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The Impact of Client and Therapist Religious Commitment on  
Psychotherapy in a University Counseling Center

Brodrick Thomas Brown

A dissertation submitted to the faculty of  
Brigham Young University  
in partial fulfillment of the requirements for the degree of  
Doctor of Philosophy

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## ABSTRACT

### The Impact of Client and Therapist Religious Commitment on Psychotherapy in a University Counseling Center

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Doctor of Philosophy

Religion is important to many Americans and the way they approach life, but psychologists are less likely than the general population to be religious. Because of this, it is important to not only know how religious commitment can influence clients' outcome and experience in psychotherapy, but also how the level of match between client and therapist religious commitment might impact those variables. The current study was undertaken in order to investigate how client religious commitment impacts distress at the beginning and end of treatment, how therapist religious commitment impacts the use of religious/spiritual interventions in therapy, and whether the level of match between client and therapist religious commitment predicts client perception of therapy and/or outcome.

Seven hundred and thirty individual therapy clients at a university counseling center completed measures of religious commitment, symptom distress, and concerns about therapy throughout their course of treatment. Forty-four therapists also completed a measure of religious commitment in addition to session-by-session checklists detailing what types of interventions they used in each appointment with participating clients. Client religious commitment was found to significantly predict lower initial distress ( $B = -0.77$ ,  $p < 0.001$ ,  $R^2 = 0.07$ , 95% CI [-0.97, -0.57]) and lower distress at the end of therapy ( $B = -0.32$ ,  $p = 0.001$ ,  $R^2 = 0.34$ , 95% CI [-0.51, -0.14]), and fewer concerns about therapy predicted better outcomes ( $B = 2.04$ ,  $p < 0.001$ ,  $R^2 = 0.38$ , 95% CI [1.52, 2.52]). Contrary to the findings of previous research, therapist religious commitment did not predict use of religious/spiritual interventions in therapy ( $B = 0.05$ ,  $p = 0.062$ ,  $R^2 = 0.09$ , 95% CI [-0.002, 0.11]). Finally, level of match between client and therapist religious commitment was not related to client concerns about therapy ( $B = -0.002$ ,  $p = 0.161$ , 95% CI [-2.40, 9.57]) or client outcomes ( $B = -0.014$ ,  $p = 0.120$ , 95% CI [-0.03, 0.004]). Possible explanations and influencing factors are put forth and the findings are discussed in the context of a highly religious population.

Keywords: Psychotherapy; religiosity; religious commitment; therapy outcome; therapist factors; therapist-client matching

## ACKNOWLEDGEMENTS

Getting a Ph.D. would be impossible without the encouragement and support of many people who have surrounded me over the past five years. All of my family members – especially Kent and Sharon Brown – have been more supportive than I could have ever asked, and spending time with them has often been the thing that gets me through the hardest moments of this journey. Right from the beginning of my graduate training, Eric Ghelfi and Sheilagh Fox were the support I could have never expected I needed, and we were shortly joined by Lindsay Fruehauf to create the friendships that deserve most of the credit for me surviving the past five years.

Being given the freedom to customize my training has been an extremely important part of my experience throughout grad school and would not have been possible without my chair, Patrick Steffen, and his support. Additionally, all of the clinical supervisors who have expressed confidence in my abilities and encouraged me to continue on a difficult path have done more for me than they will probably realize. Going back to the beginning, “Coach” Pamela Coburn got me started on this long, long road with her engaging teaching style and clear passion for the subject. Even after years of further training, I still think back to the things she taught me about psychology and about looking at the world from a different perspective.

Finally, Lars Nielsen has done more work, provided more mentorship, and encouraged more rational thinking than I could have possibly expected when I sat amongst his office plants for the first time a few years ago. His professional and personal influence is something I will appreciate for the rest of my life and I look forward to future collaboration.

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## **The Impact of Client and Therapist Religious Commitment on Psychotherapy in a University Counseling Center**

Religion is important to the majority of individuals in America and can have a significant impact on their lives (Brown et al., 2013; Hood et al., 2018). According to a 2017 Gallup poll, only about 20% of adults in the country reported that they do not have a specific religious identity, and 15% of those still considered themselves a “religious person.” In 2020, 74% of adults reported identifying with a specific religion and 73% identified religion as “fairly” or “very important” to them (Gallup, 2021). Religiosity has also been established as a predictor of positive mental health outcomes, generally (Bonelli & Koenig, 2013; Oman & Syme, 2018). Hood et al. (2018) submitted that because religion is such an important part of human experience and is often used to convey the meaning and significance of life events, it is important for psychologists to understand the impact it has.

In contrast to the general public, Post and Wade (2009) found that psychologists are less likely to be religious or believe in God than typical Americans. When asked how important religion is to them, psychologists are significantly less likely than others to respond that it is “fairly” or “very” important (Shafranske & Cummings, 2013). A handful of studies have asked these questions of both psychologists and the general population and estimates of the difference between the two groups range from 17% less to 40% less (Delaney et al., 2007; McMinn et al., 2009; Shafranske, 2000). The fact that therapists are less likely to believe that religion is important shows that it is probable for there to be at least some degree of incongruence between the typical therapist and the typical therapy client on this characteristic.

While both client and therapist factors have been repeatedly shown to impact the experience of psychotherapy and treatment outcomes for clients, neither client nor therapist

religious commitment has been specifically studied in this context (Baldwin & Imel, 2013; Bohart & Wade, 2013; Okiishi et al., 2003). Additionally, while disconnects between client and therapist religiosity could impact a client's experience of therapy, very little is known about how their religious values might interact. Previous research has exhibited mixed evidence for the impact that matching on characteristics like race and ethnicity can have on psychotherapy, but there is some indication that it can be helpful (Cabral & Smith, 2011; Dolinsky et al., 1998). The purpose of the current study is to investigate the impact that client and therapist religious commitment, independently, have on psychotherapy, including the client's perception of therapy and outcome. It will also examine how client and therapist religious commitment interact to impact psychotherapy outcome.

When discussing religion there are several terms that are important to define, and psychologists have struggled to find consistency in these definitions (Paloutzian & Park, 2021). The word "religion" most frequently denotes membership in an organized group connected by sacred beliefs, traditions, rituals, or practices (Koenig, 2009). The terms "religiosity" and "religiousness" are typically used interchangeably throughout the existing literature and the term "religious commitment" is used in a similar way. All three refer to the degree to which an individual participates in and identifies as part of a religion. Worthington (1988) defined religious commitment, specifically, as "the degree to which a person adheres to his or her religious values, beliefs, and practices and uses them in daily living" (p. 166). Spirituality, on the other hand, is less concrete, and usually indicates a more individualized relationship with something divine or transcendent that is not necessarily associated with any particular group or specific set of beliefs (Koenig, 2009; Post & Wade, 2009; Saucier & Skrzypińska 2006). An individual can identify as religious but not spiritual, spiritual but not religious, both, or neither.

While these constructs are clearly related and similar, the current study focuses on religion specifically, rather than spirituality.

### **Client Factors**

Client factors have an impact on client experience in psychotherapy, including treatment outcomes (Garfield, 1994), and Bohart and Wade (2013) found that client factors account for a significant amount of the variance in outcome between clients. They conceptualized the role of the client in therapy as an “active learner and problem solver who contributes to therapy process and outcome,” and asserted that therapists should consider clients’ preferences, values, and perceptions about therapy when decisions about treatment are made (p. 219). Client factors included aspects such as motivation, coping style, and perceptions about the therapeutic relationship. Demographic factors also predict aspects of therapeutic experience and outcome. For example, women and individuals who identify as a sexual minority were more likely to drop out of treatment sooner than others (Anderson et al., 2019). Dougall and Schwartz (2011) found that client socioeconomic status (SES) impacted the way that therapists perceived and interacted with them. Therapists were more likely to report that clients with higher SES were “dominating” them in therapy and rated higher SES clients as having milder problems than those with lower SES.

In addition, a meta-analysis of premature termination studies indicated that younger clients were more likely to discontinue therapy before treatment was completed. That same meta-analysis showed that characteristics like client gender, marital status, and educational level predicted premature termination in some cases, but there were some mixed results (Swift & Greenberg, 2012). Another meta-analysis showed that a client’s pattern of responding to and coping with their environment predicted what type of therapy would be most effective for them.

When clients had a more internalizing coping style, they benefitted more from insight-oriented therapy, while externalizing clients benefitted more from symptom-focused therapy (Beutler et al., 2011). The clients that were given the type of therapy that matched their coping style had better outcomes than those that were not matched to a significant degree with a weighted effect size of  $d = 0.55$ . This shows that nondiagnostic client factors are important to consider when deciding on what treatment would be most effective for a given client (Beutler et al., 2011). This research shows that client factors can be expected to impact measures of therapy outcome to a significant degree.

### **Client Preferences in Therapy**

Client treatment preferences should be taken into consideration, because such preferences impact therapy outcome. In its statement on evidence-based practice in psychology, the American Psychological Association (APA, 2005) indicated that client preferences should be considered when the therapeutic relationship is being formed and specific interventions are being implemented, as one of the central goals of evidence-based practice in psychology is to allow the client to choose among effective intervention options. Furthermore, actively involving the patient in the process of delivering psychological services is crucial to treatment success, as psychological services are most effective when they take into account the client's specific problems, strengths, personality, sociocultural context, and preferences, including preferences related to treatment, such as their goals, beliefs, worldviews, and treatment expectations (APA, 2005).

In a meta-analysis of 35 studies, Swift, Callahan, and Vollmer (2011) found that clients who were matched to their preferred type of therapy conditions were less likely to terminate therapy prematurely. These clients also exhibited greater improvement on outcome measures in

comparison to those who either received the opposite of their preference or when their preferences were simply ignored ( $d = 0.31$ ). An odds ratio of 0.59 indicated that individuals who were matched to their preferred therapy were about half as likely to drop out as those not in their preferred conditions. Swift et al., (2011) also found that client preferences for therapy roles, treatment types, and therapist characteristics were all important to consider. They encouraged therapists to avoid assuming that they know their client's preferences, suggesting that a discussion about preferences be had early in therapy. Once such a discussion has occurred, the therapist should either provide treatment in accordance with the client's preferences or provide a rationale for why they will not be doing so. In a follow-up meta-analysis, Swift et al. (2018) confirmed the previous findings. Clients who were matched to their therapy preferences had better outcomes (weighted effect size of  $d = 0.28$ ) and clients who were not matched to their preferred treatment were almost twice as likely to drop out of treatment early ( $OR = 1.79$ ). Given these results, they recommended three areas to consider client preferences in: therapy activity preferences, therapist preferences, and treatment type preferences.

### **Client Perceptions of Therapy**

Client perceptions of therapy and progress in treatment also impact the therapy experience, so if the client has concerns about therapy, such concerns will likely have a negative impact on his/her experience and outcomes. Raylu and Kaur (2012) found that substance abuse clients who perceived that therapy was going to be helpful were more likely to have positive changes in their mood and better outcomes overall. These clients had high expectations that they would have positive outcomes and would be open with their therapist early in therapy. Lambert and Shimokawa (2011) similarly found that clients benefitted when therapists specifically sought to understand their client's perception of therapy and satisfaction with the therapeutic

relationship. When therapists did so, the working relationship was enhanced, and clients were at lower risk of premature termination from therapy. Clients who were already at higher risk for deterioration or premature termination benefitted even more than others. Giving feedback to therapists about their clients who had negative perceptions of therapy was helpful in improving therapy experience and outcome (Lambert & Shimokawa, 2011). Tao et al. (2015) also found that clients' perceptions of their therapist's multicultural competence significantly predicted a better therapeutic alliance and improved client satisfaction with their treatment. These studies show that the client's perception of therapy influences their experience and outcomes.

