiritual leader. Treatment will refer to the overall process of client healing, composed of the psychologists' and spiritual leaders' distinct but cooperative activities.

This collaborative treatment model offers unique, consistent advantages that are often not as accessible or apparent in other R/S models. In particular the benefits associated with this treatment model are threefold: the client's experience of the positive benefits of R/S engagement, the mutual enhancement (and reduction in resistance to treatment) that simultaneous interventions foster, and the mitigation of psychologists' propensity toward being less religious than their clients.

The immediate and long-term psychological benefits of R/S engagement have been detailed above. For clients for whom religion is a salient variable, it would be foolish not to utilize the positive benefits associated with R/S involvement to assist and/or enhance the client's treatment. Of course, the opposite is true as well. Negative religious coping and engagement predicts

poorer mental health outcomes across a number of populations (Ano & Vasconcelles, 2005; Olson, Trevino, Geske, & Vanderpool, 2012; Raiabi, Saremi, & Bayazi, 2012). As will be discussed next, it behooves therapists and spiritual leaders to attend to their client's religious coping style in order to assess whether the client's religious coping is maladaptive and thus impeding psychological healing. Often one of the initial and immediate effects of R/S involvement is to reduce implicit bias and stigma against psychological interventions. Many highly religious clients will only agree to psychological interventions that include R/S components.

Since religious coping and involvement is frequently utilized by religious clients to deal with the effects of their mental illness, depending on the nature of the coping/engagement, an individual will experience either the benefits or consequences of religious involvement. In this way, religious coping and involvement is a crucial aspect of successful treatment. It is not hard to imagine a case in which a psychologist is treating an individual who is simultaneously engaged in negative religious coping strategies or practices. These maladaptive practices could negate or inhibit treatment efficacy. Attending to the client's religious coping and engagement style may not only reduced an impediment to treatment gains, but also increase treatment gains by allowing the client to receive benefits from positive religious coping in addition to the gains from psychological interventions. Thus, the relationship between therapy and religious coping is reciprocal. Therapeutic tools may help one move from negative to positive religious coping, which in turn allows one to experience the benefits of religious coping, which subsequently has potential to reduce even further impediments or resistance to therapy. Alternatively, and in some ways equally detrimental to treatment, a client may utilize a positive religious coping strategy in an inappropriate way or time in therapy, preventing them from experiencing either the full benefits of religious coping or therapy.

Another benefit of the collaborative treatment model is that it allows non-religious therapists to engage and treat religious clients without ignoring or negating an important variable for the client. It is well documented that psychologists as a whole are less religious than the population that they serve (Delaney, Miller, & Bisono, 2007). Delaney et al. found, however, that of the psychologists surveyed 82% believed that religion was beneficial to mental health. Unfortunately, this means that while psychologists may perceive religion as helpful to their client they may not feel comfortable or competent to discuss religious concepts, doctrines, and/or practices in a therapeutic setting. So, while the majority of therapy clients desire that their therapist address religious and spiritual issues (Rose et al., 2001), many therapists may not feel comfortable addressing these issues (Hathaway, Scott, & Garver, 2004). With this model therapists can work with a client of any religious faith or denomination, while not personally subscribing to the same doctrines or having a religious affiliation themselves.

PREREQUISITES

There are four essential prerequisites that must be present in order for this collaborative treatment model to work effectively. The therapist and spiritual leader must possess the ability to collaborate, they must have shared values, the interventions must be cooperative (but distinct), and the therapist must utilize a cognitive-behavioral (CBT) framework.

First, explicit to the concept of a *collaborative* treatment model is the ability for therapists and pastors to successfully work together. In order to for this relationship to be effective, basic elements of effective collaboration—qualities such as good communication, respect and trust—must be present.

Second, the therapist and client must have shared values. While the practitioner and spiritual leader need not have the same or even similar religious beliefs, it is important that they share overall values. This means that the therapist or pastor may have to put aside personal beliefs for broader values such as a common desire to see an individual heal and flourish or helping a client achieve their personal therapeutic goal. When the pastor and therapist's personal beliefs are at odds, a trusting relationship based on communication and respect can often allow the dyad to find common understanding and shared ground from which they can begin to collaboratively treat the client.

