c0006 CHAPTER 6

Spirituality, religion, and eating disorders

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s0010 Introduction

p0055 Eating disorders (EDs) are among the most complex and multifaceted psychological disorders. Decades of research suggest biological components as well as sociocultural influences on the etiology and progression of ED pathology (Keski-Rahkonen, Raevuori, & Hoek, 2018; Treasure, Claudino, & Zucker, 2010). The role of spirituality/religion (S/R) in the development, maintenance, and treatment of EDs has recently emerged as a salient sociocultural factor worthy of exploration.

p0060 The DSM-V (American Psychiatric Association, 2013) currently recognizes four distinct categories of EDs, which share several overlapping characteristics. Anorexia nervosa (AN) is characterized by an extreme restriction of energy intake leading to a significantly low body weight in the context of age, sex, developmental stage, and overall physical health. In addition, those with a diagnosis of AN exhibit an extreme fear of

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gaining weight and usually place undue value on weight and shape for self-evaluation. Further, they may have a difficult time identifying the seriousness or extremity of their level of thinness. Bulimia nervosa (BN) is characterized by recurrent episodes of binge eating (i.e., eating objectively larger than normal amounts of food in a discrete period of time while experiencing a sense of loss of control and/or shame around eating), followed by the use of compensatory behaviors (i.e., purging, laxative use, excessive exercise) to counteract the binge episode(s). In addition, individuals with BN place undue emphasis on weight and shape for self-evaluation. Binge ED was added as a separate diagnostic category in the newest revision of the DSM and includes recurrent episodes of binge eating without the use of compensatory behaviors seen in BN. Remaining EDs that do not fit specifically into the above category are labeled as other specified feeding or ED. It is important to note that this diagnosis does not imply disorders of lesser clinical severity but rather diagnostic ambiguity or a transition period from one ED to another (American Psychiatric Association, 2013).

p0065 In addition to the full-blown EDs mentioned above, there exists a continuum of related behaviors or symptomatology that can collectively be referred to as disordered eating pathology (DEP), which can refer to both cognitive aspects of ED symptoms (i.e., high levels of body dissatisfaction, guilt or shame around food, weight and shape overvaluation) or the behavioral aspects of EDs (i.e., restricting total or specific food intake, bingeing and/or purging, or other compensatory behaviors, etc.). All of these can be considered core features of EDs (Fairburn, Cooper, & Shafran, 2003) and risk factors for their development even in the absence of a formal diagnosis. Therefore, much of the empirical research conducted on nonclinical samples focuses on DEP. While individuals that do go on to develop full-blown EDs may have some qualitative differences to those that remain in a subclinical category, high levels of DEP are the most proximal risk factors for the development of EDs and the research in nonclinical samples has made significant contributions to understanding S/R mechanisms and underpinning of these conditions.

s0015 Research connecting spirituality/religion to eating disorder behaviors

p0070 Historically, many religious and spiritual traditions have elaborate symbolism and rituals related to food. It has long been noted that asceticism and

transcendence of the physical are a part of many religious traditions and food denial or fasting is often used as a form of religious devotion (Brumberg, 2000; Vandereycken & Van Deth, 1994). In addition, feminist scholars have argued that particularly for women, the use of their bodies as a vessel for religious expression has been culturally sanctioned and often is/was the only means women had of expressing their suffering (Lelwica, 2010). This is evidenced in case studies of fasting saints and modern-day ascetics (Brumberg, 2000; Lelwica, 2010). However, only more recently has empirical research focused on not only the association between S/R and DEP, but more specifically the psychological mechanisms through which S/R forces manifest themselves as relevant influences in the development of ED-related psychopathology.

p0075 Similar to the literature related to overall mental health, components of S/R have been found to have both a positive and negative impact on DEP and EDs (Akrawi, Bartrop, Potter, & Touyz, 2015; Berrett, Crowton, & Richards, 2018; Homan & Lemmon, 2016). It is possible that S/R exerts a direct positive effect on the reduction of ED symptomatology through a general reduction in overall levels of distress (Henderson & Ellison, 2015). Conversely, it may have a direct negative impact as related to a need for self-control in the case of restricting behaviors, or feelings of failure to self-regulate in the case of bingeing and an attempt to correct for this through the use of compensatory behaviors (Exline, Homolka, & Harriott, 2016). However, there is greater empirical support to suggest that S/R mitigates or exacerbates EDs and DEP specifically through the mediating/moderating role it exerts on psychological variables known to be associated with these symptoms (including but not limited to depression, anxiety, self-esteem, and body dissatisfaction) (Exline et al., 2016; Homan & Lemmon, 2016; Weinberger-Litman, Latzer, Litman, & Ozick, 2018; Weinberger-Litman, Rabin, Fogel, Mensinger, & Litman, 2016).

