Religious Commitment, Religious Harm, and Psychological Distress: Course of Treatment Outcomes

Dane Abegg

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Religious Commitment, Religious Harm, and Psychological Distress:

Course of Treatment Outcomes

Dane Abegg

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

Doctor of Philosophy

Stevan Lars Nielsen, Chair
Ellie Young
G. E. Kawika Allen
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ABSTRACT

Religious Commitment, Religious Harm, and Psychological Distress: Course of Treatment Outcomes

Dane Abegg
Department of Counseling Psychology and Special Education
Doctor of Philosophy

This study examines the intersection of religion, mental health, and psychotherapy, specifically focusing on the concept of religious injury or harm. The literature review reveals a gap in research regarding the identification of religion as a potential source of emotional pain in religious individuals. To address this gap, this longitudinal study utilized intake data from 1303 clients and follow-up data from 748 clients three months after the completion of psychotherapy treatment. Primary objectives of the study were to examine whether religious commitment changes over the course of psychotherapy, explore if religious commitment influences mental health counseling outcomes, and better understand the relationship between psychological distress, religious commitment, and therapy outcomes among individuals who perceive religion as having harmed them. The results demonstrate that regardless of religious injury status, psychological distress decreased throughout the treatment period. Furthermore, psychotherapy not only reduced psychological distress but also altered client's religious commitment. Higher religious commitment at follow-up appeared to mitigate the negative effects of religious harm on therapy outcomes, resulting in lower levels of religious harm and improved therapy outcomes. These findings suggest that psychotherapy can effectively alleviate psychological distress and modify religious commitment for individuals who perceive religion as harmful. This research contributes to the existing literature on psychology and religion and emphasizes the need for further exploration of the complex relationship between religion, mental health, and therapeutic interventions.

Keywords: psychotherapy outcomes, religious commitment, religious injury, Religious Commitment Inventory-10 (RCI-10), Outcome Questionnaire-45 (OQ-45).
ACKNOWLEDGEMENTS

Completing this study and obtaining my doctorate degree has been paved with relentless support, unwavering dedication, and a series of invaluable contributions from mentors, family, and loved ones. Foremost among these is my wife and my best friend, April. This acknowledgment is but a meager tribute to your enduring patience, support, and love through the highs and the lows. When we brainstormed this graduate school undertaking years ago, we had no idea what we were getting into; no one said it would be easy, they only said it would be worth it…hopefully the value of this degree and comes in many forms in the future! Our journey together is an epic one. We’ve had three kids, moved seven times, lived in five cities and three states over this “adventure.” The pandemic was sticky and at times downright rough. Regardless of the strain, we learned to roll with it, laugh through it, and somehow managed to keep our date nights every week. Cheers to the drink runs and thrift shop rummaging! To my kids: For the first time in your lives, I will not have homework. I hope that my education will help to bring you a better life and shape me into a better father through your life.

Dr. Lars Nielsen, your exceptional guidance and mentorship have been instrumental in shaping not only my academic pursuits, but also my broader perspective on philosophy, psychotherapy, assessment, and research. Research meetings went beyond academics and masterfully turned into life and career mentoring. By luck, we closed the data gathering for this study right before the pandemic changed the world. We weathered the hysteria of the assessment class, and I was proud to help shape the curriculum by being your TA. For a supervisor, mentor, teacher, and Pizzaiolo, you are “pretty ok.”

Finally, to those who have been especial supports. To my Father-in-Law Gary: Early on in my master’s degree, you were working with a consultant and when you introduced me, told
the consultant that after my master’s, I would get a doctorate. We had talked about that dream, but you said it with such certainty that my own confidence grew. Thank you for answering my phone calls and questions. You’ve taught me how to balance work with play, gave me a desk in your own office so I could grind through the pandemic and stay on track I have enjoyed creating memories by working and vacationing together, and you have become someone whose insight and opinion that I value. Thank you for getting my family this far. John - it's not often you come across a friend and a resource rolled into one, and I've been fortunate that over time, our interactions have shifted from mere acquaintance to a firm friendship. Whether we have been bouncing ideas off each other, shooting the breeze, problem-solving, or working through challenging situations, your perspective and insights have always been enriching and have this accomplishment more enjoyable. Cory; friend, confidant, and conversationalist for over twenty years, across two nations, multiple states, colleges, and sundry adventures in word and deed.
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DESCRIPTION OF DISSERTATION STRUCTURE

This dissertation, *Religious Commitment, Religious Harm, and Psychological Distress: Course of Treatment Outcomes* is written in a hybrid format. This hybrid format combines traditional dissertation and journal publication layouts. The preliminary pages reflect requirements for submission to the university. The dissertation report is presented as a journal article and conforms to length and style requirements for submitting research reports to psychology and education journals. The extended literature review is included as an appendix.
Introduction

It is understood that religiosity is multi-faceted and complex; to the credit of many contemporary psychologists and researchers, the convergence between psychological and religious matters has become increasingly acknowledged (Shafranske & Malony, 1990; McCullough, 1999; Post & Wade, 2009; Worthington et al., 2003).

Although it has been recommended as an avenue of research (George et al., 2000), the literature has not yet explored whether religion has been identified as a source of emotional pain in religious persons/individuals. As such, there is an emerging interest in the role that religion plays in a person's mental health, particularly as it pertains to religious commitment and the potential for religious harm or injury. However, data regarding the prevalence of religious-related emotional distress (hereafter called religious injury or religious harm) among religious populations has not been examined; the effect of psychotherapy on religious commitment for religious clients who may or may not have experienced religious injury also remains uninvestigated.

Notwithstanding the growing body of literature regarding the intersection of psychology and religion, noticeable gaps remain: (a) Research on whether religious commitment changes over the course of psychotherapy has not yet been addressed; (b) Little work has been done to understand how factors such as religious commitment influence mental health counseling outcomes; (c) George et al. (2000) encouraged researchers to include in their work people who had experienced psychological pain associated with religion and who felt “that religion has harmed them” (p. 113). Only one study has been conducted to date that asked this question, and no analysis has been done to understand the implications of religious injury on a client’s religious commitment or psychotherapeutic outcomes (Sanders et al., 2015).
Defining and Understanding Religious Commitment

Psychological studies of religion and psychotherapy are complicated by how religiosity is measured (Hill & Pargament, 2003; Worthington et al. (2003) defined religious commitment as “the degree to which a person adheres to his or her religious values, beliefs, and practices and uses them in daily living overall” (p. 85). Worthington et al. (2003) suggest that studying religious commitment offers a pragmatic strategy for understanding religiosity.

In a general sense, religious commitment encompasses salient differences among believers and nonbelievers as identified by several scholars who study religiosity: beliefs, behaviors, and participation in a faith community; interrelated religious schemas and typologies that may overlap or reinforce one another: and internalized, externalized, or quest orientations which impact a person’s perspectives and interactions (for examples, see Abe-Kim et al., 2004; Gartner, 1996; Gorsuch & McPherson, 1989; Worthington, 1988).

Because religion is a widely experienced human phenomenon, it has been suggested that psychologists continue to research how it shapes mental health and how it interacts with psychotherapy (Hill & Edwards, 2013; Hood et al., 2018). While research on religiosity has revealed many relationships between psychology and mental health, outcome research on how psychotherapy affects religious commitment does not appear to have been rigorously addressed. Clinicians surveyed by Hathaway et al. (2004) reported that psychological treatment affected the religious functioning of their clients (p. 102), but their reports were based on non-specific recollections and did not examine actual change or extent of change in client religiosity. I can find no prospective studies of change in client religious commitment over the course of psychotherapy.
Six studies have examined the relationship between psychological distress and religiosity. The relationship is inconsistent: Zinnbauer and Pargament (1998) found that significant adverse stress and life experiences have an unpredictable effect on an individual’s religiosity, causing some to increase in their religiosity, while others seem to lose their faith and religious commitment. While religion generally appears to be a protective factor against physical and mental illness (VanderWeele, 2017) and can provide its adherents with social connections and coping mechanisms (Wang et al., 2016), research has also demonstrated discrepancies in the protective nature of religiosity.

Religious commitment has been demonstrated to buffer the impact of religious doubts and struggles on depressive symptoms (Abu-Raiya et al., 2016). These struggles have been defined as “something in a person’s current belief, practice, or experience [that] caus[es] or perpetuat[es] distress” (Exline, 2013, p. 459) but the focus for this research has been on maladaptive religious coping mechanisms (Bjorck & Thurman, 2007) or types of strain experienced (Pargament, 2007) while overlooking the possibility that religious individuals experience pain or injury through their religious engagements. Recognizing this inconsistency, Abu-Raiya et al. (2016) and van Tongeren et al. (2021) encouraged longitudinal research, examining if and how religious concerns, religious commitment, and psychological distress interact.

Psychological Distress, Religiosity, Religious Injury, and Psychotherapy

Although many factors could impact the strengthening or weakening of an individual’s religious commitment and changes in a person’s psychological distress, one factor that has not yet been addressed is a religious individual’s belief that religion has hurt them. I found no focused investigations of how religion is a source of emotional pain. I found no studies about: (a)
how prevalent religious injury is among religious adherents; (b) how religious injury impacts religious commitment; (c) how the religious commitment of those who have had painful religious experiences varies compared to those who have not; (d) differences in psychological distress between religious individuals who have painful religious experiences compared to those without religious injury; and (e) how religious commitment and psychological distress change during psychotherapy. This gap in the literature has been recognized by researchers; Koenig et al. (2001) called for outcome research examining religiosity and mental health and Exline (2013) suggested that researchers examine longitudinal outcomes and psychological mediators, as well as how religious struggles result in religious growth or decline (p. 469). Krause et al. (1998) reported that some religious individuals experienced psychological distress due to their religious community’s values, expectations, and social interactions.