Swift and Derthick (2013) asserted that clients' expectations about therapy outcomes and expectations of the therapy process are both important, and they recommended that clinicians spend time increasing client buy-in about therapy and the therapeutic relationship. In a list of interventions for improving client expectations they included increasing clients' faith in their therapist, presenting a convincing treatment rationale, and comparing their progress with their expectations. Swift, Greenberg, Whipple, and Kominiak (2012) also suggested that one important way to keep clients from terminating therapy early is to increase their faith in their therapist by addressing expectations, hopes, and preferences for treatment early in the process. Finally, Bachelor (2013) found that clients and therapists have different perceptions of how good the therapeutic alliance is, and the client's ratings have a significant impact on therapy outcome. They asserted that it is important that clients perceive that treatment could be effective and that their therapist is credible and helpful. Therefore, understanding clients' perceptions or concerns about therapy progress and their relationship with their therapist could provide helpful information to predict their outcomes and experience in therapy overall.

**Religiosity**

Higher religiosity has been consistently associated with improved mental health outcomes in general (Shafranske & Cummings, 2013) and therefore may be related to lower distress in clients who are entering therapy. Brown, Elkonin, and Naicker (2013) stressed that religious beliefs are such a large part of some individuals lives that in order to understand someone fully, it is probably necessary to understand their religious beliefs. Oman and Syme (2018) performed a meta-analysis of studies linking religiosity to positive health outcomes like longevity, dementia prevention and coping, physical health, psychological well-being, and other mental health outcomes. They argued that the existing evidence establishes that religion and spirituality have a strong positive influence on health overall. In another meta-analysis, McCullough (1999) found that religious involvement was positively related to several measures of mental health and increased the effectiveness of other (non-religious) coping strategies. In addition, Bonelli and Koenig (2013) completed a systematic review and found that 93% of studies on the relationship between religiosity and mental health indicated that religious involvement was associated with positive mental health outcomes. All of the studies involving individuals with dementia, suicidality, and stress-related disorders found positive impacts in addition to most of the studies on depression and substance abuse. Koenig (2009) also corroborated these findings, reporting that religiosity was related to positive outcomes in substance abuse, psychotic disorders, suicidality, and anxiety. Individuals experienced decreased panic symptoms, lowered likelihood of relapse in substance use, and fewer deaths by suicide. They emphasized that religious beliefs and practices can represent powerful sources of comfort, hope, and meaning in individuals from various demographic groups (Koenig, 2009).

In young adults, specifically, it has been shown that religiosity is associated with better adjustment. For example, Yonker et al. (2012) found that young adults who were more religious were less likely to be depressed or engage in risk behaviors like underage drinking, smoking marijuana, smoking, sexual activity, and substance use. Overall well-being and self-esteem were also positively correlated with religiosity in these same individuals. Hardy et al. (2011) also found that religious individuals were more likely than most of their peers to be in mature stages of identity development. In addition, Exline et al., (2020) found that both current and lifetime religious/spiritual struggles are more common in college students who have disengaged from religion – even if they still identify as spiritual.

Religious beliefs impact many parts of an individual's life, including how they cope with difficulties. Positive religious coping strategies can increase positive mental health outcomes and are related to better recovery from adverse life events in individuals who use them. These positive strategies include things like seeking spiritual connection, seeking divine direction, obtaining support from clergy members, and helping others in a religious context (Pargament et al., 2004). However, Pargament et al. (2004) also found that some religious coping strategies can have negative impacts on individuals' mental health. For example, considering a difficult situation to be punishment from God, questioning God's love, passively waiting for God to take control of the situation, and pleading for direct intervention were related to negative outcomes. Importantly, both positive and negative coping strategies can come from the same religious beliefs and be used by the same individual. Both types of coping strategies had long-term impact in addition to short-term consequences for the individuals using them (Pargament et al., 2004).

While the majority of evidence indicates that religiosity is related to positive mental health outcomes, some additional research has indicated that there can be negative effects.



Johnson and Hayes (2003) found that 26% of incoming clients in a university counseling center reported experiencing considerable distress due to religious or spiritual issues. The individuals who reported religious or spiritual distress were also more likely to report increased distress surrounding loss of relationships, sexual assault, confusion about values, problematic relationships with peers, and sexual concerns. They were also likely to perceive difficulties as being punishment for one's sins. Adams (2018) pointed out that religious perfectionism is higher in some religious groups and could lead to difficulties. They indicated that while religiousness may often provide protection from many mental health concerns, it can also lead to religious perfectionism that can be related to poor mental health outcomes. While investigating the impact of religiosity on lesbian, gay, and bisexual Black Americans, Walker and Longmire-Avital (2013) found that religious individuals were more psychologically resilient than non-religious individuals. However, this was only true for those who also endorsed high internalized homonegativity, indicating that the relationship between resilience and religiosity is complex, but that the use of religion as a coping tool and homosexuality are not mutually exclusive (Walker & Longmire-Avital, 2013). The findings from these studies indicating the potential for negative effects from religiosity suggest that while there is significant evidence that religiosity can be psychologically beneficial, it is worthwhile to continue to investigate the relationship between them.

### **Therapist Factors**

Therapist factors have an impact on client experience and outcome in therapy (Anderson et al., 2009). Baldwin and Imel (2013) found that therapists differ in their effectiveness, in that some therapists' clients have significantly better outcomes than other therapists'. In a meta-analysis, they established that therapist effects explained about 5% of the variance in outcome

between clients, which is similar to the effect for the therapeutic alliance. They also pointed out that even small effects can make a large difference in public health over time. Additionally, Okiishi et al., (2003) found that therapist effects could account for a full standard deviation difference in outcome from the best to worst therapists. Those therapists whose clients improved most rapidly, improved at a rate that was ten times faster than the average for the study. The therapists whose clients improved the slowest actually showed an average increase in clinical symptoms among their clients. These findings show that the therapeutic outcomes of a client can be significantly impacted by the therapist with whom they work. Therapist characteristics that impact client experience include the therapist's values. Previously, therapists were expected to be value-free in therapy, but in recent years it has become clear that doing so is likely impossible (Tjeltveit, 1986; Williams, 2018). Corey et al. (2007) recommend that therapists need to at least be conscious of their values and how they impact their assumptions, core beliefs, and biases. Religious values are one specific area in which therapists may differ, and those differences can have an impact on their practice of psychotherapy.

### **Therapist Religiosity**

Therapist religiosity has an impact on their use of religious interventions in therapy, in that if a therapist is religious, they are more likely to use religious interventions or address spiritual or religious topics in therapy. Cummings et al. (2014) performed a systematic review of 29 studies and found that higher therapist religiosity or spirituality predicted more favorable attitudes toward using religious or spiritual themes in therapy, more frequent integration of them in treatment, and more confidence in their ability to do so. Therapists also appeared to prefer clients who share their religious/spiritual beliefs and values. Shafranske and Malony (1990) stated that psychologists' personal orientation toward religiousness and spirituality were the

primary determinants of their approach to these types of issues. Specifically, therapist attitudes matter more than even their clinical training. While the majority of the participants agreed that psychologists have the training necessary to work with clients on religious issues, only about 30% described being personally competent to do so. Additionally, Walker et al. (2005) found that therapists who were more religious were more likely to engage in religious interventions during treatment. Therapists' personal religiousness and practice of religious behaviors predicted more frequent use of religious interventions and self-reported competency. Interestingly, when they received clinical training specifically geared toward integrating religion in therapy, therapists felt more competent and used religious interventions more frequently.

Though training therapists in religious topics may be beneficial, they do not typically receive a significant amount of training in how to use religious interventions in therapy. Barnett and Johnson (2011) pointed out that religious issues are often entangled with clients' other presenting problems. Thus, they suggested that therapists need to be sure that they are including religion in therapy in an ethical and responsible way. In 2011 only about one fourth of the psychology graduate programs in America offered a single course covering the subject of religion and spirituality in mental health. Additionally, only about 16% of clinical programs reported that they provided a course, clinical supervision, and conducted research on the topic (Schafer et al., 2011; Vieten et al. 2013). Walker et al. (2011) found that while many clients wanted to discuss religious topics in therapy, clinical directors at mental health clinics expressed concern about the idea that clients would request religious interventions. Oxhandler and Parrish (2018) reported that most therapists had positive views toward involving religious or spiritual topics in therapy, but they did not feel confident in their ability to do so appropriately. Only about 10% of the therapists said that they used empirically supported treatments that included

religious or spiritual interventions. Hathaway et al. (2004) stated that psychologists only discuss spiritual and religious concerns with 30% of their clients, and only 28% of clinicians reported having received any training concerning religious or spiritual topics in a university setting. Overall, therapists are unlikely to feel competent or comfortable with integrating religious interventions unless they are religious themselves, and they are probably not educated on how to do so effectively.

### **Religious Interventions**

Though it seems the majority of clinicians do not include religious interventions in their approach to therapy, religious clients benefit from these interventions. In a systematic review, Paukert et al. (2011) found that therapy that included religious interventions was “at least as effective” as secular forms of therapy. They did not differentiate between individuals with high or low religiosity, so individuals who were more religious may have benefitted even more from the religious therapies. Razali et al. (1998) studied religious clients that were diagnosed with generalized anxiety disorder or major depressive disorder. The clients who received therapy that included religious interventions improved significantly faster than those in the non-religious intervention group. Specifically, those in the religious intervention group had better outcomes after four weeks and twelve weeks of treatment, and after six months they had the same level of improvement as those who did not get religious interventions. This shows that they benefitted from therapy faster and maintained their improvements over time. The purpose of the religious interventions was to help the clients cope using their religious and/or spiritual resources.

Meta-analyses have also supported the use of religious interventions in therapy. Captari et al. (2018) found that psychotherapy that included religious and spiritual techniques was more effective than no-treatment controls and alternative secular therapies to a significant degree

(Hedges  $g = 0.74$ ). While therapy that included religious topics (e.g., religious-accommodative CBT) consistently performed equivalently to non-religious therapy (e.g., typical CBT) on psychological outcomes, clients rated their “spiritual well-being” as having improved more in the therapy that included religious and spiritual techniques ( $g = 0.34$ ). In another meta-analysis, Smith et al. (2007) found that approaches that included religious or spiritual adaptations were more effective than other types of therapy for clients with depression, anxiety, stress, and eating disorders as their main concerns. They noted that the religious/spiritual therapy had a greater impact on measures of well-being than measures of mental health symptoms. In the studies analyzed by Smith, et al., adaptations included activities like discussing religious issues, praying in session, and using scripture to dispute thoughts during session. They reported that learning to apply their own religious or spiritual beliefs to their mental health or well-being concerns seemed to be very helpful for clients.

