

Review articles (systematic or scoping)

Cognitive-Behavioral Therapy with Religious/ Spiritual Influence: A Systematic Review

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Abstract

There is an increase in studies on Cognitive-Behavioral Therapy integrated with religiosity/spirituality. The objectives of this research are to present a systematic review of the literature on the impact of Religious/Spiritual Cognitive-Behavioral Therapy on mental health; whether it presents good results and whether these are superior to conventional Cognitive-Behavioral Therapy; and to verify the scientific quality of these studies. Multiple databases were consulted. Thirty studies were included in this research, which randomized or non-randomized clinical trials, semi-experimental clinical trials and single-group clinical trials. These studies addressed depression, anxiety, obsessive-compulsive disorder, stress, quality of life, and increased positive Religious/Spiritual Coping and decreased negative Religious/Spiritual Coping. The vast majority of the included studies demonstrated improvement in the participants' symptoms, although methodological flaws were found in a considerable number of these studies, highlighted by the use of the Grades of Recommendation, Assessment, Development, and Evaluation system. There are studies that demonstrated equivalent results between conventional Cognitive-Behavioral Therapy and Religious/Spiritual Cognitive-Behavioral Therapy, so that the former cannot be stated as superior to the latter, although Religious/Spiritual Cognitive-Behavioral Therapy may be attractive to populations that demonstrate greater resistance to seeking psychotherapy, and approaching the patient through their Religiosity/Spirituality may lead to content that would not be presented in psychotherapy, once the patient wishes for this demand to be worked on, it is pertinent that the professional is available to develop the work.

Keywords: psychology, cognitive behavioral therapy, mental health, religion, spirituality

TERAPIA COGNITIVO-COMPORTAMENTAL COM INFLUÊNCIA RELIGIOSA/ESPIRITUAL: UMA REVISÃO SISTEMÁTICA

TCC com Influência Religiosa/Espiritual

Resumo

Há um aumento de estudos da Terapia Cognitivo-Comportamental integrada com religiosidade/espiritualidade. Os objetivos desta pesquisa são apresentar revisão sistemática da literatura sobre o impacto da Terapia Cognitivo-Comportamental Religiosa/Espiritual sobre a saúde mental; se apresenta bons resultados e se estes são superiores à Terapia Cognitivo-Comportamental convencional; e verificar a qualidade científica desses estudos. Foram consultadas múltiplas bases de dados. Trinta estudos foram incluídos nesta pesquisa, sendo ensaios clínicos randomizados ou não randomizados, ensaios clínicos semiexperimentais e ensaios clínicos de grupo único. Estes estudos trabalharam com depressão, ansiedade, transtorno obsessivo-compulsivo, estresse, qualidade de vida, aumento do Coping Religioso/Espiritual positivo e diminuição no Coping Religioso/Espiritual negativo. A grande maioria dos estudos incluídos demonstra melhora nos sintomas dos participantes, embora tenham sido encontradas falhas metodológicas em quantidade considerável destes estudos, assinaladas a partir do uso do sistema Grades of Recommendation, Assessment, Development, and Evaluation. Há estudos que demonstraram resultados equivalentes entre a Terapia Cognitivo-Comportamental convencional e a Terapia Cognitivo-Comportamental Religiosa/Espiritual, de modo que não se pode afirmar a superioridade daquela em relação a esta, embora a Terapia Cognitivo-Comportamental Religiosa/Espiritual possa ser atrativa para populações que demonstrem maior resistência a procurar psicoterapia, e abordar o paciente por meio de sua Religiosidade/Espiritualidade pode levar a conteúdos que não seriam apresentados em psicoterapia, uma vez que o paciente deseje que esta demanda seja trabalhada, é pertinente que o profissional esteja disponível para desenvolver o trabalho.

Palavras-chave: psicologia, terapia cognitivo-comportamental, saúde mental, religião, espiritualidade

TERAPIA COGNITIVO-CONDUCTUAL CON INFLUENCIA RELIGIOSA/ESPIRITUAL: UNA REVISIÓN SISTEMÁTICA

TCC con influencia religiosa/espiritual

Resumen

Hay un aumento en los estudios de Terapia Cognitivo-Conductual integrada con religiosidad/espiritualidad. Los objetivos de esta investigación son presentar una revisión sistemática de la literatura sobre el impacto

de la Terapia Cognitivo-Conductual Religiosa/Espiritual en la salud mental; si presenta buenos resultados y si estos son superiores a la Terapia Cognitivo-Conductual convencional; y verificar la calidad científica de estos estudios. Se consultaron múltiples bases de datos. Treinta estudios fueron incluidos en esta investigación, siendo ensayos clínicos aleatorios o no aleatorios, ensayos clínicos semiexperimentales y ensayos clínicos de un solo grupo. Estos estudios abordaron la depresión, la ansiedad, el trastorno obsesivo-compulsivo, el estrés, la calidad de vida y el aumento del afrontamiento religioso/espiritual positivo y la disminución del afrontamiento religioso/espiritual negativo. La gran mayoría de los estudios incluidos demuestran una mejoría en los síntomas de los participantes, aunque se encontraron fallas metodológicas en un número considerable de estos estudios, resaltados utilizando el sistema de Grados de Recomendación, Valoración, Desarrollo y Evaluación. Existen estudios que han demostrado resultados equivalentes entre la Terapia Cognitivo-Conductual convencional y la Terapia Cognitivo-Conductual Religiosa/Espiritual, por lo que no se puede afirmar la superioridad de la primera sobre la segunda, si bien el Terapia Cognitivo-Conductual Religiosa/Espiritual puede ser atractivo para poblaciones que muestran mayor resistencia a buscar psicoterapia, y abordar al paciente a través de su Religiosidad/Espiritualidad puede llevar a contenidos que no se presentan en psicoterapia, una vez que el paciente desea que se trabaje esa demanda es pertinente que el profesional esté disponible para desarrollar el trabajo.

