Review

The role of spirituality and religion in the strength base approach to mental health treatment among African-American women

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The significance of spirituality and religion in dealing with various stressors has been debated among mental health practitioners, counselors, and researchers for quite some time. It was only in 1994 that the American Psychiatric Association included in its well known diagnostic statistical manual (DSM) a new category for religious or spiritual problems with diagnostic criteria of loss of faith, problems with religious conversion, or questioning of spiritual values. Researchers observed that questioning (or loss of) faith, for example, could cause distress and mimic the symptoms of psychiatric disorder, and noted similarities between the symptoms of spiritual distress and those of depression which necessitates addressing spirituality while treating depression or other mental and health conditions. This paper demonstrates how spirituality and religion are interrelated to cultural values and the belief systems of ethnic minorities, and their role in mental health treatment among African American women.

Key words: African-American, counseling, religion, spirituality, faith, Church, black community, mental health, substance abuse, strength base approach.

INTRODUCTION

The significance of spirituality and religion in dealing with various stressors among African Americans is evident throughout history. For example, black churches remained far and beyond religious institutions; they were social clubs, political activist groups, art galleries, supporters of educational institutions, and music and culture centers for African-American families during some of the most challenging times in American history. In essence, the lives of blacks has historically centered around their churches. In the 1950s, Abraham Maslow's theoretical construct of self-actualization, which included spirituality and religiosity, provided prominence for counseling professions; and in 1994, the diagnostic statistical manual (DSM-IV) included a new category for religious or spiritual problems with diagnostic criteria of loss of faith, problems with religious conversion, or questioning of spiritual values. Lukoff et al. (1995) observed that questioning (or loss of) faith, for example, could cause distress and mimic the symptoms of psychiatric disorder. Likewise, McEwen (2004) noted similarities between the symptoms of spiritual distress and those of depression, which necessitates addressing spirituality while treating depression or other mental and health conditions. Giligan and Furness (2006) saw the need for practitioners to understand and appreciate how faith, religion, and spirituality are interrelated to cultural values and the belief systems of ethnic minorities, in an effort to gain cultural competency.

In the case of African American women, studies linked them with ineffective emotional coping (Ehrmin, 2002), feelings of guilt and shame (Ehrmin, 2002), and the internalizing of racism and familial abuse (Constantine, 2006), and are found to be at risk for being dually diagnosed with post-traumatic stress disorder (Montoya et al., 2003). African American women tend to experience greater distress related to co-morbid mental health issues (Zule et al., 2002) and evidently abuse of alcohol in order to cope.
Therefore culturally-relevant considerations for African American women in substance abuse and mental health treatment include attentions to internalized negative stereotypes, spirituality and safety (Lewis, 2004). Furthermore, Brome et al. (2000) found that: (a) African American women in the high spirituality group expressed a more positive self-concept, active coping style, perceptions of family climate, and attitudes toward parenting than their women counterparts in the low spirituality group; (b) the high spirituality group expressed greater satisfaction with their social support than women in the low spirituality group. This paper will focus on:

(1) The historical roots of spirituality and religion in mental health.
(2) The potential benefits of integrating religion and spirituality in clinical Mental Health Counseling with African-American women clients.
(3) The possible disadvantages or challenges to integrating spirituality and religion in the therapeutic process.
(4) The recent attempts in integrating spirituality and religion into mental health treatment strategies.

HISTORICAL ROOTS OF SPIRITUALITY AND RELIGION IN MENTAL HEALTH

Religion and mental health issues have long been viewed to have a strained association because those suffering from mental health issues tend to fear stigmatization in religious communities, while on the other hand; mental health professionals tend to be suspicious of the role of religion in the therapeutic process. Dr. Janet Taylor, a psychiatrist who appears frequently on television shows said that those African Americans who are in the bottom of the socio-economic ladder and socially isolated feel even today that, "I don't want anyone in my business and I have to deal with my problems myself" (Ebony, 2012:1-2). Secondly, mental health professionals are often trained to leave out religion from the professional boundaries when treating their patients based on various erroneous grounds of justification that religion is either Freud's concept of "universal obsessional neurosis" (Peter, 1995:435) or a method of "irrational thinking" or "awfulizing" (Ellis, 1957, 1962). According to Freud ([1927] 1964:61):

“If [religion] succeeded in making the majority of mankind happy, in comforting them, in reconciling them to life, and in making them into vehicles of civilization, no one would dream of attempting to alter the existing conditions”.

