CE 3.0 contact hours

ABSTRACT: *Despite use of current standards of care—antidepressant medications and psychotherapy—to treat depressive symptoms, results experienced by patients and reported in the literature have been inconsistent. Religiously integrated cognitive behavioral therapy (RCBT) is an evidence-based alternative to cognitive behavioral therapy. A type of RCBT, biblical counseling is a viable option for patients experiencing depressive symptoms. Nurses need an awareness of biblical counseling as a therapeutic option for patients who are open to spiritually based care for depression.*

KEY WORDS: *biblical counseling, cognitive behavioral therapy (CBT), depression, nursing, psychotherapy, religiously integrated cognitive behavioral therapy (RCBT), spiritual care*

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*Names changed to protect privacy.

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Jenny is nearing the end of her shift on the cardiac care unit. As she enters Mr. Donaldson's* room, she finds him with the covers pulled up over his head and the room dimly lit from the TV. She gently announces her presence and asks, "Mr. Donaldson, how can you see the TV with those covers pulled up like that?" When Jenny uncovers his head, she notices tears on his cheeks. "Mr. Donaldson, are you okay?" Mr. Donaldson does not stop Jenny from removing the covers and makes no meaningful eye contact.

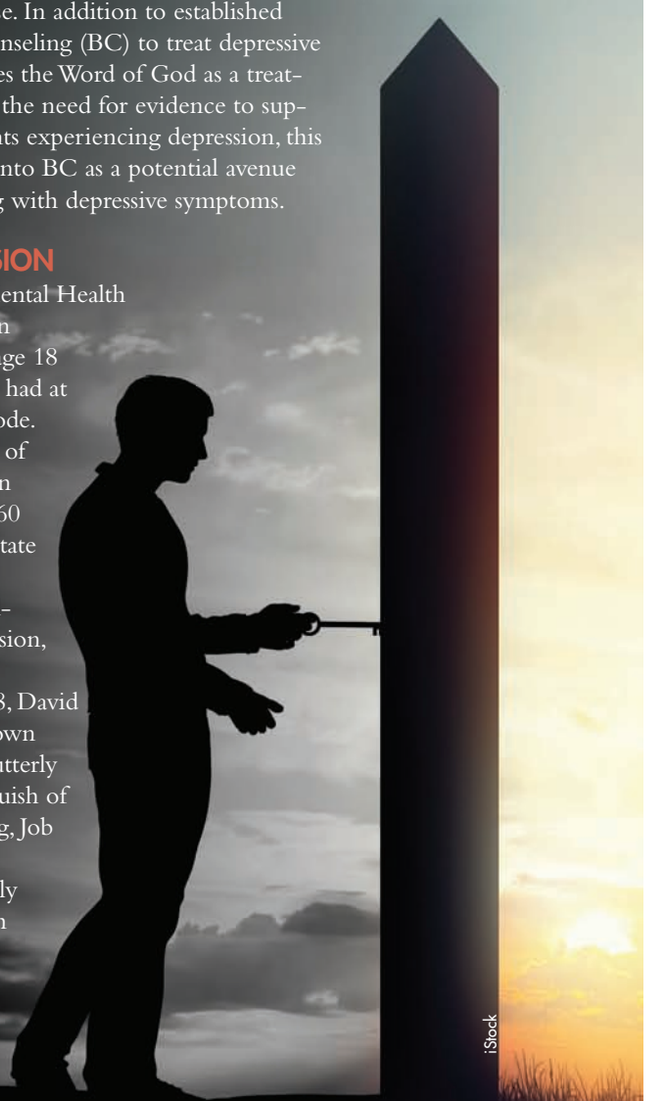
Staring blankly, he replies, "Oh, it's just the news."

Mr. Donaldson is 2 days post open-heart surgery. As Jenny performs her assessment, she asks about his plans upon discharge. The more they talk, the more concerned Jenny becomes. Although his vital signs are within normal range and his surgical site looks good, Jenny observes that Mr. Donaldson has become increasingly withdrawn since surgery. She has observed previously in patients that, even though they are recovering physically, some individuals cannot seem to shake a cloud of despair and hopelessness. Jenny reviews Mr. Donaldson's chart and notes that he considers himself a churchgoer. In considering his disturbed emotional state, Jenny ponders whether Mr. Donaldson's religious beliefs might be a resource for alleviating his depressive symptoms.