Palabras clave: psicología, terapia cognitivo-conductual, salud mental, religión, espiritualidad

This study explored the terms religion, religiosity, and spirituality. To facilitate their differentiation, the following definitions are provided. Religion is understood as a set of associations belonging to an institution, generally following a tradition, and encompassing a transcendent reality (Koenig, 2012). This often encourages followers of the religion to perform different practices, whether in the form of rituals or in actions considered beneficial to themselves and others (Pargament, 2012; Argyle & Beit-Hallahmi, 1975 as cited in Pargament, 1997; Zangari & Machado, 2018). Religiosity, according to Moreira-Almeida, Lotufo Neto, and Koenig (2006), can be understood as the influence that religious implications have on a person's decisions and lifestyle, which involves, for example, attendance at religious meetings, prayer, meditation, reading religious texts, and subjective religiosity (which can be understood as the importance that religion has in someone's life). Thus, it can be inferred that religiosity refers to the lived experience and that it may contain elements of a given religion.

One definition of spirituality is that of Puchalski et al. (2009), which conceives it as the way people seek and express meaning and purpose. It also refers to the way they experience their connection with the moment, with themselves, with others, with nature, and/or the sacred. According to Pargament et al. (2013), spirituality refers to the search for the sacred, understanding sacred as synonymous with sanctified, holy, or consecrated (Rosmarin, 2018). This work will present articles that use these terms as complementary practices.

There has been an increase in studies on Religiosity/Spirituality (R/S) in the health field and in Psychology (Lucchetti et al., 2021; Pargament, 2023), and Cognitive Behavioral Therapy (CBT) has followed this movement in recent decades (Propst et al., 1992; Costa & Moreira-Almeida (2021).

For example, Lucchetti et al. (2021), through a narrative review, pointed out that higher levels of R/S are generally associated with lower levels of depression, suicide and substance use disorder. McCrae (1984) stated that people seek religion not only when faced with situations of suffering, but also in their daily lives, through music, prayers, contemplation of the beauty of nature and silent reflections. The study by Rosmarin and Koenig (2020) also showed that religion can offer comfort, support and hope in situations of distress, through cognitive, emotional and behavioral mechanisms.

In his book "Spiritually Integrated Psychotherapy: Understanding and Addressing the Sacred", Pargament (2011) presented an account of the treatment of a depressed patient who wondered when her suffering would end, and the author identified a spiritual tone in this, since she had revealed to him that she attended a religious service. When asked if she would like to address these issues in her treatment, the patient responded affirmatively and then several R/S issues were addressed. Pargament (2011) identified improvements in the patient, such as greater awareness of her capabilities and a greater sense of hope for the future.

From this, the author pointed out that addressing R/S issues in the psychotherapy process, when the patient wishes, can lead to impacts on other aspects of life, including alleviating symptoms related to mental disorders. Thus, many other people could respond that

they would also like to have this topic addressed in their treatments, since R/S is related to several aspects of their lives (Pargament, 2011; Pargament, 2023). As mentioned previously, one of the approaches in Psychology that has accompanied this movement towards the inclusion of R/S is CBT. In fact, when R/S elements are included in CBT, the terminology Religious CBT (RCBT) or Religious Cognitive Therapy (RCT) is used. This approach is given this name in several studies present in this research (Akuchekian et al., 2011; Alagheband et al., 2019; Aouchehian et al., 2017; Hosseini et al., 2017; Hosseini et al., 2018; Koenig et al., 2015; Pearce & Koenig, 2016; Propst et al., 1992; Tulbure et al., 2018).

Koenig et al. (2015) presented CBT that integrates religious/spiritual elements in the treatment of people with depression and chronic medical illnesses, through the reading of sacred scriptures, reflection on the teachings of each religion of the study participants and by encouraging prayers. Therefore, in this work, RCBT will be understood as the CBT approach that integrated elements of this nature.

Therefore, considering the importance of the theme of religiosity/spirituality and the growing number of studies on RCBT, this research aimed to: present a systematic review of the literature on the impact of RCBT on mental health; verify whether this impact is positive and whether it is superior to the impacts generated by conventional CBT; and verify whether the studies on RCBT have scientific quality.

Method

This study is a systematic literature review. It follows the PRISMA recommendation, an acronym for Preferred Reporting Items for Systematic Reviews and Meta-Analyses (Page et al., 2021). The search and selection of articles were carried out independently by two researchers, who then conducted a double check.

This research is registered with code CRD42021223765, on the *International Prospective Register of Systematic Reviews* (PROSPERO) platform.