The third prerequisite required for this treatment is the utilization of a CBT framework by the therapist. The reason for using CBT rather than a psychodynamic, humanistic, or any other approach (we do believe that other modalities can be used within this model) is the ease with which religious concepts can be conceptualized (at least broadly) in CBT terms. In CBT the causal chain of events follows a consistent pattern. There is an activating event, which is perceived by an individual. The individual's appraisal of the event gives rise to beliefs or cognitions. These cognitions and/or beliefs subsequently result in feelings and/or behaviors from the individual. These feelings or behaviors can either become activating events in themselves or they can cause events to ensue in one's environment that give rise to other activating events. Similarly, for religious clients, events in one's environment activate religious beliefs and/or cognitions. These beliefs and cognitions can lead to feelings and behaviors which, much like in CBT, can become activating events or can influence one's environment in ways that give rise to other activating events which elicit subsequent religious beliefs and/or cognitions. Both CBT and religion concern themselves with individual's beliefs and behaviors. Both systems recognize the reciprocal relationship of thoughts and behaviors as well. For this reason the collaborative treatment process utilizes an overarching CBT framework because it allows for both psychological and spiritual concepts to be readily identified and conceptualized by their lowest common denominator—beliefs and behaviors. It also permits therapists and spiritual directors to see how a maladaptive automatic thought

might be treated with a spiritual coping thought or how maladaptive spiritual behaviors might be decreased by recognizing the thought errors that drive them.

Finally, as alluded to previously, it is essential that the respective interventions remain distinct. Psychologists should only perform psychotherapeutic interventions. Therapists should not engage in theological debate, nor should they fancy themselves exegetical experts. Despite using only CBT techniques, it is acceptable and even encouraged that the therapist's intervention touch on and remain open to the influence of religious themes that have been collaboratively discussed with the spiritual leader (e.g., encouraging engagement in religious activities and utilizing religiously themed reality testing, coping thoughts and rational responses). Conversely, the spiritual leader should focus solely on developing the client's relationship with God and fostering positive religious coping strategies. Spiritual leaders should not practice therapy or counseling techniques; their intervention should be strictly spiritual in nature.

THE APPROACH

Generally speaking, the approach of this treatment flows from the overall goal of the treatment. The goal of the treatment is to provide an individual with sufficient psychological relief and coping skills that they can fully embrace and utilize the positive benefits and social support found in their religious community. The determination of the goal for this treatment results from the evidence presented above. Any activity that can assist a client motivationally, supportively, or by increasing self-efficacy so that they are able to experience gains from therapy more quickly, deeply, or broadly should be utilized. Therapy is time limited. In order to maintain, support, and further the progress made in therapy, it makes sense to transition the individual into a supportive religious community. Conceptually, this collaborative model functions like a zipper (Figure 1). The interventions cooperate and build upon each other, utilizing gains achieved within one to motivate, facilitate or solidify change in the other.

Beginning: Intake and Conceptualization

To begin the process, the therapist should conduct a thorough psychosocial intake with the client. The purpose of this intake is twofold: to gain enough information to make an accurate psychological diagnosis and to begin an initial case conceptualization and functional analysis of the client's maladaptive thoughts and behaviors. Following the initial interview the therapist and spiritual leader should meet and begin to conceptualize the case together. The psychologist should present the diagnosis(es) to the spiritual director who

