

Effectiveness of religiously tailored interventions in Christian therapy

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Abstract

Christian therapy is sought by many clients, yet the existing research examining its effectiveness is sparse. Clients ($n = 220$) and their therapists ($n = 51$) in 6 Christian agencies and 1 secular agency across the United States participated in a study of Christian therapy. Clients and therapists in Christian therapy generally believed that religiously tailored interventions were appropriate. Clients in Christian therapy and secular therapy reported feeling equally close to their therapists and equal (and appreciable) improvements in their presenting problems over time. Compared with therapists in the secular agency, those in Christian agencies used secular interventions as frequently and religious interventions more frequently. Across all agencies, clients with high religious commitment reported greater closeness with their therapists and greater improvement in their presenting concerns when receiving religious interventions than did clients with low religious commitment.

Religion and spirituality are important to many people seeking psychotherapy (Rose, Westefeld, & Ansley, 2001; Sperry & Shafranske, 2005). The growing literature investigating religion, spirituality, and psychology often cites the large majority of Americans who report a belief in a personal God (about 90%; Gallup Organization, 2005; Griffith & Griffith, 2002; Richards & Bergin, 2000), profess some religious affiliation (approximately 90%; Gallup Organization, 2001; Richards & Bergin, 2000), and report that their religion is very important to them (59%, Gallup Organization, 2001). Furthermore, many individuals use religious methods, such as prayer or religious reframing, to cope with difficulty in their lives (Koenig, 1995; Pargament, 1997).

These findings, however, are not necessarily reflected throughout the world. For example, in some parts of the world religious belief and religious service attendance is much lower. Of the 10 countries in the world with the largest proportion of atheists (40–85%), 7 are in Europe; of the top 50, 28 are on the European continent (Zuckerman, 2005). In Australia the percentage of adherents to religion is also lower than in the United States but not by the same margin as Europe, with more than 75% claiming some religious affiliation (Humphreys & Ward, 1995). In other parts of the world, religious belief is equal to or greater than that in the United States. For example, in parts of Asia (e.g., Thailand,

Cambodia) and the Middle East (e.g., Bahrain, Kuwait), the population of religious adherents approaches 100% (Adherents.com, 2005).

These findings suggest that clients in the United States and in other parts of the world are likely to have some affiliation with religion and may seek support through their religious or spiritual beliefs, practices, and experiences. Therefore, many of these clients may desire religious content to be a part of their therapy. A survey of 74 individuals in a variety of mental health settings in the Midwest supports this conclusion (Rose et al., 2001). The majority of these individuals reported that they felt it was appropriate for therapists to discuss religious and spiritual concerns (63%) and preferred that their therapists do so (55%). Only a minority of these clients (18%) explicitly reported that they would prefer not to have religious interventions used in therapy for reasons ranging from being not religious to preferring the expertise of a minister.

Johnson and Hayes (2003) reported the prevalence rates of religious and spiritual concerns in a sample of 5,472 college students throughout the United States. For the total sample, which included those who had sought counseling and those who had not, 26% reported at least a moderate amount of distress from religious or spiritual problems. The prevalence of religious and spiritual concerns was smaller, but still considerable (19%), in the

subgroup of students who had sought services at university counseling centers ($n = 2,754$).

Given the importance of religion and spirituality in the lives of many clients and the desire to address these issues in therapy, the need for therapists to be open and sensitive to their clients' religious or spiritual lives is crucial. This was first suggested by Bergin (1980) in his landmark article on religion and values in therapy. Since then, psychotherapists and other mental health professionals have been encouraged to attend to the diverse ways that clients experience the religious or spiritual domain and to how those beliefs, practices, and experiences facilitate or hinder healing. This message of religious sensitivity has been heard in clinical psychology (Richards & Bergin, 1997), counseling psychology (Worthington et al., 2003), clinical social work (Northcut, 2000), family therapy (Carlson, Kirkpatrick, Hacker, & Killmer, 2002), and school counseling (Sink & Richmond, 2004). These authors from across subfields of professional psychology and allied professions agree that ethical and culturally sensitive therapy should include an awareness of the religious and spiritual values of clients.

Research suggests that there is some agreement among therapists that religious and spiritual issues can be integrated into therapy (Carlson et al., 2002; Richards & Potts, 1995). Both therapists chosen for their religious affiliation (e.g., Mormons; Richards & Potts, 1995) and therapists chosen without regard for religiosity (e.g., members of the American Association of Marital and Family Therapists; Carlson et al., 2002) agree that some religious and spiritual interventions, such as silent prayer for clients and discussions of spiritual experiences, are appropriate to use in therapy. They also appear to agree that some religious interventions should not be used, such as praying with a client or suggesting that the client join or leave a religion. This general agreement, however, should not be misinterpreted to mean that all agree. Certainly, the specifics of what religious and spiritual interventions are and are not appropriate in psychotherapy are still being debated.

Effectiveness of Religiously Tailored Interventions

The term *religiously tailored intervention* is intentionally broad, including many different efforts to attend to religious and spiritual issues in therapy. It can include a technique as general as asking clients about their spiritual experiences or an intervention as specific as a ritual or practice based on a particular religious worldview (e.g., praying the Christian Lord's Prayer or teaching Zen Buddhist meditation).

The current research on religiously tailored interventions appears to indicate that clients are interested in religious and spiritual interventions, and therapists believe that at least some, but certainly not all, of these interventions are appropriate to use in therapy. Although these are important findings, they do not address whether these interventions are actually effective. Regardless of whether clients desire them or therapists see them as appropriate or ethical, if religious and spiritual interventions are not effective (or, worse, are harmful), then serious questions need to be raised about their use in a course of treatment.

Some limited empirical studies have explored the efficacy of religiously tailored interventions. One review and meta-analysis explored nine studies that compared traditional therapies (often behaviorally oriented) with the same treatment accommodating a Christian worldview (Worthington & Sandage, 2002). On the basis of their results, Worthington and Sandage claimed that the religious-integrated therapy examined in the studies seemed to be as efficacious as traditional therapy. However, they argued that, because of design and other limitations, conclusions should remain tentative. These limitations included the small number of studies, the small number of participants in each study, the use of only cognitive-behavioral therapies (CBTs; mostly to treat depression), and the lack of actual clients seeking treatment. They also agreed that future research should address process-related variables, such as the quality of the client-therapist relationship and how therapist and client characteristics relate to in-session behaviors. Furthermore, they asserted that "effectiveness studies are sorely needed" to determine whether these effects are applicable to actual therapy as it is practiced in the field (p. 477).