The PICOT procedure (Abreu et al., 2023) was used to locate the studies. P: stands for population; I: intervention; C: comparator; O: outcomes; and T: study types. The following parameters were used: population: patients with any health need; intervention: CBT and Cognitive Therapy that used religious/spiritual elements; comparator: other psychotherapeutic treatments or who did not receive psychotherapeutic treatment; outcomes: statement of improvement or worsening of symptoms or syndromes; type of study: randomized or non-randomized clinical trials, cohort studies, case-control studies, cross-sectional studies, and descriptive studies. The search for scientific articles was carried out in 2021, without restrictions on language or publication date, in the following electronic databases: Latin American and Caribbean Literature in Health Sciences (LILACS), PsycInfo, Electronic Psychology Journals (PePSIC), Scientific Electronic Library Online (SciELO), Scopus, Web of Science (WOS), World Health Organization Information System (WHOLIS), Medical Literature Analysis and Retrieval System Online (Pubmed/Medline), and Cochrane. The descriptors used for the bibliographic search were: religiosity,

religiousness, spirituality, spiritual, religious, and religion, in the field of spirituality; “religious coping” and “spiritual coping,” in the field of religious/spiritual coping; and “cognitive behavioral therapy,” “cognitive behavioural therapy,” “cognitive therapy,” and “behavioral cognitive therapy,” in the field of CBT.

A process of article selection was carried out based on the criteria described in the research question. From this, the outcomes of the resulting articles were counted, and the seven most researched syndromes or clinical characteristics were selected: depression, anxiety, Obsessive-Compulsive Disorder (OCD), stress, quality of life, positive and negative Religious Spiritual Coping (RSC). Improvement was defined based on what was stated by the authors of the study, that is, a study was considered to have shown improvement for each of these outcomes when this fact was stated and presented by its authors. Finally, to assess the quality of the studies, the GRADE (Grades of Recommendation, Assessment, Development, and Evaluation) system was followed, which assesses the quality of evidence and classifies the strength of recommendations of systematic reviews. GRADE proposes assessing risk of bias, inconsistency, indirect evidence, and imprecision (Guyatt et al., 2011). Since no meta-analysis was performed, the aspect of imprecision was not assessed for any of the outcomes. To assess the risk of bias, the following categories were considered: random sequence generation, allocation concealment, blinding of participants and personnel, blinding of outcome assessment, incomplete outcome data, selective reporting, and other sources of bias. To assess inconsistency, the populations, sample size calculation, proportion of male and female subjects (greater than 60%), and comparators were analyzed. And to assess indirect evidence, the following categories were considered: population, intervention, comparator, direct comparison, and outcome.

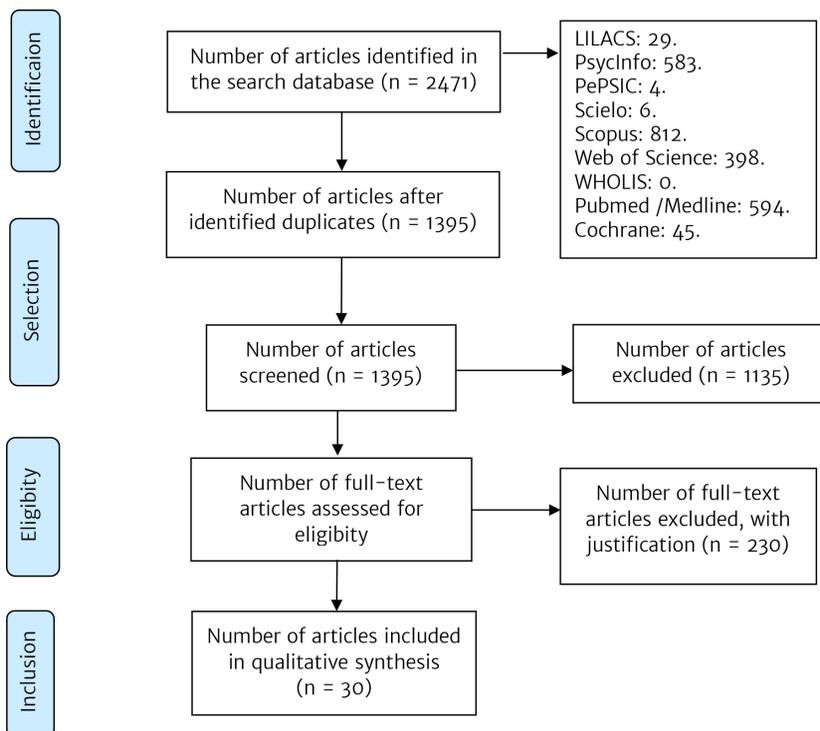
Results

The following numbers of studies were obtained in each of the databases: 29 in Lilacs, 583 in PsycInfo, 4 in PePSIC, 6 in Scielo, 812 in Scopus, 398 in Web of Science, 0 in WHOLIS, 594 in Pubmed and 45 in Cochrane — totaling 2471 articles. After eliminating duplicates, a total of 1395 studies were obtained, which were screened by title and abstract, verifying the inclusion and exclusion criteria. The texts of 260 articles were selected and read in full, and of these, 230 were excluded. Thus, 30 articles were included in this research.

Below there is a chart of the process carried out to include the studies that make up this research.

Figure 1

Flowchart of the inclusion of studies in this research.



The results were then grouped by type of study (randomized clinical trials and non-randomized, single-group and semi-experimental clinical trials) and by syndrome or clinical characteristic. The assessment of the GRADE categories was also described, namely: risk of bias, inconsistency and indirect evidence. In the appendices, there are data extracted from each study.

Studies on Depression

Fifteen randomized clinical trials were selected. In eight studies (Ebrahimi et al., 2013; Hosseini et al., 2017; Hosseini et al., 2018; Johnson & Ridley, 1992; Koenig et al., 2015; Pearce & Koenig, 2016; Pecheur & Edwards, 1984; Rosmarin et al., 2010), no significant differences were noted in the results obtained by RCBT and the comparator. In seven studies (Alagheband et al., 2019; Armento et al., 2012; Aslami et al., 2017; Cajanding, 2016; Ford & Garzon, 2017; Propst, 1980; Propst et al., 1992), the results obtained by RCBT were superior to the results of the comparator. It is noteworthy that in all studies there was an indication of improvement in depressive symptoms after the application of RCBT.

