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The Effectiveness of RCBT in the Treatment of Depression among Clergy in Kenya

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ABSTRACT

Mental health in the clergy is as crucial as it is for the general population, with studies indicating that clergy suffer from depression at rates higher than the general public, underlining the need for effective interventions (Eagle et al., 2019; Proeschold-Bell et al., 2013). Factors such as long working hours, inadequate pay, and feeling unprepared for their roles contribute to high depression rates among clergy (Krejcir, 2016). Many pastors internalize these challenges, leading to frustration and depression (Ruiz-Prada, 2021). Clergy often resort to spiritual coping mechanisms, including prayer and consulting senior pastors, rather than seeking professional mental health treatment. Hence, Religious Cognitive Behavioral Therapy (RCBT) could be more suitable for clergy despite limited research on its effectiveness. This study assessed the efficacy of RCBT in reducing depression among clergy in Kenya, using a quasi-experimental design with control and experimental groups, including pre- and post-tests. A sample of 123 clergy (26-65 years old, 88 males) from Love INC, Kenya, was screened for depression using the Beck Depression Inventory-II (BDI-II). Of the 64 clergy who met the criteria for depressive symptoms, 52 were willing to undergo intervention, and 26 were randomly assigned to both the control and experimental arms. The experimental group received a 10-week, weekly RCBT intervention, while the control group received no treatment. Data were analyzed using SPSS. Results from an independent samples t-test showed a significant reduction in depression scores for the experimental group compared to the control group ($t48 = -2.49$, $p = .016$). The experimental group's mean depression scores decreased from 19.96 (SD = 6.57) at baseline to 12.20 (SD = 6.42) at the study's end, while the control group's scores remained nearly unchanged. The large effect size at the end of the study (Cohen's $d = -.703$) demonstrated RCBT's effectiveness in alleviating depression symptoms. These findings suggest RCBT could be an effective mental health intervention for clergy and encourage further research into its application for other mental health conditions within this group. It also promotes awareness that religious leaders can seek help for depression while maintaining their faith.

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KEYWORDS

RCBT, Effectiveness, Clergy, Depression, Treatment, BDI II, Intervention

BACKGROUND TO THE STUDY

Cognitive Behavior Therapy (CBT) is among the most extensively used treatment methods because it has received much scientific validation (Carlson & González-Prendes, 2016). The evidence base of CBT is quite solid, notably for the treatment of depressive and anxiety disorders, narcotic misuse disorders, and anger management issues (Hofmann et al.,2012). It is the most often utilized intervention by therapists based on research at 43%, followed by cognitive therapy (18%) and behavior modification (12.6%) (Pignotti & Thyer, 2009).

According to Beck (1976), CBT comprises various treatment interventions based on the core idea that an individual's beliefs and thoughts are the most important drivers of one's expressions and conduct to life happenings. Beck and Beck (2011) note that our responses to circumstances are determined by how we mentally analyze and evaluate events. The assignments and judgments about those events are shaped by basic ideas about oneself, others, and the larger world. In other words, core convictions begin forming in childhood and frequently portray the mental

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images and thoughts the individual has absorbed via initial encounters with parents, family members, caregivers, society, and school, among others.

Beck et al. (2013) submit that CBT evaluation aims to gather data about the client to conceptualize the case, diagnose problems, clarify the CBT model, and design a therapeutic intervention for the patient. They also state that when used in conjunction with a typical clinical examination, a spiritually modified evaluation can help clinicians adequately grasp the link between a client's spiritual convictions and rituals with the issue being addressed. In CBT, psychoeducation is critical because the goal is to assist clients in developing skills that will allow them to be their therapists eventually and to utilize these capacities to alter thoughts, feelings, and conduct (Costa & Moreira-Almeida, 2022).

A person's culture and the probable effect of religion and spirituality (R/S) perspectives considerably impact the development of one's values and beliefs (Beck, 2011). Religion and Spirituality (R/S) are essential factors in the lives of many individuals. Yet, R/S and their impact on mental health are topics that are often overlooked in clinical practice (Carlson & González-Prendes, 2016).

