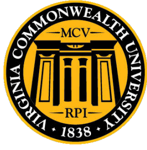

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College of Humanities and Sciences
Virginia Commonwealth University

This is to certify that the dissertation prepared by Joshua N. Hook entitled The Effectiveness of Religiously Tailored Couple Counseling has been approved by his committee as satisfactory completion of the dissertation requirement for the degree of Doctor of Philosophy.

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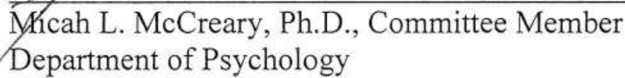

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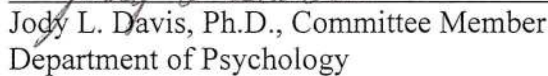

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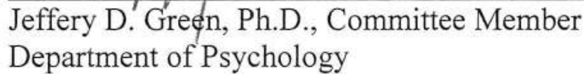

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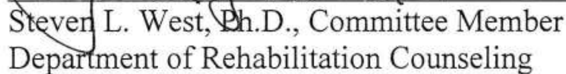

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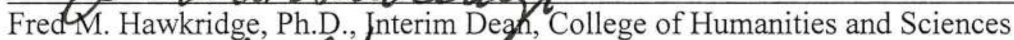

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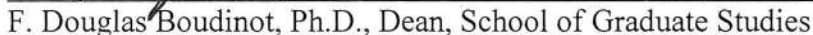

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The Effectiveness of Religiously Tailored Couple Counseling

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy at Virginia Commonwealth University

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Abstract

THE EFFECTIVENESS OF RELIGIOUSLY TAILORED COUPLE COUNSELING

By Joshua N. Hook, M.S.

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy at Virginia Commonwealth University

Virginia Commonwealth University, 2009

Major Director: Everett L. Worthington, Jr., Ph.D., Professor, Department of Psychology

Large numbers of couples seek treatment from religious counselors who integrate religion and spirituality (R/S) into counseling. The present dissertation reviewed the literature examining the effectiveness of R/S counseling. Several R/S treatments were helpful in treating psychological problems. There was little evidence that R/S treatments outperformed secular treatments. In Study 1, a nationwide survey was conducted that examined the beliefs of Christian counselors about integrating R/S into couple counseling. Christian counselors (N = 630) completed measures of religious commitment, experience in couple counseling, attitudes toward using religious techniques in couple counseling, and the use of theory in couple counseling. Counselors were highly religious, and religious commitment was a positive predictor of viewing religious techniques as appropriate. Christian couple counseling was popular and widely practiced, although there was wide variation in the number of couples seen per counselor. Counselors were

influenced by both secular and Christian theories of couple counseling. There were several differences between professional, pastoral, and lay counselors, indicating that each subgroup be treated separately rather than grouped together. In Study 2, the nature of Christian couple counseling was described and the effectiveness of Christian couple counseling was examined using a longitudinal study. Counselors ($N = 20$) completed a measure of religious commitment, and clients ($N = 60$) completed measures of religious commitment, the use of religious and secular techniques in counseling, relationship satisfaction, working alliance with the counselor, and satisfaction with counseling at three time points during counseling. Religious techniques were common in couple counseling, and most were used in about 50% of the sessions. The religious commitment of counselors was a positive predictor of the number of religious techniques used in counseling. Clients attending Christian couple counseling reported increases in relationship satisfaction and working alliance with the counselor over time, and reported high levels of satisfaction with counseling. Working alliance with the counselor was a positive predictor of both relationship satisfaction and satisfaction with counseling. A close match in religious commitment between counselor and client did not predict greater improvement in relationship satisfaction, but it did predict a stronger working alliance throughout counseling.

Chapter 1

INTRODUCTION

The relationship between religion, spirituality, and psychology has historically been tenuous, and many psychologists have criticized religion as harmful (e.g., Freud, 1927/1961; Skinner, 1953). Recently, however, psychologists have begun to study the possible benefits of religion and spirituality to physical and mental health (e.g., Koenig, McCullough, & Larson, 2001; Miller & Thoresen, 2003; Powell, Shahabi, & Thoresen, 2003).

One question about the relationship between religion, spirituality, and psychology that is especially pertinent to counseling psychology is whether it is effective to tailor counseling interventions to the religious beliefs and worldviews of clients. In 1999, the APA Division of Psychotherapy Task Force was commissioned to determine empirically supported relationship factors in counseling (Norcross, 2002). Besides working alliance and empathy, which were deemed empirically supported, several methods of customizing counseling to clients on the basis of their nondiagnostic personal characteristics were determined to have "promising" empirical support. Tailoring counseling to the religious beliefs and values of clients was one of those (Worthington & Sandage, 2002). The Psychotherapy Task Force called for more research assessing the efficacy and effectiveness of tailoring counseling to the client's religious beliefs and values (Norcross).

Furthermore, although there are some outcome studies that evaluate the efficacy and effectiveness of religious tailoring for individual counseling, there are almost no

studies that evaluate the efficacy and effectiveness of religious tailoring for couple counseling. This is disconcerting, especially considering that religious couple counseling is common (Worthington, 1996; Wylie, 2000). In this dissertation, I review the literature on evidence-based religious and spiritual therapies in Chapter 2. The review of the literature in Chapter 2 is not intended to lead directly to the subsequent empirical studies. Rather the purpose of the review is to write a self-contained, publishable review of empirical research that will inform, but not lead directly to, the studies.

In Chapters, 3, 4, 5, and 6, I report two studies that examine the nature and effectiveness of religious couple counseling from a Christian perspective. Specifically, in Chapter 3, I write a general statement of the problem to introduce the topic I am addressing. In Chapter 4, I report the results from a nationwide survey of Christian couple counselors. In Chapter 5, I describe the techniques used in Christian couple counseling, and examine the effectiveness of this counseling as indexed by (a) improved relationship satisfaction, (b) improved working alliance with the counselor, and (c) satisfaction with counseling. Furthermore, I examine aspects of the counselor, clients, and techniques used to evaluate the extent to which these factors contribute to effective counseling. In Chapter 6, I provide a general discussion of the two studies in the context of the extant literature.

Chapter 2

REVIEW OF THE LITERATURE

Empirically Supported Religious Therapies

The relationship between psychology and religion has been tenuous. Many psychologists have questioned the value of religion or criticized religion as harmful (e.g., Freud, 1927/1961; Leuba, 1950; Skinner, 1953; Vetter, 1958). Others have held a more positive and hopeful view of religion (James, 1902/1985; Jung, 1954/1968). Over the years, the attitudes of psychologists toward religion have generally become more positive, and many psychologists appear to value the role of religion in people's lives (Shafranske, 1996). Furthermore, research has generally found a positive relationship between religiousness and positive physical and mental health (Koenig et al., 2001; Miller & Thoresen, 2003; Powell et al., 2003).

The U.S. population is highly religious, with about 92% claiming affiliation with an organized religion (Kosmin & Lachman, 1993), and 96% reporting a belief in God or universal spirit (Gallup, 1995). Furthermore, surveys have indicated that about 90% of Americans pray, 71% are members of a church or synagogue, and 42% attend worship services weekly (Hoge, 1996). Thus, psychologists are likely to encounter clients for whom religion and spirituality is an important aspect of their lives.

Some psychologists have posited that incorporating religion and spirituality into therapy may have important effects on outcome (Shafranske, 1996; Wade, Worthington, & Vogel, 2007; Worthington, Kurusu, McCullough, & Sandage, 1996; Worthington & Sandage, 2002). Indeed, the volume and quality of research on the inclusion of religion

and spirituality in therapy has increased dramatically over the past 25 years (Worthington & Sandage, 2002). However, although the recent advances in religious and spiritual interventions are promising and exciting; little has been written about the empirical status of such counseling interventions (see Hodge, 2006 for an exception). The purpose of the present review is to use the criteria presented by Chambless and Hollon (1998) to evaluate the efficacy and clinical significance of religious therapies.

The guidelines presented by Chambless and Hollon (1998) provide a unifying framework to determine the level of empirical support for a specific therapy. Namely, to be designated as empirically supported, a treatment must either (a) outperform a no-treatment control group, placebo, or alternative treatment, or (b) be equivalent to a treatment already established in efficacy in a study that has sufficient power to detect moderate differences. Furthermore, for a designation of *efficacious*, the superiority of the treatment must be shown in studies by at least two independent research labs. If only one study indicates the superiority of a given treatment, or if all the studies examining a given treatment are contained within one research lab, the treatment is designated *possibly efficacious*. Finally, for a designation of *efficacious and specific*, the treatment must outperform an alternative treatment such as a pill or psychological treatment (rather than simply a no-treatment control) in at least two independent research labs.

When conducting the present review, several decisions had to be made about how to apply the criteria set forth by Chambless and Hollon (1998). One decision addressed which studies to include in the review of the literature. It was decided to include both published and unpublished studies. Although unpublished studies may suffer from

reduced methodological rigor, including only published studies may result in publication bias. Also, the scope of this review was limited to investigations that examined a religious or spiritual therapy for a mental health problem that occurred in an individual or group counseling format. The examination of treatments for medical problems (e.g., Cole, 2005) or specific religious interventions that occur outside of a therapeutic context, such as intercessory prayer (see Hodge, 2007 for a review), were not included in the present review. Furthermore, because the purpose of this review was to determine the empirical status of religious and spiritual therapies, only randomized clinical trials (RCTs) were included in the present review.

A second decision that needed to be made when conducting the present review involved sample size. Investigations were included regardless of sample size. Chambless and Hollon (1998) note that in order to detect medium-sized differences in treatment outcome studies, a study must have at least 50 participants per condition. Outcome studies of religious or spiritual therapies often suffer from small sample sizes. This is not a problem when one treatment outperforms another, but may prove problematic when trying to determine whether a therapy is equivalent to a treatment already established in efficacy. Chambless and Hollon suggest that if a study shows no differences between one treatment and a treatment already established in efficacy, *and* the study has at least 25-30 participants per condition, then it is reasonable to conclude that the two treatments are equally efficacious. Studies with small samples are included in the present review of the literature. They are not, however, used to determine equivalence among treatment conditions if no significant differences are obtained between treatments.

A third decision addressed whether studies were considered to be evaluations of the same treatment or separate treatments. Treatments were considered unique based on the type of psychopathology addressed (e.g., depression and anxiety). Also, therapies from different religious or spiritual affiliations (e.g., Christian and Muslim) were considered evaluations of separate treatments, even if they addressed the same psychological disorder. Furthermore, therapies were considered unique if the type of psychological theory driving the treatment differed (e.g., cognitive and psychodynamic). Generally, if therapies were from the same school of psychotherapy (e.g., cognitive and cognitive-behavioral), they were considered to be an evaluation of the same treatment, even when there were minor differences in the treatment protocol.

A final decision addressed how treatment outcomes are determined. First, most outcome studies involve at least a pretest posttest design, and may include one or more follow-up measures. Although evaluating the long-term effects of specific therapies is important, follow-up studies are difficult to interpret, due to problems such as clients pursuing additional treatment and differential retention rates (Chambless & Hollon, 1998). Thus, although follow-up data are reported, determinations of efficacy status were made based on data from pretreatment and posttreatment. Second, studies may use multiple measures of the dependent variable. When studies used multiple measures, I attempted to focus on a set of central variables that have demonstrated evidence of reliability and validity in previous research.

Other factors that are important when evaluating therapies include clinical significance and effectiveness. Clinical significance addresses whether or not the changes

that occurred as a result of a treatment are large enough to be clinically meaningful (Chambless & Hollon, 1998). Effectiveness data address whether a treatment can be shown to work in actual clinical practice (Chambless & Hollon). In the present review, data on clinical significance and effectiveness are reported where present, but are not used to determine the efficacy status of therapies. When discussions of clinical significance or effectiveness are omitted from a section, the reader can assume that there are currently no data present to address these questions.

Method

To identify outcome studies of therapies that incorporated religion or spirituality, I searched the following databases: *PsychINFO*, *Social Sciences Citation Index*, and *Dissertation Abstracts International*, with the combinations of the following key words: religion, spirituality, counseling, and therapy. The search was conducted between November 15, 2007 and December 15, 2007. After conducting the literature search, I read the abstracts and obtained the relevant articles. I also examined the reference sections of the relevant articles for other studies that should be included in the review. A total of 19 studies met inclusion criteria for this study as of January 1, 2008.

Results

The studies in the present review addressed problems in seven areas: depression (seven studies), anxiety (four studies), unforgiveness (three studies), schizophrenia (one study), alcoholism (one study), eating disorders (one study), and marital issues (one study). One additional study addressed general psychological problems. Religious or spiritual worldviews represented in the present review include Christianity (ten studies),

Islam (four studies), Taoism (one study), and a more generic spirituality (four studies). The results are organized first by problem area, then by religious or spiritual worldview. A summary of all studies can be found in Table 1.

Depression

Seven studies have evaluated religious or spiritual therapy for depression. These studies fall into two categories. Five studies evaluated a Christian version of cognitive therapy for depression, and two studies evaluated a Muslim version of supportive psychotherapy for depression.

Christian Accommodative Cognitive Therapy

Christian accommodative cognitive therapies (CT) generally retained the main features of the existing secular theory, yet placed the therapy in a religious context. Techniques such as cognitive restructuring and guided imagery were integrated with Biblical teaching and religious imagery.

Efficacy status. Propst (1980) assigned 44 religious college students who were mildly or moderately depressed to one of four conditions: religious imagery (n = 9), nonreligious imagery (n = 11), therapist contact plus self-monitoring (n = 13), and self-monitoring (n = 11). Participants in the religious imagery, nonreligious imagery, and therapist contact plus self-monitoring conditions participated in eight one-hour therapy groups that met twice per week. Participants in the self-monitoring condition were given no treatment but filled out daily mood cards. The religious imagery therapy condition outperformed the self-monitoring condition on depression as indexed by the depression subscale of the short form of the MMPI (Overall, Butcher, & Hunter, 1975) but not the

Table 1

Empirical Status of Religious and Spiritual Therapies

Treatment	Study	Treatment Conditions	Major Results*
		Efficacious treatments	
Depression Christian CT	Johnson et al. (1994)	1. CRET (*n* = 13) 2. RET (*n* = 16)	1 = 2
	Johnson & Ridley (1992)	1. CRET (*n* = 5) 2. RET (*n* = 5)	1 = 2
	Peucher & Edwards (1984)	1. RCBM (*n* = 7) 2. SCBM (*n* = 7) 3. WLC (*n* = 7)	1 = 2 > 3
	Propst (1980)	1. Religious Imagery (*n* = 9) 2. Non-religious Imagery (*n* = 11) 3. Therapist + Monitoring (*n* = 13) 4. Monitoring Only (*n* = 11)	1 = 2 = 3 > 4
	Propst et al. (1992)	1. RCT (*n* = 19) 2. NRCT (*n* = 19) 3. PCT (*n* = 10) 4. WLC (*n* = 11)	1 = 2 = 3 > 4
		Possibly efficacious treatments	
Anxiety Christian DM	Carlson et al. (1988)	1. DM (*n* = 12) 2. PR (*n* = 12) 3. WLC (*n* = 12)	1 > 2 > 3
Spiritual Group CBT	Nohr (2001)	1. SCBT (*n* = 41) 2. CBT (*n* = 26) 3. WLC (*n* = 14)	1 = 2 > 3
Taoist CT	Zhang et al. (2002)	1. CTCT (*n* = 46) 2. BDZ (*n* = 48) 3. Combined CTCT BDZ (*n* = 49)	1 = 3 > 2
Unforgiveness Christian Group	Rye & Pargament (2002)	1. Religious (*n* = 19) 2. Secular (*n* = 20) 3. Comparison (*n* = 19)	1 = 2 > 3
	Rye et al. (2002)	1. Religious (*n* = 50)	1 = 2 > 3

		2. Secular (n = 49) 3. Comparison (n = 50)	
Spiritual Group	Hart & Shapiro (2002)	1. Spiritual (n = 30) 2. Secular (n = 31)	1 > 2
Alcoholism Twelve-step Faciliation	Project Match Research Group (1997)	1. TSF 2. CBT 3. MET	1 = 2 = 3
Marital Discord Christian Group CBT	Combs et al. (2000)	1. THC (n = 15 couples) 2. WLC (n = 16 couples)	1 > 2
General Psychological Problems Christian LC	Toh & Tan (1997)	1. LC (n = 22) 2. WLC (n = 24)	1 > 2
	Unable to determine efficacy status		
Depression Muslim psychotherapy	Azhar & Varma (1995a)	1. Religious (n = 15) 2. Control (n = 15)	1 > 2
	Azhar & Varma (1995b)	1. Religious (n = 32) 2. Control (n = 32)	1 = 2
Anxiety Muslim psychotherapy	Azhar & Varma (1994)	1. Religious (n = 31) 2. Control (n = 31)	1 = 2
Schizophrenia Muslim-accommodative CBT	Wahass & Kent (1997)	1. Muslim CBT (n = 3) 2. Control (n = 3)	1 > 2
Eating Disorders Spiritual Group Intervention	Richards et al. (2006)	1. Spirituality (n = 43) 2. Cognitive (n = 35) 3. Emotional support (n = 44)	1 = 3 > 2

Note. CT = cognitive therapy; CRET = Christian rational-emotive therapy; RET = rational-emotive therapy; RCBM = religious cognitive behavior modification; SCBM = secular cognitive behavior modification; WLC = wait list control; RCT = religious cognitive behavioral therapy; NRCT = standard cognitive behavioral therapy; PCT = pastoral counseling treatment; DM = devotional meditation; PR = progressive relaxation; SCBT = spiritual cognitive behavioral treatment; CBT = cognitive behavioral treatment; CTCT = Chinese Taoist cognitive therapy; BDZ = benzodiazepine medication; TSF = twelve-step facilitation; MET = motivational enhancement therapy; THC = traits of a happy couple; LC = lay counseling.
* Major results indicate statistically significant differences among treatments at posttest; see text for follow-up results. Treatments are designated by number in previous column.

Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). There were no significant differences between the religious imagery therapy condition and the other treatment conditions.

Peucher and Edwards (1984) assigned 21 Christian college students who were mildly or moderately depressed to one of three conditions: religious cognitive behavior modification (RCBM; $n = 7$), secular cognitive behavior modification (SCBM; $n = 7$), and a wait-list control (WLC; $n = 7$). Each participant in the RCBM and SCBM conditions was seen individually for eight 50-minute therapy sessions that met twice per week. Both the RCBM condition and the SCBM condition outperformed the WLC on depression as indexed by the BDI. There was no significant difference between the RCBM condition and the SCBM condition.

In a related study examining cognitive behavioral therapy (CBT), Propst, Ostrom, Watkins, Dean, and Mashburn (1992) assigned 59 depressed Christian adults to one of four conditions: religious cognitive behavioral therapy (RCT; $n = 19$), standard cognitive behavioral therapy (NRCT; $n = 19$), pastoral counseling treatment (PCT; $n = 10$), and a wait-list control (WLC; $n = 11$). Each participant in the RCT, NRCT, and PCT conditions was seen individually for 18, 50-minute therapy sessions. All treatment conditions outperformed the WLC on depression as indexed by the BDI. There were no significant differences between the RCT condition and either the NRCT condition or the PCT condition.

Examining a different offshoot of CT, rational-emotive therapy (RET; Ellis & Grieger, 1977), Johnson and Ridley (1992) assigned 10 Christian adults who were at least

mildly depressed to one of two conditions: Christian rational-emotive therapy (CRET; $n = 5$) and secular rational-emotive therapy (RET; $n = 5$). Each participant in the CRET and RET conditions was seen individually for six 50-minute therapy sessions that met twice per week. Although both the CRET and RET conditions improved on depression as indexed by the BDI from pretest to posttest, there was no significant difference between the CRET and RET conditions.

In a similar follow-up study, Johnson, Devries, Ridley, Pettorini, and Peterson (1994) assigned 29 Christian adults who were at least mildly depressed to one of two conditions: Christian rational-emotive therapy (CRET; $n = 13$) and secular rational-emotive therapy (RET; $n = 16$). Each participant in the CRET and RET conditions was seen individually for eight, 50-minute therapy sessions. Again, although both the CRET and RET conditions improved on depression as indexed by the BDI from pretest to posttest, there was no significant difference between the CRET and RET conditions.