Subjective well-being or the broad, personal assessment of one’s quality of life (Diener et al., 2018) appears to be reduced by negative interactions within church settings (Ellison et al., 2009; Krause et al., 2000; Nguyen et al., 2020).

**The Role of Religious Struggles in Contributing to Psychological Distress**

Two recent studies examining nationwide, representative samples of over 3,000 participants (Abu-Raiya et al., 2015; Pomerleau et al., 2020) found that, even in non-clinical populations, religious struggles contributed to the psychological distress experienced after stressful life events. Stress appeared to be complicated by revaluation of values, beliefs, and worldviews, causing doubts, conflicts, and tension about religious matters. Bockrath et al., (2021) similarly found in a meta-analysis that increased religious concern was associated with decreased psychological well-being.
Religious concerns and struggles reflect several themes, including alienation from and anger toward God, blaming God for struggles, having social resentments and conflicts, finding hypocrisy among other religious individuals, and experiencing religious doubts, all of which entail an individual experiencing discomfort, grievance, offense, alienation, and other emotional problems. These problems could be thought of as religion related injuries that may shape religious engagement and correlate with increased psychological distress (Exline et al., 2014).

Religious concerns tend to co-occur with experiences of sexual assault, suicidality, confusion regarding beliefs and values, and relationship concerns (Johnson & Hayes, 2003). Collectively, this literature suggests that an individual can experience distress and pain because of their affiliation with, participation in, or experiences with religion. These religious experiences can be viewed by those who experience them as religion causing injury or harm.

**Purpose of the Study**

While these studies acknowledge that religion and mental health are multi-faceted, the direct relationship between what people think of as religious injury, religious commitment, and psychological distress is unknown. The notion that religiosity can subjectively coexist with both psychological well-being and distress has only begun to be addressed in the literature (Abu-Raiya et al., 2016; Smith et al., 2003).

The current study appears to be the first to examine the possibility that religious commitment changes over the course of psychotherapy and to attempt to measure such change. This study also appears to be the first attempt to assess whether religiosity changes among psychotherapy clients who have experienced religious harm. I attempted to measure change in religiosity over the course of treatment and measure the role of religious harm in change in religiosity during psychotherapy. The goal of this research is to answer the call for integrating
research into clinical practice (APA Presidential Task Force on Evidence-Based Practice, 2006) and to inform clinicians as they attempt to improve their multicultural competencies as a feature of evidence-based practice.

The current research provided data on the religious commitment of those who report religious harm or injury compared to those who do not report such injury, differences in psychological distress between these groups, and data about how religious commitment and psychological distress change among those who do or do not report religious harm.

**Research Questions**

The following questions were answered in this study:

1. Is there a difference in psychological distress between clients who report religious harm at intake and those who do not?
2. Is there a difference in how psychological distress changes during therapy among clients who report religious harm at intake and those who do not?
3. What is the relationship between the report of religious harm at intake and report of religious commitment?
4. Does the relationship between the report of religious harm at intake and change in report of religious commitment after treatment?
5. Is there a direct effect of religious commitment on change in distress during therapy?
6. Is the relationship between religious commitment and change in distress mediated by report of religious harm?

**Method**

The data used for this study was gathered between 2018–2019 as part of a larger research program supported by the Templeton Foundation examining religiosity and psychotherapy.
outcomes (Nielsen et al., 2023). After receiving approval from the university's institutional ethics review board, students seeking therapy at the university's counseling center (Counseling and Psychological Services—CAPS) were invited to participate in the study before they attended their first psychotherapy appointment.

**Setting**

CAPS is located on campus at a large, private, religiously affiliated university with an enrollment of approximately 31,000 graduate and undergraduate students. The university favors enrollment and employment of religious affiliates, and more than 98% of students, staff, and faculty are members of the affiliated church. Students, staff, and faculty are required to receive an ecclesiastical endorsement attesting to their faith and adherence to church behavioral standards as a condition of admission or employment. As a condition of continued enrollment or employment the ecclesiastical endorsement must be renewed annually.

The counseling center had approximately 21,000 individual appointments in 2019. It staffed an average of 30 psychologists, five predoctoral interns, and 20 doctoral practicum trainees. Over the two years the study was conducted, 75 professionals and trainees provided psychotherapy to CAPS clients; 60 of these therapists and therapists-in-training completed consent forms and participated in the research. These therapists represented diverse theoretical orientations (multiculturalism, feminism, cognitive-behavioral therapy, compassion-focused, acceptance and commitment therapy, client-centered, etc.).

Clients were assigned to therapists in a quasi-random manner: Most clients were assigned to therapists based on therapist availability and matching open hours to schedules. Clients were then seen as often as therapist and student schedules permitted. Female clients sometimes requested female therapists, which was followed by similar quasi-random matching based on
availability and matching of schedules. Students with higher symptom severity were generally assigned to more senior therapists.

**Participants**

All CAPS clients who participated were students enrolled in classes at the university. The ecclesiastical endorsement procedure indicates that almost every client participant reported active religious affiliation, belief, and adherence to religious behavioral standards within a year of participating in the study. The only inclusion criteria for clients were consent and completion of CAPS and study intake procedures. From 3,930 clients treated at CAPS during the time the study was conducted, 1,303 (33.16%) consented to participate in the study and completed intake measures; 748 (57.4% of 1,303; 19.0% of 3,930 CAPS clients) completed study measures three months after the end of their psychotherapy treatment. The mean age for student-participants was 21.5 (SD = 3.34). Table 1 gives demographic information for client participants.

<table>
<thead>
<tr>
<th>Baseline Characteristic</th>
<th>Frequency</th>
<th>Percent</th>
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</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
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<tr>
<td>Male</td>
<td>393</td>
<td>30.2%</td>
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<tr>
<td>Female</td>
<td>882</td>
<td>67.7%</td>
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<tr>
<td>Not reported</td>
<td>28</td>
<td>2.1%</td>
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<tr>
<td><strong>Sexual Orientation</strong></td>
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<tr>
<td>Straight</td>
<td>793</td>
<td>60.9%</td>
</tr>
<tr>
<td>LGBTQ</td>
<td>77</td>
<td>5.9%</td>
</tr>
<tr>
<td>Not reported</td>
<td>433</td>
<td>33.2%</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
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<td></td>
</tr>
<tr>
<td>European/White</td>
<td>1069</td>
<td>82.0%</td>
</tr>
<tr>
<td>Racial/Ethnic Minority</td>
<td>136</td>
<td>10.4%</td>
</tr>
<tr>
<td>Not reported</td>
<td>98</td>
<td>7.5%</td>
</tr>
</tbody>
</table>
**Study Sequence**

Students seeking CAPS services complete online problem, symptom, and demographic surveys. This intake procedure was modified to include a brief description of the research and an option for students to either decline or indicate interest in participation. Interested students were then contacted by email and smartphone text invitations that included links to the research consent form and pre-treatment assessments (described below in the Measures and Procedures section). Clients were offered a $5 incentive to complete an initial set of measures, $5 for weekly assessments, and $25 to complete follow-up measures three months after concluding their course of treatment at CAPS. Incentives were approved by the institutional ethics review board.

**Measures**

**The Outcome Questionnaire – 45.2 (OQ-45).** The OQ-45 (Lambert et al., 2004) is a 45-item self-report measure designed to evaluate indicators of overall psychological functioning with subscales for symptom distress, interpersonal relations, and social role functioning (work, school, etc.), yielding a total score derived from the sum of the three subscales. The subscales were not used for this study. The OQ-45 is ideally administered weekly before seeing the mental health counselor. It is standard practice for CAPS to administer, score, store, and retrieve data from the OQ-45 electronically. Participants were asked to endorse how frequently each event or situation described by the 45 items occurred over the previous week, never, rarely, sometimes, frequently, almost always. The 36 negatively worded items are scored 0 to 4 respectively; 9 positively worded items are reverse scored, 4 to 0, respectively.

Responses across the 45 items were summed to create a total score, with higher scores indicating greater psychological distress and worse interpersonal and social role functioning. The total score could range from 0 to 180. The OQ-45 manual (Lambert et al., 2004) describes a
minimal improvement criterion, the statistical midpoint between the scores of individuals in 
standardization samples in treatment and those not in treatment is 63.44; a score of 64 or higher 
is statistically more like the scores of individuals receiving mental health treatment; a score of 63 
or lower is more like the scores of individuals in standardization samples not receiving mental 
health treatment. The manual also reports good internal consistency and test-retest reliability: 
Cronbach’s $\alpha = .93$; $r_{\text{test-retest}} = .80$. The $\alpha$ for OQ-45 scores in the current study was 0.93. The 
test-retest $r$ for this sample was $r_{\text{test-retest}} = .53$. The test-retest value for this sample is 
substantially lower because $r_{\text{test-retest}} = .80$ reported in the manual came from a non-clinical 
sample of volunteers who were not receiving mental health treatment; $r_{\text{test-retest}} = .53$ in this 
sample reflects change effects from psychotherapy. The median OQ score over 16 years of 
treatment at CAPS (2006–2020) is 72. Table 2 gives descriptive statistics for the OQ-45 for this 
sample.