Three non-randomized clinical trials (Hawkins et al., 1999; Mathieson et al., 2012; and Tulbure et al., 2018) and one semi-experimental study (Rosmarin et al., 2019) were also selected. In one of the studies (Tulbure et al., 2018), RCBT obtained results similar to those of the comparator. In the study by Hawkins et al. (1999) RCBT obtained results that were somewhat superior to those of the comparator. And, in two studies (Mathieson et al., 2012; Rosmarin et al., 2019), RCBT had positive results, but was not compared with any intervention.

Studies on Anxiety

Five randomized clinical trials were selected. In one of them (Ford & Garzon, 2017), no significant differences were observed in the results obtained by RCBT and the comparator. In four studies (Alagheband et al., 2019; Armento et al., 2012; Aslami et al., 2017; Rosmarin et al., 2010), the results obtained by RCBT were superior to those of the comparator. It is noteworthy that in all studies, there was an indication of improvement in anxiety symptoms after the application of RCBT.

A single-group study (Pityaratstian et al., 2007), three non-randomized clinical studies (Mathieson et al., 2012; Tulbure et al., 2018; Wang et al., 2016) and two semi-experimental studies (Hamid, 2020; Rosmarin et al., 2019) were also selected. In Tulbure et al. (2018), the results obtained by RCBT were similar to the results of the comparator. In two studies (Hamid, 2020; Wang et al., 2016), the results obtained by RCBT were, in some way, superior to those of the comparator. In three studies (Mathieson et al., 2012; Pityaratstian et al., 2007; Rosmarin et al., 2019), RCBT had positive results, but was not compared with any other intervention or control group.

Studies on OCD

Two randomized clinical trials were selected (Akuchekian, Almasi et al., 2011 and Akuchekian, Jamshidian et al., 2011). In both, RCBT showed results with some improvement in relation to the comparator results.

A single-group study was also selected (Aouchekian et al., 2017). In it, the results obtained by RCBT were positive, but they were not compared to any other type of intervention or control group.

Studies on Stress

Four randomized clinical trials were selected (Ford & Garzon, 2017; Knabb & Vasquez, 2018; Rosmarin et al., 2010; Trammel, 2018). In all of them, RCBT showed results with some improvement in relation to the results of the comparator.

A non-randomized clinical study was also selected (Wang et al., 2016). Here, RCBT obtained superior results to the results obtained by the comparator.

Studies on Quality of Life

Two randomized clinical trials were selected (Armento et al., 2012; Cajanding, 2016). In both, RCBT showed results with some improvement in relation to the comparator results.

Two semi-experimental clinical studies (Hamid, 2020; Ravaei et al., 2013) and one non-randomized clinical study (Tulbure et al., 2018) were also selected. In Tulbure et al. (2018), RCBT obtained results similar to those obtained by the comparator. In the research by Hamid (2020), RCBT obtained results that were somewhat superior to those of the comparator. And, in the study by Ravaei et al. (2013), RCBT obtained positive results, but was not compared to any other intervention or control group.

Studies on Positive Spiritual Religious Coping

Four randomized clinical trials were selected. One of them (Rosmarin et al., 2010) showed that the results obtained by RCBT and the comparator were equal. Three studies (Armento et al., 2012; Johnson & Ridley, 1992; Luskin et al., 2005) showed that RCBT obtained superior results to the comparator.

A non-randomized clinical study was also selected (Hawkins et al., 1999) in which RCBT obtained results that were somewhat superior to the results obtained by the comparator. In the single-group study chosen (Subica & Yamada, 2018), RCBT obtained positive results for the outcome in question, although it was not compared with another intervention or control group.

Studies on Negative Spiritual Religious Coping

Two randomized clinical trials were selected, and in one of them (Pearce & Koenig, 2016) RCBT obtained similar results in relation to the comparator. And, in the other study (Rosmarin et al., 2010), RCBT obtained results that were somewhat superior to the comparator.

A non-randomized clinical study was also analyzed (Wang et al., 2016), in which RCBT obtained results that were somewhat superior to the results obtained by the comparator.

Systematization of GRADE assessments

For randomized clinical trials, the systematization of GRADE assessments is described in Table 1. For other types of studies, the systematization of GRADE assessments is described in Table 2.

Table 1*Systematization of GRADE assessments for randomized clinical trials*

Outcome	Risk of bias	Inconsistencies	Indirect evidence
Depression	Serious (9/15 studies with serious risk of bias)	Serious (different populations, lack of sample size calculations, imbalance in the number of men/women, different comparators)	No indirect evidence (sufficiently direct evidence on population, intervention and outcome)
Anxiety	Serious (4/5 studies with serious risk of bias)	Serious (different populations, lack of sample size calculations, imbalance in the number of men/women, different comparators)	No indirect evidence (sufficiently direct evidence on population, intervention and outcome)
OCD	Serious (2/2 studies with serious risk of bias)	Serious (different populations, lack of sample size calculations, imbalance in the number of men/women, unspecified comparators)	No indirect evidence (sufficiently direct evidence on population, intervention and outcome)
Stress	Not serious (2/4 studies with serious risk of bias)	Serious (different populations, lack of sample size calculations, imbalance in the number of men/women, different comparators)	No indirect evidence (sufficiently direct evidence on population, intervention and outcome)
Quality of life	Not serious (1/2 study with serious risk of bias)	Serious (different populations, lack of sample size calculations, imbalance in the number of men/women, different comparators)	No indirect evidence (sufficiently direct evidence on population, intervention and outcome)
Positive RSC	Serious (2/3 studies with serious risk of bias)	Serious (imbalance in the number of men/women, lack of specification of the scales applied)	No indirect evidence (sufficiently direct evidence on population, intervention and outcome)
Negative RSC	Not serious (0/2 studies with serious risk of bias)	Serious (different populations, lack of sample size calculations, imbalance in the number of men/women, different comparators)	No indirect evidence (sufficiently direct evidence on population, intervention and outcome)