In sum, three studies from two different labs showed that Christian accommodative CT for depression outperformed a no-treatment control group. Two studies showed no differences between Christian-accommodative CT and a therapy already established in efficacy, however, the sample sizes from these studies were not large enough to provide evidence for efficacy based on the guidelines set forth by Chambless and Hollon (1998). However, on the basis of the three studies that do show the superiority of Christian accommodative CT relative to a no-treatment control group, Christian accommodative CT should be viewed as an efficacious treatment for depression.

Follow up results. The maintenance of treatment effects for Christian accommodative CT has been explored in four of the five above studies. Generally, treatment gains from Christian accommodative CT have been maintained at follow-up. At a six-week follow up, Propst (1980) found a trend at the $p = .10$ level for the religious imagery group to exhibit less depression as indexed by the MMPI-D than the other conditions. At a one-month follow up, Pecheur and Edwards (1984) reported that participants in both the RCBM and SCBM conditions had maintained their treatment gains. Similarly, at a three-month follow up, Johnson et al. (1994) reported that participants in both the CRET and RET conditions had maintained their treatment gains. Propst et al. (1992) conducted both a three-month and two-year follow-up, and found that all treatment conditions (RCT, NRCT, and PCT) had maintained their treatment gains at both time points.

Clinical significance. Three of the five studies reported data on the clinical significance of treatment effects, that is, whether the treatments produced meaningful changes in a person's daily life. Propst (1980) noted the percentage of individuals at posttest that still scored in the depressed range on the BDI (i.e., BDI > 9). Participants in the religious imagery condition had fewer depressed individuals at the end of treatment (14%) than either the self-monitoring condition (60%, $p < .05$) or the nonreligious imagery condition (60%, $p < .05$). Similarly, Propst et al. (1992) reported that participants in the RCT condition had fewer depressed individuals at the end of treatment (15.8%) than did the WLC condition (60%, $p < .05$). Johnson et al. (1994) reported that participants in the CRET and RET conditions had approximately equal rates of depressed

individuals at the end of treatment (CRET: 23%, RET: 19%) and follow-up (CRET: 23%, RET: 44%). Propst et al. also assessed clinical significance using a reliable change index, which calculates change from pretest to posttest divided by the standard error of measurement (Jacobson, Follette, & Revenstorf, 1984). Both the RCT condition (68.4%) and the PCT condition (80%) had greater percentages of participants who showed meaningful change on the BDI relative to the WLC condition (27.3%, both $ps < .05$). Johnson et al. evaluated the percentage of participants whose posttreatment and follow-up scores on the BDI were more than two standard deviations below the pretreatment mean of the sample (see Jacobson & Traux, 1991). At posttreatment, 56% of participants in the CRET condition and 62% of participants in the RET condition had clinically meaningful change. The rates at follow-up were 69% for CRET and 44% for RET.

Effectiveness. There has been some research evaluating the effectiveness and clinical utility of Christian accommodative CT. Propst (1980) found that participants in the therapist contact plus self-monitoring condition rated their therapist as less skilled than the other therapy conditions. Johnson and Ridley (1992) found no differences between participants in the CRET and RET conditions on ratings of the counselor's expertise, trustworthiness, and attractiveness. Interestingly, Propst et al. (1992) had both religious and nonreligious therapists conduct both standard and religious CBT. Nonreligious therapists were effective at delivering religious CBT, suggesting that nonreligious therapists may be able to incorporate religion into therapy effectively even when the religious techniques do not align with the therapist's own worldview.

Muslim Psychotherapy

Muslim psychotherapy consisted of discussions of religious issues that pertained to participants (e.g., reading verses from the Koran, the use of the Prophet as a model for changing one's lifestyle, and encouragement to pray). In the studies that evaluated Muslim psychotherapy, this therapy was given in addition to weekly supportive psychotherapy and mild doses of antidepressant medication.

Azhar and Varma (1995a) assigned 30 Muslim patients from Malaysia who met DSM-III-R criteria for major depression to one of two conditions: religious condition ($n = 15$) and control condition ($n = 15$). Participants in both conditions were given weekly supportive psychotherapy (12-16 sessions) and antidepressant medication (dothiepin, 100-150 mg/day). The religious condition was also given additional religious psychotherapy. Although both conditions improved over time, the religious condition outperformed the control condition on depression as indexed by the Hamilton Rating Scale for Depression (HRSD; Hamilton, 1967) at one month, three months, and six months.

In a similar study by the same laboratory, Azhar and Varma (1995b) assigned 64 Muslim patients from Malaysia who met DSM-III-R criteria for dysthymic disorder to one of two conditions: religious condition ($n = 32$) and control condition ($n = 32$). Participants in both conditions were given weekly supportive psychotherapy (15-20 sessions) and antidepressant medication. The religious condition was also given additional religious psychotherapy. Although both conditions improved over time, the religious condition outperformed the control condition on depression as indexed by the

HRSD at one month and three months. There was no difference between conditions at six months.

In sum, one study showed that Muslim psychotherapy, when combined with supportive psychotherapy and antidepressant medication, outperformed supportive psychotherapy and medication alone. A second study from the same lab showed that Muslim psychotherapy, when combined with supportive psychotherapy and antidepressant medication, outperformed supportive psychotherapy and medication alone at first, but the effect had disappeared by the end of treatment (six months). However, no determination about the efficacy status of Muslim psychotherapy for depression can be made because it was combined with antidepressant medication and supportive psychotherapy. As Chambless and Hollon (1998) note, it is possible that the effects of a psychological treatment that is combined with a medication or placebo may not be additive but interactive, meaning that the psychological treatment may be effective only in combination with the medication or placebo.

Anxiety

Four studies have evaluated religious or spiritual therapies for anxiety. One study evaluated a Christian devotional meditation program, one study evaluated a Muslim version of supportive psychotherapy for anxiety, one study evaluated a Taoist version of cognitive therapy for anxiety, and one study evaluated a spiritually informed cognitive behavioral treatment to manage stress and anxiety.

Christian Devotional Meditation

Relaxation has long been viewed as an important psychological intervention (Jacobson, 1938). Studies have found that practices such as meditation can often have similar effects as muscle relaxation (Raskin, Bali, & Peeke, 1980). Christian devotional meditation has long been emphasized in the Christian church, and generally involves practices or disciplines of quiet reflection on certain passages of Scripture or prayer (Carlson, Bacaseta, & Simanton, 1988).

Carlson et al. (1988) randomly assigned 36 Christian undergraduate students to one of three conditions: devotional meditation (DM; $n = 12$), progressive relaxation (PR, $n = 12$), and a wait-list control (WLC; $n = 12$). Participants in both the DM and PR conditions were given six 20-minute sessions, three times per week for two weeks. Participants in the DM condition listened to passages of Scripture, devotional thoughts, and prayers while being monitored physiologically. Participants in the PR condition listened and participated in relaxation instructions (Bernstein & Borkovec, 1973). During the test sessions, participants in the DM condition had lower muscle tension than participants in the PR condition. After treatment, participants in the DM condition also reported less anger and anxiety than participants in the PR and WLC conditions. In sum, one study showed that Christian devotional meditation outperformed both a wait-list control and a progressive relaxation condition. Based on this study, Christian devotional meditation should be viewed as a possibly efficacious treatment for anxiety.

Muslim Psychotherapy

Similar to Muslim psychotherapy for depression, Muslim psychotherapy for anxiety consisted of discussions of religious issues that pertained to participants (e.g.,

reading verses of the Koran, prayer as a form of relaxation). In the one study that evaluated Muslim psychotherapy for anxiety, this therapy was given in addition to weekly supportive psychotherapy and anxiety medication.

Azhar, Varma, and Dharap (1994) randomly assigned 62 Muslim patients from Malaysia who met DSM-III-R criteria for generalized anxiety disorder to one of two conditions: religious condition (n = 31) and control condition (n = 31). Participants in both conditions were given weekly supportive psychotherapy (12-16 sessions) and benzodiazepine medication. The religious condition was also given additional religious psychotherapy. Although both conditions improved over time, the religious condition outperformed the control condition on anxiety as indexed by the Hamilton Rating Scale for Anxiety (HRSA; Hamilton, 1959) at three months. There was no difference between conditions at six months.

In sum, one study showed that Muslim psychotherapy, when combined with supportive psychotherapy and antianxiety medication, outperformed supportive psychotherapy and medication alone at first, but the effect disappeared by the end of treatment (six months). However, similar to the findings for Muslim psychotherapy for depression, no determination about the efficacy status of Muslim psychotherapy for anxiety can be made because it was combined with anti-anxiety medication and supportive psychotherapy.

Taoist Cognitive Therapy

Taoist cognitive therapy shares broad principles with cognitive therapy, yet it is based in the philosophy of Taoism, which focuses on conforming to natural laws, letting

go of excessive control, and the flexible development of personality (Zhang et al., 2002). The goal of Taoist cognitive therapy is to regulate negative affect, correct maladaptive behavior, and change modes of thinking and coping (Zhang et al.).

Zhang et al. (2002) randomly assigned 143 Chinese patients who met CCMD-2-R criteria for generalized anxiety disorder to one of three conditions: Chinese Taoist cognitive therapy (CTCT; n = 46), benzodiazepine medication (BDZ; n = 48), and combined CTCT and BDZ treatment (n = 49). CCMD-2-R criteria are similar to that of the DSM-IV, except the minimum time symptoms must be present is three months rather than six months (Lee, 1996). Participants in the CTCT condition and combined condition were given weekly one-hour therapy sessions for one month, and biweekly therapy sessions for five months. Participants in the BDZ condition had the same schedule, yet met for only ten minutes per session. At one month, participants in the BDZ and combined conditions outperformed participants in the CTCT condition on psychological symptoms, as indexed by the Symptom Checklist (SCL-90; Derogatis, 1977). However, at the end of treatment (six months), participants in the CTCT and combined condition outperformed participants in the BDZ condition. There was no difference at six months between the CTCT and combined conditions. In sum, one study showed that Taoist cognitive therapy outperformed a drug treatment condition. Based on this study, Taoist cognitive therapy should be viewed as a possibly efficacious for anxiety.

Spiritual Cognitive Behavioral Treatment

The spiritual cognitive behavioral treatment (CBT) intervention to reduce stress and anxiety was based on a CBT model (Beck, 1984). Several suggestions and

illustrations to incorporate spirituality were offered, including refuting irrational beliefs by spiritual truths, finding meaning and growth from difficult events, and including a comforting spiritual figure in guided imagery.

Efficacy status. Nohr (2001) randomly assigned 67 undergraduate students to one of three conditions: spiritual cognitive behavioral treatment (SCBT; n = 41), cognitive behavioral treatment (CBT; n = 26), and wait-list control (WLC; n = 14). Participants in the WLC condition were assigned to the CBT condition after completing pretest and posttest measures. Participants in both the SCBT and CBT conditions completed four weekly sessions of 1.5 hours each in a group format. Both the SCBT condition and the CBT conditions outperformed the WLC condition on the on psychological symptoms as indexed by the SCL-90-R (Derogatis, 1992). There was not a significant difference between the SCBT and CBT conditions. In sum, one study showed that a spiritual CBT treatment group outperformed a wait-list control. Based on this study, spiritual CBT group treatment should be viewed as a possibly efficacious treatment for anxiety.

Follow-up results. Nohr (2001) evaluated the maintenance of treatment gains at one month after treatment ended. Gains on the SCL-90-R were maintained for both the SCBT and CBT conditions. This finding should be viewed cautiously, however, because only 25% of the participants who completed pretest and posttest measures returned to complete the follow-up measures.

Clinical significance. Nohr (2001) evaluated the percentage of participants in each condition that exhibited reliable improvement. A participant was considered reliably improved if the difference between the pretest and posttest scores on the SCL-90-R were

twice the standard error in the improved direction (Speer & Swindle, 1982). Thirty-one percent of participants in the SCBT condition exhibited reliable improvement, compared to 14% of participants in the CBT condition and 7% of participants in the WLC condition. Nohr also examined a subsample of participants who were in the clinical range of the SCL-90-R at pretest (SCBT, 41%; CBT, 30%; WLC, 29%). Percentages of this clinical population that exhibited clinically significant improvement, defined as both exhibiting reliable improvement and having scores at posttest that were closer to the mean of the normal population than the clinical population, were as follows: SCBT, 50%, CBT, 33%; WLC, 0%.

Unforgiveness

Three studies have evaluated religious or spiritual therapies for unforgiveness. These studies fall into two categories. Two studies evaluated a Christian version of the REACH model of forgiveness (Worthington, 1998), and one study evaluated a spiritual 12-step type program that was adapted to focus on forgiveness issues.

Christian Accommodative Forgiveness Interventions

Both the studies that evaluated Christian accommodative forgiveness interventions were based on the REACH model of forgiveness (Worthington, 1998), which involves five steps: Recall the hurt, Empathize with the one who hurt you, Altruistic gift of forgiveness, Commitment to forgive, and Holding onto forgiveness. For the Christian accommodative interventions, participants were encouraged to (a) draw on their religious beliefs while working toward forgiveness, (b) draw on religious sources of

support when forgiving, and (c) use prayer and Scripture to help with the forgiveness process.

Efficacy status. Rye and Pargament (2002) randomly assigned 58 Christian female college students who had experienced an offense within the context of a romantic relationship to one of three conditions: religious forgiveness group (RF; n = 19), secular forgiveness group (SF; n = 20), and comparison group (n = 19). Each participant in the RF and SF conditions attended six, 90-minute weekly group sessions. The comparison group received no treatment. Both the RF and SF groups outperformed the comparison group on forgiveness as indexed by the Rye Forgiveness Scale (Rye et al., 2001). There was no difference between the RF condition and the SF condition.

In a related study by the same lab, Rye et al. (2005) randomly assigned 149 divorced adults to one of three conditions: religious forgiveness group (RF; n = 50), secular forgiveness group (SF; n = 49), and comparison group (n = 50). Each participant in the RF and SF conditions attended eight, 90-minute weekly group sessions. The comparison group received no treatment. Both the RF and SF groups outperformed the comparison group on forgiveness as indexed by the Rye Forgiveness Scale. There was no difference between the RF condition and the SF condition.

In sum, two studies from the same lab showed that Christian accommodative forgiveness interventions outperformed a no-treatment control group. Based on these findings, Christian accommodative forgiveness interventions should be viewed as a possibly efficacious treatment for unforgiveness.

Follow-up results. Both of the above studies evaluated the maintenance of treatment effects at a six-week follow up. In both studies, both the RF and SF conditions had maintained their treatment gains.

Effectiveness. Rye and Pargament (2002) asked participants in both the RF and SF conditions to rate the program on several dimensions (e.g., enjoyment of program, willingness to recommend the program to a friend, usefulness of homework assignments, relevance of program content, group leader competence). Although participants in both conditions rated the program favorably, participants in the SF condition reported that they enjoyed the program more than did participants in the RF condition.

Spiritual Forgiveness Intervention

The study that evaluated a spiritual forgiveness intervention was a 12-step type program that was adapted to focus on forgiveness issues (Hart & Shapiro, 2002). The intervention emphasized addiction to grudges, guilt, and shame. The intervention led participants through a "spiritual solution" to the problem of powerlessness over anger, and suggested that the reliance on a higher power was required to experience release from the bondage of anger.

Efficacy status. Hart and Shapiro (2002) randomly assigned 61 sober adult members of Alcoholics Anonymous (AA) to one of two conditions: spiritual forgiveness group (SP; $n = 30$) and secular forgiveness group (SEC; $n = 31$). Each participant in the SP and SEC conditions attended ten, 2-hour biweekly group sessions. Participants in both groups also received ten emotionally supportive phone calls from the group leader over the twenty week span of the intervention. The SEC treatment was based on the

process model of forgiveness (Enright & Coyle, 1998). The SP group outperformed the SEC group on forgiveness as indexed by the Transgression-Related Interpersonal Motivations Inventory (TRIM; McCullough et al., 1998). In sum, one study showed that a spiritual forgiveness intervention outperformed a secular forgiveness intervention that has been established in its efficacy. Based on this study, this spiritual forgiveness intervention should be viewed as a possibly efficacious treatment for unforgiveness.

Follow-up results. Hart and Shapiro (2002) evaluated the maintenance of treatment effects at a four-month follow up. Both the SP and SEC conditions maintained their treatment gains at follow-up.

Schizophrenia

One study evaluated a Muslim-accommodative treatment for schizophrenia. This treatment involved cognitive behavioral therapy (CBT) that integrated religious beliefs and practices with coping strategies for dealing with auditory hallucinations (e.g., encouraging clients to follow Islamic prayer patterns, read the Koran, listen to Islamic guidance through audio-cassettes, evaluate the content of the voices in light of Islamic doctrine). This treatment was given in addition to psychotropic medication.

Efficacy Status

Wahass and Kent (1997) randomly assigned 6 male inpatient subjects from Saudi Arabia who met the ICD-10 criteria for schizophrenia to one of two conditions: Muslim CBT (n = 3) and comparison (n = 3). The participants in the Muslim CBT condition received three weekly one-hour individual therapy sessions for a nine-week period (maximum 25 sessions). The participants in the comparison condition received no

therapy. Participants in both groups continued their medication for the duration of the study. Two of the three participants in the Muslim-accommodative CBT condition improved on the frequency of their auditory hallucinations as indexed by the Structured Auditory Hallucinations Interview (SAHI; Kent & Wahass, 1996). None of the three participants in the comparison condition improved. However, likely due to low power of the present study, the authors did not report a direct comparison between the two conditions.

In sum, one study showed that Muslim CBT, when combined with medication, may have beneficial effects on schizophrenia. However, because there was no direct comparison between conditions, and because therapy was combined with medication, no determination of the efficacy status of Muslim-accommodative CBT can be made.

Follow-up Results

Wahass and Kent (1997) evaluated the maintenance of treatment effects at a three-month follow-up. Participants in the Muslim CBT condition did regress somewhat at follow-up, although the level of symptoms at follow-up was lower than at pre-test.

Alcoholism

One study evaluated a spiritual therapy for alcoholism. It evaluated a program called twelve step facilitation, which encouraged clients to view alcoholism as a spiritual and medical disease (Project Match Research Group, 1997). Its goals were to foster acceptance of the disease of alcoholism, and to develop a commitment to attend Alcoholics Anonymous and begin to work through the 12 steps.

Efficacy Status

The Project Match Research Group (1997) randomly assigned 952 outpatient subjects and 774 aftercare subjects to one of three conditions: twelve-step facilitation (TSF), cognitive behavioral coping skill therapy (CBT), and motivational enhancement therapy (MET; *ns* for each group not reported). Each treatment modality was administered individually over a period of 12 weeks. TSF and CBT consisted of weekly treatment sessions, whereas MET consisted of four sessions, which occurred at week one, two, six, and twelve. Participants in all conditions improved from pretest to posttest on percent days abstinent (PDA) and drinks per drinking day (DDD). There were no significant differences between any conditions on either of these variables. In sum, one study with sufficient power to detect medium-sized effects showed that a spiritual treatment for alcoholism was equivalent with a treatment already established in efficacy. Based on this finding, twelve-step facilitation should be viewed as a possibly efficacious treatment for alcoholism.

Follow-up Results

The Project Match Research Group (1997) evaluated the maintenance of treatment effects at a three-month, six-month, nine-month, and one-year follow-up. All three conditions (TSF, CBT, and MET) maintained their treatment gains at each follow-up.

Eating Disorders

One study evaluated a spiritual therapy for eating disorders. It evaluated a spiritual group treatment in which participants read the book *Spiritual Renewal: A Journey of Faith and Healing* (Richards, Hardman, & Berrett, 2000), which is a self-help

workbook that consists of non-denominational readings consistent with a Judeo-Christian tradition including topics such as spiritual identity, grace, forgiveness, repentance, faith, prayer, and meditation. Participants also met in a group to discuss issues and complete exercises pertaining to the readings.