DSM-III-R also made references to religion to illustrate psychopathology in terms of catatonic posturing, delusion, incoherence, magical thinking, and poverty of content of speech, etc. Disagreeing with such "negative religious bias", Post (1990:813) declared that, "After a thorough literature search, I am not aware of proof that in the religious context there is an unusually high incidence of mental illness" and "Few psychiatrists are trained to understand religion, much less treat it sympathetically". Lukoff et al. (1995) also observed that despite the importance of religious and spiritual dimensions in shaping individuals' cultural milieu and their illness patterns, mainstream psychiatry "tended to either ignore or pathologize the religious and spiritual issues that clients bring into treatment" (1995: 467). Pargament (2007:4) expressed a similar view:

“When people walk into the therapist's office, they don't leave their spirituality behind in the waiting room. They bring their spiritual beliefs, practices, experiences, values, relationships, and struggles along with them. Implicitly or explicitly, this complex of spiritual factors often enters the process of psychotherapy. And yet many therapists are unaware of or unprepared to deal with this dimension in treatment”.

On the other hand, Jung ([1938]1975) indicated that inner transcendent experience is vital for a person's ability to withstand worldly temptations; Fankl ([1948] 2000) saw that one's innate need to find meaning and purpose is essential to attain a healthy life; and numerous studies (Jones, 1993; Lindgren and Coursey, 1995; Ellison and Levin, 1998; Pargament and Brant, 1998; Tepper et al., 2001; Koenig et al., 2001) showed a significant positive correlation between religion/spirituality and mental health. For the first time, DSM-IV included the category of "Religious or Spiritual Problem" (V62.61) for psychiatric consultation and treatment purposes and stated that (American Psychiatric Association, 1994:843):

“This category can be used when the focus of clinical attention is a religious or spiritual problem. Examples include distressing experiences that involve loss or questioning of faith, or questioning of other spiritual values which may not necessarily be related to an organized church or religious institution”.

When consumer background variables such as gender and culture are considered, it is evident that African American women rely on prayer and faith as key components of preventive health measures. For that reason, they are more likely to be involved in church activities and opportunities for prayer (Boyd-Franklin and Lockwood, 1999; Parham et al., 2000) than Whites (Chatters et al., 1999) and African American men (Chatters et al., 1999; Levin et al., 1994). The Black Church has a special significance in the African American community throughout history (Brice-Baker, 1994; Cole
and Guy-Sheftall, 2003; Oliver, 2000). Studies also indicated that spirituality and religion among African Americans play a prominent role by transforming their experiences into psychological strength and an ability to deal with their on-going struggles (Collins, 1991; Comas-Diaz and Greene, 1994). For example, in a pilot study of 11 African American women in breast cancer treatment from the mid-Atlantic and southeastern United States, Morgan et al. (2006) found significant relationships between spiritual well-being and quality of life domains of physical, emotional, and functional well-being. Newlin et al. (2008), in their study of 109 African American women with type 2 diabetes, found that religion and spirituality were related to glycemic control, with evidence of psychosocial mediation lacking.

**POTENTIAL BENEFITS OF INTEGRATING RELIGION AND SPIRITUALITY IN CLINICAL MENTAL HEALTH COUNSELING WITH AFRICAN-AMERICAN WOMEN CLIENTS**

Many studies found that spiritual meditation (Wachholtz and Pargament, 2005), spiritually augmented cognitive behavioral therapy (D’Souza et al., 2002), religiously based therapy consisting of readings from sacred texts, participating in religious discussions in treatment, prayers of relaxation (Azhar and Varma, 1995), Christian-oriented forgiveness workshops ( Worthington, 2004), or a combination of a spirituality group that read a spiritual workbook followed by discussions at weekly meetings; a cognitive group that read a cognitive-behavioral self-help workbook followed by discussions at weekly meetings; and an emotional support group that discussed a variety of non-spiritual topics (for example, self-esteem, nutrition, etc.) at weekly meetings, showed significantly greater improvement in clients’ mental health issues such as distress, anxiety disorder, dysthymic disorder, and vascular headaches. Watlington and Murphy (2006) found that African American survivors who experienced higher levels of spirituality and greater religious involvement reported fewer depressive symptoms (for example, sadness, pessimism, and worthlessness). Another study showed that spiritual well-being (along with hope, self-efficacy, coping, social support-family, social support-friends, and effectiveness of obtaining resources) among African American survivors has a protective factor against suicide attempts (Meadows et al., 2005). These findings suggest the need for comprehensive coping strategy program intervention integrating religion and spirituality in clinical Mental Health Counseling for African-American women with suicide attempts and other mental health disorders.