Table 2

Systematization of GRADE assessments for non-randomized clinical trials, semi-experimental clinical trials, and single-group studies

Outcome	Risk of bias	Inconsistencies	Indirect evidence
Depression	Serious (4/4 studies with serious risk of bias)	Serious (different populations, lack of sample size calculations, imbalance in the number of men/women, different comparators)	No indirect evidence (sufficiently direct evidence on population and intervention)
Anxiety	Serious (6/6 studies with serious risk of bias)	Serious (different populations, lack of sample size calculations, imbalance in the number of men/women, different comparators)	No indirect evidence (sufficiently direct evidence on population, intervention and outcome)
OCD	Serious (1/1 study with serious risk of bias)	Serious (imbalance in the number of men/women, lack of control group)	No indirect evidence (sufficiently direct evidence on population, intervention and outcome)
Stress	Serious (1/1 study with serious risk of bias)	Serious (lack of sample size calculation, imbalance in the number of men/women, lack of specification of the control group)	No indirect evidence (sufficiently direct evidence on population, intervention and outcome)
Quality of life	Serious (3/3 studies with serious risk of bias)	Serious (lack of sample size calculations, imbalance in the number of men/women, different comparators)	No indirect evidence (sufficiently direct evidence on population, intervention and outcome)
Positive RSC	Serious (2/2 studies with serious risk of bias)	Serious (lack of sample size calculations, imbalance in the number of men/women, different comparators)	No indirect evidence (sufficiently direct evidence on population, intervention and outcome)
Negative RSC	Serious (1/1 study with serious risk of bias)	Serious (lack of sample size calculation, imbalance in the number of men/women, lack of specification of the control group)	No indirect evidence (sufficiently direct evidence on population, intervention and outcome)

Discussion

The impact of Religious Cognitive Behavioral Therapy on mental health

Based on the evaluation of the studies included in this research, it can be considered that RCBT had a significant impact on the mental health of participants, since the vast majority of articles present this type of therapy as having contributed positively to reducing symptoms of depression, anxiety, OCD, stress, increasing quality of life and positive RSC, and reducing negative RSC, although methodological flaws were identified in most of these studies.

Since there is research showing that RCBT is as effective as conventional CBT, it could be inferred that the use of the latter would be sufficient to treat the various health demands. However, it is worth noting that there are studies that point to RCBT as an effective alternative in the treatment of patients who consider themselves religious, since the presence of R/S elements in the treatments can be perceived as familiar to the patients.

It is worth noting that R/S is presented in different ways in the studies; whether through interventions carried out by researchers — which include, for example, the use of CBT techniques

to access, explore and intervene in the field of religiosity/spirituality of subjects — or through the verbal expressions of the research participants themselves. Below, the systematization of the different presentations of RSC in the studies included in this article will be presented.

Integration of Cognitive–Behavioral Therapy with Religiosity/Spirituality

Looking at these studies as a whole, it is difficult to understand what exactly integration with religiosity/spirituality is, given the variety of resources and techniques used.

Some used psychoeducation and integrated religious practices into it (Alagheband et al., 2019; Propst et al., 1992; Pearce & Koenig, 2016; Rosmarin et al., 2019; Tulbure et al., 2018; Wang et al., 2016).

Most studies (Alagheband et al., 2019; Aouchehian et al., 2017; Hamid, 2020; Hawkins et al., 1999; Koenig et al., 2015; Propst et al., 1992; Rosmarin et al., 2019; Subica & Yamada, 2018; Tulbure et al., 2018; Wang et al., 2016) sought to integrate religious principles to explain CBT techniques (e.g., for behavioral activation, participants were told that God asks people to do good things, even if they do not feel like doing them). This was also noted by Costa and Moreira–Almeida (2021) in their systematic review. They noted that participants were encouraged to satisfy God's will and described these interventions as a way to increase trust in God (Alagheband et al., 2019; Hamid, 2020; Tulbure et al., 2018). Reading sacred or religious texts and books, mantras, telling and reading stories, songs, performing prayers, reflecting on teachings, phrases from people recognized in religion and meditation were used (Alagheband et al., 2019; Aouchehian et al., 2017; Armento et al., 2012; Aslami et al., 2017; Ford & Garzon, 2017; Hamid, 2020; Hawkins et al., 1999; Hosseini et al., 2018; Ravaei et al., 2013; Johnson & Ridley, 1992; Knabb & Vazquez, 2018; Koenig et al., 2015; Mathielson et al., 2012; Pearce & Koenig, 2016; Pecheur & Edwards, 1984; Propst, 1980; Propst et al., 1992; Rosmarin et al., 2010; Trammel, 2018; Tulbure et al., 2018; Wang et al., 2016). It is unclear whether the impact on mental health was due to the activation of the behavior or the religious/spiritual content, that is, whether the content may be a confounding variable and whether its real role in moderating the effect is unknown.

