




**UNC School of Social Work Clinical Lecture Series**

**The Use of "Religious CBT" for Major Depression in Patients with Chronic Medical Illness**



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**Introduction**

1. Prevalence and causes of depression
2. How to recognize depression
3. Treatments for depression
4. Treatment side-effects
5. Psychotherapy for depression
6. Duke Religious CBT for Depression Study

**Depression- Prevalence/Causes**

1. Hospitalized medical patients\*
  - 20% major depression (MD)
  - 30% minor depression
  - 50% no depression
2. < 50% are treated (including those with MD)
3. Causes are usually the severity of the illness, the degree of functional disability, lack of coping resources

\* Koenig et al. (1997). Depression in medically ill hospitalized older adults: Prevalence, correlates, and course of symptoms based on six diagnostic schemes. *American Journal of Psychiatry* 154:1376-1383

**Diagnosis**

SIG E CAPS

S - Sadness, depressed mood, or irritability\*  
 I - Interest (loss)\*  
 G - Guilt or feeling like a burden on others

E - Energy (loss), fatigue

C - Concentration (decreased)  
 A - Appetite (loss), weight loss  
 P - Psychomotor retardation or agitation  
 S - Suicidal thoughts or desire to die  
 S - Sleep problems

**Diagnosis**  
 (major depression)

1. Depressed mood/sadness or loss of interest during past 2 weeks (or 2 weeks of past month)
2. Four of any of the following during that period:
  - loss of Interest (if not included in #1)
  - Guilt or feeling like a burden
  - Energy loss or fatigue
  - difficulty Concentrating
  - loss of Appetite or >5 lb weight loss
  - Psychemotor retardation or agitation
  - Suicidal thoughts or wanting to die
  - Insomnia or hypersomnia

**Diagnosis**

Use "inclusive" approach to counting symptoms

### Treatment

FIRST, if **significant** suicidal thoughts, protect and refer/treat

- thoughts about wanting to die
- occasional thoughts about wanting to end one's own life
- **persistent** thoughts of wanting to end one's own life
- thoughts about **how** to end one's life
- **plan** to end one's life
- more urgent if **history** of prior suicide attempts

### Treatment

1. Antidepressant Drugs
2. Electroconvulsive Therapy (and transcranial magnetic stimulation)
3. Psychotherapy

### Treatment Side Effects

1. Antidepressants
  - Nausea or GI upset
  - Dizziness or other CNS effects
  - Interaction with other medications (Coumadin)
  - Hypertension (Effexor) or hypotension (tricyclics)
  - Agitation
  - Insomnia (Wellbutrin, Paxil, Zoloft, others)
  - Weight loss (Wellbutrin) or gain (Remeron)
  - Psychosis (bupropion)
  - Loss of libido/sexual side-effects

### Treatment Side Effects

2. Electroconvulsive therapy
  - memory problems
  - complications from treatment itself (cardiac, neurological)
  - short-acting (relapse common without continuing treatment)

### Treatment Side Effects

3. Psychotherapy
  - if suicidal, may not be appropriate alone
  - time and effort
  - cost

### Psychotherapy

1. Cognitive Behavioral Therapy (CBT)
2. Interpersonal Psychotherapy
3. Supportive Psychotherapy
4. Psychodynamic Psychotherapy

## Psychotherapy Study

### Conventional vs. Religious Cognitive Behavioral Therapy (CBT) for Major Depression in Patients with Chronic Illness

## Rationale

1. Depression is widespread in chronic medical illness
  - often result of the challenges of coping with related life stressors
  - associated with physiological changes:
    - immune / endocrine / cardiovascular
  - predicts medical morbidity/mortality
    - heart disease / stroke / cancer / dementia
    - mortality
  - genetic predisposition

## 2. Religious involvement is widespread

- “important part of daily life”
- 65% US, 75% in Southeast US (Gallup)
- “very important”
- 56% US, 69% Southeast (Pew Foundation)
- used to cope with chronic illness
- 90% (5 or higher on 1-10 scale)
- 42% (10)

## 3. Religious resources typically ignored in psychotherapy

- psychologists/psychiatrists less religious than US population
- longstanding conflict between religion & mental health care

## 4. Empirical preference:

77%- 83% of adults aged 55 or older with depression & and co-morbid chronic medical illness prefer to include religion in psychotherapy

## 5. Religious involvement is related to less depression and faster recovery from depression

- 272 of 444 studies (61%)
- 119 of 178 better quality (67%)

## 6. Especially for those with chronic medical illness

- 53% -70% increase in speed of remission of depression

- 7. Religious involvement is related to significantly better immune functioning (14 of 25 studies) and better endocrine functioning (19 of 30 studies)
- 8. There may be a genetic predisposition to R/S, and this may have something to do with the serotonin transporter and serotonin receptor functions (genetic polymorphisms)