**Religious Harm.** Religious harm was assessed by asking each participant if they 
believed that “religion has hurt you or contributed to some of your challenges.” Yes was coded 1, 
No was coded 0. The question was included among intake questions devised by the authors of 
the multisite Templeton Religion and Spiritually Integrative Psychotherapy Study (Richards et 
al., 2023). Participants were also given the chance to explain their experience of religious injury 
in a separate, open-ended follow-up item. Of 598 participants who reported that they had 
experienced religious injury, 486 (81.3%) provided open-ended explanations of their religious 
injury. While not the primary focus of this paper, these detailed accounts of religious injury 
could be classified into five categories:

- Behavioral expectations, including excessive pressure, shame, and perfectionism 
  related to living within religious standards, behaviors, or values.
• Theological dissonance which involved holding incongruous beliefs, having religious questions/doubts, or lacking spiritual fulfillment.

• Interpersonal concerns, which encompassed feelings of judgment or conflict with religious family, community, or leaders.

• Social justice issues, which included racial, gender, and LGBTQ+ concerns.

• Traumatic events in Religious Settings, such as sexual assault, abuse, or other morally reprehensible acts committed by someone in the religious community.

The initial religious injury question was repeated at follow-up, which took place three or more months after client-participants completed therapy. The test-retest correlation of responses for this sample was \( r_{\text{test-retest}} = .53 \). Percentages of client-participants who gave yes and no answers before treatment and at follow-up are reported in Table 3 below.

**The Religious Commitment Inventory-10 (RCI-10).** The Religious Commitment Inventory-10 (Worthington et al., 2003) is a brief 10-item measure that assesses how strongly an individual “adheres to his or her religious values, beliefs, and practices, and uses them in daily living” (p. 85). Sample items included “my religious beliefs lie behind my whole approach to life” and “I enjoy spending time with others of my religious organization.” Ratings are, 1, *not at all true of me*, 2, *somewhat true of me*, 3, *moderately true of me*, 4, *mostly true of me*, and 5, *totally true of me*. A global religious commitment score was derived by summing responses across the ten items, with a range between 10 to 50. Higher scores indicated greater religiosity. The RCI-10 was developed using a sample of 1300 individuals including mental health therapists, outpatient community clients, and university students. In addition to a total religious commitment score, the RCI-10 was designed to produce subscales for intrapersonal and
interpersonal religious commitment. Factor analyses found such high correlations between the subscales that Worthington et al. (2003) advised, “the one-factor model is preferable” (p. 93).

Cronbach’s $\alpha = .92$ was reported for the one-factor RCI-10 model (Worthington et al., 2003); $r_{\text{test-retest}} = .87$ at a 3-week follow-up. Subsequent work by other scholars has found alphas between 0.94 to 0.97 (Davis et al., 2015; Friedlander et al., 2010; Post & Wade, 2014). Cronbach’s $\alpha = .91$; $r_{\text{test-retest}} = .82$ for the current study. Table 2 gives descriptive statistics for the RCI-10 for this study’s participants.

**Standard Dataset (SDS).** The SDS is a set of demographic questions developed by the Center for Collegiate Mental Health (CCMH, 2016) and used by its consortium counseling centers. It is electronically administered, scored, and stored upon intake for each new course of treatment at CAPS. It includes questions about age, ethnicity, gender, religion, and sexual identity (hereafter referred to as sexual minority status).

### Table 2

*Descriptive Statistics*

<table>
<thead>
<tr>
<th>Measure</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Treatment OQ-45 Total</td>
<td>1303</td>
<td>67.10</td>
<td>25.870</td>
</tr>
<tr>
<td>Follow-Up OQ Total</td>
<td>748</td>
<td>59.45</td>
<td>25.668</td>
</tr>
<tr>
<td>Pre-Treatment RCI-10 Total</td>
<td>1289</td>
<td>38.0605</td>
<td>8.97915</td>
</tr>
<tr>
<td>Score</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-Up RCI-10 Total Score</td>
<td>762</td>
<td>37.87</td>
<td>8.862</td>
</tr>
<tr>
<td>Valid N (listwise)</td>
<td>715</td>
<td></td>
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</tr>
</tbody>
</table>
**Procedures**

Students were invited to participate in the research when they requested psychotherapy at CAPS. With other CAPS clients, study participants completed standard, pretreatment measures through a web-based, online platform as part of pretreatment assessment. Upon consenting to participate in this research, they were directed to a separate, online platform that administered the initial research measures. They were assigned to a CAPS therapist according to standard procedures and received treatment as usual. As this was a naturalistic study, therapists provided mental health counseling according to their preferred theoretical orientation. Client participants were invited to complete the follow-up measures three months after psychotherapy ended and paid $25 upon completion of all follow-up measures; participants received a pro-rated part of the $25 incentive for partial completion of follow-up measures. Therapist participants were recruited by email and word-of-mouth. Therapists were instructed to treat their participant clients as they would typically treat nonparticipating clients. However, at the end of each therapy session with a participant client, the participant therapists filled out a Therapist Session Checklist (TSC) detailing interventions, theoretical orientation, and topics discussed during the session. TSC patterns are not discussed here.

**Results**

**Report of Religious Harm**

The data were analyzed using IBM SPSS Statistics (Version 28). A One-Sample Binomial Test was used to understand what proportion of religious individuals in psychotherapy have experienced personal religious injury. As noted, 52% of clients reported religious injury. The exact Clopper-Pearson 95% confidence interval (CI) suggests that the proportion of religious clients who have experienced religious harm could be as low as 49% and as high as 55%. As
already noted, \( r_{\text{test-retest}} = .53 \). Table 3 presents the distribution of client-subjects reporting religious harm before treatment and at follow-up. There is a net 6.8% increase in numbers of clients who report experiencing religious harm, an increase of 6.8% from 48.6% of clients before treatment to 55.4% at follow-up. This 6.8% increase is statistically significant: when evaluated with a \( t \)-test: \( t (604) = 3.46, p < .001 \) (two-tailed). A sign test yields a Z score of 2.60, \( p = .009 \). Student-clients were, therefore, more likely to report an increase in having experienced religious harm after psychotherapy compared to before beginning psychotherapy.

Table 3

*PreTreatment Religious Harm * Follow-Up Religious Harm

<table>
<thead>
<tr>
<th>Variable</th>
<th>FollowUp Religious Harm</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>PreTreatment Religious Harm</td>
<td>0 (Not harmed by religion)</td>
<td>N</td>
</tr>
<tr>
<td></td>
<td>70.4%</td>
<td>29.6%</td>
</tr>
<tr>
<td></td>
<td>1 (Harmed by religion)</td>
<td>N</td>
</tr>
<tr>
<td></td>
<td>17.3%</td>
<td>82.7%</td>
</tr>
<tr>
<td>Total</td>
<td>N</td>
<td>270</td>
</tr>
<tr>
<td></td>
<td>44.6%</td>
<td>55.4%</td>
</tr>
</tbody>
</table>

Outcome, Religious Commitment, and Religious Harm

The first analysis addressed questions 1 and 2. I looked for differences in OQ-45 total scores associated with a report of religious injury evident in change in client OQ-45 scores from pretreatment to follow-up. This was accomplished with a 2 by 2, repeated measures ANOVA: Change in OQ-45 scores by Report of Religious Harm. There were significant main effects for Religious Harm and for Change; \( F_{\text{injury}} (1, 634) = 42.92, p < .001 \), Cohen’s \( d = 0.52 \), \( F_{\text{change}} \)
(1,634) = 39.99, \( p < .001 \), Cohen’s \( d = 0.24 \). The significant Religious Harm effect shows that clients who reported Religious Harm had higher OQ-45 scores than clients who did not report Religious Harm. The significant Change effect shows that OQ-45 scores decreased among all clients.

The Change by Report of Religious Harm interaction effect was not significant: \( F_{\text{Harm x Change}} (1,634) = .462, \ p = .497 \). Figure 1 presents average OQ-45 total scores for the Change by Harm interaction. The significant Change effect is evident in the downward trajectories in OQ-45 scores. The significant Harm effect is evident in the distance between both pretreatment and follow-up Harmed and Not Harmed OQ-45 scores and the distance between the two, downward change trajectories. The absence of a Change by Harm effect is evident in the apparently parallel trajectories of the two lines. Change in psychological distress over the course of psychotherapy did not differ between clients who reported they were Harmed by religion.

**Figure 1**

*OQ-45 Scores for Change by Harm Interaction*
These results allow me to give clear answers to my first two research questions:

1. Is there a difference in psychological distress between clients who report religious injury and those who do not? Yes, those who reported religious injury reported more symptoms than those who did not. On average, those who reported harm reported symptoms that were slightly more than one-half of a standard deviation more frequent than those who did not report religious injury (Cohen’s $d = 0.52$).

2. Is there a difference in how psychological distress changes during therapy among clients who report religious injury and those who do not? No, both groups improve at the same rate. However, those who report harm report more symptoms before and after treatment. Their reported symptoms are severe enough that they do not, on average, reach the minimum criterion for recovery (OQ-45 $\leq 63$). Those who do not report harm are, on average, below this same minimum criterion for recovery before they begin treatment.

**Religious Commitment and Religious Harm**

In order to answer questions 3 and 4, I next examined the relationship between religious injury and religious commitment over time. I used the same two by two, repeated measures, Change by Report of Religious Harm ANOVA approach used to examine OQ-45 scores. The results of this 2 by 2 ANOVA for RCIs paralleled the 2 by 2 ANOVA for OQ-45 scores; this is evident in Figure 2.