Another example of this is the practice of Mindfulness. There are studies that promoted Christian Mindfulness Training (Ford & Garzon, 2017) an adaptation to encompass the Christian worldview and breathing exercises, body scanning and prayer; in another study, mindfulness was accompanied by religious beliefs and practices used to motivate changes in cognition and behavior (Koenig et al., 2015); and finally the concept of mindfulness was used in the control group (Tulbure et al., 2018).

Religious language was used to strengthen hope, forgiveness, gratitude, involvement in altruistic social activities, among others, to decrease the strength of spiritual struggles (Alagheband et al., 2019; Aouchehian et al., 2017; Koenig et al., 2015; Pearce & Koenig, 2016; Tulbure et al., 2018).

Two studies (Koenig et al., 2015; Pearce & Koenig, 2016) developed manuals for applying RCBT to the religions present in them (Christian, Jewish, Muslim, Buddhist and Hindu), seeking

to maintain the principles of RCBT regardless of the religion, but respecting each one according to its belief system. Another study (Tulbure et al., 2018) developed manuals for applying conventional CBT and RCBT.

In some forms of psychotherapy, people could express their religious experiences in the sessions — for example: how they dealt with problems, verbalize their own faith in God, differentiate between good and evil, have hope and trust in God and share their perceptions about life after death (Hosseini et al., 2017; Hosseini et al., 2018; Mathielson et al., 2012; Propst et al., 1992; Tulbure et al., 2018).

Some studies have sought to integrate patients' personal religious beliefs into the research (Alagheband et al., 2019; Armento et al., 2012; Hosseini et al., 2017; Koenig et al., 2015; Mathielson et al., 2012; Pearce & Koenig, 2016; Pecheur & Edwards, 1984; Propst et al., 1992; Rosmarin et al., 2010; Rosmarin et al., 2019; Subica & Yamada, 2018; Tulbure et al., 2018), either to challenge them using CBT or to validate them, seeking to strengthen the quality of the relationship with other people or the relationship with God.

The studies by Armento et al. (2012), Aslami et al. (2017), Hosseini et al. (2018), Koenig et al. (2015), Pearce and Koenig (2016), Tulbure et al. (2018) and Subica and Yamada (2018) have focused on promoting the practical application of R/S during or after treatment, that is, when participants perform or are encouraged by researchers to perform tasks understood as religious/spiritual — praying, talking to people from the same religious community or participating in spiritual retreats — with the aim of strengthening aspects of R/S.

On the part of the patient, feeling welcomed in the demands they present, including R/S; being questioned about what relates to their religious beliefs and what contributes to their suffering; and being respected in what they believe is a fundamental part of the work of Psychology. These demands should not be neglected, since they may contain numerous issues related to the current life situation of patients. However, studies need to be better focused to define which religious variables are truly therapeutic.

Quality of Studies on Cognitive-Behavioral Therapy that Work with Religiosity/Spirituality

Regarding the quality of the works included in this research, there are studies that did not specify how R/S was approached or only mentioned it, with expressions such as “development of coping strategies” or stated that the interventions respected religious aspects (Akuchekian, Almasi et al., 2011; Akuchekian, Jamshidian et al., 2011; Cajanding, 2016; Ebrahimi et al., 2013; Pityarastian et al., 2007) — which made it difficult to discriminate R/S resources that may have been used by participants or researchers. Similarly, the lack of description of CBT that worked with R/S contributed to the inclusion of studies understood as RCBT; however, they were included without clarity about what the authors understood about this type of therapy (Akuchekian, Almasi et al., 2011; Aouchekian et al., 2017; Pityarastian et al., 2007). Furthermore, there was an absence of a RCBT application protocol or specification of techniques and other procedures used — which would have facilitated the understanding and replication of the treatment (Armento

et al., 2012; Akuchekian, Almasi et al., 2011; Ebrahimi et al., 2013; Hamid, 2020; Hawkins et al., 1999; Johnson & Ridley, 1992; Koenig et al., 2015; Luskin, et al., 2005; Mathieson et al., 2012; Pearce & Koenig, 2016; Propst, 1980; Propst et al., 1992; Rosmarin et al., 2019; Wang et al., 2016). Most studies did not provide definitions of religion, religiosity, and spirituality— except for the studies by Alagheband et al., 2019, Hawkins et al., 1999, and Subica and Yamada, 2018. This made it difficult to understand exactly what religiosity and spirituality are.

Some studies did not specify what the control group was (Akuchekian, Almasi et al., 2011; Akuchekian, Jamshidian, 2011; Aslami et al., 2017; Ravaei et al., 2013; Wang et al., 2016), which reduced the inconsistency score and increased the indirect evidence score in the GRADE system.

Another aspect that is considered important to mention is that the study by Tulbure et al. (2018) presents the work as a randomized clinical trial at several points in the text, but in the limitations of the study it is declared as non-randomized. Based on the interpretation of the study, it was understood that this was a non-randomized clinical trial due to the statement that participants were distributed between groups according to their declared religiosity.

Specifically following the GRADE system criteria, only the studies by Pecheur and Edwards (1984); Rosmarin et al. (2010); Ebrahimi et al. (2013); Cajanding (2016); Koenig et al. (2015); and Pearce and Koenig (2016) showed methodological designs and results considered to be of good quality, although they presented problems in the blinding of participants and researchers and did not report side effects (which is called selective reporting according to GRADE) and assessment of the risk of bias. Ebrahimi et al. (2013); Koenig et al. (2015); and Pearce and Koenig (2016) did not perform calculations to estimate the sample size in their studies; and Ebrahimi et al. (2013), Pecheur and Edwards (1984) and Rosmarin et al. (2010) used the waiting list as comparator in their studies, another inconsistency.