Clients also report that religious interventions can be helpful in therapy. Martinez et al. (2007) interviewed individuals who had received therapy at a university counseling center and found that highly religious clients found religious interventions to be helpful, overall. Clients rated in-session interventions (e.g., reading scripture, discussing religious topics, etc.) as more helpful, but less appropriate when compared with those that happened outside of sessions (e.g., involving religious community resources, inviting the client to pray on their own, etc.). Religious interventions that were considered both appropriate and helpful by participants included referencing scriptural passages, teaching spiritual concepts, encouraging forgiveness, and therapists conducting assessments of client spirituality. The most common client concerns about using religious interventions were that the therapist was acting in an ecclesiastical role and that the timing of the interventions was not ideal. Martinez et al. (2007) suggested that therapists

should be sure that all religious interventions clearly match the client's values, readiness, and reason for seeking therapy. Currier et al. (2020) found that, at intake, a majority of clients in one outpatient therapy clinic expressed the desire for their therapist to be "spiritually affirming" and almost one-third hoped to address religious or spiritual issues in therapy.

### **Therapist and Client Matching**

The congruence or matching between client and therapist factors can have an impact on outcome and the client's perception of therapy. For example, there is some evidence that outcomes are improved when clients are matched with therapists on variables like ethnicity, race, religiosity, and other personal characteristics. Dolinsky et al. (1998) found that clients who reported feeling like they had a "positive match" with their therapist were more likely to have a positive perception of their progress in therapy and the therapeutic relationship. In this study, "match" referred to the level to which the therapist and client felt that they were similar in several different areas including sense of humor, political values, and personal values. Flaskerud and Liu (1991) found that Asian therapy clients whose language or ethnicity matched their therapist were more likely to remain in treatment longer and were less likely to terminate therapy prematurely. Morrison and Borgen (2010) performed a qualitative study of incidents in therapy that hindered progress and the development of the therapeutic relationship. They found that the most common types of event that disrupted progress were when the client's actions were contrary to the therapist's belief system, the therapist had limited empathy as a result of their blind spots and biases, and when the therapists and client had different expectations within the same religion. This indicates that differences between a client and therapist can lead to difficulties in treatment.

The benefits of matching between clients and therapists have mixed evidence. In a meta-analysis, Cabral and Smith (2011) reported that matching according to race or ethnicity is probably less important than establishing cultural competency among therapists. However, they indicated that there are some individuals or groups that may benefit from matching. They found that clients typically had a strong preference for a therapist whose race or ethnicity matched their own ( $d = 0.63$ ) and viewed therapists who matched them on race or ethnicity more positively ( $d = 0.32$ ). While the average effect size of outcome variables was quite small ( $d = 0.09$ ), African American clients tended to have somewhat better outcomes ( $d = 0.19$ ) when matched to their therapist. Additionally, Asian American clients showed no initial preference for matching, but perceived matching therapists more positively, while the opposite was true for Hispanic/Latino(a) clients. They said that groups that have strong racial or ethnic identification and wariness about bias in mental health services provided by Caucasian therapists are more likely to benefit from matching. The results confirmed that matching was more salient for people of color than White/European American clients. Smith and Trimble (2016) also performed a meta-analysis and found that studies that included white clients are less likely to find effects for matching effects. Client-therapist matching on race or ethnicity led to clients of color being more likely to stay in therapy. Higher effect sizes also showed that matching impacted treatment completion more than the number of sessions a client attended.

Therapist and client matching on religiosity may have a positive impact on psychotherapy experience and outcomes, but little research exists on the topic. Gregory et al. (2008) found that when individuals not engaged in psychotherapy were given written descriptions of psychotherapists, the highly religious clients preferred any therapist that also belonged to a major religion (Christian, Jewish, or Islamic). However, while they were more likely to want to see a

psychologist who identified with one of these religions over someone who was atheist, there were no significant differences between the three major religions. This indicates that the psychologist's religious affiliation does not matter to the clients as much as the fact that they are religious. In a qualitative study, Martinez et al. (2007) found that clients in a religious university's counseling center were impacted by their perception of a convergence of religious beliefs with their therapist. Clients felt more comfortable with their therapist and were more confident in their therapist's credibility if they felt like that convergence was present.

Another qualitative study indicated that having their own religious or spiritual beliefs or having similar beliefs to their clients made it easier for therapists to engage with clients on religious topics. Alternatively, both having "clashing" beliefs, morals, or values, with the client and being uncomfortable with religious or spiritual issues oneself made it uncomfortable for therapists to talk about religious issues with clients who wanted to discuss such matters (Brown et al., 2013). Kelly and Strupp (1992) investigated whether matching between client and therapist on various values were helpful and found that religious values were the only variable where similarity was correlated with positive outcomes in therapy. Overall perceived match was positive, but specific variables other than religious values did not have a significant impact individually, and even the religious values only showed a positive impact on one outcome measure. Therefore, while the evidence for client-therapist matching is mixed overall, there is some indication that convergence could be positive in psychotherapy.

### **Current Study Aims and Hypotheses**

As has been discussed, religiosity has an important impact on many individuals' lives and mental health. The current literature indicates that religious commitment is related to positive mental health outcomes in general, but there is a dearth of research that addresses how client and



therapist religiosity influence outcome in psychotherapy. Much of the research that does exist focuses exclusively on psychotherapy that is overtly religious or specifically emphasizes religious themes. While these approaches are important to investigate, the current study aimed to expand understanding of how client and therapist religious commitment, and the congruence between them, influence therapy outcome in standard therapeutic approaches in a naturalistic setting.

Because religiosity is related to better mental health, it was hypothesized that clients with higher religious commitment would have lower distress at the beginning of therapy compared to those with lower religious commitment. While the existing research does not indicate how religious commitment might influence psychotherapy outcome, benefits do exist for individuals who use positive religious coping strategies, and there is a well-established positive relationship between religiosity and mental health. Therefore, it was hypothesized that individuals who were more religiously committed would have better outcomes. Specifically, it was hypothesized that clients with higher religious commitment would have less distress at the end of their course of treatment than those with lower religious commitment when controlling for initial distress. It was also hypothesized that outcomes would be better for clients who reported fewer concerns about therapy.

Since therapists are more likely to engage in religious interventions when they are religious themselves, it was hypothesized that therapists who were higher in religious commitment would engage in more religious interventions each session on average over the course of therapy. Additionally, a better match between client and therapist religious commitment was hypothesized to predict better client perception of treatment progress, including their willingness to be open and honest in therapy and perception of their therapist's

understanding of their problems. In a related point, it was also expected that a better match between client and therapist religious commitment would predict better therapy outcomes.

Overall, the hypotheses were as follows:

1. Higher client religious commitment would
  - a. be related to lower initial distress
  - b. predict lower distress at the end of treatment when controlling for initial distress
2. Fewer client concerns about therapy progress would predict better outcomes in therapy
3. Higher therapist religious commitment would predict higher average number of religious interventions used per session
4. There would be an interaction between therapist and client religious commitment on therapy outcome
  - a. A better match between therapist and client religious commitment would predict fewer client concerns about therapy progress
  - b. A better match between therapist and client religious commitment would predict better therapy outcome

Overall, this study helps to fill the knowledge gap that exists in this area of psychotherapy research and assist clinicians in knowing what to expect from clients and their outcomes based on their religious commitment. It also introduces the question of whether clients would do better with therapists who match their level of religious commitment. This information would be especially valuable for individuals who provide psychotherapy in highly religious communities.

## Method

### Participants

Participants in the study were recruited from Counseling and Psychological Services (CAPS) at Brigham Young University (BYU). The client participants were students at the university who were enrolled in classes and seeking to begin psychotherapy at CAPS. Clients who were already involved in individual therapy were also eligible for participation in the study. If a client was in therapy with more than one therapist during the course of the study, only the data from the first round of therapy with a therapist participant were used. As part of admittance to the university, an “ecclesiastical endorsement” must be obtained from their religious leader and renewed throughout their time at the school. A part of this endorsement is confirming continued participation in religious activities throughout the student’s time in school. This process creates a unique set of participants for this study in particular, due to the fact that each of them has at least officially declared that they are religious in some form.

Of the 1303 clients who consented to participate in the project, 730 completed the questionnaires included in this study. The remaining individuals were not included for various reasons, including not attending any therapy appointments, never completing the CAMOS questionnaire, withdrawing from the study, etc. Clients were 69% female, 30% male, and less than 1% identified as transgender or did not wish to respond. Ninety percent of clients were between the ages of 18-25. Less than 1% were 17 and 9% were above 25, with the maximum age being 66 years. When asked to identify their ethnicity in an open response format 84% of clients identified as White or Caucasian; 4.8% as Latinx; 4.2 as multiracial; 3.8% as Asian/Asian American; 0.6% identified as Pacific Islander; 0.6% identified as Black/African American; and

1.6% identified as Native American, other, or did not specify an ethnicity. These demographic variables are also reported in Table 1.

**Table 1**

*Client Demographic Information*

Characteristic	n	%
<b>Gender*</b>		
Female	504	69
Male	219	30
Transgender or “Do not wish to respond”	7	<1
<b>Age</b>		
<17	8	<1
18-25	657	90
>25	65	9
<b>Race/Ethnicity**</b>		
White/Caucasian	614	84
Latinx/Hispanic	35	4.8
Multiracial	31	4.2
Asian/Asian American	28	3.8
Pacific Islander	6	0.8
Black/African American	4	0.6
Other	12	1.6
<b>Religious Affiliation</b>		
Christian	693	95
<i>Latter-day Saint</i>	679	93
Specific affiliation other than Christian	22	3
Atheist or Not Religious	15	2

*Note.* N=730

\*Options for gender self-identification included in the demographic survey were “Female,” “Male,” “Transgender,” and “Do not wish to respond” \*\*Race/Ethnicity data were gathered via open-ended responses to the prompt “What is your ethnicity?”

Ninety-five percent of clients identified their religious affiliation as Christian, with 3% identifying as another affiliation and 2% as atheist or not religious. Of those who listed a specific religious denomination (686 of clients), 99% were members of the Church of Jesus Christ of Latter-day Saints. Almost 97% of clients said “Yes” to the question, “Is religion important to

you?” and 51.8% selected yes to the question “Has religion hurt you?” All individual therapy clients at the counseling center were eligible to participate, with no other inclusion or exclusion criteria.

Therapist participants consisted of 44 individuals who consented to be a part of the project and completed the Religious Commitment Inventory – 10 (RCI; Worthington et al., 2003). Therapists included various ages, training levels, and experience. Of the participating therapists, 69% who included a specific religious denomination in an open-ended explanation of their religious/spiritual beliefs indicated at least some connection to the Church of Jesus Christ of Latter-day Saints. A small number (10%) mentioned Christianity being a part of their belief system but did not identify the Church of Jesus Christ of Latter-day Saints. All therapists and clients who are members of the Church are required by the university to regularly attend religious services. Therapists received a \$10 incentive for completing the RCI-10 before the study began and a \$10 incentive each time they completed the Therapist Session Checklist (TSC; described below) after treating a client-subject.

## **Measures**

### ***The Outcome Questionnaire***

The Outcome Questionnaire – 45.2 (OQ; Lambert et al., 2004) was designed to measure three aspects of an individual’s level of functioning: levels of symptom distress, performance in various social roles and activities, and perceived quality of interpersonal relationships (Beckstead et al., 2003). Some of its main functions are to measure the level of distress an individual is experiencing at the time of administration and to be sensitive to change over short periods of time (Lambert et al., 1998; Wells et al., 1996). Vermeersch et al. (2004) concluded that the OQ Total score was sensitive to change in multiple populations, including college counseling centers,

and was used to track the outcomes of clients during therapy through administrations that occurred within the 24 hours before each appointment. In different populations, the OQ total score has test-retest reliability scores in the .80 - .90 range (Pearson product-moment correlation coefficient) and internal consistency of .93 (Cronbach's alpha; Lambert et al., 1998; Vermeersch et al., 2004). The Cronbach's alpha for the initial completion of the OQ for the current study's sample was 0.92 and for the final completion of the OQ the Cronbach's alpha was 0.94.

