

Everett L. Worthington, Jr.*

What a Difference 35 Years Can Make

A Cloudy Future for the Religious and Spiritual in Psychotherapy in Light of Past Revolutions and Present Generational Pressures

DOI 10.1515/opth-2016-0012

Received December 17, 2015; accepted January 26, 2016

Abstract: I review changes in social trends, psychological science, psychotherapy practice, and theology—which have been so profound they have often seemed like revolutions—since the landmark publication by Allen E. Bergin, “Psychotherapy and Religious Values,” in 1980. I attempt to predict some current and future trends that will shape the practice and research in the treatment of religious people for psychological disorders, including theological changes toward more open theology, less doctrinally centered religions, more attention to individual spirituality, and more relational psychology and theology. In the field of psychotherapy research, efficacy studies are no longer the gold standard of research, replaced by large trials demonstrating effectiveness and dissemination. The expensive research required will likely cut the amount of research done on religiously and spiritually accommodated treatments; thus winnowing of treatments is likely in the future. Practitioners will need to become competent to counsel people using many religious and spiritual accommodations. I acknowledge that predicting the future accurately is at best tentative, and I urge that this be read with circumspection.

Keywords: religion; spirituality; psychotherapy

Allen E. Bergin published the landmark article “Psychotherapy and Religious Values” in the *Journal of Consulting and Clinical Psychology* in 1980. I start this article describing my personal reflections over almost 40 years as a clinician and researcher who has practiced and studied psychotherapy interventions, including ways of adapting them to religious and spiritual clients. After these reflections, I describe how psychotherapy has evolved (within larger contexts) in the 35 years since Bergin. I then speculate about the future of psychotherapy and psychotherapy research involving treatment of religious people, based on past trends.

It is difficult for professionals entering the field since the mid-1980s, especially in the present era in which society values inclusion of various diverse personal characteristics, to actually understand the context of psychology prior to Bergin’s article. Let me offer a personal case study to describe it. I will take a USA-centered approach throughout the present article, even though globalization is an important reality today. Psychotherapy is still located mostly in the USA and other first-world countries, so I will focus on my country of residence and not on all of the countries I regularly visit and hope to visit, which deserve their separate analyses.

Case Study

Bergin’s article was published two years after I became an assistant professor. With Bergin’s publication, the change in the climate was profound. It felt like a revolution had occurred. I had graduated in 1978 from the University of Missouri-Columbia (UMC) in Counseling Psychology. At that time the UMC interpreted separation of church and state narrowly to mean that a state employee (such as an intern or student in a doctoral program) employed or trained at the university should not introduce religion into the state-

*Corresponding author: Everett L. Worthington, Jr., Virginia Commonwealth University, E-mail: eworth@vcu.edu

supported psychotherapy treatment provided in a university counseling center. If the client initiated the conversation, the counselor could respond.

As a Christian, I was interested in the newly emerging movement in cognitive therapy (CT), especially as presented in Mahoney's behavioral self-control (e.g., Thoresen and Mahoney),¹ and the cognitive-behavior therapy (CBT) of Meichenbaum.² In fact, I pursued dissertation research in that direction. Little had been written on professional religious or spiritual counseling besides books by pastoral counselors (e.g., Clinebell³). But books were beginning to appear like the surprisingly behaviorally influenced approach by Jay Adams, *The Christian Counselor's Manual*, which differed substantially from Adams' polemical writing and was quite psychological. A few professional psychologists were starting to write explicitly Christian books, like Gary Collins' *Effective Counseling*. Most influential to me was cognitive-therapy-informed *Effective Biblical Counseling* by Lawrence J. (Larry) Crabb, Jr.

People at the UMC University Counseling Service knew of my Christian beliefs and values, so they referred to me any client who happened to mention the "R word" (religion) in their intake interview. Actual religiously oriented psychotherapy supervision was impossible at UMC. So we typically (by implicit consensus) ignored that religious aspect of my psychotherapy when in supervision. At UMC I did not have a single conversation with a supervisor (in all of my practica and two years of internship) about religion or spirituality, and no professor ever mentioned religion in a class.

After my faculty appointment at Virginia Commonwealth University (VCU), I accumulated training hours for licensure and was fortunate to have Stanley R. Strong join the faculty in 1981, giving me at least some post-PhD pre-licensure supervision in religiously oriented psychotherapy. (In those days no one even considered it important for licensure to have explicit supervised experience with religious clients.) In 1980, though, Allen Bergin's article brought a few other Christian psychotherapists out of the woodwork. I formed a religiously oriented psychotherapy discussion group—of faculty from psychology and elsewhere around the university—that survived about one year. I then joined a larger such group that had sprung up at a local Richmond church.

When I was licensed in 1981, I established a part-time practice keeping three Christian couples in couple therapy as clients continually. I did not limit my practice to Christians, but my referral base was from a city-wide Christian church base. I soon supplemented direct couple therapy with those couples by serving as clinical supervisor for two explicitly Christian counseling agencies in the city.

I conducted some analogue studies in psychotherapy research in the 1980s, and I was excited when some new Christian CBT studies were published.⁴ In 1984 Rod Goodyear, editor of *Journal of Counseling and Development*, recruited me to write a review of the literature on religious counseling.⁵ I followed that with a theoretical article in the *Journal of Counseling Psychology* on religious values⁶, and a major contribution in *The Counseling Psychologist* on religious development across the life span.⁷ That same year, 1989, I was on a joint symposium at New Orleans with Larry Beutler, who had studied secular group therapy and found that clients sometimes changed religious values to more closely resemble their psychotherapists' religious values. Those talks were eventually published as refereed articles.⁸ Bergin's *JCCP* root had finally born counseling psychology fruit within the secular literature.

By 1996 the field of religiously accommodated psychotherapy intervention had mushroomed. I summarized that growth with a review paper in *Psychological Bulletin*.⁹ By then many other changes were occurring to make incorporating religious values in psychotherapy acceptable across the psychotherapy

1 Thoresen and Mahoney, *Behavioral Self-Control*.

2 Meichenbaum, *Cognitive-Behavior Modification*.

3 Clinebell, *Basic Types of Pastoral Care*.

4 See Propst, Ostrom, Watkins, Dean and Mashburn, *Comparative Efficacy*; Pecher and Edwards, *Comparison of Secular and Religious*.

5 Worthington, "Religious Counseling."

6 Worthington, "Understanding the Values."

7 Worthington, "Religious Faith Across the Lifespan."

8 Beutler and Bergan, "Value Change"; Worthington, "Psychotherapy and Religious Values."

9 Worthington, Kurusu, McCullough and Sandage, *Empirical Research*.

field. These included dramatic growth of multiculturalism, popularity of CBT, and a strong push for evidence-based practices in psychotherapy (previously called *empirically validated* and then *empirically supported* treatments), due to managed mental health care in the late 1980s. After these developments, psychotherapy with religious clients required a strong empirical base, and psychotherapy researchers were poised to stand and deliver. Since then, religiously accommodated treatments have been increasingly studied.

Changes Affecting Psychotherapy and Religious Values

Psychotherapy as a profession did not transform from being leery of religion to accepting it. The changes occurred due to wider cultural and professional transformations. Sociologists may disentangle the true causes with some confidence; I am limited to more of an educated lay perspective. However, I offer my observations as background to my speculations about the potential future for religiously and spiritually accommodated psychotherapy.

Psychological Evolution of Generations

The baby boomers (born 1946-1964) changed the face of mental health. They were introspective and self-absorbed.¹⁰ In contrast to previous generations, for whom psychotherapy was almost an admission of personal inadequacy,¹¹ for the boomers psychotherapy was a black badge of courage. In the crucial 1980-2000 decades the oldest boomers were ages 34 to 54 and the youngest were 16 to 36. They were the primary consumers of psychotherapy, and with their giant population bubble they made psychotherapy popular.

Following the baby bust (sometimes called Generation X, born 1964-1988), the millennials arrived. Jean Twenge said the millennials might be named after a version of Windows, the Millennial Edition (or Generation ME), or perhaps the iGeneration or iGen.¹² She argued that GenMe has a psychological focus that is “very different from the boomer focus on introspection and self-absorption: GenMe is not self-absorbed; we’re self-important. We take it for granted that we’re independent, special individuals, so we really don’t need to think about it.”¹³ But that millennial generation is also financially squeezed. They have high fixed costs for housing, healthcare insurance, loan payback, and childcare. Eating out is a necessity (given two-worker households), as are phone plans and multimedia centers. Those fixed expenses are accompanied by decreased wages because employers can expect that both parents will work. The result is that individuals and couples have less disposable income and less freedom for maneuvering than in many previous generations.

Changes in Lifestyles and in Families

These generational factors are exacerbated by social changes. For the boomers, everyone seemed to own a car. Mobility was taken for granted, especially in the middle socioeconomic class and above. Longstanding communities of the “greatest generation” were disrupted. In lower socioeconomic classes, urbanization and absent fathers (due to mobilization, divorce, unwillingness to marry, crime and imprisonment, etc.) took its toll on the family. Throughout all socioeconomic classes, changes in marriage patterns toward cohabitation and acceptability of births to single parents destabilized the traditional nuclear family.