p0080 Some elements of S/R have been shown to prevent or lessen the development of ED symptoms in nonclinical samples, (Akrawi et al., 2015; Hall & Boyatzis, 2016; Richards, Weinberger-Litman, Susov, & Berrett, 2013; Weinberger-Litman et al., 2016) and among clinical samples, have been shown to be useful in recovery from EDs, which will be discussed in detail later in this chapter (Berrett et al., 2018; Richards et al., 2018; Richards, Hardman, & Berrett, 2007). S/R factors have specifically been shown to reduce body image–related distress, a proximal risk factor for ED development.

p0085 In a study of college women with high levels of body dissatisfaction, women who rated S/R as being highly important were more likely to use prayer or meditation to cope with body image–related distress (Jacobs-Pilipski, Winzelberg, Wilfley, Bryson, & Taylor, 2005). Reading theistically centered positive body affirmations reduced the established negative psychological effects of exposure to ultrathin models relative to a control group (Boyatzis, Kline, & Backof, 2007). Additionally, women who exhibit a secure nonanxious attachment to God have been shown to have lower levels of body dissatisfaction after viewing media images than those women with an anxious attachment style (Homan, 2012). Further, this reduction in body dissatisfaction was shown to be mediated by a reduction in social comparison which has been shown to be associated with DEP (Homan & Lemmon, 2014). Finally, this relationship was also illustrated with regard to body appreciation, which refers to positive feelings toward one's body, and has been shown to be associated with reduced DEP (Homan & Lemmon, 2016). Body appreciation should be considered an important factor in prevention and treatment of DEP as increased positive feelings toward one's body can mitigate the negative impact of cooccurring body dissatisfaction. The impact on social comparison was moderated by a secure attachment to God whereby those women who were more securely attached were more likely to maintain favorable levels of body appreciation despite engaging in social comparison processes or viewing images previously associated with a decrease in body appreciation (Homan & Lemmon, 2016).

p0090 However, S/R can also have negative effects on ED symptoms. In some research, individuals have been shown to use religious motivation to justify symptoms (Joughin, Crisp, Halek, & Humphrey, 1992; Marsden, Karagianni, & Morgan, 2007; Morgan, Marsden, & Lacey, 2000) or feelings of unworthiness (Richards et al., 2018). In clinical samples, individuals with EDs report feeling a sense of spiritual estrangement and alienation (Richards et al., 2018). Many ED patients perceive God negatively as being wrathful, vindictive, impersonal, or uncaring (Richards et al., 2018). This is consistent with the concept of divine struggle, or having negative thoughts and feelings about God, which predicts distress over time and is associated with both restrictive and dysregulated symptoms of EDs (Exline et al., 2016). Divine struggle is associated with greater levels of neuroticism, trait anger, and lower self-esteem, all of which are associated with the development of DEP and EDs and may be representative of these underlying psychological mechanisms

(Exline et al., 2016). Greater levels of negative religious coping (often characterized by feeling abandoned or punished by God), which may also represent religious struggle, have also been shown to be associated with higher levels of DEP (Latzer et al., 2015). High levels of divine struggle, feelings of unworthiness, and a punitive view of God and S/R in general may be related to the observation that many women with EDs report that the ED has replaced previous S/R elements in their lives and the disorder itself begins to take on an almost spiritual identity (Lelwica, 2010; Richards et al., 2018; Richards et al., 2007).

p0095 In addition, attention has been paid to underlying motivation for religious practice and research has consistently demonstrated that an extrinsic religious orientation (i.e., a focus on the external or social aspects of religious experience) has been shown to be associated with higher levels of ED symptoms in clinical samples (Smith, Richards, & Maglio, 2004) and higher levels of DEP and body dissatisfaction in nonclinical samples (Weinberger-Litman, Rabin, Fogel, & Mensinger, 2008). For example, among inpatients being treated for bulimia and college students who had scored within the clinical range on a measure of DEP, there was a positive association between an extrinsic religious orientation and disordered eating and body dissatisfaction (Smith et al., 2004). Consistent with these results, in a large nonclinical sample of women determined to be at increased familial risk for the development of disordered eating (based on family dysfunction and parental history of and ED), an extrinsic religious orientation was predictive of greater levels of disordered eating and strengthened the relationship between family dysfunction and ED symptoms (Forthun, Pidcock, & Fischer, 2003).