In addition, the OQ includes a cutoff score of clinical distress at 64, meaning that the distress experienced by individuals who score below 64 is not considered to be at the clinical level, while scores at or above 64 do indicate a clinical level of symptom distress (Lambert, et al., 1998). Overall, the OQ total score is considered to be a satisfactory measure of client's changes in distress level over the course of therapy. The change in OQ total scores from the beginning of therapy and the end of therapy was used as a variable for therapy outcome.

### ***The Religious Commitment Inventory***

The Religious Commitment Inventory – 10 (RCI; Worthington et al., 2003) is designed to measure individuals' religious commitment, which Worthington (1988) defined as "the degree to which a person adheres to his or her religious values, beliefs, and practices and uses them in daily living" (p. 166). The RCI-10 was administered in order to assess religious commitment at the beginning and end of treatment (for the client participants) and once at the beginning of their participation (for the therapist participants). Respondents read statements and select a number between one and five on a Likert scale from "Not at all true of me" to "Totally true of me." These statements include "I make financial contributions to my religious organization," "My religious beliefs lie behind my whole approach to life," and "I keep well informed about my

local religious group and have some influence in its decisions.” The full RCI-10 is provided in Appendix A.

The RCI-10 psychometric data support the measure as an accurate representation of the individual’s religious commitment. It was adapted from the 17-item RCI-17 (McCullough et al., 1997) to provide a more accessible version that retained or improved upon the psychometric properties of the previous iteration. In a series of six studies, Worthington et al. (2003) determined that the RCI-10 has high internal consistency with a coefficient alpha of 0.93, test-retest reliability of 0.87 with three weeks between administrations, and high construct, concurrent and discriminant validity when compared to other measures. In factor analyses, all of the items on the RCI-10 loaded onto one of two factors which were identified as interpersonal religious commitment and intrapersonal religious commitment. The two were highly correlated, indicating that they are two parts of the more general construct of religious commitment. Overall, Worthington et al. (2003) determined that the RCI-10 has adequate psychometric properties, especially when applied to Christian individuals. Based on their findings, they also specifically noted that the measure is well-suited for use in research occurring within university and college counseling centers. The Cronbach’s alpha for the current sample was 0.91, indicating good internal consistency.

### ***The Clinically Adaptive Multidimensional Outcome Survey***

The Clinically Adaptive Multidimensional Outcome Survey (CAMOS; Sanders et al., 2018) is a measure designed to be used for routine outcome monitoring. This 25-item questionnaire was developed from a 42-item version after factor analyses with three separate samples of psychotherapy clients. The CAMOS was intended to assess different dimensions of client concerns and distress, five of which were identified in an exploratory factor analysis.

These dimensions are psychological distress, relationship distress, spiritual distress, physical health distress, and concerns about therapy. The model fit was found to be very good in confirmatory factor analyses that were performed on the different samples, as well. Cronbach's alpha for each dimension was at least 0.8 and good factor correlations between dimensions indicated that all five dimensions had good internal reliability.

Sanders et al. (2018) also found that the individual CAMOS dimensions can be used independently in order to monitor client concerns in specific areas. For this study, only the concerns about therapy subscale will be used as a measure of the clients' perception of therapy progress. This subscale assesses client distress about therapy, uncertainty about whether they can be honest with their therapist, and uncertainty that their therapist will understand their concerns. The concerns about therapy subscale showed good internal consistency with a Cronbach's alpha ranging from .80 to .84 in the different samples. The Cronbach's alpha for this study was 0.81. The client participants in this study took the full, 25-item CAMOS as part of their weekly set of questionnaires, in addition to the OQ and other measures. The last time that they completed the survey, the sum of their responses on the four questions that make up the concerns about therapy subscale were used as the measure of client perception of therapy progress.

### **Therapy Session Checklist**

The therapy session checklist (TSC) is an online checklist that therapist participants complete after each therapy session with a client participant. It consists of sections where the therapist can mark which theoretical orientation they were using during the session, psychological interventions, spiritual interventions, topics that were discussed, and their intentions for – or the purpose of – the session. While the third section is called “spiritual interventions” it includes interventions that address religious issues as well. Items include



“explored religious questions or doubts,” “referred to religious community,” and “used religious bibliotherapy,” among other options. The full spiritual interventions section can be seen in Appendix B. Though therapist participants completed the entire TSC for each session as part of a larger research project, the current study only includes information from the spiritual interventions section to track how many religious or spiritual interventions therapists used in sessions. As noted above, therapist-participants received \$10 for each TSC they completed.

### **Procedure**

All procedures for the project were approved by the BYU Institutional Review Board. Client participants were recruited via flyers placed in the waiting area of the counseling center. If they showed initial interest on the CAPS intake paperwork, they were sent an email inviting them to complete a few additional questionnaires including a consent form and the RCI-10. At that point, they were assigned to a therapist in the counseling center in accordance with normal procedures and completed the OQ before each session in order to track outcome. Clients were initially paid a small monetary incentive of \$5 for completing the initial questionnaires (including the RCI-10) and \$5 for completing the OQ before each therapy session in addition to other questionnaires that were not included in this study that the clients took regularly throughout therapy. Three months after their last session of therapy, client participants received an email inviting them to complete the follow-up questionnaires, which again included the RCI-10 (among others) but was not used for the current study. They were given \$25 when they completed the follow-up questionnaires. If they were still a student at BYU, client-participants were paid directly into their BYU financial account, if no longer enrolled, a check was sent to them at the address that they provided at the beginning of the study.

Therapist participants were recruited through email and in-person invitations. Once they consented to be a part of the study, they completed the RCI-10, which was deidentified in order to protect the therapists' confidentiality. They provided treatment as usual to their clients, which included therapies from several different theoretical orientations including cognitive behavioral, acceptance and commitment, mindfulness-based, client-centered, integrative, and others. The therapists were instructed to treat their participant clients as they typically would non-participating ones. Therapists were paid \$30 for completing an initial training about their participation in the research and then \$10 per session completed with a client participant for filling out the TSC, detailing what was done during the session. All therapist participant incentives were delivered via Visa gift cards.

### **Data Analysis**

Data were analyzed using regression models to investigate the hypotheses, including multilevel models in the case of each hypothesis that directly involves therapist data since all therapists will have multiple clients. All analyses were completed using Stata 16.1. For hypothesis 1a, the relationship between client RCI and initial distress was addressed using regression of client RCI score on initial OQ score. Linear regression was also used for hypothesis 1b to model the relationship between client RCI score and final OQ score, with client RCI predicting the final OQ score as a measure of therapy outcome – controlling for initial OQ. A regression of final OQ on first OQ in order to establish a regression coefficient that represents the particular client's change over the course of therapy. That coefficient was then used in a regression model to determine whether OQ change was predicted by the client's concerns about therapy progress, addressing hypothesis 2. A regression approach was also used to investigate

the relationship between therapist religious commitment and the average number of religious interventions that they used in each session, addressing hypothesis 3.

Multilevel regression was used in order to examine whether level of match between client and therapist religious commitment predicted client concerns about therapy, as anticipated in hypothesis 4a. The degree of matching between therapist and client religious commitment was estimated using their respective scores on the RCI in a regression interaction model. An identical approach was used for hypothesis 4b to determine whether client and therapist RCI match predicted therapy outcome for the client but used the OQ change score instead of the clients concerns about therapy. A multilevel model was used in both of these analyses because client RCI scores need to be nested within their therapists' RCI scores. The product of the two RCI scores was used in a cross-level interaction in order to obtain a score that represents the level of matching, which was then entered into a regression with the clients' perception of therapy score.

## Results

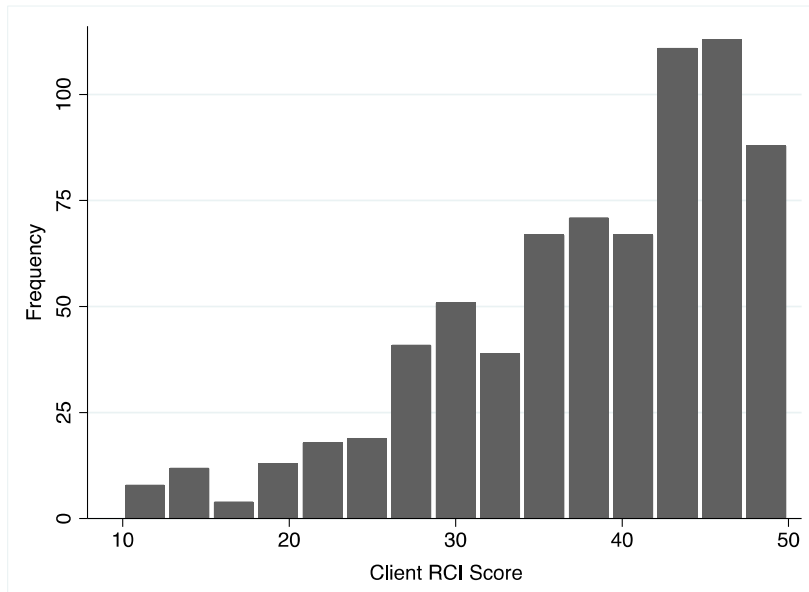
### Descriptive Statistics

All client participants completed the RCI at the beginning of their participation in the study. Their scores were skewed but showed a fair amount of variability, with a mean score of 39.95, ( $SD = 9.01$ ). Some individuals reached the minimum and maximum scores of 10 and 50, respectively. In their reports of normative data for the measure, Worthington, et al. (2003) indicated that the mean RCI scores in a typical university student population ranged from 22.8 ( $SD = 10.5$ ) to 25.7 ( $SD = 11.9$ ). Christian students at "explicitly Christian colleges" had mean RCI scores of 38.5 ( $SD = 7.9$ ) while the mean for clients in Christian agencies was 37.0 ( $SD = 10.4$ ). While the religious commitment of clients included in this study is higher than at other

counseling centers, it is not far from what the creators of the RCI reported for some other religious institutions. A distribution of client RCI scores is seen in Figure 1.

**Figure 1**

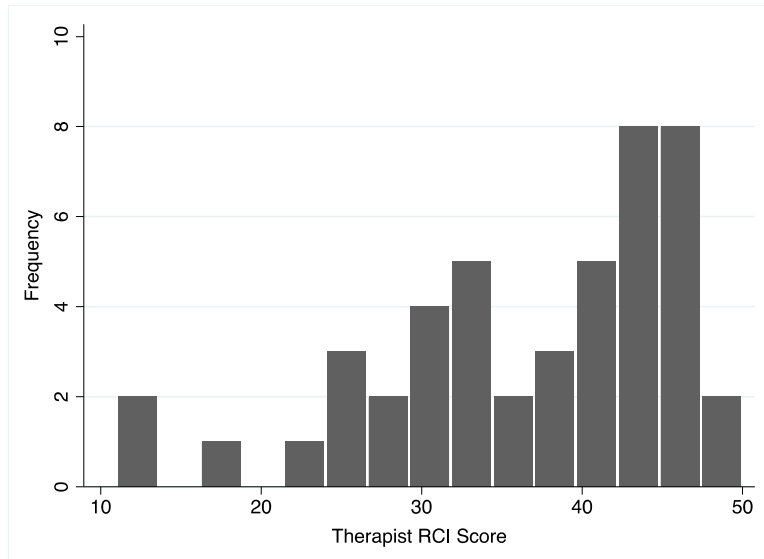
*Distribution of Client Religious Commitment Inventory (RCI) Total Scores*



Therapist participants also completed the RCI as planned, and data showed a similarly negative skewed as client scores. The mean score for therapists was 36.57 ( $SD = 9.38$ ) with scores ranging from 11 to 50. In the normative data provided by Worthington, et al. (2003), therapists in a “secular agency” had a mean RCI score of 25.5 ( $SD = 11.3$ ) while the mean of those at a Christian agency was 45.9 ( $SD = 4.4$ ). Thus, as with clients, therapist RCI scores were not unexpected given normative data. The distribution of therapist RCI scores is seen in Figure 2.