By the time of the millennials, the internet and cheap and available travel made worldwide social connections the norm. Domestically, a high abortion rate had become established, changing the nature of the family by reducing the number of unwanted children, but yielding a number of social changes that turned out to be socially positive according to some analysts. For example, Levitt and Dubner,

¹⁰ Twenge, *Generation Me*.

¹¹ Brokaw, *Greatest Generation*.

¹² Twenge, *Generation Me*.

¹³ Ibid., 4.

in *SuperFreakonomics*, presented much evidence in support of the proposition that it was actually the spread of legal abortion that resulted in reduced crime rates, fewer children living in poverty, fewer socially-forced marriages, less child and spouse abuse, and other positive social trends. They argued that many social ills were due to people having many unwanted babies, especially in lower socioeconomic classes.¹⁴

Other social changes have reached fruition from their origins in the boomer free-speech, free-love, and anti-establishment ethos. Many have culminated in the GenMe open tolerance of individualistic social openness. This has contributed to the rise of cultural sensitivity to gender issues, race and ethnicity relations, LGBTQ lifestyles, and other individual differences.

Unhappiness of Millenials

Twenge has described GenMe as the most open, yet least happy generation. She has argued that GenMe adults have budgets strained by expectations of their individual specialness and entitlement, resulting in purchasing luxuries considered to be necessities. They have experienced a sense of specialness through their lifelong imbibing of a water of positive self-esteem. The GenMe adult's life circumstances were organized around their experiences of high costs of rent, food, healthcare, and childcare; of constant advances in communication technology making demands to keep up with technological innovations; of availability and expectations for travel to exotic places to tally "experiences." But as expenses have increased (relative to past generations), there has not been a corresponding increase in available resources. In fact, there has been a decrease of availability of jobs, pay rate per job, expectation of stay-at-home moms (or dads), and expectation for advancement. The increase in expenses and decrease in resources combine to render millennials the most depressed, anxious, and miserable generation.¹⁵

Redistribution of the Population by Age

The generational differences will have other profound effects in society. For example, the population distribution is rapidly shifting from the past population pyramid (fewer elderly down to many children) to a population rectangle (about equal numbers across all ages). This means that not only are the numbers of older adults increasing simply because population is increasing, but the relative number of older adults is dramatically increasing, which will place demands on healthcare funding. With this population shift, religiously and spiritually oriented psychotherapists will need to develop increased capabilities in counseling elderly people. Some issues that will demand competence more than in the past are (a) dealing with healthcare issues and health psychology/behavioral medicine and (b) counseling for bereavement, anticipation of death, and issues of meaning and (perhaps) forgiveness.

In addition, this evolving population distribution toward the elderly end of the spectrum will affect where people live. The current steady worldwide trend toward urbanization will accelerate as the population shifts toward increased numbers of the elderly. Urban activity centers will drive population growth. In the 1940s urban planners could build a church and a community would grow up around it. That church was the hub of an activity center. In the 1950s they could build a golf course or housing project and a community would grow up around it. By the 1970s and thereafter, urban planners could build a shopping mall and a community would grow up around it. But in the future urban planners will need to build a healthcare campus around which a community can grow. Those campuses will provide comprehensive wrap-around healthcare services within a compact geographic area. The availability of services will permit people in the local area to have access to most of their physical and mental healthcare services without having to drive to get there. Even for people not living in the community, these campuses will be convenient one-stop shopping sites for healthcare needs.

Because of the aging population, financial strains will be more prevalent. Even though there is a widening

¹⁴ Levitt and Dubner, *SuperFreakonomics*.

¹⁵ Twenge, *Generation Me*.

wealth gap between the average elderly person and the average young adult, a large portion of the elderly population did not plan ahead financially and thus have low incomes and minimal savings. Even at the young end of the population rectangle, the financial strains on millennials are great. Much of their money is obligated for housing, childcare, insurance, and loan payback. Yet access to healthcare for millennials will be increasingly important across the lifespan, as they come to have more healthcare costs. All ages will need access to a complex of healthcare, especially after the Affordable Healthcare Act of 2010 and its implementation. More people will want to live close to population centers—not merely to be in urban areas but to be in proximity to healthcare campuses in urban areas so that they will have ready access to healthcare.

The implications for psychotherapy include likelihood that most psychotherapists will live in population centers and work on healthcare campuses. The inevitable result of this residence and employment shift for psychotherapists will be diverse communities, diverse clients, diverse religious/spiritual clients, and diverse-age clients who are evenly distributed across the age span. There will be a strong increase in aging boomer clients, many of whom have grown up on non-traditional religious and spiritual beliefs and practices. Psychotherapists must develop increased skills and capabilities to deal with many different religious and spiritual issues, and few will have the luxury of treating clients from one religious or spiritual population, which was much more possible in the past.

Unemployment and Under-Employment

Speculating even further, still other changes can be considered likely. There is a projected shift for the post-emerging adult generation—those who have been in first jobs for a while and are forming families. The Department of Labor predicts that by 2020, there will be a substantial mismatch in job skills needed and job skills present in the workforce.¹⁶ Middle-skill workers, those with more than a high school diploma and less than a college degree, will be in short supply. High school educated adults will not be able to get the jobs they need, and many adults with a college degree will be under-employed. This will result in career dissatisfaction for millennials who have been educated to believe that they can and should be employed in jobs allowing creativity, freedom, and meaningful contribution.

Social and Societal Revolutions Affecting Religion

As the millennial generation assumes additional responsibilities of starting a family, they will be even more stressed. Traditionally couples starting a new family tend to enter formal religious communities for the sake of their children. But will they do so if they are financially stressed, under-employed or unemployed, and not have grown up in a religious community (which is increasingly prevalent)?

Spiritual Revolutions Since 1960

The 1960s culture experienced the importation of Eastern religions, including their secularizations in meditation, yoga, and drug-related spirituality. At the end of the 1960s there was a huge influx of immigrants from Southeast Asia due to the conflict in Vietnam (and nearby areas), bringing many people who practiced Eastern religions within the borders of the United States. Additionally, Vietnam vets filled the VAMC system with (a) people who were depressed, felt rejected for their military service and sacrifices, and were experiencing PTSD¹⁷—a sense of moral injury inflicted on themselves¹⁸; (b) depression, alcohol and drug dependencies that were treated in spiritual (but not religious) AA-based programs¹⁹; and

¹⁶ *Occupational Outlook Handbook*.

¹⁷ Bryan, Theriault and Bryan, 2015, “Self-forgiveness, posttraumatic stress, and suicide attempts.”

¹⁸ Drescher, Foy, Kelly, Leshner, Schutz and Litz, “Exploration of the Viability and Usefulness”; Litz, Stein, Delaney, Lebowitz, Nash, Silva and Maguen, “Moral Injury and Moral Repair.”

¹⁹ Stein, Mills, Arditte, Mendoza, Borah, Resick, Litz and Strong Star Consortium, “A Scheme for Categorizing”; Toblin, Riviere, Thomas, Adler, Kok and Hoge, “Grief and Physical Health Outcomes.”

(c) individuals with high suicide risk.²⁰ Many veterans had also been exposed to Eastern spirituality in Vietnam or afterwards in the USA as a result of the openness to Eastern religious perspectives, just as those who did not do military service had been exposed to street drugs and Eastern philosophies and religions. As a result, many in the boomer generation entered psychotherapy, pursued psychological awareness, and attempted to sort out their psychological disorders while they were particularly attuned to spirituality—especially Eastern religions and philosophies.

Not all were oriented to non-religious or Eastern spirituality. The Jesus revolution of the late 1970s and early 1980s and the quickly following Charismatic renewal²¹ provided a cadre of baby boomers who had related together, had emotional experiences with Christian faith, and seen healings and miracles. They were particularly attracted to theologically conservative Evangelical theologies, whether they gravitated to faith commitments of Pentecostal, Charismatic, Evangelical, Baptist, theologically conservative Roman Catholic, or Bible-based independent community churches. Thus they were seeking belief-based, religious value-based psychotherapies. These developments provided a huge demand-side push toward religiously accommodated treatments, especially Christian-accommodated treatments or more generally theistically accommodated treatments.²²

But by GenMe, the spiritual landscape had changed. As Christian Smith and his colleagues have noted,²³ millennials in strong majority—even committed Christians—believe in Moralistic Therapeutic Deism, which is characterized by the following beliefs:

1. God exists; God created and ordered the world and watches over human life on earth.
2. God wants people to be good, nice, and fair to each other, as taught in the Bible and by most world religions.
3. The central goal of life is to be happy and to feel good about oneself.
4. God does not need to be particularly involved in one's life except when God is needed to resolve a problem.
5. Good people go to heaven when they die.