Religious Integrated Cognitive Behavioral Therapy (RCBT) is a therapy for depression and anxiety among Christian clients that has been clinically tested (Koenig et al., 2015; Pearce & Koenig, 2013; Smith et al., 2007; Wade et al., 2007; Worthington et al., 2011). RCBT is based on the same ideas and approach as traditional CBT. However, it utilizes the client's faith tradition to help identify and replace unhelpful beliefs and actions that contribute to depressive symptoms. Clients are taught to use their religious beliefs to replace negative and incorrect ideas with biblical concepts that promote mental wellness during RCBT. Pearce et al. (2015) state that one difficulty with RCBT is therapists' unfamiliarity with religious traditions other than their own. Thus, when a therapist's religious inclination differs from a client's, the therapist is required to communicate this with clients during the initial session. To solve this issue, Pearce et al. (2015) designed manuals to offer therapists an abundance of conversation scripts to utilize, as well as notes and directions for therapists addressing religious themes and resources discussed in the therapy handbook.

According to empirical investigations, religiously incorporated psychotherapies are more beneficial among people with stronger religious beliefs, mitigating the usage of RCBT in religious clients (Koenig & Pearce, 2021). Pargament (2013) argues that religion is "the pursuit for sense-making" within customary conventions, but spirituality is the "quest for the holy," with the holy being God or higher power. Mamani et al. (2010) state that religion and psychotherapy share common objectives where R/S and counseling attempt to develop a sense of belonging, address issues concerning the purpose of one's existence, and foster support networks. Therapy helps to establish clients' existing resources and capabilities, and religion and spirituality are frequently cited as a pillar of fortitude for many clients (Van Wormer & Davis; Pew, 2013). Although R/S is common among individuals and experts recognize its relevance, it is frequently neglected in treatment. Traditionally, religion and spirituality have been excluded from psychology to increase their scientific legitimacy. Famous philosophers have also influenced the traditionally antagonistic connection between religion and psychology (Dwyer, 2010; Mahoney & Shafranske, 2013).

The rising body of information about the association between religion and psychological health implies that therapists should pay close attention to their clientele's religious and spiritual beliefs when providing therapy. Clinicians encountering clients from varied religious origins may feel uneasy discussing religion and spirituality. However, according to Dwyer (2010), failure to address these concerns might unwittingly signal an implicit rejection of the client's essential core views. This can reduce therapeutic efficacy or possibly injure the patient (Hodge, 2008).

To ignore R/S when the client wants to use it in treatment is also a breach of self-determination (Hodge & Bonifas, 2010). Rosmarin (2018) observes that it is amoral for clinicians not to embrace religiosity in therapy. In concurrence, Post and Wade (2009) found that most patients wanted their clinicians to tackle spirituality in psychotherapy. Moreira-Almeida et al. (2014) additionally forwarded that faith influences psychological well-being. In light of these considerations, according to Koenig (2012), religion and spiritual views may impact how people understand and interpret critical life events, leading to better adaptability and less distress.

It thus appears that RCBT, which focuses on beliefs, is a suitable approach for addressing religious and spiritual difficulties deeply entrenched within value systems. Costa & Moreira-Almeida (2022) assert that since 84 percent of the world's population is religiously affiliated, therapists must familiarize themselves with spiritually integrated treatments. Participating in religious activities has been linked to improved mental health (Koenig, 2008), while participation in religious services is seen to be a defensive element against completing suicide (Kleiman & Liu, 2014).

Costa and Moreira-Almeida (2022) agree and further assert that a religion-adapted CBT is required since it can help spiritual clients feel more at ease with psychotherapy while also assisting the clinician in identifying and mobilizing religious or spiritual resources that the patient may have, which may ultimately aid in the therapeutic process.

According to Koenig et al. (2020) RCBT is as efficacious as CBT in treating depression and anxiety and more so than CBT in highly religious patients. Captari et al. (2018) conducted a meta-analysis of religious-centered therapies (non-Christian and Christian). They assessed the outcomes of 97 studies (the bulk of which focused on

depression or psychological distress). Compared to no treatment, religiously customized psychotherapy improved clients' negative psychological symptoms significantly (Hedges g = 0.74, p< 0.001). Similarly, Koenig and Pearce's (2021) meta-analytic study found that out of 28 clinical trials, 17 (61 percent) that utilized a religious intervention (Christian and non-Christian) considerably reduced depressive indicators when likened to typical non-religious interventions or a control state. On the contrary, however, religious interventions were shown to be less helpful in two trials (7 percent).