Nurses in acute care, outpatient, and home care can acknowledge how often patients who are suffering with acute and chronic illnesses experience despondency. The signs and symptoms these patients manifest can be consistent with a diagnosis of depression. Biblical counselors do not diagnose. In addition to established medical treatment, biblical counseling (BC) to treat depressive symptoms is an avenue that uses the Word of God as a treatment approach. In response to the need for evidence to support the use of BC with patients experiencing depression, this article provides nurses insight into BC as a potential avenue for referral for people suffering with depressive symptoms.

PREVALENCE OF DEPRESSION

The National Institute of Mental Health (2019) reported that in 2017, an estimated 17.3 million adults (age 18 and older) in the United States had at least one major depressive episode. This number represented 7.1% of U.S. adults. The Greek physician Hippocrates, who lived from 460 to 377 BC, first described the state of depression as "melancholia" (DeRubeis & Strunk, 2017). Although not expressed as depression, biblical evidence of depressive symptoms is noted. In Psalm 38, David described himself as "bowed down and brought low," "feeble and utterly crushed," and "groaning in anguish of heart." In his extensive suffering, Job lamented, "I have no peace, no quietness, I have no rest but only turmoil" (Job 3:26, NIV). Jonah was so distraught, he said to God, "Take away my life, for it is better for me to die than to live" (Jonah 4:3, NIV).



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By Denise Ogorek and Janalee Isaacson

Biblical Counseling

An Alternative for Treating Depressive Symptoms

Nurses in acute care, outpatient, and home care can acknowledge how often patients who are suffering with acute and chronic illnesses experience despondency.

Depression is a global affliction. The World Health Organization (WHO) reports that more than 300 million individuals worldwide experience depression in their lifetime; up to 800,000 people die by suicide as a result (WHO, 2018). Other consequences of depression are relationship problems, loss of work productivity, social isolation, substance abuse, and declining physical health (WHO, 2018).

TRADITIONAL TREATMENT OPTIONS

The American Psychiatric Association (APA) has developed evidence-based practice guidelines for treating mental health conditions, including depression. The current APA practice guideline (APA, 2010) for major depressive disorder (MDD) provides recommendations for initial treatment options for the patient experiencing mild to moderate depression. This includes using an antidepressant medication (ADM), with or without psychotherapy. The effectiveness of various classes of ADMs is comparable; healthcare providers must consider potential side effects and safety profiles (APA, 2010). These medications often cause multiple side effects such as adverse sexual issues, sedation, and weight gain. Many ADMs can interact with other medications a patient is using (APA, 2010).

In conjunction with pharmacotherapy, the APA's (2010) current treatment recommendation for MDD includes some type of psychotherapy. One common form of psychotherapy is cognitive behavioral therapy (CBT), which is also named in the current practice guidelines. In CBT, the therapist encourages the patient to reflect on negative thoughts and behavior patterns with the goal of changing thoughts, perceptions, and behaviors to more effectively interact with others and the patient's environment (APA, 2019). Regardless of the treatment selection—ADM, CBT, or both—the outcomes are variable (Kraus, Kadriu, Lanzenberger, Zarate, & Kasper, 2019), so clinicians and researchers continue to explore alternatives.

INTRODUCTION TO BIBLICAL COUNSELING

In contrast to medical-based treatment, BC views the patient's depressive symptoms through the lens of the Judeo-Christian Bible (See Sidebar 1: *History of Biblical Counseling*). In this way, BC approaches the plan of care through the literal meaning of psychology: "the study of the soul" (MacArthur, 2005, p. 7). Scripture portrays depression with a variety of descriptive passages, including "a burden too heavy to bear" (Psalm 38:4, NIV) and hearts that are "troubled" (John 14:27). Psalm 102:4 states, "My heart is sick, withered like grass, and I have lost my appetite" (NLT). Psalm 34:18 references people who are "crushed in spirit" (NIV).