- 9. Psychotherapy is proven treatment for depression
  - Cognitive-behavioral therapy – most common treatment
  - Developed by Aaron Beck, improved by Judy Beck
  - Delivery methods
    - self-administered via book (Feeling Good)
    - in-person, with therapist
    - telephone, with therapist
  - Barriers to psychotherapy are many
    - access (referral, getting to therapist office)
    - compliance (high dropouts)

- 10. There is evidence that when religion is integrated into psychotherapy, CBT in particular, the result is faster remission of depression (vs. conventional CBT)
  - Propst 1988
  - Propst et al.,1992
- 11. Considering religion a resource in psychotherapy may also increase referrals from clergy, and improve the maintenance of effects of therapy after formal therapy ends (with ongoing support from the faith community)

**Conclusion:**  
 A clinical trial is needed to test the effects of religious CBT vs. conventional CBT for depression to see if RCBT is better, the same, or worse than CCBT in

- (1) relieving depression in religious patients and
- (2) reversing the adverse biological changes associated with depression

**The Study**

Funding Source: Templeton Foundation

Study Design

Phase I:  
 (Rounsaville 1a) [refine intervention and protocol]

Phase II:  
 (Rounsaville 1b) [proof of concept trial for effect size]

Rounsaville, BJ, Carroll, KM, Onken, LS (2001). A stage model of behavioral therapies research: Getting started and moving on from Stage I. *Clinical Psychology: Science and Practice* 8:133-142

- Phase I
- 1. Develop an RCBT treatment manual, adapted to the negative thinking of chronically ill patients, to guide a therapeutic intervention in Christian, Jewish, Muslim, Buddhist, and Hindu patients
  - 2. Determine whether adequate numbers of depressed persons with chronic illness can be identified, recruited, assessed and retained during the intervention
  - 3. Determine if delivering CBT by telephone, by instant messaging online via the Internet or by Skype, is the most accessible and acceptable way of treating depressed medical persons
  - 4. Give therapists experience with online, Skype, and telephone methods of delivering CBT.

- Phase II**
1. Determine if RCBT is more, similar, or less effective than CCBT in religious patients with disabling chronic illness
  2. Determine if RCBT is more, similar to, or less effective than CCBT in reducing anxiety and improving optimism, life satisfaction, daily spiritual experiences, social and physical functioning
  3. Determine if RCBT is more, similar to, or less effective than CCBT in:
    - (a) reducing cortisol, norepinephrine and epinephrine;
    - (b) reducing pro-inflammatory cytokines; and
    - (c) increasing anti-inflammatory cytokines (i.e., optimize balance of endocrine / immune functions affected by MD)

- Phase II (cont.)**
4. Determine if genetic polymorphisms that increase susceptibility to depression are more prevalent in deeply religious depressed subjects vs. those less religious (serotonin transporter-linked promoter region genotype SL/SS, the rs6295 5-HT1A receptor genotype CG/GG, MAOA-uVNTR promoter high-activity-allele carriers)
  5. Determine if RCBT is more effective than CCBT in the presence of one or more of these genetic polymorphisms, and whether treatment efficacy is moderated by the religiosity.

**Study Details**

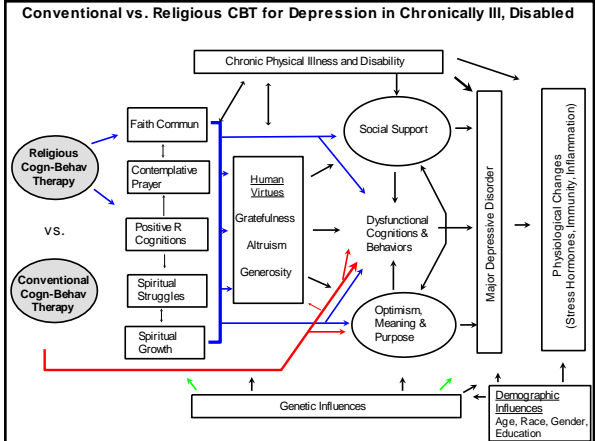
Randomize 50 eligible patients to either RCBT or CCBT (all patients receive proven treatments for depression)

Ten 50-min CBT therapy sessions delivered over 12 weeks

Religion-integrated therapy based on participants beliefs

There is no cost to patient, and patient receives compensation for assessments, and providing blood and urine samples

50% chance of being randomized to Conventional vs. Religious CBT



- Specifics of Two Interventions**
- Conventional CBT**
- Session 1. Discussion of the patient's experience of depression and current life situation, including family relationships, introduce CBT.
- Session 2. Focuses on behavioral activation, increasing pleasant events and mastery experiences. Intro secular mindfulness med.
- Session 3. Focuses on learning to identify moods, and to identify thoughts accompanying changes in mood. Continue to introduce mindfulness.
- Session 4. Focus on both cognitive and behavioral methods for evaluating thoughts; develop more realistic appraisals; begin mindfulness meditation practice.
- Session 5. Focus on using CBT methods for dealing with themes of loss associated with chronic illness & disability.