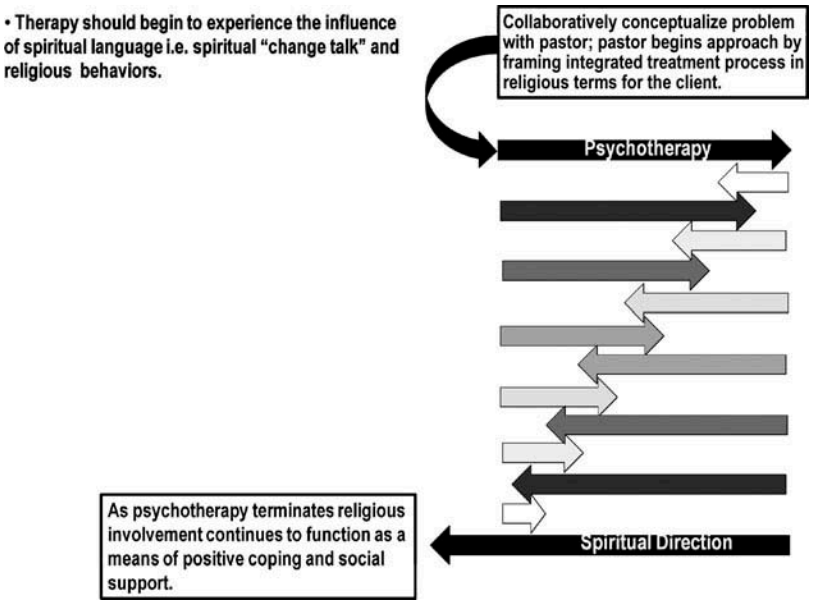

FIGURE 1 Collaborative Treatment Approach

Note. Interventions integrate like a zipper, remaining distinct, but cooperating with and building upon gains achieved by the other. Length of the arrow represents the primacy of the intervention within the treatment. Shading of the arrow represents the intensity of the chosen intervention.

should try to conceptualize the psychological diagnosis in spiritual terms. That is, the spiritual leader should frame the problem as the negation or deficiency of a theological gift or virtue (e.g., depression corresponds to a lack of hope; anxiety can be conceptualized as a lack of peace). Collaborative agreement between the psychologist and spiritual leader concerning how to conceptualize the case in terms and constructs that are mutually agreeable is important. Following agreement, the spiritual leader should then meet with the client and present the religiously framed conceptualization to the client as the ultimate goal of the spiritual intervention. The purpose of this is to give the client a spiritual (not just a psychological) metric with which to measure their progress. It may be the case that the client may not experience significant psychological symptom reduction, but may make personally meaningful gains in quality of life areas—in this case spiritual progress/growth. Or, the opposite may occur; the client may experience psychological gains, but not spiritual gains. This, however, will allow the client to utilize their psychological gains to pursue personal, meaningful growth in their religious faith life following the termination of therapy. Regardless, conceptualizing the psychological problem in spiritual terms presents the problem in language with which the client is familiar, which can often be comforting and assuring for clients unfamiliar with psychotherapy.

This spiritual conceptualization will serve as the architectonic framework for the entire collaborative intervention. The psychologist should consider himself/herself and even represent himself/herself to the client as employing psychological techniques and exercises to serve this spiritual end. The reason for this, as stated previously, is highly religious clients may be more likely to engage in psychotherapy if they do not perceive it as a threat to or in competition with their religious life/spiritual growth. Construing psychological interventions as being in service of spiritual growth/ends will assist in this perception. Also, since the client will eventually terminate psychotherapy and rely upon their religious community, conceptualizing the overarching problem in spiritual terms may assist in helping the client experience continuity in their own conceptualization of the problem.

The First Half of Treatment: Psychological Priority

Following the psychological intake and the religious framing, both of which should occur in the first session of each respective treatment, the collaborative treatment should continue with priority and precedence being given to psychological interventions over and beyond the concerns and interventions of the spiritual leader. The psychological intervention should be potent and intense during this period of treatment with spiritual direction playing a more supportive role. Ultimately, the priority and intensity of the psychological interventions will wane as treatment progresses.

During the period in which the psychological intervention has priority, the supportive role taken by spiritual direction should remain related to the therapist's intervention. If, for example, a therapist was beginning with behavioral activation, the spiritual leader might provide a relevant context or occasion in which the activation can occur (e.g., serving at a soup kitchen, group Bible study).

The Second Half of Treatment: Spiritual Direction Priority

Ideally, spiritual direction should become the primary intervention (both in priority and potency) midway through treatment. At this point psychological interventions should take a supportive role. However, when the spiritual direction takes precedence, its focus should not be unrelated to the psychological work but rather should (from a spiritual perspective) continue to address the needs and problems addressed by the psychological work. For example, if the maladaptive core theme "I am not loveable" was addressed during the psychological intervention, then the spiritual intervention might focus on themes and passages from holy books concerning God's love and care for the individual. Or, the person might be encouraged to join a small group (such as a men's or women's group) for social and spiritual support in which they are likely to experience love and compassion from other's in their religious community.