There were significant main effects for Religious Harm and for Change: $F_{\text{Harm}} (1, 646) = 63.78, p < .001, \text{Cohen’s } d = 0.63, F_{\text{Change}} (1, 646) = 12.28, p < .001, \text{Cohen’s } d = 0.13$. The significant Religious Harm effect shows that the average difference evident in Figure 2 is significant: Clients who reported Religious Harm had lower RCI scores, meaning they reported
less religious commitment, than clients who did not report Religious Harm. The significant Change effect shows that RCI scores decreased significantly from before to after treatment among all clients. The Change by Report of Religious Harm interaction effect was not significant, $F_{\text{Harm} \times \text{Change}} (1,646) = 1.31, p = .25$, showing that change in RCI scores did not differ between those who reported and those who did not report religious injury.

The Change effect is evident in the downward trajectories in RCI scores in Figure 2, though, on average, the decrease in RCI scores is less than 1 point on the RCI total score. This yields a small effect size of $d = 0.13$. The significant Injury effect is evident in the distance between both pretreatment and follow-up RCI scores. This difference yielded a medium to large effect size of Cohen’s $d = 0.63$. These results allow me to give clear answers to my third and fourth research questions:

3. What is the relationship between the report of religious harm and report of religious commitment? Report of religious injury is associated with a significantly lower level of religious commitment. Average religious commitment among those who reported religious harm is more than six tenths of a standard deviation lower than those who did not report harm (Cohen’s $d = 0.63$).

4. Does the relationship between report of religious harm and report of religious commitment change after treatment? No, the relationship between report of injury and religious commitment did not change over the course of treatment. There was a significant, but small decrease in religious commitment, a bit more than one tenth of a standard deviation decrease (Cohen’s $d = 0.13$)
Interactive Relationships and Effects

I used a Maximum Likelihood Estimates path analysis to answer questions 5 and 6; that is, I used path analysis to evaluate the direct and mediated relationships between religious commitment at follow-up, religious harm at follow-up, and therapy outcomes as measured by OQ-45 score at follow-up. My goal was to determine the direct effect of religious commitment on therapy outcomes and to explore how this relationship changes when accounting for the mediating role of report of religious harm at follow-up. The path model was estimated using AMOS 28 (Arbuckle, 2019).

Figure 3 presents hypothesized relationships between the variables I examined. Arcs with arrows at both ends represent hypothesized correlations. Lines with single arrows represent regression parameters for hypothesized predictive relationships. Reciprocal regression
relationships are hypothesized between OQ-45 score at follow-up and report of religious harm at follow-up, between OQ-45 score at follow-up and report of religious commitment (RCI) at follow-up, and between report of religious harm at follow-up and RCI score at follow-up. Reciprocal regression relationships were modeled and tested based on the possibility that either or both variable pairs could have a causal impact on the other at follow-up or that both could have simultaneous causal impacts on each other. For example, change in OQ-45 at follow-up could effect change in report of religious harm at follow-up or report of religious harm at follow-up could effect a change in OQ-45 score at follow-up or both variables could effect a change in the other. The same reciprocal relationships could be present for the two other two pairs of follow-up measures, OQ-45 score at follow-up with RCI score at follow-up and report of religious harm at follow-up with RCI score at follow-up. A reciprocal relationship would occur if effects differed for subsets of participants. For example, a reciprocal relationship would occur if change in OQ45 score at follow-up among some participants effected change in religious harm, while change in religious harm at follow-up among other participants effected change in OQ-45.
Figure 2

Hypothesized Model Relationships Between Variables for SEM

Figure 4 presents the result of estimating the parameters in the model. As suggested by Hu and Bentler (1998), model fit was evaluated using cutoffs of .95 or greater for the comparative fit index (CFI) and the Tucker-Lewis index (TLI). The root-mean-square residual (RMSEA) cutoff of <.08 (Wang & Wang, 2019) was used. The hypothesized model was an adequate fit with the data, $\chi^2 (df=3, N=1303) = 6.57, p = .087$; CFI = 0.999; TLI = 0.963; RMSEA = 0.03. Correlations, means, and standard deviations of variables in the model are found in Table 4. Significant correlations and regression relationships in Figure 4 are depicted with solid arcs and solid lines. Non-significant correlations and regression relationships are depicted with dashed lines. Except for the reciprocal regression relationships between follow-up OQ-45
scores, religious harm reports, and RCI-10 scores—the main focus of the research—only significant correlation and regression coefficients are included in Figure 4.

The most important measures in the study were pretreatment and follow-up indicators of symptoms and problems as evident in OQ-45 scores, pretreatment and follow-up reports of religious harm, and pretreatment and follow-up indicators of religiosity as evident in RCI scores. These are evident in Figures 3 and 4 as black boxes with white lettering. My goal was then to examine the relationships between these three indicators at follow-up. As would be expected, each of these pretreatment measures was a strong predictor of its corresponding follow-up measure:

1. For OQ-45\textsubscript{Follow-up}, $B_{\text{OQ-45}} = 0.47 \times \text{Pretreatment OQ-45}$ ($p < .001$), meaning that after adjusting for all other predictors, OQ-45 at follow-up was predicted to be 0.47 times the pretreatment OQ-45 score.

2. For RHarm\textsubscript{Follow-up}, $B_{\text{RHarm}} = 0.46 \times \text{Pretreatment RHarm}$ ($p < .001$), meaning that after adjusting for all other predictors, the probability that a client will report religious harm at follow-up is predicted to be 0.46% the probability of reporting religious harm before treatment began.

3. For RCI\textsubscript{Follow-up}, $B_{\text{RCI}} = 0.64 \times \text{Pretreatment RCI}$ ($p < .001$), meaning that after adjusting for all other predictors, RCI at follow-up is predicted to be 0.64 times the pretreatment RCI score.
### Table 4

**Correlations, Means, and Standard Deviations of Variables in SEM**

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<thead>
<tr>
<th>Variables</th>
<th>1</th>
<th>2</th>
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<th>4</th>
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<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
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<tbody>
<tr>
<td>Pretreatment OQ-45, $M = 67.10, \text{SD} = 25.36$</td>
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<td>Follow-up OQ-45, $M = 59.68, \text{SD} = 25.71$</td>
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<td></td>
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<td>Age, $M = 21.57, \text{SD} = 2.92$</td>
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<tr>
<td>Sex at birth, 69.1% females (coded 1)</td>
<td>.05</td>
<td>.00</td>
<td>-.25***</td>
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<td>Ethnic minority, 16.2% minorities (1)</td>
<td>.13**</td>
<td>.02</td>
<td>.03</td>
<td>-.03</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Pretreatment religious harm, 48.6% harmed (1)</td>
<td>.21**</td>
<td>.23***</td>
<td>.09*</td>
<td>-.12**</td>
<td>.02</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up religious harm, 55.4% harmed (1)</td>
<td>.17***</td>
<td>.26***</td>
<td>.00</td>
<td>-.02</td>
<td>-.05</td>
<td>.53***</td>
<td></td>
<td></td>
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<tr>
<td>Sexual minority, 8.9% minorities (1)</td>
<td>.10*</td>
<td>.15***</td>
<td>-.05</td>
<td>-.03</td>
<td>.03</td>
<td>.20***</td>
<td>.19***</td>
<td></td>
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<tr>
<td>Spiritual / religious confusion, $M = 0.93, \text{SD} = 1.23$</td>
<td>.27***</td>
<td>.18***</td>
<td>-.04</td>
<td>.06</td>
<td>.06</td>
<td>.35***</td>
<td>.33***</td>
<td>.25***</td>
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<td></td>
</tr>
<tr>
<td>Importance of religion, $M = 0.13, \text{SD} = 0.40$</td>
<td>-.14***</td>
<td>-.09*</td>
<td>-.10*</td>
<td>.16***</td>
<td>-.10*</td>
<td>-.20***</td>
<td>-.20***</td>
<td>-.23***</td>
<td>-.32***</td>
<td></td>
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<tr>
<td>Pretreatment RCI, $M = 38.92, \text{SD} = 8.97$</td>
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<td>-.22***</td>
<td>-.03</td>
<td>.11**</td>
<td>-.16***</td>
<td>-.30***</td>
<td>-.29***</td>
<td>-.25***</td>
<td>-.41***</td>
<td>.56***</td>
<td></td>
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<tr>
<td>Follow-up RCI, $M = 37.80, \text{SD} = 8.94$</td>
<td>-.26***</td>
<td>-.25***</td>
<td>-.07</td>
<td>.12**</td>
<td>-.13**</td>
<td>-.27***</td>
<td>-.32***</td>
<td>-.26***</td>
<td>-.41***</td>
<td>.63***</td>
<td>.82***</td>
</tr>
</tbody>
</table>

*Note. $N \geq 605$ for all variables in SEM*

* $p < .05$ (two-tailed). ** $p < .01$ (two-tailed). *** $p < .001$ (two-tailed).
Figure 4

SEM Results of Parameters of Estimated Model

$$\chi^2 (3) = 6.57, \ p = .087$$
Note in Figure 4 that pretreatment OQ-45 was the only significant pretreatment predictor of OQ-45 at follow-up. Note that in addition to pretreatment report of religious harm, ethnic minority clients were significantly less likely to report religious harm at follow-up, $B = -0.13$ ($p = .013$), while clients who reported distress arising from religious confusion (R. Confusion) were significantly more likely to report religious harm at follow-up, $B = 0.42$ ($p = .005$).