- Conventional CBT (cont.)**
- Session 6. Focuses on underlying assumptions, rules and core beliefs that give rise to negative thoughts & emotions, and on identifying alternative beliefs.
- Session 7. Focus on CBT methods for evaluating thoughts/emotions related to lack; switch to feeling thankful for good in life; expression of gratitude exercises.
- Session 8. Focus on CBT methods for behavioral exposure for worry/anxiety, other methods to counteract self-centeredness; encourage altruistic, generous behaviors.
- Session 9. Emphasize stress-related growth; focuses on guilt, shame, anger; utilizes CBT tech such as responsibility pie chart, others.
- Session 10. Review, termination, focuses on maintaining treatment gains, hope in future.

**Religious CBT**  
**Session 1.** Same as CCBT; assess religious beliefs, background; introduce RCBT rationale; introduce memory verse and focus on positive scriptures.  
**Session 2.** Same as CCBT; complete religious assessment, discuss role of faith and prayer. Intro Christian contemplative prayer.  
**Session 3.** Same as CCBT; place within a framework of Christian belief system; finalize socialization into RCBT; work with pt to identify memory verse.  
**Session 4.** Same as CCBT; challenging unhealthy thoughts; place within a Christian religious context; begin contemplation Christian practice  
**Session 5.** Same as CCBT; place within framework of Christian belief system; sacred loss, Biblical examples; spiritual self.

**Religious CBT (cont.)**  
**Session 6.** Same as CCBT; focus on dealing with spiritual struggles, negative religious beliefs involving anger, guilt, resentment toward God and others.  
**Session 7.** Same as CCBT; focus on taking things for granted; Biblical examples of grumbling; religious reasons for gratitude; expression of gratitude to God exercises.  
**Session 8.** Same as CCBT; focus on expressing religious gratitude by practicing altruism and generosity to counteract worry, anxiety; stress religious reasons for altruism.  
**Session 9.** Same as CCBT; focus on spiritual growth from Christ perspective; focus on positive outcomes thru series of exercises.  
**Session 10.** Same as CCBT; emphasizes spiritual reasons for & ways to maintain hope.

**How can social workers refer relevant clients to study?**

- Flyers are available
- Contact Dr. Koenig and learn about the study [Harold.Koenig@duke.edu](mailto:Harold.Koenig@duke.edu) or call 919-681-6633

**Further Reading**

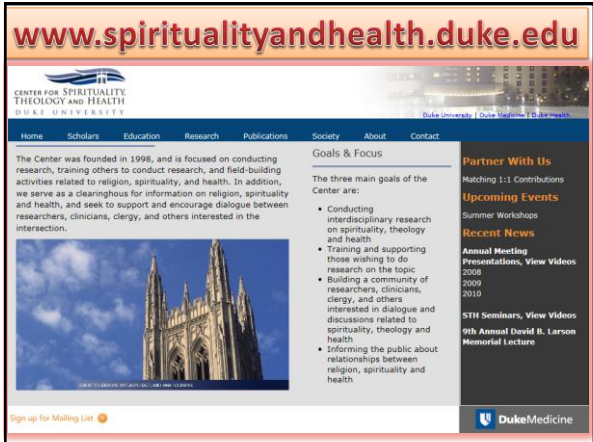
1. *Spirituality in Patient Care* (Templeton Press) (clinician)
2. *Healing Power of Faith* (Simon & Schuster, 2001) (patient)
3. *Medicine, Religion and Health* (Templeton Press, 2008) (patient/clinician)
4. *Spirituality and Health Research: Methodology, Measurement, Analyses, and Resources* (Templeton Press, 2011) (researcher)
5. *Handbook of Religion and Health* (Oxford University Press, 2001; and Second Edition, 2012) (clinician and researcher)

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- Strengths and weaknesses of measures of religion/spirituality
- Designing different types of research projects
- Primer on statistical analysis of religious/spiritual variables
- Carrying out and managing a research project
- Writing a grant to NIH or private foundations
- Where to obtain funding for research in this area
- Writing a research paper for publication; getting it published
- Presenting research to professional and public audiences; working with the media

**Partial scholarships are available for the financially destitute**

**If interested, contact Harold G. Koenig: [Harold.Koenig@duke.edu](mailto:Harold.Koenig@duke.edu)**

**Questions and Discussion**