p0100 It has been suggested that religious orientation represents a particular cognitive or motivational style (Kirkpatrick & Hood, 1990) that engenders specific patterns of psychological and behavioral responses. In fact, an extrinsic religious orientation is consistently associated with greater levels of depression, anxiety, and low self-esteem in studies examining DEP, as well as general mental health (Weinberger-Litman et al., 2016), suggesting that an extrinsic orientation may be a proxy for additional psychological processes shown to contribute to EDs and DEP. It is therefore also likely that religious orientation is associated with specific psychosocial experiences that in turn are related to DEP. In recent studies, the association between an extrinsic orientation and DEP was found to be largely mediated by greater vulnerability to the internalization of negative sociocultural ideals and harmful media messages (e.g., ideas related to thinness and

beauty) in both US and international samples (Weinberger-Litman et al., 2016, 2018). An extrinsic religious tendency was therefore associated with a greater vulnerability to external messaging in general, suggesting that this paradigm taps into one of the potential ways in which S/R factors represent complex cognitive and psychological mechanisms that may be linked to mental health outcomes.

p0105 Recent decades have seen significant advances in understanding the biological basis of EDs. Structural and functional neuroimaging studies have begun to elucidate the brain regions and the neurochemical disruptions associated with different variants of EDs (Favaro, Monteleone, Santonastaso, & Maj, 2018). Further, these studies help to understand how dysregulation of certain reward circuitry contributes to overlapping and disparate symptomatology across the EDs (Frank, 2015). In addition, significant research has focused on genetic variations in the systems that may contribute to ED symptoms (Culbert, Slane, & Klump, 2018). To date, there have not been any published studies that explore how the psychobiology of EDs may relate to elements of S/R. However, consistent research demonstrates a neurological basis for and response to spiritual experiences (Rim et al., 2019). Further, functional imaging studies are able to differentiate types of spiritual experiences based on activation in various brain regions (Miller et al., 2019). Therefore, it would be of particular interest to understand whether individuals with EDs or at high risk for their development exhibit differential neural responses to S/R imagery or tasks. In addition, the neurobiological impact of integrating S/R factors into psychological and behavioral treatment could elucidate the underlying mechanisms associated with the influence of S/R elements.

p0110 Taken together, the positive and negative aspects of S/R with regard to ED development suggest that internalized religious beliefs (Weinberger-Litman et al., 2016) and lower levels of divine struggle (Exline et al., 2016) may lead to a greater sense of solid identity formation and meaning in life. Particularly for adolescents, this can have a powerful salutary effect when it comes to the ability to withstand constant bombardment by media images and unrealistic expectation of beauty and thinness. Beyond this, it suggests that tapping into the elements of S/R beliefs that reduce negative affect, promote the formation of values, and encourage individuals to view the body as worthy of love and care (Strenger, Schnitker, & Felke, 2016) may reduce risk for the development of EDs in high-risk women. Conversely, religious experiences that induce feelings of guilt, shame, or failure may increase the impact of religious mechanisms

that enhance deleterious psychological processes. Below, we integrate these findings and discuss the utilization of empirically supported strategies for incorporating elements of S/R into treatment.

s0020 Clinical issues and recommendations

p0115 Many practitioners and scholars have published books and articles that provide insights into how to integrate spiritual perspectives into ED treatment. Table 6.1 summarizes some of the contributions in this domain, including feminist, integrative-medical, metaphorical, narrative, Protestant Christian, and 12-step approaches (e.g., Berrett, Hardman, & Richards, 2010; Emmett, 2009; Johnson & Sansone, 1993; Johnston, 1996; Lelwica, 1999, 2010; Maine & Kelly, 2005; Manley & Leichner, 2003; Richards et al., 2007; Ross, 2007). These writers have also described a variety of spiritual therapeutic techniques that can be used for treating those with EDs.