In an earlier study, Koenig et al. (2015b) compared the efficacy of Standard Cognitive Behavioral Therapy (SCBT) and Religiously Integrated Cognitive Behavioral Therapy (RCBT) for treating depressive symptoms in chronically ill patients with severe depression. The study used a multisite randomized clinical trial design to administer RCBT remotely, primarily due to participants' physical health concerns. The intervention consisted of ten 50-minute sessions provided online over 12 weeks, with 94% of sessions conducted by telephone, 5% through Skype, and 1% via instant messaging. Participants (n = 93) were randomly assigned to either RCBT (46) or CBT (47) and were evaluated at 4, 8, 12, and 24 weeks using the BDI II to track depression symptoms. The RCBT intervention included five variations: Christian, Buddhist, Muslim, Hindu, and Jewish. Eight master's level certified counselors administered the treatment following a structured manual modeled after a typical CBT handbook. Depression levels decreased for both therapies from the baseline to the 12-week follow-up (d = 3.02 for RCBT and 2.39 for CBT), with over half of the participants in complete remission at 24 weeks. Treatment adherence was comparable across groups, except for more religious individuals, who adhered to RCBT at a slightly higher rate (85.7% vs. 65.9%, p = 0.10). At 12 weeks, no significant difference in result was seen between the two groups (B = 0.33; SE, 1.80; p = 0.86). Rates of response and remission were similarly comparable. Overall, religiosity significantly interacted with the treatment group (B = -0.10; SE, 0.05; p = 0.048), suggesting that RCBT was more effective in more religious participants. These preliminary data show that CBT and RCBT are comparable therapies for severe depression in individuals with chronic medical conditions. The study concluded that RCBT might enhance a client's sense of purpose in life more than conventional CBT and suggested that client religiosity might affect treatment effectiveness and adherence. Overall, CBT and RCBT were found to be comparable therapies for severe depression in individuals with chronic medical conditions.

Similarly, Koenig et al. (2015a) evaluated the impact of RCBT over the standard CBT (SCBT) on optimism in patients with comorbid major depressive disorder (MDD) and health issues. The study included 132 individuals, aged 18-85, randomly assigned to the RCBT (n=65) or SCBT (n=67) group, each receiving ten 50-minute interventions primarily via phone over twelve weeks. Optimism levels were measured at the start, after twelve weeks, and after twenty-four weeks using the Life Orientation Test-Revised, whereas religiousness was evaluated with a 29-item scale at baseline. The results, analyzed with mixed effects growth curve models, showed that both therapies boosted optimism with no substantial difference over time. The mixed effects growth curve models comparing the change in optimism revealed that both RCBT and SCBT increased optimism over time in all the treatment groups (B=0.75, SE=0.57, t=1.33, p=.185).

Furthermore, higher baseline religiosity predicted an increase in optimism over time (B =0.07, SE=0.02, t=4.12, p < .0001), and higher baseline optimism predicted a faster decline in depression over time (B=0.61, SE=0.10, t=6.30, p < .0001). Greater baseline religiosity was associated with larger increases in optimism, and higher initial optimism led to a quicker reduction in depressive symptoms, regardless of therapy type. Overall, RCBT and SCBT showed equal efficacy in boosting optimism, with religiosity enhancing optimism independently of the treatment method. It thus seems that a component of religion is beneficial in promoting mental wellness.

According to Worthington et al. (2011), by simply listening to patients without offering counsel, it is frequently possible for them to resolve their spiritual concerns independently. Hence, a therapist who is not Christian does not have to be an expert on such perspectives. It is critical to emphasize that Christian-integrated therapy is based on the client's Christian beliefs, not the therapist's religious (or agnostic) convictions.

According to Koenig and Pearce (2021), therapists play a crucial role in helping clients make therapeutic and self-care use of their religious beliefs and practices. This does not necessitate the therapist to be religious but rather to assist clients in examining spiritual difficulties and their potential relationship to mental health problems, such as depression. When situations are beyond the psychotherapist's competence, Koenig and Pearce (2021) suggest directing them to the clergy, who can be valuable collaborators and consultants. These situations include answering theological inquiries, providing spiritual guidance, absolution, or giving spiritual sacraments like communion and, in many situations, prayer. Lastly, Koenig and Pearce (2021) advise that clients' Christian viewpoints in treatment should always be approached with care and compassion to prevent excessive influence.