These beliefs characterize adolescents as described in *Soul Searching: The Religious and Spiritual Lives of American Teenagers*²⁴ and young adults from the same cohorts in *Souls in Transition: The Religious and Spiritual Lives of Young Adults*.²⁵

In short, most of the millennials in the United States believe in God, some supreme being, or something spiritual or transcendent. Yet for many their spirituality is a felt spirituality that is revealed in but does not seem to touch their everyday behavior—unless a problem arises beyond their control. Religious accommodation of psychological treatments rarely makes sense to the cohort of GenMe. Instead, spiritual accommodation, including full-blown acceptance-oriented multiculturalism and sensitivity to diversity, mandate that every religious and spiritual group's spirituality be recognized and respected. The GenMe self-absorption means that the GenMe psychotherapy patients expect individualized treatment. They demand accommodation and respect for their particular brand of spirituality, no matter how idiosyncratic.

Cultural Sensitivity to Diversity Revolution

There has been a steady and perhaps increasing rise of cultural sensitivity including sensitivity to issues of gender, race and ethnicity, LGBTQ, and other individual differences. This has come about largely by contact with people who have a variety of differences. New patterns in mobility, communication, and international collaboration have shaped new generations of people with different needs and expectations

²⁰ Drescher et al., "Exploration of the Viability and Usefulness."

²¹ Fiddes, Martin and Mullen, *The Theology of the Charismatic Movement*.

²² Richards and Bergin, *Handbook*.

²³ Smith and Denton, *Soul Searching*; Smith and Snell, *Souls in Transition*.

²⁴ Smith and Denton, *Soul Searching*.

²⁵ Smith and Snell, *Souls in Transition*.

about treatment. People expect (and demand) that diversities of all sorts be not only respected but honored, making them more likely to expect accommodation of psychological treatment to their own religious and spiritual preferences. And if accommodation is not forthcoming, clients will seek treatment where it is and possibly (in our litigious society) demand redress publicly and perhaps legally.

Reagan's Accountability Revolution

Ronald Reagan's election ushered in an era of conservative politics from 1981 to 1989 that changed the face of mental health, much as the Affordable Healthcare Act of 2010 (Obamacare) is changing physical and mental healthcare. Reagan brought in an era of awareness of fiscal responsibility and accountability joined with across-the-board slashing of government spending except for a massive buildup in defense spending that increased the national debt. However, some historians credit this buildup with creating economic pressures that pushed the USSR out of existence and ended the Cold War.

The accountability revolution had two (perhaps three) major implications for psychotherapy. First, it ushered in managed mental health care, affecting psychotherapy directly. Second, it almost certainly created more public need to study forgiveness and reconciliation, since former Cold War enemies were now supposed to reconcile and get along. Third, a change which might be attributed at least partially to the end of the Cold War was an acceleration of the positive psychology movement as the mood of the country changed. So Reagan's revolution likely affected treatment and thus religiously accommodated treatments.

Terrorism and Radical Islamic Fundamentalism

While a vast majority of Muslims are God-fearing and peaceful, there has been renewed activity aimed against "enemies of Islam" and toward establishing *sharia* within Muslim-dominated territories and countries.²⁶ In many ways, these trends have increased polarization because their views are at odds with many people's beliefs: Christian, Hindu, Buddhist, or strictly non-religious and secular. This has set a climate of anxiety, fear, and feelings that trend toward hatred in many, along with additional anxieties and existential worry. The visible and vocally religious identity of some terrorist groups has turned some people away from all religions, created polarizations in many people whose religion is threatened, and instilled fear in people who might be subject to violence at the hands of religious radicals.²⁷ This has had an inevitable backlash against any group of religious people who state their beliefs openly and without intellectual compromise. The anxieties from terrorism are consistent with other social trends toward favoring diversity and enforcing sensitivity to diversity. The result in many people is ironic. They value all kinds of diversity except religious diversity—sometimes resenting only radical religious differences, but sometimes extending their dislike to other religious faith commitments. This will exert inevitable pressure on religious accommodation in psychotherapy, especially if the polarization, anxieties, and fear do not abate or if they increase.

Revolutions in the Field of Psychology

In addition to broad shifts in culture, there have been revolutions within the discipline of psychology, which might be likened to what Stephen Jay Gould referred to as "punctuated equilibria": sporadic evolutionary phase shifts.²⁸ So I will treat these as a series of micro-revolutions and try to examine the cross-connections across areas.

²⁶ Rippin, *Muslims*.

²⁷ Hutchinson, *Hunt terrorists*.

²⁸ Gould, *Punctuated Equilibrium*, 26.

Cognitive Revolution

In 1974 Dember proclaimed that the cognitive revolution had come.²⁹ Therapists jumped on the bandwagon that experimental cognitive psychologists had started up. Cognition had traditionally been equated with explicit, rational, logical reasoning. But the new revolution in cognitive psychology was more concerned with implicit cognition³⁰ (note fallout from the social and societal revolutions discussed previously). The implications for psychotherapy were to validate some of the speculations of Freud at the turn of the twentieth century, though the dynamic unconscious motivations and sexual and death instincts were not embraced widely.

A revolution occurred in psychotherapy as well. People abandoned client-centered psychotherapy, behavioral therapy, and psychoanalytically informed psychotherapy to embrace CT and CBT.³¹ Unlike the revolution in cognitive psychology, which de-emphasized rational cognition, cognitively oriented psychotherapy emphasized rational and logical reasoning. CT and CBT taught clients that their behavior or emotions were due not to reactions to situations but to self-talk or beliefs. This necessarily involves explicit cognition. CT and CBT were especially amenable to accommodating religious psychotherapy, particularly informed by Evangelical Protestant theology, which also emphasized explicit beliefs. The presence of PhD and PsyD training programs at Fuller Theological Seminary, Rosemead School of Psychology, George Fox, Wheaton, Azusa Pacific, and Regent University, along with explicit training programs at what is now Richmond, led to an increase in studies of religiously accommodated CT and CBT.³²

The Emotion Revolution

Within the last 20 years in psychology (apart from psychotherapy), there has been a rise in the primacy of emotion. Emotion researchers like Antonio Damasio,³³ Paul Ekman,³⁴ and others have aimed researchers at investigating emotional processes and understanding emotions as embodied combinations of events that occur in the working memory (i.e., giving rise to feelings), as well as in brain circuitry, associations, hormones, facial musculature, and even gut feelings. In recent years, other less explicitly belief-oriented treatments have been developing alongside CT and CBT, like emotionally focused therapy, ACT, new psychodynamic attachment-based approaches, and interpersonal approaches, among others.³⁵ The implication for psychotherapy is that emotions have been attended to with even more care than when Carl Rogers³⁶ was in his ascendancy. However, emotions are understood as being more complex and more intertwined with cognition, especially implicit cognition.

The Positive Psychology Revolution

Seligman and Csikszentmihalyi³⁷ proclaimed a positive psychology revolution, embracing the neglected step-child positive half of psychology. This approach sought to treat psychology as composed of two sets of processes: (a) the negative, which had traditionally been emphasized and provided with funding bases, and (b) the positive. Many social and cultural changes have led to the rise of positive psychology, such as relative affluence that freed many people from thinking so much about deprivation and suffering and allowed them to turn their attention to flourishing.

²⁹ Dember, "Motivation and the Cognitive Revolution."

³⁰ Kahneman, *Thinking, Fast and Slow*.

³¹ Norcross, Vandenbos and Freedheim, *History of Psychotherapy*.

³² McMinn et al., "Religious and Spiritual Diversity."

³³ Damasio, *The Feeling*.

³⁴ Ekman, Levenson and Friesen, "Autonomic Nervous System Activity."

³⁵ Norcross, Vandenbos and Freedheim, *History of Psychotherapy*.

³⁶ Rogers, *Client-Centered Therapy*.

³⁷ Seligman and Csikszentmihalyi, "Positive Psychology".

Mental-Health-Related Developments Outside Psychology

Mental health-related changes and developments will also likely make a big impact on future treatment. These include advances in psychopharmacology, brain scanning technology, and genetic diagnostics.

The Psychopharmacology Revolution

Whereas many changes have been made in psychotherapies, especially in demonstrating the efficacy of different approaches and treatments, the real changes in treatment efficacy have been made in psychopharmacology. Generations of new psychoactive drugs have made giant inroads in the treatment and maintenance of gains in many previously seemingly intractable disorders.³⁸ While a combination of psychopharmacology and psychological treatment is still preferred for some disorders, for others psychopharmacology alone has been enough to manage people's troublesome behavior. Psychologists have begun to participate on wrap-around integrated teams that treat people using medical and psychological methods, including input from nurses, occupational therapists, clergy, and other mental health professions.

The Neuropsychology Revolution

The public have become enamored with brain scanning technology. It can seem from articles in public media sources that brain scanning is the definitive trump card of psychological science. In fact, there is much information about structure and function that scanning technologies can supply, and there are many neuropsychological assessment technologies. Recently Lenkov, Volnova, Pope, and Tsytsarev described many of the possibilities for various methods.³⁹ However, studies also noted the limitations for a number of scanning technologies.⁴⁰ These include electroencephalography (EEG), functional magnetic resonance imaging (fMRI), positron-emission tomography (PET), low-resolution electromagnetic tomography (LORETA), single photon emission spectroscopy (SPECT), near-infrared spectroscopy (NIRS), and optical imaging of intrinsic signals (IOS). Many of the limitations involve cost, equipment availability, low sample sizes, and potentially difficult-to-interpret findings. For example, fMRI can reveal which parts of the brain are more active during cognition, but the real causal action might actually be occurring at a different site, upstream where neural inhibition is turned off or restrained. Thus although it appears that particular activity is causing brain and behavior changes, the increased activity is the product of more important changes elsewhere.