SUMMARY OF THE TREATMENT MODEL PRINCIPLES

1. Collaboratively conceptualize the presenting psychological problem as the negation or deficiency of a theological gift or virtue:
   - Through collaborative dialogue with the therapist, the pastor should determine a theological gift/virtue corresponding to the psychological problem and its symptom presentation. In terms familiar to the client, this gift/virtue functions as the overarching direction/orientation toward which mental and spiritual growth and healing are aimed.
   - Following the psychological intake and determination of the theological direction which treatment will proceed, the pastor should meet with the client and frame/contextualize therapy and spiritual direction in terms of the corresponding gift/virtue.
2. Perform a thorough case conceptualization and functional analysis that includes primary symptoms, maintaining behaviors, reoccurring automatic thoughts, and maladaptive core themes.
   - Therapists should identify and share maladaptive behaviors and cognitive themes/schemas with the pastor as they become evident. The pastor and therapist should discuss how these themes are related to the spiritual gift/virtue that is serving as the overall framework for the collaborative treatment.
   - Encourage the pastor to share cognitive and behavioral themes/patterns (either spiritual or psychological) that are impeding spiritual direction. The therapist should identify the thought error and/or maladaptive aspects of these cognitions and behaviors.
   - The maladaptive themes and behaviors shared between professionals should be collaboratively translated into each respective discipline's relevant language. In this way, each professional has a current understanding of the client's case in their own language and is able to implement an intervention that is both relevant to the problem and consistent with the other intervention.
3. While the psychological intervention has priority, coordinate psychological behavioral activation with the activation of religiously oriented activities.
   - When utilizing behavioral activation, the spiritual leader should offer the therapist suggestions as to religiously oriented activities, settings, or behaviors in which the client can engage. The therapist should help the client explore these possibilities. The spiritual leader can also suggest these behavioral options to the client, who can then discuss them in therapy.
4. While the psychological intervention has priority, coordinate cognitive restructuring tasks with prayer and meditation exercises concerned with complementary religious themes and scriptural passages.

- Based on the shared case conceptualization and understanding of the problem, collaboratively determine with the pastor religious passages, themes and principles that correspond to client's maladaptive automatic thoughts/core themes and which can be utilized in reality testing and/or as coping thoughts.

5. If behaviorally oriented exercises occur during the phase of treatment in which spiritual direction is the primary intervention, the therapist should focus on identifying, challenging, and changing cognitions that may be impeding the desired spiritual behavior. The therapist should help ensure that the activation is appropriate for gaining the desired types of positive reinforcement, changing particular cognitive expectations or appraisals, or exposing the client to the appropriate gradient of stimulus within a behavioral hierarchy.
6. If cognitive restructuring through meditation and reflection on Scripture passages occurs during the phase of treatment in which spiritual direction is the primary interventions, the therapist should determine whether behavioral activation or cognitive restructuring through reality testing and developing coping thoughts will best meet the desired goals of the spiritual intervention (the therapist will know these goals through weekly dialogue with the spiritual leader).
7. Halfway through the treatment process the primacy of the interventions should switch from primarily psychological with supportive spiritual direction to primarily spiritual direction with psychological support.
   - Midway through the overall session total the therapist should begin to heavily emphasize/encourage/engage the client's utilization of religiously oriented behavioral and cognitive strategies, as well as the discussion of these strategies in session (spiritual "change talk").

PRELIMINARY ETHICAL CONSIDERATIONS

Provide Comprehensive Informed Consent

Clients need to be informed and educated on the conjoint treatment process and its implications for treatment from the outset. Clients have a right to know the reasons for choosing a conjoint treatment and the role that consultation plays in the treatment model. They also must sign a release of information, giving each professional permission to discuss the case with the other.

Manage Religious Countertransference

Therapists should be mindful of their own reaction to the client's religious identity. Both positive and negative impressions can negatively impact the course of therapy. Therapists should consider how this might occur in the

dyadic relationship and take steps to mitigate and/or prevent it (Barnett & Johnson, 2011).

Address Disagreements Between Clergy and Psychologist

Two professionals treating a common patient concurrently may occasionally differ in opinions on important treatment decisions. While it is not essential that the therapist and spiritual leader have the same particular religious beliefs, it is important that they broadly share common values. If possible, therapists and spiritual leaders should meet prior to the beginning of treatment and discuss areas and topics relevant to the presenting problem and treatment that may give rise to value conflicts. These areas and topics should be openly acknowledged and a collaborative and concerted effort to reconcile these differences should be made. Clients are at risk of harm if an unresolved dispute over values influences clinical work or if the dispute becomes visible to the client. If the value conflict is unable to be resolved prior to the beginning of treatment, the psychologist may determine that it is best to find a spiritual leader with whom they have similar values. If differences cannot be reconciled before working with the client, the professionals must take steps to mitigate the impact on the client.