p0120 We believe that there is value in all of these approaches depending on the treatment context and patients' cultures and religious backgrounds and encourage practitioners and researchers to familiarize themselves with the approaches that seem most relevant for them. Because of space limitations, the clinical recommendations offered in the remainder of this chapter will be based primarily on the treatment approaches developed during the past two decades by Berrett, Hardman, and Richards and their collaborators (e.g., Berrett et al., 2010, 2018; Hardman, Berrett, & Richards, 2003; Lea, Richards, Sanders, McBride, & Allen, 2015; Richards et al., 2007, 2013, 2018).

s0025 A spiritually integrative treatment model for eating disorders

p0125 Fig. 6.1 presents a conceptual model for a spiritually integrative treatment approach to EDs. This model, which has been adapted and expanded upon from Richards et al. (2018), represents the relationship between spirituality and ED treatment and recovery. On the left side of the figure, ED development and pathology are influenced by decreases in spiritual connection—and vice versa. The core clinical issue when patients are entrenched in their ED is that their locus of identity and worth is grounded in external criteria and values. Their true identity and worth have been lost in the worship and false promises of the ED (Hardman et al., 2003). What is meant by worship in this context is that in the natural development of the ED illness, patients unknowingly begin putting

t0010 **Table 6.1** Spiritual approaches for treating eating disorder patients.

Author(s)	Conceptual framework	Role of spirituality in recovery	Spiritual interventions
Berrett, Hardman, and Richards	Theistic, integrative, multidisciplinary	Reclaiming one's sense of spirituality and placing faith in a Higher Power and the love of significant others rather than in the false promises of the ED can empower patients with a sense of hope, purpose, and spiritual worth, which motivates and facilitates physical and emotional healing and growth	Learn to "listen to one's heart;" solo times for contemplation, prayer, and spiritual journaling; reading sacred writings; spirituality and 12-step groups; service; forgiveness; art therapies; spiritual mindedness; giving and receiving gifts of love; living in a principled manner; spiritual assessments
Johnston	Feminist, metaphorical	Reclaiming one's feminine, intuitive capacities facilitates recovery	Connecting to one's heart; cultivating a state of receptivity; being still; focusing on being instead of doing; mindfulness; honoring one's emotions; keeping a journal of hunches and insights; testing and following one's intuitions
Manley and Leichner	Narrative, feminist, cognitive, spiritual	Spirituality can empower adolescents to discover and implement values of personal significance	Spirituality group; motivational work
Maine	Feminist, integrative	Spirituality is one part of a healthy, more complete and balance approach to living that can help women clarify their values and nurture their faith	Quiet time for reflection; mindfulness meditation; seeking balance; pondering the legacy one wishes to leave; clarifying one's values and priorities; learning to breath fully; learning to love one's body
Lelwica	Feminist, spiritual	Spirituality can help women reject the dogma that having a perfect body will give them health, happiness, and well-being and instead find meaning and	Mindfulness; cultural criticism; developing an embodied ethics of eating; building nourishing relationships; accepting one's self and body; experiencing and accepting

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		purpose through a connection to the sacred	pain and suffering; extending compassion to self and others
Ross and Wingate	Integrative-medical, (body−mind−spirit)	Getting in touch with the deeper urges of the soul or spirit and with their spiritual longings can help patients find their passion in life and bring renewed vigor for and purpose in life	Buddhist prayer; guided imagery; hypnosis, mindfulness meditation; progressive relaxation; yoga; bodywork therapies; practicing gratitude; forgiveness; nurturing inspiration and awe; enjoying art; serving others; going to church; relationships with pets; supplements and herbs
Emmett	Psychospiritual, existential	Spirituality can help patients reclaim the self and restore a healing sense of wholeness and holiness	Facilitating psychospiritual literacy; conducting a spiritual assessment; psychospiritual restructuring; encouraging authenticity; affirming spiritual worthiness; sowing seeds of faith, hope, and love
Cumella, Eberly, and Wall	Protestant Christian	Spiritual healing and growth are necessary for physical, psychological, and social recovery and growth	Spiritual assessment; classes to explore spiritual issues; daily attendance at chapel; songs of praise and worship; Celebrate Recovery groups; Christian 12-step groups
Johnson, Sansone, and Yeary	12-Step, theistic	Faith in and reliance on a Higher Power rather than self is essential for overcoming addictive eating-disordered behaviors	Group support; confession; restitution; seeking forgiveness from God and others; prayers of petition and invocation; meditation; service to others

Source: Adapted from Richards, P. S., Weinberger-Litman, S. L., Susov, S., & Berrett, M. E. (2013). Religiousness and spirituality in the etiology and treatment of eating disorders (pp. 319−333). In K. I. Pargament, J. Exline, J. Jones, A. Mahoney, & E. Shafranske (Eds.), *APA handbook of psychology, religion, and spirituality* (Vol. 2). Washington, DC: American Psychological Association.