Utilizing a relational framework, Mattis and Jagers (2001) also suggested that the role of religion and spirituality among African Americans should be considered in the contexts of relationships within and across various domains of human ecology (for example, individual, family, community, and society) along with responsible agents (for example, family members and peers) for transmission and maintenance of religious values and across generations, and that the need for attention to the affective, cognitive, and behavioral correlates should be explored to determine relational quality, commitment, and resilience. Furthermore, Mattis (2002) conducted a content analysis of the narratives of 23 African American women and found that religion/spirituality help them to:

1. Interrogate and accept reality.
2. Gain the insight and courage needed to engage in spiritual surrender.
3. Confront and transcend limitations.
4. Identify and grapple with existential questions and life lessons.
5. Recognize purpose and destiny.
6. Define character and act within subjectively meaningful moral principles.
7. Achieve growth.
8. Trust in viability of transcendent sources of knowledge and communication.

Wallace and Bergeman (2002) extracted another theme based on life story interviews with 10 African American elders (58-88 year-old): that is, the participants’ reserve potential comprising of spirituality and religiosity. These African American women elders reportedly used their spirituality and religiosity as a reserve resource from which they were able to draw in time of stress, and managed to grow stronger from their hardships. Therefore, their spirituality and religiosity helped as a coping mechanism and/or as a mechanism of self-enhancement.

**POSSIBLE DISADVANTAGES OR CHALLENGES TO INTEGRATING SPIRITUALITY AND RELIGION IN THERAPEUTIC PROCESS**

**Disadvantages**

Although there is a preponderance of evidence about the positive effects of integrating religion and spirituality in treatment plans for mental disorders especially when coping with particular stressors (Pargament and Brant, 1998), there is a possibility that religion may at times produce negative outcomes. For example, Ellison and Levin (1998) point out that certain rigid self-deprecating religious beliefs such as sinfulness, guilt, or unattainable ideals that may be stemming from over-identifying with saviors or faith communities may constitute conflict with recovery goals of consumers as well as therapists. Others also pointed out that negative aspects of spirituality, such as spiritual struggle, anger of God, or
viewing their suffering as a sin could result in poor medical compliance and slow down or prevent recovery processes (Parsons et al., 2006). Fallot (1998a:37) summarizes the dilemma thus:

“Religious and spiritual concerns may become part of the problem as well as part of the recovery. Some people have experienced organized religion, for example, as a source of pain or guilt or oppression. Rather than being a positive resource for recovery, religion in this sense may merely deepen and complicate the need for recovery. Alongside those who experience the faith community as welcoming and hospitable are those who find it stigmatizing and rejecting. Alongside those who feel uplifted by spiritual activities are those who feel burdened by them. And alongside those who find comfort and strength in religiousness are those who find disappointment and demoralization. Given the relative neglect of religious issues in the mental health field, however, and given a history of overemphasis on the difficulties associated with religion, it is important to see that for many people with severe mental illnesses, spirituality is a core element in the narrative context for recovery”.

Fallot (1998a:43) also made clear that “if an assessment supports the value of religion in a particular consumer's recovery, clinicians should be prepared to support collaboratively the consumer's convictions and practices”. In a recent study of 17 African American women with breast cancer, Gaston-Johnsson et al. (2013) found that these women used more positive religious coping and experienced less distress and greater spiritual well-being, but catastrophizing has a negative effect on spiritual well-being. Based on these findings, the authors suggested that nurses need to work collaboratively with African American women to reinforce beneficial coping patterns and approaches, and that a tailored comprehensive coping strategy program intervention for African American women with breast cancer (CCSP-AA) administered by a nurse could be taught to assist African American patients in coping more effectively.

Challenges across the system

Researchers studied system-level challenges including but not limited to access (for example, inaccessible location, transportation problems, lack of health insurance or limited coverage, and high costs of health care services), inadequate service availability (for example, shortage of group counseling opportunities, and in-home services), social issues (for example, lack of child care), poor quality of care (for example, limited access to culturally competent clinicians), among others (see for additional discussion; Ward et al., 2009; Cristancho et al., 2008; Tidwell, 2004).

Challenges of dealing with stigma

African Americans in general and African American women in particular continue to face discrimination, prejudice, stigmatization, and stereotypes in health care because of their poorer health status and generally low socio-economic status. For example, Welch (2003:32) quotes the experience of a 40-year-old African American woman, Betty, with a health care provider during a visit:

“I went to this doctor. I had an infection...She said, "How many sex partners do you have?" I said "Gulp"...She said, "Oh, you don't know how many"...I felt like I was a little piece of garbage. I was just...stereotyped: "There was a little black woman who's out having all of these men who comes here with an infection...”

