REFOCUSSING THERAPY:
The Effectiveness and Uniqueness of a God-Based Therapy Method

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Jennifer A. Sharkey

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Abstract

Refocussing Therapy (RFT) is a God-based theory and psychotherapy approach. The aim of the present study was to evaluate the effectiveness and uniqueness of RFT using a quasi-experimental mode of investigation. Over a period of four months pre- and post-treatment assessments of 49 RFT clients' mental health status and religious coping were made using the TOP v 4.1 and RCOPE measures. Changes were also assessed for a comparison group of 10 pastoral care (PC) recipients. Significant positive treatment gains were reported by RFT clients, while PC recipients had smaller but generally positive treatment gains. Positive religious coping improved for both the RFT group and the PC group. However, negative religious coping reduced significantly for the RFT group but increased for the PC group. Findings offer preliminary support for the effectiveness of RFT, and indicate that RFT impacts significantly upon clients' clinical status and religious coping. Further research is recommended to determine the efficacy of RFT.

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Forward

As Refocussing Therapy (RFT) is a relatively new therapy approach, this thesis begins with an overview of the general sociological and psychological context within which it has evolved. Issues influencing both the development of the religion-psychology integration and the consequences of this integration for psychological treatment will be discussed in *chapters one* to *four*. A comprehensive description of the RFT method will be outlined in *chapter five*. *Chapter six* considers methodological issues related to this study, *chapter seven* outlines the methodology used. *Chapter eight* presents the results of this study, including data analysis of: the demographic and characteristic differences among participants; participants' reported experience of therapy; the changes occurring post-therapy on the TOP v 4.1 and the RCOPE; and of correlations between the scores on these scales as well as on the RCI-10. Finally, *chapter nine* discusses the findings including strengths, limitations, complexities, and implications for both clinical practice and future research.

This thesis therefore will provide a synopsis of the background and context for the development of RFT, a critique of current psychological theory relating to RFT, a description of RFT, a rationale for the research methodology employed in this study, an outline of the results attained, and a discussion regarding the implications of these results.

Chapter One:

Introduction

"Spiritually oriented psychotherapy is coming of age as a speciality area of psychotherapy."

(Sperry & Shafranske, 2005, p. 4)

Overview

This chapter examines the rationale for the present study, outlines the current interest in the mental health benefits of religion, and considers the contemporary psychological understanding of the concepts of spirituality and religion.

Rationale for Research

Research increasingly points to the therapeutic relevance of individuals' religious and spiritual perspectives, behaviours, and experiences. Religion and spirituality shape clients' worldviews and significantly impact upon their mental health, physical health, and general wellbeing. Worldwide, religion holds meaning and influence for millions of people. It should come as no surprise then that religion is now an area of psychological attention in many universities. Yet despite burgeoning interest regarding the benefits of incorporating spirituality into therapy, very few therapy models have been developed to specifically tap into this resource. While the major theoretical orientations may have components which are sympathetic to a spiritual worldview, none are explicitly aligned with it.

Refocussing Therapy (RFT) is a God-centred theory and therapy approach developed by New Zealander Diane Divett over the last ten years. It has been described as "a remarkable contribution which has the potential to be very influential to the practice of counselling internationally" (Steven, 2005). The potential of this therapy model requires evaluation in order to ascertain its actual effectiveness. This thesis seeks to add to the small but growing body of RFT research by investigating the therapy model's effectiveness.

Current Interest in the Mental Health Benefits of Religion

Spirituality and religion are once again being acknowledged within the mental health profession. "The alienation that has existed between the mental health professions and religion for most of the 20th century is ending" (Richards & Bergin, 2000, p. 3). Religious experience, having been ignored by science and marginalized by theorists, is now being discovered to be a robust clinical variable, and consequently a variable worthy of investigation and integration into psychological treatments (George, Ellison, & Larson, 2002; Larson & Larson, 2003; Pargament, 2002a, 2002b; Powell, Shahabi, & Thoresen, 2003). A substantial body of literature now exists connecting religion and spirituality to physical health (George et al., 2002; Laubmeier, Zakowski, & Bair, 2004; Powell et al., 2003; Rippentrop, 2004; Seeman, Dubin, & Seeman, 2003; Thoresen, Oman, & Harris, 2005), mental health (Bonner, Koven, & Patrick, 2003; Corrigan, McCorkle, Schell, & Kidder, 2003; Koenig & Larson, 2001; Plante & Sharma, 2001; Whitcomb, 2003; Yangarber-Hicks, 2004) and general well-being (Bremer, Simone, Walsh, Simmons, & Felgoise, 2004; Ferriss, 2002; Francis, Robbins, & White, 2003; Walsh, Bremer,

Felgoise, & Simmons, 2003; Wigert, 2002). The role of religiosity in physical and mental health and in the psychology of coping has in very recent times been addressed in every major medical, psychiatric, psychological and behavioural medicine journal (Baumeister, 2002; Emmons, 1999; Miller & Thoresen, 2003a; Mills, 2002; Sperry, 2000). Whereas only a decade ago university libraries were bereft of books addressing spirituality in clinical practice (Sperry & Shafranske, 2005), there are now many to choose from (e.g., Frame, 2003; Miller, 2003; Miller, 1999; Miller & Delaney, 2005b; Richards & Bergin, 2005, 2000; Sperry, 2001, 2005).

Many factors have contributed to the renaissance of spirituality within psychology. The emergence of positive psychology in recent years has seen a focus on strengths alongside vulnerability and psychopathology in clinical practice (Kogan, 2001). The strengths of a person's religion and spirituality have been the sine qua non of much recent research. The resources found therein have been shown to have real significance for people's mental health and well-being (Braam et al., 2004; Cacioppo & Brandon, 2002; Ferriss, 2002; Pargament, Koenig, Tarakeshwar, & Hahn, 2004; Patrick & Kinney, 2003; Pearce, Little, & Perez, 2003; Seeman et al., 2003; Vitale, 2002). As well, there has been a widespread sociological shift within the Western cultural paradigm. Prominent sociologists Bauman (2000; 2001) and Giddens (1999) depict the modern impact of detraditionalisation, individualisation, globalisation, and secularisation as having contributed to the creation of a social climate devoid of coherence and meaning. It seems that the materialistic philosophy of the 1980's and 1990's has experienced an insurgence by many in developed countries who are now searching for meaning beyond acquiring money and possessions. In American Gallup polls between 1994 and 1998 the

number of people indicating that they had a personal need for spiritual growth increased by 24% (as cited in Miller & Thoresen, 2003b). Issues of spirituality have become increasingly cogent in this current milieu.

The growing re-awareness of the potential benefits of spirituality is beginning to impact upon models of psychotherapy. Within New Zealand, Maori have become politically and socially active in rediscovering their spiritual traditions (Durie, 1995). This revival of spirituality has also revived a sense of well-being and identity among Maori and has set a role-model for the greater valuing of spirituality among other New Zealand populations (Saunders, 2001). Spirituality is a cultural reality. Of the 3,880,481 people recorded in the 2001 New Zealand census (New Zealand Statistics, 2001), over half (2,029,053) described themselves as Christians, just over a quarter (1,021,908) described themselves as non-religious, and the remainder were depicted as being from a variety of other religions. Furthermore, a New Zealand Herald poll of 1000 people in 2005 found 68% believed in God (Harvey, 2005).Thus, religious and spiritual concerns may have relevance in psychotherapy for a significant proportion of the New Zealand population.

In the USA, acknowledgement and recognition of a client's religious beliefs and history is no longer merely desirable but is mandated. The American Psychological Association (1992) and the American Psychiatric Association (1995) practice guidelines call for an assessment of clients' religious beliefs and background prior to any form of psychotherapeutic intervention. The New Zealand Code of Ethics also encourages sensitivity to diversity (New Zealand Psychological Society, 1986). This includes responding to the cultural and social backgrounds of clients in ways which will ensure

"competent and culturally safe service" (Principle 1.4.1.) and referring clients to appropriate services when their concerns are beyond the psychologist's expertise (Principle 2.1.6.). As a number of presenting problems may include religious or spiritual concerns, particularly for highly religious clients, the interaction between both psychological practice and theological praxis may be necessary. Guiding ethics generally now advocate for the inclusion of religion in psychotherapy when it is salient for the client (Eck, 2002), and many other academics are advocating for the assessment of spirituality to be included in a client's initial assessment (e.g., Brennan & Heiser, 2004; Fallot, 2001; Gordon & Mitchell, 2004; Hodge, 2005; Miller & Thoresen, 2003a; Moncher & Josephson, 2004; Sexson, 2004; Tse, Lloyd, & Petchkovsky, 2005; Zaccariello, 2004).

Defining Spirituality and Religion

The terms *spirituality* and *religion* have proven chameleonic over the years. Whereas they seem to have been used interchangeably in literature at the beginning of the twentieth century, at the beginning of the twenty first century they have become differentiated (Sperry & Shafranske, 2005), although there is a lack of consensus as to their rudimentary definitions. The word 'religion' derives from the Latin word 'religare' meaning 'to link', to make connection with God (Rizzuto, 2005). Over time, religion has generally come to be seen as a means of expressing spirituality primarily through institutionalised beliefs and behaviours (Fontana, 2003). Spirituality has generally taken on the more munificent meaning, representing personal, private beliefs and behaviours

that reflect the human need for transcendence and connectedness (Miller & Thoresen, 2003a; Myers, 2000; Seybold & Hill, 2001).

Pargament (1997), defines religion as "a search for significance in ways related to the sacred" (p. 32), the sacred being those things that are holy, including ideas such as God and the transcendent, or objects closely related to these. Pargament argues that the differentiation between spirituality and religion has caused an unhelpful dichotomy between the two terms (Hill & Pargament, 2003a). In his definition, spirituality and religion are intimately connected. Nonetheless, it seems to be commonly perceived among academics that spirituality and religion are distinct but overlapping constructs (Larson, Swyers, & McCullough, 1998). A search for the sacred may be attempted through religious observances, but religious observances are not always a search for the sacred.

Allport and Ross (1967) differentiated two types of religious orientation – intrinsic and extrinsic. Intrinsic religion was defined as internalised faith which relates to personal expressions of religion, in other words, the more spiritual aspects. Extrinsic religion is not internalised and is only pursued for its external benefits, such as social support. As such, it generally relates to the more institutionalised expressions of religion. Allport (1960) describes extrinsically motivated persons as using their religion and intrinsically motivated persons as living their religion. The majority of research on intrinsic and extrinsic religiosity seems to regard the two concepts as polarised - existing at either end of a continuum. However, individuals may be neither intrinsically nor extrinsically motivated, or conversely, they may be both at once (Wenger & Yarbrough, 2005). Recent studies indicate that it is religiosity (intrinsic/extrinsic) rather than

spirituality (intrinsic) alone or religion (extrinsic) alone which seems to have the greatest impact upon well-being (Baetz, Larson, Marcoux, Bowen, & Griffin, 2002; Ball, Armistead, & Austin, 2003; Carothers, Borkowski, & Lefever, 2005; Milevsky & Levitt, 2004; Strawbridge, Shema, Cohen, & Kaplan, 2001). For example, Baetz and colleagues' study of 88 Canadian mental health patients identified that frequency of worship attendance alongside the use of religion as a coping resource, and intrinsic religiousness, were the combined factors of religious commitment that impacted upon treatment outcomes. For the purposes of this study the term religion will be used in its broadest sense, including both institutionalised religious observances and personal expressions.

Summary

There is a growing and significant interest in religion and spirituality within psychological academia. The present study is guided by the rationale that God-centred psychotherapy models are both requited and reasonable. The aim of the present study is to investigate such a model, Refocussing (RFT), regarding its effectiveness and to explore some of the unique characteristics which may contribute to its effectiveness.

Chapter Two:

Background for Religion and Psychology Integration

"Perhaps the core assumption of transpersonal psychology is that individuals are essentially spiritual beings rather than simply a self or a psychological ego."

(Lukoff & Lu, 2005, p. 177)

Overview

Psychology and religion have had a lengthy and tumultuous relationship. This chapter reviews the literature regarding the historical and contemporary nature of this relationship, including the research relating to the benefits of religion to mental health.

Historical Background of the Religion and Psychology Convergence

Psychological therapy and religion have always shared a number of commonalities. Religion, like therapy, can offer a framework within which people can change, grow and participate in relationships. Religion, like therapy, can help people gain a sense of self, purpose and meaning (Bergin, 1991). Pastoral carers have inevitably combined spiritual care with the psychological care of their congregations. As peoples' beliefs impact upon their values and worldview, and these in turn influence their psyche, it becomes problematic to separate spiritual issues from the general psychological issues of an individual.

Historically and literally psyche was the soul, and psychology the study of the soul (Miller & Delaney, 2005b). Theological concepts regarding the spirit and soul vary according to the different religious traditions. Body, mind and spirit/soul are fundamentally unified in the Judeo-Christian understanding of human nature (Moberg, 2002), with the spirit/soul being considered the essence of the person (Miller & Delaney, 2005a). The soul, 'nephesh' in the Hebrew of the Old Testament, represented the whole of the person. The person does not have a soul, the person is a soul. In the New Testament, the soul – 'psyche' in the Greek, continued to describe the whole person, embracing the physical life of the individual, the emotional centre of the person, and the eternal nature of the person (Beck, 2003). Throughout the proceeding centuries however, many writers chose to separate soul and spirit (Fontana, 2003). This dichotomy of soul and spirit has allowed for, and has to some extent created, a similar separation of psyche from spirituality. With the separation of psychology and religion at the turn of last century, psychology replaced the notion of soul with terms such as self, person, individual and identity.

Of course, a difficulty in defining both the spirit and the soul is that neither are material objects which can be removed from the human being and dissected on a laboratory table. Rather, as with other intangible entities, we understand them by examining their influence upon observable human life. Another complication with this process is the lack of concurrence among experts regarding the definition of spirit and soul, leaving the researcher grasping for constructs with which to work. This is an intrinsic aspect of the nature of the spirit and soul – that they cannot be simply defined, that they are ethereal, existing both in the material human body and yet beyond it.

Psychology has similar dilemmas in distinguishing between the mind and the brain. Two competing theories, monism (the brain generates mind) and dualism (the mind utilises the brain), have been argued over since Descartes (Fontana, 2003). Despite the preference in western thinking towards reductionism, science has yet to come up with a model that comprehensively explains how thoughts arise, or incontrovertible answers as to whether the mind has an immaterial or material existence. In both the psychological and theological domains the ethereal qualities of human nature remain broadly debated but variously and insubstantially defined.

Religious leaders and psychotherapists both essentially care for this non-material aspect of a person. Prior to the advent of psychology and psychotherapy, religious and spiritual leaders were regularly sought out to attend to peoples psychic troubles. Religious thinking and particularly Judeo–Christian beliefs have influenced the progression of psychological philosophy and practice through the centuries (Cahill, 1998; Frank, 1993). Robinson (1981) goes so far as to state that "the emergence of Christianity must be counted as an occurrence whose importance to Psychology is matched, if at all, only by the Hellenic epoch" (p. 111). Christian thinkers such as Augustine (354-430), Aquinas (1225-1274), Jonathan Edwards (1703-1758), Thomas Upham (1799-1872), Soren Kierkegaard (1813-1855), William James (1842-1910) and G. Stanley Hall (1844-1924) have all made their impact upon current Western psychological thought (Delaney & DiClemente, 2005; Miller, 2005). Nonetheless, over the last century the definition of the psyche has moved away from a spiritual locale and narrowed to the mind, then behaviour or even neural activity (Miller & Delaney, 2005b). Ironically, psychology has neglected the psyche of its original definition, the soul and self of a person. By the

middle of the 20th century Allport (1950, p. v) reported that psychology had become soul-less. During this period of "disengaged subjectivity" (Taylor, 1989, p. 514), the self was both disembodied and removed from its social context (Jankowski, 2003). The result is a pervasive theme of disconnection wherein the individual struggles to find a sense of personal and social meaning (Martin, 2000).

This modern conceptualization of self, in combination with the generally recognised lower levels of religiosity and spirituality found among psychologists and psychotherapists (Rochow, 2002), has promoted a certain type of psychotherapy development over the course of the 20th century. Therein, entities or phenomena that could not be observed empirically were presumed not to exist at all. Consequently, the study of religion and spirituality and of their impact upon human well-being has been significantly less prolific than their worldwide influence mandates. While two of psychology's founding fathers, G. Stanley Hall and William James, considered religion and spirituality to be worthy phenomena for research (Delaney & DiClemente, 2005), many of psychology's great contributors through the last century have ignored religion, pathologised it, or reduced it to other underlying psychological, physiological or social machinations. Watson (1925) was opposed to the notion of a consciousness because he linked it with the soul. He defined behaviourism as different from all other schools of psychology due to its focus upon the behaviour of a person as opposed to the soul of a person. Freud (1961) considered religion to be a dangerous illusion. Leuba (1925) criticized religion as irrational and pathological. Skinner (1953) described it as punitive and exploitative, and Ellis (1980) stated that religious belief "always leads to poor emotional health and decreased long-range happiness" (p. 327).

Much of the antagonism towards the integration of psychology and religion has also come from those of religious inclination. Religious leaders have frequently expressed distrust of psychology. Pope Leo XIII described psychotherapy as destructive (Gillespie, 2001), and many Christian authors over the last century (e.g., Bobgan & Bobgan, 1987; Bulkley, 1993; MacArthur, 1991) have criticized psychology as being reductionistic, deterministic, self-aggrandising and essentially a competing form of religion. In fact, psychotherapy has been described in the literature as just that – "a new paradigm for living", replacing "old religious and spiritual values" (Tantam & van Deurzen, 1999, p. 231), and a recent article by Miller and Hubble (2004) has been humorously titled: *Further archaeological and ethnological findings on the obscure, late 20th century quasi-religious earth group known as the "therapists".*

Despite the bad press, the inclusion of religion and spirituality in the discipline of psychology has had many supporters as well. James (1902) stated that, at its best, religion was a pathway to the highest of human potentials. Jung (1969) saw spiritual development as important for balance, harmony, and wholeness. He also considered that the most common concern people entered therapy with was ultimately "that of finding a religious outlook on life" (as cited in Allport, 1950, p. 79). Allport's (1950) classic book on the role of religion in relation to the individual personality adopted a neutral stance on religion – which was in stark contrast to many of his peers who were antagonistic. Erikson (1963) and Maslow (1970) seemed to view spiritual belief and meaning as integral to the process of personal development. Bergin's (1980b) landmark work on religion and psychotherapy preceded a succession of writings on the relevance of religion to psychology.

At the beginning of the 21st century, it appears that confidence is growing rapidly regarding the consideration of religion in psychotherapy on both ethical and evidential grounds. It is interesting to note that in recent years, in light of the profusion of research contradicting his initial stance, Ellis has reversed some of his thinking. He now states that, "religious and nonreligious beliefs in themselves do not help people to be emotionally "healthy" or "unhealthy". Instead, their emotional health is significantly affected by the ***kind*** of religious and nonreligious beliefs that they hold" (2000, p. 30, author's emphasis).

The Religion and Health Connection

Religion has emerged in research over the last few decades as a highly salient factor in relation to health. There have now been several meta-analyses on specific health factors in relation to religious belief and practice. A meta-analysis of 42 studies totalling nearly 126,000 people found that active religious involvement increased by 29% the likelihood of living longer (McCullough, Hoyt, & Larson, 2000). One study followed 21,000 American adults over nine years and discovered that attending religious services more than once a week increased the average lifespan by seven years, even after accounting for social, economic, health and lifestyle confounds (Hummer, Rogers, Nam, & Ellison, 1999). Lack of obesity is the only other protective factor which comes close to this effect (Larson & Larson, 2003). Conversely, religious and spiritual distress, especially feeling abandoned by God, questioning God's love, and feeling at the mercy of the devil, actually increased the risk of mortality by as much as 28% (Pargament, Koenig, Tarakeshwar, & Hahn, 2001).

The psychological health value of religious adherence depends on multiple factors: the form of religion, the definition of mental and emotional health, the specific social context, the way in which religion is integrated into an individual's life, and in particular, the type of religious beliefs and experiences each person has. In a broad sense, the importance of integrating religious concerns in psychotherapy is highlighted by the positive relationships found between religion and mental health. As alluded to by Ellis, however, the kind of religious beliefs one maintains is important and impacts upon mental health outcomes. The ability to separate out those factors which produce negative and those which produce positive outcomes in psychotherapy is essential to the continued development of this field.

The findings of the positive relationship between religion and mental health are summarized by Richards and Bergin (2000). Religious people in general have increased life satisfaction, sense of well-being, empathy and altruism. As well, they have decreased anxiety, neurotic guilt, depression and suicidal tendencies and are less likely to divorce, use and abuse drugs and alcohol, and to have teenage pregnancies. A meta-analysis of 34 studies (Hackney & Sanders, 2003) concurred with Richard and Bergin's findings, wherein stronger personal religious devotion correlated positively with mental health outcomes. While research on the religion and mental health relationship is predominantly American in origin an Australian sample of 989 adults produced comparable results (Francis & Kaldor, 2002). Intrinsically religious people generally appear to cope with life's adversities better than those with weak or no religious faith (Miller & Thoresen, 2003b).

In relation to mental health specifically, religion may be influential as both a potential health factor and a coping resource. In a study of more than 400 mental health patients in America (Tepper, Rogers, Coleman, & Maloney, 2001), 30% described their religious beliefs or activities as "the most important thing that kept (them) going" (p.662). This same study correlated the number of years that patients had used religious coping with lower total symptomatology. The researchers concluded that "religion may serve as a pervasive and potentially effective method of coping for persons with mental illness, thus warranting its integration into psychiatric and psychological practice" (p. 660).

Specific aspects of mental health such as depression, substance abuse, and suicide have also been examined in relation to religious commitment. A recent large scale (N = 4863) American study (Nisbet, Duberstein, & Conwell, 2000) found that those who were not regular worship attendees were four times more likely to commit suicide than those who were, even after controlling for the frequency of social contact. Given the comparatively high suicide rates in New Zealand (New Zealand Health Information Service, 2002), this statistic is worthy of greater attention, particularly by those who are attending to the needs of suicidal clients. Similarly, McCullough & Larson's (1999) review of over 80 studies indicated that those who highly valued their religious faith and participated in a religious group were substantially less likely to experience a major depressive episode. A comparable relationship has been reported for substance abusers (Miller, 1998). Individuals with substance abuse problems were found to have low levels of religious involvement, and religious (re)engagement was correlated with more rapid recovery. Social support, while an important factor in the religion and mental health

equation, appears to function as a moderator rather than a mediator in these relationships (Baetz et al., 2002; Dulin, 2005; Larson & Larson, 2003).

Neglect of religious issues in clinical care seems to be an incongruous oversight. As Tepper and his colleagues (2001, p. 660) noted: "The mental health field has created a plethora of sophisticated treatment strategies and a highly systemised base of clinical knowledge that has – perhaps inadvertently – neglected to take into account the personal resources and meaningful strategies used by persons of mental illness to sustain coping ability and strength. One of these strategies is religious coping."

Summary

The difficulty found in separating the 'soul' of theology from the 'self' of psychology has resulted in an enduring though at times troubled relationship between the two disciplines. In recent years this relationship has become more amicable, in part due to changes in society, but also due to the growing research base that indicates a strong positive correlation between healthy aspects of religiosity and enhanced mental health. This relationship under-girds and bolsters the theoretical foundation of RFT

Chapter Three:

How is Religion Health-Promoting?

"Individuals who attach differently to God will cope differently with major life events. How they cope ...has direct implications for adjustment."

(Belavich and Pargament, 2002, p.26)

Overview

The correlation between religion and mental health begs the question as to its mediators and moderators. If we can understand why and how religion has a positive impact upon mental health, then potentially we can take advantage of that relationship in the psychotherapy process. This chapter seeks to elucidate some of the key known factors that help answer the questions regarding how and why religion may be effective, and in so doing, lay a foundation for explaining the mechanisms under-girding the effectiveness of RFT.

How does Religion Impact upon a Person's Psyche?

What is it about religion and spirituality that might account for the positive relationships noted in the previous chapter? Research indicates that there are possible physiological, psychological and social mediators. Factors such as lifestyle (Chliaoutakis, Drakou, & Gnardellis, 2002; King, 1990; Powell et al., 2003), social and supportive networks (Dulin, 2005; Salsman, Brown, & Brechting, 2005), a worldview

which promotes well-being (Dull & Skokan, 1995; George et al., 2002; McIntosh, 1995; Pollard & Bates, 2004), raised self-esteem arising from the belief that one is loved by God (Ball et al., 2003; Carothers et al., 2005; Krause, 2003), and an optimistic explanatory style (Möller & Reimann, 2004; Salsman et al., 2005; Sethi & Seligman, 1993) are all potential mediators. However, many of the studies examining the correlation between religion and health control for these confounds and still show a significant relationship pointing to something else more intrinsic in religion. Hill and Pargament (2003b) argue that researchers have "overlooked the possibility that something inherent within the religious and spiritual experience itself contributes or detracts from physical and mental health" (p. 66).