Although efforts to investigate religiously tailored interventions as specific ingredients of change appear to support their efficacy, this research is limited by the same constraints as research on other specific ingredients in traditional psychotherapy. As Wampold (2001) argues, research on the efficacy of specific ingredients cannot control for the efficacy of common factors, such as a therapeutic relationship with a trusted expert, hope in the treatment, and so on. Thus, in research comparing religiously tailored interventions with traditional interventions, similarities in treatment may result from common factors that both types of interventions promote rather than from the specific interventions themselves. Thus, it might be that a religiously tailored intervention (the specific ingredient) helps a religious client to feel more trusting, leading to a closer therapeutic bond (the common factor) and eventually to better

outcomes. This is in line with theory (Frank, 1982; Rosenzweig, 1936) and research (see Wampold, 2001) indicating that the truly curative factors in psychotherapy appear to be factors common to all treatments. Given this conclusion, some have argued that research on specific ingredients should be redirected toward the exploration of variables that promote or inhibit the common factors (e.g., Ahn & Wampold, 2001).

Effectiveness of Religious Matching

One potentially fertile area in the investigation of common factors is the match between therapist and client. In the area of religiously tailored interventions, the effectiveness of the similarity of religious commitment between a client and therapist has received some empirical attention. Houts and Graham (1986) found an interaction effect between therapist and client religiosity on therapists' type of attribution for a fictitious client's difficulty. Religious therapists made more internal attributions for the nonreligious client's problem, whereas nonreligious therapists made more internal attributions for the problems of the very religious client. However, there were no systematic differences in ratings of prognosis or psychological disturbance between the religious and nonreligious therapists. This coincides with results from an earlier study of similar design that found no differences between religious and nonreligious therapists in ratings of a fictitious client (portrayed as religious or not) regarding attractiveness, diagnosis, or prognosis (Lewis & Lewis, 1985).

Both of these studies examined the therapists' perceptions and evaluations of clients, but this may miss a crucial element in therapy: the importance of the client's perceptions. Worthington (1988) proposed a theoretical model with two principal propositions that attempts to explain this importance. First, highly religious clients tend to use religious evaluations more often than clients of moderate or low commitment. Second, because of this tendency to make religious evaluations, religious matching would affect the process, perceptions, and outcome of therapy for the highly religiously committed more than the less religiously committed. In a study of 36 client-therapist dyads, Kelly and Strupp (1992) provided some empirical evidence for this hypothesis. They found that greater similarity between therapists and clients on the value placed on salvation (which may be an approximation of religious commitment similarity) was positively correlated with more client improvement as rated by independent clinicians. As a result, Kelly and Strupp suggested that "patient-therapist similarity on religious values may function as a *matching variable*"

(p. 39), promoting better outcomes when the match is greater.

These results were similar to those of a study investigating the experience of 30 clients in therapy at a university counseling center (Martinez, 1991). In that study, both client and therapist reports of improvement were positively related to clients having more theologically conservative therapists than themselves. Thus, clients whose values were more theologically conservative than their therapists' values improved less. These results suggest that less religiously conservative clients do well with either conservative or liberal therapists, whereas more religiously conservative clients do better with religiously conservative therapists. This supports Worthington's (1988) claims that religious matching will be most important to clients with high religious commitment to the degree that conservative religious values were related to religious commitment in this sample, as has been found elsewhere (e.g., Duriez, 2003).

Propst, Ostrom, Watkins, Dean, and Mashburn (1992) compared religiously integrated and traditional CBT with 59 Christian individuals from the community. They found that the religiously integrated CBT was more effective for reducing symptoms of depression than the other treatments, indicating that Christian participants might respond best to religiously tailored interventions. Therapists' religious orientation was not disclosed to the participants. The therapists merely followed the manuals for each condition. Nevertheless, participants who worked with the nonreligious therapists (providing Christian CBT) improved significantly more than those working with religious therapists. In contrast to the research cited previously, this suggests that correspondence in religious commitment itself may not be the most important factor, but that the interventions congruent with the client's religiosity might be more relevant.

Current Study

Most of the research just discussed has investigated the efficacy of religiously tailored interventions as they occur in explicitly Christian therapy, indicating that at least in controlled studies of nonclients these interventions appear to be beneficial. However, little is known about the effectiveness of Christian therapy as it is practiced with clients in actual agencies. This is a serious limitation if for no other reason than the frequency with which explicitly Christian therapy is practiced in the United States (Wylie, 2000). Each year a large clientele specifically seeks this form of treatment. Therefore, an important next step for research in this area is to explore the impact of

religiously tailored interventions on the perceptions and outcome of Christian therapy as it is practiced in the field.

However, exploring Christian therapy empirically is complicated because there appears to be no clearly demarcated form of Christian therapy. It is defined variously as treatment offered by a therapist who is Christian, therapy using methods consistent with a Christian worldview, therapy using Christian practices such as prayer, or therapy that advertises itself as explicitly Christian. However, Christian therapy in general appears to share at least two characteristics: (a) It is labeled as explicitly Christian in orientation by the therapist or agency despite the fact that it may use many or a few techniques that are explicitly tailored to Christians (e.g., reading Scripture, praying), and (b) it attempts to provide clients who profess a commitment to Christianity with therapists who share that conviction. As a result, we have used these two characteristics to define Christian therapy for the purpose of this investigation. We note that, according to our definition, the therapists might or might not (a) self-identify as Christians (although it is reasonable to suspect that most will) or (b) use techniques that are explicitly tailored to Christians (e.g., quoting the Bible, praying).

To build on previous findings, we first examined the degree to which therapists rate as appropriate and use religiously tailored interventions in Christian (vs. secular) therapy and the degree to which their clients are comfortable with these interventions. We expected that therapists conducting Christian therapy would believe that religiously tailored interventions are appropriate and use them frequently, more so than therapists conducting secular therapy. We also expected that their clients would express comfort with these interventions. Next, we examined whether Christian therapy would be reported to be effective in an actual client population. On the basis of the previous laboratory research, we hypothesized that Christian therapy would be positively rated by clients and expected that it would be as effective as secular therapy. Finally, we examined whether the similarity between client and therapist on religious commitment would be related to the perceptions of closeness with the therapist and client-rated change in presenting problem. We hypothesized that greater correspondence between client and therapist on religious commitment would be related to greater closeness and more change when relationship-congruent (i.e., religious interventions in high religious dyads) rather than relationship-incongruent interventions were used. To understand the findings about Christian therapy in context, we have also provided a comparison sample from one

secular agency. This agency is not intended to represent all of secular therapy but is used primarily as a backdrop for understanding the unique aspects of the Christian therapy that we investigated.

