Article

Psychotherapy with African American Women with Depression: Is it okay to Talk about Their Religious/Spiritual Beliefs?

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Abstract: A growing body of research focusing on African Americans' mental health is showing that this group relies heavily on their religious/spiritual beliefs and practices to cope with mental health issues including depression. Unfortunately, the psychotherapy literature provides little guidance on how to incorporate religion/spirituality into psychotherapy with African American women. With the growing cultural diversity of the U.S. population, there has been more emphasis on providing patient-centered culturally sensitive care, which involves providing care that is respectful of, and responsive to, individual patient preferences, needs, and values. This paper provides a synthesis of literature that psychotherapists could use to become more culturally sensitive and patient-centered in their clinical practices; that is, to recognize and integrate religion/spirituality into their work with African American women experiencing depression, and possibly other groups with similar needs.

Introduction

African American women's use of mental health services is lower than other groups, and when they do seek professional treatment many of them terminate treatment prematurely in part because their racial and or cultural needs have not been addressed [1–3]. Results of a study examining acceptability of depression treatment, suggested that compared to Whites, African Americans were less likely to find either antidepressant medication or counseling acceptable [4]. These research results then raise the question, how are African American women actually coping with depression?

There is a growing body of literature indicating that African American women rely on religious beliefs and practices to cope with health problems including depression. Chatters, Taylor, Jackson, and Lincoln [5] examined religious coping among African Americans, Caribbean Blacks, and non-Hispanic Whites when dealing with stressful situations, they found that African Americans (90.4%) and Caribbean Blacks (86.2%) reported higher use of religious coping compared to non-Hispanic Whites (66.7%). In another study, Dessio *et al.* [6] found that 43% of African American female participants used religion to cope with serious health problems including depression, cancer, and heart disease 'in the past year'.

African American women's low use of mental health services, high rates of premature termination from counseling, and high reliance on religious/spiritual coping to manage depression, raises two questions: (1) are African American women's low use of professional mental health services related to receiving conventional mental health services rather than psychotherapy incorporating religion/spirituality? and (2) do psychotherapists know when and how to incorporate religion/spirituality into psychotherapy in working with African American women with major depressive disorders (MDD)? Currently, these two questions are unanswered due to: (1) limited use of religion/spirituality in psychotherapy; (2) little or no training provided to psychologists and clinical social workers regarding use of religious/spiritual psychotherapy [7,8]; and (3) little published literature to help psychotherapists incorporate religion/spirituality into psychotherapy when working with African American clients [7].

Use of the Patient-Centered Culturally Sensitive Health Care Model (PC-CSHC) has the potential to address some of the issues discussed above. The PC-CSHC Model postulates: (a) training provided to both the patient/client and health care provider can promote provision of patient-centered culturally sensitive health care; (b) when patient-centered culturally sensitive health care is provided to patients/clients it influences patients/clients perceived levels of provider cultural sensitivity and interpersonal control (psychological empowerment), which in turn impact patient/client level of engagement in healthier behaviors, and satisfaction with health care; (c) patient/client satisfaction with health care in turn influences treatment adherence; (d) level of treatment adherence and level of engagement in healthier behaviors which directly influence patients health outcomes [9,10]. See Figure 1 for depiction of the PC-CSHC Model. The PC-CSHC Model was developed to help guide researchers and providers in promoting culturally sensitive health care practices and research, with the goal of providing high quality of care and reducing health disparities [10].
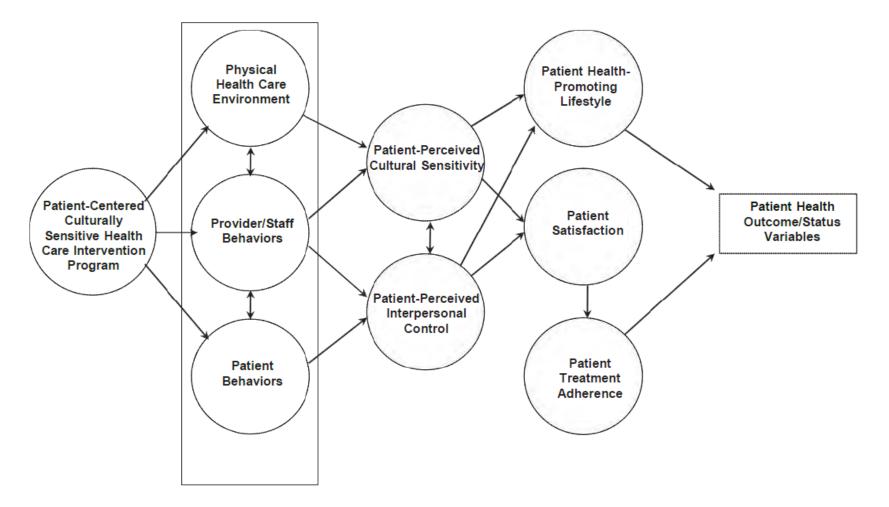
Figure 1. Patient-Centered Culturally Sensitive Health Care Model.