The Genetics Revolution

Similar to changes in psychopharmacology and in assessment of brain functioning and structures, progress in mapping of the human genome, including development of supercomputers and computational sophistication to analyze that mass amount of data, enabling the potentiality for genetic diagnostics and the resulting comprehension of physical and chemical aspects of protein structure and function, are providing new avenues for understanding current and even future behavior.⁴¹ People can even pay to determine whether they have genetic predispositions to mental health disorders. In the future this might affect the numbers of people who have psychological disorders, as genetic profiling on children in utero may cause parents to elect abortion when a serious problem is shown to be within the genetic predisposition.

However, psychological disorders are almost always on some spectrum. A common finding is that people who have bipolar disorders, for example, tend to have relatives who are over-represented as highly

³⁸ For one of many examples of meta-analyses, see Dold, Li, Gillies and Leucht, "Benzodiazepine Augmentation of Antipsychotic Drugs."

³⁹ Lenkov, Volnova, Pope, and Tsytsarev, "Advantages and Limitations of Brain Imaging."

⁴⁰ Bennion, Ford, Murray and Kensinger, "Oversimplification."

⁴¹ Collins, *Effective Counseling*.

productive adult achievers.⁴² Perhaps the same genes that produce manic episodes in one sibling activate creative and productive energy in genetically related relatives. Thus genetics interventions can possibly be used proactively to help reduce some psychological problems, but it is an open question whether doing so might actually harm the gene pool and reduce extraordinary achievement in others.

It is not too implausible to think that such genetic technology could someday be used for eugenic purposes. (Scientific advances have had such sordid uses in the past.) If people did not value religion, for example, and they had their children tested for genes that predisposed for religion, they might make choices about abortion, or they might even choose not to have children. Such ethical and moral questions are always on the horizon for technological advances.⁴³

Most likely the biggest impact on genetically influenced treatment will not be through the composition of people's DNA, but through scientists' ability to affect genetic expression. *Epigenetics* is the influence of genetic expression (thus influence on phenotype) without modifying the genetic sequence (i.e., maintaining an unchanged genotype). Many factors can influence genetic expression, such as age, environment, lifestyle, and disease status. Genetic expression can be modified through influencing (a) DNA methylation, (b) histone modification, or (c) non-coding RNA that can turn off or turn on genes. It is easily within the realm of plausibility that psychotherapists will begin intentionally aiming portions of their treatment at changing factors that can turn off or on genes, even if a person has been genetically tested and comes to psychotherapy thinking he or she is predetermined for a mental illness (or safe from developing one).

The Multicultural Revolution

Multiculturalism came to prominence during the 1970s with a rise in post-modern philosophy.⁴⁴ Truth began to be defined not relativistically, but as pertaining to particular cultural communities. For the study of religion and spirituality in psychological science and psychotherapy, this was a positive development. Religion ostensibly would not be marginalized (any more than other diverse communities were marginalized). I am not sure that this has occurred with religion in practice, as many in the United States do not see religion as a diversity issue. In fact, many still see it as a majority issue and therefore not due the same considerations as racial and ethnic minorities or even majorities that had been socially disadvantaged historically (e.g., women).

Revolutions Within Psychotherapy Practice

The Managed Mental Health Care Revolution

In the 1970s and early 1980s, the cost of psychotherapy was out of control. Private practices multiplied. Patients paid out of pocket for psychotherapy and then filed their bills with their insurance companies for reimbursement. Psychotherapists were regularly charging well over \$100 per hour. (Considering the standard of living in 1980, that fee would be inconceivably high today.)

A social transformation, necessitated partially by huge costs of hospitalizing people with serious mental illnesses and serious emotional disorders, and made possible by the advances in psychopharmacology that made reduction and management of psychological symptoms possible in many disorders (e.g., bipolar disorder, schizophrenia, depression, and anxiety), brought about a movement of de-institutionalization of patients with psychological disorders. Millions of patients who had previously stayed in hospitals for years were released—many in two weeks or thereabouts—and treatment consisted of medications they received at community service boards (CSBs) and other outpatient treatment. The strain on psychotherapists, especially those in state-supported CSBs, was overwhelming and increasing daily.

⁴² Hinshaw, *Origins*.

⁴³ See Kass, *Life, liberty*.

⁴⁴ Fukuyama and Sevig, "Integrating Spirituality."

In 1984 a sea change occurred. A team led by Ken Howard completed a study analyzing the dose-response relationship including thousands of psychotherapy cases. It showed that most of the gains in psychotherapy, regardless of type, were made in the first seven sessions.⁴⁵ With increased pressure from insurance companies to control costs, from the entire mental health system to alleviate the strain of increased numbers of people desiring psychotherapy, from Reagan-informed public opinion to demonstrate accountability trickling into psychotherapy, and from clinical science regarding the number of sessions that yielded maximum rates of change in seven or fewer sessions, the psychotherapy industry was transformed. Managed mental health care companies sprang up. They created panels of approved providers; placed limits on number of sessions, often four; and required lengthy treatment plans, progress reports, and long justifications for additional sessions beyond four (rarely approved). Furthermore, managed mental health care demanded that treatments be efficacious. The movement to identify empirically validated (later called empirically supported) treatments began.⁴⁶

Empirically supported treatments were those validated as superior to a control condition (i.e., no treatment, alternative treatment, or treatment as usual). Superiority required at least two randomized controlled trials done in independent laboratories. Later that concept gave way to evidence-based treatments, which might be supported with a more nuanced case for efficacy that included case studies, *N*=1 design studies, non-randomized field studies, RCT trials (more than two, from many different labs being preferable), effectiveness trials using community treatment facilities, and later dissemination trials.

Recognizing the power of the therapeutic relationship, Norcross and others led a movement based on the idea that patient factors—common relationship factors in treatment (e.g., working alliance, empathy, relationship damage repair, counseling style) and other relationship considerations (e.g., matching patients to treatments and matching relationship factors of patients to treatments)—were perhaps even more important than mere efficacy of treatment.⁴⁷ These *evidence-based relationship factors* have been reviewed and meta-analyzed and have become a corpus of studies that the joint Task Force on Relationship Factors in Psychotherapy evaluated as strongly indicative of an evidence-based relationship factor.⁴⁸

The Joint Task Force on Evidence-Based Relationship Factors recommends that religious and spiritual matching has the highest level of empirical support. Many of these pre-2010 studies were driven by Christian psychologists, though it is unclear whether this trend will maintain. There are now Jewish-accommodated,⁴⁹ Hindu-accommodated,⁵⁰ Buddhist-accommodated,⁵¹ and Muslim-accommodated psychotherapies.⁵² (In fact, putting *Muslim* and *psychotherapy* into PsycINFO yields 140 hits). And client demand is pushing for additional religiously or spiritually accommodated therapies to gain empirical support and become evidence-based practices. This acceptance will require (a) client demand, (b) psychotherapist willingness to invest in religiously or spiritually accommodating treatments, and (c) continued cultural support for tailoring treatments to clients with special preferences, like religious or spiritual orientation. Given the increase in studies of different religiously accommodated treatments, the body of literature is different. When the Task Force on Evidence-Based Relationship Factors reconvenes, it will be interesting to see whether the power of accommodating treatments to religions as a client-matching variable has been diluted, strengthened, or left unchanged with that increase in desired diversity.

Consideration of both evidence-based treatments and evidence-based relationship factors has become the current standard for evidence-based practice in psychology.⁵³

⁴⁵ Howard, Kopta, Krause and Orlinsky, "The dose-effect relationship."

⁴⁶ Chambless and Hollon, "Defining Empirically Supported"; Chambless and Ollendick, "Empirically Supported Psychological Interventions"; Chambless, Sanderson, Shoham, Bennett-Johnson, Pope, Crits-Christoph et al., "An Update."

⁴⁷ Norcross, *Psychotherapy Relationships That Work*; Norcross, *Evidence-Based Responsiveness*.

⁴⁸ Norcross, *Evidence-Based Responsiveness*.

⁴⁹ Rosmarin, Pargament, Pirutinsky and Mahoney, "A Randomized Controlled Evaluation."

⁵⁰ Sharma and Tummala-Narra, "Psychotherapy with Hindus."

⁵¹ Desmond, *Self-Compassion in Psychotherapy*; Hayes, Strosahl and Wilson, *Acceptance and Commitment Therapy*.

⁵² Abu-Raiyu, "Working with Religious Muslim Clients."

⁵³ For a history, see Worthington, Wade and Hoyt, "Evidence-Based Practice."