Depression generally emanates from one or more causes such as possible biochemical differences, genetics, stressful life events, medication, and physical illness or conditions (Harvard Health Publishing, 2019). Over time, the resulting low mood can spiral into despair. For Mr. Donaldson, his need for cardiac surgery, which was out of his control, may have been a causative factor. People may enter the downward spiral following other stressful life events such as a baby's birth, death of a loved one, loss of a job, or abuse (Łosiak, Blaut, Kłosowska, & Łosiak-Pilch, 2019). When emotional responses to the initial event are ineffectively managed or ignored, depressive symptoms can ensue, such as in Mr. Donaldson's situation. Biblical counseling can interrupt this cycle and bring healing by addressing the heart of the issue.

Specifically, BC is a viable alternative for the APA nonpharmacologic recommendations. To date, research is lacking that supports the effectiveness of BC as part of the treatment plan for patients experiencing depression. A related form of CBT has emerged and is aligned with BC. Religiously integrated cognitive behavioral therapy (RCBT), a term coined by Harold Koenig et al. at Duke University, is a psychotherapeutic approach that uses CBT techniques integrated with the patient's religion as a foundation for therapy (Koenig, Pearce, Nelson, Shaw, et al., 2015). RCBT manuals have been created for Christian, Jewish, Muslim, Buddhist, and Hindu faiths.

In their initial research, Koenig et al. compared standard CBT with RCBT

in persons with a chronic medical illness who were also experiencing depression. Subsequent research focused on the outcomes of optimism, purpose in life, and gratitude. Participants in each of the studies received ten 50-minute sessions by Internet or telephone over 12 weeks using manuals corresponding to their religious traditions. Follow-up assessment occurred at 12 and 24 weeks following completion of the sessions (Koenig et al., 2015).

The initial study explored the impacts of religious versus conventional cognitive behavioral therapy (CCBT) for major depression in persons with chronic medical illness. Data indicated that the impacts of CCBT and RCBT were equivalent. No statistically significant difference was found in the Beck Depression Inventory (BDI) scores for patients who participated in either type of psychotherapy, RCBT or CCBT, at 12 weeks (p = .91) or at 24 weeks (p = .66). In individuals who were identified with more religious ideologies, RCBT demonstrated greater efficacy (p = .048). Also, adherence to treatment was observed to be slightly greater in the more religious participants, the RCBT group (p = .10) (Koenig et al., 2015) (Table 1).

Koenig et al. then studied the effects of RCBT and CCBT for increasing optimism in individuals with chronic medical illness and depression. The study showed that both forms of psychotherapy noticeably increased optimism in individuals with chronic medical illness and depression, though RCBT did not provide statistically stronger results (Koenig et al., 2015). However, a higher baseline religiosity among study participants did predict an increase in optimism over time. Additionally, a higher baseline optimism predicted a faster decline in depressive symptoms over time, and this was a statistically significant finding. Both these indicators were independent of treatment group (Koenig et al., 2015).

Koenig's research team also explored the concept of purpose in life (PIL), a term that refers to the principle introduced by psychiatrist Viktor Frankl in his theory of meaning (Smith & Liehr, 2018). Frankl validated his theory while a prisoner in four concentration camps in World War II. In addition to atrocities he endured, Frankl watched as many fellow prisoners perished. In those who survived, he observed a well-developed PIL. From catastrophic, life-changing events such as those experienced as a prisoner of war to the more common challenges faced by people every day as part of life, Frankl's theory has relevance across all healthcare disciplines (Smith & Liehr, 2018).

Koenig and colleagues continued to explore the impact of RCBT and of CCBT on PIL in clients with major depression and chronic medical illness. They found that in highly religious individuals, RCBT was more effective than CCBT in increasing PIL, with p = .026 and Cohen's d = .64. Analysis of data collected revealed a positive correlation between baseline religiosity and PIL (p < .0001), and the possibility to predict an increase of PIL over time (p < .0001) (Daher et al., 2016).