One way for psychologists to avoid potentially harmful disagreements with spiritual leaders is to develop a preexisting relationship with a spiritual leader with whom similar values are shared. This individual will function as the spiritual leader for all of the cases that the psychologist believes may be enhanced by the collaborative treatment model.

Clearly Delineate Psychological Interventions With Religious Content From Spiritual Direction

It was alluded to in the prerequisites that the psychological intervention must remain separate from the spiritual intervention. Following this requisite, it is important that the therapist be aware of crossing the line between therapy and religious advice or debate. A good question to ask might be: Would a third party payer be concerned if they knew the content of the intervention? (Gonsiorek, Richards, Pargament, & McMinn, 2009).

CASE EXAMPLE

The client with whom this model was initially implemented was a 59-year-old Caucasian male, who shall be called Tom for the sake of this narrative. Tom had been married to his wife for 40 years. The couple had four children together, ranging in ages from 19 to 35. Tom reported a positive relationship

with his wife, though the couple had seen marital counselors in the past because of communication issues. At the beginning of psychotherapy Tom's wife drove him to the therapy sessions because he was too anxious to drive at all. His wife also accompanied him into the first therapy session. Tom depended on his wife not only for transportation, but also as a mediator for social interactions because he felt unable to interact with individuals. His wife also provided him with reminders of dates, appointments, and other daily tasks that he needed to complete. Tom reported that he had been employed with the same Christian missionary organization for approximately 30 years (and had been affiliated with the organization for almost a decade prior). Tom stated that in recent years the organization had increased the required fundraising necessary for all missionaries. This was accompanied by a drop in Tom's funding. Falling short of his required funding caused tremendous anxiety for Tom. He avoided the problem until the organization brought it to his attention that the issue needed to be addressed. In July of 2012 Tom was ordered to attend an out-of-state conference aimed at assisting missionaries who had not met fundraising goals. He stated that the organization's attention to his fundraising made him feel scrutinized, as if he was always being closely watched. This was further compounded by a persistent fear that his position and status within the mission was in jeopardy due to his fundraising difficulties and what he perceived to be a deficiency in his knowledge and skill set for his field of employment. While at the conference, Tom's anxiety became so intense that he experienced what seemed, based on his description, to be a panic attack. At the time, however, many of the individuals around Tom believed he was suffering a stroke because his speech became slurred and his thought process disoriented. He was taken to the hospital by ambulance and following an evaluation it was determined that he had not suffered a stroke. Tom returned home with his wife, but stated that his paranoid feelings and thoughts about the mission's scrutiny of him persisted. At this time Tom also began to experience a depressive episode. In September of 2012 Tom had a psychotic break with paranoid delusions. He eventually came to believe that the mission had planted cameras in his home and was constantly watching him. This caused him tremendous anxiety and as a result of these delusions Tom took his vehicle and drove around all night, eventually sleeping in the car because he refused to return home. The next day when he returned home, Tom agreed to be hospitalized at the local psychiatric facility. Following his hospitalization, Tom was placed on an indefinite leave of absence by the mission organization in order to give him time to recover from his episode.

Tom was referred to psychotherapy by his pastoral counselor, a former Christian missionary whose wife developed bipolar disorder while the couple was in the mission field. The pastoral counselor had no formal psychological training, but he was generally familiar with psychological terms and concepts as CEO of the Grace Alliance (GA), a religiously based organization

that provides training and collaborative partnerships for churches and other organizations seeking to learn about mental illness, as well as recovery programs and support groups for individuals suffering from mental illness. Tom's wife had brought him to GA because he was experiencing depression and anxiety symptoms. Tom's wife thought the problem was spiritual in nature. After meeting with the pastoral counselor at GA for one session, Tom had the psychotic break, which required psychiatric hospitalization for a few weeks. At that time Tom was placed in contact with a psychiatrist, who prescribed medication. Initially, Tom did not take the medication. Following a period of psychoeducation on mental illness at the GA, Tom consented to taking his medication. After he had met with his pastoral counselor for a few sessions and the nature of the presenting problem was explained and explored, it was recommended that psychotherapy would be beneficial for Tom. At the outset, Tom and his wife were resistant to the idea of psychotherapy. The couple was afraid that psychotherapy might contradict and invalidate their worldview and faith tradition. It was explained, however, that Tom would be engaged in a model of treatment that would utilize his religious involvement and faith as a means of promoting and sustaining growth. It should be noted that, despite needing a higher level of clinical intervention and care, Tom would not have engaged in psychotherapy had this model not been available. It was important to Tom that his faith not simply be respected, but used throughout the treatment process.