In addition to RCI measured before treatment, R. Confusion was a significant negative predictor of RCI at follow-up, $B = -0.35$ ($p = .041$); ranking religion as important in one’s life (R. Import) was a strong positive predictor of RCI at follow-up, $B = 5.26$ ($p < .001$). Hereafter, when I refer to OQ-45 at follow-up, report of religious harm at follow-up, and RCI at follow-up, I am referring to regression scores for these variables adjusted for all other predictors.

As shown in Figure 4, there were no significant direct predictive effects between adjusted RCI score at follow-up (i.e., adjusted for pretreatment RCI and all other predictors) and adjusted OQ-45 score at follow-up (i.e., adjusted for pretreatment OQ-45), $B = -0.29$ ($p = 0.07$). There was no evidence for the reciprocal prediction between adjusted OQ-45 score at follow-up and adjusted RCI score at follow-up, $B = -0.11$, ($p = .24$). There was no evidence of a predictive effect between adjusted OQ-45 at follow-up and adjusted religious harm of follow-up (i.e., religious harm at follow-up adjusted for pretreatment report of religious harm and all other predictors), $B = 0.00, p = .95$. There was no evidence that report of religious harm at follow-up, adjusted for other predictors, effected adjusted RCI at follow-up, $B = -0.54$, ($p = .95$).

Hypothesized relationships in the path model account for 29% of the variability in outcome as measured with follow-up OQ-45 scores ($R^2 = .29$), 34% of variability in likelihood of reporting religious harm at follow-up ($R^2 = .34$), and 70% of the variability in religious commitment after psychotherapy as measured with the follow-up RCI score ($R^2 = .70$).
There is evidence in Figure 4 of a significant negative effect of adjusted RCI at follow-up on report of religious harm at follow-up adjusted for all other predictors, $B = -0.008$ ($p = .009$). This suggests that after accounting for all other predictors, including pretreatment report of religious harm, the probability that a client will report religious harm at follow-up decreases by 0.8% for each point of adjusted RCI score at follow-up.

There is also evidence in Figure 4 of a significant positive effect of report of religious harm at follow-up, adjusted for all other predictors, on symptom change as measured with the OQ-45, $B = 6.97$, ($p = .009$). This suggests that after adjusting for all other predictors, clients who report religious harm after psychotherapy would be expected to have an adjusted OQ-45 score at follow-up 6.97 points higher than that among clients who do not report religious harm at follow-up.

There is a significant, negative, indirect effect for follow-up religious commitment on follow-up OQ-45 score through follow-up religious harm, $\beta = -0.021$, ($p < .05$). This means that for one-point increase in adjusted RCI score at follow-up, adjusted OQ-45 score at follow-up is predicted to decrease 0.021 points based on the associated decrease in the likelihood of report of religious harm at follow-up.

The results suggest that report of religious harm at follow-up plays a mediating role in the relationship between religious commitment at follow-up and therapy outcomes as measured by the OQ-45 score at follow-up. This means that religious commitment at follow-up is indirectly related to therapy outcomes through its effect on religious harm at follow-up. Higher levels of religious commitment at follow-up are associated with lower likelihood of reporting religious harm at follow-up, which in turn is associated with lower symptoms and better therapy outcomes at follow-up. Additionally, report of religious harm at follow-up is associated with worse therapy
outcomes. This means that after accounting for all other predictors and correlates of the final OQ score, report of religious harm is associated with approximately seven additional points on the OQ ($B = 6.97$).

The path model allowed me to answer research questions 5 and 6:

5. Is there a direct effect of religious commitment on change in symptoms or problems during therapy? No, there was no evidence that religious commitment after therapy (RCI score at follow-up) directly predicts change in problems as measured at follow-up (OQ-45 at follow-up). Nor was there evidence for the reverse relationship; change in OQ-45 at follow-up did not predict RCI score at follow-up.

6. Is the relationship between religious commitment and change in symptoms or problems mediated by report of religious harm? Yes, religious commitment at follow-up (RCI at follow-up) was a negative predictor of report of religious harm at follow-up. A higher RCI score at follow-up yields a lower likelihood that clients will report religious harm at follow-up. This ameliorating relationship between religious commitment at follow-up and harm is quite important because reporting religious harm at follow-up predicts approximately 7 extra points worse outcome at follow as measured with the adjusted OQ-45 at follow-up.

**Discussion**

This study investigated the relationship between religiosity and mental health outcomes, with a focus on how religious injury, a person’s broad belief that religion has hurt them or contributed to some of their emotional concerns, impacts religious commitment and psychological symptoms. The study allowed participants to self-define and report whether religion had negatively impacted their emotional well-being.
The Complex Relationship Between Religiosity and Mental Health

The study demonstrated a nuanced relationship between religiosity and mental health. Regardless of religious injury status, all participants exhibited decreased psychological distress over treatment, adding to the evidence for the well-established effectiveness of psychotherapy (Wampold & Imel, 2015). The current study also demonstrated that when clients are troubled or harmed by religion, psychotherapy not only reduces psychological distress but can also reduce the client’s religious commitment in a way that is statistically significant, although this decrease may not be practically meaningful. Analogous research has similarly demonstrated that higher education has complicated effects on religiosity: Schwadel (2011) found that while college education reduces biblical literalism and denomination exclusivity, it appears to increase report of the importance of religion and religious participation but has no effect on the belief in deity.

The Role of Religious Harm in Contributing to Psychological Distress

The proportion of religious clients who have experienced religious harm was 52%. Analysis of more comprehensive explanations from these individuals revealed themes including behavioral expectations, theological dissonance, interpersonal concerns, social justice issues, and traumatic events. Notably, clients who reported religious harm had significantly greater emotional distress than those who did not. These participants, predictably, exhibited less commitment to their religious beliefs. The belief in having been hurt by religion or its contribution to one's emotional distress appeared to worsen the positive relationship between religiosity and therapy outcomes at follow-up. However, higher religious commitment at follow-up seems to mitigate this relationship, resulting in lower levels of religious harm at follow-up and thus, better therapy outcomes.
Implications and Limitations

These findings contribute valuable insights to the body of psychological research, underscoring the intricate relationship between religiosity and mental health outcomes. It becomes clear that while religiosity generally correlates with positive mental health outcomes, there exists a subset of individuals who experience psychological distress due to their interactions with religious values, expectations, and societal constructs. This study, however, has certain limitations. The selection of the sample from a conservative religious university, while providing unique insights, might constrain the generalizability of the findings to broader populations due to potential influences from the specific religious environment and biases within the university. Also, while the uniformity of religious beliefs in the sample allows for focused investigation, it may limit variability and restrict generalizability. Similarly, studying a similar-aged college population provides valuable insights into the experiences of young adults but may not apply to other age groups or life stages. Future research should aim to replicate this study in diverse religious contexts and populations, considering different age groups and refining the measure of religious harm to capture the construct more accurately.

It will be important in future research to broaden our understanding of religious harm. The open-ended explanations of religious harm offered by 486 of these clients will be a good beginning point. For example, how do behavioral expectations, interpersonal concerns, social justice issues, and traumatic events overlap with a sense of theological dissonance? For example, a person describing religious harm as arising from traumatic events could be referring to an interpersonal problem existing in the organization of a church or an intrapersonal problem leading to doubt about why God would allow such trauma.
The results of this study shed light on the complex interplay between religiosity, religious harm, and mental health outcomes. The experiences of religious harm appear to contribute significantly to psychological distress and alter the dynamics of religious commitment and mental health outcomes. These results and potential future aims would likely make Albert Ellis chuckle, as even he revisited his initial dogmatic antagonism toward religion and, near the end of his life, determined that religion could support emotionally healthy functioning in individuals (Ellis, 2000).
References


https://doi.org/10.1080/08952841.2020.1829938


APPENDIX A

Review of the Literature

Religiosity has been theorized as a common developmental human experience (Fowler, 1981; Jones, 1994) and a facet of multiculturalism (American Psychological Association, 2003, 2017) because religious culture, belief, and identity shape the relationships, sense of self, and behavior of religious people. In 2017, Gallup reported that 80% of Americans have a religious affiliation, and 95% of American adults consider themselves to be religious, even if they do not identify with a specific denomination. Generally, positive mental health outcomes are correlated with religiosity (Bonelli & Koenig, 2013; Oman & Syme, 2018). Cross-cultural, interfaith research has found that 20% of nonreligious respondents were formerly religious in their lives, and even after disaffiliating from religion, religious worldviews still influence these people (van Tongeren et al., 2021).

Classically discussed by Bergin (1992), the changing values championed by mental health professionals often contradict traditional religious beliefs and values, and, with this tension, psychologists are more likely to stigmatize or pathologize faith, belief, or religious identity as being harmful to its participants. Because most Americans hold religious beliefs which shape their lives (Brown et al., 2013; Hood et al., 2018) and because research shows that a substantial number of clients seeking help for mental health issues (between 26% and 33%) present with religious or spiritual concerns (Johnson & Hayes, 2003), it is probable that a mental health professional will encounter people of faith with various levels of religious commitment in their clinical practice.
Theoretical Framework of Religiosity

Definitions of religiosity thematically address the notion that one’s personal spiritual beliefs are reified in some way within an organized community that shares beliefs, values, and traditions (Zinnbauer et al., 1997). Religion has been conceptualized by Koenig et al. (2001) as a visibly organized system of beliefs that is community-focused, contains doctrines that separate good from evil, with external, authoritarian practices oriented toward encouraging proper behavior. Hill et al. (2000) described religion as the “feelings, thoughts, experiences, and behaviors that arise from a search for the sacred . . . that receive validation and support from an identical viable group of people” (p. 66). Religious commitment is used to describe the way “religion influences worldview and is most salient in environment, behavior, and cognition” (Worthington, 1988, p. 168). Religion is a nuanced combination of intrapersonal and interpersonal attitudes and actions, suggesting that it is important for measures of generalizable, broad religiosity to accurately assess both the public and private religious lives of an individual.