RCBT is similar to classic CBT in that it uses the same participatory, directive, and Socratic tactics and is theoretically founded on the same theories. In RCBT, on the other hand, the client's Christian beliefs, practices, values, teachings, and ideology are utilized to help the client change harmful thinking patterns and behaviors. According to Koenig and Pearce (2021), Christian ideas and resources give a "truth" criterion to evaluate a client's thoughts and behavior. In other words, rather than having a therapist assist a client in

defining what is authentic or beneficial, the client turns to their Christian belief system and worldview for guidance. This helps individuals connect their cognitions, behaviors, and beliefs about what is real, meaningful, and valuable. This value-based approach to therapy provides this client-centered incentive for progress.

Pearce (2016) articulates that a Christian who is depressed may find prayer difficult. Rather than immediately resume praying in the manner they did before becoming depressed, which is highly likely to fail, a CBT approach might suggest beginning with very brief prayers and progressively increasing in length as they gain the ability to manage more lengthy ones. A similar strategy can be applied to Bible reading. They also observe that many people experiencing mental and emotional difficulties would rather receive care from clergy than from formal mental health facilities.

Christians typically base their worldviews and value systems on biblical teachings. In line with RCBT principles, clients learn the need to nourish their brains with religious scriptures and teachings to counteract negative and ruminative ideas that result in unpleasant feelings. "Do not conform to the pattern of this world, but be transformed by the renewing of your mind," according to a Christian verse. Then you will be able to evaluate God's perfect, good, and acceptable will and accept it." (Romans 12:2). Clients are either given a Bible passage that pertains to the session's subject or the option of picking their text for scripture remembering and contemplative prayer (Koenig & Pearce, 2021). The theological reflections help clients dispute widespread problematic thinking patterns (for example, all-or-nothing thinking), which assist them in comprehending how these thinking styles may contradict their religious beliefs and values. Following that, clients are encouraged to use their religious beliefs and resources to combat harmful or erroneous ideas, hence building successful new beliefs and behavioral responses (Koenig & Pearce, 2021).

Finally, clients are urged to participate in religious activities, the goal being to receive help from this community while assisting at least one other person. This enables individuals to fulfill the Christian mandate to love and care for one another and usually leads to clients experiencing social support. Giving and receiving social help has been associated with a decreased risk of depression (Krause, 2009; Seligman et al., 2005).

Despite the recognized importance of mental health within the clergy community, there is a lack of tailored interventions that align with their religious beliefs and practices (Salwen et al., 2017). Most documented intervention studies have looked at Christians but not the clergy specifically. In Kenya, clergy members often carry the dual burden of providing spiritual guidance and support to their congregations while grappling with internal struggles, including high rates of depression. This study sought to address the pressing need for effective and culturally sensitive interventions by investigating the potential of RCBT in alleviating symptoms of depression among clergy members in Kenya.

METHODOLOGY

The study utilized a quasi-experimental research design (pretest-posttest) with a control group. Fifty-two respondents (n=26 control and n=26 experimental) had purposively been selected from 123 clergy affiliated with Love INC. Kenya, based on meeting the cut-off score of 10 in the BDI-II. Data was collected virtually using the Becks Depression Inventory (BDI-II). The BDI-II has shown high construct validity for the medical symptoms it measures. Beck's research found that the alpha value in outpatients was 0.92. The BDI-II also has a 0.71 correlation with the Hamilton Depression Rating Scale, a 0.93 one-week test-retest reliability, and a 0.91 internal consistency. Assignment to either control or experimental group was done through simple random sampling to control for biases. The experimental group was administered a 10-week intervention of RCBT virtually through Google Meet in an individual format, but no intervention was given to the control group. Assessments for both the experimental and control groups were done at baseline, midline, and end line using the BDI-II.

RESULTS

An independent samples t-test was conducted to compare depression remission between the experimental and control groups at the three timelines and the intervention's subsequent effect size.