The Evidence-Based Religiously Accommodated Treatment Revolution

This demand for accountability along with the response of clinical scientists with empirical evidence enables religiously oriented psychotherapists to consider choosing treatments that have been proven acceptable, reimbursable, efficacious for their religious clients. The accumulating psychological scientific evidence has supported primarily cognitive and CBT treatments.⁵⁴ That was a happy coincidence because religious psychotherapists sought to deal with religious clients, and the important part of religion—at least at that time— was considered to be the clients' religious beliefs and values. It has been no surprise that gathering evidence of religiously accommodated psychotherapy has become essentially accumulating RCTs of religiously accommodated CT and CBT.⁵⁵ In fact, what was perhaps the first meta-analysis of religious and spiritual treatments involved only five religiously accommodated CBT and CT treatments for depression.⁵⁶

In the years since the early accumulation of evidence-based practices, more attention has been paid to how psychotherapy is actually practiced in the psychotherapy office. This attention has led to providing practice-based evidence, which is valuable in its own right and additionally figures into effectiveness research and dissemination of evidence-based practices, as discussed later in this article.

The Diagnostic Revolution

Advances in psychological assessment, neuropsychology, and genetics have yielded potential new diagnostic methods like fMRIs that will likely make a significant impact on future treatment. These are largely undeveloped or are too expensive for most people to afford, and insurance will not cover them.

In addition, the assessment methods are too expensive in time and money to implement in a randomized controlled trial. It is virtually impossible to imagine that such sophisticated methods could ever be employed on effectiveness research in the clinic at a variety of sites or that system-wide use of sophisticated assessment methods might ever be available. The resources required are just too expensive to believe they would ever be used; thus these methods will only be usable in randomized controlled efficacy trials. Because sophisticated assessment methods generally are so labor intensive that they limit sample size, it is unlikely that these assessments will make a large system-wide impact on psychotherapy research and practice. However, there are many portable assessment options that employ technology. For example, potential new diagnostic methods like mobile-devices (e.g., Fit-Bit©) can be used by psychotherapists to monitor behavior of clients in health-related treatments.

Other changes in psychotherapy are likewise likely to profoundly affect the future. New modes of treatment have been developed: for example, distance delivery of psychotherapy via the internet has been used in VAMCs and state community service boards in serving patients in rural areas and in the military. However, internet counseling has yet to become widespread for private counseling.

The Post-Efficacy Revolution

Another current revolution is a move from emphasizing efficacy research using randomized controlled trials to employing effectiveness research and dissemination research. It was extremely important as we passed through managed mental health care and Reaganomics to demonstrate that treatments were efficacious. The field responded admirably. We have had many efficacy trials, and those have been reviewed and meta-analyzed in Worthington, Hook, Davis, and McDaniel.⁵⁷ Many randomized controlled trials have been conducted using religiously accommodated treatments, most accommodated for Christianity.⁵⁸ However, studies with high internal validity might differ substantially from those with higher external validity, representing what psychotherapists actually do in the counseling room.

⁵⁴ Worthington, Hook, Davis, Gartner and Jennings, "Conducting Empirical Research."

⁵⁵ Worthington, Johnson, Hook and Aten, *Evidence-Based Practices for Christian Counseling*.

⁵⁶ McCullough, "Research on Religion-Accommodative Counseling."

⁵⁷ Worthington, Hook, Davis and McDaniel, "Religion and Spirituality."

⁵⁸ For a review, see Hook et al., "Empirically Supported Religious and Spiritual Therapies."

External validity of evidence-based treatments through effectiveness research

There are two major types of these effectiveness studies. In field studies⁵⁹ the researcher simply tries to see how things are done in the field. But there also are controlled effectiveness trials. These trials use more controls, often asking practicing psychotherapists to employ manual-directed evidence-based treatments in their practice with real clients, sometime comparing clients who are randomly assigned to treatment as usual or to the manual-driven intervention.⁶⁰ Studies with controls like this are a substantial step up in being able to reveal causes for change over simply looking at field studies. Field studies could show treatments to be effective because of many reasons, including client selection into different types of treatments, psychotherapist allegiance, psychotherapist demand characteristics, and other reasons.

However, problems exist in moving from efficacy trials to effectiveness trials. Some psychotherapists are opposed to changing away from the theories and approaches they are familiar with. Psychotherapists can be trained to conduct evidence-based treatments using lectures, manuals, meetings with the psychotherapists, monitoring, and supervision.⁶¹ But, beyond mere training, other problems exist. Once psychotherapists have been trained, they rarely use the evidence-based treatment as it was presented in the manual. Instead, they select portions, using some portions and ignoring other portions of the treatment, and they make individualized modifications based on their clinical experience or clinical intuition.⁶²

The problems emerging from research on effectiveness trials are discouraging. Numerous studies have shown that when therapists in the community use evidence-based treatments, these advances typically do not outperform treatment as usual⁶³—which is not the usual finding in efficacy studies. But practicing psychotherapists seem less willing to adhere to manuals than do psychotherapists in controlled efficacy studies, and, unlike many graduate student psychotherapists who participate in efficacy trials, they typically have had extensive experience with their “treatment as usual.”

External validity through dissemination trials

The next step beyond controlled effectiveness trials is dissemination trials in which a mental health system identifies a treatment as accepted widely as evidence-based with a possibility of being adopted as one of two or three acceptable treatments for a particular type of problem throughout a large system.⁶⁴ The large systems include state mental health systems, Veterans Administration Medical Centers, or large community systems like Pacific Clinics System in California or Stars Community Services in California. In a dissemination trial, psychotherapists must adhere to approved treatments, enabling comparisons across the system since the number of treatments is limited and data are available on psychotherapists. In addition, there are opportunities to monitor the adherence of psychotherapists to the treatment protocol over time and to investigate reasons that psychotherapists depart from acceptable and approved protocols.⁶⁵

The findings of dissemination trials are variable, involving different treatments in different systems with different types of psychotherapists and clients. However, we might be able to make a reasonably accurate generalization. Typically dissemination trials do not provide the overwhelmingly positive effects that seem typical of randomized clinical trials.⁶⁶ In fact, generally, dissemination trials are hard pressed,

⁵⁹ See Hook, Worthington, Atkins and Davis, “Religion and Couple Therapy.”

⁶⁰ Laurenceau, Stanley, Olmos-Gallo, Baucom and Markman, “Community-based Prevention of Marital Dysfunction.”

⁶¹ For reviews, see Beidas and Kendall, “Training Therapists”; Herschell, Kolko, Baumann and Davis, “The Role of Therapist Training”; see also Beidas, Edmunds, Marcus and Kendall, “Training and Consultation”; Jensen-Doss, Hawley, Lopez and Osterberg, “Using evidence-based treatments.”

⁶² Southam-Gerow, Rodriguez, Chorpita and Daleiden, “Dissemination and Implementation.”

⁶³ Southam-Gerow, Rodriguez, Chorpita and Daleiden, “Dissemination and Implementation”; Southam-Gerow, Weisz, Chu, McLeod, Gordis and Connor-Smith, “Does Cognitive Behavioral Therapy.”

⁶⁴ McHugh and Barlow, “The Dissemination and Implementation of Evidence-Based Psychological Treatments,” *Dissemination and Implementation of Evidence-Based Psychological Interventions*.

⁶⁵ Sholomskas, Syracuse-Siewert, Rounsaville, Ball, Nuro and Carroll, 2005, “We Don’t Train in Vain.”

⁶⁶ McHugh and Barlow, “The Dissemination and Implementation of Evidence-Based Psychological Treatments,” *Dissemination and Implementation of Evidence-Based Psychological Interventions*.

despite huge numbers of clients and psychotherapists, to show that treatments are effective. This does not refer to religiously accommodated treatments for depression, but to a step up—cognitive behavioral treatments for depression or anxiety⁶⁷ regardless of whether religion or spirituality is mentioned.

Therefore, the gold standard of psychotherapy research has moved from efficacy studies to evidence-based treatment. A volume of efficacy research must be supplemented by effectiveness research in the actual community of psychotherapists and clients, and the highest level of confidence in treatments should be dissemination research in big systems using strong, evidence-based treatments.

In the field of religiously accommodated treatments, the only existing dissemination or controlled effectiveness trial was of Markman and Stanley's Christian PREP.⁶⁸ PREP has been used widely in the army and in federal government-sponsored research efforts disseminated to help couples in lower socioeconomic groups. However, it has not been shown to produce strong effects. The dissemination trial of the Christian-accommodated version of PREP was a study of 217 couples from 57 churches in the Denver area, all using the PREP program. Newly married couples were randomly assigned to one of three intervention conditions: (a) PREP delivered by university clinicians, (b) PREP delivered by religious clergy, or (c) treatment as usual. Self-reported relationship satisfaction, negative behavior, and positive behavior were assessed at pre-intervention, post-intervention, and 1-year follow-up. Trajectories of relationship satisfaction showed no change over time and did not differ across conditions. However, when PREP was delivered by clergy, negative behavior of wives did show greater decreases than treatment as usual. All conditions showed declines in positive behavior, but clergy-delivered PREP produced less decline than treatment as usual or treatment delivered by university clinicians.⁶⁹ This research on religiously accommodated PREP was consistent with much of the other research on effectiveness and dissemination of evidence-based treatments. Typically evidence-based treatments have been shown to achieve much less success than previously anticipated. While evidence-based practices seemed like a great advance in psychotherapy, doubts cloud the horizon.