Regarding the outcome of gratitude, researchers observed that less depression was found in individuals who reported higher levels of gratitude (Pearce et al., 2016). In generating gratitude, RCBT was compared with CCBT in religious persons with chronic medical illness and depression. Between those patients participating in RCBT and CCBT, no statistically significant difference was observed in

Table 1. Summary of Research Findings

Author/ Year	Article Title	Outcomes Measured	Findings	Notes
Koenig et al. (2015)	Religious vs. CCBT for MDD in persons with chronic medical illness: A pilot randomized trial.	BDI scores at 12 weeks and at 24 weeks	NSS between groups 12 weeks (p = .91) 24 weeks (p = .66)	Authors noted greater efficacy of RCBT in participants with greater religiosity.
Koenig, Pearce, Nelson, & Daher (2015)	Effects of religious versus CCBT on optimism in persons with major depression and chronic illness.	Optimism	NSS between groups (p = .185)	Authors noted that a higher baseline religiosity independent of treatment group predicted an increase in optimism over time (p < .0001) and a faster decline in depressive symptoms over time (p < .0001).
Pearce et al. (2016)	Effects of religious versus CCBT on gratitude in MDD and chronic medical illness: A randomized clinical trial.	Gratitude	NSS between groups; gratitude increased regardless of treatment group (p= .0002).	Authors noted that a higher level of baseline religiosity predicted an increase in gratitude scores, independent of treatment group.
Daher et al. (2016)	Effects of religious vs. CCBT on PIL in clients with MDD and chronic medical illness: A randomized clinical trial.	PIL	• RCBT more effective than CCBT in increasing PIL in highly religious individuals (p = .026, and Cohen's d = .64). • Positive correlation between baseline religiosity and PIL (p < .0001). • Possibility to predict an increase of PIL over time (p < .0001).	Authors noted that increased PIL may depend on the religiosity of the client.

Note. BDI = Beck Depression Index; CCBT = conventional cognitive behavioral therapy; MDD = major depressive disorder; NSS = no statistical significance; PIL = purpose in life; RCBT = religious cognitive behavioral therapy.


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gratitude scores at any point. Gratitude scores increased regardless of treatment group ($p = .0002$) and when evaluated as a change over time. Findings revealed that a higher level of baseline religiosity predicted an increase in gratitude scores independent of treatment group CCBT ($p < .0001$) and RCBT ($p = .002$) (Pearce et al., 2016).

All of Koenig's research included patients practicing one of five major religions: Christianity, Judaism, Islam, Buddhism, or Hinduism. Based on the data collected and published, Koenig et al. have confidence that incorporating patients' religion impacts the treatment for depression (2015). The work of these researchers has contributed significantly to the body of knowledge in this area. However, because the research presented includes patients practicing a variety of religions, specific approaches need additional study and documentation. For this reason, this article spotlights data related to the management of patients experiencing depressive symptoms and for whom the

Sidebar 1. History of Biblical Counseling

The principle of counseling from the Bible originates with Scripture, according to Lambert (2011). In the 16th and 17th centuries, Puritans inscribed the first formal biblical counseling in hundreds of works on the "personal ministry of the Word" (Lambert, 2011, p. 25). Puritan pastor William Bridge, in his 1649 classic, *A Lifting Up for the Downcast*, provided counseling approaches using biblical application. He did not use the term "depression," but rather "sadness," "discouragement," "cast down," and "disquieted." Following this, 100 years passed before another work arrived on the Christian approach to interpersonal ministry (Lambert, 2011).

Lambert, past Executive Director of the Association of Certified Biblical Counselors, identified many reasons for the shift away from biblical counseling during the 1800s and the 1900s, a shift he calls "theological neglect." In a sincere effort to help others, many professionals offered philosophies independent of one another and without careful alignment with the Word of God (Lambert, 2011). Lambert observed that when Christians are not vigilant, the "faith's psychology will recede and a faithless psychology will ascend" (2011, p. 27).

Evolutionary biology emerged around in the mid-1800s; the publication of Charles Darwin's *On the Origin of Species* in 1859 challenged the Bible's authority. Although theologians came together to address significant issues of biblical authority and the origin of the universe, counsel from the Bible was not addressed. Hence, secular psychology and counseling approaches began to develop to fill the void (Lambert, 2011) and grew, led by the work of Wilhelm Wundt and Sigmund Freud. For example, Wundt posited that thoughts and feelings originate from the physical body. His work is credited as providing the initial steps of psychology emerging as a science (Lambert, 2011). Freud initiated psychotherapy, believing the church had failed in this area; he pursued removing the practice of counseling from the church (Lambert, 2011).