Method

Participants

Participants included 220 clients and 51 therapists. Clients were predominantly Caucasian ($n=177$ [80.5%]; 24 African Americans [10.9%]; 6 Asian Americans [2.7%]; 4 Hispanics [1.8%]; 9 other [4.1%]) and female ($n=155$ [70.5%]; 62 males [28.2%]; 3 [1.3%] did not respond). The average age of the clients was 35.5 years ($SD=12.2$, range = 14–74). Clients reported a range of presenting concerns. Depression (48%), marital–couple difficulties (43%), child–family problems (30%), and anxiety (30%) were the most common reasons for seeking therapy. Most clients ($n=127$ [58%]) reported that two or more problems had brought them to therapy.

Therapists were also predominantly Caucasian ($n=48$ [94.1%]; 2 African Americans [3.9%]; 1 [1.9%] did not respond) and female ($n=37$ [72.5%]; 14 men [27.5%]). The average age of the therapists was 37.2 years ($SD=11.8$, range = 23–61). The majority of therapists were master's level ($n=32$ [63%]); some held doctoral degrees ($n=5$ [10%]), and others were in training for their master's or doctorate ($n=14$ [27%]). (Note that all trainees practiced as part of their training and were supervised by licensed mental health professionals.) The majority of therapists were (or were being) trained in the field of psychology ($n=23$ [45.1%]) or marital and family counseling ($n=17$ [33.3%]). The other therapists represented the fields of social work ($n=6$ [11.8%]), pastoral counseling, ($n=4$ [7.8%]), and rehabilitation counseling ($n=1$, [2%]).

Measures

Demographic questions. Both therapists and clients answered questions about age, ethnicity, and gender. In addition, therapists responded “yes” or “no” to whether “they would be open to discussing religion if it came up in therapy” and whether they “would ever use explicit religious practices (e.g., prayer, scripture) in therapy.” Clients indicated from a list of 10 common problems (plus an “other” category) which problems were their “reason(s) for seeking therapy.” Clients also responded “yes” or “no” to whether they believed that their therapists (a) were “committed to a formal religion” and (b) were “open to discussing religion if it came up.” Finally, clients

responded “yes” or “no” to whether religion had ever been discussed in their therapy sessions.

Religious Commitment Inventory-10 (RCI-10; Worthington et al., 2003). Clients and therapists completed the RCI-10, a 10-item scale that measures commitment to one’s religion. Each item is rated using a 5-point Likert scale (1 = *not at all true of me*, 5 = *totally true of me*). Sample items include “My religious beliefs lie behind my whole approach to life” and “I often read books and magazines about my faith.” In previous research using various samples of university students ($N_s = 155, 132,$ and 468), the normative means for the RCI-10 were 23.6 ($SD = 10.8$), 25.7 ($SD = 11.9$), and 22.8 ($SD = 10.5$), respectively. Normative data were similar for adults from the community and for clients and therapists (see Worthington et al., 2003). Across several studies, the RCI-10 exhibited strong estimated internal reliability (all Cronbach’s $\alpha_s > .92$). Test–retest reliability was also adequate (3 week = .87). The RCI-10 has shown evidence of construct validity, being strongly correlated with other measures of religious commitment, beliefs, and spirituality (Worthington et al., 2003). For the current sample, the RCI-10 had a high estimated internal reliability (Cronbach’s $\alpha = .96$).

Ratings of individual interventions (client form). A list of 13 interventions was created for the purpose of this research project. Religiously tailored interventions were chosen from a list compiled through a literature review of studies investigating religious interventions in therapy.¹ Seven of the most frequently investigated religiously tailored interventions were chosen. Nathaniel G. Wade and Everett L. Worthington, Jr., in consultation with an experienced therapist, created a list of six interventions that they considered typical interventions in secular or traditional psychotherapies to use as a comparison. To validate the distinction between these types of interventions (religious vs. secular), five practicing therapists, who were recruited through peer nomination as experts in religious–spiritual issues in therapy, provided ratings. They had an average of 22.8 years of therapy experience (range = 9–40 years). Four self-identified as Christian and one self-identified as an atheist–agnostic. The therapists categorized the interventions as clearly religious, clearly not religious, or ambiguous. Five of the seven hypothesized religious interventions were clearly identified as religious by the therapists. The other two interventions (“discussed forgiveness of self” and “discussed forgiving others”) received mixed ratings and were not reliably distinguished from the secular interventions. Five of the six secular interventions were

distinguished from the religious interventions. One, “focused on thoughts and beliefs,” received mixed ratings that did not distinguish it from the religious interventions. The use of the term *beliefs*, although intended to measure CBT-oriented interventions, was most likely confused with religious beliefs. Although data regarding these three ambiguous interventions are reported in the tables, because they were not clearly categorized, they were not included in analyses that compare interventions as a group (religious or secular).

Completing this rating form was a two-step process. First, clients identified from the list of 13 interventions only those that occurred in the just-completed session. Second, using a 5-point Likert scale (0 = *very uncomfortable*, 5 = *very comfortable*), they rated their comfort with only those interventions that had just occurred, leaving the other items blank. Each item was then analyzed separately. This allowed us to assess both the frequency of and comfort with the use of the individual interventions.

Ratings of individual interventions (therapist form). To understand the general attitudes of the therapists, we asked therapists to rate the appropriateness of six religious–spiritual interventions (adapted from the clients’ list and a review of the research literature). Therapists rated each of the six interventions on a 3-point Likert scale (1 = *inappropriate*, 3 = *appropriate*). Unlike the clients, therapists rated all the interventions regardless of whether they had just used them. Therefore, therapists rated their potential or general practices as possible future events rather than specific interventions that had just occurred.

Closeness with therapist. To assess the closeness of the client–therapist relationship (from the client’s perspective), we asked clients, “How close do you feel to your therapist?” Clients rated closeness with their therapists on a 7-point Likert scale (1 = *not at all close*, 7 = *very close*). We conducted a separate study to evaluate the validity of our one-item measure. Fifty clients, mostly female ($n = 35$ [70%]) young adults (age range = 17–32 years; $M = 22.6$, $SD = 3.5$), in individual therapy at a university counseling center completed our measure of client-perceived closeness ($M = 4.9$, $SD = 1.1$, range = 1–7) and the Working Alliance Inventory–Short Form (WAI-SF; Tracey & Kokotovic, 1989; $M = 69.3$, $SD = 10.7$, range = 46–84). Evidencing construct validity, the one-item measure of closeness with therapist was significantly correlated with general working alliance ($r = .67$, $p < .001$) and with the three subscales of the WAI-SF: Bond ($r = .66$, $p < .001$), Tasks ($r = .65$, $p < .001$), and Goals ($r = .56$,

$p < .001$). Supporting criterion-related validity, closeness with therapist was also associated with the number of sessions the client had completed ($r = .39$, $p < .001$).