Richards, Berrett, Hardman, and Eggett (2006) randomly assigned 122 women who met the DSM-IV criteria for anorexia nervosa, bulimia nervosa, or eating disorder not otherwise specified (NOS) to one of three conditions: spirituality group (n = 43), cognitive group (n = 35), and emotional support group (n = 44). All participants were housed in a private inpatient facility for women with eating disorders. All participants received the regular inpatient treatment program, which consisted of individual psychotherapy, group psychotherapy, experiential and expressive activities, family counseling, nutritional counseling, and a 12-step group. In addition, all participants met for a one-hour group discussion. Participants in the spirituality and cognitive groups were also given readings and self-help exercises. Treatment continued until participants were discharged from the inpatient facility. Although participants in all conditions improved from pretest to posttest, the spirituality group outperformed the cognitive group on eating disorder behavior as indexed by the Eating Attitudes Test (EAT; Garner & Garfinkel, 1979). There was no significant difference between the spirituality group and the emotional support group.

In sum, one study showed that a spiritual group treatment for eating disorders, when combined with an extensive inpatient treatment regimen, outperformed a cognitive group treatment. However, similar to the findings for Muslim psychotherapy for

depression and anxiety, no determination about the efficacy status of the spiritual group treatment for eating disorders can be made because it was combined with an extensive inpatient treatment program that included various other types of counseling.

Marital Issues

One study evaluated a Christian cognitive-behavioral marriage enrichment program. It evaluated a group training program called the Traits of a Happy Couple (Halter, 1988). The program teaches communication skills, cognitive reframing, conflict resolution skills, behavioral exchange, and relationship enhancement. Christian theological principles and Scripture were explicitly integrated and discussed throughout the program.

Efficacy Status

Combs, Bufford, Campbell, and Halter (2000) randomly assigned 31 Christian couples to one of two conditions: the Traits of a Happy Couple (THC; n = 15 couples) and a wait-list control group (WLC; n = 16 couples). Participants in the THC condition completed five two-hour weekly group training sessions. The THC condition outperformed the WLC on marital satisfaction as indexed by the Dyadic Adjustment Scale (DAS; Spainer, 1976), and had an effect size at post-test of .95. In sum, one study showed that a Christian cognitive-behavioral marriage enrichment program outperformed a wait-list control. Based on this study, Christian cognitive-behavioral marriage enrichment should be viewed as possibly efficacious treatment for marital discord.

Follow-up Results

Combs et al. (2000) evaluated the maintenance of treatment effects at a six-month follow up. Participants in the THC condition generally maintained their treatment gains at follow-up, and had an effect size at follow-up of .78.

General Psychological Problems

One study evaluated a Christian church-based lay counseling program. Lay counselors working at the First Evangelical Free Church of Fullerton, California, were trained over a period of one year. Counselors were trained in counseling skills in the context of time-limited therapy (Mann & Goldman, 1982).

Efficacy Status

Toh and Tan (1997) randomly assigned 46 Christian adult clients to one of two conditions: lay counseling (LC; n = 22) and a wait-list control (WLC; n = 24). Participants in the LC condition were seen for ten weekly individual sessions. The LC condition outperformed the WLC on general psychological symptoms as indexed by the Brief Symptom Inventory (BSI; Derogatis & Spencer, 1982). In sum, one study showed that a Christian lay counseling program outperformed a wait-list control. Based on this study, Christian lay counseling should be viewed as a possibly efficacious treatment for general psychological problems.

Follow-up Results

Toh and Tan (1997) evaluated the maintenance of treatment effects at a one-month follow-up. Participants in the LC condition generally maintained their treatment gains at follow-up.

Effectiveness

Both the lay counselors and clients provided feedback about the counseling sessions via a post-counseling questionnaire. The average rating or evaluation of the counseling experience by the client was “very good.” The average rating of the counseling experience and the client’s progress as given by the counselor tended to range from “good” to “very good.” Thus, clients were generally satisfied with their lay counseling experience.

Discussion

The present review attempted to identify efficacious religious and spiritual therapies using the criteria of Chambless and Hollon (1998). Several important findings should be noted. First, of all the religious and spiritual therapies reviewed, only Christian cognitive therapy for depression met the criteria to be considered an efficacious treatment. However, the dearth of efficacious religious and spiritual therapies seems to be mainly due to the lack of research in this area. This may seem surprising given the increased interest in the intersection of psychology, religion, and spirituality in recent years (Worthington et al., 1996; Worthington & Sandage, 2002). However, this increased level of interest in the field in general has not been followed by many high quality controlled outcome studies.

For the outcome studies that have been conducted, the general findings in the present review are positive. Several different types of religious and spiritual therapies for different types of psychological problems were helpful for participants, and many were deemed possibly efficacious. However, replication is necessary for a therapy to be considered empirically supported, and most of the therapies in the present review have

either (a) consisted of only one study, or (b) been conducted by only one lab of researchers. Thus, religious and spiritual therapies for anxiety, unforgiveness, schizophrenia, alcoholism, eating disorders, marital discord, and general psychological problems are at this point promising, although the body of research on these interventions has not yet reached the volume required for empirical support.

In addition to evaluating the efficacy of specific religious and spiritual therapies, the present review also evaluated the specificity of specific religious and spiritual therapies, that is, whether therapies outperformed a placebo control or another viable treatment (Chambless & Hollon, 1998). There was almost no evidence that any religious or spiritual therapies were specific. Although most studies found that the religious or spiritual therapies either (a) outperformed a control group or (b) were equivalent to a treatment already established in efficacy, almost none found that a religious or spiritual therapy outperformed a placebo control or other viable treatment. This is an interesting finding given that most participants in the studies of the present review were religious or spiritual, and some researchers have advocated a matching hypothesis, whereby clients are thought to have better outcomes when matched with therapies that are consistent with their religious or spiritual beliefs (Wade et al., 2007; Worthington & Sandage, 2002). The results of the present review show little evidence that religious or spiritually-accommodative therapies are more effective than secular therapies. Thus, I agree with McCullough (1999), who suggested that the decision to use religious approaches be made on the basis of client choice.

There are several limitations to the present review. In addition to the small number of studies, the quality of the religious and spiritual outcome studies was an issue. Several studies were excluded from the present review because they either (a) did not have a control or comparison group, or (b) did not randomize participants to condition. Several factors besides the actual treatment can influence outcomes in non-experimental or quasi-experimental designs, making conclusions based on such studies necessarily tentative. Furthermore, even for some studies included in the present review, it was impossible to determine the efficacy status of certain therapies because they were only tested in combination with another treatment or set of treatments.

Other methodological issues were found in the studies in the present review. First, many of the therapy situations in the outcome studies were different from therapy in the "real world." Many of the participants in the efficacy studies are not people who have sought therapy for their problems. Many were not diagnosed to have a psychological disorder. Instead, participants are often recruited for a study and are screened to meet clinical criteria on a screening instrument (e.g., minimum cutoff on the BDI). Thus considering (a) motivation to seek therapy, (b) degree of clinical disturbance, and (c) degree to which the participants meet all criteria for diagnosis with a psychological disorder, the participants in these studies may differ from actual clients. Furthermore, many studies have involved therapists-in-training rather than experienced therapists.

Second, there are issues with the standardization of treatments across studies. The treatments given have often been secular psychotherapy treatments that have been religiously accommodated to religious participants. However, these secular treatments are

religiously accommodated in different ways across studies. For example, although several studies have accommodated CBT to Christians, there has been little standardization from study to study. Few manuals have been created. Fewer manuals have been used in more than one study. Investigators typically do not specify which religious elements are part of the religious accommodation.

Third, there are issues with how treatment outcomes are evaluated. Sample sizes are generally small, and many studies suffer from low power. In addition, the degree of clinically significant change has rarely been assessed. Often the dependent measure has been a self-report measure of psychological symptoms, such as the BSI, which may not reflect clinically meaningful change. Furthermore, outcomes generally measure the overall effect of a treatment on psychological symptoms. Component analyses of effective components of treatments are rare. One must reluctantly conclude that the scientific standards in this research field are not comparable to the clinical science investigating secular treatments.

Based on the findings of the present review, as well as the weaknesses noted in the studies reviewed, I believe that an aggressive research agenda is warranted. First, the volume of outcome research examining religious and spiritual therapies must be increased. The current review of the literature indicates that religious and spiritual therapies are helpful for treating many areas of psychopathology; however, studies in several areas have yet to be replicated. Second, the methodological rigor of the studies examining religious and spiritual therapies must be increased. Recommendations for researchers include consistent use of control groups and randomization to treatment, the

use of actual clients and therapists, the standardization of treatments and the use of manuals, an increase in sample size and power, and a focus on clinically significant change. Third, future research should examine the religious commitment of participants, in order to examine whether religious and spiritual therapies are more effective for those with high levels of religious commitment.

In closing, the present review provides evidence for the continued use and research on religious and spiritual therapies. The extant research is generally positive: religious and spiritual therapies tend to perform well against no-treatment controls and perform equally well against treatment already established in efficacy. This should not be surprising, as most religious and spiritual therapies retain important aspects of secular therapies, but also tailor such interventions to match the client's worldview. Indeed, such tailoring has recently been the subject of increased discussion and research (Norcross, 2002). However, there is currently little evidence that religious and spiritual therapies outperform established secular therapies, even for religious and spiritual clients. Thus, the question of whether to use a religious or spiritual therapy may be more an issue of client preference rather than an empirical decision.

CHAPTER 3

GENERAL STATEMENT OF THE PROBLEM

In Chapter 2, I conducted a review of the literature on the status of empirically supported religious and spiritual therapies. In general, there was evidence for the positive impact of religious and spiritual therapies. Many such therapies were shown to be helpful in reducing psychological symptoms in participants. In light of these findings, an aggressive research agenda was called for, specifically to (a) increase the volume of empirical research on religious and spiritual therapies, and (b) increase the level of methodological rigor of these studies.

In this dissertation, I examined the nature and effectiveness of religious couple counseling from the Christian tradition. Although there are several books and articles that describe approaches to Christian couple counseling (e.g., Worthington, 1996), there has been very little empirical research that (a) describes exactly what occurs in Christian couple counseling, and (b) evaluates whether such counseling is effective. Indeed, there have been only two empirical studies that have evaluated the efficacy or effectiveness of a Christian couple counseling treatment (Combs et al., 2000; Trathen, 1995). One of these treatments (Trathen, 1995) evaluated the efficacy of a pre-marital education program, thus, the couples participating in this study are likely quite different from couples attending counseling for actual couple problems.

In Chapter 4, I examined the nature of Christian couple counseling. Specifically, I conducted a nationwide survey of Christian couple counselors in order to describe Christian couple counseling empirically. Then, in Chapter 5, I evaluated the effectiveness

of Christian couple counseling. Although I did not be conduct a randomized clinical trial, this study addresses some of the methodological concerns identified in the review of the literature. Specifically, this study (a) incorporates a longitudinal design, (b) has adequate power, (c) examines couple counseling with actual clients and counselors, and (d) assesses the religious commitment of clients.

The proposed studies should have important implications for the research and practice of Christian couple counseling. Christian couple counseling is widely practiced; it is essential to examine whether this type of counseling is effective, the kinds of interventions that contribute to its effectiveness, and characteristics of clients for whom it is most effective.

CHAPTER 4

STUDY 1: CHRISTIAN COUPLE COUNSELING BY PROFESSIONAL, PASTORAL, AND LAY COUNSELORS FROM A PROTESTANT PERSEPCTIVE: A NATIONWIDE SURVEY

Statement of the Problem

Polls have estimated that approximately 82% of American adults identify themselves as Christians (Hoge, 1996). Of those, about 68% identify as Protestants, and 32% identify as Catholics. Thus, there are large numbers of people in the United States who are highly committed to the Christian religion, many of whom are Protestants. Most adults are married or in a committed couple relationship, and many couples have problems. Thus, I believe that there is a high need for couple counseling in which at least one partner is a highly committed Christian. Indeed, Christian couple counseling is highly advocated among the laity (Chapman, 2003; Dobson, 2004). For many Christian couples, seeking explicitly Christian counseling is a priority if they must attend counseling (Ripley, Worthington, & Berry, 2001). Many will not attend counseling unless the counselor is a professing Christian. Furthermore, many expect or demand that faith issues be dealt with during counseling.

Several Christian approaches exist to help restore damaged marriages and couple relationships. For example, Worthington (1996) edited a volume in which therapists described eight different theoretical approaches to Christian marital therapy. Several Christian marital intervention programs exist, including Marriagebuilders (Harley, 1996), Saving Your Marriage Before It Starts (SYMBIS; Parrot & Parrot, 1996), Marriage

Encounter (Silverman & Urbaniak, 1983), Christian marriage counseling (Clinton, 1999), Emotionally-focused counseling for a Safe Haven (Hart & Morris, 2003), Hope-focused Couple Counseling (Worthington, 2005), and Christian Prevention and Relationship Enhancement Program (Christian PREP; Stanley, Trathen, McCain, & Bryan, 1998).

Although there are several theories of Christian couple counseling, and this type of counseling is widely practiced, empirical research on Christian couple counseling is virtually nonexistent (for reviews, see Ripley & Worthington, 1998; Worthington, Shortz, & McCullough, 1993). Clinical scientists do not know who conducts Christian couple counseling, which types of people seek counseling with professional, pastoral, or lay counselors, or whether such counseling is effective. In recent years, researchers have determined guidelines for evaluating the efficacy, clinical significance, and effectiveness of various treatments (Chambless & Hollon, 1998). Christian couple counseling has almost no empirical research supporting its efficacy or effectiveness (see Combs et al., 2000, and Trathen, 1995, for two exceptions with marital and premarital enrichment, respectively). This is a disturbing problem, especially given the popularity of such counseling.

There are understandable reasons why such research has been slow to develop. One anecdotal speculation is that some Christians distrust psychological research and place more trust in their theological interpretation of Christian scriptures and authority of Christian leaders in matters of soul care (i.e., psychological and relational care of people as humans in spiritual context). However, a reason that is probably more widespread among Christians has to do with the origin of Christian couple counseling relative to

secular approaches to couple counseling. Secular approaches are often driven by master therapists who are writers and researchers. Leaders create theories and articulate these in books and manuals. Researchers organize clinical trials to test the efficacy of specific theories. Eventually, field studies (i.e., effectiveness research) are done to determine how the approach is used in the field. The approach may then be evaluated to be an empirically supported intervention.

In Christian couple counseling, in contrast, most professional Christian counselors (who often are involved in training pastoral and lay counselors) were themselves trained in some secular approach to couple counseling. However, the Christian population that supplies many of their clients demands explicit use of Christian principles and practices (i.e., prayer, Scriptural citation or explanation, or Christian reading). Counselors *individually* answer that demand by integrating the Christian principles and practices idiosyncratically to fit their clientele. Thus, creating a manual to serve as the basis for a clinical trial is—at this point—virtually impossible if one wishes to accurately represent the essence of an agreed upon approach to Christian couple counseling—or even to accurately represent the varieties of Christian couple counseling.

I believe that the route to creating such manuals must proceed along steps. First, I must determine what characterizes professional, pastoral, and lay Christian counseling. I suspect that the three differ substantially. Second, I must determine what therapist and client characteristics predict effective outcomes and counseling processes within lay, pastoral, and professional Christian couple counseling. Third, best practices can be identified and catalogued and a manual of best practices can be created. Fourth, Christian

couple counselors can be persuaded to participate in manual-driven controlled clinical trials and the efficacy of Christian couple counseling can be determined.

The development of secular approaches to couple counseling, which generally involves (a) a conceptual framework that leads to (b) manual-driven efficacy research that leads to (c) effectiveness studies that (d) feedback and modify the conceptual framework could be considered a top-down approach. The development of a religious approach to couple counseling, which I have described above as involving (a) effectiveness studies that lead to (b) a conceptual framework that leads to (c) manual-driven efficacy research could be considered a bottom-up approach. Both approaches lead to the same place: a feedback system that consists of a conceptual framework that drives research, which in turn influences theory.

The present study is an initial empirical study of Christian couple counseling. It was designed to investigate three types of Christian couple counseling (done by professionals, pastors, and lay people). In addition, it is limited to describing counseling within a theologically conservative, Protestant context. I attempt to answer the following questions:

- Who conducts Christian couple counseling?
- How popular is Christian couple counseling?
- How committed are Christian couple counselors to their religion?
- What is the attitude of Christian couple counselors toward incorporating religion and spirituality into counseling?

- How competent do Christian couple counselors perceive themselves at addressing religious issues when they arise in counseling?
- What theories are most influential in the practice of Christian couple counseling?

Method

Participants

Participants were 630 members of the American Association of Christian Counselors (AACC) who responded to an email request to participate in a survey over the web. AACC is a professional organization consisting of about 30,000 counselors who practice from a Christian worldview. Most are professional therapists and pastoral counselors (ordained clergy with special training and certification in pastoral counseling). AACC members also include pastors who counsel as part of their clerical duties and lay counselors (who are trained and may have completed a training curriculum to offer sub-professional-level counseling under the auspices of a church). Participants were 305 males (49%) and 319 females (51%; 6 unspecified). The mean age was 51 years (range, 23 to 80 years). The sample was mostly Caucasian (89%) but included African Americans (6%), Latinos (2%), Asians (1%), and others (2%). Emails were sent to 1500 professional, 400 pastoral, and 184 lay counselors on the AACC mailing list. The final sample included 405 professional, 157 pastoral, and 63 lay counselors (5 unspecified), which reflected a response rate of 27% for professional, 39% for pastoral, and 34% for lay counselors.

Design

This study used a cross-sectional, correlational design.

Measures

Participants completed a 55-item questionnaire that includes the following items.

Demographics. Participants provided their age, gender, ethnicity, religious affiliation, religious denomination, and marital status. They also reported level of education, field of training, and type of couple counseling conducted (see Appendix A).

Experience in couple therapy. Participants estimated their experience conducting couple counseling, including years of experience, number of couples seen in counseling, number of couples seen conjointly, number of couples seen in Christian couple counseling (explicitly defined as involving both partners who professed to be Christian and addressing Christian values or issues explicitly at least once during counseling), percent of couple cases in which religion had been an issue in counseling, and estimated percent of couples seen in counseling who eventually end their relationship (see Appendix A).

Religious commitment. Participants completed the Religious Commitment Inventory-10 (RCI-10; Worthington et al., 2003; see Appendix A). The RCI-10 consists of 10 items that assess one's dedication to one's religion. Participants rate their agreement with each item on a 5-point rating scale from 1 = *not at all true of me* to 5 = *totally true of me*. Worthington et al. (2003) found estimated inter-item reliability (i.e., using Cronbach's alpha) for the RCI-10 on several samples to range from .88 to .98 for the full scale. Estimates of temporal stability at 3 weeks and 5 months were reported as .84-.87 for the entire scale. In six studies, Worthington et al. (2003) reported evidence for construct validity. Participants who endorsed salvation as one of the top 5 values on

Rokeach's Value Survey scored higher on the RCI-10 than did other participants (Worthington et al., 2003). The RCI-10 was positively correlated with numerous measures of religiosity. Therapists who belonged to a religion had higher scores than those who did not belong to a religion. Furthermore, when comparing Buddhists, Christians, Hindus, and Muslims with nonreligious participants on the RCI-10, the nonreligious group scored lower than all religious groups (Worthington et al., 2003). For the current sample, the Cronbach's alpha coefficient was .81 (95% CI = .78-.83).

Attitude toward incorporating religion in couple counseling. Participants answered questions that addressed their attitude toward incorporating religion in couple counseling (see Appendix A). First, participants indicated whether they would be open to discussing religion if it came up in couple counseling, and whether they would ever use explicit religious practices (e.g., prayer, scripture) in couple counseling. Second, participants were given a list of ten religious techniques similar to those used in research on individual psychotherapy (e.g., Wade et al., 2007). They indicated the degree to which they thought each technique was appropriate in couple counseling from 1 = *inappropriate* to 3 = *appropriate*. Four techniques were considered overt religious techniques (i.e., pray with a client during session, use religious language or concepts during counseling, recommend client use of religious or spiritual books, and recommend client participation in their religion). Six techniques were considered non-obvious religious techniques, and included private counselor behaviors (i.e., pray for a client privately between sessions), techniques that might or might not be framed as religious techniques (i.e., various forms of forgiveness), and knowing a client's religious background. For the current sample,

Cronbach's alphas were .72 (95% CI = .68-.76) for the overt religious techniques and .43 (.36-.50) for the non-obvious religious techniques.