Given the importance of religion/spirituality for African American women with life stressors and mental health challenges; use of the PC-CSHC can potentially aid in providing patient-centered culturally sensitive care in a manner that recognizes these women's religious/spiritual beliefs and incorporates those beliefs into psychotherapy.

Using the tenets of PC-CSHC, the purpose of this paper is to provide a synthesis of literature that can be used to inform training of psychotherapists to become more patient-centered and culturally sensitive in their clinical practices. Such training can potentially help psychotherapists to recognize and integrate religion/spirituality into their work with African American women experiencing depression. A further aim is to use the synthesis of the literature to inform future research. To this end, we: (1) Examined current mental health literature with a focus African American women, depression, mental health service use and quality of care, use of religious/spiritual coping, and the role of Black churches. (2) Discussed implications for future research, training, and clinical practice with a focus on religion/spirituality among African American women.

For the purpose of this paper we will use the terms religious/spiritual, and religion/spirituality. Koenig, McCullough & Larson, [11] defines religion as an organized system of beliefs, practices, and rituals designed to facilitate closeness to God, and spirituality is defined as a personal quest for understanding answers to ultimate questions about life, meaning, and relationships to the sacred. A person can be religious and spiritual, religious but not spiritual, spiritual but not religious, or neither religious nor spiritual [12]. Although the terms religious and spiritual are distinct, they have overlapping meaning [13] and are often used interchangeably among African Americans. There is, however, debate among researchers about the definition of these constructs [7,14]. See Zinnbauer, Pragament, & Scott, 1999 [15] for more details about these debates.

To remain consistent with the PC-CSHC model we decided to focus our definitions of these constructs on the self-definitions common among African Americans. When examining self-definitions of religiosity and spirituality, Chatters found that Americans irrespective of race/ethnicity generally characterize themselves as both spiritual and religious [5,16]. Yet, similar research findings indicated African Americans were even more likely to identify as both spiritual and religious [16–18]. Since African Americans tend to identify as both religious and spiritual, and use these terms interchangeably in their identification, for the purpose of this paper, we chose to use the terms religious/spiritual, and religion/spirituality as defined by Koenig, McCullough & Larson, [11].

Synthesis of Relevant Literature

African American Women and Major Depressive Disorder

According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR), the guidelines used by mental health providers to diagnose mental illness, MDD symptoms cluster on five dimensions: emotional; behavioral; physiological; motivational; and cognitive [19]. Some of the specific symptoms associated with MDD include: depressed mood; feelings of sadness; hopelessness; worthlessness; helplessness; changes in sleep habits (increase or decrease); lack of motivation and energy; difficulty concentrating; recurrent thoughts of death; and in cases of severe MDD present and past suicide attempt(s).

MDD is increasingly becoming a national health crisis. According to the National Institute of Mental Health (NIMH), in any one-year period, MDD affects more than 12 million women (12%) and more than 6 million men (7%) in America. MDD is also the most common mental illness among all women, especially women of childbearing and childrearing ages [20]. Women affected with severe MDD are at increased risk of attempting suicide [21]. Equally concerning, by 2020 depression will be the second most common disorder afflicting the elderly [22]. MDD is also becoming a global concern. By the year 2030 depression will be one of the top three leading causes of death in the world [23].

Although the 12-month prevalence of MDD among African Americans and Caucasians are similar, 5.9% and 6.9% respectively, African Americans (56.5%) report more severe symptoms and associated disability than Caucasians (38.6%) [24]. Specific to women, the prevalence of depression is twice the rate for men [25]. Poverty has been identified a risk factor for the development of MDD [26], particularly among women. Poverty is such a powerful risk factor among women that McGrath *et al.*, [27] postulates that a woman experiencing poverty is on a "pathway to depression." Given that African American women are heavily burdened by poverty, child rearing responsibilities, and an increased likelihood of racial and gender discrimination, they are at high risk for MDD [28,29]. More specifically, due to the intersection of gender and poverty, low-income African American women are at particularly high risk for experiencing depression at some point in their lifetime [30]. Such that a national study conducted by the California Black Women's Health Project showed 60% of African-American women have symptoms of depression [31].