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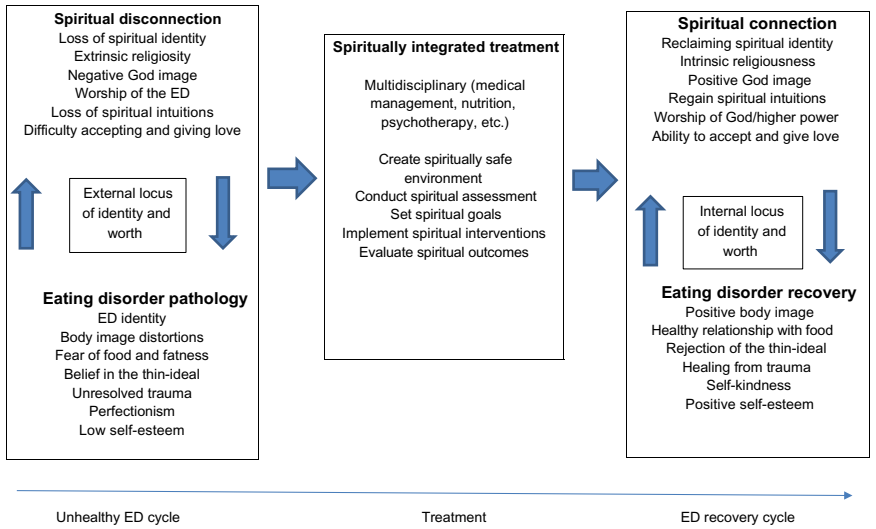

f0010 **Figure 6.1** Role of spirituality in eating disorder (ED) treatment and recovery. *Adapted from Richards, P. S., Caoili, C. L., Crowton, S. A., Berrett, M. E., Hardman, R. K., Jackson, R. N., & Sanders, P. W. (2018). An exploration of the role of religion and spirituality in the treatment and recovery of patients with eating disorders.* Spirituality in Clinical Practice, *5, 88–103.*

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more faith in illness as the solution or answer to their suffering. The middle of Fig. 6.1 is intended to illustrate that spiritually integrated treatment helps break the unhealthy ED cycle. Spiritually integrated treatment helps patients reconnect with religious and spiritual resources in their lives (Richards et al., 2007). This enables them to begin the healthy cycle of ED recovery. On the right side of Fig. 6.1, it can be seen that ED recovery is influenced by spiritual connections—and vice versa. During spiritually integrated treatment, shifting attention from disordered eating to healthy living allows patients to rediscover areas of their lives that have been neglected during their disorder. A renewed spiritual connection shifts patient's locus of identity and worth from external to internal criteria and values, which facilitates healing and ED recovery. We elaborate further on this model below.

s0030 ### *Loss of spiritual connection*

p0130 Spiritual connection refers to the quality of patients' relationship with their spirituality, which they may define as their God or Higher Power; those who love them; their own hearts; their sense of purpose, meaning, and deepest desires; their own best self; their connection with nature; or any other spiritual source. Spiritual connection is often lost in the drive to maintain disordered eating. For many women, as their ED becomes more severe, their connection to God or their Higher Power decreases. The ED becomes the focus of the woman's attention and worship and replaces God and spiritual sources of identity and coping. Furthermore, as women disconnect from spiritual sources of meaning and support, they rely more fully on the ED and thinness as their source of meaning and as an escape from their emotional pain. This creates a vicious cycle where spiritual disconnection and ED pathology mutually and destructively influence each other (Richards et al., 2007, 2018). In our clinical work, we have noticed that the loss of spiritual connection in patients' lives is manifested in numerous ways, including (1) loss of spiritual identity, (2) focus on extrinsic versus intrinsic religious motivations, (3) negative images of God or spirituality, (4) worshiping or placing faith in the ED as an answer or solution to their suffering, (5) loss of spiritual intuitions, and (6) difficulty in accepting and giving love. Due to space limitations, we can only briefly describe each of these spiritual problems here, but we have described them and other spiritual problems in more detail in previous publications (e.g., Berrett et al., 2010, 2018; Richards et al., 2007).