Table 1: The Descriptives for Depression Scores Across the Three Timelines

Group	Timeline	N	Mean(M)	Std. Deviation	Std. Error Mean
Experimental	Baseline	26	19.96	6.57	1.29
	Midline	26	15.27	6.40	1.26
	End line	25	12.20	6.42	1.28
Control	Baseline	26	17.31	6.85	1.34
	Midline	26	17.50	6.33	1.24
	End line	25	16.80	6.66	1.33

The descriptives (means, standard deviations) show remission of depression scores across the three timelines for the experimental group. Specifically, the mean depression score decreased from M=19.96(SD= 6.57) at baseline to

M=15.27(SD=6.40) at the mid-point assessment and further to M=12.20(SD=6.42) at the end of the study. Conversely, the control group exhibited no steadfast remission in depression scores over the same periods, with mean scores fluctuating from M=17.31(SD=6.85) at baseline to M=17.50(SD=6.33) at the mid-point assessment and then decreasing slightly to M=16.80(SD=6.66) at the end of the study.

Table 2: The Independent Samples Test

Timeline	Levene's Test for Equality of Variances								
	F	Sig.	t	df	p	Mean Difference	S.E	95% C. I.	
								Lower	Upper
Baseline	0.031	0.861	1.43	50	0.16	2.65	1.86	-1.08	6.39
Midline	0.215	0.645	-1.26	50	0.21	-2.23	1.77	-5.78	1.32
Endline	0.037	0.848	-2.49	48	.016*	-4.6	1.85	-8.32	-0.88

The findings indicate that there was a significant difference in depression scores between the experimental and the control group at the end line (t_{48} = -2.49, p =.016). Specifically, the average depression scores (mean differences) for participants in the experimental group were 4.6 points lower than those in the control group at the end of the study. This suggests that the intervention had a significant effect in reducing depression symptoms among participants in the experimental group compared to those in the control group. However, no significant differences were found between the two groups at baseline (p = .16) or midline (p = .212) assessments. These findings support the efficacy of the intervention in producing meaningful reductions in depression scores among participants in the experimental group compared to those in the control group over the course of the study. The subsequent effect sizes were also obtained, as shown in Table 3.

Table 3: Independent Samples Effect Sizes

Timeline	Test	Standardizer[a]	Point Estimate	95% C. I	
				Lower	Upper
Baseline	Cohen's d	6.70895	.396	-.155	.943
	Hedges' correction	6.81172	.390	-.153	.928
	Glass's delta	6.84555	.388	-.170	.938
Midline	Cohen's d	6.36807	-.350	-.896	.199
	Hedges' correction	6.46562	-.345	-.883	.196
	Glass's delta	6.33246	-.352	-.901	.203
End line	Cohen's d	6.54153	-.703	-1.272	-.128
	Hedges' correction	6.64601	-.692	-1.252	-.126
	Glass's delta	6.65833	-.691	-1.272	-.097

a. The denominator is used to estimate the effect sizes.
Cohen's d uses the pooled standard deviation.
Hedges' correction uses the pooled standard deviation plus a correction factor.
Glass's delta uses the sample standard deviation of the control (i.e., the second) group.

The effect sizes calculated using Cohen's d, Hedges' correction, and Glass's delta indicate the magnitude of the difference between the experimental and control groups regarding depression scores at baseline, midline, and end-line assessments. Cohen's d effect sizes show a large effect size at the end line (d=-.703;95%C. I -1.272 to -.128), showing that there was a notable remission of depression symptoms in the experimental group at the end line as compared to the control group. This suggests that the intervention substantially reduced depression scores among participants in the experimental group by the end of the study.

Moreover, examining the trend from baseline to midline to end line, the effect size progressively increased from d = 0.396 (indicating higher depression scores in the experimental group at baseline) to d = -0.350 (indicating lower depression scores in the experimental group at midline) and finally to d = -0.703 (highlighting even further reduction in depression scores in the experimental group at end line). The negative values for the effect sizes at the midline and end line indicate that the experimental group exhibited fewer depression symptoms compared to the control group at these time points. Therefore, RCBT is an effective therapy for the treatment of depression among clergy in Kenya.

DISCUSSION

The depression raw scores (means, standard deviations) showed remission of depression across the three timelines for the experimental group. Specifically, the

depression mean score decreased from 19.96 at baseline to 15.27 at the mid-point assessment and further to 12.20 at the end of the study. Conversely, the control group exhibited no steadfast remission in depression scores over the same periods, with mean scores fluctuating from 17.31 at baseline to 17.50 at the mid-point assessment and then decreasing slightly to 16.80 at the end of the study.