Mental Health Service Use and Quality of Care

The high prevalence of MDD among African American women does not translate to increased use of mental health services. Historically and currently, African American women tend to underutilize mental health services, relative to other groups [32,33]. A recent study with a sample of 3,570 (56% of the sample were female) showed that only 26.1% of African Americans with MDD used specialty mental health care within a 12-month period. Furthermore, only 28% of African Americans with severe MDD sought treatment within a 12-month period [24]. Health disparities research has shown that African Americans, including African American women's low use of mental health services is in part due low access to mental health services due to poverty resulting in lack of health insurance [34]. Low use of treatment services is also due in part to the quality of mental health care they receive [34]. For instance, although psychotherapy care is preferred among African Americans [4] research has shown they receive culturally insensitive psychotherapy care, resulting in high rates of premature termination from mental health services [35].

The issue of quality of care specifically culturally insensitive care or care that does not meet the cultural needs of clients is a concern among African American clients/patients [34]. In a study of 201 African Americans (134 women and 66 men), which examined participants perceptions of psychotherapy and psychotherapists, findings showed concerns about quality of care. For instance, a participant who had used mental health services in the past stated, "it doesn't seem like they're truly concerned about you, what you could possibly be going through. You know, it's just like "I'm about to get paid…. your hour is up" [35].

Poor quality of care is also evident in disparities in rates of diagnoses. Cheung and Snowden [36] reported that schizophrenia diagnosis rates among African Americans were sometimes twice as high as those for Whites, but that Whites were diagnosed with affective disorders (*i.e.*, depression) at nearly twice the rate of African Americans. This finding suggests that African Americans are more likely to be diagnosed with schizophrenia and less likely to be diagnosed with an affective disorder compared to Whites. It is possible these racial differences in psychiatric diagnoses may be due to diagnosticians' misunderstanding of ethnic/ racial differences in psychopathology [37,38].

There have also been reports of problems with communication. An analysis of patient-physician encounters indicates that physicians may be more likely to minimize emotional symptoms of African American than of Whites [39]. Also, relative to Whites, African Americans were more likely to rate their visits with White physicians as less participatory [37].

Missing from the quality of care research is use of religion/spirituality practices in psychotherapy. Is it possible that incorporating religion/spirituality in psychotherapy with African American will improve quality of care? Furthermore, is it possible that because African American women rely on religion/spirituality, incorporating religion/spirituality into psychotherapy might actually increase use of mental health services by this group? The section below will help to answer some of these questions.

African American Women and Use of Religious/Spiritual Coping with MDD

Research suggests religiosity and spirituality are integral to African American culture, identity, and coping [40–44]. "Many African Americans are raised with an internalized sense of connectedness to religious values, which provide a sense of purpose, power and self-identity" [42]. Prayer and religion have been cited as primary coping skills used by African Americans in dealing with personal problems: cancer; recovery from substance abuse; pregnancy or infant loss [41]; agoraphobia; bipolar disorder; and depression [44–48]. In comparison with Caucasians, African Americans regularly endorse more use of prayer and spiritual coping strategies [5,41,46,49].

Despite African American's heavy reliance on religious/spiritual coping, research examining religious/spiritual coping in association with MDD outcomes is limited. In addition most of the studies available have used small sample sizes, which were often not representative of African Americans, and were conducted in the 1990s. However, more recently, there has been an increase in research in this area. For the purpose of this paper, we chose to focus on studies using larger samples, and some of the more recently published literature examining religious/spiritual coping in association with MDD and other mental health outcomes.

Brown & Gary [50] examined whether degree of religiosity was related to levels of depression. The sample comprised of non-institutionalized African American adult men (N = 142) from a large northeastern U.S. city. The Center for Epidemiological Studies Depression Scale (CES-D) scale was used to measure levels of depression. The CES-D is a 20-item self-report inventory developed by National Institute of Mental Health to assess the frequency and severity of depression symptoms, with a possible range 0–60. A standard cutoff score of 16 indicates depressive symptoms. Differences in mean scores in the CES-D were examined across a measure of participation in personal, group, or institutional religious activities, ranked into three groups of high, medium, and low religiosity. A

protective trend was apparent in the findings, such that low, medium and high religiosity was associated with decreasing CES-D scores (12.78, 12.08, and 11.30, respectively). However, the sample was non-clinical, meaning they did not have clinical depression (CES-D score of 16 or higher), and results did not achieve statistical significance.