Since Tom was already being seen by his pastoral counselor at GA, some variations were made to the model. His presenting psychological problem was not couched by the pastoral counselor in explicitly spiritual terms directly related to the clinical diagnosis (as recommended in the model). However, Tom had seen his pastoral counselor for approximately four sessions and the two had begun to work on spiritually related issues and themes relevant to helping Tom deal with the symptoms of his mental illness. Particularly, they focused on understanding and relying upon God's compassionate and loving character in light of the difficult experiences associated with mental illness. For the sake of continuity and consistency, it was decided that it would be beneficial for the pastoral counselor to continue to focus on God's character with Tom rather than switch gears and couch Tom's psychological problems in relevant spiritual terms.

Tom entered his first session of psychotherapy with his wife by his side. The overall collaborative treatment model was explained to Tom and his wife. Following a brief explanation, the limits of confidentiality were discussed, especially as they pertained to this particular treatment collaboration. Tom signed a release of information form allowing the therapist to have contact with his pastoral counselor and share relevant details of his case for treatment purposes. It was agreed that therapy would last for 12–14 sessions. Tom was also informed that he would be given a Beck Depression Inventory

(BDI) and a Beck Anxiety Inventory (BAI) at the beginning of each session for the purposes of tracking his progress in therapy.

At the time of his first session Tom's affect was flat, his speech was drastically slower than normal rate and rhythm. Both he and his wife reported his mood as depressed. Tom's memory was impaired, as evidenced by his inability to recall distant and recent events. His cognitive processing speed was significantly slower than normal. Tom's presentation seemed almost catatonic. His wife answered most of the background questions and filled in significant portions of detail where Tom was only able to recall brief portions of events or broad facts. Following the background history, the cognitive-behavioral model and its conceptualization of the relationship between events, beliefs, feelings, and behaviors were explained.

After the first session, the therapist was contacted by Tom's pastoral counselor via e-mail. They agreed that it would be most convenient for both of their schedules to discuss the case over the phone. The details of the case were discussed and a working case conceptualization was formed. Since Tom was no longer experiencing paranoid delusions or psychosis, it was agreed that the primary problems were depression, which resulted in severe anhedonia and increased sleep, as well as pervasive anxiety, which was causing Tom to isolate from personal relationships, avoid driving, and disengage from behaviors geared toward getting his job back. The therapist informed the pastoral counselor that he would be utilizing behavior activation initially in order reduce the amount of time the client's stayed in bed by finding positively reinforcing behaviors and activities.

For the second session (and the remainder of the sessions), Tom was invited back to the therapy room alone. This was done in order to try and increase his self-efficacy and reduce his dependence on his wife. Tom's anxiety level was significantly higher throughout the entire second session. The session began, however, with a review of the CBT model and the relationship between events, beliefs, feelings, and behaviors. Tom was able to identify an automatic thought that undergirded his anxiety: "Who am I without the mission?" He also identified a deeper core theme that contributed to both is anxiety and depression: "I am not valuable." The remainder of the session was spent determining Tom's daily tasks and brainstorming activities that he enjoyed and in which he could participate. Since he noted that he had been trying to walk once a day, it was decided that he would increase his daily walk to twice a day (once in the morning and once in the evening).

It became clear after the second session that Tom's case would not be clearly delineated into a behavior intervention phase and a cognitive intervention phase (or vice versa). Due to the interplay between his depression and anxiety (e.g., not engaging in desirable social situations due to anxiety about what others would think about him), cognitive and behavior interventions were explored and implemented simultaneously in each session. This naturally meant that Tom's pastoral counseling was trying both

to find religiously oriented activities in which Tom could participate, while challenging maladaptive cognitions with Christian themes.

While behavioral activation was the primary intervention during the first five sessions, Tom's severe anhedonia made it difficult for him to choose activities and his anxiety regarding driving and social relationships created resistance even toward activities in which he wanted to engage. Tom reported that he spent much of the day in bed. However, as modeled in the collaborative treatment, Tom's pastoral counselor supported the behavioral intervention by providing religiously oriented contexts or activities in which Tom could engage. He attempted to help Tom schedule faith-based, rewarding activities such as church attendance, Bible study, prayer, and a church home group. For example, at the suggestion of his pastoral counselor Tom attended a morning men's group, which he enjoyed. He stated, however, that he was unable to attend the meeting more frequently because he did not drive. Therefore, during the second and third sessions in therapy maladaptive cognitions concerning driving were targeted. Tom was encouraged to practice driving small distances (to the end of his road) as a means of gradually exposing himself to his feared activity. By the fourth session Tom reported that he had driven a short distance to a religious function with his wife in the car. Also, by session four Tom's affect was no longer flat, but significantly blunted. He regained congruence between his affect and the content of his thoughts very slowly with each session.