Perceived Competence in addressing a religious issue in couple counseling. Participants indicated how competent they viewed themselves to be at addressing a religious issue in couple counseling from 1 = *would almost certainly refer or consult* to 5 = *completely competent* (see Appendix A).

Use of theory in couple counseling. Participants first indicated how important it was that they have been trained in a particular type of couple counseling approach, (e.g., workshop, course, or full training program) from 1 = *totally unimportant* to 5 = *totally important*. Participants then indicated how influential each of 13 couple counseling theories is in informing their practice of Christian couple counseling, from 1 = *not at all influential* to 5 = *strongly influential* (see Appendix A). Ten theories were considered secular theories. Three theories were considered Christian theories. Four of the secular theories were considered empirically supported couple therapy approaches, as described by Baucom, Shoham, Mueser, Daiuto, and Stickle (1998). These empirically supported theories had accumulated a body of research evidence that supported their efficacy from more than one research group. For the current sample, the Cronbach's alpha coefficients were .86 (95% CI = .84-.88) for all, .85 (95% CI = .83-.87) for the secular, .69 (95% CI = .64-.73) for the Christian, and .73 (95% CI = .69-.77) for the empirically supported theories.

Procedure

Counselors who were members of AACC and who were on AACC's email list received an invitation to participate in the study via email. Those who desired to participate in the survey were directed to a website where they read a description of the study and their rights as a participant. Those who wished to complete the survey indicated consent electronically, and completed all questionnaires online. After completing the questionnaires, participants read a debriefing form and were given the contact information of the researchers should they have further questions or concerns.

Hypotheses and Planned Analyses

Hypothesis #1

Statement. Christian couple counselors will report being highly committed to their religious faith, at least one standard deviation above the norm for secular counselors.

Justification. Worthington et al. (2003) reported norms for religious commitment for counselors in both Christian and secular agencies. Counselors in Christian agencies reported a much higher level of religious commitment (M = 46) than did counselors in secular agencies (M = 26). Worthington (1988) theorized that people with high religious commitment (greater than one standard deviation above the mean) evaluate their world based on their religious values.

Analysis. Descriptive statistics for religious commitment were examined, and compared to established norms.

Hypothesis #2

Statement. Participants will report that using religious techniques in couple counseling is appropriate. Pastoral counselors will report that using religious techniques

in counseling is more appropriate than will professional counselors. Viewing religious techniques as appropriate will be predicted by personal religious commitment.

Justification. In past studies that have examined the use of religious techniques in counseling, Christian counselors report that incorporating religion into counseling is appropriate (Wade et al., 2007) and common (Walker, Gorsuch, & Tan, 2004). Furthermore, since pastoral counselors generally practice in the context of a church, I predict that they will view the use of religious techniques as more appropriate than professional counselors. Also, studies on the use of religious techniques in counseling have found that counselors who are highly religious generally have more positive attitudes toward incorporating religious techniques into counseling (Shafranske & Malony, 1990; Walker et al., 2004).

Analysis. Descriptive statistics for the appropriateness of using religious techniques in couple counseling were examined. A one-way analysis of variance (ANOVA) was conducted with appropriateness as the dependent variable and type of couple counseling conducted (professional, pastoral, and lay) as the independent variable. This ANOVA was followed up with a post-hoc Tukey HSD to examine specific differences between groups. A regression analysis was conducted with appropriateness as the dependent variable and religious commitment as the independent variable.

Hypothesis #3

Statement. Counselors will perceive themselves to be competent at addressing a religious issue in couple counseling. Lay counselors will perceive themselves to be less competent than either professional or pastoral counselors.

Justification. All participants are members of AACC, which is a professional organization of Christian counselors. Thus, it is predicted that most members of this professional organization will view themselves as competent to address religious issues in counseling. Furthermore, lay counselors have completed much less training than either professional or pastoral counselors. Thus, they should view themselves to be less competent in addressing a religious issue should it arise in counseling.

Analysis. Descriptive statistics for perceived competence were examined. A one-way analysis of variance (ANOVA) was conducted with perceived competence as the dependent variable and type of couple counseling conducted (professional, pastoral, and lay) as the independent variable. This ANOVA was followed up with a post-hoc Tukey HSD to examine specific differences between groups.

Hypothesis #4

Statement. Professional counselors will report that receiving training in a specific theoretical approach to couple counseling is more important than will pastoral or lay counselors. Also, professional counselors will report that secular and empirically supported theories are more influential to their practice of couple counseling than will pastoral or lay counselors. Pastoral and lay counselors, on the other hand, will report that Christian theories are more influential to their practice of couple counseling than will professional counselors.

Justification. Professional counselors, many of whom have been trained in secular institutions, should place a greater emphasis on theory than pastoral counselors, many of whom have been trained in Christian institutions, and lay counselors, who generally do

not have formal counseling training. Furthermore, professional counselors, because of their training in secular institutions, should report being more influenced by secular theories. Similarly, because many professional counselors may have been trained in institutions that emphasized research, they should report being more influenced by empirically supported theories. Pastoral and lay counselors, on the other hand, will generally have been trained in theological institutions or churches, and should report being more influenced by Christian theories.

Analysis. Three one-way analyses of variance (ANOVA) were conducted with secular theories, empirically supported theories, and Christian theories as the dependent variables, and type of couple counseling conducted (professional, pastoral, and lay) as the independent variable. These ANOVAs were followed up with post-hoc Tukey HSD tests to examine specific differences between groups.

Results

The results for professional, pastoral, and lay counselors are organized by research question.

Who Conducts Christian Couple Counseling?

Demographic and professional background information professional, pastoral, and lay counselors are summarized in Table 2. There were several differences based on type of counselor. Both professional (59.6%) and lay (63.9%) counselors were more likely to be female than were pastoral counselors (23.9%, *p*'s $< .001$ for both). Although there were no significant age differences, lay counselors had fewer years experience ($M = 7.66$, $SD = 6.94$) than both professional ($M = 13.86$, $SD = 8.98$, $p < .001$) and pastoral (M =

Table 2

Demographic and Background Information for Professional, Pastoral, and Lay Counselors (Study 1)

Variable	Professional	Pastoral	Lay	Overall F-ratio	Significant Differences (Tukey HSD)
Mean Age	50.61 (10.48)	52.63 (10.16)	52.71 (9.77)	2.77	
Mean Years Experience	13.86 (8.98)	16.06 (9.96)	7.66 (6.94)	19.36 ***	Past > Prof * Past > Lay *** Prof > Lay ***
Gender (% Female)	59.6%	23.9%	63.9%	34.00 ***	Prof > Past *** Lay > Past ***
Education					
Doctoral (PhD, PsyD, EdD, MD)	22.3%	30.6%	6.4%	7.58 **	Prof > Lay * Past > Lay ***
Masters (MA, MS)	75.5%	33.8%	27.4%	68.73 ***	Prof > Past *** Prof > Lay ***
Masters in Divinity (MDiv)	1.0%	14.0%	3.2%	24.09 ***	Past > Prof *** Past > Lay **
Less than Masters	1.2%	21.6%	62.9%	149.41 ***	Past > Prof *** Lay > Prof *** Lay > Past ***
Field of Training					
Marriage/Family Therapy	59.8%	58.6%	47.6%	1.66	
Psychology	42.0%	29.3%	19.0%	8.71 ***	Prof > Past * Prof > Lay **
Theology	24.0%	66.2%	22.2%	55.25 ***	Past > Prof *** Past > Lay ***
Social Work	13.8%	7.0%	7.9%	3.04 *	
Rehab Counseling	5.9%	10.2%	6.3%	1.60	
Medicine	1.2%	3.8%	6.3%	3.98 *	Lay > Prof *
Ethnicity				12.77 *** (white vs. non-white)	Past > Prof ***
White/Caucasian	93.6%	79.6%	83.9%		

Black/African American	2.7%	11.5%	9.7%		
Latino/Latino American	1.2%	5.7%	1.6%		
Asian/Asian American	1.0%	.6%	1.6%		
Other	1.5%	2.5%	3.2%		
Current Marital Status (% Yes)	89.6%	93.5%	88.3%	1.14	
Ever Divorced (% Yes)	25.4%	18.1%	46.8%	9.85 ***	Lay > Prof ** Lay > Past ***
Religious Denomination					
Baptist	24.0%	23.1%	34.4%	1.71	
Non-denominational/Bible	17.8%	22.4%	14.8%	1.13	
Pentecostal/Charasmatic	11.4%	21.2%	19.7%	5.03 **	Past > Prof **
Mainline Protestant	15.6%	7.7%	8.2%	3.82 *	Prof > Past *
Roman Catholic	1.5%	2.6%	1.6%	.38	
Other Protestant	29.7%	23.1%	21.3%	1.84	

Note. Percentages in Field of Training add to more than 100% because some participants indicated training in more than one area.
* $p < .05$, ** $p < .01$, *** $p < .001$

16.06, *SD* = 9.96, $p < .001$) counselors. Lay counselors were also less likely to have an advanced degree (37.1%) than were professional (98.8%, $p < .001$) or pastoral (78.4%, $p < .001$) counselors. Although pastoral and professional counselors were equally likely to have a doctorate, pastoral counselors were more likely to have a master's in divinity (14%) than were professional counselors (1.0%, $p < .001$). Professional counselors were more likely to have a master's degree in counseling (75.5%) than were pastoral counselors (33.8%, $p < .001$). Professional counselors were more likely to be trained in psychology (42%) than were pastoral (29.3%, $p < .05$) or lay (19.0%, $p < .01$) counselors. Pastoral counselors, on the other hand, were more likely to be trained in theology (66.2%) than were professional (24.0%, $p < .001$) or lay (22.2%, $p < .001$) counselors. Although the majority of all participants were Caucasian (89.0%), pastoral counselors were more likely to be non-White (20.4%) than were professional counselors (6.4%, $p < .001$). Furthermore, while most participants were married (about 90%), lay counselors were more likely to have been divorced (46.8%) than were professional (25.4%, $p < .01$) or pastoral (18.1%, $p < .001$) counselors.

All participants self-identified as Christian. Counselors identified with a wide variety of Christian denominations (see Table 2). The denominations with the largest identification were Baptist (25%), Nondenominational or Bible Christian (19%), Pentecostal/Charismatic (15%), and Mainline Protestant (13%). There were a low number of Roman Catholics (2%) in my sample, which is different from previous findings on religious identification among counselors (Shafranske & Malony, 1990) and is likely due to the sample represented; AACC has strong roots in the Protestant tradition.

How Popular is Christian Couple Counseling?

Participants estimated the total number of couples they had seen in counseling during their career (see Table 3). Six outliers were identified based on counselors who reported seeing over 300 couples per year of counseling experience. Outliers were capped (at 300 couples per year) and recoded. Counselors reported a wide range in number of couples seen per year. Lay counselors reported seeing fewer couples per year ($M = 5.59$, $SD = 8.05$) than did professional counselors ($M = 22.03$, $SD = 45.57$, $p < .05$). There was no significant difference between pastoral counselors ($M = 16.09$, $SD = 38.77$) and either professional or lay counselors. Counselors reported seeing most couples conjointly (87%), although lay counselors reported seeing a smaller percentage of couples conjointly (78%) than did professional counselors (88%, $p < .01$) or pastoral counselors (87%, $p < .05$). Participants also estimated the number of couples seen in explicitly Christian couple counseling, *defined as involving both partners as Christian and addressing Christian values or issues explicitly at least once during counseling*. Counselors indicated that three-fourths of the couples were seen in Christian couple counseling, although pastoral counselors indicated that a greater percentage of their couples were seen in explicitly Christian counseling (83%) than did professional counselors (72%, $p < .001$). Finally, participants estimated the number of couples that in therapy that eventually ended their relationship. Overall, counselors report that therapy is generally successful (about 16% of couples eventually end their relationship), although professional counselors reported that a greater percentage of couples eventually ended their relationship (17%) than did lay counselors (11%, $p < .05$).

Table 3

Practice Information for Professional, Pastoral, and Lay Counselors (Study 1)

Variable	Professional M (SD)	Pastoral M (SD)	Lay M (SD)	Overall F-ratio	Significant Differences (Tukey HSD)
Couples Seen Per Year	22.03 (45.57)	16.09 (38.77)	5.59 (8.05)	4.38 *	Prof > Lay *
Percent Seen Conjointly	87.99% (22.03)	86.98% (19.45)	77.67% (31.59)	5.07 **	Prof > Lay ** Past > Lay *
Percent Christian Counseling	72.23% (26.54)	83.30% (19.80)	75.14% (29.26)	10.06 ***	Past > Prof ***
Percent Estimated Breakup	16.75% (14.83)	14.36% (13.46)	10.90% (14.85)	4.71 **	Prof > Lay *
Percent Cases Religion Salient	80.39% (28.50)	89.05% (23.03)	72.09% (40.89)	8.38 ***	Past > Prof ** Past > Lay **

* $p < .05$, ** $p < .01$, *** $p < .001$

How Committed are Christian Couple Counselors to their Religion?

Christian couple counselors are highly committed to their religion, as indexed by the RCI-10 ($M = 46.82$, $SD = 3.62$). The range of possible scores on the RCI-10 is from 10 to 50. This finding is similar to the norms for counselors conducting individual therapy in Christian agencies presented by Worthington et al. (2003), and much higher than the norms for counselors in secular agencies ($M = 25.5$, $SD = 11.3$). Worthington (1988) theorized that people with high religious commitment (greater than one standard deviation above the mean) evaluate their world based on their religious values. In the United States, Worthington et al. (2003) found a mean of 26 and standard deviation of 12 for general samples of adults. Thus, according to theory (Worthington, 1988), Christian couple counselors are likely to evaluate their world and make many decisions based on their religious values.

There was a significant difference in religious commitment based on type of couple counseling conducted, $F(2, 604) = 3.05$, $p < .05$. Pastoral counselors reported higher religious commitment ($M = 47.42$, $SD = 2.90$) than did professional counselors ($M = 46.59$, $SD = 3.89$, $p < .05$). It should be noted, however, that professional Christian couple counselors still report extremely high levels of religious commitment (much higher than the cutting score of 38, which is one standard deviation above the mean in a general sample of adults). There were no significant differences in religious commitment between lay counselors ($M = 47.03$, $SD = 3.23$) and either pastoral counselors or professional counselors.

What is the Attitude of Christian Couple Counselors toward Incorporating Religion and Spirituality into Counseling?

Religion is a common topic in Christian couple counseling. Participants reported that religion has been brought up in counseling with approximately 82% of their couple cases. Religion was more likely to be a salient topic in pastoral counseling (89%) than either professional counseling (80%, $p < .01$) or lay counseling (72%, $p < .01$). Across all types of counseling, Christian couple counselors are open to incorporating religion and spirituality into counseling. All of the respondents indicated that they would be open to discussing religion if it came up in couple counseling. Almost all (98.4%) reported that they would use explicit religious practices in couple counseling.

Counselors generally thought that using religious techniques in couple counseling were appropriate (see Table 4). Although all techniques were highly endorsed, overt religious techniques ($M = 2.83$, $SD = .30$) were endorsed less than non-obvious religious techniques ($M = 2.95$, $SD = .12$, $t = 11.48$, $p < .001$). There was a difference in the appropriateness of using religious techniques in couple counseling based on type of couple counseling conducted. Pastoral counselors thought that using overt religious techniques ($M = 2.89$, $SD = .24$) was more appropriate than did professional counselors ($M = 2.81$, $SD = .31$, $p < .01$). However, there was no difference between pastoral and professional counselors on the perceived appropriateness of non-obvious religious techniques ($p = .52$). Similarly, there were no differences in either overt or non-obvious techniques between lay counselors and professional or pastoral counselors.

Table 4

Appropriateness of Using Religious Techniques in Couple Counseling (1 = Inappropriate to 3 = Appropriate) for Professional, Pastoral, and Lay Counselors (Study 1)

Technique	Professional M (SD)	Pastoral M (SD)	Lay M (SD)	Overall F-ratio	Significant Differences (Tukey HSD)
Overt Techniques	2.81 (.31)	2.89 (.24)	2.81 (.31)	4.63 *	Past > Prof **
Pray with a client during a session	2.74 (.47)	2.91 (.29)	2.84 (.37)	8.83 ***	Past > Prof ***
Using religious language or concepts during counseling	2.83 (.39)	2.87 (.34)	2.79 (.41)	1.10	
Recommend client use of religious or spiritual books	2.91 (.30)	2.92 (.27)	2.92 (.27)	.12	
Recommend client participation in religion	2.74 (.50)	2.86 (.36)	2.68 (.57)	4.69 *	Past > Prof * Past > Lay *
Non-obvious Techniques	2.95 (.12)	2.96 (.10)	2.93 (.16)	1.60	
Know a client's religious background	2.94 (.23)	2.95 (.21)	2.87 (.38)	2.81	
Pray privately for a client between sessions	2.99 (.12)	2.98 (.14)	2.98 (.13)	.33	
Discuss forgiveness of each other	2.99 (.09)	2.99 (.11)	3.00 (.00)	.50	
Promote apologies	2.88 (.32)	2.91 (.29)	2.92 (.27)	.58	
Discuss forgiveness by God	2.90 (.30)	2.97 (.18)	2.89 (.32)	3.24 *	Past > Prof *
Discuss forgiveness of oneself	2.96 (.21)	2.95 (.25)	2.90 (.35)	1.52	

* $p < .05$, ** $p < .01$, *** $p < .001$

Among Christian couple counselors, viewing religious techniques to be appropriate for use in counseling was predicted by the counselor's religious commitment and the number of cases in which religion has been an issue in counseling. I conducted a multiple regression using the summed endorsement of all overt and non-obvious religious techniques as the criterion variable and religious commitment and percent of cases in which religion has been an issue in counseling as predictor variables. The model was significant, $F(2, 571) = 30.43$, $p < .001$, $R^2 = .10$. Counselors who report high religious commitment (beta = .19, $p < .001$), and a high percentage of cases in which religion has been an issue in counseling (beta = .21, $p < .001$), report that using religious techniques in counseling is more appropriate.

How Competent Do Christian Couple Counselors Believe Themselves to be at Addressing Religious Issues When They Arise in Counseling?

Counselors were generally confident in their abilities to address a religious issue in couple counseling ($M = 4.26$, $SD = .76$). Using simultaneous multiple regression, I found that self-rated competence in addressing a religious issue was predicted by religious commitment, years of experience, gender, and the percent of cases in which religion has been an issue in counseling, $F(4, 572) = 27.78$, $p < .001$, $R^2 = .16$. Counselors who reported higher religious commitment (beta = .22, $p < .001$), more years of experience (beta = .16, $p < .001$), a higher percentage of cases in which religion had been an issue in counseling (beta = .17, $p < .001$), and being male (beta = .16, $p < .001$) reported a higher level of perceived competence in addressing a religious issue in couple counseling.

There was a significant difference in the perceived competence in addressing a religious issue in couple counseling based on type of couple counseling conducted, $F(2, 610) = 14.79$, $p < .001$. Pastoral counselors ($M = 4.29$, $SD = .78$) and professional counselors ($M = 4.33$, $SD = .69$) reported greater perceived competence in addressing a religious issue than did lay counselors ($M = 3.79$, $SD = .87$, $p < .001$ for both). There was no significant difference in perceived competence between pastoral counselors and professional counselors.

What Theories are Most Influential in the Practice of Christian Couple Counseling?

Theory drives much of clinical practice. Thus, I was interested in the secular and Christian theories that were influential in the practice of Christian couple counseling. Most counselors believed that it was important to be trained in a specific theoretical approach ($M = 4.34$, $SD = .63$). There was no difference in the self-reported importance of training in a specific theory based on type of couple counseling conducted, $F(2, 543) = 2.49$, $p = .08$. Counselors reported being influenced by a wide variety of theories (see Table 5).