Pargament, Koenig and Perez (2000) identified five key elements of religion which are potentially involved in its health enhancing potential. These include: provision of frameworks for meaning making, empowerment through a sense of control beyond oneself, comfort from the sense of being known and being in the hands of 'One beyond ourselves', intimacy with others through spiritual solidarity, and assistance in making major life transformations. It is possible that these elements enhance health in much the same way as other forms of positive adjustment impact on health – via physiological processes including cardiovascular, neuroendocrine, and immune functioning (Kiecolt-Glaser, McGuire, Robles, & Glaser, 2002; Seeman et al., 2003; Smith & Ruiz, 2002; Steptoe, 1998; Travis & Arenander, 2004). Neuroimaging studies have indicated that during spiritual and meditative practices the frontal lobes, parietal lobes, thalamus, and limbic system are activated (Newberg & d'Aquuili, 2001) and activity in the dopamine system is increased (Kjaer et al., 2002). Newberg and D'Aquili (1998) suggest that

because spiritual experiences may impact upon autonomic function and other cortically mediated cognitive and emotional processes they may be able to be utilized to assist in the therapy of various disorders.

God and Attachment Theory

While there are broad and varied explanations for the mental health benefits of religious adherence attachment theory provides a framework from which to examine some of the possible psychological mechanisms. Bowlby (1980) theorised that infants innately seek contact and comfort from a significant and more powerful person in their lives, especially in threatening or distressing situations. The consequences of this seeking can influence the development and maintenance of schemas which then affect the ways in which the individual approaches life. Ainsworth, Blehar and Waters (1978) categorised these 'infant' and 'significant other' relationships into three groups: secure, avoidant and anxious/ambivalent. Secure infants (and their secure adult counterparts) have comfortable, trusting relationships. Avoidant infants (and adults) convey an absence of need for proximity to significant others. Anxious/ambivalent infants (and adults) on the other hand express a great and at times overwhelming need for proximity to significant others, while deriving only limited security from them.

Relationship with a 'significant other' is the cornerstone of both attachment theory and the Christian religion. Most systems of religious belief are intended to bring people closer to the transcendent. A central theme in theistic religions, and certainly within Christianity, is conscious and intentional contact with God (Miller, 2005). Some attachment theorists (Kaufman, 1981; Kirkpatrick, 1999) have compared God to an

attachment figure. God as "our Father" is a key construct in Christian thinking (e.g. Matthew 6:9; Romans 8:15). A survey of American psychiatric inpatients indicated that many mental health clients desired to know God and experience his nearness (Fitchett, Burton, & Sivan, 1997). An individual's experience of an accessible, available transcendent 'other' has potentially significant psychological implications.

There are now sound theoretical grounds to believe that a client's secure relationship with God can contribute positively to a healthy mental state (Benson & Spilka, 1973; Hill & Pargament, 2003a). Given the nature of attachment theory it is assumed that a secure sense of attachment to God will produce a greater sense of security, comfort, self-esteem and resilience within people. Consistent with this hypothesis, studies have shown that people who report a closer connection to God also have a loving and caring image of God (Birgegard & Granqvist, 2004) and have less depression and higher self-esteem (Adler, 2003; Maton, 1989), less loneliness (Kirkpatrick, Kellas, & Shillito, 1993), increased relational maturity (Gall, 2004; Hall & Edwards, 2002), more happiness and life satisfaction (Kennedy, 1998) and greater psychosocial competence (Pargament, Smith, Koenig, & Perez, 1998). Secure attachment to God appears to regulate affect and improve coping in stressful situations. As such, its potential as a therapy factor becomes cognisant. Fredrickson (2002, p. 212) makes the statement that, "perhaps what is truly human about our emotional lives then is our ability to open our minds far enough to fathom or create a connection with God, or another Higher Power. This broadened mindset can in turn provide a wellspring of profoundly experienced emotions, many of them positive". The creation of such profoundly experienced positive

emotions is an inherently desired component of many psychotherapy models (Lohr, Olatunji, Parker, & De Maio, 2005).

Individuals' image of God refers to their mental representations and affective experience of God, both of which determine the nature of their relationship with God (Tisdale et al., 1997). A recent clinical outcomes study found that over the course of general outpatient psychotherapy, clients' images of God became increasingly positive (Cheston, Piedmont, Eanes, & Lavin, 2003). Given that a positive relationship between self-worth and images of God as loving and forgiving has been reported (Bassett & Williams, 2003; Francis, Gibson, & Robbins, 2001), an increase in affirmative God images during therapy could potentially result in improved well-being. Along the same vein, an American study of 46 psychiatric patients found that the more negative a person's image of God, the more likely personality pathology is to be present (Schaap-Jonker, Eurelings-Bontekoe, Verhagen, & Zock, 2002). While positive feelings about God did not appear to be associated with personality pathology, the more negative an individual felt about God, the more features of personality disorder were present, particularly borderline personality disorder and schizoid and schizotypal traits. Although research is as yet limited, the substance of an individual's image of God appears to be a potential fruitful line of therapeutic inquiry and attention.

There is evidence to suggest that while secure attachment to God tends to evolve naturally from a secure attachment with one's parents it may also take a compensatory form, wherein secure attachment to God can compensate for insecure parental attachment (Birgegard & Granqvist, 2004; McDonald, Beck, Allison, & Norsworthy, 2005). The idea of a person's impression of God arising from family of origin dynamics is not new.

Freud considered that peoples' God concepts developed as an extension of their attitude towards their father (cited in Allport, 1950). It is also an interesting observation that spirituality and human attachment are both mediated by limbic circuitry and the temporal lobe (Mayes, Swain, & Leckman, 2005; Norris, 2005). Perhaps attachment to a significant other is neurologically similar to attachment to God.

The proposition that a person's attachment to God forms a compensatory or even complimentary relationship to parental relationships is compatible with RFT. In RFT it is acknowledged that one's accessible connection to a loving and beneficent parental God is potent in the transformation of cognitions, emotions and behaviours. A secure relationship with a deity who is viewed as a reliable, helpful and caring parent is a potential therapeutic resource. Helping religious patients to utilise this resource may lead to faster resolution of psychiatric symptoms (Koenig, Pargament, & Nielsen, 1998). It seems therefore that a therapeutic model which increases a client's secure attachment to God could have obvious benefits.

God and Coping Methods

Spiritual coping has been postulated to serve as a mediator of attachment and the ability to adjust to stressful events (Belavich & Pargament, 2002). Attachment theory and coping theory both deal with the question of how people will respond to threats, losses, and challenges. Attachment theory provides an explanation for individual differences in the ways in which people cope with stressful situations (Granqvist, 2005). In accordance with attachment theory, an individual's mode of attachment to God will influence their conceptualisations of threatening situations, the coping style they employ,

and their consequent adjustment to the stressful event (Maynard, Gorsuch, & Bjorck, 2001). Religious coping is widely and in general effectively employed by those with psychological concerns and mental health problems, particularly by those who appear to have a strong and positive attachment to God (Tepper et al., 2001). Pieper's (2004) study of 118 psychiatric patients in the Netherlands reported that having a positive relationship with God correlated very strongly with positive religious coping. It appears that secure attachment to God potentially relates to positive religious coping deployment and insecure attachment to God potentially relates to negative religious coping deployment (Belavich & Pargament, 2002).

For many people religion is both an accessible and compelling way of coping, providing answers to the intangible aspects of life as well as influencing perceptions, attributions and affects (Shafranske & Sperry, 2005). As such, religion relates to one of the psychotherapist's key tasks - that of identifying and integrating clients' beliefs, values and practices in a manner which will enhance their coping ability. Religion offers solutions to the human existential crisis of being finite and limited, potentially complimenting non-religious coping which emphasises personal control, by incorporating the infinite and limitless. An individual's appraisal of their available resources will impact upon the coping strategies they engage in (Bouchard, Guillemette, & Landry-Leger, 2004). When God is conceived of as accessible and available, this may impact upon the type and effectiveness of coping activated by the individual.

Pargament's (1997) summary of 79 studies indicated that across all levels of stressful events, those who utilise religious coping demonstrate better outcomes then those who do not. It appears that religious coping adds a unique dimension to an

individual's capacity to cope, above and beyond the contributions of non-spiritual coping (Belavich & Pargament, 2002; Brown, Nesse, House, & Utz, 2004; Simoni, Martone, & Kerwin, 2002). Generally speaking, those who are more religiously committed are more likely to use religious coping, and the more stressful the situation the more likely people are to use religious coping (Vandecreek et al., 2004). As stress intensifies, the benefits of religious coping appear to increase (Pargament, 1997).

Coping involves those mechanisms an individual uses to function effectively when confronting a stress inducing situation (Friedman, Chodoff, Mason, & Hamburg, 1963). Vandecreek et al.'s (2004) study on the correlation between religious and non-religious coping indicated that they are moderately related but separate constructs, with religious coping tending to have a more emotional as opposed to problem solving focus. Problem solving and emotion focused coping correspond in part with 'primary control' and 'secondary control' (Rothbaum, Weisz, & Snyder, 1982). Primary control (problem solving) involves changing the external situation, and secondary control (emotion focused coping) involves changing the self. Thus, it is possible that religious coping assists an individual to adjust to those things which are out of their control, or which, in order to be controlled, require transformation of the self.

Religion may generate emotion focused coping in a variety of ways: transpersonally through the intimacy, hope, and meaning a relationship with God can engendered; personally by enhancing self-esteem and a sense of personal control, and through positive reappraisal of the event and available resources; and interpersonally through the contact and sharing with others in religious contexts. Religious coping can be active or passive, but it appears that the predominantly helpful aspect of religious

coping is that which emanates from a secure base in the divine relationship (Smith, 2001). Pargament and his colleagues (1988) have identified patterns of religious coping styles which they define as positive and negative, and which associate with secure and insecure attachment to God. A recent meta-analysis of 49 relevant studies supported the hypotheses that positive and negative forms of religious coping correlate with positive and negative adjustment to stress, respectively (Ano & Vasconcelles, 2005). Religious coping that indicates a secure relationship with God has been associated with numerous positive mental health outcomes in a variety of studies, including enhanced psychosocial adjustment, and reduced depression and anxiety (Bush et al., 1999; Cole, 2005; Koenig et al., 1998; Nairn & Merluzzi, 2003; Pargament, Ellison, Tarakeshwar, & Wulff, 2001; Pargament et al., 2000; Wong-McDonald & Gorsuch, 2000). Spiritual support which emphasises emotional reassurance from God, close relationship to God and guidance in problem solving from God, promotes the use of positive religious coping and tends to emerge in the research as the strongest predictor of positive outcomes (Krause, Ellison, Shaw, Marcum, & Boardman, 2001; Pargament, 1997).

Conversely, negative religious coping, which is marked by a tenuous relationship with God and an ominous view of life, is tied to poorer mental health outcomes. An insecure attachment to God, in which God is perceived as punitive, abandoning or unsupportive, is correlated with increased anxiety and depression and lowered well-being (Cole, 2005; Exline, 2002; Phillips, Pargament, Lynn, & Crossley, 2004; Smith, Pargament, Brant, & Oliver, 2000). Individuals with anxious or avoidant attachment to God are more likely to utilise negative religious coping strategies and to have less positive overall outcomes during a stressful period (Belavich & Pargament, 2002).

Pargament et al. (1988) have identified three distinct orientations of religious coping: self-directing, deferring, and collaborative. The *self-directing* style is an individual style of coping independent from any influence or help from God. While self-directed coping is useful in many situations, it may be disadvantageous in those situations that the individual has little control over. While it appears to correlate with a greater sense of self esteem and positivism in individuals (Pargament et al., 1988) and may or may not relate to positive adjustment in stressful situations (Pargament, 1997) it also correlates with an insecure attachment to God (Belavich & Pargament, 2002) and lowered spiritual well-being (Wong-McDonald & Gorsuch, 2004). When self-directed coping is tied to the concept of an abandoning God, anxiety increases and self-esteem decreases (Phillips et al., 2004).

In the *deferring* style responsibility for coping is deferred to God. Individuals utilising this religious coping style tend to have lower self-esteem, lower sense of personal control, less strategic ability and less tolerance (Pargament, 1997). The deferring individual is generally extrinsically motivated, looking to an external authority for guidance and help (Pargament et al., 1988). However, a deferring style of coping may be useful in those situations where the individual has little control. In these situations, the deferring of problem solving to a stronger and wiser being may be empowering for the individual. The *collaborative* style sits in between the self-directed and the deferring styles in that it involves the sharing of responsibility regarding problem solving between the individual and God. Collaborative problem solving is the only religious coping style which consistently correlates with positive adjustment to stressful events. Those who use the collaborative style tend to have a more committed and

intrinsic religiousness. The active give and take between the individual and God in this style of coping, and the secure attachment observed in this relationship (Belavich & Pargament, 2002), seems to increase the individuals sense of personal competence (Pargament, 1997), empowerment and involvement in recovery-promoting activities (Yangarber-Hicks, 2004).

Figure 1 provides a basic outline for the pathways discussed above. It needs to be noted that each of these pathways can also produce alternative outcomes depending upon: (a) the personality factors and coping disposition of the individual; (b) the individual's situation and its demands; (c) the cognitive and affective appraisals the individual makes of their situation; and (d) the resources available to the individual (Bouchard et al., 2004; Everly & Lating, 2002; Snyder, 2001).

Insert Figure 1 here

Intrinsic and Extrinsic Religiosity

Secure attachment to God and positive religious coping are linked to internalised, well embedded, and intrinsically motivated religion (Belavich & Pargament, 2002; Pargament, 2002a). Methods of coping generally arise from one's framework of values, meaning and understanding. The more integrated these are the more effective they will be (Gall et al., 2005). Greater intrinsic religiousness has been correlated with increased sociability, sense of well-being, tolerance, self-esteem and intellectual efficiency, and conversely, with less anxiety, depression and social dysfunction (Ayele, Mulligan, &

Gheorghiu, 1999; Baetz et al., 2002; Bergin, Masters, & Richards, 1987; Park, Murgatroyd, & Raynock, 1998; Ryan, Rigby, & King, 1993; Sullivan, 2005).

While positive well-being is linked to intrinsically motivated and well-embedded religion, negative well-being is conversely linked to imposed and unexamined religion (Pargament, 2002a). Religious integration, the degree to which an individual's religious beliefs, practices, relationships, and motivations are integrated with each other, may well be "the most critical question for psychologists interested in evaluating the efficacy of religion" (Pargament, 2002a, p. 177), and consequently of the therapy then offered to the individual. This very concept, of the human need for self integration, appears out of the literature as a central premise for the offering of a holistic therapy model inherently incorporating intrinsic religiosity.

Quantum Change

Quantum changes are those epiphanies and sudden insights that transform lives. William James (1902) discussed these types of personality changes at the turn of the 19th century in his lectures on "The Varieties of Religious Experiences", and Maslow (1964) described a similar, if not identical phenomenon which he deemed 'peak experiences'. Maslow considered the 'peak experience' to be the essence of religious or spiritual experience, although he saw its origin as being cognitive (Christopher, Manaster, Campbell, & Weinfeld, 2002). Jung (Alcoholics Anonymous, 1976, p. 27) also talks about 'vital spiritual experiences' which have the potential to eliminate negative behaviours. However, while several eminent psychologists have described the concept of quantum change, and while the possibility of rapid and lasting positive personality

change is of great relevance to the task of psychotherapy, very little theory or research has been developed around the notion.

Miller and C'de Baca (2001, p. 4) describe quantum change as "vivid, surprising, benevolent and enduring personal transformation". These are changes which cannot be explained as normal responses to the occurrences of life. They are strikingly memorable inner experiences which bring about unexpected change in the very essence of a person's psyche. James (1902) described two forms of these transformational experiences, one being a gradual and continuous process of change – what Miller and C'de Baca (2001) describe as 'the insightful type', and one being a sudden and discrete occurrence, the 'mystical type'. Both types of change are holistic transformational change involving "thoughts, actions, emotions and spirit" (p. 39). It is as if the person walked through a one-way door, never to return to being that same person again. The two types, insightful and mystical, are distinct though not separate, as though lying upon a bimodal distribution.

For many people quantum change occurs during a specific spiritual activity, such as prayer, or involves a spiritual experience such as an awareness of a transcendent presence beyond themselves (Miller, 2004). This may result in changes to perceptions of control, such as deferring control to God or a higher power, or conversely, regaining lost personal power through collaboration with God or a higher power. In this way quantum change aligns with Pargament's religious coping styles, although coping styles are generally deemed to be relatively consistent patterns of the personality (Bouchard et al., 2004; Knoll, Rieckmann, & Schwarzer, 2005; Maynard et al., 2001), whereas quantum change involves a transformational change in coping style. Quantum change does not

align with a learning model of behaviour change. How these sweeping transformational change occurs has yet to be explained, but nonetheless, the changes appear to be enduring (C'de Baca & Wilbourne, 2004). Unlike the sudden changes that can occur in therapy when hope is dramatically elevated but which then disappear again (Yalom, 2002), in quantum change there is an enduring adjustment to the personality – or what might be called the spirit – of a person. Is it possible to initiate this sort of change in therapy? The majority of people who reported a quantum change did so in the presence of a 'holy Other' (Miller & C'de Baca, 2001). Is it possible that facilitating the relational experience of God's presence in therapy might produce change akin to quantum change? Certainly the phenomena should be of interest to psychotherapists. Quantum change may be one of the as yet unaccounted for change dynamics in the religion and mental health equation. Based on the literature, a proposed pathway for these benefits is detailed in Figure 2.

Insert Figure 2 here

Summary

It appears from the research that mental health is positively influenced by many aspects of religious experience and belief and their associated behaviours. Of particular relevance to psychotherapy are the concepts of attachment to God, religious coping style, intrinsic and extrinsic religion, and quantum change. Knowing that these factors may play a determinant role in mental health leads to the next question: what should this mean for the practice of psychotherapy?

Chapter Four:

Implications of Religion for Psychotherapy

"If the concept of God has any validity or any use,
it can only be to make us larger, freer, and more loving.
If God cannot do this, then it is time we got rid of Him."

(James Baldwin, 1963)

Overview

This chapter discusses the implications for psychological treatment of the influence of religion upon mental health. Given that religion appears to influence mental health, how might it then be a useful component of psychotherapy? The question of how religion influences an individual's search for psychological treatment is also considered. Finally, several existing models of religious therapy, other than RFT, are described and discussed.

How does Religion Impact upon Psychotherapy?

Religion and spirituality may impact upon psychotherapy in a number of ways. Firstly, they can positively and negatively influence an individual's perceptions of their circumstances and their available resources. Secondly, they can function as actual resources – as means of coping, and of personal integration and resolution. Thirdly, they may be the specific focus of therapy when existential and spiritual conflicts are integral to

the individual's presenting symptoms. The more religious a client is, the more significant the implications of incorporating their beliefs into their psychological treatment, although the implications of this incorporation will potentially vary depending upon the type of religious beliefs a person professes and the manner in which religion is integrated into their lives.

A person's image of God appears to have significant psychosocial, emotional and spiritual correlates (Cheston et al., 2003; Murray-Swank & Pargament, 2005; Piedmont, Williams, & Ciarrocchi, 1997). Richards and Bergin (1997a) suggest that therapists should identify a client's image of God for two reasons: interventions enabling clients to increase their experience of God's love and support have the potential for powerful therapeutic effects, and a client's image of God also provides the therapist with insight into the client's image of self and significant others. Incorporating religion and spirituality in therapy should be the most efficacious for those who have an existing positive religious coping style (Pargament, Ellison et al., 2001). Increasing levels of positive religious coping and decreasing levels of negative religious coping may also impact positively upon therapeutic outcomes (e.g., Murray-Swank & Pargament, 2005). Approaches to psychotherapy in which spirituality is a collaborative effort between the individual and God (i.e., joint responsibility for problem solving) should have greater psychological benefits than approaches which either defer solely to God or neglect God altogether (McIntosh, 1995; Pargament et al., 1988).

To conclude from the research, the integration into therapy of certain aspects of religious experience should have significance regarding psychotherapy outcomes for religiously committed people. These aspects of religious experience include:

a) Appraisal of God as a benevolent accessible attachment figure, and the internalisation and integration of this appraisal into the individual's orienting system.

b) Augmentation of positive religious coping which emanates from a collaborative relationship with God in which problem solving involves give and take between God and the individual.

c) Reduction of negative religious coping wherein the relationship is tenuous and collaboration with God stymied.

It can be inferred from the research that altering an individual's concepts of, attachment to, and experience of God may impact upon their use of religious coping which in turn may influence the individual's mental health outcomes. The integration of these components into therapy with religious individuals may be advantageous and also defensible given the weight of evidence indicating the potent source of therapeutic gain such aspects of religion can offer (Borman & Dixon, 1998; Koenig & Cohen, 2002).

Help-seeking by Religious People

Religious commitment also impacts upon individuals' approaches to and involvement in therapy. An unfortunate outcome of the before mentioned animosity between religious and psychological worldviews has been a commensurate distrust between religious clients and psychological therapists. Religious clients may fear their beliefs will be discounted, belittled or even violated by mental health practitioners (Cutland, 2000; Macmin & Foskett, 2004; McMinn, Chaddock, Edwards, Lim, & Campbell, 1998). There may be some basis for this angst with one study indicating that

psychologists have less optimistic expectations for therapy with religious individuals (Gerson, Allen, & Gold, 2000). There is also evidence to suggest that religious individuals prefer to approach and disclose to religious clergy or religiously similar therapists (Abe-Kim, Gong, & Takeuchi, 2004; Mitchell & Baker, 2000; Ripley, Worthington, & Berry, 2001). On a practical level, religious clergy may be more accessible to individuals than mental health professionals and as a consequence may be the first 'port of call' for the treatment of psychological concerns.

Many clients appear to welcome and in fact desire the opportunity to bring up spiritual and religious issues in psychotherapy (Cole, 2005; Phillips, Lakin, & Pargament, 2002; Post, Puchalski, & Larson, 2000; Rose, Westefeld, & Ansley, 2001). Because highly religious clients tend to view religious issues as central to counselling (Myers, 2004; Rose et al., 2001; Wyatt & Johnson, 1990), the integration of religion into therapy appears to be highly regarded by religiously committed individuals (Belaire & Young, 2002; Turton, 2004), and may result in client expectations of better outcomes (McCullough & Worthington, 1995; Ripley et al., 2001). However, the effect of matching the religious values of the client and therapist on actual outcome is unconfirmed, as few studies have been done and those that have show evidence both for and against it (Propst, Ostrom, Watkins, & Dean, 1992; Worthington & Sandage, 2002).

One of the benefits of using a therapy model which explicitly integrates religion and psychology is client awareness of the therapist's orientations prior to or upon requesting therapy. Some surveys have shown mental health professionals to be significantly less religious than their clients. In one American study 51% of psychologists reported that religion was not very important to them compared with 11%

of the general population (Shafranske, 2000). New Zealand psychotherapists appear to be more secular than most with 62% from a sample of 251 stating that they had no religious affiliation, (Smith & Orlinsky, 2004) compared with 26% of the general population (New Zealand Statistics, 2001). As well, there still appears to be a residual effect of the historical negativity towards religion among mental health professionals with 45% of a sample of 89 mental health professionals in Britain expressing the belief that religion might lead to mental ill health (Foskett, Marriott, & Wilson-Rudd, 2004).

Bergin (1980a, p. 97) states that "it is inevitable that the therapist be ... a moral agent". As research indicates that clients will incline towards the orientation of their therapists over the course of therapy (Beutler, Machado, & Neufeldt, 1994), there is the risk that therapists may, intentionally or not, 'convert' their clients to a secular stance. Conversely, there is the ethical concern that a religiously orientated therapy model will impose a particular exclusive worldview upon the client. However, when this is acknowledged at the outset of therapy, and efforts are made within the therapy structure for the therapist to remain a facilitator of the client's process rather than to advocate for their own convictions, a high degree of therapeutic concurrence and safety can ensue.

Existing Psychological Interventions Integrating Religion

Many books and articles have been written about integrating religion and therapy (e.g., Griffith & Griffith, 2002; McCullough, 1999; Miller, 1999; Richards & Bergin, 1997b; Shafranske, 1996; Worthington, Kurusu, McCullough, & Sandage, 1996). This integration has frequently appeared to be a haphazard process, with numerous intervention strategies springing up without any systematic collaboration or evaluation

among them. Despite some commonalities in terms of their historical roots and purpose, psychology and religion have different traditions of scholarship, different languages and ultimately different primary goals. This makes the process of integration complex and some psychologists are calling for a more systematic partnership between science and religion (Barbour, 2000).

Alcoholics Anonymous (AA).