Brown and colleagues used data from a community survey of African American adults from a northeastern city (N = 451) to examine the relationship between several measures of religiosity and scores on the CES-D [50]. In this study, a 10-item summary index of religiosity was constructed from several items assessing institutional and non-group religious activities, as well as attitudes about religion. Analyses revealed a significant inverse association between religiosity and depressive symptoms. CES-D scores were lower in successively higher categories of religiosity for both men and women.

Another study of religion and depression by the same investigators was based on a sample of 537 African American adult men from an eastern U.S. city [51]. The researchers used the CES-D scores to assess depressive symptoms. Regression analysis results revealed significant protective effects for both religiosity and presence of denominational affiliation. After controlling for a variety of socio-demographic variables, denominational affiliation maintained a significant protective effect against depression.

A subsequent investigation by Brown and colleagues included a more explicitly clinical and epidemiological focus using data from a sample of African American men ($N = 865$) [52]. The past-year prevalence of depressive symptoms was assessed and found that the one-year prevalence rate of major depression among participants without a religious affiliation was 6.4%, the highest for any category of any exposure variable in the study except for poor health status (6.9%). However, after adjusting for the effects of various measures of socio-demographic and household characteristics, such as health, stress, and family history of mental illness, the odds ratio associated with lack of a religious affiliation was no longer statistically significant [52].

In a more recent study, in which data from the National Survey of American Life (NSAL) and the National Comorbidity Survey-Replication (MCS-R) were used to examine racial and ethnic differences in the use of complementary and alternative medicine (CAM) for the treatment of mental disorder and substance use disorders among African Americans, Black Caribbean and Whites. CAM "is a group of diverse medical and health care systems, practices, and products (*i.e.*, chiropractic, massage, acupuncture and megavitamins), that are not presently considered part of conventional medicine" (CAM Basics). Results indicated a higher proportion of Whites (39%) used CAM for mental disorders or substance use disorder compared to African Americans (24%) and Black Caribbeans (12%) [53]. Yet, consistent with current research, a higher proportion of African Americans (18%) reported using spiritual healing by consulting with their spiritual and religious leaders than either Black Caribbeans (13%) or Whites (9%) [53].This finding builds on other recent research using the NSAL which found that compared with Whites, African Americans are more religious and more likely to rely on religious coping for their mental health needs [5,54].

Although the research by Brown and colleagues make a significant contribution to the sparse literature in this area, most of the study samples were primarily African American men, thus limiting generalizability of study results to African American women. Similarly, although more recent literature documents African Americans tendency to rely on spirituality and religious coping to address

mental health needs, none of the studies examined effectiveness of psychotherapy incorporating religion/spirituality in reducing symptoms of MDD. Given that within the African American community, women, the elderly and those facing health problems are more likely to tap into religion/spirituality as a coping mechanism [33,55], efficacy research examining health outcomes associated with use of psychotherapy integrated with religion/spirituality are critically needed. Such research has the potential to increase delivery of culturally sensitive patient-centered care to African American women.

Cultural Competence and Psychotherapy

With the increasing focus on cultural competence in an effort to meet the needs of culturally diverse individuals, psychologists and researchers are challenged to integrate multicultural strategies into psychotherapy [56]. Psychologists are becoming more culturally competent in addressing the needs of culturally diverse clients, but incorporating the religious and spiritual worldviews of clients including African American clients is still lagging [57].

The slow pace in which religion and spirituality is emphasized in the psychotherapy literature is not surprising given the limited courses and training in religious/spirituality. For instance, Young *et al.* [58] found that only 23 of 94 counseling programs accredited by Council for Accreditation of Counseling and Related Educational Programs (CACREP) offer only one specific course on spirituality and religion in counseling. Furthermore, content analysis of syllabi for spirituality courses showed inclusion of religion/spirituality in the curriculum was addressed in limited detail [59].