There were several differences in the influence of specific theories based on type of couple counseling conducted (see Table 5). Professional counselors reported being more influenced by the secular theories ($M = 2.81$, $SD = .76$) than were pastoral counselors ($M = 2.45$, $SD = .95$; $p < .001$) or lay counselors ($M = 2.40$, $SD = .99$; $p < .01$). Similarly, professional counselors reported being more influenced by the four empirically supported couple theories (Behavioral Couple Therapy, Cognitive-Behavioral Couple Therapy, Insight-Oriented Couple Therapy, and Emotion-Focused Couple Therapy;

Table 5

Between-Group Differences for the Influence of Theory in the Practice of Christian Couple Counseling (1 = Not at all influential to 5 = Strongly influential) for Professional, Pastoral, and Lay Counselors (Study 1)

Theory	Professional M (SD)	Pastoral M (SD)	Lay M (SD)	Overall F Ratio	Significant Differences (Tukey HSD)
Secular Theories	2.81 (.76)	2.45 (.95)	2.40 (.99)	10.65 ***	Prof > Past *** Prof > Lay **
Empirically-Supported Secular Theories	3.04 (.87)	2.65 (1.06)	2.44 (1.03)	14.59 ***	Prof > Past *** Prof > Lay ***
Behavioral Couple Therapy (Jacobson & Margolin, 1979)	3.39 (1.22)	2.87 (1.23)	2.75 (1.34)	13.00 ***	Prof > Past *** Prof > Lay **
Integrative Behavioral Couple Therapy (Jacobson & Christensen, 1996)	2.39 (1.19)	2.25 (1.13)	2.29 (1.13)	.74	
Cognitive-Behavioral Couple Therapy (Baucom & Epstein, 1990)	3.47 (1.25)	2.99 (1.33)	2.73 (1.24)	12.77 ***	Prof > Past ** Prof > Lay ***
Insight-Oriented Couple Therapy (Snyder & Wills, 1989)	2.54 (1.25)	2.27 (1.25)	2.02 (1.11)	5.25 **	Prof > Lay *
Emotion-Focused Couple Therapy (Greenberg & Johnson, 1988)	2.90 (1.32)	2.56 (1.30)	2.51 (1.38)	4.40 *	Prof > Past *
Solution-Focused Couple Therapy (de Shazer, 1985)	3.28 (1.24)	2.65 (1.35)	3.00 (1.33)	12.04 ***	Prof > Past ***
Systems Therapy (Minuchin, 1974)	3.72 (1.18)	2.55 (1.38)	2.44 (1.51)	56.67 ***	Prof > Past *** Prof > Lay ***
PREP (Markman, Floyd, & Stanley, 1988)	2.31 (1.39)	2.08 (1.24)	2.59 (1.55)	2.84 $^{+}$	Lay > Pastoral $^{+}$
Interpersonal Communication Program (Miller, Nunnally, & Wackman, 1976)	2.43 (1.33)	2.42 (1.35)	2.37 (1.31)	.05	
Relationship Enhancement (Guerney, 1977)	2.09 (1.24)	2.17 (1.20)	2.29 (1.23)	.69	
Christian Theories	2.86 (1.04)	3.13 (1.09)	3.24 (.93)	5.12 **	Past > Prof * Lay > Prof *
Christian Couple Counseling (Clinton, 1999)	3.15 (1.34)	3.51 (1.26)	3.75 (1.15)	7.75 ***	Past > Prof * Lay > Prof **
Hope-Focused Couple Therapy (Worthington, 2005)	2.58 (1.35)	2.79 (1.38)	2.76 (1.37)	1.36	
Relationship Counseling (Parrott & Parrott, 1996)	2.90 (1.30)	3.16 (1.38)	3.33 (1.17)	3.96 *	Lay > Prof $^{+}$

$^{+}p < .10$ * $p < .05$, ** $p < .01$, *** $p < .001$

Baucom et al., 1998; $M = 3.04$, $SD = .87$) than were pastoral counselors ($M = 2.65$, $SD = 1.06$, $p < .001$) or lay counselors ($M = 2.44$, $SD = 1.03$, $p < .001$). On the other hand, professional counselors reported being less influenced by the Christian theories ($M = 2.86$, $SD = 1.04$) than were pastoral counselors ($M = 3.13$, $SD = 1.09$, $p < .05$) or lay counselors ($M = 3.24$, $SD = .93$, $p < .05$).

I also analyzed the influence of specific theories within my groups of professional, pastoral, and lay counselors. Professional counselors were equally influenced by secular ($M = 2.81$, $SD = .76$) and Christian theories ($M = 2.86$, $SD = 1.04$, $p > .05$), although they were more influenced by the empirically supported theories ($M = 3.04$, $SD = .87$) than the Christian theories ($M = 2.86$, $SD = 1.04$, $p < .01$). Pastoral and lay counselors, on the other hand, were more influenced by the Christian theories than either the secular theories or the empirically supported theories (all p's $< .01$).

Discussion

The present study surveyed professional, pastoral, and lay Christian couple counselors on their commitment to their religion, their attitudes toward incorporating religion into counseling, their self-reported competence at addressing religious issues, and the types of theories that influenced their practice.

Christian professional couple counselors are similar to secular counselors in their level of training and experience at counseling (Doherty & Simmons, 1996). Christian couple counseling is popular; however, there is a large variation in the number of couples seen in Christian couple counseling. Some counselors appear to have full-time practices involving primarily couples, whereas other counselors have a more diverse practice or

may counsel part-time. About three-fourths of couple counseling conducted by Christians is considered Christian couple counseling, defined as involving both partners as Christians and addressing Christian values or issues explicitly at least once during counseling.

Because Christian couple counseling is widely practiced, I encourage researchers and clinicians to collaborate to begin to define what exactly constitutes Christian couple counseling. My findings have suggested that this might depend to some extent on who is doing the Christian counseling. Throughout this paper, I have noted several differences between professional, pastoral, and lay couple counselors.

As a group, Christian couple counselors are highly religious, and view religious and spiritual techniques as appropriate for use in counseling. This finding is in contrast to previous research on secular couple counselors, who are mixed in their views about using religious and spiritual techniques (Carlson, Kirkpatrick, Hecker, & Killmer, 2002). The religiosity of counselors impacts their views on incorporating religion into counseling. Counselors who were more religious were more likely to view using religious techniques as appropriate. This result replicates previous findings that point to a positive relationship between counselor religiousness and willingness to address religious issues in counseling (Shafranske & Malony, 1990; Walker et al., 2004). It also provides support to Worthington's (1988) argument that the counselor's religious values impact the counseling process.

Counselors are influenced by Christian couple counseling and secular approaches, especially approaches that have garnered empirical support (Baucom et al., 1998). A

couple who seeks counseling from a Christian professional counselor may be more likely to encounter treatments and techniques whose care methods have been supported by research, such as behavioral or cognitive-behavioral techniques. The couple who seeks counseling from a pastoral counselor or lay counselor may be more likely to encounter treatments and techniques that arise from Christian theories.

The present study has several limitations. First, there was a modest response rate, although this is common for internet-based or mail-based national surveys. For example, Doherty and Simmons (1996) and Carlson et al. (2002) had return rates of 34% and 38%, respectively, for national mail surveys. Second, the sample is limited to Christian (mainly Protestant) counselors with conservative theologies. Any generalizations should be made cautiously or not at all. Third, all measures were self-report. Thus, causal inferences are not appropriate.

Despite these limitations, the present study sheds some light on the Christian couple counselor. Christian couple counseling is popular and widely practiced. There are differences among professional, pastoral, and lay counselors. These differences help guide a couple's decision for where to seek counseling yet may also merely reflect expectations that attend counseling in different settings. Counselors are generally highly religious, perceive themselves to be competent at addressing religious issues, and view religious techniques to be appropriate for use in couple counseling. Personal religiousness appears to impact one's views on integrating religion into counseling, but most counselors are amenable to incorporating a religious couple's religion if the couple requests it.

Future research must determine whether Christian couple counseling is effective. Ideally, such counseling—by professional, pastoral, and lay counselors—should be investigated according to which types of specific practices produce the best outcomes for different types of clients by different types of counselors. Previous research on religiously tailored individual counseling has generally found that religiously tailored therapies are either more effective (Smith, Bartz, & Richards, 2007) or as effective as secular therapies (e.g., McCullough, 1999; Wade et al., 2007, Worthington & Sandage, 2002). Thus, I predict that religiously tailored couple counseling will be effective as well.

CHAPTER 5

STUDY 2: THE EFFECTIVENESS OF RELIGIOUSLY TAILORED COUPLE COUNSELING

Statement of the Problem

Relationship satisfaction typically declines after marriage or cohabitation (Glenn, 1998; Kurdek, 1998), and around 43% of first marriages end in separation or divorce within 15 years (United States Census Bureau, 2002). This decline in relationship satisfaction may lead to couple distress. Couple distress has been linked to a variety of mental health problems (Halford, Bouma, Kelly, & Young, 1999; Whisman, Uebelacker, & Weinstock, 2004). Couple counseling is the most widely researched method for alleviating couple distress and its associated negative consequences (Baucom et al., 1998; Christensen & Heavey, 1999; Shadish & Baldwin, 2003; Snyder, Castellani, & Whisman, 2006).

Several factors contribute to effective counseling. One important aspect of effective counseling may be to tailor the counseling to the client's personal characteristics, proclivities, and worldviews (Norcross, 2002). In 1999, a task force was commissioned by the APA Division of Psychotherapy (Division 29) to determine empirically supported relationship factors in therapy. Besides working alliance and empathy, which were deemed empirically supported, several efficacious methods of customizing counseling to clients on the basis of their nondiagnostic personal characteristics were determined to have "promising" empirical support. Tailoring counseling to the religious beliefs and values of clients was one of those (Worthington &

Sandage, 2002). The Psychotherapy Task Force called for research assessing the effectiveness of tailoring counseling to client's religious beliefs and values (Norcross).

Tailoring Counseling to the Religious Beliefs and Values of Clients

Counseling can be tailored to the religious beliefs and values of clients in two ways. First, religious techniques can be used in the counseling session. Second, the counselor and client can be matched on religious beliefs and values. Several studies have examined how counseling with individuals has been tailored to the religious beliefs and values of clients; however, there are few data on tailoring couple counseling to religious clients.

The use of religious techniques in individual counseling. Several studies have examined the use of religious techniques in individual counseling (e.g., Moon, Willis, Bailey, & Kwasny, 1993; Richards & Potts, 1995; Shafranske & Malony, 1990; Walker, Gorsuch, & Tan, 2005; Walker, Gorsuch, Tan, & Otis, 2008). A recent meta-analysis examined data from 1,037 explicitly religious counselors and reported the frequency of using spiritual or religious techniques with religious clients (Walker et al., 2004). Forgiveness was used in 42.2% of therapy cases, the use of scripture or teaching biblical concepts was used in 39.2% of counseling cases, confrontation of sin was used in 32.6% of counseling cases, and religious imagery was used in 29.1% of counseling cases. Thus, religious techniques are common among religious counselors working with individual religious clients. One methodological concern with past studies of religious techniques in therapy is that counselors have estimated how often they use religious techniques generally (e.g., Richards & Potts). This method may be subject to recall bias and may

also be influenced by counselor intent or an idealized depiction rather than actual behavior. Another approach that is potentially less susceptible to bias might be to ask clients to report the religious techniques used in their actual counseling sessions. In fact, recall bias would likely be introduced if clients tried to recall the frequency with which counselors used various methods over two or more sessions. The recall bias might occur due to forgetting or to distortion from overgeneralization based on the general counseling relationship. Thus accurate recall is most likely if a client reports on the most recent session.

Using this client reporting method, the extent to which individual Christian counselors used religious techniques in the most recent session was examined (Wade et al., 2007). Christian counseling was studied because it may use religious techniques more widely than any form of counseling in the United States (Wylie, 2000). Techniques of interest included: praying with or for the client, discussing forgiveness of others, and quoting or referring to scripture (Wade et al.). According to clients' reports, counselors in religious settings used religious techniques in individual counseling more often than did counselors in secular settings. For counselors in religious settings, clients reported that prayer was used in 60% of counseling cases, forgiveness was used in 34% of counseling cases, and scripture or teaching biblical concepts was used in 52% of counseling cases. The differences between reports of counselors (Walker et al., 2004) and clients (Wade et al.) highlight the value of client reports: clients' perceptions of whether a technique is used may be more relevant to counseling than self-estimated counselor behavior. In sum, across separate studies, researchers have surveyed religious counselors or their clients to

identify the religious techniques that are used in individual counseling. There are no studies that have examined the use of religious techniques in couple counseling.

The efficacy and effectiveness of using religious techniques in individual counseling. Efficacy and effectiveness ask related but different questions. *Efficacy* refers to whether a treatment works under controlled, laboratory conditions, whereas *effectiveness* refers to whether a treatment works in "real world" settings (Chambless & Hollon, 1998). Several studies of individual psychotherapy have assessed the efficacy of using religious techniques (for a review, see Chapter 2). For example, five studies have investigated Christian accommodative cognitive therapy for depression. Three studies (Pecheur & Edwards, 1984; Propst, 1980; Propst et al., 1992) compared Christian-accommodative and secular versions of cognitive-behavioral therapy (CBT) for depression. Two studies (Johnson & Ridley, 1992; Johnson et al., 1994) compared Christian-accommodative and secular versions of rational-emotive therapy (RET) for depression. McCullough (1999) conducted a meta-analysis of these five studies, and found that clients in religion-accommodative therapy showed a non-significant trend toward more improvement in depressive symptoms (i.e., lower scores on the Beck Depression Inventory, Beck et al., 1961) than did clients in standard counseling conditions. Based on these results, McCullough (1999) suggested that the choice to use religion-accommodative approaches might best be based on client choice. Indeed, highly religious people tend to prefer explicitly religious counseling (Worthington et al., 1996). However, in studies that have assessed the efficacy of religious techniques, random assignment, rather than client choice, has been used as the basis for therapy. Studies that

assess the effectiveness of religious techniques in clients who have chosen religious therapy may be a valuable addition to the field.

One study has examined the effectiveness of using religious techniques with clients who have chosen explicitly religious individual therapy (Wade et al., 2007). Clients were surveyed to determine whether the use of religious techniques in individual therapy contributed to the amount of change in problem severity since the beginning of therapy. For clients with high religious commitment, therapy using religious techniques resulted in higher levels of client-reported change than did therapy that did not use religious techniques (Wade et al.). For clients with low religious commitment, however, therapy using religious techniques resulted in lower levels of client-reported change than did therapy that did not use religious techniques (Wade et al.). Thus, in individual therapy, using religious techniques is helpful for highly religious clients but may be detrimental for others. This tailoring approach is complemented by matching counselor and client on religious beliefs and values.

Matching of counselor and client on religious beliefs and values. The effects of matching of counselor and client on religious beliefs and values have been studied in several ways. First, research has examined the preferences of clients for a counselor who shares their religious beliefs and values. Highly religious clients usually show a strong preference for a counselor who shares their religious beliefs and values (e.g., Guinee & Tracey, 1997; Keating & Fretz, 1990). Second, four studies (Kelly & Strupp, 1992; Martinez, 1991; Propst et al., 1992; Wade et al., 2007) examined the effects of religious matching of counselor and client on outcome. The results are mixed. Kelly and Strupp

found that client-counselor similarity on valuing salvation was positively correlated with independent clinician's ratings of client improvement, showing the positive effect of religious matching. Martinez (1991) found that client-counselor similarity on religious values was correlated with counselor's ratings of client improvement, but was uncorrelated with client's ratings of their own improvement. Propst et al. found no difference in client improvement between religious counselors and nonreligious counselors using religiously accommodative CBT with depressed religious study participants. They proposed that the actual religious techniques used in religious counseling may be more important than the religious beliefs and values of the counselor. In a survey of individual Christian and secular counselors and clients in the community, Wade et al. examined whether matching the counselor and client on religious commitment using the Religious Commitment Inventory-10 (RCI-10; Worthington et al., 2003) contributed to effective counseling. No significant interaction was observed between counselor and client religious commitment on client outcome. Thus, there is some evidence that matching the counselor and client on religious beliefs and values contributes to effective counseling. However, the data are mixed, and there is a growing awareness that more research is needed on this topic (Worthington et al., 1996; Worthington & Sandage, 2002). In addition, the topic of using religious techniques and matching counselor and clients on religious beliefs and values has been addressed only rarely in couple counseling (see Ripley et al., 2001).

Tailoring Couple Counseling to the Religious Beliefs and Values of Clients

Theories of couple counseling that are tailored to the religious beliefs and values

of clients are common. For example, Worthington (1996) reviewed eight different theoretical approaches to Christian marital therapy. Several religious marital intervention programs exist. Traditionally, these have included Marriagebuilders (Harley, 1996), Saving Your Marriage Before It Starts (SYMBIS; Parrot & Parrot, 1996), Marriage Encounter (Silverman & Urbaniak, 1983), and The Christian Prevention and Relationship Enhancement Program (Christian PREP; Stanley et al., 1998). Unfortunately, a review in 1998 revealed that empirical research on the effectiveness of tailoring couple therapy to the religious beliefs and values of clients was virtually nonexistent (Ripley & Worthington, 1998). Since that time, although there has been some theoretical and practical writing examining religious tailoring in couple counseling (e.g., Beach, Fincham, Hurt, McNair, & Stanley, 2008; Duba & Watts, 2009; Onedera, 2008), the status of empirical research on Christian tailored couple approaches has changed little.

One study was designed to inform the influence of tailoring couple therapy (Ripley et al., 2001). The religious commitment of 211 married Christians was assessed using a scale that eventually became the RCI-10 (Worthington et al., 2003). These participants then read vignettes that varied based on the counselor's (a) use of religious techniques in counseling, and (b) religious affiliation. Participants reported their preferences for couple counseling as described in that vignette, as well as how effective they expected that counseling to be (Ripley et al., 2001). Participants who were highly religious preferred a counselor who was willing to use religious techniques in counseling and who shared similar beliefs and values as the client. They also expected such counseling to be more effective. Participants who were not highly religious showed no

differences on both preference for counseling or expected effectiveness. Thus, this study provides data consistent with the view that tailoring couple counseling to the religious beliefs and values of clients is preferred by clients and may maximize expectations of effectiveness. Stronger support for this view might be provided by a study of couple counselors and clients that addressed therapeutic techniques, matching of religious beliefs and values, and specific indicators of effectiveness.

In sum, couple distress is linked to mental health symptoms. Couple counseling is effective at alleviating couple distress. One way to increase the effectiveness of counseling may be to tailor it to clients' personal characteristics, including religious beliefs and values. Some studies of *individual* counseling have shown that, for highly religious clients, using religious techniques in counseling and matching the counselor and client on religious beliefs and values may have positive effects on counseling outcome. The present study applies these results from individual counseling to a study of couple counseling. This study used a longitudinal design to examine the nature and effectiveness of Christian couple counseling. I investigated the following questions:

- What religious and secular techniques are used in Christian couple counseling?
- What is the effectiveness of Christian couple counseling, as indexed by improved relationship satisfaction, improved working alliance with the counselor, and satisfaction with counseling?
- Does using religious techniques in the counseling sessions contribute to more effective outcomes? For what types of clients is incorporating religious techniques helpful?

- Does matching the therapist and client on religious beliefs and values contribute to more effective outcomes? For what types of clients is matching helpful?

Method

Participants

Participants were 20 counselors recruited from the American Association of Christian Counselors (AACC) and the Christian Association for Psychological Science (CAPS), and their couple clients (60 individuals from 32 couples). Counselors were 11 females and 9 males. Nine counselors were licensed practitioners, and eleven were counselors in training. The mean age was 39 years (range, 23 to 68 years). Counselors were 90% Caucasian and 10% African-American. All counselors self-identified as Christian. Counselors reported an average of 8 years of counseling experience (SD = 9 years). Overall, counselors reported having a very high level of religious commitment (M = 43.05, SD = 5.14). Clients were 32 males and 28 females. In four couples, only the male partner participated in the study. The mean age was 36 years (range, 20 to 60 years). Clients were 81% Caucasian, 9% African-American, 5% Latino, and 5% Other. Almost all (98%) clients self-identified as Christian. Clients reported above-average religious commitment (M = 33.98, SD = 8.91), although they were less religiously committed than were counselors. Almost all (97%) were married. 18% of clients reported that they had been previously divorced.

Design

This study used a longitudinal design.

Measures

Demographics. At the first time point (session 1), participants (counselors and clients) provided basic demographic information (see Appendices A and B). Counselors provided their name, age, gender, ethnicity, religious affiliation, and number of years of counseling practice. Clients provided their counselor's name, as well as their own name, partner's name, age, gender, ethnicity, religious affiliation, and marital status. Identifying information was given for matching purposes only.