Probably the most well-known intervention that integrates a spiritual element is Alcoholics Anonymous (AA). The AA has been a highly successful treatment intervention for the past 70 years and received America's highest scientific prize for medical progress, the Lasker Award (Vaillant, 2005). Millions of people have participated in AA's program of alcoholism recovery, and there are 2,000,000 members (Alcoholics Anonymous World Services Inc, 1998). Multiple studies collectively involving more than a thousand individuals have suggested good clinical outcomes for those participating in the AA program (Emrick & Tonigan, 1993). AA was developed by Bill Wilson in 1935 in response to his own spiritual quantum change experience and consequent recovery from alcoholism following years of binge drinking. Although AA is not affiliated with any religion, spiritual awakenings are considered a key mechanism of change (Lobdell, 2004). Within the 12-steps of the AA program, individuals paradoxically are empowered as they admit their own powerlessness and submit their lives to a 'higher power'. They spiritually cleanse their lives through the confession of wrongdoings, and they intentionally seek conscious contact with God (Alcoholics Anonymous, 1976).

Within the AA approach lies the premise that in order to give up a negative habit, a positive habit needs to take its place (Vaillant, 2005). This is a shifting of focus – a refocus. The shift of dependence from alcohol and self to dependence upon God is a theme which relates to issues of attachment. It appears possible that as an individual's secure attachment to God or a 'higher power' increases, their negative clinical symptomatology, in this case alcohol addiction, decreases (Sachs, 2003). There are similar correlations between the AA model and positive religious coping in that deferring to and collaboration with God are the preferred means of coping. The AA model also appears to purposefully incorporate steps which will generate a genuine quantum change, in fact this intention seems to underlie the change mechanisms inherent in the program. Spiritual awakening is not only a prominent feature of the AA program, but also an effective one. In a recent study of 587 individuals, those who reported a spiritual awakening during their AA involvement were nearly four times more likely to be abstinent after three years than those who reported never having had a spiritual awakening (Kaskutas, Turk, & Bond, 2003). Further research has found that the spiritual awakening AA members experience relates to a transcendent 'other', in other words an attachment experience, rather than more general self-transcendent spirituality (Zemore & Kaskutas, 2004).

Religion accommodating CBT and REBT.

While the AA is a unique self-contained therapy model, there have been several successful efforts at accommodating religion and spirituality in existing psychotherapies. Cognitive-behavioural therapy (CBT) and rational-emotive behavioural therapy (REBT)

approaches that accommodate or integrate religious practices have been developed (Azhar, 1994, 1995a, 1995b; Backus, 1985; Craigie, 1989; Hawkins, Tan, & Turk, 1999; Johnson, 2001; McMinn, 1991; Nielsen, Johnson, & Ellis, 2001; Norcross, 2002a; Pecheur & Edwards, 1984; Propst et al., 1992; Tan & Ortberg, 2004; Wright, 1986). These generally include using scriptural support to counter irrational or self-defeating beliefs, and religious imagery to increase comfort or reduce anxiety. A meta-analysis of many of these studies (McCullough, 1999) has provided some evidence, albeit modest, of efficacy in improving mental health under specific conditions. All the Christian-accommodating interventions were as effective and several were more effective than their non-religiously accommodating counterparts. In one study, 59 participants with depressive disorders were randomly allocated to CBT, Christian-based CBT, pastoral counselling or wait-list control (Propst et al., 1992). Both the Christian-based CBT participants and the pastoral counselling participants had significantly less depression post-treatment than the CBT or wait-list participants.

Inner Healing models.

Within Christian literature, 'Inner Healing' appears as a common method of modern therapeutic intervention. This was initiated in the Charismatic movement of the 1960's and has now spread to mainline Protestant, Evangelical, Catholic, and other Christian denominations (Johnson, 2005). Johnson's (2005) doctoral dissertation examined four of the more well-known approaches to inner healing. These include; "Christian Healing Ministries" (Francis and Judith MacNutt), "Deep Healing Ministries" (Charles H. Kraft), "Elijah House" (John Loren and Paula Sandford), and "Theophostic

Ministries" (Ed M. Smith). Of these, only Theophostic has apparently undergone any published research (Kleinschuster, 2004; Lewis, 2001; Witherspoon, 2003), and this was with $N = 1$ case studies. Theophostic is also the only approach providing a coherent step-by-step model of practice.

Theophostic Ministry is a form of 'healing of memory' prayer. It is estimated that more than 300,000 individuals have received this type of intervention and more than 15,000 people have taken the basic Theophostic training (Bidwell, 2001). The Theophostic intervention consists of the identification of maladaptive cognitions followed by prayer in which God is called upon to reveal their cause. This usually involves the practitioner encouraging the client to free associate the cognitions with memories. Once a memory surfaces, the client is exhorted to re-experience this, during which the practitioner asks God to reveal truth to the client (Garzon & Poloma, 2005). This form of intervention almost entirely pivots around painful memories and their associations and as such may ignore other therapy needs, as well as being potentially re-traumatising. Nonetheless, it appears to be the one Christian-based therapy model which has undergone any academic inquiry, albeit scanty.

Summary

Those components of religion which appear to have the most benefit for mental health include a secure attachment to God displayed in a positive religious coping style. Therefore, a therapy model which can improve a religious individual's attachment to God and associated positive styles of religious coping may have corresponding benefits to their mental health. Many religious individuals seem to desire, and may benefit from, a

religiously sensitive psychotherapy intervention and/or therapist. The existing interventions which incorporate religion appear to be generally effective, although many remain untested. As yet there are few specific theories and models of God-centred psychotherapy.

Chapter Five:

Refocussing Theory and Therapy

"Christ with me, Christ before me, Christ behind me,
Christ in me, Christ beneath me, Christ above me,
Christ on my right, Christ on my left,
Christ when I lie down, Christ when I sit down,
Christ when I arise"

(Saint Patrick, 387-493)

Overview

The following chapter outlines the theory and model of Refocussing Therapy (RFT). A description of the different components unique to RFT is included, as well as a summation of the research that has already been carried out on RFT.

Development and Description of Refocussing Theory and Therapy

Refocussing Therapy is a distinct model of Christian psychotherapy that has been developed by New Zealander Diane Divett. It has been designed specifically but not exclusively for the Charismatic Christian culture and combines aspects relevant to the Maori culture which Divett grew up in. Both the Charismatic Christian culture (which in New Zealand is almost indistinguishable from the local Pentecostal Christian culture, but which more resembles the 'neo-charismatic' movement than classical Pentecostalism), and the Maori culture place a high value on holistic well-being. This conception of

holistic well-being, or wholistic well-being as Divett describes it, has strongly influenced Divett's work. The Charismatic Christian culture has a distinct worldview which integrates "premodern miracles, modern technology and post modern mysticism" wherein the natural and supernatural are merged (Pargament, Poloma, & Tarakeshwar, 2001, p. 274). Pentecostal/Charismatic Christianity is the fastest growing sector of Protestant Christianity worldwide and has been predicted to overtake Catholicism as the predominant global form of Christianity sometime during the 21st century (Robbins, 2004). Divett's model of RFT therefore targets a broad and growing global population group. Her doctoral thesis (Divett, 2004) outlines the development and definition of the theory of Refocussing (RT) and its therapeutic practice (RFT).

Divett describes the quintessence of RFT as being applied Christianity (Divett, 1997). It is presupposed that God exists and that he can and does personally intervene in peoples lives. The presence of the Holy Spirit in psychotherapy is a salient issue for many Christians. However, "an exhaustive search of the literature reveals that there is an inadequate emphasis on this topic" (Fee & Ingram, 2004, p. 104). A basic premise of Christianity is that people can change through the power of the Holy Spirit, whose work, while not directly observable, is evident through the effects produced (John 3:8). What Divett seeks to do is create an invitation in therapy for the Holy Spirit to produce such change.

In developing RFT's theoretical framework Divett has gleaned from established theological, psychological, and therapeutic theory (Kay, 2002b). Her model acknowledges that spirituality, alongside the many psychological suppositions, offers a unique set of resources for living. In integrating these perspectives, she has attempted to

capture those aspects which have already proven effective and from them create a holistic incorporated model. There is a primary acknowledgement of the importance of client safety in therapy (Lambert, 2004). The now generally accepted 'givens' of therapy are fundamental to RFT, including a positive therapeutic alliance, therapist empathy, positive regard and congruence, goal consensus and collaboration, customising the therapy relationship to the individual client, providing feedback, and therapist accountability (Beutler et al., 2004; Norcross, 2002a).

Refocussing Needs Based Theory

Refocussing theory is based upon the supposition that people's needs influence their functioning. When needs are not met or are met in inadequate or harmful ways, then dysfunction may result. These needs may be transpersonal (spiritual), interpersonal (social, vocational, recreational), and intrapersonal (intellectual, emotional, moral and physical). According to Refocussing theory, such needs require identification (focus) and attention (refocus) in order that they may be resourced, resolved or healed. The RFT model provides a method for empowering individuals to focus and refocus with the intention of holistic well-being ensuing (Divett, 2005b). Needs are identified as a common construct employed by both psychology and theology (Boa, 1994). Within Christian theology, needs are identified as principally relating to the restoration of intimate relationship between the Creator and the people he created (Howe, 1995). This restoration has become possible through Jesus' death on the cross, whereby Christ has quintessentially met the needs of all humankind. What is more, he has also endowed Christian believers with the Holy Spirit – God's empowering presence (Fee, 1994).

"God...who made the world and everything in it...has no needs. He himself gives life and breath to everything, and he satisfies every need there is" (Acts17:24-25).

Refocussing theory proposes that therapy should focus on unmet needs in order that they are not minimised or denied (Divett, 2004). However, there is also recognition that what people focus on is what they are likely to experience. Divett, along with others, was concerned that the revisiting of negative experiences in therapy was potentially re-traumatising and as such, "could be likened to a form of abuse" (p 190), unless a resolution of some sort was to be forthcoming. In her study of individual therapy clients, Divett became aware that the answers to people's problems were not generally found when they remained focused on the problem itself. However, when they refocused on God as the provider of solutions, a way was created for people to examine their needs and problems from a solution based paradigm rather than a problem based paradigm.

God Spaces

Divett termed this God-focused solution-based paradigm the 'God Space'. This was the space from which people could examine their problems from another perspective and focus on what God might *show*, *tell* or *give* them for their needs. It describes peoples' awareness or knowledge of God as he reveals himself to them, as is conveyed in the New Testament, "His Spirit witnesses with our spirit that we are the children of God" (Romans 8v16). The *Bible* identifies the activity of the Holy Spirit in the lives of believers in various locatable ways. For example, the Holy Spirit is said to come upon (Acts 1v8), come within (Acts 4v31) and fill up (Ephesians 5v18) believers. Jesus designates the Holy Spirit as Paraclete (John 14:16), a Greek verbal adjective referring to

one who comes alongside a person to comfort, or encourage them. Believers are exhorted to "keep in step with Him" (Galatians 5v25). Not only is the activity of the Holy Spirit in the direction of the believer, but the believer is instructed also to "reach out for him and find him, though he is not far from each one of us. For in him we live and move and have our being" (Acts 17v27). All these statements are descriptive of activity which is perceivable, identifiable, and locatable. The concept of locating God as a therapeutic resource is not new. Griffith (1986) also talked about the locating of God as being an essential component of the therapy process. Prior to this, several earlier mystics and bible teachers also described God as someone who could be located and accessed (e.g. Brother Lawrence and St. Therese of Lisieux).

The Holy Spirit is described as *the* Counsellor (John 14:26) who "will teach you all things" and the one by whom God reveals his wisdom to us (1 Corinthians 1:10). Ephesians 1:17-18 (NIV) describes it this way;

> I keep asking that the God of our Lord Jesus Christ, the glorious Father, may give you the Spirit of wisdom and revelation, so that you may know him better. I pray also that the eyes of your heart may be enlightened in order that you may know the hope to which he has called you, the riches of his glorious inheritance in the saints, and his incomparably great power for us who believe.

RFT essentially supports the biblical notion that God is accessible as a positive, supportive, and resourceful attachment figure, whose key ambition is to mend the broken hearted and comfort the distressed (Isaiah 61:1-3). In this sense, God is available in therapy as a therapist.

Divett undertook a year long ethnographic study in 1995 examining the mental health outcomes of the 'Renewal' which occurred in Toronto in 1994 and had subsequently impacted thousands of churches around the world. During this study, Divett examined the consequences of people "coming close to God and having Him coming close to them" (James 4v8). Divett asked simple questions such as: "If He comes close to you, then where does He come close to you from? And if He comes close, how close is that? And what is that like when He comes close to you? What happens when He comes close to you?" (Divett, 2005a, p. 49). She discovered that people had more than one God Space and that these God Spaces could be located, accessed and developed in a manner that could provide people with solution producing information and experiences. Thus the God Spaces have become the central focus of the seven foci used in RFT.

Research has indicated that "the helpfulness or harmfulness of an individual's search for the divine depends on the kind of God the person discovers and the kind of relationship he or she forms with that God" (Pargament & Mahoney, 2002, p. 649). People seem to adjust better to negative events when they are reframed in the light of a larger, benevolent, spiritual intention (Pargament, 1997). This positive reviewing of events corroborates with RFT's purpose in getting people to refocus on a beneficent God attachment figure. Boyd (2003, p. 355) adds to this understanding with his statement that, "nothing is clearer than the fact that Jesus wanted his hearers to think of God, not as some angry, vengeful Super Tyrant, but rather as valuing and caring toward them. God is the source of sacred safety." Studies have shown that when individuals are primed to positive attachment figures (in the form of memories, pictorial representations and

proximity-related words), their mental representations of others and their circumstances can be altered in helpful ways (Milkulincer, Birnbaum, Woddis, & Nachmias, 2000; Milkulincer et al., 2001; Milkulincer, Gillath, & Shaver, 2002).

Similarly, in Poloma's (1996) study of the Toronto renewal phenomena 91% of respondents said they came to know "the Father's love in new ways". Further research by Poloma and Hoelter's (1998) found a strong association between Toronto participant's experience of spiritual healing (improved relationship with God) and inner healing (improved self-image and/or relationships with others). Other research has shown that an individual's experience of God's presence correlates with their experience of God's care for them and their consequent positive feelings about themselves (Greenway, Milne, & Clarke, 2003). It appears that it is this positive intimacy with God which has the potential to transform the individual's perception and experience of their life; past, present and future.

Glasser's reality therapy (1965) parallels this idea by focusing on an individual's basic need to love and be loved. Glasser states that every person has a need for at least one other person in their life that will care for them and about whom they can care for. This person need not be someone in direct tangible relationship with them, as long as there is a strong feeling of his existence. Research indicates that people are not so influenced by received social support, as they are by perceived social support (Salsman et al., 2005). In RFT, the opportunity to love and be loved by a significant other is made imminent and accessible via the God Spaces. In object relations terms, as the individual begins to seek a new object relation in the person of God, an object relation potentially unencumbered by deleterious associations, they can override their resistance to change.

As Rizzuto (2005, p. 39) puts it, "we define who we are by believing who or what (the divine or transcendent realities) are". Buber (1970) further emphasises the *who* in our relating to the divine. He asserts that in an I-it mode of relating, the object is a means to an end. However, in the I-Thou encounter, a deeper level of relationship with its concomitant reciprocal exchanges results. Buber (p.186) states "I require a You to become; becoming I, I say You. All actual life is encounter".

Within RFT the I-Thou encounter is the defining moment, and is brought into focus using the God Spaces. The therapist facilitates the client's locating, accessing and developing of their God Spaces through the use of orientating questions. These include questions such as: "Where is God for you right now? What are you thinking, feeling, sensing or seeing? Is He inside or outside of you? Below or above you? In front of or behind you?" As the client orientates to 'God being in their space', the therapist can then begin to access and develop that experience with the client using questions such as: "What is He like when He's there like that? Anything else about that? What is happening for you right now as He's there like that?" During this interaction, the client may be experiencing God from a specific focus, such as affect. In that case, questions may follow relating to that unique experience: for example, "Whereabouts is that feeling? What is that feeling like? What does God know about that feeling? What would God do with that feeling? Is there anything that you want to have happen regarding that feeling?"

The Theophostic model utilises imagery of Jesus in the context of a person's memories (Smith, 1996). Deep Healing Ministries utilise 'faith picturing' which again seems aimed at imaging Jesus in memories. The founder of Deep Healing Ministries describes faith picturing as not merely a product of people's imagination but as a function

of a person's spirit in interaction with God's Spirit (Kraft, Kearney, & White, 1993), a concept which RFT would cautiously concur with. In contrast however, RFT specifically locates God (Father, Son and Holy Spirit) in the here and now, although the context of people's imagery may include memories as well. Additionally, RFT is conscious of the fact that individuals process uniquely in visual, auditory, emotional, physiological and cognitive ways, and allows for this variation in the model.

In many respects, RFT is similar to Gendlin's (1981) Experiential Focusing method, and Greenberg's (2002) Emotion-Focused therapy. The philosophy underlying Gendlin's approach is centred on the notion that humans have bodies that live in situations. Gendlin and others (Hendricks, 2001) found that as people in therapy focused on the immediately sensed experience they have in their bodies in a given situation, they were able to assign meaning to the sensed experience in a way that increased the benefits of therapy. In a similar way, RFT focuses on the immediately sensed experience, not only of a person in their situation, but also of their experience of God. A primary objective in emotion-focused therapy is the integration of head and heart through the client expressing and reflecting on their immediate sensory and bodily felt experience in the presence of an 'other' (Greenberg & Watson, 2006). For RFT clients, this other is not simply the therapist, but more essentially, God. Hinterkopf (1994) expanded the experiential focusing therapy approach to incorporate spirituality. Case study examples of this approach appear to illustrate a therapy methodology similar to RFT (Hinterkopf, 2005). However, RFT is unique in it that it seeks to avoid fusing clients with negative past experiences and thus re-traumatising them. It does this by prior development of and

frequent referral to a client's God Space/s during the activation of maladaptive core experiences.

Within the RFT approach, case studies investigating individuals use of their God Spaces have demonstrated some potent effects, including physical healing as well as notable modifications of maladaptive cognitions, emotions and behaviours (Cameron, 2003a, 2003b; Divett, 1995b, 2002, 2004; Jenkins, 1999, 1999a, 2005a; Kay, 2000, 2000a, 2001, 2001a, 2002a; Spain, 1999, 2000, 2002, 2002a, 2002b). In many accounts the changes that occur resemble quantum change, with significant and enduring transformations taking place after one or two sessions. There are also many accounts of long-term on-going RFT therapy work which are more in keeping with traditional therapy process.

The Seven Foci

The seven foci, including the God Spaces, are means by which needs can be identified and focused upon. These foci are used depending upon the information and cues a client gives the therapist, and are themselves informed by various psychological and theological theories regarding human needs. These may pertain to unmet past needs represented in theories developed by Maslow, Erickson and Freud; to present needs, represented in some Existential theories, Gestalt, Person-Centred and Systems theories; and to future needs, represented in some Existential, Logotherapy and even Cognitive Behavioural theories.

It could be contended that theology addresses past, present and future needs in every dimension of human experience and expression. As Hill & Pargament (2003, p.

66) state, religion and spirituality are complex processes involving "cognitive, emotional, behavioral, interpersonal, and physiological dimensions." While verbal, conceptual processing is an acknowledged component of RFT, 'implicit relational knowledge', as described by Hall (2004), which integrates affect, cognition and behaviour, is more in keeping with the RFT model. Subsymbolic emotional processing, nonverbal symbolic emotional processing, and verbal symbolic processing (Bucci, 1997) are all components of the model which find their expression via the foci. The foci are intended to allow a means for a holistic approach to dialoguing with an individual's presenting problems. They reflect a current trend in psychology and neuroscience away from a longstanding focus on cognitive processes towards that of emotion, and the self (Hall & Porter, 2004; Jankowski, 2003; Thiselton, 2004).

The foci are as follows;

1. *The God Focus.* This is the central focus of RFT and as referred to above, is generally deemed the God Space. Within the Christian culture, and in particular the Charismatic Christian culture, the concept of 'God with us' is a given. By using the God focus, people can locate, access and develop what they uniquely know of the experience of God 'being with them'. The God focus helps clients to consider how God sees their need and can facilitate resourcing, resolving or healing of the need.
2. *The Cognitive Focus.* This involves the exchange of information, the explaining of ideas and concepts, the setting of goals and the monitoring and assessing of the therapy, as well as the client's cognitive insight and understanding during the process.

3. *The Affective Focus.* Affect in general is the focus here with particular emphasis being given to 'child within' work. Cues alert the therapist to affective states, with emphasis on what the client intrinsically and emotionally knows.
4. *The Senses Focus.* The way in which people attend to or experience their different senses during therapy can provide helpful information. Within RFT there is also credence given to the unique way in which individuals may access information through a preferred sense.
5. *The Physiological/Body Focus.* In this focus, the therapist attends to the phenomenology of the client – watching what they 'act out' or determining what they sense with their bodies and focusing the client's awareness on what the behaviour or sense represents for them.
6. *The Evil/Demonic Focus.* In line with Christian theology, sin, evil and demons are valid constructs which are at times the focus of therapy. This focus engages the same client empowering approach as the other foci.
7. *The Symbolic Focus.* This focus uses symbolism such as drawing, sand tray work, psychodrama and music to externalize clients' information, memories, feelings or experiences. Once externalised, these symbols can be altered and a new experience created.

Clean Language

The foci are intended to allow access to a client's own phenomenology. This is managed by using 'Clean Language'. Clean Language is a term derived from the work of New Zealand therapist David Grove (1995; Grove, 1998). Clean Language, while similar

to client-centred therapy, is instead 'information-centred'. Lawley and Tompkins (2000, p.52) describe the three functions of Clean Language as being: (1) to acknowledge the client's experience as they describe it; (2) to orientate the client's attention to an aspect of their perception; (3) to send them on a quest for self-knowledge. Generally speaking, Clean Language is the working mode of communication used by the therapist in RFT.

Clean Language has many therapeutically relevant attributes. Firstly, it provides a level of safety in the interactions that occur within therapy. Divett (2004), along with others (Culbertson, 2000; Wehr, 2000; Zweig, 2001), was concerned at the potential abuse of power which can occur when those with religious authority, such as pastors and church counsellors, address the concerns of potentially vulnerable clients. Clean Language uses the client's own language, rather than suggestions from the therapist, to guide the session. In so doing it protects both the purity of the client's information and experience, and prevents the therapist from dominating the interactions with their own thoughts, beliefs and language. This helps to ensure that the client's experience of RFT is not manipulative or coercive, a matter of ethical as well as practical relevance.

Secondly, Clean Language allows each client's experiences to be understood in the context of the interrelationships of their own language and symbolism, experience, belief, enculturation, and communication style. Owen (1996, p. 271) defines the aim of Clean Language as "investigation of the relationship between speech, lived experience, and memory in a phenomenological manner". As such, it is ideally suited to the holistic style of therapy advocated by RFT. The use of Clean Language also creates the possibility of RFT being helpful to the large percentage of the population who consider

themselves spiritual but not religious, in that Clean Language can preserve inter-denominational and potentially non-religious considerations.

The use of Clean Language can facilitate a rapid process of engagement with intense and traumatic memories and emotions. Typically, Grove's Metaphor Therapy is completed within only three or four sessions (Wing, 1994), and while most RFT sessions are also completed within this time (Kay, 2002b), Divett was concerned that such a rapid and intense process could create fusion with traumatic memory and related emotions. In her attempt to avoid re-traumatising clients Divett has added safety and orienting questions to the application of Clean Language within RFT, for example: "are you okay with this process or experience?" and "Is what is happening to you a good experience or a bad experience?" (Divett 2004, p.260). She has also softened the very constrained use of language, naturalising the approach somewhat.

The Case of Rhona

An outline of the RFT therapy model process is presented in Figure 3, and an example of Divett's Clean Language and the Refocussing process is presented below.

Insert Figure 3 here

This transcript is taken with permission from the Refocussing Manual (Divett, 2005a, p. 53):

"Rhona presented for individual counselling hoping to resolve her anger problem. As I questioned Rhona using a 'pure language process' and helped her to discover

where 'God was for her', she was empowered by the Holy Spirit to deal with her main issue which was repressed anger towards her parents. In the counselling process, Rhona drew the part of her that was angry with her parents. As she did so, her jaw began to vibrate at what could only be described as an abnormal rate. Because it was abnormal, I wondered if a Renewal experience (Holy Spirit manifestation) was being facilitated. After noticing her jaw vibrating I began asking her questions:

T = *Therapist*

R = *Rhona*

T: And when your jaw is vibrating like that what is happening to you?

R: It's tight, it's hard.

T: And when it's tight and hard, tight and hard like what?

R: It's angry. It's real angry. It's a rage.

T: What kind of anger is that when it's really angry and rage.

R: It's horrible, (pause) it's, it's horrible. It's like a coil.

T: And when it's horrible, and it's like a coil, whereabouts did horrible coil come from?

R: It, it came from my father when he was hitting me.

T: And what else was there about when a father was hitting you?

R: I couldn't speak back.

T: And when you couldn't speak back, what else was there about that?

R: All the anger got stuck. That's it – that's what this is.

T: And what do you need for that?

R: I need God to stop it.

T: And can God stop it?

R: Yes, I think so.

T: And where is God for you?

R: He's here. He's here – near my mouth. That's Him. He's here near my mouth.

T: And what's He like when He's here near your mouth?

R: He – He's like cotton wool.