Religious and Spiritual Changes Affecting Accommodation

Changes in Modern Theology Toward More Openness and More Relationality

Theological changes may push toward more open theology,⁷⁰ arising from openness in social and societal issues, increase in acceptability of evolution, seeming headlong acceleration of change, and gradual dislodging of conservative social and often theological values. Such changes have led in many instances to more erosion of Reformed theological perspectives and acceptance of perspectives that emphasize free will and an undetermined view of the future.

Thus in the United States religious changes—like less doctrinally centered religions and more acceptance of spirituality rather than a collection of codified religious doctrines in mainline churches—have multiplied. However, many conservative and Reformed theologies still exist, resulting in more polarization in the religious and theological spheres. As theologians have grappled with this polarization, there has been a shift toward more relational theologies. These include theology that focuses on people's relationship with God (rather than doctrinal and creedal beliefs) and people's relationships with each other (which reflects societal attunement to social justice). Brooks has analyzed Western social evolution as flowing from moral realism to romanticism. Moral realism embraces a view of human nature that assumes that people are flawed and fallible. Romanticism assumes that human nature involves a more positive, humanistic outlook. Brooks argued that romanticism emerged in the 18th century, but only in the 20th century did it begin to supplant moral realism, and only in the 21st century has it become a dominant philosophy. As

⁶⁷ Ibid.

⁶⁸ Laurenceau, Stanley, Olmos-Gallo, Baucom and Markman, "Community-Based Prevention."

⁶⁹ Johnson, "Healthy Marriage Initiatives."

⁷⁰ Boyd, *Benefit of the Doubt*.

romanticism took root, Reformed theologies lost hold, and theologies that emphasized inner spirituality gained support.⁷¹

Changes in Emphasis in Psychology from Religion to Spirituality

Increasingly over the last 60 years, the scientific study of the psychology of religion and spirituality has reflected philosophical shifts between treating the terms together and focusing on spirituality rather than religion. Religion is characterized by people who believe, value, and practice things that a community of believers believe, value, and practice. Religion is based in a faith community. Spirituality, however, is about feelings of closeness to what one considers to be sacred.⁷² Spirituality is an individual construct.

To get a feeling for the effect, I entered the terms religi* and spiritua* in *PsycINFO* with years 1960-1969, 1970-1979, 1980-1989, 1990-1999, 2000-2009, 2010-2015. Two conclusions might be drawn from the summary (see Table 1). First, the numbers of citations of both have increased, suggesting that scientific attention to religion and spirituality has become much more acceptable. If rates are consistent throughout the remainder of the decade, about six times as many citations of religi* will characterize the 2010-2020 decade as characterized the decade preceding Bergin's (1980) article, with about 47 times as many citations of spiritua*. Second, the attention to the spiritual is increasing with each passing decade. The ratio of religi* / spiritua* has dropped from 10.0 in the decade prior to Bergin's landmark article to 1.8 today. This signifies, among other things, a continued march (or headlong race) toward individualistic spirituality and away from community-based religion. As Christian Smith has noted, Moralistic Therapeutic Deism seems to be the philosophy of the second decade of the 21st century.⁷³

Table 1. Prevalence of Religi* and Spiritua* by Decade in PsycINFO

Decade	Religi*	Spiritua*	Ratio religi* / spiritual*
1960-1969	2,140	163	13.1
1970-1979	4,035	403	10.0
1980-1989	6,911	1,435	4.8
1990-1999	9,920	4,023	2.5
2000-2009	23,157	12,499	1.9
2010-2015 (adjusted by multiplying by 10/6)	21,273 (35,455)	11,400 (19,000)	1.8

Changes in Types of Religiously Accommodated Treatments

However, in recent years there has been a marked shift in distribution of studies across religious and spiritual approaches. Buddhism has gained in popularity. In psychotherapy this has resulted in much attention to mindfulness interventions of a variety of types. The shift away from more conservative, Evangelical Christianity been pronounced. In 1999 McCullough meta-analyzed only CBT interventions. By 2010 there were many other varieties of religious and spiritual interventions.⁷⁴ By 2013 diversity of available religiously and spiritually oriented interventions had increased even more,⁷⁵ and in my perception this trend continues as we enter 2016.

⁷¹ Brooks, *The Road to Character*.

⁷² Davis et al., "Development of the Sources."

⁷³ Smith and Denton, *Soul Searching*; Smith and Snell, *Souls in Transition*.

⁷⁴ Worthington, Hook, Davis and McDaniel, "Religion and Spirituality."

⁷⁵ Worthington, Hook, Davis, Gartner and Jennings, "Conducting Empirical Research."

Future Implications

All of these changes suggest that mental health treatment will not be similar to what it was in 1980. In fact, we observe the trajectories as they form.

Treatments Will Become Even More Specifically Tailored to Particular Types of Clients

The world has become increasingly internationalized and diverse. The *Zeitgeist* is such that attention to diversity will be increasingly required, and social and political sanctions will be imposed if minority positions that do not value diversity and inclusiveness are expressed. Psychotherapists, due to many factors mentioned above, must be even more multiculturally competent and culturally humble⁷⁶ than is required today, especially in diverse religions.

Treatment Accommodation Will Trend toward Worldwide Religious and Spiritual Preferences

One of the biggest shifts has been from cognitive-behavioral therapy, which is more accommodated to Evangelical Christianity, to treatments more accommodated to variants of Christianity (more generically Christian, more Roman Catholic) and to other religions (Jewish, Muslim, and Buddhist). Because psychotherapists and potential clients will concentrate in population activity centers built around urban healthcare complexes, psychotherapists will likely be required more than previously to treat people who are religiously and spiritually different from themselves.

More Treatments Will Accommodate for Spirituality rather than for Religions

Religious experience has been increasingly privatized. The implication of this is that more treatments will be accommodated to people's individualized experience of relationship with the Sacred (however they identify the Sacred), and that means it will be more spiritually rather than religiously focused.

Some Formerly Religious Practices Will Increase in Secular Psychotherapy

In addition, the lines between the secular and the religious have become increasingly blurred. This has decreased the number of explicitly religiously accommodated treatments that appear in practitioners' eclectic book of evidence-based practices. But it has also resulted in heretofore identified Christian practice (e.g., forgiveness, prayer, centering) as well as Buddhist-originated methods (e.g., mindfulness, meditation, yoga, self-compassion) being prominently portrayed, taught, and learned as religion-free methods (or at least methods that do not require formal adherence to the religion of origin). Many are now used as secularized methods in secular psychotherapy. It is an empirical question whether secularizing treatments previously identified as religious will strip them of their power to affect people's lives.

More Religiously and Spiritually Accommodated Treatments Will Probably Be Delivered in Healthcare Campuses than in Churches

As I have argued, the action centers of the future will largely be in urban areas, and the center of those areas will likely be in healthcare campuses. Those campuses will seek to provide comprehensive wrap-around healthcare and mental healthcare services within a compact geographic area requiring little travel. I predict that more psychotherapists will locate in those centers where more of their potential clientele are living. As healthcare becomes the organizing point of society, mental healthcare will be included. Religiously and spiritually oriented treatments will likely shift out of churches, especially if trends toward decreasing religious involvement maintain.

⁷⁶ Hook, Davis, Owen, Worthington and Utsey, "Cultural Humility."

Choices among Evidence-Based Religiously Accommodated Psychotherapy Practices Will Likely Narrow Drastically

In the past, as many research studies involving randomized controlled trials have been done and as research has accumulated, an increasing number of treatments have been advanced as evidence based. The list has grown unmanageably long. But recent trends in effectiveness research and dissemination research have shown that efficacy-supported treatments cannot be used in the community with effectiveness equal to internally valid lab results.

So we are likely to see a decrease in number of treatments identified as top-level evidence-based practices in psychology. Those highly recommended treatments will soon, I believe, require effectiveness and dissemination support to be judged as evidence-based gold-standard treatment. Financial support, as always, will determine much of the landscape of the next generation of psychotherapy research. In Freud's day financial support was provided by individual clients, who supported time- and fund-intensive psychoanalysis. Over the last 50 years, financial support has been provided by universities and government grants, available in sizable amounts but mostly to support efficacy trials. Now with more interest in community-based effectiveness research and in system-applied dissemination research, only the strongest, most efficacious treatments will be supported at the level to complete effectiveness or dissemination trials.

Thus there is likely to be a substantial winnowing of treatments over the next 25 years. This will not benefit religiously accommodated treatments. In this separation-of-church-and-state era, government funding sources will be reluctant to support many (if any) of the specifically religiously accommodated treatments, especially if further limited by special populations. For example, it is unlikely that a large dissemination trial for cognitive-behavioral treatment of Christians suffering from anxiety will occur in large systems like the VAMC or a state government.

In addition to the reduction of specific evidence-based religiously accommodated treatments that will not be supported by effectiveness and dissemination trial research, there will be pressure for psychotherapists to competently treat a diverse population who live in urban action centers. Psychotherapists will be forced to seek wide training in religious and spiritual treatment accommodations and be competent in many or to affiliate with other practitioners who are competent in diverse treatments and are available for referral.

Thus when Bergin wrote his seminal article, he initiated a golden age of practice and research on psychotherapy that has been religiously and spiritually accommodated. But from my vantage point the future looks a lot cloudier for continued growth of such treatments.