Religious commitment. At the first time point (session 1), both counselor and clients completed a measure of religious commitment (See Appendix A). Religious commitment was measured with the Religious Commitment Inventory-10 (RCI-10; Worthington et al., 2003). For a description, see Study 1. For the current sample, the Cronbach's alpha coefficient was .85 (95% CI = .73-.93) for counselors and .91 (95% CI = .88-.94) for clients.

Religious techniques used in counseling. A list of 15 techniques was created for the purpose of this study (See Appendix B). These techniques were adapted from a previous study that assessed the use of religious techniques in individual therapy (Wade et al., 2007). Six items represent techniques that are directly related to religious or spiritual commitments (e.g., "Our therapist actually quoted or referred to scripture/sacred writings"). Nine items were categorized as "secular." These have no direct association with religious or spiritual commitment (e.g., "Our therapist focused on changes in our marital/couple behavior"). At the second time point (session 4), clients indicated (a) whether each technique was used in the previous session and (b) how often each technique was used in the past four sessions. The use of religious and spiritual techniques

over the first four sessions was then summed. For the current sample, the Cronbach's alpha coefficient was .82 (95% CI = .73-.88) for religious techniques and .74 (95% CI = .63-.84) for secular techniques.

Couple distress. At each time point (session 1, 4, and 8), each client's level of couple distress was evaluated by the Revised Dyadic Adjustment Scale-4 (RDAS-4; Sabourin, Valois, & Lussier, 2005; see Appendix B). The RDAS-4 is a four-item self-report scale that measures couple adjustment (endpoints vary; e.g., "Please describe the degree of happiness in your relationship"). It is a brief version based on the Dyadic Adjustment Scale (Spainer, 1976), which is a widely used measure of couple adjustment. In a series of studies, Sabourin et al. provided evidence for the reliability and temporal stability of the RDAS-4. The RDAS-4 was also able to classify distressed and nondistressed couples with a high degree of accuracy (Sabourin et al.). Furthermore, the RDAS-4 was able to predict whether couples would terminate their relationship. For the current sample, the Cronbach's alpha coefficient ranged from .72 (95% CI = .57-.82) to .82 (95% CI = .70-.90).

Working alliance. At each time point (session 1, 4, and 8) each client's feelings about the therapeutic alliance was evaluated by the bond subscale of the short form of the Working Alliance Inventory (WAI-SF; Tracey & Kokotovic, 1989; see Appendix B). The bond subscale is a four-item self-report measure of the development of a personal bond between counselor and client (e.g., "My counselor and I trust one another"). Clients rate the degree to which they agree or disagree with statements on a 7-point scale from 1 = *strongly disagree* to 7 = *strongly agree*. Tracey and Kokotovic found evidence for the

estimated internal consistency and the factor structure of this subscale. For the current sample, the Cronbach's alpha coefficient ranged from .88 (95% CI = .81-.92) to .94 (95% CI = .91-.96).

Satisfaction with counseling. At the final two time points (session 4 and 8), each client's satisfaction with counseling was evaluated by the Client Satisfaction Questionnaire (CSQ; Larsen, Attkinson, Hargreaves, & Nguyen, 1979; see Appendix B). The CSQ is an eight-item self-report measure of the extent to which clients are satisfied with the counseling they have received (e.g., "How would you rate the quality of counseling you have received?"). Clients rate the degree to which they agree or disagree with statements on a 4-point scale (endpoints vary). The CSQ is a widely used brief global measure of client satisfaction, and has evidence supporting its internal consistency and validity (Attkisson & Zweck, 1982; Larsen et al.). For the current sample, the Cronbach's alpha coefficient ranged from .88 (95% CI = .82-.92) to .94 (95% CI = .91-.97).

Procedure

Counselors were recruited from the American Association of Christian Counselors (AACC) and the Christian Association for Psychological Studies (CAPS). Interested counselors were contacted by the PI, and the inclusion criteria and procedures of the study were explained. Counselors who wished to participate in the study completed a short survey (see Appendix A), which included demographic information and the RCI-10. Counselors offered couple clients who initiated counseling after agreed-upon participation of the counselor the opportunity to participate in the study. Clients who wish

to participate were given information about informed consent in writing. After giving consent, participating clients filled out demographic measures, the RCI-10, the DAS-4, and the WAI-SF at time 1 (session 1). At time 2 (session 4), participating clients filled out the measure of techniques used in counseling during the most recently completed session, the DAS-4, the WAI-SF, and the CSQ. At time 3 (session 8), participating clients filled out the DAS-4, the WAI-SF, and the CSQ. At each time point, clients completed hard-copies of the questionnaires, and placed the questionnaires in an addressed, stamped envelope which was mailed to the research team in Virginia. Participating clients were informed that their individual responses would remain confidential, be analyzed by a research team in Virginia, and that individual results would not be communicated to the agency or counselor; thus, there was no risk for repercussions for the therapeutic relationship.

Hypotheses and Planned Analyses

Hypothesis #1

Statement. Clients in Christian couple counseling will report experiencing moderate levels of religious techniques. The presence of religious techniques in counseling will be predicted by (a) counselor religious commitment and (b) client religious commitment.

Justification. Counselors and clients in individual religious counseling have reported moderate levels of religious interventions (Walker et al., 2004; Wade et al., 2007). I expect similar levels of religious techniques to be present in religious couple counseling. Furthermore, in Study 1, I found that attitudes toward using religious

techniques in couple counseling were predicted by counselor religious commitment. Thus, the likelihood of using religious techniques in couple counseling should also be predicted by counselor religious commitment. Counselors may also tailor their use of religious techniques in counseling based on their perception of the client's level of religious commitment.

Analysis. To assess the presence of specific techniques in therapy, the frequencies of each technique used in the most recently completed counseling session were analyzed. To examine the relationship between religious commitment and religious techniques used, I summed the presence of religious techniques used in the first four sessions. Because data are nested (individuals within couples), this hypothesis was tested using a two-level multilevel modeling regressions with summed religious techniques as the dependent variable, and counseling religious commitment and client religious commitment as independent variables.

Hypothesis #2

Statement. Clients in Christian couple counseling will report improvement over time in (a) relationship satisfaction and (b) working alliance with the counselor. Client will also report a high level of satisfaction with counseling. Working alliance with the counselor will positively predict relationship satisfaction. Working alliance with the counselor and relationship satisfaction will positively predict satisfaction with counseling.

Justification. Effectiveness studies have generally shown that counseling is effective (Seligman, 1995). This has been shown to be true for religious individual

counseling (Wade et al., 2007) as well as secular marriage counseling (Doherty & Simmons, 1996). Indeed, the vast majority of outcome research on religious counseling has shown that religious counseling works, although it does not work significantly better than secular counseling (see Chapter 2). Developing a strong working alliance is an important factor in successful counseling, and it is likely that having a strong working alliance and showing improvement in one's couple relationship will affect general satisfaction with counseling.

Analysis. Because data are nested (repeated measures within individuals within couples), this hypothesis was tested using two three-level multilevel modeling regressions with the outcome measure (i.e., DAS-4, WAI-SF) as the dependent variable and time as the predictor. A model was also tested with relationship satisfaction as the dependent variable and working alliance as a predictor. Client satisfaction with counseling was not measured at session 1. The means for client satisfaction at session 4 and 8 were examined. A two-level (individual within couple) multilevel modeling regression was conducted with satisfaction with counseling as the dependent variable and relationship satisfaction and working alliance as predictors.

Hypothesis #3

Statement. The use of religious techniques in couple counseling will contribute to improved (a) relationship satisfaction and (b) working alliance for highly religious clients. However, this effect will not be found for clients who are not highly religious.

Justification. It has been suggested that counseling is most helpful when the techniques are matched with certain characteristics of the client (Norcross, 2002).

Evidence has accumulated that tailoring interventions to the religious beliefs and values of clients is effective (Worthington & Sandage, 2002). In the one effectiveness study of religious individual counseling, Wade et al. (2007) found an interaction between the client's religious commitment and the use of religious techniques in counseling. Namely, for clients with high religious commitment, the use of religious techniques was associated with greater client change and greater working alliance. However, this effect was not found for clients with low religious commitment.

Analysis. Because data are nested (repeated measures within individuals within couples), this hypothesis was tested using two three-level multilevel modeling regressions with the outcome measure (i.e., DAS-4, WAI-SF) as the dependent variable and time, client religious commitment, the use of religious techniques in counseling, and their interactions as predictors.

Hypothesis #4

Statement. Matching on religious commitment by counselor and clients will contribute to improved (a) relationship satisfaction and (b) working alliance.

Justification. There is some evidence that matching the counselor and client on religious beliefs and values contributes to more effective counseling outcomes. For example, Kelly and Strupp (1992) found that client-counselor similarity on valuing salvation was positively correlated with independent clinician's ratings of client improvement. Martinez (1991) found that client-counselor similarity on religious values was correlated with counselor's ratings of client improvement, but was uncorrelated with client's ratings of their own improvement. Furthermore, highly religious clients usually

show a strong preference for a therapist who shares their religious beliefs and values (e.g., for individual therapy, Guinee & Tracey, 1997; Keating & Fretz, 1990; for couple therapy, Ripley et al., 2001).

Analysis. Because data are nested (repeated measures within individuals within couples), this hypothesis was tested using two three-level multilevel modeling regressions with the outcome measure (i.e., DAS-4, WAI-SF) as the dependent variable and time, the difference between partner's religious commitment, the difference between client and counselor religious commitment, and their interactions as predictors.

Results

After discussing data cleaning, the results for this study are organized by research question. A table of means for the main variables is provided in Table 6.

Data Cleaning

The data were checked for the assumptions of missing data, outliers, and normality. Missing data is generally not a major problem for multilevel modeling, and thus participants were included in the study as long as either they or their partner completed data from at least 2 time points. If clients had missing data from less than half the items on a scale, mean substitution was used to correct for missing data. If clients had missing data from more than half the items on a scale, the total scale score for that scale was not computed. The data were then checked for outliers (i.e., values with standardized scores less than -3 or greater than 3). There were two low outliers at each time point for working alliance, and one low outlier at the third time point for satisfaction with counseling. However, these values were not extreme (i.e., they represented low to

Table 6

Means and Standard Deviations for All Variables (Study 2)

Variable	Time 1 M (SD)	Time 2 M (SD)	Time 3 M (SD)
RCI-10 (Counselors)	43.05 (5.32)		
RCI-10 (Clients)	33.98 (8.91)		
RCI-10 Difference Between Partners	6.51 (4.27)		
RCI-10 Difference Between Client and Counselor	10.54 (8.11)		
RDAS-4	14.21 (2.43)	14.90 (2.60)	15.18 (2.80)
WAI-SF	23.34 (3.44)	24.69 (2.87)	25.32 (3.08)
CSQ		27.98 (3.52)	28.94 (3.99)

Note. RCI-10 = Religious Commitment Inventory-10; RDAS-4 = Revised Dyadic Adjustment Scale-4; WAI-SF = Working Alliance Inventory-Short Form (bond subscale); CSQ = Client Satisfaction Questionnaire.

moderate working alliance and moderate satisfaction) and are thought to represent true values. Thus, these outliers were retained in the analysis. The data were then checked for normality. The working alliance and satisfaction with counseling variables were slightly negatively skewed and positively kurtotic. However, the skew was mild (values slightly above one), and represented the nature of the distribution; namely, that the majority of participants reported high levels of working alliance and satisfaction with counseling. Thus, scores on these variables were not transformed.

What Religious and Secular Techniques Are Used in Christian Couple Counseling?

The percentages of clients who reported that specific religious or secular techniques were used in the more recently completed counseling session are summarized in Table 7. Several secular techniques that represented major secular theories of couple counseling were very highly endorsed (e.g., solution-focused, emotion-focused, behavioral, and cognitive techniques), occurring in the majority of sessions. Techniques that examined childhood experiences, issues related to forgiveness, and the relationship between the counselor and client were also endorsed in over half the sessions. Consistent with my hypothesis (Hypothesis 1), clients reported a moderate amount of religious techniques used in sessions. Most religious techniques (i.e., discussion of religious faith, assignment of religious tasks, prayer in session, scripture, and forgiveness by God) were used in about half the sessions. The technique of the counselor telling the client he or she had been praying for the client outside of session was rarely used.

It was hypothesized (Hypothesis 1) that the use of religious techniques in counseling would be predicted by counselor religious commitment and client religious

Table 7

Techniques Used in Most Recently Completed Counseling Session (Study 2)

Technique	Used in Most Recent Session	
	Yes (%)	No (%)
Secular		
We focused on the solution(s) to our couple problems.	96.5	3.5
Our counselor focused on our emotions.	91.2	8.8
Our counselor focused on changes in our marital/couple behavior.	86.0	14.0
Our counselor focused on our thoughts/beliefs.	83.9	16.1
We discussed either my own or my partner's childhood experiences during the session.	67.9	32.1
We discussed either my own forgiveness of my partner or my partner's forgiveness of me.	61.4	38.6
One or both of us apologized for wronging the other, actually saying the word "sorry" or "I apologize" or something similar.	54.4	45.6
Our counselor discussed our relationship with him or her.	53.7	46.3
We discussed self-forgiveness	39.3	60.7
Religious		
We had a discussion about religious faith.	61.4	38.6
Our counselor assigned either me, my partner, or both of us together religious tasks (like praying, reading scripture, or going to church) to do outside of the therapy hour between two sessions.	53.6	46.4
Our counselor prayed with me, my partner, or us as a couple during the session.	47.4	52.6
Our counselor actually quoted or referred to scripture/sacred writings at some time during the session.	44.6	55.4
We discussed forgiveness *by God* for myself or my partner.	43.9	56.1
Our counselor told us this week that he or she has prayed for me, my partner, or us outside of counseling.	14.0	86.0

commitment. This hypothesis was tested using a two-level (individual within couple) multilevel modeling regression with summed use of religious techniques as the dependent variable, and counselor and client religious commitment as independent variables. This hypothesis was partially supported. Both counselor religious commitment ($p = .05$) and client religious commitment ($p = .09$) showed trends toward being positive predictors of the amount of religious techniques used in counseling.

What is the Effectiveness of Christian Couple Counseling, as Indexed by Improved Relationship Satisfaction, Improved Working Alliance with the Counselor, and Satisfaction with Counseling?

It was hypothesized (Hypothesis 2) that, over the course of counseling, clients would report improvement over time in relationship satisfaction and working alliance with the counselor. This hypothesis was tested using two three-level (repeated measures within individuals within couples) multilevel modeling regressions with relationship satisfaction and working alliance as dependent variables and time as the predictor. This hypothesis was supported. Time was a positive linear predictor of relationship satisfaction ($p < .05$). Each four sessions of counseling was associated with a .40 point increase on the DAS-4 (20 point scale; see Figure 1). The quadratic term for time was not significant. Time was also a positive linear predictor of working alliance ($p < .01$). Each four sessions of counseling was associated with a 1.04 point increase on the WAI (28 point scale; see Figure 2). The quadratic term for time was not significant.

It was hypothesized (Hypothesis 2) that clients who had a strong working alliance with their counselor would report more improvement in relationship satisfaction. This

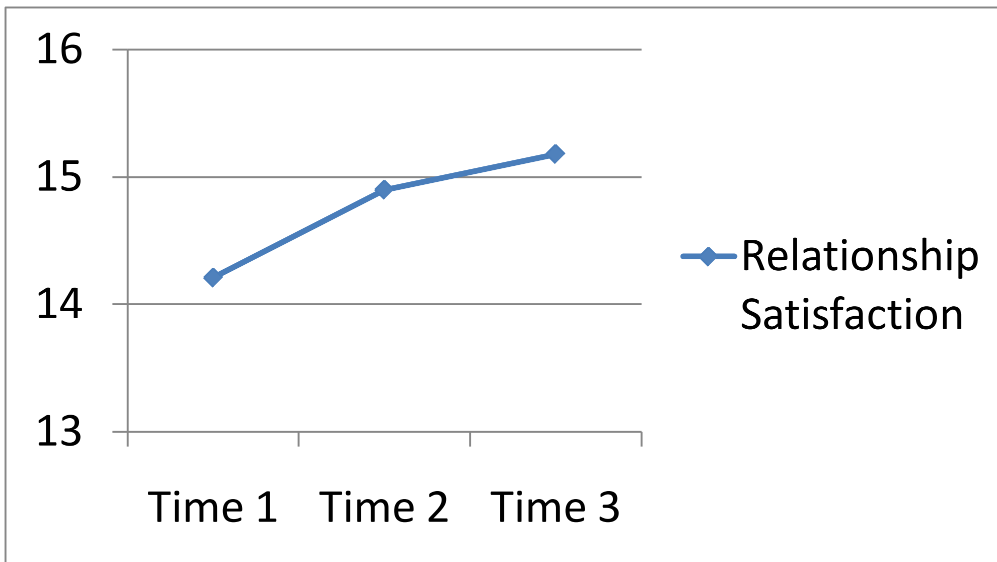

Figure 1. *The effect of time on relationship satisfaction (Study 2).*

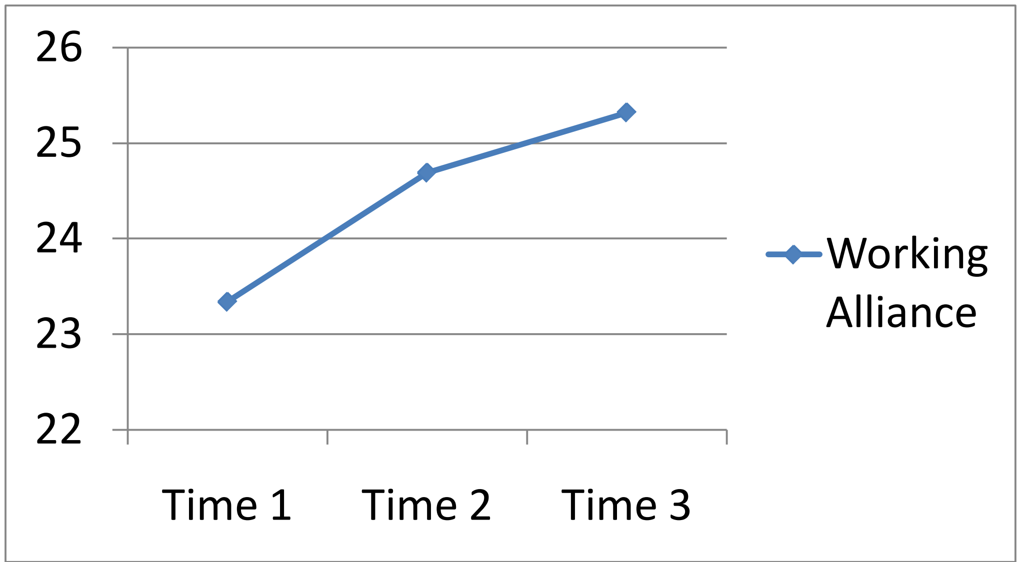

Figure 2. *The effect of time on working alliance (Study 2).*

hypothesis was tested using a three-level (repeated measures within individuals within couples) multilevel modeling regression with relationship satisfaction as the dependent variable and time and working alliance as predictors. This hypothesis was supported. Working alliance was a positive linear predictor of relationship satisfaction ($p < .01$). A one standard deviation increase in working alliance was associated with a .49 point increase on the DAS-4 (20 point scale; see Figure 3).