T: And when He is like cotton wool, what else is there about God who is like cotton wool?

R: That God is like cotton wool and He can fix the anger in my mouth.

T: And can a God like that God who is like cotton wool fix a mouth like that mouth?

R: Yes, yes.

T: And what is happening now?

She begins to weep as her mouth continues to vibrate wildly. She describes how God, like cotton wool, is wrapping up her mouth and protecting her from all that anger. She then becomes very peaceful… Several months later, Rhona reported the following: "That rage has gone. It was like a coil that was inside me. I've had it ever since I was a toddler, but I can't believe it has all gone. There is a peace inside me that I haven't ever known before."

Research regarding the physiological manifestations sometimes accompanying an experience of the presence of God in an individual's life is scant. In a survey of 918

individuals, a correlation emerged wherein the more physical manifestations a participant experienced, such as Rhona's vibrating jaw, the more likely the individual was to report positive emotions (Poloma & Hoelter, 1998). People also seem to report these experiences as positive and often life changing (e.g., Miller & C'de Baca, 2001; Poloma, 1996).

Homework

RFT has a complicit homework component. In line with research indicating that homework assignments enhance psychotherapy outcomes, and that homework compliance is a "consistently significant predictor of treatment outcome" (Kazantzis & Lampropoulos, 2002, p. 577), RFT emphasises the out of session practice of that which is learned in sessions. In particular, clients are encouraged to 'go to their God Spaces' as a resource available to them whenever they need it. Divett and her colleagues have also designed various activities which can be carried out by the client in their own time to further their progress.

RFT Research Background

Divett has gathered a team of therapists trained in RFT and is the director of 'Refocussing Therapy', which incorporates a counselling agency, a NZQA recognized training school, self-awareness groups and RFT supervision. In order to practice RFT, counsellors and pastors must attend a week long workshop and receive an 'Introductory Certificate in Refocussing Therapy'. To obtain this certificate participants must show evidence of aptitude in; the use of Clean Language, the use of the seven foci and in

particular the God Spaces, and in basic counselling skills such as developing rapport, ensuring safety, and maintaining confidentiality. As well, practising RFT therapists are expected to attend supervision with a trained and qualified RFT supervisor. A second, advanced level workshop is also available for those who have completed the first. Divett (1997) has developed a manual which all workshop participants receive and are expected to refer to in their practice. There are now outposts of RFT in New Zealand, Australia, Switzerland, Germany and South Africa.

Individual casework research has been carried out on the RFT process (Cameron, 2003a, 2003b; Divett, 1995, 1995a; Jenkins, 1999, 1999a, 2005b; Kay, 2000, 2000a, 2001, 2001a, 2002a; Spain, 1999, 2000, 2002, 2002a, 2002b). Kay (2002b) also completed a masters thesis evaluating 134 clients' experiences of RFT. In this thesis, Kay used an anonymous questionnaire to gather information regarding RFT clients' demographics, their experiences of RFT, and which aspects of RFT they found helpful or unhelpful. Kay discovered that RFT clients were representative of the general New Zealand psychotherapy client population in terms of age, gender and ethnicity in that they were predominantly female, middle aged and white (Manthei & Miller, 2000). These clients presented with a fairly predictable range of therapy issues including grief and loss, marriage issues, anorexia, sexuality issues, depression, sexual abuse and adolescent transition issues. Some also presented with crisis of faith issues. While the RFT process specifically incorporates spirituality it is not limited to issues that are spiritual in nature (Divett, 2004). In Kay's study most of the clients were part of the Charismatic Christian culture and they appeared to be deliberately seeking a mode of therapy which integrated their spirituality as a fundamental aspect of their functioning. While these results are

probably indicative of the population currently using RFT, the spread of RFT in the last three years means that a potentially broader population is now taking advantage of this therapy model.

The very positive results Kay discovered clearly support further research of RFT. 97% of the clients in her study reported that their expectations were met in terms of achieving their goals in RFT, and almost 100% said they experienced positive changes as a result of therapy compared to the general average of 75% of clients experiencing positive changes as a result of therapy (Lambert & Bergin, 1994). These results were achieved in the majority of cases in less than five sessions. It is apparent from this study that clients generally perceive RFT to be effective and empowering, although it is worth noting here that placebo effects and client therapy allegiance were not accounted for in Kay's research. These are however important outcomes, especially from a model catering specifically to a cultural minority group (Charismatic Christians).

An honours thesis investigating the God Spaces was carried out by Calvert (2005) in conjunction with the current study. In Calvert's study ($N = 66$) clients reported similarly positive outcomes from RFT, with the vast majority stating that they had some form of problem resolution occur, with 45% describing the resolution as complete. The most frequently reported therapeutic experiences were "a sense of hope for the future" (90% of clients), "a new perspective on the problem" (88% of clients), and a "sense that God is in control" (85% of clients) (p. 64). God Spaces were singled out by clients as the most helpful aspect of RFT. While restoration of hope and gaining a new perspective are common and desired in many therapy models, the unique feature of RFT is that clients attribute the source of these experiences to God.

Summary

RFT has a comprehensive 'needs based' theory and a clear working model of practice based around the God Spaces, the seven foci, and Clean Language. Research to date has shown promising results which provide a solid basis for further research. The next chapter will outline the proposed research methodology for this study.

Chapter Six:

Measuring Therapy Outcomes

"Science without religion is lame; religion without science is blind."

Albert Einstein (1879-1955)

Overview

This chapter seeks to explain the rationale for the methodology employed in this research study. An explanation and description is provided regarding the type of research method used. Other common factors that may influence the outcomes of the study are investigated. Finally, the key variants in this study – religious commitment, clinical status, and religious coping - will be expounded upon.

The Role and Rationale of an Effectiveness Study

As an intervention for treating psychological problems, psychotherapy has been extensively researched and is generally shown to be more effective than no treatment (Charman, 2004; Seligman, 1995). Across a broad range of literature, research is deemed a fundamental and indispensable component of psychological practice. Psychotherapies are now expected to have sound research evidence of treatment effectiveness (Evans, 2000). RFT has had an initial evaluation in the form of repeated case studies (Cameron, 2003a, 2003b; Divett, 1995, 1995a; Jenkins, 1999, 1999a; Kay, 2000, 2000a, 2001, 2001a, 2002a; Spain, 1999, 2000, 2002, 2002a, 2002b). Divett (2004) has carefully

observed the RFT model in action over the last ten years and has made grounded theoretical extrapolations regarding it. Kay's (2002b) research also added rich information and verified consumer satisfaction. However, given the widespread and increasing utilisation of the RFT model, it was decided that an investigation was needed to determine quantitatively that RFT did indeed produce generally positive changes, and to what extent. This study looks at the effectiveness of RFT treatment potency when tested in routine clinical contexts.

The simplest method for evaluating a psychological treatment is to observe the severity of clients' symptoms before and after treatment. If the treatment is effective, the symptoms should diminish. In any observational research there will inevitably be potential confounding variables. These consist of those variables other than treatment which may influence outcomes, such as the client's pre-existing characteristics or environmental situation. As a proportion of mental health symptoms remit without any specific formal treatment (Bower, 2003) the mere passage of time may in fact be responsible for the changes observed. Because both time and treatment may influence client outcomes a simple examination of symptoms before and after treatment will not necessarily determine which is responsible for any observed changes. Consequently, though this study has been carried out in a naturalistic setting, a control group (possibly better described as a comparison group) has been employed. A control group allows for the comparison between those who receive therapy and those who do not.

Ideally the participants will be randomly assigned to either the treatment or the control group, but this was not possible in this study. Ethical concerns were raised regarding the use of a delayed-treatment control group as those not receiving treatment

when it is needed may be severely disadvantaged or even harmed. It was decided that people visiting a pastor or minister for pastoral care would provide an adequate comparison group, in that while individuals would not be randomly assigned, their characteristics should not differ too greatly, including the potential confound of religiousness which has been shown to independently impact upon mental health. While RFT would be unique to the non-control group, other factors may account for the results in this study. Therefore an unambiguous answer to the question of RFT effectiveness is not possible. However, an answer concerning whether the provision of RFT makes a difference to a clients' overall distress can be attempted and extraneous factors can be considered.

Common Therapy Factors

Psychotherapy works for a number of reasons. These reasons are the source of ongoing debate and research. If the active ingredients of psychotherapy were incontrovertibly clear and predictable we would have no need for the current prevalence of psychotherapy models. However, while each therapy model recommends its own specific and unique factors as the catalysts to positive outcomes in therapy, common factors may mediate treatment outcome (Lambert, 2005). Common factors are those therapeutic factors common to all forms of psychotherapy, while unique factors are those which differ across therapies. Lambert's (1992) controversial analysis of outcome studies determined that only around 15% of the positive outcome of psychotherapy related to unique factors. According to Lambert, another 15% can be attributed to clients' hope and expectancy, 40% to the client and their environment, and 30% to

common factors within therapy. While Lambert's conclusions have been challenged (Nathan & Gorman, 2002) his premise that common factors significantly influence psychotherapy outcomes has been repeatedly upheld in research (Jorgensen, 2004). While this current study does not directly or broadly investigate common factors, it notes that they exist and that they may influence the RFT outcomes. Elements of these common factors are discussed below.

Therapist Variables

Therapies are never separate from those who are delivering them and therapist factors are shown to be predictive of treatment outcomes (Shirk & Karver, 2003). A study of 91 therapists over a two and a half year period found that the clients of the most effective therapists reported significant changes within a few weeks of therapy, whereas the clients of the least effective therapists felt the same or worse after almost three times as much treatment (Okiishi, Lambert, Nielsen, & Ogles, 2003). Observable traits such as therapist sex, age and race generally appear to have little impact upon treatment outcome, although the matching of therapist's personal traits to client's personal traits (including spiritual beliefs) has been related to reduced treatment dropout (Beutler et al., 1994). Studies regarding the significance of the type and length of a therapist's training upon treatment outcomes have given conflicting results (e.g. Bein et al., 2000; Luborsky, McLellan, Woody, & Seligman, 1997). It appears that what is relevant may be the extent and quality of contact with clients rather than specific therapist proficiencies (Lambert, 2004). Generally, the quality of the therapeutic relationship has been correlated with treatment outcomes (e.g., Andrews, 2000; Stevens, Hynan, & Allen, 2000). Therapist

motivation potentially influences therapy outcomes (Riemer, Rosof-Williams, & Bickman, 2005). Therapists are more efficacious when they provide treatment consistent with their preferred mode of working (Wampold, 2001). For therapists who place a high value on spirituality the opportunity to work within a spiritual model may be their preferred mode of working.

Client Variables

Studies have also suggested that client variables represent the greatest contribution to therapy outcome (Lambert, 1992; Zuroff et al., 2000). These variables include external (e.g. social support) and intrinsic factors (e.g. intelligence); invariant (e.g. gender), stable (e.g. personality traits) and variable (e.g. motivation) factors. Client variables observed in this study are discussed here in the order in which they are discussed in other sections of this study (i.e. not necessarily in order of importance).

Gender.

Gender impacts upon help-seeking behaviour in that more women than men seek out therapy, and women tend to have higher negative scores on mental health measures than men do (Kessler, Brown, & Broman, 1981; Wang, Berglund, & Olfson, 2005). However, in a recent study investigating 6,146 patients, gender accounted for very little of the variability in actual therapy outcomes (Wampold & Brown, 2005). Other studies have indicated conflicting reports of gender differences with respect to peoples attitudes in procuring professional therapy, and regarding therapy (Yi & Tidwell, 2005; Yoo, Goh, & Yoon, 2005). Gender differences are noted in the diagnoses of mental ill-health with

men more likely than women to present with alcohol and drug abuse problems (Isenhart, 2005), mania (Kawa, Carter, & Joyce, 2005), and violence (Swanson, Holzer, Ganju, & Jono, 1991). Women on the other hand are more likely to present with expressed panic (Zimmermann, Pin, & Krenz, 2004), depression, (Brownhill, Wilhelm, & Barclay, 2005; Marcus, Young, & Kerber, 2005), and sleep problems (Li, Wing, & Ho, 2002).

Age.

Age impacts upon help-seeking behaviour, with the elderly generally being less likely than younger people to seek help from a mental health professional (Alea, Cunningham, & Swanson, 2003), and when they do seek help, they have greater levels of psychological distress (Klap, Unroe, & Unützer, 2003; Wang et al., 2005). However, age appears to have no significant impact upon actual therapy outcomes (Wampold & Brown, 2005).

Ethnicity.

Ethnicity can impact upon therapy outcomes in a variety of ways, but this impact tends to be limited (Lambert, 2004). Minority indigenous ethnic groups have tended to exhibit increased alcohol and drug abuse (Beals, Novins, & Whitesell, 2005). Recent New Zealand research has reported Maori as having higher rates of mental disorder than non-Maori, in particular, depression, anxiety, substance abuse (MaGPIe Research Group, 2005), and sleep disorders (Paine, Gander, & Harris, 2004). A recent study discovered that ethnicity combined with varying education levels influenced premature termination

of therapy (Williams, Ketring, & Salts, 2005), and studies in America have shown that African Americans and Native Americans sought less help from mental health services than European Americans, often preferring to seek help from religious services instead (Ayalon & Young, 2005; Harris, Edlund, & Larson, 2005).

Education.

Level of education has been related to varying diagnoses of mental health. Lower levels of education have been found to correlate with higher levels of depression (Franko, Striegel-Moore, & Bean, 2005; Lee, Casanueva, & Martin, 2005), however, there appears to be little research to suggest that educational achievement has a significant impact upon therapy outcomes. There is some indication that those with higher levels of education are more likely to feel comfortable seeking help from the mental health profession (Yi & Tidwell, 2005).

Number of sessions.

On average, clients spend between 10-19 sessions in psychotherapy (Arauz, 2002; Callahan & Hynan, 2005; Kinsey, 1999). There appears to be a consistent relationship between the number of sessions a client has in therapy and the degree of improvement they realise. This relationship is characterised by rapidly increasing returns as psychotherapy progresses, including improvement which occurs even before the first session of therapy has taken place, with a slowing of returns after the first ten sessions (Kopta, Howard, Lowry, & Beutler, 1994). Lambert, Hansen, and Finch (2001) examined the recovery rates of 6,072 mental health clients. Their findings suggest that

50% of clients (including those who begin treatment in the dysfunctional or functional range) would improve after seven sessions of psychotherapy, and 75% after 14 sessions. Rates of recovery are of course dependent somewhat upon the client's degree of dysfunction, with Lambert and his colleagues study showing that those who had more severe and longstanding symptomatology generally exhibited slower and less significant gains.

Research has also indicated that rapid early response to psychotherapy (within the first three sessions) predicts a client's improved status at the conclusion of therapy. In Haas, Hill, Lambert, and Morrell's study of 147 clients who obtained treatment from a university counselling centre, 80% of the rapid responders had positive change following therapy, compared with 55% of the moderate responders and 45% of the slow responders. It appears that there is a difference in the way early responders engage in therapy compared with later responders. While the active mechanism linking early response to positive outcomes is as yet undetermined, it may include the client's readiness to change, or verify the substantial influence of common factors (e.g. suggestion, persuasion, treatment credibility, therapist attention, working alliance, expectancy, therapist allegiance and effort justification) in therapy gains (Lambert, 2005; Lohr et al., 2005).

Previous hospitalisation and presenting problems.

As has been noted, increased severity of symptoms, comorbidity of symptoms, and low levels of functioning all correlate positively to poor treatment outcomes (Jorgensen, 2004; Lambert, 2004). Previous hospitalisation may indicate long-standing mental health issues which tend to be slower and more difficult to change (Cappeliez,

Latour, & Guirguis, 1997). However, in Wampold's (2005) recent study initial diagnosis accounted for an insignificant degree of the variability in outcomes among clients .

Perceived helpfulness of therapy and therapist.

Client expectancy and rating of the therapy experience has a strong relationship to duration of treatment, although not necessarily to treatment outcome (Dew & Bickman, 2005). A client's idealisation of the therapist and the therapy process has been associated with positive outcomes (Ablon & Jones, 1999). The relationship between the therapist and client has generally been shown to contribute significantly to therapeutic outcomes (Beretta et al., 2005; Zuroff et al., 2000). In a study of 254 patients with personality disorders therapeutic alliance correlated significantly with therapy outcome (Konzag, Bandemer-Greulich, & Bahrke, 2004). This relationship between the therapist and client has been variously defined according to the many therapy traditions, but most would agree that the therapeutic alliance is valuable in psychotherapy due to its social impact (Hentschel, 2005; Huber, Henrich, & Brandl, 2005).

An interesting feature of RFT in relation to therapy factors is the dynamic of God as a therapist, personally involved in the therapeutic relationship. If it is, as many assert, the social and relational factors in therapy which primarily elicit change (Jorgensen, 2004), then relationship with God could be considered a potential therapeutic factor. As well as this, the concept of God as a therapist in the process of RFT may specifically impact upon the outcomes. As has already been postulated, the awareness of God as a secure attachment figure may increase positive religious coping and reduce negative

religious coping which in turn may increase well-being. Similarly, the awareness of God as an empathic therapist collaborating in the therapy process may also produce beneficial outcomes. As such, the character and influence of God as a therapist, and the development of a positive therapeutic relationship between the client and God, could be seen as not merely a common factor in RFT but as a factor unique to the model.

The Role and Measurement of Religious Commitment

A client variable relevant to this study is that of the client's level of religiosity. Studies have indicated that individuals with high levels of religious commitment have correspondingly low levels of anxiety, depression and personality pathology and higher levels of ego strength than individuals with lower levels of religious commitment (Laurencelle, Abell, & Schwartz, 2002; Levin & Chatters, 1998). Therefore, it may be assumed that highly religious clients will have less initial symptomatology than less religious clients, although this assumption may be impacted by the type of religiosity a person adheres to. While questions about the definitive truth of religious beliefs do not fall within the scope of psychology, what does fall within its scope is examination of the implications of religious behaviour and beliefs. It appears that people with higher levels of religious commitment tend to have observably better mental health than those with lower levels of religious commitment. This study therefore examines the religious commitment levels of its participants both in view of their potential confounding effect, and as an independent variable of interest.

The Role and Measurement of Clinical Change

The intent of psychotherapy is generally to improve mental health – clients' clinical status. Clinical change is widely recognised as being measured in terms of outcomes in three content domains: symptomatic functioning (e.g. depression, anxiety, psychosis etc.), interpersonal problems (e.g. friendship and family relations), and social role performance (e.g. work adjustment and quality of life) (Kraus, Seligman, & Jordan, 2005; Lambert, 2004). Most research uses the American Psychiatric Association's (1994) DSM-IV categories for diagnosis of symptoms (Lambert, 2004). Unfortunately much research, tends to be limited to investigating Axis I diagnoses. Due to the DSM-IV's polythetic nature, two clients with very few common symptoms may receive a common diagnosis, and additionally two clients may gain a common diagnosis for Axis I disorder while one client may also have a complicating Axis II personality disorder or Axis III medical condition. Nonetheless, the DSM-IV Axis I classification system is helpful in that it is widely used and recognised and broadly covers a range of presenting problems common to most therapy situations.

The Role and Measurement of Religious Coping

Despite the fact that coping styles appear to be a predictor of outcome in psychotherapy (Goldstein, 1999), very few studies appear to have measured actual changes in individuals' coping styles and their relationship to therapy outcomes. Although research has documented that an individual's coping strategies remain relatively stable and unchanged over time (Bouchard, 2003; Bouchard et al., 2004; Penley & Tomaka, 2002), altering cognitive appraisals has also been shown to alter

individuals' coping strategies and styles (Bouchard et al., 2004). A recent study investigated the daily changes in coping of 43 individuals over a week long period (Gunthert, Cohen, & Butler, 2005). Positive coping variables were associated with reduction in depression, in line with the researchers' hypothesis that coping ability would predict rates of improvement in therapy.

As with secular coping, individual differences are apparent in religious coping. Pargament (2005, p. 7-8; 2000) has defined many of these in the RCOPE measure. He has identified these religious coping styles as either positive or negative depending upon the nature of the outcomes they produce in stressful situations. For this study the positive religious coping styles compose of: *Benevolent religious reappraisal/spiritual support* - redefining the stressor through religion as benevolent and potentially beneficial; *Collaborative /low self-directing religious coping* - seeking control through a partnership with God in problem solving; *Active religious surrender* - an active giving up of control to God in coping; and *Religious purification/forgiveness* - searching for spiritual cleansing and peace through religious actions. The negative religious coping styles compose of: *Passive religious deferral* - passively waiting for God to control the situation; Punishing *God reappraisal* - redefining the stressor as a punishment from God for the individual's sins; Pleading *for direct intercession* - seeking control indirectly by pleading to God for a miracle or divine intercession; and *Spiritual discontent* - expressing confusion and dissatisfaction with God's relationship to the individual in the stressful situation.

Ano and Vasconcelles' (2005) meta-analysis of 49 religious coping studies measuring a total of 13,512 participants across all the studies, found a moderate

correlation between positive religious coping and positive psychological outcomes, and an inverse relationship between positive religious coping and negative psychological outcomes. Negative religious coping was not found to be related inversely to positive psychological outcomes but it was positively associated with negative psychological adjustment. The researchers concluded that positive religious coping may serve some adaptive functions in relation to stressful events, but while negative religious coping may be harmful it does not necessarily preclude positive outcomes and it may also represent stress-related growth, although negative religious coping may become particularly arduous for those under greater stress and over the longer term.

Pastoral Care as a Comparison Group

Pastoral care is the activity by a religious mentor of fostering spiritual well-being in individuals or groups (Lartey, 2003). Morrison (2005) describes pastoral care as essentially reminding people of God's presence. While the focus of pastoral care would appear at first glance to be predominantly spiritual and theological, the present day model of Christian pastoral care is often a therapeutic one, and some would say it functions largely as a form of psychotherapy (Lartey, 2003). Jung (1978, p. 336) stated that "religions are psychotherapeutic systems in the truest sense of the word, and on the grandest scale". Psychotherapies share three characteristics: the therapist-client relationship; their interpersonal setting; and a recognisable model of psychopathology (Roth & Fonagy, 2005). Within the Christian pastoral care tradition, the recognisable model of psychopathology and its cure has generally been developed around theologies

of redemption emphasising the sinfulness of humankind and the corresponding redemption wrought by Jesus Christ's death on the cross.

For the purposes of this study, pastoral care is differentiated from pastoral counselling. Pastoral care encompasses any activity a pastor might engage in one on one with a member of their congregation for the purposes of caring for their holistic spiritual well-being. Pastoral counselling would be a specific form of counselling carried out by a trained counsellor in the pastoral context of the church. While pastoral care and psychotherapy share overlapping constructs regarding the psychological care of people, they are not synonymous activities. Pastoral care relationships are unique, and differ from therapeutic bonds in that they generally arise from within a God-centred covenantal community. While therapists and counsellors may see their clients only within the bounds of the formal therapy arrangement, pastors may encounter their congregants on many levels, both formal and informal, and often over many years.

Pastoral care may be used to describe a range of activities from brief encounters regarding theological issues to involvement and counsel regarding longstanding complex personal, interpersonal, or transpersonal problems (Greenwald, 2003). A sample of 97 pastors in America indicated that the most common presenting problems pastors see are pre-marital and marital counselling, parenting issues, grief and loss issues and substance abuse counselling. On average, pastors in one study reported spending nine hours a week counselling congregants (Burgess, 1998). Despite the regularity of counselling undertaken by pastors and clergy, it appears that comparatively few are professionally trained in matters of psychology (Bergin, 1991), and there is a dearth of published research in mainstream mental health journals regarding the role of pastors and clergy

(Weaver, 1998). A study of lay church counsellors showed that pastoral counselling had more effect than no counselling (Toh & Tan, 1997), but there is little to be found in the literature regarding the effectiveness of pastoral counselling and care. Krause and colleagues (2001) explored the nature of religious coping in relation to support received in religious settings. They discovered a positive correlation between a church member's religious coping and the emotional support they had received from their pastor. One could presume that pastoral care will have some positive effect on an individual's religious coping and also on their mental health outcomes.

Summary

This study of RFT is a quasi-experimental pre- and post-therapy investigation in a naturalistic setting. Factors common to most psychotherapy models may also impact upon the results of this study and thus are considered in the methodology. Religious commitment, religious coping and mental health status are the main variables to be measured, with changes to religious coping potentially acting as a unique mechanism in the RFT model.

The previous chapters gave an overview of the history of the religion and psychology convergence, discussed the efficacious aspects of religion, considered the implications of these aspects for psychological treatment, described RFT, and looked at the measurement of related aspects of RFT. This research aims to determine what the clinical treatment outcomes of RFT are, and how these relate to religious coping styles. The specific hypotheses of the present study are described below.