Temple Scale of Relative Change (Sloane, Staples, Cristol, Yorkston, & Whipple, 1975). Clients rated the amount of relative change (called client-rated change) in the presenting problems since the beginning of psychotherapy on a 13-point scale (0 = *very much worse*, 6 = *no change*, 12 = *very much better or completely recovered*). The Temple Scales of Relative Change and Absolute Severity (see later discussion) were developed for an efficacy study comparing psychotherapy and behavior therapy. Ratings on these measures were effective in differentiating changes made by clients in treatment from control clients and were correlated with (a) longer measures of client-reported change in therapy, (b) assessments by an independent assessment team, and (c) therapist assessment of change (Sloane et al., 1975). Thus, we chose this measurement of severity because there was evidence of validity, and there was a need to use brief instruments to maximize participation and limit the demand on the resources of the participating agencies.

Temple Scale of Absolute Severity of Problems (Sloane et al., 1975). Clients rated the severity of their problems currently (called current severity) and retrospectively at the time they began therapy (called beginning severity) on single-item scales (0 = *absent*, 1 = *doubtful or trivial*, 2 = *mild*, 3 = *moderate*, 4 = *severe*). As with relative change, we chose this measurement because there was evidence of validity and a need to use brief scales.

Procedure

Clients and therapists were recruited from seven agencies from various regions of the United States. Six of these agencies were explicitly Christian in orientation but were open to clients with any or no religious orientation.² (Such arrangements are typical. Often, clients, as part of informed consent, are asked whether they wish to include or exclude specifically Christian topics from therapy.) One agency unaffiliated with any religion was used as a reference group. This secular agency, although not intended to be representative of all the varieties of secular psychotherapeutic practice, allowed us to (a) determine whether a separate distinction of Christian therapy was valid and (b) make some tentative comparisons between secular and Christian therapy. Because the secular agency was a counseling center, we split the Christian agencies into two groups for all

analyses: counseling centers and private practices. This allowed us to determine whether any effects might be due to type of setting (counseling center vs. private therapy) rather than religious affiliation (explicitly Christian vs. not).

Participating Christian agencies were solicited through advertisements and announcements made at four regional and national conferences throughout the United States in 1998 and 1999. Directors or therapists from nine agencies took registration forms, of which six eventually participated (resulting in a 66% participation rate). Nathaniel G. Wade contacted the director of interested agencies and determined whether the agency advertised itself as an explicitly Christian counseling center or practice and attempted to provide their Christian clients with therapists who shared that worldview. He then arranged for participation with an agency contact. Because we were primarily interested in therapy at Christian agencies, we only contacted two secular agencies with which we were affiliated (one counseling center and one community agency) that did not conduct explicitly Christian therapy. Although both originally agreed to participate, only one therapist and one client participated from the community agency. As a result, we could not ensure anonymity of their responses and so we disregarded their data, leaving us with one secular comparison agency.

Each agency designated 1 week for data collection. Therapists at each agency who volunteered to participate completed a single-page questionnaire (see Measures section). At the end of their session on the designated week, these therapists offered their clients the opportunity to participate in a research project that "investigates how a number of client characteristics are related to counseling." Clients of participating therapists were informed that their individual anonymous responses would be sent to a research team in Virginia and individual results would not be communicated to the agency or therapist. Clients completed a two-page survey, including demographics, religious commitment, their ratings of therapy, and questions about the use and appropriateness of religious interventions used in the session they just completed (see Measures section). Clients did not identify themselves by name but did indicate the name of their therapist, which was used to match clients and their therapists for later analyses. Clients sealed their anonymous responses in an envelope and placed the envelope in a research collection box provided by the agency. These were then mailed (unopened) to Nathaniel G. Wade. The therapists' surveys (not anonymous) were also mailed within sealed envelopes, and no individual reports concerning clients or therapists were given as feedback to the agency.

The participation of therapists in Christian counseling centers was 23 of 30 (77%); in Christian private practices, 10 of 11 (91%); and in the secular counseling center, 18 of 28 (64%). We were unable to calculate participation rates among clients because we did not have access to the total number of clients seen by the participating therapists during the measurement week nor were we informed of the number of clients who were offered the chance to participate by their therapists.

Results

Descriptive data of client and therapist characteristics and the main variables explored are provided in Table I. Data are presented for both the total sample and for the separate types of agency.

Religiously Tailored Interventions

Our first goal was to determine the degree to which therapists report and clients perceive that the therapists are willing to discuss religion, that therapists believe that the use of specific religious interventions

are appropriate, and that clients are comfortable with these interventions. We expected that therapists conducting Christian therapy would believe that religiously tailored interventions are more appropriate and use them more frequently than would therapists conducting secular therapy. We also expected that their clients would be more comfortable with these interventions than would clients in secular therapy.

Willingness to discuss religion. Frequencies of clients' and therapists' responses to questions assessing openness to religious discussions were tabulated. The question, "Would your therapist (you) be open to discussing religion if it came up?" was broadly endorsed by clients in the secular counseling center (83%, $n = 40$). In Christian therapy, endorsement was virtually unanimous (98.5% [$n = 67$] for Christian counseling centers and 100% [$n = 103$] for Christian private practices). All therapists (100%) reported that they would be open to discussing religion. In many cases, clients reported that religion had been discussed "since the beginning of therapy"

Table I. Descriptive Statistics of Participant and Therapy Characteristics Across Agency Types.

Variable	Total sample	Christian counseling centers	Christian private practices	Secular counseling center
No. clients	220	69	103	48
No. therapists	51	23	10	18
RCI-10 clients				
$M \pm SD$	33.7 \pm 12.5	34.8 \pm 11.0	38.5 \pm 12.5	21.4 \pm 11.7
Range	10–50	11–50	10–50	10–49
Therapists				
$M \pm SD$	38.7 \pm 12.4	46.2 \pm 4.2	45 \pm 5.0	25.5 \pm 11.3
Range	10–50	34–50	36–50	10–50
Therapists' years of therapy experience				
$M \pm SD$	5.4 \pm 6.9	4.1 \pm 6.8	8.5 \pm 7.4	5.3 \pm 6.7
Range	0.5–25	0.5–25	1–22	0.6–24
No. sessions reported by clients ^a				
$M \pm SD$	17.7 \pm 26.8	15.6 \pm 21.9	20.6 \pm 32.5	14.5 \pm 18.4
Range	1–182	2–124	1–182	1–105
Beginning severity of problem				
$M \pm SD$	3.5 \pm 0.7	3.5 \pm 0.8	3.6 \pm 0.5	3.3 \pm 0.7
Range	0–4	0–4	2–4	1–4
Current severity of problem				
$M \pm SD$	2.8 \pm 0.8	2.7 \pm 0.9	2.8 \pm 0.8	2.8 \pm 0.6
Range	0–4	0–4	0–4	1–4
Perceived closeness with therapist				
$M \pm SD$	5.4 \pm 1.1	5.7 \pm 1.0	5.4 \pm 1.0	5.0 \pm 1.2
Range	2–7	3–7	3–7	2–7
Client-rated change				
$M \pm SD$	2.5 \pm 1.9	2.4 \pm 2.1	2.7 \pm 1.8	2.0 \pm 1.5
Range	–5.0 to 6.0	–4.0 to 6.0	–5.0 to 6.0	–3.0 to 4.0