In a similar helping professional field, social work, the limited training in religion/spirituality is also a concern for clinical social workers who provide psychotherapy [60]. More recently, Asher [61] postulated "Over the past two decades there has been expanding exploration of spirituality and religion in social work, although they remain largely on the periphery of the profession's educational enterprise and mainstream practice." Asher further stated "My social work education and training ignored the spiritual and religious dimensions of practice."

It is evident that while a growing body of research suggests use of religious/spiritual coping to deal with mental health issues including depression is quite common among African American women [6,33,57,62], psychotherapists are not receiving adequate training to recognize and integrate religion/spirituality into psychotherapy [59–61].

Role of the Black Church in Addressing Mental Health Issues

African Americans have reported significant levels of religious involvement in their churches [63]. Furthermore, throughout history, African American clergy and the African American church have been integral in providing social services and battling oppression of African Americans [64]. Given the role of African American clergy and the African American churches, researchers are beginning to recognize the African American church as a potential preventive resource for addressing health disparities by assisting in the dissemination of health information, and education within their communities [48].

Black Churches have been the longest standing and most influential institution in African American history [65–67]. From the early 1900s, there has been continuing research interest in the patterns, and

functions of religion/spirituality in the lives of African Americans [65,66]. The definition for the terms *Black church or African American church* is to refer to churches that collectively are predominantly African American Christian churches of any and all denominations that minister to African American communities in the United States [68,69]. Although some groups of African American churches, such as the African Methodist Episcopal churches belong to predominantly African American denominations [69], many African American churches may also be a part of predominantly White denominations (*i.e.*, Lutherans, older established Episcopalians, Protestants, *etc.*). The combined term, *The Black church*, likely came into reality sometime after emancipation because at that time African Americans were free to establish separate churches, to create their own communities, and to worship in their own culturally distinct ways [68,70]. Within the Black churches, African Americans were finally able to build strong community organizations and to hold positions of leadership that were previously denied to them in America [70].

Lincoln and Mamiya [69] argued that the role of the Black Church in the African American community are more socially active in their communities and tend to participate in a greater number of community programs than are Caucasian churches. This distinctiveness may be due to the fact that African American churches are more central organizations in their communities compared with Caucasian churches. It may also be that African American church members, as well as other ethnic groups confront higher levels of poverty and other socioeconomic and social issues, and are therefore more pressured to advocate and address these issues within their congregations [69]. For example, in a national study of African American clergy, Lincoln and Mamiya [71] found 92% of Black clergy endorsed involvement of Black churches in social and political issues, and indicated it was appropriate for them to express their views in support of these issues.

In contrast to African Americans relatively low use of the formal health system, research indicates that they report a relatively high use of clergy and Black church as a resource to solve or discuss many health problems, including mental illness [47,48] and psychical illnesses such as AIDS, heart disease, and cancer [6,72]. The tendency of African Americans to use clergy for health care services that might otherwise be provided by primary care or mental health care system may be related to receiving poor quality care [34]. They may also use the Black churches because historically Black churches have functioned as social service agencies in the Black communities.

Implications for Future Research and Clinical Practice

Research

Outcome studies examining the effectiveness of religious/spiritual psychotherapy interventions are still in their infancy [73]. In fact, few empirical studies of religious/spiritual interventions in psychotherapy have been conducted [74]. And to date, no research study could be located that has examined effectiveness or health outcomes associated with use of religious/spiritual psychotherapy among African American women with MDD. These gaps in the literature underscore the need for: (1) more effectiveness research, (2) research focusing on specific racial/ethnic and cultural groups, and (3) developing and testing of psychotherapy interventions incorporating religious/spiritual for specific groups. Such research can potentially inform treatment provided to these groups. Prior to conducting

this line of research, there is however, a need for more valid and reliable measures of religion/spirituality in general [75], and especially for African Americans.

Recognizing the prominent role of Black churches in the African American community, mental health researchers could explore opportunities for collaboration to develop and test effectiveness of religious/spiritual psychotherapy interventions. Giving voice to religious/spiritual African Americans in development of such interventions is critical in providing patient-centered culturally sensitive care. More specifically, studies examining African American women's needs for religious/spiritual integrated psychotherapy, and what such psychotherapy should entail is needed. Thus, studies using qualitative approaches and community based participatory design would be useful. There is also a need for studies using longitudinal design examining changes and fluctuations in religious/spiritual coping over time and implication for adjustment and mental health treatment [74]. Use of longitudinal designed studies can also provide insight about long term effects of religious/spiritual intervention over time.