Also, since Tom was not feeling motivated to pray and was experiencing what he perceived to be a disconnect from God during devotional time and Scripture reading, the pastoral counselor assisted him in finding creative ways to incorporate devotion, such as a simple scripture reflections/prayer while he was on his walk. These reflections and prayers, however, were directly related to the core theme of "I am not valuable" and "I am an unworthy servant," a theme that Tom began to articulate in the third session and one which was creating significant amounts of anxiety for Tom. His unworthy servant motif isolated him from God and others and ultimately increased his depression. Thus, Tom's pastoral counselor began focusing predominately on Tom's experience of and reflection on God's love and mercy. The pastoral counselor discussed and reflected on passages which focused on God's grace and care for struggling individuals as well as those who experienced themselves as "unworthy."

By session five it was collaboratively decided that behavioral activation was not progressing as well for Tom as hoped due to his lack of motivation and interest in activities. Therefore, a purely cognitive approach was taken aimed at targeting those thoughts and themes that were causing Tom's anxiety and contributing to his avoidant behaviors. At the end of session five, discussion was given to the concept of automatic thoughts and their relationship to feelings and behaviors. Tom's cognitive themes of having "no value" and being an "unworthy servant" were explored in their relationship to his

feelings of depression and anxiety. Tom was provided an automatic thought record for homework following the session. In the following sessions particular attention was given to Tom's primary thought errors. Tom tended toward catastrophizing, polarization, and placing unrealistic "shoulds" on himself. Through homework assignments he was challenged to recognize his thought distortions and create balanced coping thoughts. Since at this point therapy was past the halfway mark, the spiritual direction intervention was of primary import. Thus, the client's primary goals for spiritual direction were to find religiously oriented activities in which he could engage during his day, and to soften his core belief of being an unworthy servant. Tom's thoughts concerning why he was an unworthy servant and valueless were explored in light of his primary cognitive distortions. More balanced, rational thoughts were discussed in place of the maladaptive beliefs. This continued for the rest of therapy. Tom was invited to discuss what he was working on with his pastoral counselor and any barriers he was experiencing in meeting these goals. Barriers would then be collaborative problems solved in session with attention being given to equipping Tom with coping strategies (e.g., deep breathing techniques) and cognitive tools that would allow him to manage stress and/or deal with maladaptive thoughts that were impeding his spiritual progress.

During session seven Tom laughed. By the eighth session Tom's affect was more congruent and his memory and cognition had considerably improved both in therapy and in spiritual direction. His progress was reviewed in the ninth session and Tom stated that his overall anxiety concerning day-to-day tasks had decreased. Tom's pastoral counselor also noted that he was utilizing the tools he had been taught to manage stress and anxiety. By the ninth session Tom had driven to the morning men's meeting by himself. In the beginning of the twelfth session, while Tom was in the waiting room, he was observed laughing and smiling with his wife. He had driven to the appointment and was regularly attending the morning men's meeting. By this point Tom had informed his spiritual director that he was taking his anxiety medication "only on rare occasions." It was decided during the final session that Tom would continue to meet with the pastoral counselor once a week and participate in a faith-based mental health support group through GA. It was also agreed upon that Tom would come back to therapy for a 1-month booster session.

Tom was given a BDI and a BAI at the beginning of each session. His BDI and BAI scores began in the subclinical (minimal) range and consistently increased. During the fifth session his BDI score entered the moderate depression range and his BAI entered the mild range of anxiety. The BDI score remained in this range until the end of therapy, while the BAI score entered the moderate range of anxiety on the twelfth and final session of therapy. As noted above, when Tom first arrived in therapy his affect was flat and he appeared almost catatonic. Interestingly, Tom's scores on

both measures consistently increased throughout the psychotherapy process, simultaneous with his affect becoming more congruent with his thoughts and his memory and cognitive abilities improving. These increases co-occurred with the achievement of positive therapeutic gains. He began to implement strategies for reducing stress and anxiety, recognizing his thought errors, driving, and participating in meaningful social gatherings (men's group). At the 2-month follow-up Tom was given another BDI and BAI. His scores were in the minimal (subclinical) range for both.