Note. RCI-10 = Religious Commitment Inventory-10.

^aThree respondents reported a number of sessions that were more than 4 SDs away from the mean and were deleted from all analyses that included the number of sessions as a variable.

(37.5% for secular counseling center; 86.8% for Christian counseling centers; 94.2% Christian private practices).

Appropriateness of the use of six religious interventions. Therapists rated the appropriateness of using each of six religious interventions in therapy. Frequencies of responses by agency type are reported in Table II. Contingency tables were created and chi-square statistics calculated to determine whether therapists across agency types reported different levels of appropriateness of religious interventions. All religious interventions were rated as significantly different in terms of appropriateness by the therapists in the three types of agencies except for “knowing about the client’s religious background.” For the other five religious interventions, therapists in the Christian counseling centers and practices reported that they were more appropriate to use than did therapists in the secular counseling center (see Table II).

Comfort with the use of different interventions. Clients were asked to rate their comfort with the specific religious, secular, and other interventions that were used in their just-completed therapy session.³ We calculated the mean level of comfort with the use of

the specific interventions across the three agency types (Table III). One-way analyses of variance were computed on each of the 12 interventions to determine whether clients in the three different settings reported different mean levels of comfort with the interventions. For all of the religious interventions, clients from the secular counseling center were significantly less comfortable than were clients from either Christian counseling centers or Christian private practices (see Table III for *F* values). There were no significant differences in comfort ratings between clients at the two types of Christian agencies. Clients across the agencies reported no significant differences in their comfort with the secular interventions. Clients in the Christian counseling centers and private practices reported more comfort with discussions of forgiving themselves than did clients in the secular agency.

Frequency of the use of religious and secular interventions. Because clients only reported their comfort with interventions that had just occurred in their last session, we were also able to calculate the frequency with which these interventions occurred across settings. Frequencies of the use of religious, secular, and other interventions were tabulated for each client (Table IV).

Table II. Therapists’ Ratings of the Appropriateness of Using Each of Six Religious and Spiritual Interventions in Therapy.

Intervention/T response ^a	Christian counseling centers	Christian private practices	Secular counseling center	Total	χ^2	Cramer’s <i>V</i>
Know client’s religious background					1.61(2)	.18
Inappropriate	0.0	0.0	0.0	0.0		
Neutral	4.3	0.0	11.1	5.9		
Appropriate	95.7	100.0	88.9	94.1		
Pray with client					31.21*(4)	.55
Inappropriate	0.0	0.0	44.4	15.7		
Neutral	21.7	0.0	44.4	25.5		
Appropriate	78.3	100.0	11.2	58.8		
Pray privately for a client					17.39*(4)	.41
Inappropriate	0.0	0.0	11.1	3.9		
Neutral	0.0	0.0	33.3	11.8		
Appropriate	100.0	100.0	55.6	84.3		
Use religious language or concepts					13.80*(4)	.37
Inappropriate	0.0	0.0	11.1	3.9		
Neutral	4.3	10.0	38.9	17.6		
Appropriate	95.7	90.0	50.0	78.4		
Recommend religious or spiritual books					17.72*(4)	.42
Inappropriate	0.0	0.0	22.2	7.8		
Neutral	13.0	0.0	38.9	19.6		
Appropriate	87.0	100.0	38.9	72.5		
Recommend participation in religion					22.28*(4)	.47
Inappropriate	4.3	10.0	44.4	19.6		
Neutral	17.4	0.0	38.9	21.6		
Appropriate	78.3	90.0	16.7	58.8		

^a*N* = 51 (23 Christian counseling centers, 10 Christian private practices, 18 secular counseling center). T = therapist.

**p* < .008, the Bonferroni-corrected alpha level for these analyses.

Table III. Client-Rated Comfort With the Interventions Used in the Just-Completed Session.

Variable	Christian counseling centers	Christian private practices	Secular counseling center	ANOVA <i>F</i>	Partial η^2
Religious interventions					
Pray with or for client	4.5 ± 0.8 _a	4.7 ± 0.6 _a	2.1 ± 1.2 _b	38.79*(2, 124)	.39
Quoted/referred to scripture	4.3 ± 0.8 _a	4.5 ± 0.8 _a	3.0 ± 1.3 _b	13.83*(2, 117)	.19
Forgiveness by God	4.3 ± 0.8 _a	4.3 ± 0.8 _a	2.8 ± 1.6 _b	11.51*(2, 102)	.19
Discussed religious faith	3.9 ± 1.0 _a	4.3 ± 0.7 _a	3.0 ± 1.6 _b	7.85*(2, 99)	.14
Assigned religious task	4.1 ± 0.9 _a	4.2 ± 0.8 _a	2.9 ± 1.1 _b	7.53*(2, 92)	.14
Secular interventions					
Focused on changes in behavior	4.2 ± 0.8 _a	4.2 ± 0.9 _a	3.9 ± 0.9 _a	1.63(2, 181)	.02
Focused on solutions to problems	4.3 ± 0.7 _a	4.4 ± 0.7 _a	4.0 ± 1.0 _a	3.34(2, 164)	.04
Focused on emotions	3.9 ± 1.0 _a	4.0 ± 0.9 _a	4.1 ± 0.9 _a	0.41(2, 158)	.01
Discussed childhood experiences	4.1 ± 1.1 _a	4.0 ± 0.9 _a	3.7 ± 1.3 _a	1.59(2, 132)	.02
Discussed therapeutic relationship	4.3 ± 0.6 _a	4.1 ± 0.8 _a	4.0 ± 1.2 _a	0.96(2, 106)	.02
Other interventions					
Focus on thoughts and beliefs	4.1 ± 0.8 _a	4.2 ± 0.8 _a	4.2 ± 0.9 _a	0.32(2, 168)	.01
Discussed forgiveness of self	3.7 ± 1.1 _a	4.1 ± 0.7 _a	3.2 ± 1.2 _b	7.95*(2, 121)	.12
Discussed forgiving others	4.1 ± 0.7 _a	4.3 ± 0.7 _a	3.5 ± 1.1 _a	4.60(2, 96)	.09

Note. Values represent mean ± standard deviation. Mean comfort levels that have the same subscripts do not differ from each other. Subsample sizes ranged from 7 to 84. ANOVA = analysis of variance.