The Hypotheses for this Research

1) Participants' religious commitment will be positively associated with their pre-therapy mental health and well-being.
2) RFT participants' mental health and well-being will improve from pre- to post-therapy, and this improvement will be more pronounced than the improvement observed for the PC comparison group.
3) RFT participants' positive religious coping will increase, negative religious coping will decrease, and overall religious coping will increase from pre- to post-therapy, and these changes will be more substantial for the RFT group than for the comparison PC group.
4) Positive religious coping style (benevolent God reappraisal, collaborative/low self-directing, active surrender, and purification/forgiveness) will be positively associated with mental health and well-being both before and after therapy.
5) Negative religious coping style (punishing God reappraisal, passive deferral, pleading for direct intercession, and spiritual discontent) will be negatively associated with mental health and well-being both before and after therapy.

Chapter Seven:

Method

"Thoughts are but dreams till their effects be tried."

William Shakespeare (1564-1616)

Overview

This chapter describes the method used to gather data relevant to investigating the effectiveness and possible mechanisms of RFT. A synopsis of the participants, measures, procedure, and data analysis is included.

Participants

The sample consisted of 85 participants, 63 of whom were RFT clients, and 23 of whom were individuals receiving pastoral care (PC). Of the RFT group 63 participants completed the pre-therapy questionnaire and 49 completed the post-therapy questionnaire. Of the PC group 21 participants completed the pre-therapy questionnaire and 10 completed the post-therapy questionnaire. Table 1 presents the demographic characteristics of this sample, and also compares them to existing survey data ($N = 134$) from RFT clients (Kay, 2002b).

Insert Table 1 here

Measures

General information.

Demographic information collected included: gender, date of birth, ethnicity, level of education, religious belief, and previous hospitalisation for mental health. This information was gathered in order to understand the nature of the client group and pastoral care group populations, and to clarify any moderating effects demographics might have upon therapy outcomes. Information regarding the quantity and helpfulness of the therapy/pastoral care sessions, the frequency of the use of God Spaces outside of therapy, and the RFT clients' perceptions of the nature of their presenting problems was also garnered using multi-choice questions with the option for including individual comment data. The list of presenting problems was developed by Calvert and Divett (Calvert, 2005) based on Divett's personal experience and on previous research (Kay, 2002b).

RCI-10.

The RCI-10 (Worthington et al., 2003), shown in Appendix A was administered as a measure of individuals' religious commitment. The 10 item measure was developed from earlier 62-item, 20-item, and 17-item versions. Items assess the value an individual places upon his/her religion (e.g., "My religious beliefs lie behind my whole approach to life"), and the extent to which this is integrated into their behaviour (e.g., "It is important to me to spend periods of time in private religious thought and reflection"). Six systematic studies involving almost 2,000 participants have been carried out to discern

the psychometric qualities of the RCI-10 (Worthington et al., 2003). Across a broad range of people including secular and Christian university students, adults from the community, married and single people, therapists and clients, and people of varying religions, the RCI-10 demonstrated relatively consistent validity, although it was considered particularly appropriate for Christians. Reliability of the measure was strong, with a Cronbach's alpha of .92 - .98 and corrected item-total correlations ranging from .69 - .94. A general sample of US adults scored a mean of 26 (SD = 12, range = 0-50). A score of 38, a standard deviation above this mean, would deem a person "highly religious". For such individuals religion is expected to strongly influence their perceptions and therefore play a significant role in their therapy (Worthington et al., 2003).

For the present study a factor analysis of the RCI-10 indicated moderate correlations among all the items and a Cronbach's alpha of .94. The ten items of the (RCI-10) were further subjected to a principal components analysis (PCA). This analysis indicated that the correlation of items was significant and measured one factor with an Eigenvalue of 6.5. The mean score for the RCI-10 was 39, (SD = 10, Mdn = 41, range = 0-50) indicating a high level of religious commitment among participants. The distribution was negatively skewed (-1.5), and consequently Pearson correlation coefficients could not be used to determine associations between the RCI-10 and other measures (Dancey & Reidy, 2004). Instead, Spearman's rho was used to measure the association between the RCI-10 and continuous variables, and Kendall's tau was used to measure the association between the RCI-10 and ordinal variables.

Treatment Outcome Package (TOP) v 4.1 Adult Clinical Scales.

The Treatment Outcome Package (TOP v 4.1 – see Appendix B) was developed by Behavioral Health Labs (BHL) to measure clinical outcomes in naturalistic settings. It was designed around the core battery criteria developed in 1994 by the American Psychological Association (Kraus et al., 2005). BHL have processed more than 250,000 TOP surveys and claim to have the largest customer base and database of clinical outcome data in America (Kelly, 2003). The TOP v 4.1 is the fifth version of TOP. Its validity has been tested against the Beck Depression Inventory (BDI) (Beck, Steer, & Ranieri, 1988), the Brief Symptom Inventory (BSI) (Derogatis & Spencer, 1982), the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) (Hathaway & McKinley, 1989), the BASIS 32 (Eisen, Grob, & Klein, 1986), and the SF-36 (Ware & Sherboume, 1992). The subscales demonstrate good convergent validity and excellent discriminant ability in relation to other scales (Kraus et al., 2005).

The TOP v 4.1 has 58 items which broadly measure a range of behavioural, health, functional, and symptom domains. Domains measured include; depression, panic (the physiological signs of anxiety), mania, psychosis (cognitive/perceptual disturbance), sleep, suicidal ideation, violence/temper, quality of life, sexual functioning, interpersonal functioning, and work functioning. Items include positive adjustment questions (e.g., "Indicate how much of the time during the past two weeks you have been satisfied with your general mood and feelings") and negative adjustment questions (e.g., "Indicate how much of the time during the past two weeks you have felt little or no interest in most things"). The Cronbach's alpha for the subscales ranged from .53 (*Mania*) to .93 (*Depression*). The test-retest reliability for the subscales was between .87 - .94, except

for *Mania* which was .76. Floor effects were evident on most subscales but not in regards to pathology, and no ceiling effects were apparent. In other words, the scale should measure the full pathological range but not necessarily the full healthy range. In a study of 20,098 adult therapy clients, within-group Cohen's *d* effect sizes ranged from .16 (*Mania*) to .53 (*Depression*), with most being in the .2-.5 range, indicating that the TOP v 4.1 may be sensitive to change associated with therapy. TOP v 4.1 was able to discriminate mental health clients from the general population 84% of the time.

In the present study the TOP v 4.1 was scored from 0-6, and higher scores were considered less severe. The 12 subscales were computed independently and as a total score by adding the average of the subscale scores together. Most of the subscales were skewed and/or had unacceptable kurtosis. The Shapiro-Wilk test of normality ($< .05$) indicated that none of the subscales were normally distributed and therefore non-parametric analyses using Spearman's rho and Kendall's tau were performed. The estimate of reliability was satisfactory (between $\alpha = .71$ and $\alpha = .96$) for most of the TOP v 4.1 subscales and *Total* scales. However, item 14 was removed from the *Work Functioning* subscale, and items 9 and 44 from the *Psychosis* subscale to bring their internal consistencies to a satisfactory level (α's $> .70$) (Myers & Well, 2003). Despite removing items 47 and 48 from the *Mania* subscale its internal consistency remained low at $\alpha = .64$. Nonetheless, analyses were still performed on the *Mania* subscale, keeping this in mind.

RCOPE.

The RCOPE (Pargament et al., 2000) is a multi-dimensional measure of how people use religion to cope with stressful events. It was developed to ascertain the use of five dimensions of religious coping; the search for meaning, control, comfort, intimacy, and life transformation, and its items describe passive, self-directed and collaborative religious coping. Two studies totalling 1091 participants from a student sample and a hospital sample were carried out to evaluate the psychometric properties of the RCOPE (Pargament et al., 2000). Exploratory factor analysis supported the theoretical framework underlying the subscales of the RCOPE measure. A confirmatory factor analysis was moderately supportive of this initial factor analysis. Cronbach's alpha for each of the RCOPE subscales was in the range of $\alpha = .78$ to $\alpha = .93$, indicating good internal consistency. The most commonly used negative religious coping method was *Pleading for Direct Intercession* (college sample, $M = 1.3$, SD = unspecified; hospital sample, $M = 1.6$, SD = unspecified, range = 0 - 3) and the most commonly used positive religious coping method was *Collaborative Religious Coping* (college sample, $M = 1.8$, $SD = 0.8$; hospital sample, $M = 2.4$, $SD = 0.7$, range = 0-3).

The RCOPE has 17 subscales, of which, due to time constraints, only eight were chosen for the current study (see Appendix C). Four subscales were used to assess positive religious coping: *Benevolent Religious Reappraisal/Spiritual Support* (8 items), *Collaborative/Low Self-Directing Religious Coping* (7 items), *Active Religious Surrender* (4 items), *Religious Purification/Forgiveness* (10 items). Positive religious coping questions included: "Looked to God for strength support and guidance", "Worked together with God as partners", "Tried to make sense of the situation with God", and

"Asked God to help me be more forgiving". Four subscales were used to assess negative religious coping: *Punishing God Reappraisal* (5 items), *Passive Religious Deferral* (4 items), *Pleading for Direct Intercession* (5 items) and *Spiritual Discontent* (6 items). Negative religious coping questions included: "Felt punished by God for my lack of devotion", "Didn't try much of anything; simply expected God to take control", "Pleaded with God to make everything work out", and "Wondered whether God had abandoned me". Items were scored from 0-3.

Total scores were generated for each subscale and the total positive religious coping scales (31 items) and the total negative religious coping scales (20 items). Additionally a total score of positive scores minus negative scores was generated. Most of the subscales were skewed and/or had kurtosis concerns. The Shapiro-Wilk test of normality (< .05) indicated that only the RCOPE *Total* pre ($\alpha = .10$) and post ($\alpha = .34$) scales and the *Pleading* ($\alpha = .27$), *Collaborative* ($\alpha = .32$) and *Purification* ($\alpha = .97$) subscales had adequate normality. As the remainder did not, non-parametric analyses were used. The estimates of reliability were generally high (between $\alpha = .71$ and $\alpha = .92$) for all of the RCOPE scales. Table 2 presents the reliability and normality statistics for each of the scales and their subscales.

Insert Table 2 here

Procedure

Approval and pilot testing.

This research was approved by the Massey University Human Ethics Committee (ALB 05/026) and the Auckland Refocussing Centre. Prior to the study beginning, twelve random candidates (family, friends and workmates) completed each of the questionnaires and gave comment on their user friendliness and appropriateness. The feedback was generally positive and it was decided to continue with the questionnaires while empowering therapists, pastors and ministers to discern their suitableness for each client/congregant.

Confidentiality and emotional safety of participants.

Confidentiality and anonymity were ensured in the covering information sheets included with every questionnaire (see Appendix D). This was maintained by having the therapists/pastors/ministers offer a part one and two envelope to every client/congregant they saw for therapy/ministry, explaining that the research being undertaken was anonymous, confidential and voluntary. Participants returned the questionnaires to Massey University using an enclosed freepost envelope. Date of birth was used to identify matching part one and two questionnaires. There was a possibility that participants may have had emotional turmoil as a result of completing the questionnaires. The information sheet enclosed with the questionnaire therefore included contact information for counsellors who could be called upon should the need arise. None of these counsellors were contacted for this purpose during the period of the study.

Recruiting of RFT and PC participants.

RFT clients and church congregants seeking pastoral care between May 2005 and November 2005 were asked to participate. Following approval by the Massey Human Ethics Committee, a letter (Appendix E) was sent to all interested pastors/ministers and RFT therapists. After this, an information sheet (Appendix F) advising them of the details of the study and their rights and responsibilities was sent to them in a package containing the requested amount of questionnaires. In order to reduce therapist allegiance factors, specific mention of the RFT model was kept to a minimum. RFT therapists distributed the questionnaires to their clients/congregants as did pastors/ministers.

RFT therapists.

Sixteen RFT full-time and part-time therapists were involved in this research. The therapists were approached through the RFT Centre, Auckland. All of those asked to be part of the study agreed to distribute the questionnaires. Of those involved, their educational qualifications ranged from secondary school level through to doctorate level, with six having achieved or being in the process of achieving a post-graduate qualification. All of the RFT therapists had completed the *Part One* and *Part Two* courses of RFT training, consisting of one week each of lectures and experiential learning. This training was NZQA approved and therapists had to achieve certain levels of competency to pass the course. Namely, the application of: Clean Language, the seven foci, locating, accessing and developing a client's God Space, and basic counselling skills including developing rapport, ensuring safety, maintaining privacy and attending

supervision (Refocussing, 2005). The RFT therapists had between 6 months and 8 years of experience in practicing RFT (average of 4 years) and were all employed in part-time (average of 2 days per week) counselling roles either in private practice or associated with a church or Christian organisation.

Pastors and ministers.

Initially, 1,352 pastors from most Christian Protestant denominations were e-mailed throughout New Zealand requesting their participation in this research. Roman Catholics were excluded only on account of the vast numbers to be contacted, and the slightly different theological traditions and corresponding pastoral care structure within the Roman Catholic Church which may have skewed an already potentially varied group (Keller, 2000; Tix & Frazier, 2005). Of those contacted, 72 responded. These 72 were contacted a second time with more information regarding the study after which 25 responded positively and requested questionnaires. These pastors spanned several denominations including Baptist, Presbyterian, New Life, Anglican, Assembly of God, Salvation Army, Worldwide Church of God and Elim. None of these pastors had a counselling qualification.

Questionnaire distribution.

A total of 550 questionnaires were distributed to RFT therapists and pastors/ministers, and a total of 143 (26%) were returned. 230 pre- and post-therapy questionnaires were sent to RFT therapists and 65 (87%) pre-therapy and 49 (65%) post-therapy questionnaires were returned. While it was not possible to ascertain with

certainty how many questionnaires had been actually handed out approximately 40 pre and 40 post were accounted for as undelivered by the RFT therapists. This produced a total RFT return rate of 76% returned. 320 questionnaires were sent to pastors/ministers. Of these, 19 (12%) pre-therapy and 10 (6%) post-therapy questionnaires were returned, yielding a total of return rate of 9% for the PC group.

The questionnaires were packaged in sealed envelopes containing an information sheet (Appendix D) and a freepost return envelope. The questionnaires were divided into part one and part two. Part one was to be handed out prior to or within the first therapy/pastoral care session and included questions regarding demographic information (Appendix A), the RCI-10 (Appendix A), the RCOPE (Appendix B) and the TOP (Appendix C). Part two was to be handed out at the completion of therapy and included the same questionnaires as well as additional informational questions about the quality of the therapy received (Appendix G). Accompanying part two was a research questionnaire developed by Sarah Calvert (2005) investigating the client's experience of God Spaces. Data from this questionnaire were also used in the present study (Appendix H). Questionnaires were to be completed by the clients/congregants anonymously and confidentially.

Data Analysis

Quantitative data was entered into a SPSS 12 data file and analysed using descriptive and inferential statistics. Factor analysis was computed for the RCI-10 but not for the RCOPE and TOP v 4.1 due to an insufficient number of participants and a large number of items. The distributions of the data sets were assessed for skewness,

kurtosis, and normality and were found to be generally skewed, leptokurtic or platykurtic, and not normal. Consequently, non-parametric tests were employed for the proceeding statistical analyses. The following independent variables were assessed: gender, age, ethnicity, level of education, hospitalisation for mental health, stated presenting problems, ratings of the perceived helpfulness of RFT, and religious commitment (using the RCI-10). Inferential analyses were carried out to determine comparisons between the present sample and an existing larger sample from a previous RFT study (Kay, 2002b), and also between the one-on-one group and the block course group in the present study.

Relationships between the categorical variables for the RFT sample, PC sample, and Kay's (2002) RFT sample were determined using the Chi-square test for independence. Kay's (2002) data were reported in percentages and therefore had to be converted back to raw frequencies to meet the statistical assumptions of the Chi-square test (Carver & Nash, 2005). Fisher's Exact Probability Test was used when cell frequencies were less than five. The Mann-Whitney *U* test was used to measure the differences between two independent categorical groups of variables on a continuous measure. The Wilcoxon Signed Rank Test was used to measure the change between scores on the same measure pre-therapy and post-therapy. Spearman's Rank Order Correlation (rho) was used to measure the strength of association between the continuous variables, and Kendall's tau was used to measure association between continuous and ordinal variables (Pallant, 2005).

Change scores were calculated by subtracting pre-therapy scores from post-therapy scores. There is controversy over the reliability and generalisability of change

scores (Miller & Kane, 2001) as they tend to be less reliable than the scores themselves and correlations between change scores are limited by ceiling effects. However, many researchers make use of them and they add richness to the data, albeit richness tempered by awareness of their limitations. Missing data were dealt with using pair-wise deletion. Though pair-wise deletion results in loss of power, it is a suitable strategy when prediction of scores using imputation is problematic (Kinnear & Gray, 2004). An alpha level of .05 was the criterion of significance for all statistical tests, and all tests were 2-tailed, unless otherwise stated. For the qualitative data participants' comments were recorded, common themes were noted, and data were then inter-rated and categorised accordingly.

Summary

The method of data acquisition for this study was via self-report questionnaires completed anonymously by 65 RFT and 19 PC participants before treatment and 49 RFT and 10 PC participants after treatment. The questionnaires included the RCI-10, the TOP v 4.1, and the RCOPE. Because the distributions of data for the dependent variables were skewed the data were analysed using SPSS 12 non-parametric tests.

Chapter Eight:

Results

"The best theology would need no advocates; it would prove itself."

(Karl Barth, 1986-1968)

Overview

The results of this study are described and discussed in this chapter in this order: 1) an overview of participant factors and relevant corresponding TOP v 4.1 and RCOPE outcomes; 2) an examination of participants' reported therapy experiences and; 3) an analysis of the pre- to post-therapy differences, changes and correlations on the TOP v 4.1 and the RCOPE measures for both the PC and RFT participants. For ease of reading, in this chapter the TOP v 4.1 measure will be referred to simply as TOP. Statistical findings are generally presented in either the tables or the text, not both. Any references to significance infer alpha coefficient values less than or equal to .05.

Impact of Factors within Therapy

As observed in the methodology section of this study, many factors can influence clients' improvements or deterioration aside from the therapy technique itself. These common factors were examined with two considerations in mind: a) extrapolation of the nature of the RFT and PC client groups; b) investigation of the potential moderating

effects of participant characteristics upon therapy outcomes. The results are presented here.

Religious commitment of participants.

RCI-10 scores for this sample (M = 39, Mdn = 41, SD = 11) were more than a standard deviation above the norm, indicating a high level of religious commitment (Worthington et al., 2003). A Mann-Whitney U test of RCI-10 scores found no significant difference between the RFT and PC groups, U (N = 83) = 530, p = .204. *Other Europeans* were found to have significantly higher religious commitment scores (M = 44, SD = 5) than *NZ Europeans*, (M = 39, SD = 10). Religious commitment did not seem to impact upon the reported helpfulness of therapy or pastoral care. However, the higher the level of religious commitment, the fewer sessions of therapy or pastoral care participants received, and the more homework (God Space use) they did.

For further analysis religious commitment was condensed into two groups - those with scores of 41 and over, and those with scores less than 41. For the RFT group, those who reported more religious commitment also reported significantly less negative religious coping, *Punishing*, *Discontent*, and significantly better total RCOPE scores, *Benevolent*, and *Collaborative* scores before therapy. On the clinical scales the more religiously committed reported significantly less *Panic*, *Depression*, *Suicide*, *Psychosis*, *Alcohol and Drug Abuse*, and total TOP scores. However, after therapy there were no significant differences noted on any of the RCOPE or TOP scales between those who were more or less religiously committed. Table 3 presents the differences between RFT participant characteristics on the TOP and RCOPE scales. Table 4 presents the

differences between PC participant characteristics on the TOP and RCOPE scales, and Table 5 presents the differences between participant factors and RCI-10 scores.

Insert Tables 3, 4, and 5 here

RCI-10 correlations.

Spearman's rho analyses indicated a significant positive correlation between age and RCI-10 scores for RFT participants. A significant negative correlation was found between initial RCI-10 scores and the number of sessions participants went on to complete, but no significant correlation was found with the reported helpfulness of therapy/pastoral care. Significant positive correlations were found between the RCI-10 scores and the following TOP scales:

A) Pre-therapy:

Interpersonal, Work Functioning, Panic, Depression, Mania, Suicide, Psychosis, Alcohol and Drug Abuse, and the TOP total.

B) Post-therapy:

Work Functioning, and *Alcohol and Drug Abuse.*

Correlations between pre-therapy and post-therapy TOP scales and the RCI-10 scores, along with other participant characteristics, are presented in Tables 6 and 7 respectively.

Insert Tables 6 and 7 here

Significant positive correlations were found between the RCI-10 scores and the following RCOPE scales:

A) Pre-therapy:

Benevolent, Collaborative, positive total, and overall RCOPE total.

B) Post-therapy:

Collaborative.

Significant negative correlations were found for these scales:

C) Pre-therapy:

Discontent, Punishing and the negative RCOPE total

D) Post-therapy:

None.

Correlations between pre-therapy and post-therapy RCOPE scales and RCI-10 scores, along with other participant characteristics, in are presented in Tables 8 and 9 respectively. Additionally, Table 10 presents the correlations between participant characteristics.

Insert Tables 8, 9, and 10 here

Gender

The gender distribution for the total sample was 73% female and 27% male. This gender distribution was not significantly different from the existing RFT sample (Kay, 2002b), wherein 72% were female and 28% were male. The RFT sample had a greater

percentage of females (78%) than the PC sample (61%) but this gender difference was not significant.

There were gender differences in several of the TOP subscale scores both pre- and post-therapy. At the start of therapy in the RFT group the men had more *Violence* symptoms and poorer *Work Functioning*. For the PC group there was a significant difference in *Panic*, with men faring worse again. At the end of therapy there were no significant differences between RFT men and women on any measures. However, for PC men and women there were several differences. *Violence*, *Panic*, *Suicide*, the total TOP score, the RCOPE *Pleading*, and *Discontent* and the total negative religious coping subscales all showed significant gender differences and in every case it was the women who achieved the healthier results.

Age.

Participants ages ranged from 16 to 85 years, with a mean of 42 years (SD = 16). One participant did not specify their age. Ages were grouped into categories comparable with the existing sample, and no significant differences were found between the age distributions of the current and existing sample. There were also no significant age differences found between the RFT group (M = 37; SD = 11) and the PC group (M = 42; SD = 16).

There were significant age group differences apparent in clinical presentation and religious coping between those aged less than 40 years old and those aged 40 years and older. For the RFT group these showed up pre-therapy in the *Depression*, *Mania*, *Psychosis*, RCOPE negative total, *Punishing*, and Discontent, scales. Post-therapy, the

only subscale showing any significant age difference was the RCOPE *Punishing* subscale. On all these scales those over the age of 40 years had healthier results. For the PC participants there was only one subscale showing a pre-therapy age difference, *Work Functioning*. Post-therapy there were three: *Sleep*, *Depression*, and *Psychosis*. Once again, those older than 40 years fared better. For both the RFT and PC groups, a significant age difference was also found between denominational groups (Charismatic/Pentecostal Christians and other Christians) with Charismatic/Pentecostal Christians tending to be younger. As well, those who were younger reported significantly more presenting problems.

Ethnicity.

The largest ethnic group in the total sample was New Zealand European (65%), followed by other European (24%), Maori (7%), and other (consisting of one Asian, one Pacific Islander, and one not specified, 4%). There were no significant differences between the current sample and the existing sample, or between the RFT group and the PC group. Any significant differences found between all the ethnic groups on the measures had to be disregarded due to some groups having extremely low numbers. When broken down into two groups, *NZ European* and *Other European*, in the RFT group the *NZ Europeans* reported better Life Quality, and less RCOPE *Pleading*, but also more alcohol and drug abuse. Post-therapy they had significantly poorer *Work Functioning*, a difference not accounted for by age alone, χ^2 (5, N = 55) = 1.82, p = .150. Kendall's tau analyses indicated a correlation between *Life Quality* and ethnicity pre-

therapy, with NZ Europeans faring better than other Europeans, but this correlation had disappeared post-therapy.

Education.

Highest level of education was condensed into three categories of which 34% reported high school as their highest level of education, 23% reported a trade certificate or diploma, and 42% reported being currently at university or having completed a degree or post-graduate education. One participant did not report their highest level of education. No significant difference was found between the RFT and PC groups.

When education levels were condensed into two groups – *pre-graduate* and *graduate or post-graduate*, a significant difference was found regarding RFT participants' scores on the following scales pre-therapy: *Violence, Depression,* RCOPE *Collaborative,* and the TOP total. In every case, the pre-graduates had less healthy status. No significant differences were found post-therapy for RFT participants on any of the education levels. For the PC participants, no significant differences were found pre-therapy but post-therapy pre-graduates reported more alcohol and drug abuse symptoms. Those participants with more education were found to receive less sessions of therapy. Kendall's tau analyses indicated a positive correlation between higher education level and healthier pre-therapy *Sleep, Depression, Suicide,* and *Psychosis* and TOP total scores, but again, these correlations disappeared post-therapy.

Religion.