Researchers and academicians might also explore working with Black churches to develop training programs for psychology and social work students interested in receiving training to work with religious/spiritual clients, as well as continuing education training for licensed psychologists and clinical social workers. Also needed are clear practice guidelines regarding incorporation and use of religious/spiritual interventions in psychotherapy. Researchers can collaborate with clergy from various faiths and denominations to inform development training programs and practice guidelines.

Clinical Practice

According to the competencies developed by Burke [76] and colleagues at the 1995 Summit on Spirituality, to be competent in integrating and using religion/spirituality in psychotherapy, psychotherapists could be able to incorporate the following in their patient practice:

1. "Explain the relationship between religion and spirituality, including similarities and differences;"
2. "Describe religious and spiritual beliefs and practices in a cultural context;"
3. "Engage in self-exploration of his/her religious and spiritual beliefs in order to increase sensitivity, understanding and acceptance of his/her belief system;"
4. "Describe one's religious and/or spiritual belief system and explain various models of religious/spiritual development across the lifespan;"
5. "Demonstrate sensitivity to and acceptance of a variety of religious and/or spiritual expressions in the client's communication;"
6. "Identify the limits of one's understanding of a client's religious/spiritual expression, and demonstrate appropriate referral skills and general possible referral sources;"
7. "Assess the relevance of the spiritual domains in the client's therapeutic issues;"
8. "Be sensitive to and respectful of the spiritual themes in the counseling process as befits each client's expressed preference;" and
9. "Use a client's spiritual beliefs in the pursuit of the client's therapeutic goals as befits the clients expressed preference" [59,76].

Below is a more detailed description and discussion of some of the above-mentioned competencies, and some additional approaches generated from our review of current literature and the Patient-Centered Culturally Sensitive Health Care Model.

Understanding Conceptualizations of Religion and Spirituality

According to Burke's [76] first competency, he describes the importance of "Explaining the relationship between religion and spirituality, including similarities and differences;" While Burke's competency is important, results noted in this review triggered another essential aspect to add to Burke's competency. Given that this review describes the ways in which religious, spiritual or both religious and spiritual may be an important aspect of how individuals self-define their worldview within particular groups—mainly African American women, it is critical to reiterate the need for psychotherapists to allow clients to self-define. It then becomes the role of the psychotherapist to understand the client's self-definition (*perhaps a client may say, I am both religious and spiritual*) to discover the role of religion/spirituality in the lives of their clients.

Self-awareness

Prior to working with religious/spiritual clients, psychotherapists should become more self-aware of their own religious/spiritual beliefs and practices as well as their concerns and skepticism about religion and spirituality. According to Post [7], "awareness of one's own beliefs and biases regarding religion/spirituality will help therapists avoid imposing their own values on their clients." Use of a spiritual autobiography is one method to explore and examine one's own religious and spiritual views and values, as well as experiences, situations, and education that have led to their religious and spiritual beliefs and practices or doubts, skepticism and biases [77]. During this self-awareness process and in the process of providing psychotherapy, psychotherapists need to recognize and own their limitations. When limitations are identified, clients can be informed and referrals provided, or the psychotherapist can seek consultation from relevant clergy and religious/spiritual leaders.

Although it is helpful for psychotherapists to be somewhat knowledgeable about basic doctrines of their clients' religion/spirituality, they do not have to be experts. However, they could be open [7] to differing doctrines. Recent research indicates that when clients felt their therapist were open to discussing and respectful of their religious/spiritual beliefs it helped to strengthen the therapeutic alliance [78]. In sum, clinicians should be mindful of their own beliefs, and biases regarding religion and spirituality. When necessary seek consultation, supervision and facilitate referrals.

Client Assessment

During the initial clinical intake assessment, a scale/questionnaire capturing clients' religious/spiritual beliefs and practices could be included in the clinical assessment. Although few of the measures of religion and spiritual have been evaluated for validity and reliability [74], the RCOPE and Brief RCOPE are valid and reliable measures of religious coping [73,79]. The RCOPE is a comprehensive assessment of religious coping that can be used by researchers and practitioners to measure religious coping with major life stressors [73]. The Brief RCOPE is a shorter version of the

RCOPE, with 14 items assessing religious coping with major life stressors. The Brief RCOPE is the most commonly used measure of religious coping [79].