These incidents are not uncommon and probably instill a higher degree of fear and distrust if they have to see a psychiatrist or mental health professional. Wahl (1999) reported from a nation-wide survey of 1,301 and a follow-up survey of 100 mental health consumers that almost 80% claimed to have overheard people making hurtful or offensive comments about mental illness and half of them noticed it often or very often. Welch (2003:32) reiterated, “for many blacks, receiving health care is all too often a degrading and humiliating experience. Often insults are subtle but nonetheless perceived by the black patient”. Additionally, Mathews and Hughes (2001) found that relatively few African American lesbian and heterosexual women reported current use of mental health services, despite the evidence of substantial emotional distress. Avoidance of negative stereotyping, sober consideration of the individual, clear and respectful communication, understanding a patient's background and culture, understanding a patient's emotions and beliefs, etc. are all important to overcome the challenges related to stigmatization.

Challenges of measurement:

Several assessment methods have been proposed with various levels of complexities, and selection of the right method for a given situation for a given client profile could be challenging. For example, Koenig and Pritchett (1998) adopted a simple method of assessment that involves four "nonoffensive and easily remembered" questions to clients: Has religious faith influenced your life? How has your faith influenced your life (past and present)? Are you a part of a religious or spiritual community? Are there any
spiritual needs that you would like me to address? Then, by probing the answers further (if yes, why; if not, why not) the therapist is hoped to acquire adequate information for developing a therapeutic plan.

Fallot (1998b) recommended an assessment tool with four factors (beliefs and meaning; experience and emotion; rituals and practice; community) on one side of the grid, and two factors (explicitness of religious language and role in patient's overall well being) on the other. The therapist is expected to gain understanding of the first four factors through an open-ended conversation and rate the fifth and sixth factors. Finally, the therapist develops a treatment plan.

Fitchett (1993) proposed a seven-dimensional approach: beliefs and meanings (how the person develops a sense of purpose and meaning in life); vocations and consequences (how the person understands obligations and results of fulfilling them); experience and emotion (the affective tone of the person's spiritual life); courage and growth (how the person faces change and doubt); rituals and practice (how the person enacts key beliefs); community (how the person practices in formal and/or informal groups of shared practice); and authority and guidance (where authority for core beliefs resides).

On the other end of the continuum, Pargament (2007) suggested a detailed three-step process for measuring the role of religion and spirituality in psychotherapy, each consisting of several internal dimensions. First, the initial spiritual assessment with four dimensions of salience (spirituality to the client, religious affiliation to the client, spirituality to the problem, and spirituality to the solution); second, the signs of spiritual struggle assessment with three underlying dimensions (divine struggles, intrapsychic struggles, and interpersonal struggles); and third, the assessment of signs of spiritual resources with five pathways (the pathway of knowing, the pathway of acting, the pathway of relating, the pathway of experience, and the pathway of coping). Additionally, some clinicians suggested the use of group sessions (Kehoe, 1998; Lindgren and Coursey, 1995; Fallot and Newburn, 2000). Therefore, selection of any single or a combination of these assessment tools to suit the client's needs could be difficult or pose a challenge based on the professional background and training of the mental health professionals.

**CURRENT MENTAL HEALTH PRACTICE MODELS FOR WORKING WITH AFRICAN-AMERICAN WOMEN**

Cognitive Behavior Therapy (CBT) has been widely used for treating African-American Women suffering from mental health issues. Apart of several advantages, CBT has presented over time some inconsistent outcomes in terms of treatment efficiency when dealing with African-American Women. Studies show that CBT trajectories fail to focus on strengths and potential solutions to effect immediate changes in mental health issues among African-American Women. Additionally, CBT theoretical orientation does not take into account the unique cultural, ethnic and social influences experienced by African-American Women, which, though they appear to be pathological from outside, may have been chosen as necessary for coping with their life circumstances and simply "a matter of survival".

**Assumptions and methods of the strength-based approaches**

When working with African-American Women in mental health settings, the therapist must have working knowledge of their cultural, ethnic, and social experiences. In other words, a mental health therapist, regardless of his/her own ethnic identity, must understand the historical context of African-Americans' reluctance to pursue treatment services through institutionalized means. As Poussaint and Alexander (2000) pointed out, mental health counselors need to employ therapeutic interventions that are culturally sensitive, relevant and effective for the ethnic groups they serve. It is in this context that the Strength Based Approach appears to be an intervention treatment strategy.