The Industrial Revolution during the 1800s through the 1900s resulted in an American cultural shift as secular psychology gained awareness in understanding people and relationships (Lambert, 2011). The church, meanwhile, was focusing on revivalist efforts and defending the fundamentals of faith.

Three major wars also influenced the decline of Christian influence on counseling. The brutality of the Civil War hardened people of the United States and led to the view of pastoral counsel as weak and less valued. In World War I, psychology was introduced into the military, further alienating pastors from the role. During World War II, many chaplains were enlisted to assist psychologists, but were not well prepared or trained for the tough work they faced. This was viewed as success for psychologists and contributed to the move away from biblical reflection as a means of helping people (Lambert, 2011). These factors contributed to the shift away from the church as the primary site for counseling people. By the middle of the 20th century, Christian reflection on personal ministry from the Bible had dwindled and counseling outside the church walls was on the rise and supported by most Christians (Lambert, 2011).

Biblical counseling to treat depression is an avenue that uses the Word of God as a treatment approach.

In the 1970s, Jay Adams began to direct Christians back to Scripture as a meaningful resource (Lambert, 2011). As he stepped into the role of a pastor, Adams was burdened by the overwhelming emotional needs of his congregation, needs he did not feel well equipped to meet. This prompted him to engage in a program of study to better prepare himself for ministry. From this study emerged a biblical counseling system. A guide to the biblical approach in helping people with personal problems followed in 1970 when Adams published *Competent to Counsel* for pastors, counselors, and laypersons (Adams, 1986; Lambert, 2011). In addition to reintroducing Judeo-Christian teaching as a counseling platform, Adams and John Bettler founded the Christian Counseling & Educational Foundation (CCEF) in 1968 (CCEF, 2019).

Over the past four decades, CCEF has contributed to the biblical counseling movement. For more than 50 years, CCEF's School of Biblical Counseling has offered courses leading to a certificate. Some courses are part of an online degree program leading to a Master of Arts in counseling in cooperation with a theological seminary.

The organization's growth birthed a separate but related organization, the Institute for Biblical Counseling & Discipleship (IBCD). IBCD investigates, develops, and tests counseling methodology with a focus on equipping laypersons to implement the counseling for struggling individuals (IBCD, 2019). To assure ongoing integrity and consistency of Judeo-Christian principles and to facilitate best practice resources and strong relationships among leaders in biblical counseling, the Biblical Counseling Coalition (BCC) formed in 2010 (BCC, 2019). These organizations provide resources, including ongoing education and training in biblical counseling.

counseling approach takes the form of faith-based BC grounded in Judeo-Christian principles (See Sidebar 1: *History of Biblical Counseling*).

BIBLICAL COUNSELING FOR DEPRESSIVE SYMPTOMS

As one treatment option for those experiencing depressive symptoms, BC generally runs 12 weeks. Prior to initiating BC, the counselee completes a personal data inventory that provides demographic data, the person's reason for seeking counseling, previous treatments, expectations, and other pertinent information. The goal of the initial session is for the certified biblical counselor to learn about the counselee and his/her depressive symptoms (See Sidebar 2: *Certification in Biblical Counseling*).

According to Wayne Mack, BC consists of eight key elements (James, 2018). The first is *involvement* that refers to building a relational foundation that provides for change to occur. *Inspiration* is that aspect that provides hope to the counselee. *Investigation* is where the biblical counselor gathers pertinent information. *Interpretation* is the most important element of viewing the situation from the lens of the Bible. Building on interpretation, *instruction* is teaching to effect a change. *Inducement* refers to the role of the biblical counselor to encourage the counselee to make meaningful changes. *Implementation* is the counselee making those changes in daily life. Finally, *integration* is assuring that the changes made are sustained in the life of the counselee.

The intent for the counselee at the core of BC is a surrendered heart and an expanded knowledge and application of Judeo-Christian principles. Each subsequent session follows a consistent pattern that includes beginning and ending with prayer, biblical teaching, instruction in Judeo-Christian principles, and reflection and application of biblical principles in the form of homework (Table 2).