* $p < .004$, the Bonferroni-corrected alpha level for these analyses.

Reported Effectiveness of Christian Therapy

The second goal of this investigation was to explicitly examine whether Christian therapy is perceived to be effective in an actual client population. We explored client-perceived effectiveness both in terms of the client-therapist relationship and the outcome of therapy (client-rated change) and compared these results with those of the secular counseling agency. We hypothesized that clients in Christian therapy

would report that they felt close to their therapists and were experiencing improvement in their presenting problems. We also expected that these ratings would be comparable to the secular therapy reference group.

Perceived closeness with therapist. We investigated the perceived closeness between clients and therapists through clients' ratings of their current

Table IV. Frequency of Use of the Interventions in the Just-Completed Session.

Variable	Christian counseling centers		Christian private practices		Secular counseling center		Total ^a	
	No.	%	No.	%	No.	%	No.	%
Religious/spiritual interventions								
Pray with or for client	31	66%	47	55%	2	5%	80	45.7%
Quoted/referred to scripture	24	51%	44	52%	5	12%	73	41.7%
Forgiveness by God	21	45%	33	39%	4	9%	58	33.1%
Discussed religious faith	16	34%	35	41%	4	9%	55	31.4%
Assigned religious task	16	34%	30	35%	2	5%	48	27.4%
Secular interventions								
Focused on changes in behavior	38	81%	66	78%	33	77%	137	78.3%
Focused on solutions to problems	32	68%	60	71%	28	65%	120	68.6%
Focused on emotions	27	57%	54	64%	33	77%	114	65.1%
Discussed childhood experiences	29	62%	37	44%	22	51%	88	50.3%
Discussed therapeutic relationship	15	32%	33	39%	14	33%	62	35.4%
Other interventions								
Focus on thoughts and beliefs	32	68%	56	66%	36	84%	124	70.9%
Discussed forgiveness of self	23	49%	39	46%	15	35%	77	44.0%
Discussed forgiving others	18	38%	26	31%	8	19%	52	29.7%

^aSome clients (~20%) reported that all interventions were used in the just-completed session. This is unlikely and casts doubt on whether those data can be considered accurate reports of one session of therapy. Some clients might have reported frequency over the entire course of therapy. To estimate frequencies more conservatively, only data from participants who did not rate all the interventions were used ($n = 175$).

closeness with their therapists. Clients in Christian therapy reported an average level of closeness with their counselors of 5.5 ($SD = 1.0$, range = 3–7). We compared this rating using a two-tailed, one-sample t test with a test value of 4 (“neither close nor not close”) to determine whether clients on average were reporting closeness with their therapists. According to this test, clients in Christian therapy reported being closer to their therapists than a neutral rating would indicate, $t(170) = 8.01$, $p < .001$.

Next, because we surveyed clients at different points in therapy, we were interested in the relationship between the number of sessions a client had worked with a therapist and perceived closeness. As expected, more therapy was related to greater perceived closeness ($r = .23$, $p < .001$). Therefore, we compared perceived closeness to the therapists across the types of agency while controlling for the number of sessions a client had completed. Because our data were nested (clients within therapists within agencies), we conducted a multilevel modeling regression predicting perceptions of closeness with number of sessions and type of agency. (This type of analysis takes into account the nonindependence in the data resulting from multiple clients working with the same therapists in the same agencies; Goldstein, 2003). Type of agency was dummy coded so that the two types of Christian agencies were compared with the secular agency. As expected, the number of sessions significantly predicted closeness with therapist ($\beta = 0.81$, $SE = .15$), $t(188) = 5.39$, $p < .001$, whereas the comparisons between the agencies did not. This indicates that, when controlling for the number of sessions, there were no differences in closeness with therapist between the two types of Christian agencies and the secular agency. In other words, Christian therapy in both private practice and counseling center settings appears to be related to the same degree of client-perceived relationship closeness as a comparison secular agency.

Client-rated change in the problem. Each client rated the amount of improvement or deterioration of their problem since the onset of therapy (using the Temple Scale of Relative Change; 0 = *very much worse*, 6 = *no change*, 12 = *very much better*). To calculate client-rated change that would have more meaningful and intuitive values, we centered the scale on 0 (*no change*); negative scores indicated the problem had gotten worse and positive scores indicated improvement. To assess change as reported by clients in Christian therapy, we averaged client-rated change across the Christian agencies ($M = 2.6$, $SD = 1.9$). We compared this statistic with the test value of 0 (*no change*) using a two-tailed, one-sample t test. This test indicated that, on

the average, clients reported a significant amount of improvement since beginning therapy, $t(167) = 17.37$, $p < .001$.

Next, we correlated the number of sessions the clients had completed at the time of the assessment with client-rated change. The two were positively related, $r(206) = .27$, $p < .001$; more sessions of therapy corresponded with greater reported change. Given this significant correlation between the number of sessions and client-rated change, we conducted another multilevel modeling regression to determine differences in client-rated change between the two types of Christian agencies and the secular comparison agency while controlling for the number of sessions. As with the previous analysis, the number of sessions was significantly related to client-rated change ($\beta = 1.20$, $SE = .26$), $t(184) = 4.68$, $p < .001$, but the differences in type of agency did not predict improvement. According to these results, clients rated improvement in their presenting problems to a similar degree regardless of the type of agency. This supports our hypotheses that Christian therapy would be perceived as effective (and as effective as secular psychotherapy) in an actual client population.

Matching Between Client and Therapist on Religious Commitment

Our third goal involved the prediction of closeness and client-rated change by client and therapist religious commitment, the use of religious interventions, and the interactions among these predictors. Specifically, we hypothesized that perceptions of closeness and change would be related to the match between client and therapist on religious commitment, such that the use of religious interventions would be most effective when it is congruent with the religious commitment match between client and therapist.