**Figure 2**

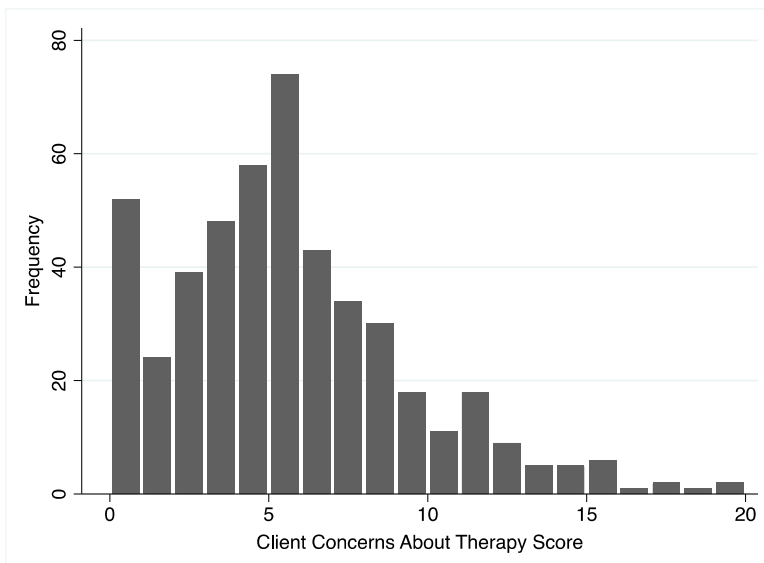
*Distribution of Therapist Religious Commitment Inventory (RCI) Total Scores*



The most recent/final CAMOS was used for this study, specifically the client concerns about therapy (CCT) progress subscale. Responses skewed toward being more positive, with a mean of 5.19 ( $SD = 3.74$ ) while scores ranged from 0 to 20 (the maximum and minimum scores). The distribution of CCT scores is shown in Figure 3.

**Figure 3**

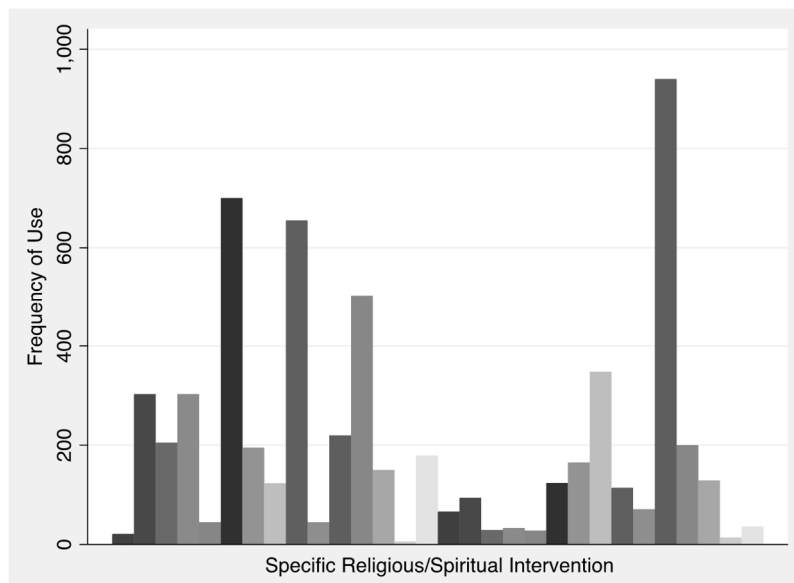
*Distribution of Client Concerns About Therapy (CCT) Subscale Scores*



In the therapy session checklist, therapist participants indicated which spiritual/religious interventions they used in each session. There was variety in the types of interventions used, as seen in Figure 4. The five most frequently used spiritual/religious interventions were “Listened to spiritual issues,” “Discussed compassion,” “Discussed hope,” “Discussed the spiritual dimensions of problems and solutions,” and “Explored religious questions and doubts,” in that order. The five least frequently used spiritual/religious interventions – starting from the least – were “Encouraged charitable service,” “Affirmed client confession/repentance,” “Used spiritual assessment,” “Encouraged spiritual journal writing,” and “Engaged in spiritual relaxation or imagery.”

**Figure 4**

*Frequency of Religious/Spiritual Interventions Use by Type*



## Religious Commitment and Distress

### *Hypothesis 1a*

To test the hypothesis that client religious commitment would predict initial distress, regression of initial OQ score on client RCI score was computed, revealing a negative

relationship between the two ( $B = -0.77$ ,  $p < 0.001$ ,  $R^2 = 0.07$ , 95% CI [-0.97, -0.57]). This is shown in Table 2 and graphically presented in Figure 5. The negative relationship indicates that for every one-point increase on the RCI, a client's initial OQ score could be expected to be 0.77 points lower, representing lower pre-treatment distress. Taking this into consideration, a client with a RCI score of 10 compared with a client with a RCI score of 50 on average would be predicted to score 30 points higher on the OQ.

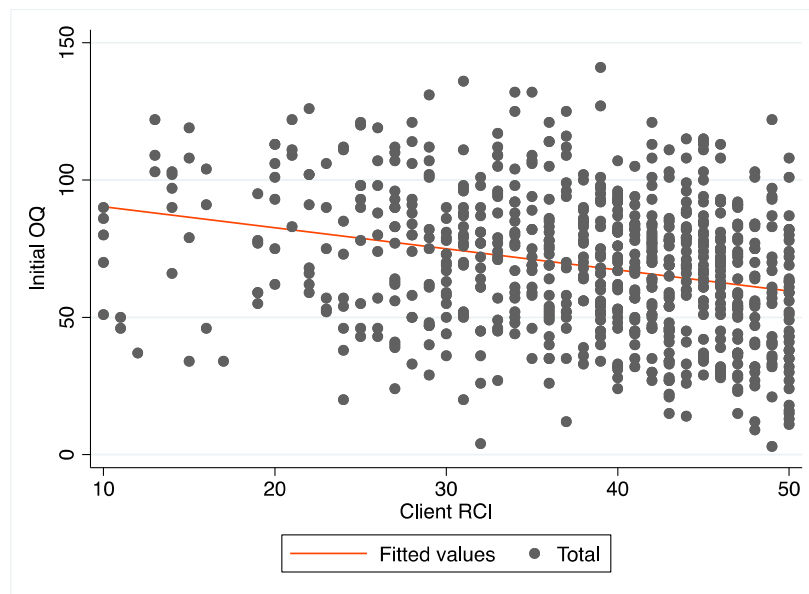
**Table 2**

*Regression of Client Religious Commitment on Initial Distress*

Effect	Estimate	SE	95% CI		<i>p</i>
			LL	UL	
Client RCI	-0.77	0.10	-0.97	-0.57	<.001

**Figure 5**

*Distribution of client religious commitment on initial distress*



***Hypothesis 1b***

The hypothesis that higher client religious commitment would predict lower distress at the end of treatment was tested using linear regression, of RCI score and final OQ score,

controlling for the initial OQ score. As seen in Table 3, RCI was found to be negatively related to final OQ, ( $B = -0.32$ ,  $p = 0.001$ ,  $R^2 = 0.34$ , 95% CI [-0.51, -0.14]) even when considering that those with lower RCI scores also had lower OQ scores before treatment. Therefore, for every point higher on the RCI, a client's final OQ score would be expected to be lower by 0.32 points. This indicates that clients with higher religious commitment will likely have slightly better outcomes from psychotherapy than others.

**Table 3**

*Regression of Final Client OQ Score*

Effect	Estimate	SE	95% CI		p
			LL	UL	
Client RCI	-0.32	0.09	-0.51	-0.14	0.001
Initial OQ	0.51	0.03	0.44	0.58	<.001

### Client Concerns About Therapy and Outcome

#### *Hypothesis 2.*

The hypothesis that fewer client concerns about therapy progress would predict lower distress at the end of treatment was addressed using regression, with final OQ score representing therapy outcome, predicted by client concerns about therapy, while controlling for initial OQ. The relationship was positive ( $B = 2.04$ ,  $p < 0.001$ ,  $R^2 = 0.38$ , 95% CI [1.52, 2.52]), showing that for every one-point increase on the CAMOS scale of client concerns about therapy, an increase of 2.04 points can be expected on the final OQ. These values are shown in Table 4. This positive relationship shows that clients who have concerns about therapy and their relationship with their therapist are likely to have significantly worse outcomes than others in psychotherapy.

**Table 4**

*Regression of Client Concerns About Therapy on Ending Distress*



Effect	Estimate	SE	95% CI		p
			LL	UL	
Client Concerns	2.04	0.27	1.52	2.52	<.001
Initial OQ	0.43	0.04	0.35	0.51	<.001

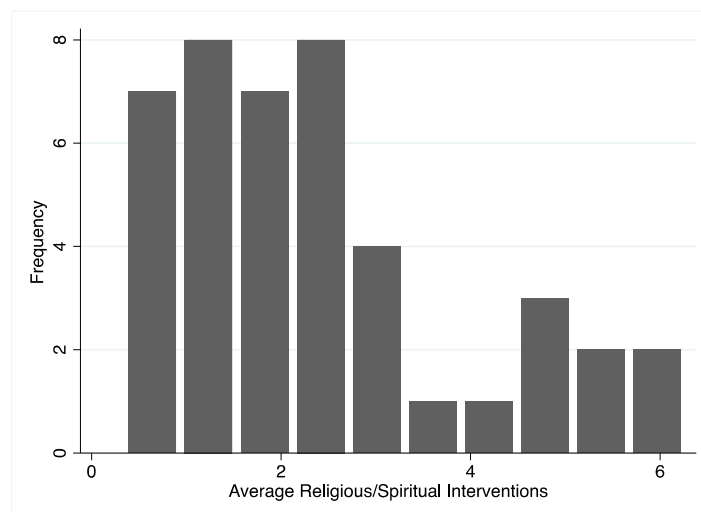
### Therapist Religious Commitment and Religious Interventions

#### *Hypothesis 3*

It was hypothesized that higher therapist religious commitment would predict higher average number of religious interventions used per session, and this was investigated via a linear regression approach, with therapist RCI predicting the average number of religious interventions that they use in each session, which was expected to result in a positive relationship. However, there was no significant relationship between therapist religious commitment and the average number of spiritual/religious interventions they used in treatment ( $B = 0.05$ ,  $p = 0.062$ ,  $R^2 = 0.09$ , 95% CI [-0.002, 0.11]). This could be due to the fact that the variability in average number of religious interventions used by therapists was low with a mean of 2.40 ( $SD = 1.62$ ) only ranging from 0.35 to 6.27, see Figure 6 and Table 5.