The majority of participants reported their religion as being Christian (95%), 2% reported having no religion and 3% reported having another religion (none specified). Three participants did not specify their religion. 78% of the total sample further specified their Christian denomination as Pentecostal and/or Charismatic, and 18% either did not specify their denomination, or specified another denomination (e.g. Presbyterian). This differs significantly from the religious composition of the existing sample wherein 92% identified themselves as Charismatic Christians. This is to be expected however, given that the current sample is drawn from across several denominations to include the PC group. The RFT sample had significantly more Charismatic Christians (95%) than the PC sample (6%). Charismatic/Pentecostal Christians were significantly younger than Other Christians, and reported finding their RFT or PC experience significantly more helpful. There were no significant differences between Charismatic Christians and other Christians on any of the scales pre-therapy. Examining the differences and correlations post-therapy was confounded by the fact that most of the Charismatic Christians had experienced the RFT intervention, whereas most of the Other Christians had experienced the PC intervention.

Number of sessions.

A portion of the questionnaires (38%) was distributed to RFT clients involved in group therapy as part of a RFT week long block seminar. These individuals underwent at least one session of RFT in a group setting, as well as undertaking exercises which are commonly used in a one-on-one RFT therapy setting such as accessing and developing a

God Space. This group of clients did not differ significantly from the remaining group of RFT one-on-one clients in terms of gender, age, ethnicity, education, previous hospitalisation, religion, or RCI-10 scores. There was also a significant difference in the number of sessions reported, χ^2 (9, N = 58) = 25.9, p = .002, with the block course having completed an average of 1.8 sessions, and a median of 1, and the one-on-one course completing an average of 3.9 sessions, and a median of 2. Although the block course group generally reported receiving only one session of RFT, they actually spent a considerable amount of time learning about the RFT process (approximately 15 hours) and involved in RFT exercises (approximately 10 hours). Consequently, the block course participants' results were excluded from all the analyses performed relating to the number of sessions received.

The number of sessions completed by the current sample was significantly different from the existing sample wherein the majority of participants (58%) had between 1-5 sessions. RFT participants received a mean of 2.5 sessions (SD = 3.5; median = 1; range = 1-20), and PC participants received a mean of 4.5 sessions (SD = 5; median = 2; range = 1-15) with the majority of participants (68%) in both groups receiving one or two sessions. The number of sessions received was significantly different for the RFT and PC groups with the PC group receiving more.

When number of sessions was condensed into two groups – *less than five* and *five or more* - significant differences were found on several of the scales. For the RFT group, those who went on to receive fewer sessions had significantly higher levels of education and better initial scores on these scales: *Interpersonal, Sleep, Panic, Depression, Mania, Suicide, Psychosis,* total TOP scores, RCOPE *Collaborative*, and *Punishing*. Post-

therapy, significant differences were found between the number of sessions received and: *Life Quality, Interpersonal, Sleep, Depression, Suicide,* and TOP total scales. Again, those who had fewer sessions had better outcomes at the end of therapy.

For the PC group, there was a significant difference found pre-therapy between the number of sessions received and: *Panic*, *Depression*, *Mania,* and total TOP scores. At this stage, the better the participants outcomes, the more sessions they would go on to receive. However, post-therapy, those who had received more sessions also had better outcomes on the: *Life Quality*, *Panic*, *Depression*, TOP total, and RCOPE Collaborative scores. Increased number of sessions also correlated with improvements in: *Panic*, $r_s = 47$, $p = .002$; *Suicide*, $r_s = 33$, $p = .034$; total positive RCOPE, $r_s = 41$, $p = .007$; *Pleading*, $r_s = 31$, $p = .049$; *Active Surrender*, $r_s = 34$, $p = .028$; and *Purification*, $r_s = 34$, $p = .029$.

Homework.

The RFT participants reported their extramural use of God Spaces. There were no significant differences found on any measures between those who used God Spaces more or less frequently outside of therapy. However, when God Space use was condensed into two groups (*daily* and *a few times a week or less*), those who used their God Spaces daily had healthier scores pre-therapy on the *Interpersonal,* and *Work Functioning* scales, and post-therapy on the *Interpersonal, Psychosis,* RCOPE *Punishing*, and *Collaborative,* scales. A negative correlation was found pre-therapy between use of God Spaces and the RCOPE *Punishing* subscale and post-therapy with the *Violence,* and RCOPE *Spiritual Discontent* subscales. God Space use also correlated positively with improvements on

the *Life Quality* ($\tau = .28$, $p = .034$), *Work Functioning* ($\tau = .26$, $p = .040$) and *Collaborative* RCOPE ($\tau = .25$, $p = .048$) scales.

Previous hospitalisation.

The number of participants who had previously been hospitalised for mental health issues was small overall (7%) but was significantly greater in the PC sample (17%) than the RFT sample (3%). However, Mann-Whitney *U* analyses showed no significant differences between those who had been previously hospitalised and those who had not, on any of the scales. Kendall's tau analyses indicated a pre-therapy correlation between previous hospitalisation and poorer *Interpersonal* functioning, though this correlation was not evident post-therapy.

Stated presenting problems of RFT participants.

RFT participants were asked to indicate one or more problems they had presented to therapy with. The mean number of presenting problems that participants specified was 3 (*SD* = 2.5, median = 2, range = 1-11). The most common presenting problem of RFT participants was "fear/anxiety/stress". This was followed closely by "seeking guidance for the future" and "relational problems". Those who reported more presenting problems also reported more pre-therapy *Panic* and *Suicide* symptoms, and post-therapy, more *Alcohol and Drug Abuse* symptoms. Table 11 presents the distribution of presenting problems of RFT participants.

Insert Table 11 here

Perceived helpfulness of therapy.

Of the 59 participants who returned their questionnaires, 56 reported on the helpfulness of their RFT or PC experience. The majority of RFT participants (52%) reported that their therapy was "extremely helpful (life changing)", with a further 39% describing their therapy as "very helpful". One of the PC participants reported that their pastoral care was "extremely unhelpful or detrimental". None of the PC participants reported their pastoral care as extremely helpful and life changing but the majority reported that their pastoral care was very helpful (63%). RFT participants' found their therapy significantly more helpful than PC participants; χ^2 (4, $N = 55$) = 17.14, p = .002. Participants' reported perceptions of the helpfulness of their therapy are presented in Table 12.

Insert Table 12 here

For the RFT group, those who found the therapy experience extremely helpful/life changing also had poorer initial scores on the: *Life Quality, Work Functioning, Violence Suicide, Psychosis,* TOP total scores, *Pleading, Discontent,* and the overall negative RCOPE scale. Kendall's tau analyses performed on condensed groupings of perceived helpfulness (Extreme helpfulness and Other helpfulness) indicated a positive correlation between perceived helpfulness of therapy and the pre-therapy RCOPE *Pleading* scale. A positive correlation was also found between the number of presenting problems and

reported helpfulness. Participants who found the RFT experience extremely helpful also reported greater improvements in *Work Functioning*, $\tau = .36$, $p = .007$.

Helpfulness of the RFT and PC experience.

Participants were asked to explain which aspects of RFT or PC they found most helpful. The responses were grouped into four categories. The first category, *Experiencing God*, described a participant's experience of God's presence or of connection or communion with God during RFT or PC. Examples included, "the sense of active engagement with God", "hearing what God has for me", and "having God address the need". The second category, *RFT or pastoral techniques*, described those aspects of therapy/care which were specific to the RFT or PC model. The predominant RFT technique reported was use of the God Spaces (57% of RFT responses), followed by drawing (22% of responses). The *n* for the PC group was too small to indicate a predominant response. RFT examples included, "using a visual component to help me understand my thoughts", "spaces – an ability to go elsewhere to find a solution", and "deliverance – being set free – wonderful!" The third category, *Insight*, referred to those paradigm shifts and internal discoveries which occurred as a result of RFT or PC. For example, "the clarity and empowerment that comes with a fresh perspective", "changed my view of how I felt about myself and others", "several issues of long standing that I had already had counselling for became so clear". The final category was the *Therapy relationship*. This described comments which reflected the nature of the relationship between the therapist/pastor and the participant. Examples included, "having a highly

skilled and sensitive counsellor", "having a good listener", and "the compassion and care, the rapport".

Responses were rated by the present author and by Diane Divett, developer of RFT. The level of inter-rater agreement between the two coders was 96%. Incongruities were discussed to determine final coding. The most frequently reported category for RFT participants was "Experiencing God" (34%). "Therapy relationship" was the most frequently reported helpful aspect of pastoral care. The frequencies and percentages of responses are presented in Table 13.

Insert Table 13 here

Unhelpful aspects of the RFT and PC experience

Sixteen participants (20%) responded to the question "please explain which aspects of the counsel/pastoral care you received you found most unhelpful". The remainder either left the space blank or reported that they had found nothing unhelpful. Of the sixteen who responded, the majority focused on specific therapy techniques they had found unhelpful (56%), while others focused on the therapy/pastoral relationship (31%). Examples included, "sometimes I felt confused by the questions, or my lack of ability to answer them", and "time limit, although I fully understand there has to be a time limit". Other comments were obscure such as "counselling components". Interestingly, three of the negative comments regarding RFT were to do with the lack of direct advice. For the PC group, four of the positive comments were to do with the receiving of direct advice.

Properties and Inter-Relations of TOP and RCOPE Outcomes

Differences between RFT and PC TOP results.

To test the hypothesis that participants' self-reported clinical status would improve following RFT, and more so than for the PC comparison group, the total TOP scores and TOP subscale scores were analysed. Before therapy, the only significant differences between the two groups were on the *Depression*, and *Mania* scales. In both domains the RFT group fared better. Post-therapy there were significant differences between the RFT and PC groups on most of the TOP scales, including; *Interpersonal, Sleep, Work Functioning, Sexual Functioning, Depression, Mania, Suicide, Psychosis,* and the total TOP score, with the RFT group faring better. These differences are presented in Table 14.

Insert Table 14 here

An exact significance 1-tailed test showed significant differences also for *Life Quality*, U ($N = 41$) = 209, $p = .028$; *Violence*, U ($N = 41$) = 244, $p = .042$; *Panic*, U ($N = 41$) = 220, $p = .041$; and *Alcohol and Drug Abuse*, U ($N = 41$) = 252, $p = .049$, again with the RFT group faring better. At this level of significance the RFT group had significantly better results than the comparison PC group across all measured clinical domains.

Changes in TOP results from pre- to post- therapy for RFT and PC

After therapy, RFT TOP total scores increased significantly, ($z = 5.58$, $p < .000$), while the PC TOP total scores did not, ($z = 1.02$, $p = .308$). All of the RFT subscale scores increased significantly, apart from *Violence*. The greatest increases were observed in the *Depression* ($z = 5.46$, $p < .000$), *Panic* ($z = 4.55$, $p < .000$), and *Suicide* ($z = 4.31$, $p < .000$) subscales. Three of the PC subscales had significant gains. These were *Panic*, *Life Quality*, and *Depression*. These changes are detailed in Table 15.

Insert Table 15 here

Differences in TOP changes for RFT and PC

Changes in participants' scores from pre- to post-therapy for each of the TOP scales were calculated. The changes for both the RFT and PC group were then compared using the Mann-Whitney *U* test. A significant difference in the amount of change experienced within each group was found on these scales: *Work Functioning*, *Suicide*, and the total TOP scores. The results are presented in Table 16.

Insert Table 16 here

Differences in RCOPE results for RFT and PC

RCOPE scores were calculated and analysed to test the hypothesis that after therapy participants' positive religious coping would increase, negative religious coping

would decrease, and overall religious coping would increase, and that the changes would be more substantial for the RFT group in comparison with the PC group. Mann-Whitney *U* analyses indicated that there were no significant differences between the RFT group and the PC group on any of the RCOPE scales pre-therapy. Post-therapy the RFT group reported significantly lower levels of these negative religious coping styles: *Pleading, Discontent,* and the negative total. They also reported significantly lower levels of *Purification* which is a positive religious coping style. The differences between the two groups are presented in Table 17.

Insert Table 17 here

Changes in RCOPE results from pre to post therapy for RFT and PC

After therapy the RFT group had a significant decrease in negative religious coping ($z = -4.29$, $p < .000$), whereas the PC group had a no significant increase in negative religious coping ($z = .00$, $p = 1.000$). This effected the overall religious coping scores creating a significant overall increase for the RFT group ($z = -4.33$, $p < .000$). The most notable changes within subscales for the RFT group were a significant increase in *Collaborative/Low Self-directing*, and a significant decrease in *Pleading for Direct Intercession.* There were also significant decreases in *Spiritual, Punishing God Reappraisal,* and *Purification/Forgiveness.* In comparison, the PC group experienced no significant changes in any scales after the pastoral care intervention. Table 18 presents the results showing the changes in the RCOPE scales.

Insert Table 18 here

Differences in RCOPE changes for RFT and PC

Changes in participants' scores from pre- to post-therapy for each of the RCOPE scales were calculated. The changes for both the RFT and PC group were then compared using the Mann-Whitney *U* test. A significant difference in the amount of change experienced within each group was found on the *Pleading* subscale. The results are presented in Table 19.

Insert Table 19 here

Correlations between TOP and RCOPE Scores

Pre-therapy TOP and RCOPE correlations

To examine the hypothesis that RCOPE scores pre-therapy would be positively associated with TOP scores pre-therapy, Spearman's rho correlations were performed upon both measures. There was a significant correlation between the total RCOPE and TOP scores (r_s =.26, p = .019). Positive correlations were also found pre-therapy between the following scales:

1. the total RCOPE score and improved:

   Life Quality, *Violence*, *Panic*, *Depression*, and *Suicide*.

2. the positive RCOPE subscale and:

   Life Quality.

3. the *Benevolent* RCOPE subscale and:

   Life Quality, *Depression*, and *Suicide*.

4. the *Collaborative* RCOPE subscale and:

   Life Quality, *Sleep*, *Violence*, *Panic*, *Depression*, *Suicide*, *Psychosis*, and the TOP total.

Negative correlations were found between between:

5. the *Purification/Forgiveness* RCOPE subscale and:

   Interpersonal, *Sexual Functioning*, and *Mania*.

6. the *Passive Deferral* RCOPE subscale and:

   Sexual Functioning.

7. the *Pleading* RCOPE subscale and:

   Interpersonal, *Sleep*, *Work Functioning*, *Panic*, *Depression*, *Mania*, *Suicide*, *Psychosis*, *Alcohol and Drug Abuse*, and the total TOP scores.

8. the *Discontent* RCOPE subscale and:

   Sleep, *Panic*, *Depression*, *Mania*, *Suicide*, *Psychosis*, and the total TOP scores.

9. the *Punishing* RCOPE subscale and:

   Violence, *Panic*, *Depression*, *Mania*, *Suicide*, *Psychosis*, and the total TOP scores.

10. the negative RCOPE subscale and:

    Work Functioning, *Violence*, *Panic*, *Depression*, *Mania*, *Suicide*, *Psychosis*, and the TOP total.

These correlations were more profuse in the *Panic, Depression, Suicide,* and the TOP total scales; and in the RCOPE scales: *Collaborative, Pleading, Discontent, Punishing,* and negative total. The results are presented in Table 20.

Insert Table 20 here

Post-therapy TOP and RCOPE correlations

To examine the hypothesis that RCOPE scores post-therapy would be positively associated with TOP scores post-therapy, Spearman's rho correlations were performed upon both measures. There was a significant correlation found between the total RCOPE and TOP scores ($r_s = .38$, $p = .003$).

There were also significant correlations between the RCOPE and TOP subscales. These included positive correlations between;

1. the total RCOPE scale and:

   Life Quality, *Interpersonal*, *Violence*, *Panic*, *Depression*, *Suicide*, and *Alcohol and Drug Abuse.*

2. the *Benevolent* RCOPE scale and:

   Life Quality, Interpersonal, Sleep, and total TOP scores.

3. the *Collaborative* RCOPE scale and:

   Life Quality, *Interpersonal*, *Sleep*, *Work Functioning*, *Violence*, *Panic*, *Depression*, *Mania*, *Suicide*, *Psychosis*, *Alcohol and Drug Abuse*, and total TOP scores.

Negative correlations were found between:

4. the *Purification/Forgiveness* RCOPE scale and:

Interpersonal, *Violence*, *Panic*, *Depression*, *Mania*, *Psychosis*, and total TOP scores.

5. the *Active Surrender* RCOPE scale and:

   Psychosis.

6. the *Pleading* RCOPE scale and:

   Life Quality, *Interpersonal*, *Sleep*, *Violence*, *Sexual Functioning*, *Panic*, *Depression*, *Mania*, *Suicide*, *Psychosis*, and total TOP scores.

7. the *Discontent* RCOPE scale and:

   Life Quality, *Interpersonal*, *Sleep*, *Violence*, *Sexual Functioning*, *Panic*, *Depression*, *Mania*, *Suicide*, *Psychosis*, *Alcohol and Drug Abuse*, and total TOP scores.

8. the *Punishing* RCOPE scale and:

   Interpersonal, *Violence*, *Sexual Functioning*, *Panic*, *Depression*, *Mania*, *Suicide*, *Psychosis*, *Alcohol and Drug Abuse*, and total TOP scores.

9. the negative RCOPE scale and:

   Life Quality, *Interpersonal*, *Violence*, *Sexual Functioning*, *Panic*, *Depression*, *Mania*, *Suicide*, and *Psychosis.*

These correlations were more profuse in the TOP scales: *Interpersonal*, *Violence*, *Panic*, *Depression, Suicide* and *Psychosis*; and total TOP scale; and in the RCOPE scales: *Collaborative, Pleading, Discontent,* and *Punishing*, negative total, and RCOPE total. The results are presented in Table 21.

Insert Table 21 here

The number of significant correlations from pre- to post-therapy was calculated. A 15% overall increase of significant correlations was found post-therapy between religious coping style and clinical symptoms. These increases were principally noted in the RCOPE *Collaborative, Purification, Discontent, and Punishing* scales, and in the TOP *Interpersonal, Violence,* and *Alcohol and Drug Abuse* scales.

Correlations between TOP and RCOPE changes from pre- to post-therapy.

Spearman's rho correlations were calculated between the amount of change from pre- to post-therapy on the TOP and RCOPE scales. Significant relationships were found in the direction expected between:

1. *Benevolent* reappraisal of God and the total TOP scores, as well as the *Interpersonal, Sleep, Sexual Functioning, Panic, Depression, Mania, Suicide, and Psychosis* subscales.
2. *Collaborative* religious coping and *Sleep.*
3. *Active Surrender* and *Depression.*
4. *Spiritual Discontent* and the TOP total scores, as well as the *Sleep, Panic, Mania, Suicide,* and *Psychosis* subscales.
5. *Punishing God* reappraisal and *Sexual Functioning.*
6. Total positive religious coping and *Sleep, Depression, Suicide, Psychosis.*
7. Total religious coping and the TOP total scores, as well as *Depression, Suicide,* and *Psychosis.*

Correlations were most prolific for the *Benevolent* and *Discontent* RCOPE scales and the *Sleep, Depression, Suicide* and *Psychosis* TOP scales. The results are presented in Table 22.

Insert Table 22 here

Summary

Overall, RFT participants reported positive and significant therapeutic changes after receiving RFT, and this was in comparison with the PC participants who had significantly less therapeutic change after receiving pastoral care. Several of the pre- and post-therapy religious coping subscale scores correlated with several of the pre- and post-therapy mental health domains. RFT participants significantly decreased in negative religious coping, and this was in comparison with PC participants who had no significant decrease. Religious commitment also correlated positively and significantly with several of the TOP mental health domains.

Chapter Nine:

Discussion

"The healing of our spirit,
in which our relationship with God is renewed and restored,
is the most fundamental area of healing."
(John Wimber, 1987, p.82)

Overview

Refocussing Therapy (RFT) has been developed and established over the preceding 15 years – a period which has seen a profusion of research regarding the impact of an individual's religion and spirituality upon their mental health. Despite the growing awareness of the therapeutic relevance of religion, very few therapy models incorporate or even acknowledge it. RFT not only acknowledges religion and spirituality, but integrates psychological theory and practice with Christian theology and praxis. This study is the first to investigate the effectiveness of this attempt.

Specifically, this study investigated the mental health status and religious coping of 63 RFT clients and 19 pastoral care participants before therapy/care and 49 RFT clients and 10 PC participants after therapy/care. At the completion of therapy the majority of RFT clients had experienced significant positive changes in mental health status (87%), and significant reductions in negative religious coping style (83%). The findings are presented in this section, along with discussion of the strengths, limitations, and clinical implications of this study, and recommendations for future research

Summary of findings

The results of this research generally support the hypotheses presented in chapter seven. The hypotheses are listed below, along with discussion regarding the relevant findings.

Hypothesis 1. Participants' religious commitment will be positively associated with their pre- therapy mental health and well-being.

A significant correlation was found between participants' level of religious commitment (as measured by the RCI-10 total scores) and their initial clinical status (as measured by the TOP v 4.1 total scores). Significant positive correlations were also found with the *Interpersonal* and *Work Functioning* subscales indicating a relationship between higher religious commitment and healthier social functioning. The *Panic, Depression, Mania, Suicide, Psychosis,* and *Alcohol and Drug Abuse* subscales all correlated negatively with participants RCI-10 scores, indicating that higher religious commitment tended to be associated with less severe clinical pathology.

As there was no significant difference in religious commitment between the RFT and PC groups, the likelihood of religious commitment confounding the results was reduced. However, what may have confounded the results was education level which was positively related to both religious commitment and mental health pre-therapy. It is possible that the RCI-10 favours more educated participants with questions such as "I often read books and magazines about my faith". However, while a higher level of education does correlate with higher religious commitment and better clinical status, in

this study religious commitment independently had a stronger relationship with clinical status.

Hypothesis 2. RFT participants' mental health and well-being will improve from pre- to post-therapy and this improvement will be more pronounced than the improvement observed for the PC comparison group.

RFT participants had significant improvements in mental health and well-being from pre- to post-therapy. The improvement noted in the TOP v 4.1 total scores was 5.58 standard deviations, at a significance level of $p < .000$. This degree of change is highly unlikely to have occurred by chance, and points to a significant change agent in the RFT process. This is also indicated by the fact that PC participants experienced a much smaller and insignificant degree of change in their TOP v 4.1 total scores.

RFT participants experienced significant changes from pre- to post-therapy across most of the TOP v 4.1 subscales including the following domains; life quality, interpersonal functioning, sleep, work functioning, sexual functioning, panic, depression, mania, suicide, psychosis, and alcohol and drug abuse. The only domain where significant change was not evident was violence. It has been noted in other studies that violent and hostile behaviour is particularly difficult to change through the general psychotherapy process, and may even deteriorate following therapy (Rice, 1997). Therefore, the result of a small but insignificant improvement in this domain could be viewed as normal and possibly positive. It appears then that RFT may be effective in producing significant changes in mental health and well-being across the majority of commonly recognised DSM-IV clinical domains.

Hypothesis 3. RFT participants' positive religious coping will increase, negative religious coping will decrease, and overall religious coping will increase from pre- to post-therapy, and these changes will be more substantial for the RFT group than for the comparison PC group.

RFT participants' positive religious coping did increase but not significantly. As participants' positive religious coping was well established at the start of the study, it may be that a ceiling effect eradicated any noticeable changes. The differences in religious coping between the RFT and PC groups were not significant either before or after therapy. However, negative religious coping significantly decreased from pre- to post-therapy for the RFT group, and this contributed to the significant increases in their RCOPE total scores. Conversely, the PC group had no significant change in negative religious coping or RCOPE total scores. After therapy the differences between the RFT and PC group were significant on both the negative religious coping subscale and the total RCOPE.

The changes in the religious coping styles of the RFT group became differentiated in the subscales. Within the positive subscales the RFT group had a significant increase in collaborative religious coping. Collaborative religious coping is low self-directing, and personal control is sought through a partnership with God in problem solving. There was also a significant change in the religious purification and forgiveness subscale however this change was a reduction rather than an increase. This result is interesting given that religious purification and forgiveness are generally deemed positive religious coping activities. It is conceivable though that the longitudinal nature of this study alters the construal of these concepts. While purification and forgiveness may be necessary and

important elements at the beginning of a recovery process (Maltby, Macaskill, & Day, 2001; Toussaint, Williams, & Musick, 2001), once that process is underway or nearing completion and difficulties are resolving or resolved, the need for purification and forgiveness may reduce. Therefore, the fact that this subscale reduced could be construed as a positive occurrence.

Within the negative subscales, there was significant reduction in "punishing God" reappraisals, pleading for direct intercession, and religious discontent. It appears that participants' conceptualisations of God became decidedly less negative and hostile, and that this reappraisal resulted in a positive alteration of the way they approached and dialogued with God. This, along with increased collaboration with God may have reduced feelings of discontent within their relationship with God and with their belief systems. Passive deferral showed notable neutrality to the change process from pre- to post-therapy.

Hypothesis 4. Positive religious coping style (benevolent God reappraisal, collaborative/low self-directing, active surrender, purification/forgiveness) will be positively associated with mental health and well-being both before and after therapy.