It was hypothesized (Hypothesis 2) that clients would report high levels of satisfaction with counseling. This hypothesis was supported. Clients reported a mean level of satisfaction with counseling of 27.98 at session 4 and 28.94 at session 8 (out of 32). It was hypothesized (Hypothesis 2) that relationship satisfaction and working alliance would predict satisfaction with counseling at both time points. This hypothesis was tested using two two-level (individuals within couples) multilevel modeling regressions with satisfaction with counseling at session 4 and 8 as dependent variables and relationship satisfaction and working alliance as predictors. This hypothesis was supported. At session 4, working alliance was a positive predictor of satisfaction with counseling ($p < .01$). A one standard deviation increase in working alliance was associated with a 1.52 point increase in satisfaction with counseling. Relationship satisfaction showed a trend toward being a positive predictor of satisfaction with counseling ($p = .07$). A one standard deviation increase in relationship satisfaction was associated with a .75 point increase in satisfaction with counseling. At session 8, working alliance was again a positive predictor of satisfaction with counseling ($p < .01$). A one standard deviation increase in working alliance was associated with a 3.07 point increase

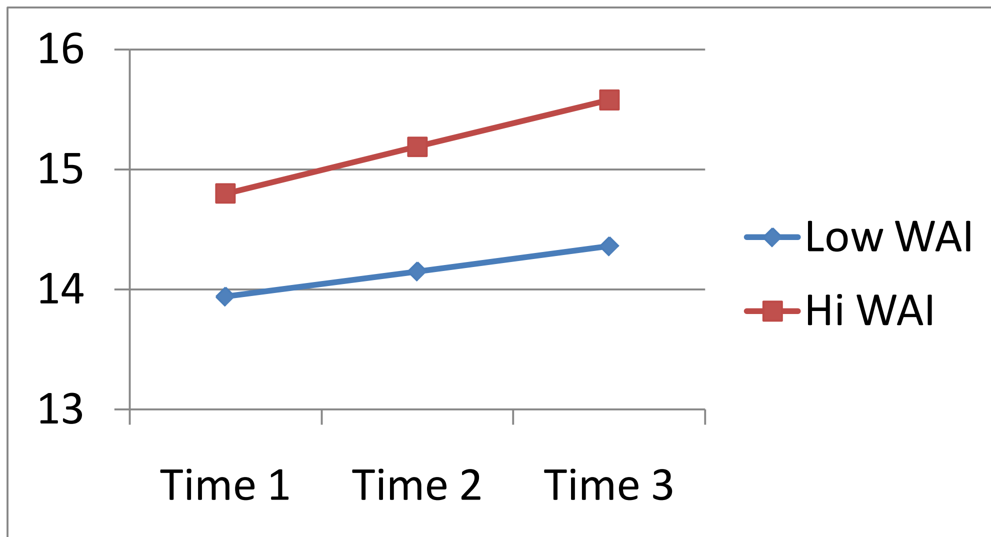

Figure 3. *The effect of working alliance on relationship satisfaction (Study 2).*

in satisfaction with counseling. Relationship satisfaction showed a trend toward being a positive predictor of satisfaction with counseling ($p = .12$). A one standard deviation increase in relationship satisfaction was associated with a .89 point increase in satisfaction with counseling. At session 8, there was also a significant interaction between relationship satisfaction and working alliance ($p < .05$). For clients with low working alliance, those with high relationship satisfaction did not have higher levels of satisfaction with counseling than did those with low relationship satisfaction ($p = .65$). However, for clients with high working alliance, those with high relationship satisfaction had higher levels of satisfaction with counseling than did those with low relationship satisfaction ($p < .01$; See Figure 4).

Does Using Religious Techniques in Counseling Contribute to More Effective Outcomes? For what Types of Clients are Incorporating Religious Techniques Helpful?

It was hypothesized (Hypothesis 3) that using religious techniques in counseling would contribute to more effective outcomes, but only for those clients who were high in religious commitment. This hypothesis was tested using two three-level (repeated measures within individuals within couples) multilevel modeling regressions with relationship satisfaction and working alliance as dependent variables and time, summed religious techniques used in counseling, religious commitment, and their interactions as predictors. This hypothesis was not supported. For clients who were high in religious commitment, there was no added benefit from using many religious techniques to either relationship satisfaction or working alliance (both *ps* > .05).

Does Matching the Counselor and Clients on Religious Beliefs and Values Contribute to

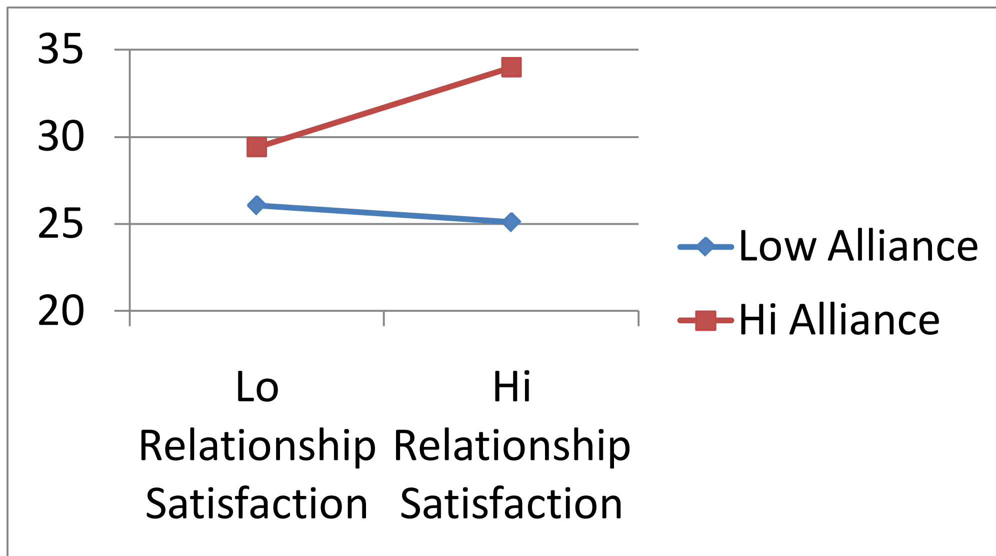

Figure 4. *The effect of relationship satisfaction and working alliance on satisfaction with counseling at session 8 (Study 2).*

More Effective Outcomes? For what Types of Clients is Matching Helpful?

It was hypothesized (Hypothesis 4) that having counselors and clients who were closely matched on religious commitment would contribute to more effective outcomes. This hypothesis was tested using a series of three-level (repeated measures within individuals within couples for relationship satisfaction and working alliance) and two-level (individuals within couples for satisfaction with counseling) multilevel modeling regressions with time, the difference in religious commitment between partners, the difference in religious commitment between counselor and client, and their interactions as predictors. This hypothesis was partially supported. For relationship satisfaction, although clients who had a greater difference in religious commitment from their partners started out with lower relationship satisfaction, this difference disappeared by session 8 ($p < .05$; see Figure 5). Similarly, clients who had a greater difference in religious commitment from their counselor started off with lower relationship satisfaction, but this difference disappeared by session 8 ($p < .05$; see Figure 6).

For working alliance, the difference in religious commitment between partners was not a significant predictor. However, the main effect of the difference in religious commitment between counselor and client was significant ($p < .05$; see Figure 7), indicating that throughout counseling, participants who had a greater difference in religious commitment from their counselor had a lower working alliance.

For satisfaction with counseling, the difference in religious commitment between partners had a trend toward significance ($p = .11$ at session 4 and $p = .06$ at session 8). A greater difference in religious commitment between partners was associated with lower

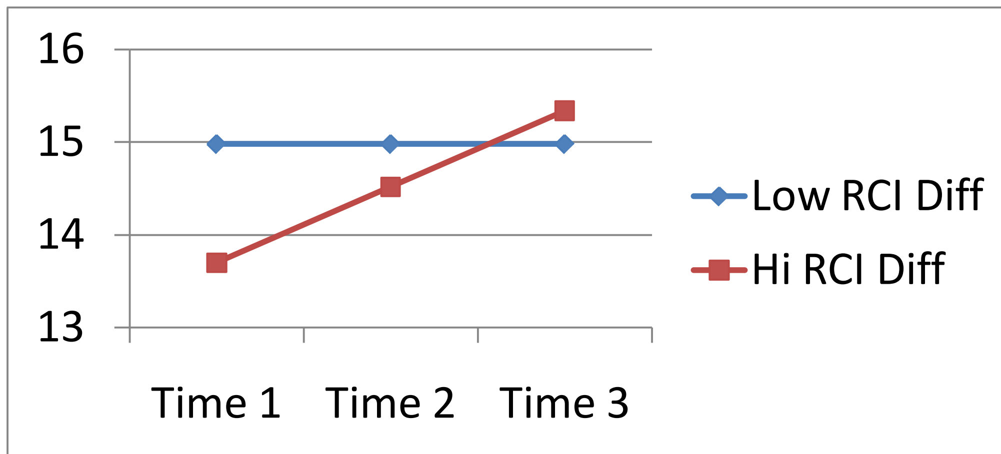

Figure 5. *The effects of partner difference in religious commitment on relationship satisfaction (Study 2).*

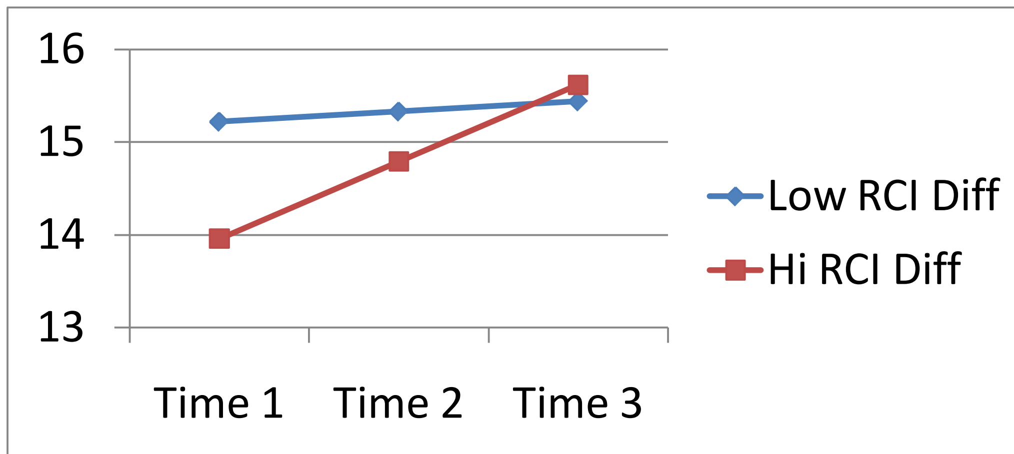

Figure 6. *The effect of counselor difference in religious commitment on relationship satisfaction (Study 2).*

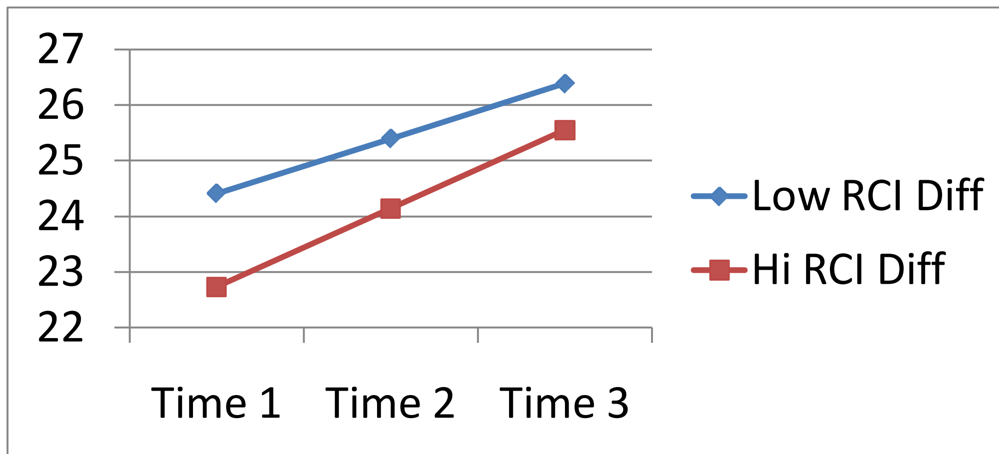

Figure 7. *The effect of counselor difference in religious commitment on working alliance (Study 2).*

satisfaction with counseling. The difference in religious commitment between counselor and client was not a significant predictor of satisfaction with counseling.

Unfortunately, due to the nature of my sample, I was unable to examine whether matching the counselor and client on religious commitment was more helpful for clients with high religious commitment. Because almost all counselors were highly religious, I did not have a subsample of clients who had high religious commitment but were also mismatched with their counselor.

Discussion

The present study examined the effectiveness of religiously-tailored couple counseling from a Christian perspective. Effectiveness was assessed by three variables: relationship satisfaction, working alliance with the counselor, and satisfaction with counseling. Furthermore, the effectiveness of religious tailoring was assessed in two ways: examining the use of religious techniques in counseling and assessing the match in religious commitment between the counselor and the clients.

Overall, clients reported that counselors used a moderate amount of religious techniques in religiously-tailored couple counseling. This level of use of religious techniques is similar to levels found in research of the use of religious techniques in religiously-tailored individual counseling (Walker et al., 2004; Wade et al., 2007). Techniques from major secular theories (e.g., solution-focused, emotion-focused, behavioral, and cognitive) were heavily used. Thus, although it appears that religious techniques are definitely present in religiously-tailored couple counseling, they are not ubiquitous in such counseling. This may also be a function of my sample. Most of the

counselors in this study were professional counselors rather than pastoral or lay counselors, who might use religious techniques more often in couple counseling than do professional counselors. Furthermore, the use of religious techniques in counseling was a factor of counselor and client religious commitment. This result supports previous research that has noted a connection between counselor religiousness and the use of religion in the counseling session (Chapter 3; Shafranske & Malony, 1990; Walker et al., 2004, 2005, 2008). There are several interpretations of the finding that client religious commitment was related to the use of religious techniques in counseling. Perhaps counselors are able to discern a client's level of religious commitment and tailor counseling accordingly. Another plausible explanation is that clients with high religious commitment are more attuned to noticing religious techniques when they are used in the counseling session.

Overall, religiously-tailored couple counseling was effective, as indexed by improved relationship satisfaction, working alliance with the counselor, and high levels of satisfaction with counseling. This finding supports prior research that has noted that religious and spiritual interventions are helpful for treating a wide variety of psychological problems (Chapter 2). Working alliance was an important factor in predicting both relationship satisfaction and satisfaction with counseling. This finding supports prior theory and research that has noted the importance of working alliance in couple counseling, as well as counseling in general (Friedlander, Escudero, & Heatherington, 2006; Hovrath & Bedi, 2002; Knobloch-Fedders, Pinsof, & Mann, 2007).

The specific effects of religious tailoring were mixed. Using many religious

techniques in counseling did not predict better outcomes for highly religious clients (although it did not produce *worse* outcomes for highly religious clients). Matching the counselor and client on religious commitment did not affect relationship satisfaction, but did affect working alliance. Having a situation in which counselor and client were mismatched on religious commitment resulted in a lower working alliance over the course of counseling (first 8 sessions). These mixed findings are somewhat consistent with previous research. As described in Chapter 2, the majority of research that has compared religiously accommodative counseling with secular approaches has found that religiously-accommodative approaches do not work better than their secular counterparts, even for generally religious clients (Note, however, that religiously accommodative approaches do not work *worse* than their secular counterparts). However, two studies have found evidence that religious counseling was more effective for highly religious clients (Razali et al., 2002; Wade et al., 2007). Previous research on religious matching in counseling has similarly been mixed with some studies finding positive results (Kelly & Strupp, 1992; Martinez, 1991) and other studies finding no effect (Propst et al., 1992; Wade et al.).

There are a few limitations to the present study. First, a specific type of counselors and clients were sampled. Counselors were all Christian and highly committed to their religion. Furthermore, most counselors were professional counselors or counselors in training. There was a broader range of religious commitment among clients, but almost all self-identified as Christian. There are consequences to having a restricted sample. This study described what is likely to occur within a professional Christian

counseling setting with clients who also identify as Christians. Generalizations to other types of counseling—such as pastoral or lay approaches, should be made cautiously if at all. In fact, in Study 1, I presented evidence that the types of couple counseling—lay, pastoral, and professional—differ substantially. Similarly, generalizations to couple counseling that is tailored to other religious or spiritual worldviews should be made cautiously if at all. Furthermore, the high levels of religious commitment among counselors made it impossible to explore situations in which the client was highly religious and the counselor was not. A second limitation of the present study concerns the research design. This was an effectiveness study of counseling in the community, and I did not employ a control group or comparison group with which to compare Christian couple counseling. Without an experimental design, conclusions about causality should be made with caution.

Despite these limitations, the present study provides important information about the nature and effectiveness of religiously-tailored couple counseling from a Christian perspective. Christian couple counseling employs many techniques that are based in secular approaches, yet also includes religious techniques. Overall, Christian couple counseling is effective and results in improved relationship satisfaction, a strong bond between the clients and counselor, and high levels of satisfaction with counseling. The results concerning the benefits of using religious techniques in couple counseling and matching the counselor and clients on religious commitment are mixed, although a close match in religious commitment resulted in a stronger working alliance throughout counseling. More research is needed in this area before conclusions can be made about

the empirical status of using religious techniques or matching in couple counseling.

Future research examining both the efficacy and effectiveness of religious tailoring in couple counseling would be helpful. This research is difficult to conduct, however. Religion is a very personal attribute, and it is difficult if not impossible to randomly assign clients to religious or non-religious counseling. Even so, perhaps controlled experiments could be conducted that examine the efficacy of specific religious techniques (see Martinez, Smith, & Barlow, 2007 for an initial investigation). Researchers conducting treatment outcome studies have found it difficult to show empirically that specific theories of counseling or sets of techniques outperform others, so perhaps the lack of consistent results on the effectiveness of religious techniques can be viewed as another piece of evidence supporting the effectiveness of the common factors found in most counseling approaches. Future studies examining the effectiveness of religiously-tailored couple counseling could be conducted using larger sample sizes. It would also be helpful to compare results from professional counselors with those from biblical counselors or with counselors who are less religiously committed.

CHAPTER 6

GENERAL DISCUSSION OF STUDIES 1 AND 2

In the above two programmatic studies, I examined the nature and effectiveness of religiously-tailored couple counseling from a Christian perspective. In Study 1, I conducted a national survey of Christian couple counselors, in which I inquired about counselors' experiences in couple counseling, and their attitudes toward incorporating religion and spirituality into couple counseling. In Study 2, I examined the nature of Christian couple counseling by assessing the religious and secular techniques that were used in the counseling session. I also evaluated the effectiveness of Christian couple counseling as indexed by improved relationship satisfaction, improved working alliance with the counseling, and satisfaction with counseling.

Christian couple counseling is widely practiced, with large numbers of couples seen in counseling every year. Christian couple counselors are similar to secular counselors in terms of training and experience in counseling, yet they have very high levels of religious commitment. There are several differences between professional, pastoral, and lay counselors. Some of these differences involve attitudes toward incorporating religion and spirituality into counseling. Although almost all Christian couple counselors reported that they thought using religious techniques in counseling was appropriate, professional counselors were somewhat less likely to view explicit religious techniques as appropriate. Professional counselors were also more influenced by secular theories of couple counseling than are pastoral and lay counselors, who were more influenced by Christian theories of couple counseling. My findings from actual

counseling sessions, which were weighted heavily toward professional counseling, supported this. Techniques from the major secular theories of couple counseling (e.g., solution-focused, emotion-focused, behavioral, cognitive) were used in the majority of sessions. Religious techniques (e.g., discussion of religious faith, prayer, reference to Scripture) were used in about half the sessions.

In both studies, I found a connection between the personal religiosity of counselors and their attitudes and use of religious techniques in counseling. Counselors with high religious commitment were more likely to (a) view religious techniques as appropriate for use in couple counseling and (b) use religious techniques in actual counseling sessions. This supports prior research that has found a positive relationship between a counselor's personal religiosity and their practice of counseling (e.g., Shafranske & Malony, 1990; Walker et al., 2004, 2005, 2008).

In a broad sense, Christian couple counseling was found to be effective. Clients showed improvement in relationship satisfaction and working alliance with the counselor, and reported high levels of satisfaction with counseling. Christian couple counseling appears to work in general. The more specific research question of whether it helps outcomes to include religious techniques in counseling or match counselor and clients on religious commitment was more difficult to answer. The one consistent finding was that counselors and clients who were mismatched on religious commitment had lower working alliance throughout counseling. This supports prior theory and research that has suggested that it may be important to match counselors and clients on religious beliefs and values (Wade et al., 2007; Worthington, 1988; Worthington & Sandage, 2002).

Besides this finding, there were no consistent findings about the helpfulness of religious tailoring in couple counseling.