In cases where clients' self-identify in the intake that they are religious/spiritual, as early as possible psychotherapists need to let clients know that they are open to discussing religion/spirituality. In particular, they should explicitly state, possibly in the first session, that they are open to and welcome a discussion of religion/spirituality if clients are interested. In addition, psychotherapists can further assess/inquire about clients' religious/spiritual beliefs, and preferences and expectations for treatment.

Some clients may come to therapy with religious/spiritual concerns/struggles; in such cases therapists should assess clients concerns by first conducting a religious/spiritual history and present religious/spiritual status in a manner similar to conducting a psychosocial history [80]. With such data the psychotherapist and client can collaboratively work on establishing an appropriate plan of care [7]. It is strongly suggested to have clients provide informed consent to receive religious/spiritual interventions, so that clients are informed and receive their preferred choice of care.

Do Not Make Assumptions

Engaging clients in developing an appropriate treatment plan of care is important because not all religious/spiritual clients may want their psychotherapy to focus on their religious/spiritual needs. In some cases, religious/spiritual clients may prefer to have religious/spirituality issues addressed by their religious/spiritual leader [7].

Types of Religious/Spiritual Interventions

Religious/spiritual interventions involve the use of techniques from formal religious traditions, which are used as adjuncts to counseling or traditional theories of counseling and are adapted to the needs and preference of religious/spiritual clients [12]. Although there are varying views regarding defining religious/spiritual interventions, there are at least three common views [7,81]. For instance, one view defines religious/spiritual interventions as any secular techniques or approaches used to strengthen the faith of a religious/spiritual client. The second view involves use of secular techniques modified to include religious content in an explicit manner (e.g., Christian cognitive therapy). The third view focuses on use of actions or behaviors derived from religious practices such as blessings, reference to sacred text including the Bible, scripture reading, and audible prayer [7,81].

Religious and spiritual interventions that can be incorporated into psychotherapy when working with clients include: therapist prayer or client and therapist prayer, teaching scriptural concepts, reference to Scriptures, religious or spiritual self-disclosure, spiritual confrontation, spiritual assessment, religious relaxation or imagery, blessing by the therapist, encouraging forgiveness, use of religious or faith community, client prayer, encouragement of confession, referral for blessing, religious journaling, spiritual meditation or relaxation, religious bibliotherapy, scripture memorization and dream interpretation [14].

It is important to note that outcomes studies on the effectiveness of these interventions are still in an infancy stage [14–73], and few empirical studies of religious/spiritual interventions in psychotherapy have been conducted [74]. However, based on clients' needs and preferences, psychotherapists with appropriate training, supervision, and consultation can use these interventions.

Partnership with Clergy

Psychotherapists could also establish partnerships with clergy and religious/spiritual leaders in an effort to seek consultation when necessary [82]. Such partnerships are critical in ensuring that psychotherapists are not inadvertently counseling outside their scope of practice or crossing "turf." Psychotherapists can also work with religious/spiritual leaders to educate them and the larger African American community about mental health, mental illness and treatment options. Such collaborations have the potential to reduce stigma associated with mental illness in the African American community and increase treatment-seeking behaviors.

Conclusions

In this paper, we provided a synthesis of literature and discussed implications for research and clinical practice that can aid psychotherapists in developing the skills necessary in providing patient-centered culturally sensitive care to African American women. Based on our review of the literature, we found a growing body of research suggests African American women rely heavily on religious/spiritual beliefs and practices to cope with mental health issues including depression. However, outcome studies examining the effectiveness of religious/spiritual psychotherapy interventions are still in an infancy stage [73]. In fact, few empirical studies of religious/spiritual interventions in psychotherapy have been conducted [59,74]. And to date, no research study could be located that has examined effectiveness or health outcomes associated with use of religious/spiritual psychotherapy among African American women with major depressive disorder. In addition, there are no clear practice guidelines regarding incorporation and use of religious/spiritual interventions in psychotherapy [59,74]. Furthermore, there is virtually no training for psychotherapists who are interested in learning procedures to incorporate religion/spirituality in psychotherapy when working with African American women. Given that current research indicated African American women are using religious/spiritual beliefs and practices to cope with depression, it is imperative that psychotherapists are able to work effectively with this group. In sum, research focusing on developing interventions examining health outcomes associated with incorporating religion/spirituality in psychotherapy is critically needed. Also needed are treatment guidelines focusing on incorporating religion/spirituality in psychotherapy, and establishing competencies for effective clinical practice. And, most importantly, training must be provided to psychotherapists interested in incorporating religion/spirituality into their clinical practice.

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