Table 2. Biblical Counseling Elements and Steps

	Activity of Biblical Counselor	Elements Incorporated
Prior to biblical counseling	Review Personal Data Inventory completed by counselee	
Initial Session	• Facilitate the development and cultivation of a relationship built on trust, respect, and compassion. • Pray • Share God's truth • Determine main issue • Discuss with counselee some initial problems • Assign homework • Present the inerrancy of the Scriptures as the foundation for and carried throughout the biblical counseling program.	• Involvement • Inspiration • Investigation • Instruction • Implementation • Integration
Sessions 2 ~ 5	• Pray • Share God's truth • Assign homework • Hold counselee accountable • Encourage any evidence of heart change	All of the above with the addition of counselor encouragement through inducement.
Sessions 6 ~ 12	• Pray • Share God's truth • Assign homework • Hold counselee accountable • Encourage any evidence of heart change	All of the above progressing in depth and consistency.
Final Session	The counselor and counselee agree that the counselee has gained knowledge, understanding, and the ability to effectively apply what has been learned.	All of the above integrated into daily life.

Note. Source: James (2018).

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Vital to each session is "the integrity of the Scriptures as the authoritative standard" (Adams, 1986, p. 18). Throughout the counseling sessions, the counselor fosters a relationship with the counselee through compassion, respect, and sincerity. MacArthur describes the focus of the counseling as person-oriented rather than problem-oriented (2005).

Hope, derived from the promises of God and a personal relationship with Jesus, is woven into each session. The counselor shares instruction providing biblical insight that can lead to new patterns of thinking about God's character, the present troubling situation, causes of the depression, and modifying words and actions (MacArthur, 2005). As the counselee seeks to put off old ways and apply and follow Judeo-Christian principles, transformation of the inner person begins. Commonly, the depression lightens or resolves as the counselee learns and practices new means to approach difficult situations, including a shift in focus and the development of habits that transform words and actions based on biblical truth (Lambert, 2011).

An integral element to the success of BC is the weekly homework. While completing these assignments, the counselee is able to work through critical elements covered in counseling sessions, and change within the inner person occurs. The homework facilitates the ongoing revelation of biblical principles appropriate to the issues, leading steadily to transformation in knowledge, belief, and action (Adams, 1986).

An example of a homework assignment for a patient like Mr. Donaldson, as a counselee, would be to read chapters one and two of the Old Testament book of Jonah. Then, the counselee is asked to list how he may or may not identify with Jonah. Next, the counselee would be directed to reread chapter two and state what Jonah did to get out of the belly of the great fish. He would proceed to reflecting on the hope that Jonah experienced. Finally, the counselee is led to apply the instructions or lessons of the Scripture passage to his or her life situation during the week, while keeping a journal of thoughts. In subsequent sessions, the counselor and counselee would review the homework responses and journal entries and discuss them in relation to application steps.

The BC process ends when growth is observed in the counselee through knowledge, understanding, and application of biblical principles to his or her life issues. This growth is further evidenced when the counselee engages in daily prayer along with regular church attendance and participation in a small study group. These activities have been demonstrated to be critical to the ongoing growth and support for the counselee (Ogorek, 2018).

Sidebar 2. Certification in Biblical Counseling

In 1970s, the Christian Counseling and Educational Foundation identified the need for a formal process to certify counselors who use the Bible as a counseling tool. This aim was meant to ensure doctrinal integrity and excellence in biblical counseling. The process led to the creation of an independent certifying body, the Association of Certified Biblical Counselors (ACBC), founded in 1976 originally as the National Association of Nouthetic Counselors under the direction of Jay Adams (ACBC, 2018).

Those studying for certification complete three elements: coursework and study in foundational biblical elements, essay testing in theology and counseling, and supervision. A certified "fellow" supervises the individual who has demonstrated counseling ability and who is pursuing certification. The supervisor serves as a mentor and leader, guiding the precertified counselor in the biblical application of the counseling practice. The approximate period to certification completion is 1 year (ACBC, 2018). To date, about 1,600 biblical counselors speaking 28 languages and practicing in 25 countries have received certification through the ACBC.