The Strength Based Approach (SBA), as a valuable mental health counseling tool, starts where the client is and uses methods of self-empowerment, self-oriented strengths, and self-motivation and encouragement. Thus, the basic assumptions of this method are non-traditional in nature and center around the philosophy that power of healing lies "within the client" rather than coming from outside. It further recognizes that (Lindsey, 2000):

1. Clients have strengths that can be tapped to resolve their problems. However, they may not be aware of these strengths because of the extent to which problems have saturated their lives and perceptions.
2. Recognizing, respecting, and making visible such strengths is a primary function of social worker/clinician/therapist.
3. Clients are experts on their own lives, while therapists and social workers offering expertise in facilitating a process through solutions to problems are discovered and accessed. Clients and therapists are collaborators, each bringing their own knowledge and expertise to the problem-solving process.
4. Clients' motivations are more readily enhanced by focusing on strengths and solutions than by extensive discussion of problems.
5. Clients are not seen as victims, but as people who have not yet been able to tap into the resources they need to solve problems. Resources may be located within clients themselves, within their social networks or
within the larger community.

Strength based cognitive behavioral therapy model

The Strength Based Cognitive Behavioral Therapy (SB-CBT) model is the combination of the two techniques; that is, the strength based therapy approach utilizes CBT principles and practices to construct new interpersonal beliefs and behaviors that promote positive client growth. In a therapist’s point of view such an approach is essential to build resilience and treat personality disorders. While treating African American women, the following four steps need to be followed to build resilience in the therapeutic process (for additional discussion on these steps, see Padesky and Mooney, 2012):

1. Search for strengths.
2. Construct a personal model of resilience (PMR).
3. Apply the PMR to areas of life difficulty.
4. Practice resilience.

The first step, search for strengths, is broad and has many “pathways” to positive qualities that are essential to strengths; including faith and spirituality. Davis (1999) suggested seven themes for constructing personally a strength/resilience model:

(1) Good health and an easy temperament.
(2) Secure attachment and basic trust in other people.
(3) Interpersonal competence including the ability to recruit help
(4) Cognitive competence; that is, ability to read, plan, self-efficacy, and intelligence.
(5) Emotional competence including diverse emotional skills such as the ability to regulate one’s emotions, delay gratification, maintain realistically high self-esteem and employ creativity and humor to one’s belief.
(6) The ability and opportunity to contribute to others.
(7) Having faith that one’s own life matters and life has meaning, including a moral sense of connection to others.

Although these themes appear to be discrete sets of attributes, they are all interconnected within the frame of client personality. Therefore, spirituality and religion can be applied in each of these steps while treating African American women.

African American women have unique coping mechanisms and historically have used self-help approaches to addressing their mental health issues. Moreover, they have a tendency to seek informal community and neighborhood resources such as church, family, neighbors, and selective coworkers to cope with mental health issues (Mathews and Hughes, 2001). Mental health therapists must make connections with African American women that signify compassion, trust, and collaboration while constructing personal models of resilience on their strengths (PMR). Mental health therapists and African American women should work as collaborators to identify clients’ personal strengths across aforementioned themes or personal domains. Once PMR is constructed, it is necessary for therapists to remind clients of their positive qualities as well as prior achievements and successes with managing stressful and challenging times and incidents. African American women, though not experts by professional standards, frequently involve themselves in supportive relationships with others in crisis. As a result, these informal relationships may become significant over this period and can be very useful to therapists not only in providing information on client history and strengths (and weaknesses and vulnerabilities) but also in helping the client with practicing resilience. Therefore, the mental health therapist should consider including those significant orders in the client’s treatment plan whenever they are available.

CONCLUSION

African American women are at high risk in terms of their mental health because of various life stressors such as their low socioeconomic status and poor physical health. However, they underutilize mental health services for various personal (for example, stigma and discrimination) and system-level (for example, lack of access to culturally competent professional and lack of health insurance). As in the past, they continue to rely primarily on their spiritual and religious strength for coping and healing in times of distress and crisis. The good news is that the mental health field began to recognize the necessity to include spirituality and religion in the comprehensive intervention strategy and several new assessment and treatment methods are being developed. The importance of cultural competence is also now being seriously considered by mental health professionals (although no formal training is given). The strength based cognitive behavioral therapy appears to be promising for effective intervention of subpopulation groups like African American women. By developing goal-oriented comprehensive intervention plans to meet individual needs and administering them collaboratively, we can hope to see more African American women coming forward to utilize mental health services.

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