#### Figure 6

*Distribution of the Average Number of Religious/Spiritual Interventions Used by Therapist Participants*



**Table 5***Regression of Therapist Religious Commitment on Average Religious/Spiritual Interventions*

Effect	Estimate	SE	95% CI		p
			LL	UL	
Therapist RCI	0.05	0.03	-0.002	0.11	0.062

**Matching on Client and Therapist Religious Commitment***Hypothesis 4a*

To investigate whether a better match between therapist and client religious commitment would predict fewer client concerns about therapy progress multilevel regression was used, where the degree of matching between therapist and client religious commitment was estimated using their respective scores on the RCI in a regression interaction model. It was hypothesized that a negative relationship would exist since a higher score on the therapy concerns subscale indicates that the client's perception of therapy progress is more negative. As seen in Table 6, however, the model was not significant. This indicated no relationship between the interaction of therapist and client RCI and CCT ( $B = -0.002$ ,  $p = 0.161$ , 95% CI [-2.40, 9.57]). Additionally, the overall model was not significant, with the  $\chi^2$  (3,  $N = 477$ ) = 8.39,  $p = 0.039$  showing no significant difference from the null hypothesis and random-effects parameter estimate equal to  $3.32e-13$ . Residual intraclass correlation also approached zero ( $ICC = 2.42e-14$ ), signifying that there is no evidence of impact at the therapist level.

**Table 6***Client Concerns About Therapy Predicted by Client and Therapist Religious Commitment*

Effect	Estimate	SE	95% CI		p
			LL	UL	
Client RCI	0.06	0.08	-0.09	0.21	0.43
Therapist RCI	0.09	0.08	-0.07	0.24	0.27
Interaction	-0.002	0.002	-0.01	0.001	0.16

***Hypothesis 4b***

Finally, a better match between therapist and client religious commitment was expected to predict better therapy outcome, which was investigated using an identical approach to the previous hypothesis. However, the OQ score was used instead of the clients concerns about therapy in order to answer whether or not the client's outcome is impacted directly by the match between client and therapist religious commitment. There was no evidence for the interaction of client and therapist religious commitment influencing therapy outcome ( $B = -0.014$ ,  $p = 0.120$ , 95% CI [-0.03, 0.004]), see Table 7. While the overall model was significant,  $\chi^2(4, N = 523) = 285.09$ ,  $p = 0.00$ , it showed no difference from the null. Again, residual intraclass correlation was very low (ICC = 0.03), signifying that there is no evidence of impact of religious commitment at the therapist level on outcome.

**Table 7**

*Client Therapy Outcome Predicted by Client and Therapist Religious Commitment*

Effect	Estimate	SE	95% CI		p
			LL	UL	
Initial Distress	0.52	0.03	0.45	0.59	<0.001
Client RCI	0.18	0.33	-0.18	0.83	0.58
Therapist RCI	0.49	0.34	-0.18	1.15	0.15
Interaction	-0.01	0.01	-0.03	0.003	0.12

**Discussion**

The purpose of this study was to investigate the role of religious commitment in the experience and outcome of clients in psychotherapy at a university counseling center. As expected, client religious commitment was found to be related to lower initial distress and both higher client religious commitment and lower client concerns about therapy predicted better therapy outcomes. However, therapist religious commitment was not related to the average number of religious/spiritual interventions used per session, which diverged from the hypothesis.

The impact of the match between client and therapist religious commitment was also investigated, but – contrary to expectations – there was no evidence that the level of match impacted the client’s perception of therapy or their outcomes.

### **Client Factors**

Clients’ religious commitment significantly impacted initial distress. In other words, a client who is more religious can be expected to be less distressed than a less religious individual when they enter psychotherapy. While the R-squared value indicates that only 7% of the variance in initial OQ score can be predicted by the RCI, this is similar to other factors in psychotherapy outcome research. Lambert and Barley (2001) reported that even variables like specific therapeutic techniques used by a therapist account for about 15% of the variance in psychotherapy outcome. Religious clients were also less distressed than their secular counterparts at the end of treatment, even when their lower initial distress was taken into account. Although the effect was small, a difference of 11 points on the RCI predicted a four-point difference in final OQ score. This change in OQ score could be conceptualized as one symptom rated as “almost always” at the beginning of treatment (e.g., “I feel stressed at work/school,” “I feel worthless,” “I have thoughts of ending my life,” etc.) being rated as “never” at the end of therapy. Additionally, a 40-point difference between two clients’ RCI scores would predict slightly more than a 14-point difference on the final OQ. A 14-point change in one client’s OQ score over their course of therapy would be considered significant improvement according to the OQ manual (Lambert, et al., 1998).

These data are aligned with previous findings that higher religiosity can predict positive mental health outcomes (Bonelli & Koenig, 2013; Koenig, 2009; McCullough, 1999; Shafranske & Cummings, 2013). Though the results of this study, were also likely influenced by the setting

in which it took place: a university sponsored by a specific religion. The positive skew of religious commitment among the participants of this study is probably representative of the university at large, where the vast majority of students are affiliated with the sponsoring religion (the Church of Jesus Christ of Latter-day Saints). This is important because students at the university who identify as low in religious commitment are in the minority and therefore could be expected to feel somewhat disconnected from the campus community and/or concerned about their standing at the university (since religious activity is required). Feeling socially isolated or worried would clearly impact their distress levels entering therapy, regardless of other presenting concerns.

Fewer client concerns about therapy also predicted decreased end-of-treatment distress. Having fewer concerns about therapy was related to lower scores on the OQ to the degree that for every point increase on the client concerns about therapy (CCT) subscale of the CAMOS (indicating additional concerns), final OQ could be expected to increase by two points (indicating higher levels of distress). Another explanation could be that a difference in seven points on the CCT would predict a 14-point increase in the OQ, equal to the cutoff for significant deterioration (Lambert, et al., 1998). Therefore, it was shown that when clients perceived that therapy was going well and rated their relationship with their therapist positively their outcomes were better. This was in line with expectations based off of previous research and shows that if other variables impact client perceptions of therapy, those variables might indirectly impact treatment outcome.

### **Therapist Factors**

While therapist religiosity was expected to predict the average number of religious/spiritual interventions that they used in therapy, this was not found in this study. There

was no significant difference in how often these therapists utilized those tools in treatment. As explored in the Introduction, other studies have shown that therapist religiosity typically predicts their comfort with including religious interventions and the frequency with which they do so (Cummings, et al., 2014; Shafranske & Malony, 1990; Walker et al., 2005). However, these results suggest that participating therapists in this study, across all levels of religious commitment, were successfully able to adapt their therapeutic approach to address their clients' needs regardless of their personal beliefs. One factor that was not addressed in this study was the nature of the specific religious/spiritual interventions that were used by the therapists. While there is variety in the type of utilized interventions, it is possible that the therapists did not view some of the listed interventions as particularly religious or spiritual (e.g., discussing compassion or hope). The lack of significant difference in average number of religious/spiritual interventions used across levels of religious commitment could potentially have been influenced by therapists using particular types of interventions more than others.

As these data were gathered at a highly religious institution where a high percentage of clients are interested in discussing spiritual or religious topics, it is likely that the therapists in this study have much more experience in dealing with religious concerns and utilizing religious interventions than the therapists at a more secular university would. Therefore, the explanations provided by previous research may not apply to the participants in this study. The overall presence of mental health concerns that are related to religion are likely very well-known to the therapists at such an institution and the religious homogeneity of the clientele might make it easier for even the least religious therapist to establish standard interventions that address those concerns. While previous research found that higher therapist religiosity or spirituality predicted more favorable attitudes toward using religious/spiritual in treatment (Cummings et al., 2014),

therapy clients in a highly religious setting would likely request those interventions more frequently. The consistent experience of addressing those issues with clients could only be expected to lead to increased therapist confidence in doing so. This confidence would be another difference from the typical therapy provider, as reported by Oxhandler and Parrish (2018) who said that most therapists did not feel confident in their ability to appropriately involve religious or spiritual topics in therapy, even if they had positive views toward doing so.

Finally, therapists' personal religiousness and practice of religious behaviors has previously predicted more frequent use of religious interventions and self-reported competency (Walker et al., 2005). However, because religious behaviors – including regular church service attendance – are a requirement for employment at Brigham Young University, they may not be an accurate measure of internalized religiosity. This study indicates that familiarity with religious behavior may be more relevant than internal beliefs. Overall, while existing research would suggest that therapists in general are unlikely to feel competent or comfortable with using religious interventions unless they are religious themselves, it seems that the therapists in this study were able to employ these interventions skillfully, regardless of levels of personal religious commitment.

### **Therapist and Client Matching**

While the previous research in matching on therapist and client characteristics is mixed, there is some evidence to suggest that matching on religiosity might be beneficial to client perception of treatment and outcome (Gregory et al., 2008; Kelly & Strupp, 1992; Martinez et al., 2007). However, this study did not show a significant relationship between congruence or non-congruence on religious commitment and client concerns about therapy or distress at the end of therapy. While somewhat unexpected given the existing research, this null finding may be less

surprising given the unique setting in which this study took place – as explained above. Some of the applicable matching literature is focused on client perception of how they matched with their therapist (Kelley & Strupp, 1992; Dolinsky et al., 1998; Martinez et al., 2007), and this study did not examine client perception of match. It is likely that the vast majority of clients were unaware of their therapists' level of religious commitment, meaning that clients might perceive a good or bad match regardless of the convergence (or lack thereof) on RCI scores. Other research has shown that therapists can be expected to have a difficult time working with clients whose beliefs or behaviors oppose their own (Morrison & Borgen, 2010; Brown et al., 2013). However, the homogeneity of the clients in a religious university's counseling center may have made it easier for therapists to become skilled at dealing with those clients.

In addition to the unique factors that impact the therapists at the center in the current study, an important aspect being a psychologist in any setting is multicultural competence. The APA has emphasized the importance of maintaining high standards when it comes to working with people in a way that takes the intersection of the various aspects of their identity into account, and religion is an important part of many individuals' identities (APA, 2002; APA, 2017). Therefore, the ability of the therapists in this study to provide therapy to clients of various levels of religious commitment – especially when different from their own – is one sign that they have developed multicultural competence in their clinical work. Given this profession-wide expectation to provide services that are inclusive to individuals of all cultural backgrounds, it might be expected that psychologists would be able to handle religious topics and deliver applicable interventions. While previous research has shown that therapists may have a difficult time navigating these types of clinical situations (Hathaway et al., 2004; Oxhandler & Parrish, 2018; Shafranske & Malony, 1990; Walker et al., 2011) this study shows that it is not inevitable



for religious differences between therapists and clients to impact the client perception of therapy or treatment outcomes.

### **Limitations**

The current study occurred in the counseling center of a university where the vast majority of students identify as religious and are expected to maintain their religious practice while enrolled. Because of this, levels of religious commitment were likely less normally distributed than would be expected at most other universities. Likewise, therapists in the study were employed by the same institution and were under the same expectations as students regarding consistent religious practice. These unique characteristics make the findings of this study more difficult to generalize, even while providing helpful insight into highly religious treatment settings. Since research shows psychologists are more likely to be irreligious than the average American, other settings might have a similar issue of low variability in religious commitment, but on the other end of the scale (Delaney et al., 2007; McMinn et al., 2009; Post & Wade, 2009; Shafranske, 2000; Shafranske & Cummings, 2013).