These findings suggest the potential efficacy of the intervention in reducing depression symptoms among participants in the experimental group compared to those in the control group. The observed pattern of decreasing depression scores in the experimental group aligns with the anticipated positive effects of the intervention.

The independent samples test provided the statistical significance of the difference between the experimental and control groups, where there was a significant difference in depression scores between the experimental and control groups at the end line (t_{48} = -2.49, p =.016). Specifically, the average depression scores for participants in the experimental group were 4.6 points lower than those in the control group at the end of the study. This suggests that the intervention had a significant effect in reducing depression symptoms among participants in the experimental group compared to those in the control group. The effect sizes calculated using Cohen's d, Hedges' correction, and Glass's delta showed a large effect size at the end line (d=-.703;95%C. I -1.272 to -.128), suggesting that the intervention had a substantial impact on decreasing depression scores among participants in the experimental group by the end of the study.

The study results concur with the findings of Pearce (2016), who highlights the importance of incorporating religious beliefs and practices into therapy for individuals experiencing depression, emphasizing the role of prayer and scripture reading in the therapeutic process. Similarly, Koenig and Pearce (2021) note that religious beliefs and practices can provide individuals with a sense of meaning and purpose, which can help them cope with life's challenges, including depression. Moreover, Koenig et al. (2020) found that RCBT is as efficacious as traditional CBT in treating depression and anxiety and potentially more effective for highly religious patients. This aligns with the observed effectiveness of RCBT in the current study, where significant reductions in depression symptoms were observed among participants receiving RCBT.

The findings of Anderson et al. (2015) and Lim et al. (2014) further support the effectiveness of RCBT in treating depression, with both studies indicating that RCBT may be equally or more effective than CBT in certain populations. Additionally, (Costa & Moreira-Almeida (2022) conducted a systematic review of randomized clinical trials comparing RCBT with non-treatment groups for various mental health conditions, including depression. Furthermore, Koenig et al. (2015a) found that both RCBT and CBT are effective in reducing depressive symptoms, with RCBT showing slightly better outcomes for more religious participants.

Studies on the effectiveness of RCBT are quite extant, but other interventions integrating spirituality into psychotherapy offer promising results in the alleviation of depression. Though it was beyond the scope of this study to compare these other interventions against RCBT, research posits that any component of spirituality integrated into psychotherapy promotes mental well-being.

Ebrahimi et al. (2013) contrasted the impact of cognitive-behavioral therapy (CBT) with spiritually integrated psychotherapy (SIPT) on the severity of depression and maladjusted behavior among dysthymic disorder clients, a subtype of depression. The study involved 62 patients from multiple centers in Isfahan, randomly divided into three experimental groups (SIPT, CBT, and antidepressant treatment) and a control group, where each group received eight therapy sessions. Data collection utilized the Beck Depression Inventory and Dysfunctional Attitudes Scale at four different stages. The efficacy of SIPT over medication was evidenced ($P < 0.01$), although it did not differ from CBT. Specifically, SIPT was more effective in the modification of dysfunctional attitudes compared with CBT and medication ($P < 0.05$). The results thus gave evidence for the beneficial effect of incorporating spirituality into psychological therapy.

The benefit of spirituality was additionally confirmed by Captari et al.'s (2018) large sample-sized meta-analytic study, which analyzed 97 outcome studies with 7,181 participants. The studies assessed the benefits of adapting psychotherapy to align with patients' religious and spiritual (R/S) beliefs. The study compared R/S with controls comprised of three groups: no-treatment, alternate secular, and additive secular interventions. The participants in the group integrating R/S fared better psychologically ($g = 0.74$, $p < 0.000$) and spiritually ($g = 0.74$, $p < 0.000$) compared to those in the no-treatment group (psychological: $g = 0.33$, $p < 0.001$; spiritual: $g = 0.43$, $p < 0.001$). The R/S integrated psychotherapies were additionally found to be as equally effective as the standard approaches in reducing psychological distress ($g = 0.13$, $p = 0.258$). However, they also led to greater spiritual well-being ($g = 0.34$, $p < 0.000$). The findings thus confirmed the favorable effect of spirituality in psychotherapy.