Case Study. Rediscovering Hope

I felt compassion as I observed the woman in the church counseling office. Tina* was well dressed and accustomed to appearing in control. However, that image was collapsing as she shared the increasingly deep sadness she had been experiencing. Information provided prior to our initial session revealed that over the past 2 years, Tina had experienced severe sadness and loneliness leading to bouts of crying. She reported that these episodes had become nearly debilitating. She denied health problems, reported taking a multivitamin daily, and testified of the strength of her 10-year marriage. A regular church attender who participated biweekly in a small group within the church, Tina admitted to infrequent personal Bible reading and prayer. Gentle probing revealed that Tina loved her husband and had an irrational fear for him and their family when he was away. I assessed that she had a big view of her husband but a small view of God.

In our first session, we discussed the hope that we can know as followers of Christ. Jesus is called the "man of sorrows" who understands the grief and worries of life (Isaiah 53:3). We read together how he endured the cross for Tina and is worthy of her faith and trust.

In following sessions, we examined Scripture for insight and direction. Tina identified with descriptions in the Old Testament book of Jonah and the experiences of this reluctant evangelist: "The flood surrounded me; all your waves and billows passed over me" (Jonah 2:3, ESV). She connected with and began to practice Jonah's ultimate decision to seek God while feeling afflicted (Jonah 2:7-9).

In the book of Ruth, we read about one woman's tragedy and her faith and trust in God. Over the next several weeks of study, discussion, and homework, Tina identified her lack of faith and trust in God and how her dependency rested solely on her husband. Midway through our sessions, I introduced Tina to the book, *Idols of the Heart* by Brad Bigney. Through ongoing discussions and homework, Tina recognized her "idol" was her husband whom she had allowed to take the place of God in her life. She asked for forgiveness and replaced her old ways of thinking and acting with those consistent with biblical principles (Ephesians 4:22-24). As Tina developed the daily disciplines of Bible reading and prayer and placed her faith and trust in God with more confidence and consistency, the episodes of sadness, loneliness, and crying decreased and eventually ceased.

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Web Resources

- **Christian Counseling & Educational Foundation**—https://www.ccef.org/
- **Association of Certified Biblical Counselors**—https://biblicalcounseling.com/
- **Institute for Biblical Counseling & Discipleship**—https://ibcd.org/
- **Biblical Counseling Coalition**—https://www.biblicalcounselingcoalition.org/

NURSING IMPLICATIONS

Nurses encounter patients in every part of the spectrum of physical, psychological, and emotional well-being and are in the unique position to come alongside patients during times of crisis. Professionally, nurses know to connect depressed patients with providers and services that can best help them during these dark times. For many, ADMs offer a part of the solution, but until patients are able to work through the heart issues that may be connected to their depression, they may experience only episodic relief.

With an understanding of the research and effectiveness of RCBT including BC, nurses may suggest to patients or to patients' primary care providers that BC is a legitimate and beneficial therapeutic alternative. This recommendation is dependent on the nurse's accurate spiritual assessment and awareness of the patient's religious/spiritual beliefs.

"Many depressed patients [that] are religious, indicate that their religious beliefs are important to their daily lives, and often use their beliefs to cope with difficult life situations," asserted Koenig (2014, p. 45). Koenig (2014) advocates for nurses to support patients' religious and spiritual beliefs while providing care, including honoring a patient's request to use his or her beliefs in psychotherapy (see Case Study).

CONCLUSION

In the patient scenario at the beginning of this article, if Jenny had been knowledgeable in the use of BC as a treatment alternative for depression, she could have applied her knowledge to suggest BC as an adjunct to pharmacologic treatment. How might information related to approaches such as BC impact the options available to Jenny and others caring for patients such as Mr. Donaldson? Depression is a serious medical condition that affects millions of Americans and its prevalence continues to increase across the age spectrum. To date, the practice guidelines, which include pharmacologic and nonpharmacologic options, have yielded variable results. Exploration of alternative approaches is needed to effectively treat this epidemic. As part of a treatment plan, BC is a nonpharmacologic

approach that employs techniques similar to those of the CBT, but does so while building specifically on the foundation of Judeo-Christian principles. Healthcare professionals including nurses and nurse researchers can advance this treatment method by continuing to develop and conduct well-designed research to contribute to a growing body of evidence related to the effectiveness of BC in treating individuals with depression.

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