Additionally, it is important to note that not all students receive their mental health treatment from the university counseling center and might instead seek therapy from providers in the community. At an institution where students' status is dependent on their religious activity, students who are experiencing changes in their religious beliefs or behaviors might be more likely to leave the university for therapy. This could be due to concerns that therapists embedded in the university would be less willing or capable of addressing changing religious beliefs or that their status at the university could be at risk. While there is no simple solution to this particular limitation, it is possible that it could have made the sample less representative of the diversity of client religious commitment.

### **Conclusions and Future Directions**

This study sought to investigate the relationship between religious commitment at the client and therapist level and variables such as initial distress, outcome, client perception of therapy, and therapist utilization of religious interventions. Results showed that higher client religious commitment did, in accordance with hypotheses, predict lower distress at the beginning of therapy and at the end (even when controlling for initial distress). As expected, higher levels of client concerns about therapy progress predicted higher distress at the end of treatment. Though higher level of religious commitment was anticipated to predict higher average number of religious interventions used per session, this was not the case. Similarly, level of congruence between client and therapist religious commitment was not significantly related to client concerns about therapy or client outcomes.

Future research could likely benefit from gathering data at sites where there is a high degree of variability in the religious commitment in both the client and therapist populations. This would provide more opportunity for highly religious individuals to be paired with therapists that are completely non-religious and vice-versa. Since previous research has shown that psychologists' use of religious interventions is often predicted by their own personal religiosity, data that come from sites that do not deal with religious topics as frequently as BYU's counseling center might also contain additional insights. Since therapists at a more secular institution or site might not have as much experience with those types of issues as a natural function of their location, their own religious commitment might impact the average number of religious interventions used as was hypothesized in this study.

### References

- Adams, M. D. (2018). Religious perfectionism: Utilizing models of perfectionism in treating religious clients. *Issues in Religion and Psychotherapy, 39*(1), 10.
- American Psychological Association. (2005, August). American Psychological Association policy statement on evidence-based practice in psychology. Retrieved July 6, 2019, from <https://www.apa.org/practice/guidelines/evidence-based-statement>
- American Psychological Association. 2017. Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality. Retrieved from: <http://www.apa.org/about/policy/multicultural-guidelines.pdf>
- Anderson, K. N., Bautista, C. L., & Hope, D. A. (2019). Therapeutic alliance, cultural competence and minority status in premature termination of psychotherapy. *American Journal of Orthopsychiatry, 89*(1), 104–114. <https://doi-org.erl.lib.byu.edu/10.1037/ort0000342>
- Anderson, T., Ogles, B. M., Patterson, C. L., Lambert, M. J., & Vermeersch, D. A. (2009). Therapist effects: Facilitative interpersonal skills as a predictor of therapist success. *Journal of Clinical Psychology, 65*(7), 755–768. <https://doi.org/10.1002/jclp.20583>
- Bachelor, A. (2013). Clients' and therapists' views of the therapeutic alliance: Similarities, differences and relationship to therapy outcome. *Clinical Psychology & Psychotherapy, 20*(2), 118–135. <https://doi.org/10.1002/cpp.792>
- Baldwin, S. A., & Imel, Z. E. (2013). Therapist effects: Findings and methods. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed., pp. 258-297). Hoboken, NJ: John Wiley & Sons.

- Barnett, J., & Johnson, W. B. (2011). Integrating spirituality and religion into psychotherapy: Persistent dilemmas, ethical issues, and a proposed decision-making process. *Ethics & Behavior, 21*(2), 147-164.
- Beckstead, D. J., Hatch, A. L., Lambert, M. J., Eggett, D. L., Goates, M. K., & Vermeersch, D. A. (2003). Clinical significance of the Outcome Questionnaire (OQ-45.2). *The Behavior Analyst Today, 4*(1), 86-97.
- Beutler, L. E., Harwood, T. M., Kimpara, S., Verdirame, D., & Blau, K. (2011). Coping style. *Journal of Clinical Psychology, 67*(2), 176–183. <https://doi.org/10.1002/jclp.20752>
- Bohart, A. C., & Wade, A. G. (2013). The client in psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed., pp. 258-297). Hoboken, NJ: John Wiley & Sons.
- Bonelli, R., & Koenig, H. (2013). Mental Disorders, Religion and Spirituality 1990 to 2010: A Systematic Evidence-Based Review. *Journal of Religion & Health, 52*(2), 657–673. <https://doi.org/10.1007/s10943-013-9691-4>
- Brown, O., Elkonin, D., & Naicker, S. (2013). The use of religion and spirituality in psychotherapy: Enablers and barriers. *Journal of Religion and Health, 52*, 1131-1146. [doi:10.1007/s10943-011-9551-z](https://doi.org/10.1007/s10943-011-9551-z)
- Cabral, R. R., & Smith, T. B. (2011). Racial/ethnic matching of clients and therapists in mental health services: A meta-analytic review of preferences, perceptions, and outcomes. *Journal of Counseling Psychology, 58*(4), 537–554. <https://doi.org/10.1037/a0025266>
- Captari, L. E., Hook, J. N., Hoyt, W., Davis, D. E., McElroy-Heltzel, S. E., & Worthington, E. L. (2018). Integrating clients' religion and spirituality within psychotherapy: A

- comprehensive meta-analysis. *Journal of Clinical Psychology*, 74(11), 1938–1951.  
<https://doi.org/10.1002/jclp.22681>
- Corey, G., Corey, M. S., & Callanan, P. (2007). *Issues and ethics in the helping professions*. Belmont, CA: Thomas Brooks/Cole.
- Cummings, J. P., Ivan, M. C., Carson, C. S., Stanley, M. A., & Pargament, K. I. (2014). A systematic review of relations between psychotherapist religiousness/spirituality and therapy-related variables. *Spirituality in Clinical Practice*, 1(2), 116–132.  
<https://doi.org/10.1037/scp0000014.supp> (Supplemental)
- Currier, J. M., Stevens, L. T., Isaak, S. L., Smith, T., & Zlomke, K. (2020). Understanding preferences for addressing spirituality among adults seeking outpatient mental health care. *Journal of Nervous & Mental Disease*, 208(6), 514–516.  
<https://doi.org/10.1097/NMD.0000000000001164>
- Delaney, H. D., Miller, W. R., & Bisonó, A. M. (2007). Religiosity and spirituality among psychologists: A survey of clinician members of the American Psychological Association. *Professional Psychology: Research and Practice*, 38(5), 538–546.
- Dolinsky, A., Vaughan, S. C., Luber, B., Mellman, L., & Roose, S. (1998). A match made in heaven? A pilot study of patient-therapist match. *The Journal of Psychotherapy Practice and Research*, 7(2), 119–125.
- Dougall, J. L., & Schwartz, R. C. (2011). The influence of client socioeconomic status on psychotherapists' attributional biases and countertransference reactions. *American Journal of Psychotherapy*, 65(3), 249–265.
- Exline, J. J., Van Tongeren, D. R., Bradley, D. F., Wilt, J. A., Stauner, N., Pargament, K. I., & DeWall, C. N. (2020). Pulling away from religion: Religious/spiritual struggles and

- religious disengagement among college students. *Psychology of Religion and Spirituality*.  
<https://doi.org/10.1037/rel0000375>
- Flaskerud, J. H., & Liu, P. Y. (1991). Effects of an Asian client-therapist language, ethnicity and gender match on utilization and outcome of therapy. *Community Mental Health Journal*, 27(1), 31-42.
- Gallup, Inc. (2017, December 22). *2017 Update on Americans and Religion*. Retrieved from <https://news.gallup.com/poll/224642/2017-update-americans-religion.aspx>
- Gallup, Inc. (2021, March 29). *Religiosity Largely Unaffected by Events of 2020 in U.S.* Retrieved from <https://news.gallup.com/poll/341957/religiosity-largely-unaffected-events-2020.aspx>
- Garfield, S. L. (1994). Research on client variables in psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change*, 4th ed. (pp. 190–228). Oxford: John Wiley & Sons.
- Gregory, C. I., Pomerantz, A. M., Pettibone, J. C., & Segrist, D. J. (2008). The effect of psychologists' disclosure of personal religious background on prospective clients. *Mental Health, Religion & Culture*, 11(4), 369–373.
- Hardy, S. A., Pratt, M. W., Pancer, S. M., Olsen, J. A., & Lawford, H. L. (2011). Community and religious involvement as contexts of identity change across late adolescence and emerging adulthood. *International Journal of Behavioral Development*, 35(2), 125-135.
- Hathaway, W. L., Scott, S. Y., & Garver, S. A. (2004). Assessing religious/spiritual functioning: A neglected domain in clinical practice? *Professional Psychology, Research and Practice*, 35, 97.

- Hood Jr, R. W., Hill, P. C., & Spilka, B. (2018). *The psychology of religion: An empirical approach*. New York, NY: Guilford Publications.
- Johnson, C. V., & Hayes, J. A. (2003). Troubled Spirits: Prevalence and predictors of religious and spiritual concerns among university students and counseling center clients. *Journal of Counseling Psychology, 50*(4), 409–419. <https://doi.org/10.1037/0022-0167.50.4.409>
- Kelly, T. A., & Strupp, H. H. (1992). Patient and therapist values in psychotherapy: Perceived changes, assimilation, similarity, and outcome. *Journal of Consulting and Clinical Psychology, 60*(1), 34.
- Koenig, H. G. (2009). Research on religion, spirituality, and mental health: A review. *The Canadian Journal of Psychiatry, 54*(5), 283–291.  
<https://doi.org/10.1177/070674370905400502>
- Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, Research, Practice, Training, 38*(4), 357–361. <https://doi-org.erl.lib.byu.edu/10.1037/0033-3204.38.4.357>
- Lambert, M. J., Gregersen, A. T., & Burlingame, G. M. (2004). The Outcome Questionnaire-45. In *The use of psychological testing for treatment planning and outcomes assessment: Instruments for adults, Volume 3, 3rd ed* (pp. 191–234). Lawrence Erlbaum Associates Publishers.
- Lambert, M. J., Okiishi, J. C., Finch, A. E., & Johnson, L. D. (1998). Outcome assessment: From conceptualization to implementation. *Professional Psychology: Research and Practice, 29*(1), 63.
- Lambert, M. J., & Shimokawa, K. (2011). Collecting client feedback. *Psychotherapy, 48*(1), 72–79. <https://doi-org.erl.lib.byu.edu/10.1037/a0022238>

- Martinez, J. S., Smith, T. B., & Barlow, S. H. (2007). Spiritual interventions in psychotherapy: Evaluations by highly religious clients. *Journal of Clinical Psychology, 63*(10), 943–960. <https://doi.org/10.1002/jclp.20399>
- McCullough, M. E. (1999). Research on religion-accommodative counseling: Review and meta-analysis. *Journal of Counseling Psychology, 46*(1), 92-98. doi:10.1037/0022-0167.46.1.92
- McCullough, M. E., Worthington, E. L., Maxey, J., & Rachal, K. C. (1997). Gender in the context of supportive and challenging religious counseling interventions. *Journal of Counseling Psychology, 44*(1), 80–88. <https://doi-org.erl.lib.byu.edu/10.1037/0022-0167.44.1.80>
- McMinn, M. R., Hathaway, W. L., Woods, S. W., & Snow, K. N. (2009). What American Psychological Association leaders have to say about psychology of religion and spirituality. *Psychology of Religion and Spirituality, 1*(1), 3.
- Morrison, M., & Borgen, W. A. (2010). How Christian spiritual and religious beliefs help and hinder counselors' empathy toward clients. *Counseling and Values, 55*(1), 25-45.
- Okiishi, J., Lambert, M. J., Nielsen, S. L., & Ogles, B. M. (2003). Waiting for supershrink: An empirical analysis of therapist effects. *Clinical Psychology & Psychotherapy, 10*(6), 361–373. <https://doi-org.erl.lib.byu.edu/10.1002/cpp.383>
- Oman, D., & Syme, S. L. (2018). Weighing the evidence: What is revealed by 100+ meta-analyses and systematic reviews of religion/spirituality and health? In D. Oman (Ed.), *Why religion and spirituality matter for public health: Evidence, implications, and resources* (pp. 261–281). [https://doi.org/10.1007/978-3-319-73966-3\\_15](https://doi.org/10.1007/978-3-319-73966-3_15)