Perceived closeness with therapist. To examine the relationship of religious commitment similarity and the use of religious interventions with the closeness with the therapist, we conducted a multilevel modeling regression predicting closeness with (a) client and therapist religious commitment, (b) the use of religious interventions, and (c) their interactions (Table V). As before, the multilevel regression accounts for the nested design, controlling for the reduction in variance that results from nonindependence of the data. Religious commitment of clients and religious commitment of therapists were two continuous variables, which we centered over zero because we were interested in their interactions (with each other and with use of religious interventions).

Table V. Results of Multilevel Modeling Regression Analyses Predicting Closeness and Change.

Variables	R ²	β (SE)	t
Predicting closeness with therapist			
Step 1: Sessions	.16*	0.844 (.16)	5.17*
Step 2: C RC	.19*	-0.024 (.01)	-1.70
T RC		-0.006 (.02)	-0.33
Rel int		0.31 (.22)	1.40
Step 3: C RC × T RC	.25*	-0.001 (.00)	-0.94
C RC × Rel Int		0.046 (.02)	2.74*
T RC × Rel Int		0.007 (.02)	0.30
Step 4: T RC × C RC	.24*	.000 (.00)	0.28
× Rel Int			
Predicting client-rated change			
Step 1: Sessions	.11*	1.35 (.27)	4.95*
Step 2: C RC	.21*	-0.021 (.02)	-0.88
T RC		-0.028 (.03)	-0.87
Rel int		0.374 (.37)	1.01
Step 3: C RC × T RC	.23*	-0.001 (.00)	-0.78
C RC × Rel Int		0.060 (.03)	2.14*
T RC × Rel Int		0.002 (.04)	0.05
Step 4: T RC × C RC	.23*	-0.001 (.00)	-0.48
× Rel Int			

* $p < .05$.

Note. R² is the variance accounted for by the variables in the step at the client level. C RC = clients' religious commitment; T RC = therapists' religious commitment; Rel int = use of religious interventions (yes or no).

Use of religious interventions was examined as a dichotomous variable, representing either present (one or more of the religious interventions was used in the session) or absent (none of the five were used). We also controlled for the number of sessions the client had completed to date. The overall regression equation was significant (see Table V for statistics). As reported, the number of sessions was significantly related to closeness. The main effects for religious commitment of the clients and therapists and use of religious interventions were not significant predictors of closeness. Only the interaction between client religious commitment and use of religious interventions was significant. The other two-way interactions and the three-way interaction were not significant (see Table V). Thus, our hypothesis that similarity between clients and therapists on religious commitment would be related to perceived closeness was not supported. Rather, client religious commitment alone interacted with the use of religious interventions to predict closeness, regardless of the therapists' religious commitment.

Simple effects of the interaction between client religious commitment and use of religious interventions were tested by calculating two beta weights of the prediction of closeness with client religious commitment (through multilevel modeling regression) when religious interventions were used (1) and when they were not (0). The beta weight

for client religious commitment when religious interventions were not used was $-.021$ ($SE = .016$), $t(140) = -1.38$, $p = .17$. The nonsignificant finding indicates that, in the absence of religious interventions, client religious commitment is not significantly related to the perception of closeness with the therapist. In contrast, the beta weight for client religious commitment when religious interventions were used was $.027$ ($SE = .011$), $t(140) = 2.58$, $p = .01$. This indicates that when religious interventions were used, clients with greater religious commitment reported being closer to their therapists than those with lower religious commitment. The small size of the beta weight indicates that this is a small effect, accounting for only a portion of the variance in perceived closeness.

Client-rated change in the problem. Next, we analyzed the relationship between religious commitment similarity and use of religious interventions and client-rated change. A multilevel modeling regression was conducted to determine differences in client-rated change since beginning therapy. Religious commitment and use of religious interventions were treated identically to the variables described in the previous analyses. Client-rated change as measured with the Temple Scale of Relative Change (centered over zero) was the dependent variable. The overall regression analysis was significant (see Table V). Mirroring the results reported previously, only the number of sessions and the interaction between client religious commitment and use of religious interventions significantly predicted change. None of the main effects, the other two-way interactions, or the three-way interaction were significant predictors (see Table V). Thus, our hypothesis that similarity between clients and therapists on religious commitment would be related to client-rated change was not supported. Instead, as with perceived closeness, the significant predictor of change (beyond number of sessions) was the interaction between the clients' religious commitment and the use of religious interventions.

Simple effects were again examined with two multilevel regressions (one for each level of use of religious interventions) predicting change with client religious commitment. For clients who did not receive religious interventions, client religious commitment was not associated with change ($\beta = -.021$, $SE = .024$), $t(140) = -0.88$, $p = .38$. In contrast, for clients who did receive religious interventions, religious commitment predicted client-rated change ($\beta = .039$, $SE = .015$), $t(140) = 2.57$, $p = .01$. These statistics indicate that for those who received religious interventions, greater client religious commitment predicted greater change in the

presenting problem. For those who did not receive religious interventions, there was no relationship between religious commitment and client-rated change. Again, the small size of the beta weight indicates that this is a small effect, accounting for only a portion of the variance in client-rated change.

Discussion

The results of the current study suggest that clients who seek and receive explicitly labeled Christian therapy, as well as those who seek and receive secular therapy, tend to feel close to their therapists and perceive therapy to be effective. Those clients who have strong religious commitments respond particularly well when therapists use discernible religious interventions. Clients and their therapists in Christian agencies representing several regions of the United States generally believed that religiously tailored interventions were appropriate in therapy and were comfortable with their use.

Similarity Between Client and Therapist on Religious Commitment

One of the most significant findings of the current research was that the interaction between client religious commitment and the therapists' use of religious interventions was related to both client perceptions of closeness to the therapist and improvement in the presenting problem. Thus, using interventions that are congruent with the clients' worldview may be important for both relationship closeness and therapeutic effectiveness. The most consistent and positive findings for both perceived relationship closeness and client-rated change were for clients who had greater religious commitments. In the absence of religious interventions in therapy, it appears that religious and nonreligious clients may do equally well. However, the use of religious interventions may provide a distinct benefit for religious clients (and conversely a disadvantage for less religious clients). This supports Worthington's (1988) hypothesis that religious commitment is important in religious therapy because people highly committed to their religion view the world in light of their religious beliefs and values.