Conclusion

Although I think that we are on the brink of a retrenchment in the field of religiously and spiritually accommodated treatments, I am not confident of my assessment. I acknowledge that in light of the often seemingly discontinuous changes in the past, predicting the future is at best tentative. When I began practicing in the 1970s, I had no idea that managed mental healthcare would occur. I had no idea of the massive changes in treatment of mentally ill people that psychopharmacological advances would bring about. I had no idea of the way evidence-based practice of psychology would develop. So I am not confident that I can see into the future as I make these speculations.

What I know, though, is that Bergin's article in 1980 created a whirlwind of change. It moved religious and spiritual accommodation into a national conversation that has changed public dissemination of mental health services for that last 35 years. What a difference it has made.

References

- Abu-Raiyu, Hisham. "Working with Religious Muslim Clients: A Dynamic Qura'nic-based Model of Psychotherapy," *Spirituality in Clinical Practice* 2 (2015): 120-133.
- Adams, Jay E. *The Christian Counselor's Manual: The Practice of Nouthetic Counseling*. Grand Rapids, MI: Zondervan, 1973.

- Beidas, Rinad S., Julie M. Edmunds, Steven C. Marcus and Phillip C. Kendall. "Training and Consultation to Promote Implementation of an Empirically Supported Treatment: A Randomized Trial," *Psychiatric Services* 63 (2012): 660–665.
- Beidas, Rinad S. and Phillip C. Kendall. "Training Therapists in Evidence-based Practice: A Critical Review of Studies from a Systems-Contextual Perspective," *Clinical Psychology: Science and Practice* 17 (2010): 1–30.
- Bennion, Kelly A., Jaclyn H. Ford, Brendan D. Murray and Elizabeth A. Kensinger. "Oversimplification in the Study of Emotional Memory," *Journal of the International Neuropsychological Society*, 19 (2013) 953–961.
- Bergin, Allen E. "Psychotherapy and Religious Values," *Journal of Consulting and Clinical Psychology*, 48 (1980): 95-105.
- Beutler, Larry E. and John Bergan. "Value Change in Counseling and Psychotherapy: A Search for Scientific Credibility," *Journal of Counseling Psychology* 38 (1991): 16-24.
- Boyd, Gregory A. *Benefit of the Doubt: Breaking the Idol of Certainty*. Grand Rapids, MI: Baker Book House, 2013.
- Brooks, David. *The Road to Character*. New York: Random House, 2015.
- Brokaw, Tom. *The Greatest Generation*. New York: Dell Publishing, 2001.
- Bryan, AnnaBelle O., Jacqueline L. Theriault and Craig J. Bryan. "Self-forgiveness, Posttraumatic Stress, and Suicide Attempts Among Military Personnel and Veterans," *Traumatology* 21 (2015): 40-46.
- Chambless, Dianne L. and Steven D. Hollon, "Defining Empirically Supported Therapies," *Journal of Consulting and Clinical Psychology* 66 (1998): 7–18.
- Chambless, Dianne L. and Thomas H. Ollendick, "Empirically Supported Psychological Interventions: Controversies and Evidence," *Annual Review Psychology* 52 (2001): 685–716.
- Chambless, Diane L., William C. Sanderson, Varda Shoham, Suzanne B. Bennett-Johnson, Kenneth S. Pope, Paul Crits-Christoph, Mary J. Baker, Benjamin Johnson, Sheila R. Woody, Stanely Sue, Larry E. Beutler, David A. Williams and Susan McCurry. "An update on empirically validated therapies," *Clinical Psychologist* 49 (1996): 5–18.
- Clinebell, Howard. *Basic Types of Pastoral Care and Counseling: Resources for the Ministry of Healing and Growth*. Nashville: Abingdon Press, 1966.
- Collins, Frances S. *The Language of God: A Scientist Presents Evidence for Belief*. New York: Free Press, 2006.
- Collins, Gardy R. *Effective Counseling*. Carol Stream, IL: Creation House, 1972.
- Crabb, Larry J. Jr. *Effective Biblical Counseling: A Model for Helping Caring Christians Become Capable Counselors*. Grand Rapids, MI: Zondervan, 1977.
- Damasio, Antonio R. *The Feeling of What Happens: Body and Emotion in the Making of Consciousness*. New York: Harcourt Brace & Co, 1999.
- Dember, William N. "Motivation and the Cognitive Revolution," *American Psychologist* 29 (1974): 161-168.
- Desmond Tim, *Self-compassion In Psychotherapy: Mindfulness-Based Practices for Healing and Transformation*. New York: W. W. Norton, 2015.
- Davis, Don E., Kenneth Rice, Joshua N. Hook, Daryl R. Van Tongeren, Cirleen DeBlaere, Elise Choeand and Everett L. Worthington Jr. "Development of the Sources of Spirituality Scale," *Journal of Counseling Psychology* 62 (2015): 503-513.
- Dold, Markus, Chunbo Li, Donna Gilliesand ans Stafan Leucht. "Benzodiazepine Augmentation of Antipsychotic Drugs in Schizophrenia: A Meta-Analysis and Cochrane Review of Randomized Controlled Trials," *European Neuropsychopharmacology* 23 (2013): 1023-1033.
- Drescher, Kent D., David W. Foy, Caroline Kelly, Anna Leshner, Kerrie Schutzand and Brett Litz. "An Exploration of the Viability and Usefulness of the Construct of Moral Injury in War Veterans," *Traumatology* 17 (2011): 8-13.
- Ekman, Paul, Robert W. Levensonand and Wallace V. Friesen. "Autonomic Nervous System Activity Distinguishes Among Emotions," *Science* 221 (1983): 1208-1210.
- Fiddes, Paul, David Martin and Peter Mullen, eds., *The Theology of the Charismatic Movement*. Oxford, England: Blackwell, 1984.
- Fukuyama, Mary A. and Todd D. Sevig. *Integrating Spirituality Into Multicultural Counseling*. Thousand Oaks, CA: Sage, 1999.
- Gould, Stephen J. *Punctuated Equilibrium*. Cambridge MA: Harvard University Press, 2007.
- Harris, Russ and Stephen C. Hayes. *ACT Made Simple: An Easy-to-Read Primer on Acceptance and Commitment Therapy*. Oakland, CA: New Harbinger Publications, 2009.
- Hayes, Stephen C., Kirk D. Strosahl and Kelly G. Wilson. *Acceptance and Commitment Therapy: The Process and Practice of Mindful Change*. 2nd ed. New York, NY: Guilford Publishers, 2011.
- Herschell, Amy D., David J. Kolko, Barbara L. Baumann and Abigail D. Davis. "The Role of Therapist Training in the Implementation of Psychosocial Treatments: A Review and Critique with Recommendations," *Clinical Psychology Review* 30(2010): 448–466.
- Hinshaw, Stephen P. "The future of the human mind: Lecture 24," in *Origins of the human mind*, Stephen P. Hinshaw. Chantilly, VA: The Great Courses, 2010.
- Hook, Joshua N., Don E. Davis, Jesse Owen, Everett L. Worthington Jr. and Shawn O. Utsey. "Cultural Humility: Acknowledging Limitations in One's Multicultural Competencies," *Journal of Counseling Psychology* 60 (2013): 353-366.
- Hook, Joshua N., Everett L. Worthington Jr., David C. Atkins and Don E. Davis. "Religion and Couple Therapy: Description and Preliminary Outcome Data," *Psychology of Religion and Spirituality* 6 (2014): 94-101.
- Hook, Joshua N., Everett L. Worthington Jr., Don E. Davis, Gartner, David J. Jennings II and Jan P. Hook. "Empirically Supported Religious and Spiritual Therapies," *Journal of Clinical Psychology* 66 (2010): 46-72.