Participants' total TOP v 4.1 scores correlated significantly with their total positive religious coping scores both before and after therapy, and consistent with other research participants utilised positive religious coping more than negative religious coping (Pargament et al., 1998). There were also significant correlations within the subscales. Participants' appraisal of God as benevolent correlated positively with their

quality of life scores and correlated negatively with their depression and suicide scores. When correlations were investigated between the degree of change in clinical status and religious coping occurring by the end of therapy, an increase in benevolent religious coping had the most significant relationships with improvements in mental health and well-being, including interpersonal functioning, sleep, sexual functioning, panic, depression, mania, suicide, and psychosis. Worthy of note are the significant relationships ($p < .000$) between benevolent appraisal increases, and depression and suicide reductions. Belief in a loving God, a God who is in control and who has good intentions towards people may induce a sense of hope, security, and relief, and so reduce hopelessness, insecurity and stress, and their related pathology (Salsman et al., 2005; Snyder, Sigmon, & Feldman, 2002). This was the stated experience of many of the RFT participants.

Positive relationships were found between collaborative coping and life quality, interpersonal functioning, sleep, and work functioning. Negative relationships were found between collaborative coping and violence, panic, depression, suicide, psychosis, and alcohol and drug abuse. Whereas benevolent appraisal of God may be viewed as primarily a cognitive activity, collaboration with God appears to engage in interactive behaviour evocative of the I-Thou encounter described by Buber (1970). In collaborative coping the participant is engaging in empowered, reciprocal, and highly relational behaviour, which is liable to activate positive attachment mechanisms. This corresponds with the clear process in RFT of connecting people interactively with God in a tangible and relational way. Collaborative coping has already been acknowledged in the literature as the most effective and commonly used religious coping method (Pargament et al.,

1988; Wong-McDonald & Gorsuch, 2000; Yangarber-Hicks, 2004). The results from this study serve to support these findings and also authenticate the supposition that the RFT process aids in increasing this valuable resource in a religious client's repertoire of coping skills.

Participants' level of active surrender to God remained virtually unchanged from pre- to post-therapy and no significant relationships with any of the mental health and well-being indices. The RFT group began therapy with slightly higher active surrender than the PC group and this had diminished insignificantly after therapy whereas the PC group's active surrender had increased, though not significantly. The religious purification and forgiveness coping style was negatively correlated with interpersonal functioning and sexual functioning before therapy implying that those participants with greater sexual and relational troubles were employing this coping style more. Post therapy religious purification and forgiveness coping correlated negatively with interpersonal functioning and positively with panic, depression, mania, and psychosis. These are thought provoking findings in the light of research highlighting the generally positive outcomes of this type of coping (Maltby et al., 2001). However, activity described in the RCOPE such as "searched for forgiveness from God", and "asked God to help me overcome my bitterness", would be expected to reduce as issues resolved during the process of therapy. The RFT model does not specifically address issues of purification or forgiveness, although it uses "the Lord's prayer" (Matthew 6:9-15) as a template for addressing and resolving issues of sin and broken relationships.

Hypothesis 5. Negative religious coping style (punishing God reappraisal, passive deferral, pleading for direct intercession and spiritual discontent) will be negatively associated with mental health and well-being both before and after therapy.

Negative religious coping reduced significantly from pre- to post-therapy for RFT clients and this was in contrast to the PC group who experienced no significant reduction. Although the PC group was small in number and further replication with a larger group is needed to corroborate the results, this finding alludes to significant, helpful components within the RFT process. RFT appears to restructure negative cognitions, emotions and behaviours related to an individual's relationship with God. In comparison, the pastoral care intervention in this study appeared to support participants' religious coping, both negative and positive, in an undifferentiated manner. Figure 4 graphs the changes that occurred in the total TOP v 4.1 and RCOPE scores from pre- to post-therapy for both the RFT and PC groups.

Insert Figure 4 here

As in previous studies (see Ano & Vasconcelles, 2005, for a meta-analysis of 49 studies) reduced negative religious coping correlated with better mental health pre-therapy, and these correlations increased post-therapy. Of the four negative religious coping indices used in this study, passive deferral to God was the only one which appeared to have no correlation at all with clinical status, aside from a pre-therapy

negative correlation with sexual functioning. Previous research has been unclear about the impact of passive deferral upon mental health. In those situations where the individual has little control of their situation, passive deferral has even exhibited characteristics of a positive coping mechanism (Yangarber-Hicks, 2004). In the present study, it seems that utilisation of a passive deferral coping style neither added to nor subtracted from the final mental health status of participants.

The remaining three negative religious coping styles – appraisal of God as punishing, pleading with God for direct intervention, and spiritual discontent correlated negatively and significantly with most of the clinical domains with the exception of work functioning. This may reflect a negative process similar to that outlined above for positive coping. As individuals view God as negative and hostile, their relationship with God becomes tenuous and their interactions become pleading and demanding. When their demands are not met, they may feel that God has abandoned them or has negative intentions towards them, which in turn may reinforce their conceptualisation of God as punishing or distant and creates spiritual discontent in the same way that punishing or distant behaviour from any significant attachment figure creates discontent. Figure 5 outlines these proposed pathways.

Insert Figure 5 here

Based on their research Piedmont et. al (1997) suggested that individuals' perceptions of God had psychosocial and emotional correlates, and that interventions

aimed at changing negative perceptions of God to positive perceptions could prove therapeutically beneficial. This study bolsters their conclusions. In particular, changes in spiritual discontent correlated with improvements in overall TOP v 4.1 scores, and specifically with sleep, panic, mania, suicide, and psychosis. In accord with attachment theory and religious coping theory (Belavich & Pargament, 2002; Maynard et al., 2001), it appears that RFT works to reduce negativity in a client's relationship with God. As with the outcomes of other studies (Ano & Vasconcelles, 2005; Cole, 2005; Pargament, Ellison et al., 2001; Smith, 2001), religious coping that indicates a positive and secure relationship with God was correlated to increased psychological well-being.

The emphasis in this study on the reduction of negative religious coping is noteworthy. Previous research has tended to emphasise the beneficial role of positive elements of religious coping (Krause et al., 2001; Pargament, 1997). It may be that because this sample of highly religious participants already had a strong degree of positive religious coping a ceiling effect occurred, causing the reduction of negative religious coping to become more apparent. In comparison with the mean scores of more than 1000 participants in Pargament's (2000) validation study of the RCOPE measure, the participants in this study showed more positive and less negative religious coping. Negativity may also have been highlighted due to the nature of the clinical measure used. The TOP v 4.1 measured four indices of well-being and seven indices of pathology, biasing the results towards reduction of negative symptoms rather than increase of positive functioning. However, as negative religious coping is tied to poorer mental health outcomes (Cole, 2005; Exline, 2002; Phillips et al., 2004; Smith et al., 2000), this may genuinely be where the dynamic occurs. Other research has emphasised the

importance of negative coping, as opposed to positive coping, for mental health (Da, 2003; Katerndahl, 1999; Li, 2004). As perceived closeness to God has been shown to predict mental health (Hill & Pargament, 2003a), the reduction of negative religious coping may correlate with a reduction in perceived distance from God, and in this manner positive mental health outcomes may occur.

General findings.

The RFT sample entered therapy with presenting problems common to the general outpatient population (Sadock & Sadock, 2003). Anxiety, relationship problems, poor sense of personal identity and depression featured highly, but the predominant stated reason for entering therapy was "seeking guidance for the future". Hence, from the outset, this client group exhibited in their therapy process a search for meaning and/or purpose, rather than simply the resolution of problems.

RFT clients expressed a great deal of confidence in the helpfulness of RFT. The majority (93%) described their RFT experience as either very or extremely helpful, and of that group, more than half (52%) stated that it was extremely helpful/life changing. Calvert's (2005) conjunct study further found that almost all (98%) of the RFT clients represented in this study reported positive outcomes as a result of RFT, including: complete or partial removal/overcoming of problems (restoration), an increased ability to cope with problems (resourcing), or the ability to accept problems (resolution). The qualitative information provided by the clients reiterated this theme of perceived positive outcomes. The components of RFT that clients found most helpful were the experiencing of God's presence in therapy (34%), and the specific RFT techniques such as the God

Spaces and drawing (32%). This is comparable with Johnson's (2005) research on inner healing prayer, which found moderate correlations between client's perceived healing and their "sensing of Jesus' presence" and "interacting with Jesus". Houston, Bufford and Johnson's (1999) survey of 178 Christian counsellors corroborates this finding. The counsellors were asked to state what they believed contributed to therapy gains in Christian counselling. The most highly endorsed ingredient for change was perceived to be the activity of God, Jesus Christ or the Holy Spirit.

In the present study, the therapeutic relationship accounted for very little (9%) of the reported helpfulness of RFT. While previous research has indicated that the therapeutic relationship generally has a substantial impact upon therapy - accounting for up to 30% of variance in therapeutic outcome (Norcross, 2002b), this anomaly may reflect two factors. Firstly, the effectiveness of RFT could indeed be in the application of its unique techniques and core suppositions. Secondly, and adding to this notion, is the possibility of a strongly perceived therapist-client relationship wherein God is the therapist. RFT therapists have commented to the author that they often overhear clients talk about the ways God has helped them during the RFT process, but the therapist seldom gets adulated. Research indicates that client idealisation of their therapist and desire for relational intimacy with their therapist correlates with positive therapy outcomes (Ablon & Jones, 1999). For the religious client, idealising God as the therapist and desiring intimacy with God are both conceivable and appropriate, and may contribute to the positive outcomes observed in this study.

Interestingly, three of the negative comments regarding the helpfulness of RFT were to do with the lack of direct advice. For the PC group, four of the positive

comments were to do with the receiving of direct advice. This compares with other research indicating that clients receiving Christian therapy expect a more directive approach than those receiving non-Christian therapy (Belaire & Young, 2002). RFT participants reported the most helpful component of therapy to be "Experiencing God" (34%). Considering that the core assumptions of RFT are based around God being the "drink for the thirst", the experience of God in therapy would be expected to be the predominant therapy mechanism experienced by participants. "Therapy relationship" was the most frequently reported helpful aspect of pastoral care. Given that pastoral care is generally performed without a structured model of care, it might be expected that participants would experience the therapy relationship as the most obviously helpful mechanism.

A significant difference emerged between denominational groups on the positive religious coping scale; however these results were confounded post-therapy by the fact that significantly more Charismatic Christians received RFT than PC. Previous research has also found differences between denominational members regarding their perceptions of God and psychological correlates (e.g., Osborne & Vandenberg, 2003). One recent study (Eurelings-Bontekoe, Hekman-van Steeg, & Verschuur, 2005) discovered a positive correlation between personality pathology and negative God concept. Additionally, they found that 12% of the variance in negative God concept was related to denomination, with members of an orthodox reformed church experiencing more negative feelings towards God than members of a Pentecostal church. Potentially the Charismatic influence on RFT's development has fashioned a therapy which reduces negativity to God but further research wherein participants from differing denominations

are randomly assigned to therapy might tease out the independent effects of denomination upon clients' outcomes.

As with previous research, age correlated positively with religious commitment (Ferraro & Koch, 1994) but not significantly with religious coping or clinical status. The gender distribution for the total sample was 73% female and 27% male. This gender distribution was similar to that generally found among psychotherapy consumers (Zarin, Young, & West, 2005). Men displayed less religious commitment than women at the start of therapy, but any gender differences on any of the scales disappeared post-RFT. However, pastoral care seemed to exacerbate the differences, and post-PC women fared better than men on several of the scales. A recurring theme among most of the common factors was that although they often appeared to influence outcomes pre-RFT, post-RFT any influence had dissipated. This alludes to the concept of the RFT model catering broadly to the individual in a non-biased manner, as well as suggesting that the unique characteristics of the RFT model engender change over and above the change related to common factors.

The number of sessions completed by RFT clients was notably small in comparison to common therapy duration (Lambert, 2004), even without including the block course group. This was also commensurate with Kay's (2002) findings. While this may be a result of the time constraints of the current research in that questionnaires may have been given out to participants prior to completion of their therapy in order to return them to the researcher in time for data analysis, it has been noted by RFT therapists (C. Jenkins & D. Spain, personal communication, October 19, 2005) that RFT clients may present for one or two therapy sessions and then re-present several weeks or months later

for further sessions, making it difficult for the therapist to determine the end of therapy. Additionally, some clients in the present study travelled from overseas for a brief but lengthy period of therapy (e.g. four to five hours), and are most likely to have reported this as one session. Nonetheless, the fact that such significant changes occurred within such a short time-span is worth further evaluation.

The rapid rate of change occurring through the RFT process may represent 'transference cure'- rapid change that occurs in the client within the first one or two sessions via a boost of hope from the therapist (Yalom, 2002). This type of change is seldom enduring. However, C'de Baca and Wilbourne's (2004) study of quantum change showed long term enduring results from brief spiritual encounters, and it may be that this is the kind of change occurring within RFT. Alternatively, it may be that the RFT techniques rapidly engage clients in a positive ongoing process, as has been reported regarding Clean Language (Wing, 1994). Whatever the mechanisms for rapid early change might be, it hints at a good prognosis for longer term outcomes (Haas, Hill, Lambert, & Morrell, 2002; Lambert, 2005). Moreover, short-term solution-based therapies such as RFT are undoubtedly of interest to insurance companies and other outcomes conscious institutions. Further research investigating changes over more sessions, over a longer period of time, and with clearer definition of the nature of "a session", is needed to ascertain whether improvements maintain. As well, research investigating the impact of shorter and longer term RFT upon varying diagnoses is warranted. In the meantime, it would seem prudent for RFT therapists to regularly collect outcome data in an attempt to ascertain a client's trajectory of change and

endeavour to engage clients in therapy until changes are well-established (Wampold & Brown, 2005).

Strengths of the Present Study

E. Johnson (1992) proposed that the experience of *self* and the experience of *God* are intimately related and mutually influence each other. This proposition generates complex questions as to the directions and nature of this influence. If spiritual experiences with a transcendent 'Other" contribute to (or detract from) psychological well-being, how does this happen? This study adds to a growing body of research beginning to address these questions (Cheston et al., 2003). The longitudinal nature of this study, as well as the specifically spiritual intervention employed (RFT) allow a unique glimpse into the correlates and potential directions of detailed spiritual and psychological change. The findings advance previous research findings which have typically been cross-sectional, and substantiate the few longtitudinal studies investigating linkages between religious coping and psychological outcomes (e.g., Pargament et al., 1994; Pargament et al., 2004; Tix & Frazier, 1998).

It appears that as RFT alters a client's perception of God (particularly by reducing negative perceptions, such as the perception of God as punishing), religious coping becomes more positive and less negative and psychological well-being is increased and pathology is reduced. While there are several cross-sectional studies investigating these relationships, this is the only quasi-experimental pretest-posttest nonequivalent control group design study to the author's knowledge which studies the outcomes of a purposeful intervention aimed at altering God conceptions and religious coping. This study also

appears to be the only New Zealand study to date investigating religious coping styles. As such, it lends credence to the generalisability of previous American research findings in the religious coping field.

Pastoral care as a comparison group (PC) was useful in that the pastoral care relationship holds credibility with its participants whilst not including specific RFT components. Thus client expectations were likely to be high for both the comparison group and the experimental group, and therapist and therapy relationship factors were likely to be significant for both groups. A further strength of this study is its naturalistic nature. Because this study was carried out in a routine practice there should be little, if any inferential distance when generalising it to other similar populations (Barkham & Mellor-Clark, 2003), particularly European, female, Charismatic/Pentecostal Christians. As the sample in this study was small and drawn from a highly religiously committed group the findings may not be generalisable to wider populations. The demographics of this sample were, however, similar to those of a previous RFT sample (Kay, 2002b) indicating that the participants in this study are representative of the RFT client population in general.

Limitations of the Present Study

A major limitation of this study is the lack of randomisation, limiting the causal inferences that can be deduced therein (Roth & Fonagy, 2005). There were distinct differences between the pastoral care (PC) comparison group and the RFT group which may have accounted for the observed differences in outcomes. In particular, the PC group had a higher rate of previous hospitalisation. Although this difference was not

significant, previous hospitalisation might imply more entrenched and severe pathology (e.g., Nasser & Overholser, 2005). Before therapy the PC group did have significantly more depression symptoms than the RFT group. This was in contrast with other research suggesting that people who seek help from religious clergy have levels of distress and psychopathology which are either comparable to or less than those who seek help from mental health professionals (Abe-Kim et al., 2004; Sorgaard, Sorenson, Sandanger, Ingebrigsten, & Dalgard, 1996). As individuals with more severe pathology tend to respond less rapidly to therapy (Charman, 2004), this may have influenced the outcomes. However, while the depression levels of the PC group were significantly different to the RFT group, they would still not be classified as severe.

While participants of this study were diagnosed using standardised measures, case specific factors such as client expectation, medical interventions, and other client variability, were not diagnosed, limiting the ability to control for these potentially confounding factors. As the participants were not drawn from clinical samples their pathological symptoms were generally mild. This restriction of range and general variability may have attenuated the correlations. A greater sample size and more distressed population may have observed different relationships. Small sample size was also an independent limitation in this study. Some statisticians recommend at least 300 participants in each sample for a comparison of treatments (Craighead, Sheets, & Bjornsson, 2005; Thase, 2002). Treatment differences may not emerge in smaller samples, although the reality is that most studies are performed with much smaller numbers than this. Generally speaking, the RFT group had an acceptable number of participants, but the PC group was small by standard definition (Cohen, 1992).

A further limitation of this study is the sole use of self-report measures. People tend to report themselves as above average in self-report tests (Holtgraves, 2004). As a result the accuracy of the results may be influenced by the participants' subjective perceptions. Social desirability may have been an additional influence, particularly in the light of the religious and therefore potentially moral nature of the study (as was the case in the study by Pieper, 2004; but not in Wenger & Yarbrough, 2005's study). The anonymity of the questionnaires should have reduced this possibility. Future studies could incorporate more objective outcome measures such as observer rated diagnoses. The fact that many questionnaires were completed pre-therapy but not post-therapy (22%) also leaves open the possibility that those who had negative or inconsequential experiences of RFT were not motivated to return the questionnaires. Nonetheless, this rate of return compares well to similar research projects (e.g., Calvert, 2005; Kay, 2002b) and the questionnaire gave opportunity for negative experiences to be anonymously expressed. Due to the confidential and naturalistic nature of the study, treatment purity could not be monitored. The degree to which therapists adhered to the RFT model is unknown, although all the therapists were regularly supervised. Further research on RFT would do well to incorporate checks for therapy integrity.

Implications for Clinical Practice

While causal inferences made on the basis of this study may be limited, there are grounds for the correlational analyses generated in this research (supported by theory and logic) to inform practice (Thompson, 2005). Conclusions about causal inferences should continue to be assessed through a variety of experimental and observational research

endeavours over time (Levin & Chatters, 1998). Nonetheless, the results of this study have several practical implications for the assessment, diagnosis, and treatment of religious individuals seeking therapy, counselling, or pastoral care. Regarding assessment, these results point to the importance of investigating a religious client's negative and positive religious coping strategies to determine whether they are a help or a hindrance to their psychological well-being. Identifying possible "red flags" (Pargament et al., 2003) early on may contribute to an effectively focused therapy process. The RFT model seems to catch red flags through the implementation of the seven foci, in particular the God Space focus.

Regarding diagnosis, it appears that certain types of religious coping may influence certain aspects of psychological well being and pathological symptoms. While this influence appears relevant generally across the clinical domains, it seems particularly relevant for the panic, depression, and suicide domains. It seems therefore that it would be prudent for therapists to consider the impact of spiritual issues upon a client's diagnosis at the initial stage of assessment, particularly when dealing with these commonly encountered domains. Interpersonal problems, including sexual functioning, may correlate specifically with religious purification and forgiveness coping. Almost all the clinical domains - life quality, sleep, interpersonal functioning, sexual functioning, violence, panic, depression, mania, suicide, psychosis, and alcohol and drug abuse - showed relationship with many or all of the elements of collaborative relationship with God (positively), or a pleading style of negotiation with God, punishing God reappraisals and/or spiritual discontentment (negatively). Therefore, to neglect discussion of the

spiritual well-being of a client in the diagnosis stage may mean the neglecting of highly relevant and enlightening information.

Regarding treatment, though the results of this study are tentative pending further research they suggest that RFT appears to be an appropriate and helpful therapy model for use with highly committed Christian clients, particularly Charismatic/Pentecostal Christians. Hackney and Sanders (2003) recent meta-analysis of 34 religion and mental health studies led them to conclude that mental health practitioners would achieve the best results in therapy by focusing on "personal devotion/relationship-with-God aspects of religiosity" (p. 52), which this study affirms and which RFT obviously aims to do. From this study it seems that increasing positive religious coping, in particular appraisal of God as a benevolent attachment figure, and decreasing negative religious coping, in particular spiritual discontent, should have the strongest correlations with improvements in the sleep, depression, suicide, and psychosis domains. The results of this study enlarge our understanding of some of the adaptive and maladaptive functions of religious coping and align these with a methodology for change - RFT.

Indications and contraindications.

This approach to psychotherapy is potentially most useful for clients who have a well-developed capacity for self-reflection and who are familiar with the spiritual dimension of their inner life. As it has been developed from a Christian theological framework, it is potentially best suited to those clients with a Christian ontology and epistemology. Nonetheless, this does not appear to exclude those who are unfamiliar with their own spirituality, and some of the RFT therapists have reported successful use

of the RFT model with clients who have no religious background, or those with non-Christian religious and spiritual beliefs (D. Divett & D. Spain, personal communication September 24, 2005). Indeed, those few individuals in this study who were not Christians still exhibited improvements following RFT.

Nonetheless, logic dictates that adjustments may need to be made when using RFT with clients who: a) do not have the mental capacity for self-reflection; b) are recovering from a psychotic episode, (although it is interesting to note that in this study, psychotic symptoms improved significantly after RFT, and improvements correlated with increased positive religious coping and decreased negative religious coping); c) have tenuous defences and may need more supportive, directive therapy before attempting inner-directed work; d) prefer not to include God or spirituality in their therapy; and e) have religious beliefs may be compromised by RFT activities which do not fit their traditions or values, and whose psychological equilibrium may be affected as a result (Elkins, 2005). From an ethical point of view, therapy should not aim to challenge the content of a client's religious belief, but rather the interpretation and evaluation of their religious perceptions. These religious perceptions seem to be the important component of the religion and mental health equation.

Recommendations for Future Research

Given the significant and positive results of this study further research into the nature of change elicited by the RFT process is warranted. In particular, research evaluating the outcomes procured over a lengthier duration of therapy with more stringent controls and a larger control group sample is needed. The longevity of

outcomes, and the reasons for the endurance of outcomes, should be investigated to broaden our understanding not only of the benefits and mechanisms of RFT, but also of the nature of spiritual change and its influence upon psychological change. Research including participants with a more diverse range and severity of symptoms would also add richness to our understanding of RFT's unique mechanisms.

As negative religious coping was associated with decreased mental health in the current study, an important further area of research would be to consider how religious discontent, pleading to God, and punishing God reappraisals, contribute to a client's diagnosis, or visa versa. The RFT modality provides a unique opportunity for this type of exploration. In particular, future research might explore changes in clients' attachment to God, conceptualisations of God, religious coping styles and mental health and well-being outcomes.

This study tentatively investigates the differences in practices and beliefs held by members of different denominational groupings, specifically, Charismatic/Pentecostal and traditional Protestant groups. More finely grained analysis of these differences may yield increasingly definitive conceptualisations of religion's efficacy and specifically of RFT's efficacy. Further investigation into the usefulness of pastoral care as a therapeutic intervention, and particularly in comparison with specific religious therapy models, could elaborate upon some of the inferences hinted at in this research. Coded comments from the pastoral care group reinforced the therapist relationship as the most helpful component of their sessions. Nonetheless, this therapist (pastoral) relationship did not appear to improve the outcomes significantly despite previous research indicating that it might (Lambert & Barley, 2002; Norcross, 2002a), and research on a larger sample over

an extended period of time is warranted to substantiate this result. Future researchers might also further investigate the changes occurring over the course of therapy to purification and forgiveness oriented religious coping.

Conclusion

Despite its limitations, this study makes a positive and strong contribution to the existing research on the RFT model and theory by quantitatively and qualitatively evaluating the change process that occurs regarding individuals' mental health outcomes over the course of therapy. It also contributes to the literature on religious coping in a unique way by providing longitudinal data regarding the adjustment of religious coping strategies over the course of therapy, and their subsequent correlations with mental health outcomes. The present study lends support to the current conceptualisation that religious coping has both negative and positive implications for mental health and throws additional light on the nature of religious coping styles, and specifically upon how a reduction in negative religious coping can provide psychological benefit to individuals.

In this study, those participants who received RFT made better therapeutic gains than those who received pastoral care alone. The gains made following RFT were significant at a $p < .001$ level across all clinical domains except for alcohol and drug abuse ($p = .019$) and violence ($p = .409$). These gains were in comparison to the predominantly non-significant gains made by PC participants. Correlated with these gains were changes to religious coping, positively with the *Benevolent God* appraisal and *Collaboration with God* coping style and negatively with the *Spiritual Discontent*, and *Punishing God Reappraisal* coping styles. Participants generally attributed the benefits of RFT to the experience of God in therapy, and to the specific RFT techniques, including the God Spaces.