Although client religious commitment interacted with use of religious interventions, there was no interaction between client and therapist religious commitment on closeness or client-rated change. This is in contrast to some findings of the importance of similarity of religious commitment between clients and their therapists. For example, Martinez's (1991) finding that theologically conservative clients improve the most with theologically conservative

therapists seemed to indicate that similarity is important. However, the findings of Propst et al. (1992) indicated that religious clients did better not when matched with religious therapists but, rather, when they received religiously oriented treatments from nonreligious therapists. One explanation that might account for these divergent results is that perhaps the crucial factor for religious clients is not whether their therapists are actually religious but whether they perceive their therapists as open, understanding, and accepting of the clients' commitments. Unless the therapists specifically advertise as Christian (or religiously oriented) therapists or disclose their religious commitments to the clients at some point in therapy, clients can only surmise their therapists' beliefs about religion from their actions. When therapists use religious interventions, it may communicate to religious clients that the therapists are open to the clients' religious values or are religious themselves. In response to this non-verbal communication, the religious clients may feel more trusting of the therapist (Richards & Davidson, 1989), which may lead to better working alliance and improved outcomes.

Still, the causal mechanisms actually creating perceptions of closeness and change are unknown and reflect a larger debate in general psychotherapy research (see Kazdin, 2005; Wampold, 2001). Empirical evidence is amassing, however, that supports the dominant role of psychotherapeutic factors that are common to all genuine therapies. If this proves to be accurate, then the specific ingredients of religious interventions (e.g., quoting sacred writing, praying with a client) may be found to be effective not through a direct link with outcomes but rather through their ability to promote common curative factors.

One important implication of the finding that client religious commitment and use of religious interventions are associated with closeness and change is that therapists with varying religious commitments may be able to work equally well with religious and nonreligious clients. If, indeed, closeness and change are moderated by the use of religious interventions with particular clients, then any therapists (regardless of their personal religiosity) can provide interventions that may be maximally effective. Therefore, therapists would not be limited by the match between themselves and their clients but could provide religious interventions to those clients who would be most likely to benefit from them.

This suggests another important implication: Assessment for religious or spiritual commitment, although often overlooked, is important for understanding the kinds of interventions a therapist could

most effectively use (Hathaway, Scott, & Garver, 2004; Richards & Bergin, 1997; Worthington et al., 2003). Assessment may be particularly important, for example, when highly religious clients are referred to a therapist because the therapist is a Christian or to receive explicitly Christian therapy. In such cases, the therapist might be well advised to assess for religious commitment and use, if appropriate, at least some explicitly Christian interventions. Assessment is also useful with less religiously committed clients, with whom religious interventions per se might be ill-advised. However, such clients may need or want to discuss emotional and relational conflicts related to religion despite or perhaps because of their low commitment (e.g., to deal with conflict they may have with an extremely religious family or to cope with feelings resulting from the rejection of religion). Thus, simple questions of religiosity ("Are you religious/spiritual?") may not capture the nuances of a particular client's concerns. Effective and brief formal assessments are available for a wide range of religious dimensions (e.g., the RCI-10 used in this study; see also Hill & Hood, 1999).

Strengths and Limitations

The current research has contributed to the understanding of what occurs in explicitly Christian therapy. No previous research has studied the correlates of actual therapy in explicitly Christian agencies in diverse locations. Past studies have mostly involved local, analogue research on people whose psychological distress was not in the clinical range. Much of what we found is what we hypothesized based on previous research and theory. However, one primary hypothesis (i.e., that religious commitment similarity between clients and therapists would predict closeness and change) was not supported. This is an important contribution as well that can inform clinical practice and stimulate further research on the significant Client \times Therapist \times Treatment interactions.

We caution the reader to carefully consider some limitations to this study. Most importantly, only one secular counseling center was surveyed. Although this group of clients and therapists was a useful comparison for the purposes of this study, readers must not generalize to all secular therapy. Our interpretations and comparisons between the Christian and secular therapy are intended to provide validity to the type of therapy (i.e., Christian) we were exploring and only secondarily to tentatively examine possible differences and similarities between explicitly Christian and general secular psychotherapy.

In addition, although we sampled from several diverse regions of the United States, we did not include agencies from all regions (i.e., the West Coast). Second, clients were volunteers from centers whose staff volunteered to participate. Thus, although the participation rate of the centers and therapists was high, we do not know the exact participation rate of the clients, and this potentially limits the generalizability of the results. Third, to limit the agencies' time and resources needed to conduct this research, we collected only client-reported measures of outcome, estimating the changes that the clients perceived. These measures do not meet the suggested standards of multimodal assessment of outcome (Goldfried, 1997). Furthermore, single-item measures were used, which was not optimal, although research suggests that single-item measures can be adequate substitutes for longer scales in some situations (de Boer et al., 2004; Rohland, Kruse, & Rohrer, 2004; Wanous, Reichers, & Hudy, 1997).

Finally, the cross-sectional nature of clients' ratings of interventions, outcome, and relationship variables provided only a snapshot at one point in their therapy, which across clients represented the full spectrum from start to near completion. This vantage point may only approximate the percentage of religious and secular techniques used with clients across their entire therapy. It is entirely possible that therapists might use fewer religious interventions at some stage of therapy (i.e., the first couple of sessions) than at others. This perspective is also limited by the lack of more objective measures of change (e.g., pre- and posttreatment measures) and does not address how the therapeutic relationship changed over time. Longitudinal methodology would be an excellent adjunct to the current perspective. Examining religious interventions, outcome, and relationship variables at multiple points across clients' therapy experiences would provide a broader picture of the interaction among these variables.

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Notes

¹ A summary table of these studies is available from Nathaniel G. Wade.

² Of the participating agencies, two were from the East (Washington, DC, and Maryland): a church-based counseling center open to the public ($n = 18$ clients, $n = 5$ therapists) and a Christian community-based practice ($n = 24$ clients, $n = 5$ therapists). Two agencies participated from the South (Mississippi and Georgia): a counseling center at a Christian seminary ($n = 36$ clients, $n = 13$ therapists) and a Christian, university-affiliated counseling center open to the community ($n = 15$ clients, $n = 5$ therapists). Two agencies also participated from the Midwest (Nebraska and Kansas): a Christian psychotherapy practice ($n = 66$ clients, $n = 3$ therapists) and a Christian private practice with a focus predominantly on marriage and family therapy ($n = 13$ clients, $n = 2$ therapists). The secular agency was a university counseling center at a large urban university in the mid-Atlantic region ($n = 48$ clients, $n = 18$ therapists).

³ About 20% of the clients ($n = 26$) rated their comfort with all of the 13 interventions, indicating that all 13 had been used in their just-completed session. Because it is unlikely that all 13 interventions occurred in a single session, there is the possibility that those clients may have been confused about the instructions. Rather than include those clients in the following analyses, we chose the more conservative approach and only included clients who rated a portion of the interventions ($n = 175$) for all analyses that dealt with frequencies of interventions. However, for analyses that addressed the question of comfort with the interventions, the whole sample was used because all data provided information about the clients' comfort levels regardless of whether the intervention had occurred.

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