Regarding indirect evidence, there was a large variation in outcomes, making it difficult to compare the studies.

Despite integrating R/S into their treatments, it is noted that the quality of the studies was assessed as serious in most of the aspects indicated by GRADE. This led to questioning the strength of recommendation of RCBT.

During the selection of articles, a study in Chinese was considered to compose the group of works to be evaluated; however, it was not possible to obtain access. Another limitation was the evaluation of an article in Persian, whose translation of the language, not so clear and at other times not provided by the automatic translator used, made it difficult to understand in Portuguese.

It was also not possible to specify the number of study participants, as well as the dropout rate, because this information was not present in most studies.

Final Considerations

Based on the objectives set out in this research, a systematic review of the literature on the impact of RCBT on mental health was presented, which was assessed based on studies that addressed depression, anxiety, OCD, stress, quality of life, positive RSC and negative RSC.

Thus, it is considered that CBT works with R/S in various mental disorders and other diseases. The studies included in the analysis of this research, for the most part, indicate an improvement in the symptoms of the participants, although they do not show superiority over conventional CBT and methodological flaws were identified. This compromised the scientific quality of the studies. However, it is noted that the inclusion of R/S in health treatments can contribute to the improvement of patients, or bring populations reluctant to begin a psychotherapeutic process closer to feeling familiar with the therapy, due to the presence of these elements.

It was found that CBT applied R/S elements in all included studies and these were indicated by the researchers as having positively helped with the outcomes, so that religious patients were able to have their R/S needs met in their treatments, seeking to reduce symptoms and achieve better levels of quality of life, gratitude and hope, for example.

For the next studies to be published, the following are some recommendations: better choice of religious and spiritual aspects to be integrated; that the authors declare their conflicts of interest; better description of the procedures; greater care with randomization and blinding; and when possible, that the contents of the sessions or interventions be better explained, especially when comparing RCBT with conventional CBT, in order to facilitate the identification of the differences between the two approaches.

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APPENDIX A

Assessment of inconsistencies in Randomized Clinical Trials, according to *Grades of Recommendation, Assessment, Development, and Evaluation*

Table 33

Assessment of inconsistency in studies on depression

Study	N	Distribution of men and women	Intervention	Comparator(s)
Rosmarin et al., 2010	125	76.6% female	Spiritually Integrated Treatment (SIT)	Progressive muscle relaxation and waiting list
Armento, McNulty and Hopko, 2012	50	31 women and 7 men	Behavioral Activation of Religious Behaviors (BARB)	Supportive Therapy
Johnson and Ridley, 1992	10	4 women and 6 men	Christian Rational Emotive Therapy (CRET)	Rational Emotive Therapy (RET)
Ford and Garzon, 2017	78	58% female and 42% male	Christian Mindfulness Training (CMT)	Regular Mindfulness (RM)
Cajanding, 2016	100	33 women and 67 men	Cognitive-behavioral intervention focusing on patient education, self-monitoring, skills training, cognitive restructuring, and development. spiritual	Control group - traditional care (medical/pharmacological optimization therapy and specific avoidable risk factor modification strategies for heart failure)
Propst et al., 1992	59	49 women and 10 men	Conventional CBT	RCBT, pastoral counseling and waiting list
Hosseini et al., 2018	160	Women only	RCBT	Standard CBT, citalopram, and usual care (physical care, medication, nutrition, activities, routine psychological follow-up, and periodic visits).
Hosseini et al., 2017	160	-	RCBT, CBT and sertraline	Control group (physical care, medication, care with to the incisions (chest) (and leg), dietary recommendations, activities, and periodic check-ups after surgery)
Ebrahimi et al., 2013	62	55% female and 45% male	SIPT	CBT, antidepressant treatment and control group (list) (waiting)
Koenig et al., 2015	132	44 women and 23 men in CBT and 47 women and 18 men in RCBT	RCBT	CBT
Pearce and Koenig, 2016	130	68.5% female	RCBT	CBT
Alagheband et al. 2019	144	72 women and 72 men	RCBT	Waiting list
Aslami et. al., 2017	75	Women only	Mindfulness based on Islamic principles. spiritual and CBT	Control group (not specified)
Pecheur and Edwards, 1984	21	19 women and 2 men	CBT and RCBT	Waiting list
Propst, 1980	44	-	Religious images (a combination of cognitive restructuring techniques and systematic desensitization with religious content) and non-religious images (a combination of cognitive restructuring techniques and systematic desensitization).	Contact with a therapist plus self-monitoring and self-monitoring alone

Table 34*Assessment of inconsistency in studies on anxiety*

Study	N	Distribution of men and women	Intervention	Comparator(s)
Rosmarin et al., 2010	125	76.6%	Spiritually Integrated Treatment (SIT)	Progressive muscle relaxation and waiting list
Armento, McNulty and Hopko, 2012	50	31 women and 7 men	Behavioral Activation of Religious Behaviors (BARB)	Supportive Therapy
Aslami et al., 2017	75	Women only	Mindfulness based on Islamic-spiritual frameworks and CBT.	Control group (not specified)
Ford and Garzon, 2017	78	58% female and 42% male	Christian Mindfulness Training (CMT)	Regular Mindfulness (RM)
Alaghebani et al., 2019	144	72 women and 72 men	RCBT	Waiting list

Table 35*Assessment of inconsistency in studies on OCD*

Study	N	Distribution of men and women	Intervention	Comparator(s)
Akuchekian et al., 2011a	90	Women only	RCBT	Control group (not specified)
Akuchekian et al., 2011b	50	47 women and 3 men	RCBT	Control group (not specified)