Loss of spiritual identity

Nearly all women who struggle with an ED lose touch with their sense of identity and worth. For those who are religiously and spiritually inclined, this includes the loss of their spiritual identity (Berrett et al., 2018; Richards et al., 2007). According to Berrett et al. (2018), "Spiritual identity is the very core of personhood … [and] represents a full and complete identity. It is the recognition, awareness, and embodiment of the whole self – the integration and acceptance of self in various sectors of life: physical, mental, emotional, relational, and spiritual" (p. 339). For many patients, the loss of their spiritual sense of identity is extremely painful because they feel that they have lost God or that God has abandoned them. They no longer feel worthy of God's love. They lose their sense of identity as a woman and as a valued creation or daughter of God and come to "see themselves exclusively as an eating disorder, or as the expression of an eating disorder" (Richards et al., 2007, p. 44).

Extrinsic religious motivations

As discussed earlier, research provides some support for the idea that those who are involved in religious communities and activities for perceived social and personal gain (i.e., extrinsic religious motivations) may be more vulnerable to EDs (Smith et al., 2004; Weinberger-Litman et al., 2008, 2016). In our clinical work, we have noticed that a major feature of ED psychopathology is an external locus of identity and worth. Religious women who are suffering with an ED may rely too heavily upon perceived approval from their religious community for their sense of identity and self-esteem.

Negative images of God

Some theistic patients feel that God abandoned them during the most difficult and traumatic times of their lives. Many patients feel that God is unreachable or capricious. Patients can also have painful beliefs that God views them as sinful, unworthy, and defective—and they feel alienated and disconnected, undeserving of God's help (Richards et al., 2007).

Worshiping or placing faith in the eating disorder

Many women suffering with EDs report that the ED becomes their God (Richards et al., 2007, 2018). Rather than placing their faith and hopes for success and happiness in God or their spiritual source, they come to believe that it is the ED—and thinness—that will give them success, love,

and happiness and solutions to their suffering (Hardman et al., 2003). Thinness becomes their object of worship. This unintentional shifting toward placing faith in the ED illness is not a conscious choice, but rather, a natural progression of the development of the illness.

Loss of spiritual intuitions

p0155 As EDs worsen, those suffering lose the ability to recognize the impressions and intuitions of their hearts because these feelings are lost in internal conflict and turmoil—and in the many negative messages of the ED mind (Berrett et al., 2010; Johnston, 1996; Richards et al., 2007). As a result, women do not trust themselves to have valid impressions or intuitions. They lose this source of emotional and spiritual guidance, which undermines their ability to make healthy choices. Rather than looking inward and trusting their own thoughts, feelings, and spiritual intuitions when making choices, they rely on excessive overthinking, the negative pressures of perfectionistic thoughts, and external criteria for success and worth provided by peers, media, and other sources of social influence and pressure.

Difficulty accepting and giving love

p0160 One of the consequences of an ED is that those suffering ED experience a diminished ability to accept and give love, which undermines their ability to deepen loving relationships (Richards et al., 2007). This inability stems in part from their feelings of shame, worthlessness, unlovability, and fear of vulnerability (Berrett et al., 2010; Richards et al., 2018). Many patients resist or refuse love from others on the grounds that they believe they are the exception to love. They believe everyone else is deserving of love, but they are not. The loss of these deeper connections of love with others often leaves patients feeling alone and lost. Their obsessive preoccupation with food, body image, and illness becomes an obstacle to love and connection with God, spirituality, and close interpersonal relationships (Berrett et al., 2010).

Guidelines for spiritually integrated treatment of eating disorders

p0165 The model described above has a corresponding set of clinical guidelines, which are consistent with the general approach of the American Psychiatric Association (2010), which recommends a multidisciplinary approach to treatment of EDs. Medical doctors, nurses, psychiatrists, psychologists, family therapists, and dietitians are part of the treatment team.