- Howard, Kenneth I., Mark S. Kopta, Merton S. Krause and David E. Orlinsky. "The Dose-effect Relationship in Psychotherapy," *American Psychologist* 41 (1986): 159-164.
- Hutchinson, Earl O. *Hunt Terrorists, Don't Witch Hunt Muslims*. Kindle Edition: Amazon.com, 2015.
- Jensen-Doss, Amanda, Kristin M. Hawley, Molly Lopez and Leticia D. Osterberg. "Using Evidence-Based Treatments: The Experiences of Youth Providers Working Under a Mandate," *Professional Psychology: Research and Practice* 40 (2009): 417-424.
- Johnson, Matthew D. "Healthy Marriage Initiatives: On the Need for Empiricism in Policy Implementation," *American Psychologist* 67 (2012): 296-308.
- Kahneman, Daniel. *Thinking, Fast and Slow*. New York: Farrar, Straus, Giroux, 2011.
- Kass, Leon. *Life, liberty, and the Defense of Dignity: The Challenge for Bioethics*. San Francisco, CA: Encounter Books, 2002.
- Laurenceau, Jean-Philippe, Scott M. Stanley, Antonia Olmos-Gallo, Brian Baucom and Howard J. Markman. "Community-Based Prevention of Marital Dysfunction: Multilevel Modeling of a Randomized Effectiveness Study," *Journal of Consulting and Clinical Psychology* 72 (2004): 933-943.
- Lenkov, Dmitry N., Anna B. Volnova, Anna R. D. Pope and Vassiliy Tsytarev. "Advantages and Limitations of Brain Imaging Methods in the Research of Absence Epilepsy in Humans and Animal Models," *Journal of Neuroscientific Methods* 212 (2013): 195-202.
- Levitt, Steven D., and Stephen J. Dubner. *Superfreakonomics: Global Cooling, Patriotic Prostitutes, and Why Suicide Bombers Should Buy Life Insurance*. New York, NY: William Morrow, 2009.
- Litz, Brett T., Nathan Stein, Eileen Delaney, Leslie Lebowitz, William P. Nash, Caroline Silva and Shira Maguen. "Moral Injury and Moral Repair in War Veterans: A Preliminary Model and Intervention Strategy," *Clinical Psychology Review* 29 (2009): 695-706.
- Mahoney, Michael J., *Cognition and Behavior Modification*. Cambridge, MA: Ballinger Publishing Co, 1976.
- McCullough, Michael E. "Research on Religion-Accommodative Counseling: Review and Meta-analysis," *Journal of Counseling Psychology* 46 (1999): 92-98.
- McHugh, R. Kathryn and David H. Barlow. "The Dissemination and Implementation of Evidence-Based Psychological Treatments: A Review of Current Efforts," *American Psychologist* 65 (2010): 73-84.
- McHugh, R. Katherin and David H. Barlow, eds. *Dissemination and Implementation of Evidence-based Psychological Interventions*. Oxford, England: Oxford University Press, 2012.
- McMinn, Mark R., Michael J. Vogel, M. Elizabeth Lewis Hall, Alexis D. Abernethy, Ryan Birch, Timofey Galuza, Jacqi Rodriguez and Kathryn Putman. "Religious and Spiritual Diversity in Clinical Psychology Doctoral Training Programs: Do Explicitly Christian Programs Differ from Other Programs?," *Journal of Psychology and Theology* 43 (2015): 155-164.
- Meichenbaum, Donald. *Cognitive-behavior Modification: An Integrative Approach*. New York: Plenum, 1977.
- Norcross, John C., ed., *Psychotherapy Relationships That Work*. New York: Oxford University Press, 2002.
- Norcross, John C., ed. *Psychotherapy Relationships That Work: Evidence-Based Responsiveness*. New York: Oxford University Press, 2011.
- Norcross, John C., Gary R. Vandenbos and Donald K. Freedheim. *History of Psychotherapy: Continuity and Change*. Washington, DC: American Psychological Association, 2011.
- Occupational Outlook Handbook*. Washington, DC: Dept. of Labor, Bureau of Labor Statistics, 2012.
- Pecher, David R. and Keith J. Edwards. "A Comparison of Secular and Religious Versions of Cognitive Therapy with Depressed Christian College Students," *Journal of Psychology and Theology* 12 (1984): 45-54.
- Propst, L. Rebecca, Richard Ostrom, Philip Watkins, Terri Dean and David Mashburn. "Comparative Efficacy of Religious and Nonreligious Cognitive-Behavioral Therapy for the Treatment of Clinical Depression in Religious Individuals," *Journal of Consulting and Clinical Psychology* 60 (1992): 94-103.
- Richards, P. Scott and Allen E. Bergin, eds. *Handbook of Psychotherapy and Religious Diversity*. Washington, DC: American Psychological Association, 2000.
- Rippin, Andrew. *Muslims: Their Religious Beliefs and Practices*. 4th ed. New York, NY: Routledge, 2013.
- Rogers, Carl R. *Client-Centered Therapy*. Boston, MA: Houghton-Mifflin, 1951.
- Rosmarin, David H., Kenneth I. Pargament, Steven Pirutinsky and Annette Mahoney. "A Randomized Controlled Evaluation of a Spiritually Integrated Treatment for Subclinical Anxiety in the Jewish Community, Delivered Via the Internet," *Journal of Anxiety Disorders* 24 (2010): 799-808.
- Seligman, Martin E. P., and Mihaly Csikszentmihalyi. "Positive Psychology: An Introduction," *American Psychologist* 55 (2000): 5-14.
- Sharma, Anu R., and Pratyusha Tummala-Narra. "Psychotherapy with Hindus," in *Handbook of Psychotherapy and Religious Diversity*. 2nd ed. eds. P. Scott Richards and Allen E. Bergin. Washington, DC: American Psychological Association, 2014, 321-345.
- Sholomskas, Diane E., Gia Syracuse-Siewert, Bruce J. Rounsaville, Samuel A. Ball, Kathryn F. Nuro and Kathleen M. Carroll. "We Don't Train In Vain: A Dissemination Trial of Three Strategies of Training Clinicians in Cognitive-Behavioral Therapy," *Journal of Consulting and Clinical Psychology* 73 (2005): 106-115.
- Smith, Christian, and Melina L. Denton. *Soul Searching: The Religious and Spiritual Lives of American Teenagers*. New York, NY: Oxford University Press, 2005.

- Smith, Christian, and Patricia Snell. *Souls in Transition: The Religious and Spiritual Lives of Young Adults*. New York, NY: Oxford University Press, 2009.
- Southam-Gerow, Michael A., Adriana Rodriguez, Bruce F. Chorpita and Eric L. Daleiden. "Dissemination and Implementation of Evidence Based Treatments for Youth: Challenges and Recommendations," *Professional Psychology: Research and Practice* 43 (2012): 527–534.
- Southam-Gerow, Michael A., John R. Weisz, Brian C. Chu, Bryce D. McLeod, Elana B. Gordis and Jennifer K. Connor-Smith. "Does Cognitive Behavioral Therapy for Youth Anxiety Outperform Usual Care in Community Clinics? An Initial Effectiveness Test," *Journal of the American Academy of Child & Adolescent Psychiatry* 49 (2010): 1043–1052.
- Stein, Nathan R., Mary Alice Mills, Kimberly Arditte, Crystal Mendoza, Adam M. Borah, Patricia A. Resick, Brett T. Litz and Strong Star Consortium. "A Scheme for Categorizing Traumatic Military Events," *Behavior Modification* 36 (2012): 787–807.
- Thoresen, Carl E., and Michael J. Mahoney. *Behavioral Self-Control*. Austin, TX: Holt, Rinehart and Winston, 1974.
- Toblin, Robin L., Lyndon A. Riviere, Jeffrey L. Thomas, Amy B. Adler, Brian C. Kok and Charles W. Hoge. "Grief and Physical Health Outcomes in U.S. Soldiers Returning from Combat," *Journal of Affective Disorders* 136 (2012): 469–475.
- Twenge, Jean M. *Generation Me: Why Today's Young Americans Are More Confident, Assertive, and Entitled—and More Miserable Than Ever Before (Revised and Updated)*. New York: Atria Paperback, 2006.
- Worthington, Everett L. Jr. "Religious Counseling: A Review of Empirical Research," *Journal of Counseling and Development* 64 (1986): 421–431.
- Worthington, Everett L. Jr. "Understanding the Values of Religious Clients: A Model and Its Application to Counseling," *Journal of Counseling Psychology* 35 (1988): 166–174.
- Worthington, Everett L. Jr. "Religious Faith Across the Life Span: Implications for Counseling and Research," *The Counseling Psychologist* 17 (1989): 555–612.
- Worthington, Everett L. Jr. "Psychotherapy and Religious Values: An Update," *Journal of Psychology and Christianity* 10 (1991): 211–223.
- Worthington, Everett L. Jr., Joshua N. Hook, Don E. Davis, Aubrey L. Gartner, and David J. Jennings II. "Conducting Empirical Research on Religiously Accommodated Treatments," in *APA Handbooks in Psychology: APA Handbook of Psychology, Religion, and Spirituality*: vol 2., ed. Kenneth I. Pargament, A. Mahoney and E. Shafranske. Washington, DC: American Psychological Association, 2013, 651–669.
- Worthington, Everett L. Jr., Joshua N. Hook, Don E. Davis, and Michael A. McDaniel. "Religion and spirituality," in *Relationships That Work: Evidence-based Responsiveness*, ed. John C. Norcross. New York: Oxford University Press, 2011, 402–419.
- Worthington, Everett L. Jr., Eric L. Johnson, Joshua N. Hook and Jamie D. Aten, eds., *Evidence-Based Practices for Christian Counseling and Psychotherapy*. Downers Grove, IL: InterVarsity Press, 2013.
- Worthington, Everett L. Jr., Taro A. Kuru, Michael E. McCullough, and Steve J. Sandage. "Empirical Research on Religion and Psychotherapeutic Processes and Outcomes: A 10-Year Review and Research Prospectus," *Psychological Bulletin*, 199 (1996): 448–487.
- Worthington, Everett L. Jr., Nathaniel G. Wade and William T. Hoyt. "Evidence-Based Practice in Psychology: What Psychotherapists Can Learn from Research on Treatment and Psychotherapist Responsiveness" in *Contemporary Theory and Practice of Counseling and Psychotherapy*, eds. Howard E. A. Tinsley, Suzanne H. Lease and Noelle S. Giffin Wiersma, Newbury Park, CA: Sage Publications, 2015, 58–88.