Implications for Practice

The findings from these two studies have important implications for couple counselors. This research is especially relevant for couple counselors who are religious, use religious or spiritual practices in counseling, or who counsel clients who may be religious. First, counselors should be aware that their own personal beliefs and values concerning religion and spirituality directly affect their work as counselors (Wiggins, 2008). Beliefs concerning religion and spirituality are often powerful determinants of one's worldview. Counselors should be cognizant of their own personal religious beliefs and values, and be aware of how these beliefs and values affect the counseling process. Counselors who had higher levels of religious commitment were more likely to use religious techniques in counseling, even after controlling for the client's level of religious commitment. It is debatable whether this is positive or negative. Couple counselors should be aware of their own beliefs and values, and critically examine their own tendency to include or not include religion and spirituality into the counseling process.

Second, the results of this research provide support for the continued practice of religiously tailored couple counseling, at least from the Christian perspective. Christian couple counseling is popular and widely practiced, yet there has been little effort to assess the effectiveness of this counseling empirically. This research is an important first step in that direction. Overall, counseling was effective as indexed by improved relationship satisfaction, working alliance with the counselor, and high levels of

satisfaction with counseling. The conclusions that are able to be made based on this research are limited. The most important limitation involves the research design and lack of a control or comparison group. Thus, even though clients in Christian couple counseling improved over time, it is incorrect to conclude with certainty that the counseling itself caused the improvement. Other factors such as regression to the mean may have affected outcomes.

Third, counselors should use caution when interpreting the specific findings of religious tailoring. Mismatch on religious commitment between the counselor and client predicted a lower working alliance across counseling. In this particular study, mismatch generally involved a highly religious counselor with a less religious client. Couple counselors who are highly religious may want to exercise caution when discussing religion and spirituality, at least until the counselor has a sense of the client's views. This may be an especially difficult issue in couple counseling because the clients themselves may or may not be matched on religious beliefs and values. Recommendations for or against the use of religious techniques in couple counseling are even murkier. There was no evidence from this study that using many religious techniques when counseling highly religious clients affects outcomes, either positively or negatively. It may be that the amount of religious techniques used in session is not an important factor in client improvement.

Implications for Research

There are several exciting areas for future research in the study of religiously-tailored couple counseling. First, the research design and methods should be improved to

further assess the efficacy and effectiveness of this type of counseling. As previously discussed, efficacy research on religiously-tailored counseling is difficult to conduct. Since religion and spirituality is a very personal issue, it is difficult to assign non-religious persons to religious counseling, or vice versa. Even with these challenges, some efficacy research is possible. For example, Christian clients could be randomly assigned to receive secular or religiously tailored interventions (using wait-list controls). It is likely that no true efficacy research might be possible in which highly religious clients are willing to be randomly assigned to secular counseling or that secular and anti-religious clients are willing to be randomly assigned to religiously tailored counseling. Thus, the more extreme individuals in belief and commitment will likely exclude themselves making valid conclusions suspect about the effects of stark mismatching. However, I believe that more controlled research is possible and necessary. For example, perhaps specific religious interventions could be studied. Religious couple counseling in which the counselor prays with the client could be compared with counseling in which prayer is not a component. Effectiveness studies could be improved by comparing different types of religious counseling. Professional couple counseling could be compared to pastoral couple counseling. Religious couple counseling from an integrationist perspective could be compared to religious couple counseling from a biblical counseling perspective.

Second, it would be interesting to explicitly ask couple clients about their experience and attitudes toward the inclusion of religion and spirituality in counseling (see Martinez et al., 2007). Do couple clients appreciate the inclusion of religion and

spirituality? Do they find religious techniques helpful? Do clients sense that they are matched or mismatched with their counselor on religious beliefs and values? Questions such as these would be interesting to explore.

Third, it would be interesting to examine religiously-tailored couple counseling from different types of religious worldviews. In the present research, I have focused on couple counseling from the Christian perspective. Furthermore, since I heavily sampled Christian organizations such as the American Association of Christian Counselors (AACC), the type of Christianity expressed is mainly limited to an Evangelical Protestant worldview. It would be interesting to examine couple counseling from other sects of Christianity, as well as other religious or spiritual worldviews.

Implications for Theory: Speculations

As a final portion of the present dissertation, I try to take seriously the approach I took in studying Christian couple counseling. I argued for a bottom-up, data-based description of Christian couple counseling (e.g., effectiveness studies leading to a conceptual framework which could be followed by efficacy trials in which Christian clients are randomly assigned to various Christian treatments) instead of a top-down, theoretical approach that has characterized most secular counseling research (e.g., a conceptual framework which is tested first in controlled efficacy trials and second in effectiveness studies, with the results of these studies being used to modify the original conceptual framework).

My studies do not provide enough empirical evidence to make sound recommendations for a manualized treatment of Christian couple counseling. However,

with that clear caveat in mind, it is important to sketch a broad outline for what a manual *might* look like after additional evidence accumulates. I presented data from a large survey of couple counselors as well as a longitudinal effectiveness study consisting of 60 clients (and 20 counselors). Based on these data, I will outline portions of a conceptual framework for Christian couple counseling that might—if subsequent data support it—be advanced as a manual of Christian couple counseling.

Self-assessment of the counselor's religiosity. The Christian couple counselor must be aware of his or her own religious beliefs, values, and commitments. In both of my studies, there was a connection between counselor's internal religiosity and (a) their views toward incorporating religion and spirituality into counseling and (b) the number of religious techniques used in actual counseling sessions. This was even true after controlling for the client's level of religious commitment. Counselors must be aware that their own beliefs and values about religion influence their work with clients in counseling.

Assessment of each client's religiosity and consideration of partner differences. Clients in a committed couple relationship do not always align on religious beliefs, values, and commitments, even if they both self-identify as Christians. My research suggests that partners who differ on religious commitment may report lower levels of relationship satisfaction. In other words, differences on religious beliefs, values, and commitments may cause problems in the couple relationship. However, my research also suggests that these problems are able to be worked on in counseling, and couples who had larger differences in religious commitments showed no differences in relationship

satisfaction by the eighth session of counseling. Perhaps this is a unique benefit to having a Christian couple counselor; namely that a counselor sensitive to religious issues can help the couple work through religious conflicts as they arise.

Consideration of differences in religiosity between clients and counselor. The counselor may or may not be aligned with the client on religious beliefs, values, and commitments. My research suggests that for Christian couple counselors, the common situation of mismatch involves a highly religiously committed counselor and a less religiously committed client. In couple counseling, this situation is more complex than in individual counseling because it is possible that a counselor may be matched with one client but mismatched with the other client. My research suggests that large differences in religious commitment between counselor and client may make developing a strong working alliance more difficult. Counselors should be aware of this and should be more intentional about working to develop a working alliance when differences exist. Counselors are encouraged to discuss differences in religious beliefs, values, and commitments with clients in order to work toward a common ground in counseling.

Importance of working alliance. Like other types of counseling, working alliance was found to be an important factor in predicting both (a) client relationship satisfaction and (b) client satisfaction with counseling. Christian couple counselors are encouraged to intentionally work to develop a strong working alliance with the couple as a whole as well as each client individually. Counselors should also stay alert throughout counseling to indications that the working alliance with one or both partners is weakening. This can be done through attendance to interpersonal cues or through periodic informal or formal

assessment.

Choice of religious and secular techniques. My research found inconsistent results on the effectiveness of certain types of counseling techniques or sets of counseling techniques. This may lend some support to the common factors approach to counseling, which downplays the importance of any specific intervention or technique, and focuses more on aspects that are present in most types of counseling. At this point, there is not enough evidence to recommend that certain techniques, religious or secular, should or should not be used in Christian couple counseling. Thus, my recommendation is that counselors use therapeutic judgment to incorporate techniques that align with the clients' preferences and comfort.

Summary

Although the relationship between psychology and religion has historically been tenuous, many researchers now acknowledge the importance of religion and spirituality, and have begun to explore how religion and spirituality might be integrated into the counseling process. The present two studies explored the nature and effectiveness of religiously-tailored counseling from the Christian perspective. A more precise understanding of the effects of such tailoring will improve our understanding of the integration of religion, spirituality, and counseling, as well as inform clinical practice for both religious counselors and counselors who see clients for whom religion and spirituality are important.

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*Indicates a study used in the review of the literature.

Appendix A

Measures Used in Study 1

Demographic Questionnaire (Therapist Form)

Your NAME: ____
Your AGE: ______________________
Your GENDER: Female Male
Your ETHNICITY/RACE: ____
Your RELIGIOUS AFFILIATION: ____

How long have you been doing therapy?
(Include all training and count any portion of a YEAR as a WHOLE year): __________________

What is your highest level of EDUCATION? (indicate one)
PhD/PsyD EdD MD MA/MS MDiv BA/BS

In what field is your TRAINING? (indicate those that apply)
Marital/Family Therapy Medicine Psychology
Rehabilitation Counseling Social Work Theology Other: ______________

What type of couple counseling do you conduct? (indicate one)
Professional counseling Pastoral counseling Lay counseling
Other:_____________________

Would you be open to discussing religion if it came up in couple counseling/therapy? (indicate one)
YES NO

With what percent of your CURRENT marital clients has religion come up since the beginning of therapy?
_____________ Percent

Do you think you would ever use explicit religious practices (e.g., prayer, scripture) in marital therapy?
YES NO

How competent do you assess yourself to be at dealing with a marital client who has a salient religious issue? (indicate one number)

Would Almost Certainly Refer or Consult	1	2	3	4	5	Completely Competent

Experience in Couple Counseling

In your entire career as a counselor, please estimate how many couples have you actually seen in couple therapy, couple enrichment, or premarital counseling (summed together). _
____

Please estimate (as part of the above estimated total) the number of those that were explicitly couple therapy. _____________________

Please estimate (as part of the estimated total of those seen in couple therapy), the ones that were seen conjointly. _______________

Please estimate (as part of the estimated total of those seen in couple therapy), the ones that you would consider Christian couple therapy (that is, involving both partners as Christians and dealing with Christian values or issues explicitly at least once during therapy. _________________

With what percent of your CURRENT marital or couple clients has religion come up since the beginning of therapy? ________________

About what fraction of your clients who work explicitly with you on their marriage or couple problems would you estimate actually break up within a year of the therapy? Please estimate to the nearest 10 %.

I estimate that _________ percent divorce or separate.

RCI-10

DIRECTIONS: Read each of the following statements. Using the scale below, INDICATE the response that best describes how true each statement is for you.

Not at all true of me	*Somewhat true of me*	*Moderately true of me*	*Mostly true of me*	*Totally true of me*
1	*2*	*3*	*4*	*5*

Statement					
1. I often read books and magazines about my faith.	1	2	3	4	5
2. I make financial contributions to my religious organization.	1	2	3	4	5
3. I spend time trying to grow in understanding of my faith.	1	2	3	4	5
4. Religion is especially important to me because it answers many questions about the meaning of life.	1	2	3	4	5
5. My religious beliefs lie behind my whole approach to life.	1	2	3	4	5
6. I enjoy spending time with others of my religious affiliation.	1	2	3	4	5
7. Religious beliefs influence all my dealings in life.	1	2	3	4	5
8. It is important to me to spend periods of time in private religious thought and reflection.	1	2	3	4	5
9. I enjoy working in the activities of my religious affiliation.	1	2	3	4	5
10. I keep well informed about my local religious group and have some influence in its decisions.	1	2	3	4	5

Attitude toward Incorporating Religion in Couple Counseling

Would you be open to discussing religion if it came up in marital or couple therapy? (indicate one)
YES NO

Do you think you would ever use explicit religious practices (e.g., prayer, scripture) in marital or couple therapy?
YES NO

DIRECTIONS: This survey explores religion in marital or couple counseling. Please read each item carefully and respond completely. For items 1-10, use the scale below and INDICATE whether you think the activities below are appropriate in counseling.

	Inappropriate	Neutral	Appropriate
1. Know clients' religious backgrounds.	(I)	(N)	(A)
2. Pray with a client during a session.	(I)	(N)	(A)
3. Pray privately for a client between sessions.	(I)	(N)	(A)
4. Use religious language or concepts during counseling/therapy.	(I)	(N)	(A)
5. Recommend client use of religious or spiritual books.	(I)	(N)	(A)
6. Recommend client participation in religion.	(I)	(N)	(A)
7. Discuss forgiveness of each other in couple counseling.	(I)	(N)	(A)
8. Promote apologies during couple counseling.	(I)	(N)	(A)
9. Discuss forgiveness by God during couple counseling.	(I)	(N)	(A)
10. Discuss forgiveness of oneself for a partner who seems to have excessive guilt.	(I)	(N)	(A)

Use of Theory in Couple Counseling

How important is it to you that you have been actually trained (in workshops, courses, or a full training program) in a particular type of marital or couple therapy approach? (indicate one)

Totally unimportant	Unimportant	Neither unimportant nor important	Important	Totally important

DIRECTIONS: We are interested in which theories and theorists of marriage or couple counseling have been most influential in your practice of marriage or couple counseling. For each theory, please use the scale below to indicate how influential that theory is in informing your practice of Christian marriage or couple counseling.

	Not at all Influential (1)	Mildly Influential (2)	Moderately Influential (3)	Influential (4)	Strongly Influential (5)
1. Behavioral Couples Therapy (Jacobson, Gottman, etc.)	1	2	3	4	5
2. Integrative Behavioral Couple Therapy (Acceptance; Christensen & Jacobson)	1	2	3	4	5
3. Insight-Oriented Couple Therapy (Snyder)	1	2	3	4	5
4. Cognitive-Behavioral Couple Therapy (Baucom)	1	2	3	4	5
5. Emotion-Focused Couple Therapy (Johnson & Greenberg)	1	2	3	4	5
6. Christian Couple Counseling (Clinton)	1	2	3	4	5
7. Solution-Focused Couple Therapy (Weiner-Davis; deShazer; etc.)	1	2	3	4	5
8. Systems Therapy (Minuchin, Haley, Madanes, other)	1	2	3	4	5
9. Hope-Focused Couple Therapy (Worthington)	1	2	3	4	5
10. PREP (Markman; Stanley)	1	2	3	4	5
11. Relationship Counseling (Parrott)	1	2	3	4	5
12. Interpersonal Communication Program (Miller)	1	2	3	4	5
13. Relationship Enhancement (Guerney)	1	2	3	4	5

Appendix B

Additional Measures Used in Study 2

Demographics (Client Form)

What is your name? ____
What is your partner's name? ____
What is your therapist's name? ____
Your AGE: ________________________
Your GENDER: Female Male
Your ETHNICITY/RACE: ____
Your RELIGIOUS AFFILIATION: ____
Your MARITAL status: ____
Have you ever been divorced? (indicate one) Yes No
Please indicate your reason(s) for seeking therapy at this time (indicate all that apply):

Marital/Couple Difficulties	Child/Family Problems	Depression
Anxiety	Alcohol/Drug Problems	Sexual Problems
Physical Difficulties	Spiritual Concerns	Career Concerns
Nonfamily Interpersonal Problems	OTHER (please specify): __________________________	

Ratings of the Therapist's Interventions in Couple Counseling (Client Form)

DIRECTIONS: First, think about the last session you had with your therapist. For each of the following activities, please indicate whether it occurred in the SESSION YOU JUST COMPLETED. Second, think about the past four sessions you have had with your therapist. For each activity, please estimate the amount of time that activity occurred, on a scale from 1 = *never occurred,* to 5 = *occurred every session.*

Did the activity occur in the last session?	**Yes (Y)**	**No (N)**	**Please estimate how often the activity has occurred over the past four sessions:** **1 = Never occurred** **2 = A few of the sessions** **3 = About half the sessions** **4 = Most of the sessions** **5 = All the sessions**
1. Our therapist focused on changes in our marital/couple behavior.	Y	N	1 2 3 4 5
2. We discussed self-forgiveness	Y	N	1 2 3 4 5
3. Our therapist focused on our thoughts/beliefs.	Y	N	1 2 3 4 5
4. Our therapist prayed with me, my partner, or us as a couple during the session.	Y	N	1 2 3 4 5
5. Our therapist told us this week that he or she has prayed for me, my partner, or us outside of counseling.	Y	N	1 2 3 4 5
6. Our therapist actually quoted or referred to scripture/sacred writings at some time during the session.	Y	N	1 2 3 4 5
7. We discussed either my own or my partner's childhood experiences during the session.	Y	N	1 2 3 4 5
8. We discussed forgiveness *by God* for myself or my partner.	Y	N	1 2 3 4 5
9. Our therapist discussed our relationship with him or her.	Y	N	1 2 3 4 5
10. Our therapist assigned either me, my partner, or both of us together religious tasks (like praying, reading scripture, or going to church) to do outside of the therapy hour between two sessions.	Y	N	1 2 3 4 5
11. We focused on the solution(s) to our couple problems.	Y	N	1 2 3 4 5
12. We discussed either my own	Y	N	1 2 3 4 5

forgiveness of my partner or my partner's forgiveness of me.			
13. One or both of us apologized for wronging the other, actually saying the word "sorry" or "I apologize" or something similar.	Y	N	1 2 3 4 5
14. Our therapist focused on our emotions.	Y	N	1 2 3 4 5
15. We had a discussion about religious faith.	Y	N	1 2 3 4 5

Dyadic Adjustment Scale-4

How often do you discuss or have you considered divorce, separation, or terminating your relationship? (indicate one)

1	2	3	4	5
All the Time	Most of the Time	Sometimes	Hardly Ever	Never

In general, how often do you think that things between you and your partner are going well? (indicate one)

1	2	3	4	5
All the Time	Most of the Time	Sometimes	Hardly Ever	Never

Do you confide in your partner? (indicate one)

1	2	3	4	5
All the Time	Most of the Time	Sometimes	Hardly Ever	Never

Please describe the degree of happiness in your relationship? (indicate one)

1	2	3	4	5
Very Unhappy	Somewhat Unhappy	Fairly Happy	Mostly Happy	Very Happy

Working Alliance Inventory-Bond Subscale (Short Form)

DIRECTIONS: Read each of the following statements. Using the scale below, INDICATE the response that best describes your feelings about counseling.

	Strongly Disagree (1)	Disagree (2)	Mildly Disagree (3)	Agree and Disagree Equally (4)	Mildly Agree (5)	Agree (6)	Strongly Agree (7)
1. I believe my counselor likes me.	1	2	3	4	5	6	7
2. I am confident in my counselor's ability to help me.	1	2	3	4	5	6	7
3. I feel that my counselor appreciates me.	1	2	3	4	5	6	7
4. My counselor and I trust one another.	1	2	3	4	5	6	7

Client Satisfaction Questionnaire (CSQ-8)

DIRECTIONS: Please answer the following questions about the counseling you have received. We are interested in your honest opinions, whether they are positive or negative. Please circle your answer. Remember, this information is confidential and will not be viewed by your counselor.

1. How would you rate the quality of counseling you have received?

4	3	2	1
Excellent	Good	Fair	Poor

2. **Did you get the kind of counseling you wanted?**

1	2	3	4
No, definitely	No, not really	Yes, generally	Yes, definitely

3. **To what extent has counseling met your needs?**

4	3	2	1
Almost all of my needs have been met	Most of my needs have been met	Only a few of my needs have been met	None of my needs have been met

4. **If a friend were in need of similar help, would you recommend this counselor to him or her?**

1	2	3	4
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

5. **How satisfied are you with the amount of help you have received?**

1	2	3	4
Quite dissatisfied	Indifferent or mildly dissatisfied	Mostly satisfied	Very satisfied

6. **Has the counseling you received helped you to deal more effectively with your problems?**

4	3	2	1
Yes, they helped a great deal	Yes, they helped	No, they really didn't help	No, they seemed to make things worse

7. **In an overall, general sense, how satisfied are you with the counseling you have received?**

4	3	2	1
Very satisfied	Mostly satisfied	Indifferent or mildly dissatisfied	Quite dissatisfied

8. **If you were to seek help again, would you come back to this counselor?**

1	2	3	4
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

Vita

Joshua Nord Hook was born on January 25, 1983, in Highland Park, Illinois. He is a United States citizen. He graduated from Lake Zurich High School, Lake Zurich, Illinois in 2001. He received his Bachelor of Science in Psychology from the University of Illinois at Urbana-Champaign in 2005, where he graduated Summa Cum Laude. He received his Master of Science in Counseling Psychology from Virginia Commonwealth University, Richmond, VA in 2007.