Medical management; nutrition and weight stabilization; medication; and individual, group, and family psychotherapies are all necessary interventions with those who have severe EDs. Within this context, spiritual perspectives and interventions are combined with evidence-based, best-practice medical and psychological treatment methods in a treatment-tailoring manner depending on patients' preferences and needs (Richards et al., 2007).

p0170 In order to implement spiritual approaches and interventions in a sensitive and effective manner, it is crucial to establish a spiritually safe therapeutic environment (Richards et al., 2007). Many patients are uncertain whether it is acceptable to talk about religious and spiritual issues during psychotherapy (Richards & Bergin, 2005), perhaps out of the misconception that the separation of church and state in government also applies to mental health treatment. This is not the case, and letting patients know that they have the right to discuss spiritual issues during treatment can help allay fears they may have about doing so. There are several things treatment providers can do to help establish a spiritually safe and open therapeutic environment. Including questions about patients' religious background, affiliation, and beliefs on intake questionnaires and other assessment measures sends the message and gives permission to talk about religious issues—and it can provide valuable information for helping therapists understand their patients' worldviews and values (Berrett et al., 2010; Richards et al., 2007).

p0175 During informed consent procedures, therapists should also explicitly tell patients that it is okay to talk about religious and spiritual issues during treatment, if the patient wishes. As treatment proceeds, if patients bring up religious or spiritual issues for discussion, therapists should, of course, listen carefully and communicate interest in learning about this area of patients' lives (Richards & Bergin, 2005). Therapists should also take a client-centered approach and seek to work within their patients' religious or spiritual framework and values. They should similarly seek to learn and use the language of patients' spirituality rather than imposing their own spiritual language or values on patients (Berrett et al., 2010). If patients seem uncomfortable or unwilling to discuss spiritual issues, treatment providers should respect their preference and treatment should proceed without a spiritual focus. Helping patients understand what spirituality is and how it may be beneficial to address in treatment can help establish a spiritually safe and open environment. We recommend that treatment providers define spirituality broadly and to seek to understand patients' beliefs

about what spirituality means to them. If spirituality is defined broadly to include things such as love, kindness, forgiveness, compassion, and hope, this can help patients more fully recognize how spiritually is evident in their lives (Berrett et al., 2010). While patients may be religious or nonreligious, we believe that all patients are spiritual in nature and that finding and embracing their spirituality can assist them in reclaiming a positive sense of identity (Berrett et al., 2018).

p0180 For patients who desire a spiritually integrated approach, assessing patients' S/R background is essential. A thorough assessment of patients' functioning should be conducted at the beginning of treatment, including their physical, nutritional, psychological, social, and spiritual functioning. A careful religious and spiritual assessment can help the treatment staff work within the patient's belief system in a respectful manner. Patients' spirituality can be assessed through written intake questionnaires, clinical interviews, and standardized measures of religious orientation and spirituality (Richards et al., 2007). Due to space limitations, we will not say more about conducting a religious and spiritual assessment here, but this information is available in other publications (e.g., Berrett et al., 2010, 2018; Richards & Bergin, 2005; Richards et al., 2007). Activities as simple as asking patients to talk about their spiritual hero, and why they chose that hero, can provide much insight into patients' spiritual beliefs and values (Berrett et al., 2018).

p0185 Spiritual interventions in treatment should not begin until after a careful assessment of the patients' psychological functioning, spiritual background and beliefs, and attitudes about exploring spiritual issues during treatment. Berrett et al. (2010) described six pathways to spiritual reconnection and recovery: listening to the heart, learning a language of spirituality, mindfulness and spiritual mindedness, principled living, receiving and giving the good gifts of love, and holding up the therapeutic mirror which reflects spiritual identity. They also described a variety of spiritual interventions that can help patients progress along these spiritual pathways toward spiritual reconnection and recovery from illness.

p0190 Interventions that can be useful during individual therapy include spiritual discussions, reading sacred writings, writings of the heart, prayer, spiritual imagery, listening to sacred music, honesty without self-judgment, repentance, meditation, time in nature, forgiveness, letter writing, letter to the ED, solo time, and spiritual journaling (Richards et al., 2007). Group and family therapy interventions can include many activities that are designed to promote openness, honesty, vulnerability,

and connections with self and others (Richards et al., 2007). Effective interventions help to make the implicit and unspoken seen and shared in a safe environment. Patients and families have opportunities to face fears, take risks, and begin practicing new perspectives, approaches, and choices for their lives and relationships. They can begin to experience the power of love, compassion, and acceptance from others, while at the same time, sharing their own good hearts and love with the people in their lives. They can confront pain, see the truths and negative costs of the ED, and open their spiritual eyes and see themselves for who they really are without the ED (Berrett et al., 2010, 2018; Richards et al., 2007).