When researching religiosity, Tsang et al. (2019) state that dispositional measures of general religiousness, such as religious commitment, are superordinate. They recommend assessing “broad individual differences in the tendency toward religious interests and sentiments” over operational measures of religiousness such as coping and orientation which assess how particular aspects of religion function” (p. 356). In their meta-analysis of religiosity, Smith et al. (2003) found that the type of religious measure used in research determined how a person's religiousness appeared to be associated with higher depressive symptoms. This may leave mental health professionals uncertain about relationships between religion and mental health in religious populations, for example:
• Eisenberg et al. (2009) found that higher religiosity was related to increased stigma against mental health counseling; however, a validated measure was not used to assess the religiousness or religious commitment of the religious participants.

• Harari et al. (2014) found that, among the Jewish population, religiosity was positively correlated with well-being among straight Jews, but in the LGBTQ Jewish community, depending on how religiosity is defined, “the relationship between religiosity and well-being is a more nuanced, complex process that can yield positive, negative, or no correlations with well-being” (p. 894).

• Lefever et al. (2018) found that religious affiliation had differing effects on cisgender and transgender or gender-nonconforming (TGNC) individuals. Religious affiliation did not buffer psychological distress for TGNC people, but cisgender individuals did have a reduction in distress associated with religiosity. This research used a dichotomized religious affiliation variable, either a total absence of religious affiliation or identity, or a denominational affiliation catch all, which included those of Christian, Muslim, Hindu, Jewish, and Buddhist beliefs. The study failed to consider commitment to the affiliation’s religious world view and did not inquire if religious participation had caused injury to the respondents.

After broadly reviewing the literature, Koenig et al. (2001, p. 123) suggested that most research on religiosity lacks consistency or conceptualizes the construct in ways that are overly subjective or broadly global. This introduces problems with measurement and operationalization of the concept. Religiosity findings accordingly change between studies with differing definitions and operationalizations of religiosity. Examples of this lack of clarity and consistency include:
• Determining the religious commitment of a nation by calculating the number of
religious books printed as a percentage of total books printed by the country (Stack,
1983).

• Asking if respondents were more or less religious than others in their local religious
community (Anson et al., 1990).

• Determining religiosity based on denomination or attendance at religious-activities
(Chan et al., 2012; Chen & Park, 2019; Reyes-Ortiz et al., 2007).

Many studies attempt to capture religious constructs without incorporating validated
measures of general religiosity, reducing the generalizability of their findings (Jeynes, 2010;
Koenig et al., 2015). Shortcomings in measurement may be understandable given the largely
personal, subjective experience of religiosity (Gorsuch, 1984). However, bridging objective
measurement with subjective experience has not stopped psychology from developing
standardized measures of psychological distress, including broad psychiatric concerns as well as
specific symptoms (Drapeau et al., 2011; Coyne, 1994; Kessler et al., 2002). Examples of
measures of psychological distress include the Symptom Checklist-90 (SCL-90; Derogatis,
2017), the Kessler Psychological Distress Scale (K10; Kessler et al., 2002), the Counseling
Center Assessment of Psychological Symptoms-62 (CCAPS-62; Locke et al., 2011), and the
Outcome Questionnaire-45 (OQ-45; Lambert et al., 2004). Likewise, psychology has become
more sophisticated and nuanced in its approach and conceptualization of multicultural
intersectional identities, such as gender, sexual orientation, and ethnicity (Donatone & Rachlin,
2013; Moleiro & Pinto, 2015; Sue et al., 1992; Verkuyten, 2018). In keeping with multicultural
guidelines and best practices adopted by the APA Council of Representatives in 2017,
developing multicultural competency entails that a psychologist recognizes the client’s
intersecting identities and cultural influences (such as religion and spirituality) and is aware of how these factors influence “psychologists’ conscious and unconscious preferences and inclinations when formulating a diagnosis, analyzing and interpreting research data, and planning interventions” (APA, 2017, p. 26). In this vein, George et al. (2000) challenged the field to develop measures of religiosity which are psychometrically validated and able to capture general religiosity in a manner that includes both attitudes and behaviors.

Religiosity researchers understand that religious commitment has a cross-cultural, cross-faith effect. Even after changing or losing faith, religiously disaffiliated people are more like currently affiliated people in their behavior and attitudes than they are to never-affiliated individuals (van Tongeren et al., 2021). Religion is a nuanced combination of intrapersonal and interpersonal attitudes and actions, suggesting that it is important for measures of generalizable, broad religiosity to accurately assess both the public and private religious lives of an individual. These findings demonstrate the importance of having a standardized measure for assessing religiosity, as well as understanding how religious commitment contributes to or alleviates the client’s stress.

**Psychologists and Religiosity**

Aside from issues of ethnicity, gender, and sexuality (Sue et al., 2019), religiosity is a likely facet where the client and psychologist may differ, and, as such, culture, values, assumptions, biases, and core beliefs can affect what a therapist attends to or addresses in clinical work (APA, 2017).

While, historically, many psychologists have been found to identify with and represent diverse religious traditions (Bergin & Jensen, 1990), it seems that today, compared to the general population, psychologists are less likely to have a salient religious identity or describe
themselves as religious. Delaney et al. (2007) and McMinn et al. (2009) found that psychologists were between 17% and 40% less likely to personally value religion compared to the general population. Hathaway et al. (2004) found that clinicians only discussed religious and spiritual issues with 30% of clients. The discomfort with incorporating religious perspectives into psychotherapy is not limited to the competency of the therapist providing therapy; in 2011, Walker et al. found that those in mental health leadership and management positions, such as clinical directors, were uncomfortable with the idea of clients requesting religious interventions, even though their clinics provided service to a predominantly religious population. For reasons such as these, Corey et al. (2007) recommended that psychotherapists increase their consciousness of how personal values (including religious values) drive and impact assumptions, biases, and core beliefs as they work with clients.

Interestingly, Rosmarin et al. (2013) and Shafranske and Cummings (2013) found that compared to the general population, psychologists are less likely to consider religiosity to be important to them or to be affiliated with a religion. These findings reinforce previous findings by Post and Wade (2009), who reported that psychologists were less likely to believe in God or have religious commitment. Given that psychologists and their potential clients may differ in religiosity, values and beliefs between therapist and client could be discordant. Historically, the commonly acknowledged founders of professional psychology separated religiosity from the science of psychology (Barbour, 1974; Ellis, 1971; Freud & Dufresne, 2012; Miller & Thoresen, 2003; Skinner, 1953). As Albert Ellis (1980) famously stated, “The less religious [clients] are, the more emotionally healthy they will tend to be” (p. 637). Along these lines, recent research by Yamada et al. (2020) found that over 30% of clients felt as if their psychotherapist had little regard for—or had even disrespected—the client’s religious beliefs.
This perception is not new. Bergin (1992) and Cummings et al. (2009) both noted that the values and discourse that professional psychology often advocates tend to be at odds with religious perspectives and values; hence whether intentionally or not, professional psychology may marginalize, stigmatize, or pathologize religious beliefs, experiences, and worldviews. This historical disregard may have made it easier to dismiss legitimate attempts to apply or adjust psychotherapeutic interventions to the diverse clientele who have benefitted from integrating spirituality and psychology (Smith et al., 2007), despite the fact that the presenting problems of many clients holistically impact the client’s life, and disregarding religious issues in therapy means ignoring or under-attending to a facet of the client’s well-being, according to Barnett and Johnson (2011).

Magaldi-Dopman et al. (2011) suggested that a client’s religious beliefs activate sensitive emotions and countertransference within the counselor, and ways of managing these religious reactions may not be adequately addressed in training. Bartoli (2007) reported that “psychotherapists do not simply receive a lack of training in religion and spirituality, but, in many cases, they have inherited a skepticism vis-à-vis religious and spiritual issues" (p. 57). This assessment appears to be accurate, as one study found that 36% of clinicians reported discomfort in working with religious issues in psychotherapy, 19% of clinicians shared that this discomfort had led them to never investigate religious issues in their client’s lives, and 71% of clinicians have not received specific clinical training in working with a client’s religious concerns (Rosmarin et al., 2013).