Bouwhuis-Van Keulen et al. (2024) likewise performed a multi-level meta-review of randomized clinical trials to compare the effectiveness of religious and spirituality-based therapy (R/S) with standard mental health treatments. The study analyzed data from 3,452 participants across diverse global settings, with individual trial sample sizes ranging from 50 to 300, and found that R/S-based therapies are generally as effective as standard treatments in improving mental health outcomes ($p< 0.05$). The study reiterated the importance of incorporating patients' spiritual and religious beliefs in therapeutic practices to boost

treatment effectiveness and further recommended more research to pinpoint specific scenarios where this approach might be particularly advantageous.

Leung and Li (2024) conducted a randomized controlled study in Hong Kong to evaluate the efficacy of a spiritual connectivity treatment for those with depressive symptoms. Most participants identified as Protestant Christian (86.0%), with a small portion identifying as non-religious (10.5%). They were randomized into the Spiritual Connectivity Group intervention (SCG, n = 28) and the Waitlist Group (WLG, n = 29). Some participants in both groups missed or attended only a few sessions, but 54 completed the assessments at all times. The intervention was conducted over eight weekly sessions, and participants engaged in personal quiet time to better manage solitude and explore their inner feelings and thoughts. They were encouraged to improve self-care, personal acceptance, personal values, and personal feelings to strengthen their connection to themselves. The study revealed that the treatment group exhibited notably greater reductions in symptoms of depression in comparison to those in the control group ($p < 0.01$), indicating that enhancing spiritual connectivity can be a valuable complement to traditional depression treatments. The authors suggested incorporating spiritual practices into mental health care for individuals open to these methods. They recommended further research to investigate this intervention's long-term benefits and broader applications.

Costa and Moreira-Almeida's (2022) meta-analytic study reviewed 237 papers on religion-adapted cognitive behavioral therapy (RCBT), examining the techniques and effectiveness from 2013 to 2017 across several databases. Depressive disorder was identified as the most commonly studied mental health condition in these clinical trials. The sample sizes of the individual studies varied from 30 to 200 participants. The review concluded that religion-adapted CBT can be as effective or even more beneficial than standard CBT, particularly for individuals with strong religious beliefs. They alluded that incorporating religious elements into therapy aligned better with patients' values, resulting in improved engagement and outcomes. The authors suggested further research to refine these techniques and encourage culturally sensitive mental health care.

Other religious affiliations have also shown the benefits of integrating spirituality into psychotherapy. Husain and Hodge (2016) highlighted that modifying cognitive behavioral therapy (CBT) to incorporate Islamic values can improve treatment outcomes for devout Muslims, resulting in quicker recovery, better adherence to treatment, lower relapse rates, and reduced disparities in care. This approach addresses the hesitation among many Muslims to seek mental health services due to fears that Western-trained therapists may not respect their religious values, thus potentially increasing access to counseling for this population.

Overall, these studies demonstrate the positive effects of R/S on psychotherapy. However, few studies exist, especially among religious communities such as clergy. The current study did not find any study on clergy supporting the therapeutic value of RCBT for depression. Clergy are a valuable group of people whose services are much sought after in society; hence, prioritizing their mental health is critical. Thus, it was deemed crucial to investigate the effectiveness of RCBT in treating depression among this cohort.

CONCLUSION

RCBT as an intervention for depression among clergy in Kenya can be framed within an integrated theoretical framework that combines cognitive-behavioral therapy principles with religious and spiritual perspectives. This integration aims to provide clergy members with an ethically sensitive and spiritually supportive approach to addressing their mental health challenges. In this theoretical framework, the principles of cognitive-behavioral therapy, which focus on identifying and changing negative thought patterns and behaviors, are combined with the religious beliefs and practices that are significant to the clergy in Kenya. By integrating these elements, therapists can tailor interventions to align with the clergy's values, beliefs, and coping mechanisms, fostering a more holistic and personalized approach to treatment.

The integration of religious and spiritual perspectives into CBT for clergy members in Kenya is a significant step that acknowledges the vital role that faith and spirituality play in their lives. This integrated approach helps clergy members draw strength from their religious beliefs, find meaning in their struggles, and utilize their faith as a source of support and resilience in times of distress. Moreover, by considering the unique social, cultural, and religious context of clergy members, therapists can tailor interventions to meet their specific needs and challenges, enhancing the relevance and effectiveness of the therapeutic process.

Overall, RCBT offers a comprehensive and relevant framework for addressing depression among clergy in Kenya, providing a meaningful and practical approach to mental health treatment that is specifically tailored to their contextual needs.

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