s0070 Ethical considerations

p0195 In keeping with evidence-based practice, we recommend that treatment providers who integrate spirituality into ED practice monitor the outcomes of treatment on a routine basis (Lea et al., 2015; Richards et al., 2007). This recommendation is based on research that shows that continuous assessment of ED patients' progress leads to treatment course correction and improved outcomes (Simon et al., 2013). Many types of research designs can contribute to the evidence base (APA, 2006), but we recommend, at a minimum, that treatment facilities use a practice-based evidence research design where treatment processes and outcomes are monitored from session to session (Barkham, Hardy, & Mellor-Clark, 2010). Computerized and online outcome assessment systems make it feasible for practitioners and treatment facilities to conduct such research. This is a worthy goal to work toward for all therapists and their patients.

p0200 Beyond remaining within an evidence-based framework, there are a variety of potential ethical pitfalls treatment providers should be alert to when integrating spirituality into treatment. These include the dual relationships (religious and professional), displacing or usurping religious authority, imposing religious values on patients, violating work setting (church-state) boundaries, and practicing outside of the boundaries of professional competence (Richards & Bergin, 2005). Due to space limitations, we refer readers to other books and articles that have discussed these concerns (e.g., Richards & Bergin, 2005; Richards et al., 2007).

p0205 Therapists should also assess whether patients wish to include discussions about their spiritual beliefs in treatment before implementing spiritual interventions. There are several situations where spiritual interventions may be contraindicated, including when patients say they would prefer not to

participate in them, when patients are delusional or psychotic, when spiritual issues are not relevant to the patient's clinical issues, and with children and adolescents whose parents have not given consent to include the discussion of spiritual issues in treatment (Richards & Bergin, 2005). Patients who are antireligious or nonreligious may be offended and feel excluded if there is too much focus on religious or spiritual issues. Therapists should always work within the belief systems of their patients and not use interventions that conflict with patients' spiritual beliefs. Patients should be encouraged to take the lead in their own spiritual journey (Berrett et al., 2010).

Discussion

p0210 Historical and more recent empirical research has led to a better understanding of the mechanisms through which S/R may be relevant to EDs. Recent research has been aimed at understanding the development and treatment of these issues in religiously and spiritually diverse communities (Akrawi et al., 2015; Hall & Boyatzis, 2016). As S/R has become more widely recognized as an important contributor to the sociocultural milieu of risk factors for EDs and related symptoms, treatment approaches addressing ED patients' S/R beliefs and concerns have been developed.

p0215 Successful treatment for EDs requires a multidisciplinary assessment and treatment approach (Brownell & Walsh, 2017). When patients reconnect with spiritual resources, they discover a source of strength and support that can sustain and motivate them during and after treatment (Berrett et al., 2018; Richards et al., 2007, 2018). When they reconnect to love of and from others, this also is a healing process. When they reconnect to themselves—who they really are—and strengthen their sense of spiritual identity and goodness, they are building a foundation for treatment, recovery, and lifelong peace. To include spiritual resources for recovery requires sensitivity and competency and in-depth emotional and spiritual work (Richards et al., 2007). We hope that treatment providers who work with ED patients will make greater efforts to include religious and spiritual resources in their work, in order to more fully facilitate and support their patients' healing and recovery.

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NON-PRINT ITEM

Abstract

Components of S/R have been found to have both positive and negative associations with eatingdisorders (EDs) as well as their most proximal risk factors. Internalized religious beliefs, lower levels ofdivine struggle, solid identity formation, and secure attachment to God can reduce overall negativeaffect, improve self-esteem, promote body appreciation and help mitigate the negative impact of social comparison and media influence thereby reducing risk of ED development. In line with these findings, we present a spiritually integrated model of treatment within the context of evidence-based andoutcome-focused treatment. This approach helps clients recover from EDs by creating a spiritually safespace where they can regain a positive spiritual identity, affirm intrinsic religious beliefs, renew positive views of God, and develop the ability to accept and give love. Ethical considerations and best-practices are outlined with regard to incorporating discussion of S/R into treatment.

Keywords: Eating disorders; spirituality; religion; disordered eating pathology; depression; anxiety