Managing values conflicts is vital for ethical clinical practice, but some have suggested that such conflicts appear to be historically unaddressed by the field (Mintz et al., 2009; Jackson & Patton, 1992). Traditionally, psychologists have been assumed to be capable of bracketing
their personal values, but research indicates that this may not be realistic or possible on both the individual and the systemic level (Crawford et al., 2015; Tjeltveit, 1986). The potential for religious biases, both by a clinician and client, is a two-way street (Worthington, 1988). In this sentiment, Lyon (2013) argues that while it may be impossible to avoid biases, “when it comes to the psychotherapeutic treatment of deeply religious people . . . there is a delicate balance to be struck between a blind acceptance and complete rejection of faith” (p. 629). From this perspective, it should be remembered that understanding and advocating for the client’s well-being in relation to their spiritual framework, whether that be in using spiritually adaptive interventions, encouraging religious activity, or disengagement, does not necessarily equate to a psychologist advocating or attacking the religion or faith structure itself. To their credit, good faith efforts have been made by researchers and practitioners to view the religious framework of a client as part of their inclusive identity, ecology, and support system (Limb et al., 2013) and to, subsequently, reduce the religious biases of the field and holistically address the therapeutic encounter to be more compatible with religiosity by using the client’s frame of reference to interpret and enhance psychotherapy in both an ethically and clinically beneficial manner (Johnson et al., 2000; Smith et al., 2007). Like other aspects of identity, sensitivity and competence when working with religious individuals is part of the modern ethical considerations of the ethical code of the American Psychological Association (APA; American Psychological Association, 2010, Principal E). The Association for Spiritual Ethical and Religious Values in Counseling has developed competencies for addressing spiritual and religious issues in counseling (ASERVIC, 2009).
**Psychotherapy and Religiosity**

Mitigating biases and being able to incorporate the client’s worldview into therapy appears to be highly attractive to clients (Blow et al., 2012). When therapists are matched to clients according to similar characteristics, clients are more likely to engage and feel more comfortable in therapy (Griner & Smith, 2006; Soto et al., 2018; van Nieuw Amerongen-Meeuse et al., 2018). This holds true for highly religious clients as well; Gregory et al. (2008) found that highly religious clients, when provided with therapist descriptions, were more likely to prefer a therapist with a religious background than a secular therapist. Interestingly, the specific religion of the therapist did not matter to the client, indicating that understanding a religious worldview is more important to the client’s process than the actual doctrine or beliefs that are held by the client and therapist.

Another important way of incorporating the client’s worldview into therapy is by integrating secular theories of change, such as Cognitive Behavioral Therapy or Rational Emotive Behavior Therapy, with religious interventions or perspectives. This provides a simple yet effective way to treat psychological concerns for religious clients (Hook et al., 2010; Nielsen et al., 2001). A meta-analysis completed by Captari et al. (2018) showed that psychotherapy that utilizes religious and spiritual interventions could be more effective than counseling using only secular interventions. In addition to a reduction in psychological distress, those receiving spiritually-integrative or religion-integrative interventions also experienced an increase in spiritual well-being compared to the secular intervention (Paragment, 2007). Smith et al. (2007) also found that overall subjective well-being is enhanced by religiously adaptive psychotherapy and that using these religiously integrative approaches was more effective than secular-focused therapy for religious clients presenting with anxiety, depression, and eating disorders. Of note,
these clients seem to experience the greatest overall well-being when the interventions assisted them in applying their beliefs to their mental health concerns and recovery process. Religiously integrative psychotherapy appears to increase the efficacy of counseling for religious clients by quickly helping clients utilize their established resources effectively. For example, Razali et al. (1998) reported that, for religious clients experiencing depression or anxiety, religiously integrative treatment hastened symptom reduction when compared to a secular control group and, after the termination of therapy, clients who received a religiously integrative course of therapy had improved outcomes after four and twelve weeks. Both religiously integrative and secular groups experienced identical outcomes at the six-month mark. Thus, the established research has demonstrated that, for religious clients, there is a beneficial treatment outcome when religiosity and psychotherapy are integrated.

Being capable of adapting well-known and broadly used theories of change to religiously and spiritually adaptive therapies seems to be most easily accomplished by therapists who are familiar with religious perspectives. Walker et al. (2005) found that these therapists were more open and felt more competent in exploring religious topics or adapting interventions to the needs of religious clients than therapists without religious backgrounds or familiarity. However, like ethnic and racial concerns (Benuto et al., 2018), gender and sexual orientation (Lindsay et al., 2019; Pepping et al., 2018), as well as multicultural competencies in general (Sue et al., 2009), when therapists receive training in religiously integrated counseling approaches, they perceive themselves to be more competent in processing religious topics with clients.

In a study by Martinez et al. (2007), religiously integrated psychotherapeutic interventions helped clients feel holistically treated, and specific interventions that were well-received by religious clients included assessments of client spirituality, encouraging forgiveness,
referral to religious community resources, as well as discussing scriptures that reinforced counseling theory. Religious interventions which were not well received by clients included therapists’ praying with clients or encouraging clients to memorize scriptures. Religious clients do seem to prefer psychotherapeutic interventions to be grounded in psychology rather than the sacerdotal. Interestingly, Koenig et al. (2016) found that religiously integrated CBT resulted in an improved initial therapeutic alliance when compared with standard CBT, but the long-term alliance was similar between religious and standard CBT. In this vein, when examining a sample of Orthodox Jewish psychotherapy clients (n = 117), control clients (n= 91), Orthodox Jewish psychotherapists (n=15), and other therapists (n = 7), it appears that having a psychotherapist who was religious or secular did not impact diagnosis or treatment duration for clients, and both secular and religious clients had similar benefits at the end of treatment (Rosmarin & Pirutinsky, 2020). Thus, it appears that a therapist’s ability to join the client’s religious worldview and navigate religious topics or interventions within the early stages of the therapeutic process is generally beneficial for the client and allows the therapist greater credibility in the client’s eyes, even if overall diagnosis, treatment, and outcomes are similar between secular and religious groups.

The Complex Relationship Between Religiosity and Mental Health

On many fronts, religion seems to be a protective factor. Religious commitment has been demonstrated to be associated with increased life satisfaction (Allen & Wang, 2014). Increased religious involvement is negatively correlated with substance use among teens (Brown et al., 2001). A meta-analysis completed by Jeynes (2010), found that individual religious faith was a significant variable in reducing the achievement gap between white and African American students. Religious participation reduces mortality odds (McCullough et al., 2000), and married
couples’ mutual religiosity is associated with higher marital functioning (Mahoney et al., 1999). Chan et al. (2012) found that for victims of natural disasters, pre-disaster religiousness predicted increased post-disaster psychosocial functioning, including lower psychological distress, an increased sense of purpose, and better access to and use of community resources. Zinnbauer and Pargament (1998) found that difficult life situations and stressors can reduce religiosity, but this reduction varies by individual according to their subjective experiences. Fallot (1998) examined therapeutic themes among inpatient participants in group counseling and found that their reports of religious experience were mixed, some patients had experienced rejection and stigma within their religious community, while others found deeper connection and support. Abe-Kim and colleagues (2004) found that higher religiosity was correlated with decreased psychological distress symptoms.

Religious tradition and denomination do not appear to decrease or enhance particular kinds of mental health concerns; for example, Alter (1989), did not find differences in elevated psychological distress scores between Catholic and Protestant Christians. In a sample of over 2,200 Catholic and Evangelical participants, Abe-Kim et al. (2004) reported that religious denomination did not effect engagement in mental health counseling and, contingent on distress and presentation of emotional and behavioral concern, these religious individuals relied on their religious community as a referral system to find an appropriate mental health provider. Historical nationwide studies have shown that over 40% of individuals sought mental health counseling from their religious leaders (Gurin et al., 1960). Furthermore, using the National Comorbidity Survey, Wang et al. (2003) voiced concern about the pathway to psychological care that religious individuals frequently take. They found that 23% of psychologically distressed individuals seek care from their religious leaders and underutilize psychiatric providers.
Studies of religious disaffiliation found that approximately 40% of the disaffiliated still attend church occasionally (Fenelon & Danielsen, 2016). Religious people also appear to drift away from their religious tradition when they experience social or political disagreements or marginalization between personal identity and values that conflict with their religious community. Intellectual skepticism and concerns with theology, interfaith partnerships, or family instability such as relationship changes like divorce also can lead to drifting away from one’s religious tradition or practice (Bahr & Albrecht, 1989; Fenelon & Danielsen, 2016; Krause & Wulff, 2004; Vargas, 2012). According to a 39-year longitudinal study completed by Fenelon and Danielsen (2016), physical health and subjective well-being appear to be negatively impacted by religious disaffiliation, with decreased well-being and poorer health being experienced by those who disengage from their religion compared to those who are continually engaged. Even after disaffiliation from religion, there is evidence of a residual effect from religiosity on behavior, emotion, and cognition, where “religious identification and belief commitment offer a comprehensive perspective in predicting how people think, feel, and act” (van Tongeren et al., 2021, p. 500).

The Role of Religious Struggles in Contributing to Psychological Distress

In a seven-year longitudinal study, Krause and Ellison (2009) found that religious people who have negative interactions with religious peers’ experience more religious doubt, internalize these doubts rather than expressing them, and avoid finding theological or interpersonal support to resolve them. Interestingly, those who suppress their religious concerns also rated themselves as having poorer physical health than those who express their concerns. This corroborates research by Evans et al. (2018), who found that religious struggles predicted psychological
distress among veterans. Rosmarin et al. (2009) similarly found that religious and spiritual concerns were correlated with poor physical and mental health among a Jewish sample.

Finally, in a randomized controlled trial examining religiosity, coping, and stress, Pirutinsky et al. (2011) found that negative religious coping mechanisms, such as disengagement or anger toward God, predicted future depressive symptoms; they suggested that “negative religious coping can be causal in depression” and that psychotherapeutic interventions would do well to “target spiritual struggles” (p. 404).