- Oxhandler, H. K., & Parrish, D. E. (2018). Integrating clients' religion/spirituality in clinical practice: A comparison among social workers, psychologists, counselors, marriage and family therapists, and nurses. *Journal of Clinical Psychology, 74*(4), 680–694.
- Paloutzian, R. F., & Park, C. L. (2021). The psychology of religion and spirituality: How big the tent? *Psychology of Religion and Spirituality, 13*(1), 3–13.  
<https://doi.org/10.1037/rel0000218>
- Pargament, K., Koenig, H., Tarakeshwar, N., & Hahn, J. (2004). Religious coping methods as predictors of psychological, physical and spiritual outcomes among medically ill elderly patients: A two-year longitudinal study. *Journal of Health Psychology, 9*, 713-730.  
doi:10.1177/1359105304045366
- Paukert, A., Phillips, L., Cully, J., Romero, C., & Stanley, M. (2011). Systematic review of the effects of religion-accommodative psychotherapy for depression and anxiety. *Journal of Contemporary Psychotherapy, 41*, 99-108.
- Post, B. C., & Wade, N. G. (2009). Religion and spirituality in psychotherapy: A practice-friendly review of research. *Journal of Clinical Psychology, 65*(2), 131–146.  
<https://doi.org/10.1002/jclp.20563>
- Raylu, N., & Kaur, I. (2012). Relationships between treatment expectations and treatment outcomes among outpatients with substance use problems. *International Journal of Mental Health and Addiction, 10*(5), 607-621.
- Razali, S. M., Hasanah, C. I., Aminah, K., & Subramaniam, M. (1998). Religious--sociocultural psychotherapy in patients with anxiety and depression. *The Australian and New Zealand Journal of Psychiatry, 32*, 867.

- Sanders, P. W., Richards, P. S., & McBride, J. A. (2018). Development of the clinically adaptive multidimensional outcome survey. *Psychotherapy Research, 28*(6), 925-939.
- Saucier, G., & Skrzypińska, K. (2006). Spiritual but not religious? Evidence for two independent dispositions. *Journal of Personality, 74*(5), 1257–1292. <https://doi.org/10.1111/j.1467-6494.2006.00409.x>
- Schafer, R. M., Handal, P. J., Brawer, P. A., & Ubinger, M. (2011). Training and education in religion/spirituality within APA-accredited clinical psychology programs: 8 years later. *Journal of Religion and Health, 50*(2), 232–239. <https://doi.org/10.1007/s10943-009-9272-8>
- Shafranske, E. P. (2000). Religious involvement and professional practices of psychiatrists and other mental health professionals. *Psychiatric Annals, 30*(8), 525-532.
- Shafranske, E. P., & Cummings, J. P. (2013). Religious and spiritual beliefs, affiliations, and practices of psychologists. In K. I. Pargament, A. Mahoney, & E. P. Shafranske (Eds.), *APA handbooks in psychology. APA handbook of psychology, religion, and spirituality (Vol. 2): An applied psychology of religion and spirituality* (pp. 23-41). Washington, DC, US: American Psychological Association.
- Shafranske, E. P., & Malony, H. N. (1990). Clinical psychologists' religious and spiritual orientations and their practice of psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 27*(1), 72–78. <https://doi-org.erl.lib.byu.edu/10.1037/0033-3204.27.1.72>
- Smith, T. B., Bartz, J., & Richards, P. S. (2007). Outcomes of religious and spiritual adaptations to psychotherapy: A meta-analytic review. *Psychotherapy Research, 17*(6), 643–655. <https://doi-org.erl.lib.byu.edu/10.1080/10503300701250347>

- Smith, T. B., & Trimble, J. E. (2016). Matching clients with therapists on the basis of race or ethnicity: A meta-analysis of clients' level of participation in treatment. In *Foundations of multicultural psychology: Research to inform effective practice*. (pp. 115–128). Washington, DC: American Psychological Association. <https://doi-org.erl.lib.byu.edu/10.1037/14733-006>
- Swift, J. K., Callahan, J. L., Cooper, M., & Parkin, S. R. (2018). The impact of accommodating client preference in psychotherapy: A meta-analysis. *Journal of Clinical Psychology, 74*(11), 1924-1937.
- Swift, J. K., Callahan, J. L., & Vollmer, B. M. (2011). Preferences. *Journal of Clinical Psychology, 67*(2), 155-165.
- Swift, J. K., & Derthick, A. O. (2013). Increasing hope by addressing clients' outcome expectations. *Psychotherapy, 50*(3), 284–287.
- Swift, J. K., & Greenberg, R. P. (2012). Premature discontinuation in adult psychotherapy: A meta-analysis. *Journal of Consulting and Clinical Psychology, 80*(4), 547–559. <https://doi.org/10.1037/a0028226>
- Swift, J. K., Greenberg, R. P., Whipple, J. L., & Kominiak, N. (2012). Practice recommendations for reducing premature termination in therapy. *Professional Psychology: Research and Practice, 43*(4), 379–387. <https://doi.org/10.1037/a0028291>
- Tao, K. W., Owen, J., Pace, B. T., & Imel, Z. E. (2015). A meta-analysis of multicultural competencies and psychotherapy process and outcome. *Journal of Counseling Psychology, 62*(3), 337–350. <https://doi.org/10.1037/cou0000086>

- Tjeltveit, A. C. (1986). The ethics of value conversion in psychotherapy: Appropriate and inappropriate therapist influence on client values. *Clinical Psychology Review*, 6(6), 515-537.
- Vermeersch, D. A., Whipple, J. L., Lambert, M. J., Hawkins, E. J., Burchfield, C. M., & Okiishi, J. C. (2004). Outcome questionnaire: Is it sensitive to changes in counseling center clients? *Journal of Counseling Psychology*, 51(1), 38.
- Vieten, C., Scammell, S., Pilato, R., Ammondson, I., Pargament, K., & Lukoff, D. (2013). Spiritual and religious competencies for psychologists. *Psychology of Religion and Spirituality*, 5, 129-144.
- Walker, D. F., Gorsuch, R. L., & Tan, S.-Y. (2005). Therapists' use of religious and spiritual interventions in christian counseling: A preliminary report. *Counseling and Values*, 49(2), 107–119. <https://doi-org.erl.lib.byu.edu/10.1002/j.2161-007X.2005.tb00257.x>
- Walker, J. J., & Longmire-Avital, B. (2013). The impact of religious faith and internalized homonegativity on resiliency for black lesbian, gay, and bisexual emerging adults. *Developmental Psychology*, 49(9), 1723–1731. <https://doi.org/10.1037/a0031059>
- Walker, D. F., Worthington, E. L. Jr., Gartner, A. L., Gorsuch, R. L., & Hanshew, E. R. (2011). Religious commitment and expectations about psychotherapy among Christian clients. *Psychology of Religion and Spirituality*, 3(2), 98–114. <https://doi.org/10.1037/a0021604>
- Wells, M. G., Burlingame, G. M., Lambert, M. J., Hoag, M. J., & Hope, C. A. (1996). Conceptualization and measurement of patient change during psychotherapy: Development of the Outcome Questionnaire and Youth Outcome Questionnaire. *Psychotherapy: Theory, Research, Practice, Training*, 33(2), 275-283.

- Williams, M. R. (2018). *Navigating conflicts between religious and professional values: Psychologists' experiences*. Available from ProQuest Dissertations & Theses Global. Retrieved from <https://search-proquest-com.erl.lib.byu.edu/docview/2124279536?accountid=4488>
- Worthington, E. L. (1988). Understanding the values of religious clients: A model and its application to counseling. *Journal of Counseling Psychology, 35*(2), 166–174. <https://doi.org/10.1037/0022-0167.35.2.166>
- Worthington, E. L. Jr., Wade, N. G., Hight, T. L., Ripley, J. S., McCullough, M. E., Berry, J. W., ... O'Connor, L. (2003). The Religious Commitment Inventory--10: Development, refinement, and validation of a brief scale for research and counseling. *Journal of Counseling Psychology, 50*(1), 84–96. <https://doi.org/10.1037/0022-0167.50.1.84>
- Yonker, J. E., Schnabelrauch, C. A., & DeHaan, L. G. (2012). The relationship between spirituality and religiosity on psychological outcomes in adolescents and emerging adults: A meta-analytic review. *Journal of Adolescence, 35*(2), 299-314.

## Appendix A

## Religious Commitment Inventory

**10-Item Religious Commitment Inventory**

*Read each of these statements and select the number that best describes how you feel:*


		Not at all true of me	Somewhat true of me	Moderately true of me	Mostly true of me	Totally true of me
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 organization.	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

Appendix B

Therapy Session Checklist – Spiritual Interventions Section

Home	TSC Tailoring	Camos	Take TSC	Review TSC
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Session Date

 Diagnosis

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Theoretical Orientation	Interventions	Spiritual Interventions	Counseling Topics	Intentions	Case Notes
		<input type="checkbox"/> Only show favorites <input type="checkbox"/> Affirmed client's divine worth <input type="checkbox"/> As therapist engaged in silent prayer <input type="checkbox"/> Discussed compassion <input type="checkbox"/> Discussed gratitude <input type="checkbox"/> Discussed humility <input type="checkbox"/> Discussed the spiritual dimensions of problems and solutions <input type="checkbox"/> Encouraged charitable service <input type="checkbox"/> Encouraged personal prayer <input type="checkbox"/> Encouraged spiritual journal writing <input type="checkbox"/> Engaged in spiritual relaxation or imagery <input type="checkbox"/> Explored questions about ultimate meaning <input type="checkbox"/> Helped in discerning Gods will <input type="checkbox"/> Listened to spiritual issues <input type="checkbox"/> Used religious bibliotherapy <input type="checkbox"/> Used spiritual confrontation		<input type="checkbox"/> Affirmed client confession/repentance <input type="checkbox"/> Affirmed trusting God <input type="checkbox"/> Clarified thoughts about evil <input type="checkbox"/> Discussed forgiveness <input type="checkbox"/> Discussed hope <input type="checkbox"/> Discussed self-control <input type="checkbox"/> Encouraged acceptance of God's love <input type="checkbox"/> Encouraged listening to the heart <input type="checkbox"/> Encouraged reconciling beliefs in God with pain and suffering <input type="checkbox"/> Encouraged spiritual meditation <input type="checkbox"/> Engaged in spiritual self-disclosure <input type="checkbox"/> Explored religious questions and doubts <input type="checkbox"/> Identified pathways to God or the sacred <input type="checkbox"/> Referred to religious community <input type="checkbox"/> Used spiritual assessment	

< 3 of 6 >