At his 2-month follow-up Tom's mood was normal and his affect was congruent with his thoughts. He laughed and joked freely. Tom's cognitive processing speed was normal and his memory appeared to be intact based on his ability to recall recent and past events. He stated that he had joined a gym and had been working out 2 to 3 times a week for the past two months. He further noted that he had regained interest in old hobbies. When asked how it felt to take pleasure in activities again Tom said, "It brings a smile and a lightness in your step." He also stated that he had started enjoying food again, joking that he had gained 15 lbs. Tom had also been invited back to the mission organization with which he worked prior to his episode. He was excited to detail an endeavor for which he had been chosen to be project lead. Tom continued to see his pastoral counselor on a weekly basis and stated that while he had only been able to attend one support group session, he intended to attend more in the upcoming weeks. The booster session included a discussion of and psychoeducation on avoidance as a possible trigger for relapse. Tom identified an emotion-laden event that he had been avoiding. It was recommended that Tom engage his pastoral counselor for Scriptural passages that would give him strength and courage. He was also encouraged to brainstorm with the pastoral counselor possible ways of relying upon his faith community to help him bear this burden.

CASE EXAMPLE SUMMARY

The collaborative treatment model functioned particularly well with Tom. His faith was a salient enough variable in his life that it was essential to incorporate it into his treatment. Furthermore, collaborating with the pastoral counselor increased the amount of information learned because it was being gleaned from another source. The pastoral counselor was able to inform the therapist of psychological concerns raised by the client (e.g., medication, memory problems), while the therapist was able to update the pastoral counselor on spiritual concerns with which the patient was struggling. Sharing information regarding the nature and status of the particular treatment intervention being employed, while informing the other provider with information directly relevant to their intervention, ensures that treatment remains comprehensive, fluid, and collaborative.

In this particular iteration of the collaborative model the spiritual leader was also able to create a more therapeutic marital environment in which the client could begin to recover. The spiritual leader met with the client and his wife in order to help the couple deal with the symptoms and consequences of mental illness as they affect a marriage. If Tom had been solely working with a psychologist this added benefit would not have been available. Thus, the collaborative model allows therapists and spiritual leaders to freely and spontaneously engage in interventions and activities that meet previously unknown or unforeseen client needs.

CONCLUSION

Therapy works. It is able to affect real changes in our clients. Factors outside of therapy, however, often contribute to a significant portion of the variance accounted for by a particular therapeutic modality. This collaborative treatment modal engages a variable that is salient to the client—religious involvement—in a deliberate and intentional way so that the benefits of religious participation can be experienced by the client. These benefits assist the therapist because they can (if used thoughtfully) serve to move a client past resistance, reduce ambivalence, or alleviate fear within the therapeutic change process.

As the field of psychology continues to develop, opportunities for collaboration with other disciplines for treatment purposes will likely increase. For the competent and effective psychologist collaboration is inevitable, but also indispensable. Therefore, psychologists should not be afraid of collaboration with spiritual leaders, but rather seek to take advantage of the benefits which religious involvement offers their clients. It becomes the job of the psychologist to prudently and intricately weave the psychological intervention together with relevant aspects of religious engagement that will allow the therapeutic treatment to be enriched and as potent as possible for the client. The psychologist does not simply acknowledge religious involvement as important to the client, but rather seeks to foster and use the client's engagement in a faith community to benefit therapy. Reaching out to religious and spiritual leaders, those intimately familiar with a domain that remains salient to the majority of Americans, can establish and forge an important relationship—one that can ultimately benefit our client's treatment.

Americans still identify themselves as religious. Association with a particular denomination is still more the norm than the exception. Striving to meet the demands of cultural competence while at the same time recognizing that we, as psychologists, tend to be less religious than the clients we see, it becomes important for practicing clinicians to have a means for engaging the client's faith in a competent and comfortable way. The proposed collaborative treatment model allows nonreligious therapists, or those who may

know little about a particular faith community, to work with highly religious clients in a culturally competent, creative, and effective way.

NOTE

1. It should be noted that the term *spiritual leader* is used in this article to denote an individual whose primary concern is the spiritual growth of the client. This individual may be a pastor, priest, pastoral counselor, or lay person within the religious community.

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