Table 36*Assessment of the inconsistency of studies on stress*

Study	N	Distribution of men and women	Intervention	Comparator(s)
Rosmarin et al., 2010	125	76.6% female	Spiritually Integrated Treatment (SIT)	Progressive muscle relaxation and waiting list
Trammel, 2018	80	-	Moving Picture Experts Group-3 (MP3) - Christian Mindfulness	Control group without intervention.
Ford and Garzon, 2017	78	58% female and 42% male	Christian mindfulness training (CMT)	Regular Mindfulness (TM)
Knabb and Vasquez, 2018	86	80 women and 6 men	The Jesus Prayer with mindfulness	Waiting list

Table 37*Assessment of inconsistency in quality of life studies*

Study	N	Distribution of men and women	Intervention	Comparator(s)
Armento, McNulty and Hopko, 2012	50	31 women and 7 men	Behavioral Activation of Religious Behaviors (BARB)	Supportive Therapy
Cajanding, 2016	100	33 women and 67 men	Cognitive-behavioral intervention focusing on patient education, self-monitoring, skills training, cognitive restructuring, and spiritual development.	Control group - traditional care (medical/pharmacological optimization therapy, and strategies for modifying avoidable risk factors). specific for heart failure)

Table 38*Assessment of the inconsistency of studies on Positive Spiritual Religious Coping*

Study	N	Distribution of men and women	Intervention	Comparator(s)
Luskin, Ginzburg and Thoresen, 2005	55	41 women and 14 men	Group intervention consisting of Rational Emotive Therapy and refocusing techniques based on positive affect. The focus of the therapy was the use of forgiveness.	Waiting list
Rosmarin et al., 2010	125	76.6% female	Spiritually Integrated Treatment (SIT)	Progressive muscle relaxation and list of wait
Armento, McNulty and Hopko, 2012	50	31 women and 7 men	Behavioral Activation of Religious Behaviors (BARB)	Supportive Therapy

Table 39*Assessment of the inconsistency of studies on Negative Spiritual Religious Coping*

Study	N	Distribution of men and Women	Intervention	Comparator(s)
Rosmarin et al., 2010	125	76.6% female	Spiritually Integrated Treatment (SIT)	Progressive muscle relaxation and waiting list
Pearce and Koenig, 2016	130	68.5% female	RCBT	CBT

APPENDIX B

Assessment of inconsistencies in non-randomized, single-group, and semi-experimental clinical trials according to the *Grades of Recommendation, Assessment, Development, and Evaluation.*

Table 40*Assessment of inconsistency in studies on depression*

Study	N	Distribution of men and women	Intervention	Comparator(s)
Rosmarin et al., 2019	107	63.6% female	Culturally adapted CBT	A group made up of non-jews (who received the same intervention).
Mathieson et al., 2012	16	13 women and 3 men	Thesis adapted to Maori	-
Hawkins, Tan and Turk, 1999	29	21 women and 8 men	Christian TCC	TCC
Tulbure et al., 2018	79	65 women and 14 men	TCCR and TCC	Waiting list

Table 41*Assessment of the inconsistency of studies on anxiety*

Study	N	Distribution of men and women	Intervention	Comparator(s)
Wang et al., 2016	58	37 women and 21 men	Spiritually Oriented Trauma-Focused CBT	Control group (not specified)
Rosmarin et al., 2019	107	63.6% female	Culturally adapted CBT	A group made up of non-Jews (who received the same intervention).
Mathieson et al., 2012	16	13 women and 3 men	Thesis adapted to Maori	-
Hamid, 2020	30	Women only	TCCR	Control group without intervention.
Pityaratstian, 2007	160	95 women and 65 men	Group CBT for PTSD in children (with adaptations including for religion)	-
Tulbure et al., 2018	79	65 women and 14 men	TCCR and TCC	Waiting list

Table 42*Assessment of the inconsistency of the study on OCD*

Study	N	Distribution of men and women	Intervention	Comparator(s)
Aouchekian et al., 2017	40	Women only	TCCR and drug therapy	-

Table 43*Assessment of the inconsistency of the study on stress*

Study	N	Distribution of men and women	Intervention	Comparator(s)
Wang et al., 2016	58	37 women and 21 men	Spiritually Oriented Trauma-Focused CBT	Control group (not specified)

Table 44*Assessment of inconsistency in quality of life studies*

Study	N	Distribution of men and women	Intervention	Comparator(s)
Ravaei, Hosseinian and Tabatabaei, 2013	30	Men only	TCCR	Control group (not specified)
Tulbure et al., 2018	79	65 women and 14 men	TCCR and TCC	Waiting list
Hamid, 2020	30	Women only	TCCR	Control group without intervention.

Table 45*Assessment of the inconsistency of studies on Positive Spiritual Religious Coping*

Study	N	Distribution of men and women	Intervention	Comparator(s)
Subica and Yamada, 2018	37	6 women and 7 men	Cognitive-behavioral intervention <i>Spiritual Strategies for Psychosocial Recovery</i> (SSPR)	-
Hawkins, Tan and Turk, 1999	29	21 women and 8 men	Christian TCC	TCC

Table 46*Assessment of the inconsistency of studies on Negative Spiritual Religious Coping*

Study	N	Distribution of men and women	Intervention	Comparator(s)
Wang et al. , 2016	58	37 women and 21 men	Spiritually Oriented Trauma-Focused CBT	Control group (not specified)

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