The relationship between religious commitment and emotional distress remains underexplored in the current literature, despite earlier recommendations suggesting its significance (George et al., 2000). At present, the literature appears to fall short of detailing the frequency of such religious harm in faith communities, as well as how religious injury might interact with religious commitment and the efficacy of psychotherapy among religious individuals. Religious engagement, while typically associated with positive psychological outcomes, can also precipitate emotional turmoil for a subset of individuals. This facet of religious experience has largely been neglected in previous research, prompting scholars such as Abu-Raiya et al. (2015) and van Tongeren et al. (2021) to urge more nuanced, longitudinal studies on the interplay between religious concerns, commitment, and psychological distress. A deeper examination of this intersection may reveal critical insights into the behavioral expectations, theological conflicts, social justice issues, and traumatic events that contribute to religious harm. The examination of religious injury and its interactions and relationships with religious commitment and emotional distress will help decipher how elements like interpersonal issues within religious organizations and doubts about divine intentions in the face of trauma feed into the broader concept of religious harm.
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APPENDIX B

Consent Forms

Consent to be a Research Subject (Client Form)

Introduction

This research study is being conducted by [include name and title of researcher(s)] at [include the institutional affiliation of the Sub Grant recipient (PI) and treatment site administrator] in collaboration with Professor P. Scott Richards at Brigham Young University (BYU) in Provo, Utah, to determine what types of spiritual approaches and interventions mental healthcare professionals use in their practices and how effective they are during the course of treatment. You were invited to participate because you are receiving services from a helping professional who uses a spiritually sensitive or spiritually integrated approach as part of her/his normal day-to-day professional practice.

Procedures

If you agree to participate in this research study, you will be asked to use an electronic device (e.g., iPad, computer) which connects to an online assessment system to complete a one-time brief background/demographic questionnaire that asks you about your age, gender, race/ethnicity, religious affiliation, country (and state or province) of residence, and attitudes and preferences toward psychotherapy. During your treatment, you will also be asked before (or after) each session to use the electronic device to complete two brief questionnaires that inquire about your psychological (depression and anxiety) distress, spiritual concerns, relationship difficulties, physical health concerns, and therapy progress. These questionnaires should not take more than 4 - 7 minutes to complete. Your therapist may also ask to complete some additional questions about your well-being and perceptions that are of special interest to her/him. These additional questions should not take more than 2 - 3 minutes to complete. Your therapist may share and discuss your responses or scores on the questionnaires with you during your treatment if he/she believes this may be helpful. The total time commitment required of you to complete the research questionnaires will be about 5 – 10 minutes each treatment session.

Risks/Discomforts

It is possible that when you complete the research questionnaires you may experience some emotional discomfort about responding to the questions. If this occurs, we encourage you to talk about your discomfort with your therapist/treatment provider. There is a slight possibility of a data breach where unauthorized individuals obtain access to your questionnaire responses. However, your therapists and treatment site are adhering strictly to the research project’s policy that names and other identifying information may NOT be entered into the assessment system. Thus, even in the unlikely event of a data breach occurring, it will not be possible for anyone to link your survey responses with your identity.

Benefits

There are no direct benefits of the research to you. If your therapist and/or treatment site choose to use your questionnaire responses for treatment planning, it is possible that the information you provide could help them monitor and enhance their treatment efforts. It is also hoped that through your participation the researchers may learn more about what types of spiritually integrated interventions and approaches can enhance mental health treatment.

Confidentiality

Institutional Review Board

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The privacy, security, and confidentiality of your questionnaire responses will be safeguarded at all times. Your therapist/treatment provider will have access to your questionnaire responses, and the anonymized data will be electronically transferred to the researchers at BYU in harmony with the terms of a secure data transfer agreement. To protect your privacy and confidentiality, your treatment site or therapist will assign you an identification (ID) number that will be used to track your questionnaire responses. Your name and other identifying information will not be entered into the assessment system; thus, the information that is electronically transferred to the researchers at BYU will not include any identifiable information. The de-identified data will be kept on a secure server and in secure electronic files at BYU and at (institutional affiliation of the Sub Grant recipient (PI)) in accordance with federal laws governing the security and privacy of research data. Your therapist and treatment site will keep a separate record of your name and ID number so that they can use your assessment data to assist in your treatment, or so that your questionnaire responses can be removed from the research data files should you choose to withdraw from the study. Your anonymity and privacy will be protected in any publications or presentations that result from the research by using only aggregated data and/or pseudonyms.

**Compensation**

There is no financial compensation for participating in this research study. However, your questionnaire responses may be helpful to your therapist and treatment team should they choose to use them to help inform your treatment.

**Participation**

Participation in this research study is voluntary. You have the right to withdraw at any time or refuse to participate entirely without jeopardy to your treatment or standing with the treatment facility and your therapist.

**Questions about the Research**

If you have questions regarding this study, you may contact [Sub Grant recipient’s (PI) name] at [contact information] for further information.

**Questions about Your Rights as Research Participants**

If you have questions regarding your rights as a research participant contact IRB Administrator at [name and contact information of the Sub Grant recipient’s (PIs) IRB committee]. (For International Research, the contact person should be someone in the local area with local contact information who would be able to inform participants of their rights. This person can be a project leader, organization director, or group facilitator. This should be a person who is not part of the research and who is able to communicate with participants in their own native language.)

**Statement of Consent**

I have read, understood, and received a copy of the above consent and desire of my own free will to participate in this study.

Name (Printed): ___________________ Signature ___________________ Date: _______________

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Institutional Review Board

2-14-2018 12-6-2018

Approved Expires
Consent to be a Research Subject (therapist form)

Introduction

This research study is being conducted by [include name and title of researcher(s)] at [include the institutional affiliation of the Sub Grant recipient (PI) and treatment site administrator] in collaboration with Professor P. Scott Richards at Brigham Young University (BYU) in Provo, Utah, to determine what types of spiritual approaches and interventions mental healthcare professionals use in their practices and how effective they are during the course of treatment. You were invited to participate because you are a helping professional who uses a spiritually integrated or spiritually sensitive approach as part of your normal day-to-day professional practice.

Procedures

If you agree to participate in this research study, you will be asked to use an electronic device (e.g., iPad, computer) which connects to an online assessment system to complete a one-time brief background/demographic questionnaire that asks you about your age, gender, race/ethnicity, religious affiliation, country (and state or province) of residence, educational degree, profession specialty, and what types of training they have received in religious/spiritual competencies. The demographic questionnaire will also ask questions about your self-efficacy at using spiritually integrated treatment approaches. During the study, you will also be asked after each session with your clients to use an electronic device to complete the Therapist Session Checklist (TSC), a process measure that asks you to briefly document the clinical issues you explored and the interventions you used. Your treatment site may also ask you complete some additional questions about your therapeutic work. The total time commitment required of you to complete the research questions will be about 2-3 minutes after each client’s treatment session.

Risks/Discomforts

It is possible that when you may experience some emotional discomfort when completing the Therapist Session Checklist (TSC) about disclosing what you did during your treatment session. However, you do not have to disclose anything about your treatment sessions with clients that you are concerned may reflect negatively on your clients, or upon your own work, or that you otherwise believe should not be entered into the research database. There is a slight possibility of a data breach where unauthorized individuals obtain access to your TSC responses. However, your treatment site and the researchers are adhering strictly to the research project’s policy that client and therapist names and other identifying information may NOT be entered into the online assessment system. Thus, even in the unlikely event of a data breach occurring, it will not be possible for anyone to link your TSC responses with your name or any other identifying information.

Benefits

There are no direct benefits to you. If your treatment site chooses to give you access to your clients’ outcome questionnaire responses and/or your TSC report for treatment planning, it is possible that the information could help you enhance your treatment efforts. It is also hoped that through your participation the researchers may learn more about what types of spiritually integrated interventions and approaches can enhance mental health treatment.

Confidentiality

Institutional Review Board

BYU

2-14-2018 12-6-2018

Approved Expires
The privacy, security, and confidentiality of your TSC responses will be safeguarded at all times. You and authorized members of your treatment site may have access to your responses, and the anonymized data will be electronically transferred to the researchers at BYU in harmony with the terms of a secure data transfer agreement. To protect your privacy and confidentiality, you will be assigned an identification (ID) number that will be used to track your responses. Your name and other identifying information will not be entered into the assessment system; thus, the information you provide that will be electronically transferred to the researchers at BYU will not include any identifiable information. The de-identified research data will be kept on a secure server and in secure electronic files at BYU and at [institutional affiliation of the Sub Grant recipient (PI)] in accordance with federal laws governing the security and privacy of research data. An authorized administrator at your treatment site will keep a separate record of you and your clients' names and ID numbers so that you can use the data to assist in treatment, or so that you and/or your clients' responses can be removed from the research data files should you or any of your clients choose to withdraw from the study. Your anonymity and privacy will be protected in any publications or presentations that result from the research by using only aggregated data and/or pseudonyms. The assessment data provided by your clients will also receive all of the aforementioned security and privacy protections.

Compensation

You will be provided with a modest financial compensation for participating in the study and for completing the Therapist Session Checklist after each of your treatment sessions. An administrator at your treatment site will inform you about the exact terms of the compensation. In addition, your TSC responses may be helpful for treatment planning should you choose to use it to help inform your treatment.

Participation

Participation in this research study is voluntary. You have the right to withdraw at any time or refuse to participate entirely without jeopardy to your employment.

Questions about the Research

If you have questions regarding this study, you may contact [Sub Grant recipient’s (PI) name] at [contact information] for further information.

Questions about Your Rights as Research Participants

If you have questions regarding your rights as a research participant contact IRB Administrator at [name and contact information of the Sub Grant recipient’s (PIs) IRB committee]. (For International Research, the contact person should be someone in the local area with local contact information who would be able to inform participants of their rights. This person can be a project leader, organization director, or group facilitator. This should be a person who is not part of the research and who is able to communicate with participants in their own native language.)

Statement of Consent

I have read, understood, and received a copy of the above consent and desire of my own free will to participate in this study.

Name (Printed): ______________________ Signature ______________________ Date: __________

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