While the integration of theology and psychology in the development of a therapy model is a relatively novel endeavour, it appears that in this case the endeavour has produced outcomes which many therapists would be happy to emulate, and further investigation of the RFT theory and model is warranted. RFT appears to cater extremely well to its specific targeted client group, namely Charismatic/Pentecostal Christians. This factor should be especially relevant to those who work with this particular client group, particularly in an era when psychotherapy research is increasingly attempting to match therapies with clients.

This study affirms Albert Ellis's statement that what matters for mental health is the kind of God we believe in. Moreover, this study sheds light upon the importance of the kind of God we interact and collaborate with. The integration of peoples' beliefs with their emotions and experience may indeed be a critical therapeutic consideration for highly religious clients and their therapists.

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Appendices

Appendix A

Front Page of the First Questionnaire:

Demographic Questions and the RCI-10

Massey University Albany Campus
School of Psychology

QUESTIONNAIRE 1.

Thank you for participating in our study of Christian/pastoral counselling.
Please complete the following information about yourself;

1. **Gender** (circle one): Female Male
2. **Date of birth**: ..... (day)/..... (month)/..... (year)
3. **To which people groups do you belong?** (tick as many as you need to):
   - o Maori
   - o New Zealand European
   - o Pacific Islander
   - o Asian (please specify).....
   - o European (please specify) .....
   - o Other (please specify) .....
4. **What is your highest level of education?** (tick one):
   - o School certificate/high school
   - o Trade or technical certificate or diploma
   - o UE/6th form/bursary
   - o Currently at university
   - o Bachelors degree
   - o Masters degree or doctorate
5. **What is your religious belief?** (tick one):
   - o None
   - o Christian (please specify your denomination) .....
   - o Other (please specify) .....
6. **Have you ever been hospitalised for mental health or substance abuse problems?**
   Yes/No

RCI-10

Instructions: Read each of the following statements. Using the scale to the right, CIRCLE the response that best describes how true each statement is for you.

	Not at all true of me 1	**Somewhat** true of me 2	**Moderately** true of me 3	**Mostly** true of me 4	**Totally** true of me 5
1. I often read books and magazines about my faith.	1	2	3	4	5
2. I make financial contributions to my religious organization.	1	2	3	4	5
3. I spend time trying to grow in understanding of my faith	1	2	3	4	5
4. Religion is especially important to me because it answers many questions about the meaning of life.	1	2	3	4	5
5. My religious beliefs lie behind my whole approach to life.	1	2	3	4	5
6. I enjoy spending time with others of my religious affiliation.	1	2	3	4	5
7. Religious beliefs influence all my dealings in life.	1	2	3	4	5
8. It is important to me to spend periods of time in private religious thought and reflection.	1	2	3	4	5
9. I enjoy working in the activities of my religious affiliation.	1	2	3	4	5
10. I keep well informed about my local religious group and have some influence in its decisions.	1	2	3	4	5

Appendix B:

TOP v 4.1

TOP v 4.1 (Treatment Outcome Package, Adult Clinical Scales)

David R. Kraus, Ph.D. Behavioural Health Laboratories, Inc., 2004

Indicate (circle one) how much of the time during the past two weeks you have ...

	All	Most	A lot	Some	A little	None
1. been satisfied with your relationship with others	□	□	□	□	□	□
2. been satisfied with your daily responsibilities	□	□	□	□	□	□
3. been satisfied with your general mood and feelings	□	□	□	□	□	□
4. been satisfied with your life in general	□	□	□	□	□	□
5. felt too much conflict with someone	□	□	□	□	□	□
6. been emotionally hurt by someone	□	□	□	□	□	□
7. felt someone had too much control over your life	□	□	□	□	□	□
8. had trouble falling asleep	□	□	□	□	□	□
9. had nightmares	□	□	□	□	□	□
10. awakened frequently during the night	□	□	□	□	□	□
11. had trouble returning to sleep after awakening in the night	□	□	□	□	□	□
12. had a paying job	□	□	□	□	□	□
13. had conflicts with others at work or school regardless of fault	□	□	□	□	□	□
14. missed work or school for any reason	□	□	□	□	□	□
15. not been acknowledged for your accomplishments	□	□	□	□	□	□
16. had your performance criticized	□	□	□	□	□	□
17. not been excited about your work or school work	□	□	□	□	□	□
18. physically hurt someone else or an animal	□	□	□	□	□	□
19. had desires to seriously hurt someone	□	□	□	□	□	□
20. had thoughts of killing someone else	□	□	□	□	□	□
21. felt that you were going to act on violent thoughts	□	□	□	□	□	□
22. felt no desire for, or pleasure in, sex	□	□	□	□	□	□
23. felt sexually incompatible with your partner or frustrated by the lack of a partner	□	□	□	□	□	□
24. felt emotional or physical pain during sex	□	□	□	□	□	□
25. had trouble functioning sexually (having orgasms,...)	□	□	□	□	□	□
26. had a racing heart	□	□	□	□	□	□
27. felt light headed	□	□	□	□	□	□
28. had shortness of breath	□	□	□	□	□	□
29. had a dry mouth or trouble swallowing ("a lump in your throat")	□	□	□	□	□	□
30. had sweaty hands (clammy) or cold hands or feet	□	□	□	□	□	□
31. had to do something to avoid anxiety or fear (washing hands,...)	□	□	□	□	□	□
32. avoided certain situations due to fear or panic	□	□	□	□	□	□
33. felt panic in places that would be hard to leave if necessary	□	□	□	□	□	□
34. felt down or depressed	□	□	□	□	□	□
35. felt little or no interest in most things	□	□	□	□	□	□

36. felt guilty
37. felt restless
38. felt worthless
39. felt tired, slowed down, or had little energy
40. worried about things
41. had trouble concentrating or making decisions
42. noticed your thoughts racing ahead
43. inflicted pain on yourself
44. felt rested after only a few hours sleep
45. thought about killing yourself or wished you were dead
46. planned or tried to kill yourself
47. felt you were better than other people
48. felt on top of the world
49. worried that someone might hurt you
50. had unwanted thoughts or images
51. seen or heard something that was not really there
52. felt someone or something was controlling your mind
53. spent more time drinking or using drugs than you intended
54. neglected school, work, or responsibilities because of using alcohol or drugs
55. felt you wanted or needed to cut down on your drinking or drug use
56. had your family, a friend, or anyone else tell you they objected to your alcohol
57. or drug use
58. found yourself thinking about a drink or getting high
59. used alcohol or drugs to relieve uncomfortable feelings such as sadness,
60. anger or boredom

Appendix C

RCOPE

RCOPE

KENNETH PARGAMENT, PH.D. BOWLING GREEN STATE UNIVERSITY, 2000

These items ask how you coped with negative events which occurred **in the last few weeks**.
To what extent did you do what the item says – how much or how frequently.
Don't answer on the basis of what worked – just whether or not you did it.
Circle the answer that best applies to you.

	Not at all	Somewhat	Quite a bit	A great deal
1. Pleaded with God to make everything work out	❑	❑	❑	❑
2. Tried to deal with the situation on my own without God's help	❑	❑	❑	❑
3. Worked together with God to relieve my worries	❑	❑	❑	❑
4. Wondered whether God was punishing me because of my lack of faith	❑	❑	❑	❑
5. Didn't try much of anything; simply expected God to take control	❑	❑	❑	❑
6. Knew that I couldn't handle the situation so I expected God to handle it for me	❑	❑	❑	❑
7. Prayed for a miracle	❑	❑	❑	❑
8. Worked together with God as partners	❑	❑	❑	❑
9. Saw my situation as part of God's plan	❑	❑	❑	❑
10. Decided that God was punishing me for my sins	❑	❑	❑	❑
11. Questioned the power of God	❑	❑	❑	❑
12. Tried to deal with my feelings without God's help	❑	❑	❑	❑
13. Did my best and then turned the situation over to God	❑	❑	❑	❑
14. Felt punished by God for my lack of devotion	❑	❑	❑	❑
15. Tried to make sense of the situation with God	❑	❑	❑	❑
16. Turned the situation over to God after doing all that I could	❑	❑	❑	❑
17. Sought comfort from God	❑	❑	❑	❑
18. Trusted that God would be by my side	❑	❑	❑	❑
19. Didn't try to do much; just assumed God would handle it	❑	❑	❑	❑
20. Did what I could and put the rest in God's hands	❑	❑	❑	❑
21. Made a deal with God so that He would make things better	❑	❑	❑	❑
22. Wondered if God allowed this event to happen to me because of my sins	❑	❑	❑	❑
23. Pleaded with God to make things turn out OK	❑	❑	❑	❑
24. Made decisions about what to do without God's help	❑	❑	❑	❑
25. Trusted that God was with me	❑	❑	❑	❑
	❑	❑	❑	❑

26. Depended on my own strength without help from God
27. Tried to see how the situation could be beneficial spiritually ☐ ☐ ☐ ☐
28. Didn't try to cope; only expected God to take my worries away ☐ ☐ ☐ ☐
29. Bargained with God to make things better ☐ ☐ ☐ ☐
30. Tried to make sense of the situation without relying on God ☐ ☐ ☐ ☐
31. Looked to God for strength, support and guidance ☐ ☐ ☐ ☐
32. Thought that the event might bring me closer to God ☐ ☐ ☐ ☐
33. Tried to find a lesson from God in the event ☐ ☐ ☐ ☐
34. Took control over what I could and gave the rest up to God ☐ ☐ ☐ ☐
35. Tried to see how God might be trying to strengthen me in this situation ☐ ☐ ☐ ☐
36. Wondered what I did for God to punish me ☐ ☐ ☐ ☐
37. Asked God to help me be more forgiving ☐ ☐ ☐ ☐
38. Wondered whether God had abandoned me ☐ ☐ ☐ ☐
39. Confessed my sins ☐ ☐ ☐ ☐
40. Felt angry that God was not there for me ☐ ☐ ☐ ☐
41. Tried to be less sinful ☐ ☐ ☐ ☐
42. Sought help from God in letting go of my anger ☐ ☐ ☐ ☐
43. Asked forgiveness for my sins ☐ ☐ ☐ ☐
44. Questioned God's love for me ☐ ☐ ☐ ☐
45. Sought spiritual help to give up my resentments ☐ ☐ ☐ ☐
46. Searched for forgiveness from God ☐ ☐ ☐ ☐
47. Sought God's help in trying to forgive others ☐ ☐ ☐ ☐
48. Wondered if God really cares ☐ ☐ ☐ ☐
49. Asked God to help me be less sinful ☐ ☐ ☐ ☐
50. Voiced anger that God didn't answer my prayers ☐ ☐ ☐ ☐
51. Asked God to help me overcome my bitterness ☐ ☐ ☐ ☐

Appendix D

Pre-Therapy and Post-Therapy Information Sheets for Participants

MASSEY UNIVERSITYALBANY CAMPUS

SCHOOL OF PSYCHOLOGY

CHRISTIAN COUNSELLING STUDY

Information Sheet 1.

You are warmly invited to participate in a research project being undertaken by Jenny Sharkey (Masters student) and Sarah Calvert (Honours student) from Massey University. This project will examine the therapeutically related changes that occur during Christian/pastoral counselling.

In order to participate you need to complete the enclosed questionnaire before or just after your first session with your counsellor or pastor and mail it to us in the enclosed postage paid envelope. The entire questionnaire is expected to take approximately 15-20 minutes to complete. Another questionnaire will be given to *all* counselees at the conclusion of your counselling/pastoral sessions (this helps keep it anonymous). It is important for the study that both questionnaires are completed.

If you decide not to participate at either time, there will be no impact upon your counselling sessions. Your counsellor/pastor will not know whether you have completed the questionnaires, nor will they see your questionnaires. Questionnaires are **anonymous** and **confidential**.

No names or identifying information will appear on any documentation. Only summary data will be used for research projects and publications. A summary of the results will be posted on the Refocussing website between January and May 2006. You may also request a copy from the Refocussing Office. Questionnaires will be stored under locked conditions in the School of Psychology for five years and then will be destroyed.

If completion of this questionnaire causes you any undue distress, please contact your counsellor/pastor or the Refocussing Therapy offices for free and confidential help. If you have any concerns or questions regarding this research, please contact the research supervisor or the Refocussing Office;

Supervisor contact details:

Dr Dave Clarke

Atrium 3.29, Massey University

(09) 414 0800, ext 9075

d.clarke@massey.ac.nz

Refocussing Office details:

Jenny Sharkey and Sarah Calvert

145 Newton Rd, Auckland

(09) 373 5238

info@refocussing.co.nz

www.refocussing.com

- **Your participation in this study is voluntary.**
- **Completion and return of the questionnaire implies your consent.**
- **You have the right to decline to answer any particular question.**
- **Your results will be confidential and anonymous.**

We are very grateful for your contribution to this research and hope that you will reap some of the benefits of it through the potential improvements made to Christian counselling in New Zealand.

THANK YOU!

Jenny Sharkey and Sarah Calvert

This project has been reviewed and approved by the Massey University Human Ethics Committee, ALB application 05/026. If you have any concerns about the conduct of this research, please contact Associate Professor Kerry Chamberlain, Chair, Massey University Campus Human Ethics Committee: Albany, telephone 09 414 0800 x 9078, email humanethicsalb@massey.ac.nz.

MASSEY UNIVERSITY ALBANY CAMPUS

SCHOOL OF PSYCHOLOGY

CHRISTIAN COUNSELLING STUDY

Information Sheet 2.

This research project, being undertaken by Jenny Sharkey (Masters student) and Sarah Calvert (Honours student) from Massey University, aims to examine the therapeutic changes that occur during Christian/pastoral counselling. **Whether or not you completed the first questionnaire we would be grateful if you would complete this one** and return it in the enclosed envelope.

This questionnaire is expected to take approximately 20 minutes to complete. If you decide not to participate at either time, there will be no impact upon your counselling sessions. Your counsellor/pastor will not know whether you have completed the questionnaires, nor will they see your questionnaires. Questionnaires are **anonymous** and **confidential**.

No names or identifying information will appear on any documentation. Only summary data will be used for research projects and publications. A summary of the results will be posted on the Refocussing website between January and May 2006. You may also request a copy from the Refocussing Office. Questionnaires will be stored under locked conditions in the School of Psychology for five years and then will be destroyed.

If completion of this questionnaire causes you any undue distress, please contact your counsellor/pastor or the Refocussing Therapy offices for free and confidential help. If you have any concerns or questions regarding this research, please contact the research supervisor or the Refocussing Office;

Supervisor contact details:
Dr Dave Clarke
Atrium 3.29, Massey University
(09) 414 0800, ext 9075
d.clarke@massey.ac.nz

Refocussing Office details:
Jenny Sharkey and Sarah Calvert
145 Newton Rd, Auckland
(09) 373 5238
info@refocussing.co.nz
www.refocussing.com

- **Your participation in this study is voluntary.**
- **Completion and return of the questionnaire implies your consent.**
- **You have the right to decline to answer any particular question.**
- **Your results will be confidential and anonymous.**

We are very grateful for your contribution to this research and hope that you will reap some of the benefits of it through the potential improvements made to Christian counselling in New Zealand.

THANK YOU!

Jenny Sharkey and Sarah Calvert

This project has been reviewed and approved by the Massey University Human Ethics Committee, ALB application 05/026. If you have any concerns about the conduct of this research, please contact Associate Professor Kerry Chamberlain, Chair, Massey University Campus Human Ethics Committee: Albany, telephone 09 414 0800 x 9078, email humanethicsalb@massey.ac.nz.

Appendix E

Informative Letter to Pastors and Ministers

(Massey Letterhead)

10 May 2005

Dear ,

For my Masters thesis at Massey University I am doing a study on the therapeutic changes that occur as a result of Christian pastoral care. Another aspect of the study will examine Refocussing Therapy. Refocussing Therapy is a Christian counselling model developed by Dr Diane Divett (www.refocussing.com). I would be grateful for your help in this study.

I would like to survey individuals who come to see you for pastoral care. This simply involves you posting (or handing) a postage paid envelope to the individual ***prior to*** their first session with you. I will send you the envelopes which will contain an information sheet and questionnaire. I have attached a copy of the information sheet and questionnaire for your information. It doesn't matter if you see individuals once or for several sessions. At the last session (or if it is ongoing, at session 4 or 5), I would like you to hand them another envelope containing another information sheet and questionnaire to take home to complete.

So in a nutshell - *all you have to do* is give them two envelopes;

1) Give them one envelope at the start of seeing them
2) Give them another envelope at the end of seeing them or after 4 or 5 sessions.

The questionnaire is **anonymous** and **confidential** and takes about 15-20 minutes to complete. Individuals will mail their questionnaires directly to me. You will not know if they have completed the questionnaires, nor will you see any of the information in the questionnaires. Likewise, I shall not know who the individuals are or who they went to for pastoral care. A summary copy of all the results will be sent to you. If you have already received training in Refocussing Therapy or have a qualification in counselling please let me know.

If you have any concerns or questions regarding this research, please contact me (or my research supervisor);

Jenny Sharkey
PO Box 8005
Symonds St, Auckland
(09) 373 5238
e-mail: thesharks@xtra.co.nz

Supervisor:
Dr Dave Clarke
Atrium 3.29, Massey University
(09) 414 0800, ext 9075
d.clarke@massey.ac.nz

Please contact me immediately if you would like to participate in the study. I sincerely hope you do! There is very little research internationally on Christian counselling and pastoral care and yet there is ample research extolling the virtues of positive Christianity for mental health, physical health and general well-being. I believe

this research is timely and could carry great significance for the Christian and secular world in terms of the way we care for people.

I look forward to collaborating with you in the enhancement and expansion Christian care in New Zealand.

Yours faithfully,

Jenny Sharkey

This project has been reviewed and approved by the Massey University Human Ethics Committee, ALB application 05/026. If you have any concerns about the conduct of this research, please contact Associate Professor Kerry Chamberlain, Chair, Massey University Campus Human Ethics Committee: Albany, telephone 09 414 0800 x 9078, email humanethicsalb@massey.ac.nz.

Appendix F

Information Letter for Therapists, Pastors and Ministers

(Massey Letterhead)

29th August 2005

Dear ,

Thank you so much for volunteering to help with my research project!

Here are the envelopes for you to dispatch to the participants. Envelopes are labelled 1. and 2. Please post (or hand) an envelope 1. to new participants prior to their first session with you. When the participant has completed all their sessions with you, hand them (or post) envelope 2.

Participants will mail their questionnaires directly to me. You will not know if participants have completed the questionnaires, nor will you see any of the information in the questionnaires. The entire questionnaire is expected to take approximately 15-20 minutes. No identifying information will be gathered to ensure anonymity and confidentiality. Only summary data will be used for research projects and publications. A summary of the results will be posted to you at the completion of the study. Questionnaires will be stored under locked conditions in the School of Psychology for five years and then will be destroyed. Participation in this study is voluntary. Participants are free to withdraw at any time.

If you have a participant who becomes distressed as a result of participating in this study they will be entitled to free counselling regarding this distress, offered either by yourself or by contacting me at;

Jenny Sharkey
Refocussing Office
PO Box 8005
Symonds St, Auckland
(09) 373 5238
info@refocussing.co.nz

If you have any concerns or questions regarding this research, please contact me or;

Research Supervisor:
Dr Dave Clarke
Atrium 3.29, Massey University
(09) 414 0800, ext 9075
d.clarke@massey.ac.nz

Maori Advisor:
Peter Keegan
Faculty of Education, Auckland University
(09) 373 7599, ext 84406
p.keegan@auckland.ac.nz

Thank you for your contribution to this research. Your assistance is greatly appreciated!

Yours sincerely,

Jenny Sharkey

This project has been reviewed and approved by the Massey University Human Ethics Committee, ALB application 05/026. If you have any concerns about the conduct of this research, please contact Associate Professor Kerry Chamberlain, Chair, Massey University Campus Human Ethics Committee: Albany, telephone 09 414 0800 x 9078, email humanethicsalb@massey.ac.nz.

Appendix G

Front Page of the Second Questionnaire

MASSEY UNIVERSITY ALBANY CAMPUS
SCHOOL OF PSYCHOLOGY

QUESTIONNAIRE 2.

Thank you again for participating in our study of Christian/pastoral counselling.
Please complete this information about yourself:

1. **Gender** (circle one): Female Male

2. **Date of birth**: .....(day)/.....(month)/.....(year)

3. **What is your highest level of education?** (tick one):
   - o School certificate/high school
   - o Trade or technical certificate or diploma
   - o UE/6th form/bursary
   - o Currently at university
   - o Bachelors degree
   - o Masters degree or doctorate

5. **How many counselling/pastoral care sessions did you have?** .....

6. **How would you describe the counsel/pastoral care you received**? (tick one):
   - o Extremely unhelpful (detrimental)
   - o Not at all helpful (complete waste of time)
   - o Somewhat helpful
   - o Very helpful
   - o Extremely helpful (life changing)

7. **Please explain which aspects of the counsel/pastoral care you found most unhelpful**:
   (please do not include identifying detail or names)

8. **Please explain which aspects of the counsel/pastoral care you found most helpful**:
   (please do not include identifying detail or names)

Appendix H

God Spaces Questionnaire

GOD SPACES QUESTIONNAIRE (Edited Version)

SARAH CALVERT, MASSEY UNIVERSITY, 2005

1. Please tick the needs or problems you hoped to have dealt with in RFT

- ☐ Sadness/grief
- ☐ Fear/anxiety/stress
- ☐ Physical problem
- ☐ Relationship difficulties
- ☐ Addictions or unhealthy behaviours
- ☐ Sexual/emotional/physical abuse
- ☐ Poor sense of personal identity
- ☐ Low self-esteem
- ☐ Problems in relationship with God
- ☐ Demonic Problems
- ☐ Other:

3. Have you used your God Space outside of therapy, and if so, how often?

- ☐ YES, daily
- ☐ YES, a few times a week
- ☐ YES, weekly or less
- ☐ NO, never

Tables

Table 1
Sample Characteristics and Differences between Groups

Variable	Total				Kay's[a] RFT sample		Difference between RFT and PC sample	Difference between RFT and Kay's
	RFT		PC					
	n	(%)	*n*	(%)	(%)	*df*		
Gender								
Female	49	(78)	14	(61)	(28)	1	$\chi^2 = 2.50$	$\chi^2 = 0.83$
Male	14	(22)	9	(39)	(72)			
Age								
16-29	17	(27)	4	(18)	(20)	3	$\chi^2 = 1.20$	$\chi^2 =$
30-39	23	(37)	8	(35)	(20)			13.09*
40-49	13	(21)	4	(17)	(46)			
50-85	10	(16)	7	(31)	(14)			
Ethnicity								
Maori	4	(6)	2	(9)	(5)	3	$\chi^2 = 0.30$	$\chi^2 = 0.14$
NZ European	39	(62)	14	(61)	(91)[b]			
Other European	16	(25)	4	(17)	-			
Other	2	(3)	1	(4)	(3)			
Education								
High school/UE	19	(30)	10	(44)	-	2	$\chi^2 = 0.60$	-
Trade cert/dip.	14	(22)	6	(26)	-			
At uni /degree +	29	(46)	7	(30)	-			
Religion								
Char. Christian	59	(95)	1	(6)	(92)	2	$\chi^2 = 43.60$*	$\chi^2 = 2.22$
Other Christian	1	(2)	14	(82)	(7)			
Other religion or none	2	(4)	2	(12)	(1)			
Been hospitalised?								
Yes	2	(3)	4	(17)	-	1	$\chi^2 = 5.10$*	-
No	59	(94)	19	(83)	-			
No. of sessions								
1-5	41	(66)	9	(39)	(58)	1	$\chi^2 = 2.80$	$\chi^2 = 8.23$*
6-20	7	(11)	3	(13)	(34)			

Note: *n*'s vary due to missing values. Fishers exact test of significance is used where cells had less than five

[a] Existing sample is reported in Kay (2002b), and was from a post therapy survey of 134 RFT clients.

[b] Non-NZ Europeans combined with NZ Europeans

* $p < .05$

Table 2
Cronbach's Alpha Statistics for the RCOPE and TOP v 4.1 Scales

Scale	No. of items	Shapiro-Wilks	Cronbach's Alpha
TOP v 4.1			
Total Score	58	.002	.954
Life Quality	4	.049	.882
Interpersonal Functioning	5	.000	.785
Sleep	4	.000	.907
Work Functioning	4	.002	.707
Violence	4	.000	.939
Sexual Functioning	4	.000	.739
Panic	8	.000	.827
Depression	10	.021	.927
Mania	3	.021	.642
Suicide	5	.000	.843
Psychosis	4	.000	.696
Alcohol and Drug Abuse	6	.000	.957
RCOPE			
Positive Total	31	.118	.902
Negative Total	18	.001	.876
Benevolent Reappraisal/Spiritual Support	8	.013	.809
Punishing God Reappraisal	5	.000	.841
Collaborative/Low Self-Directing	8	.042	.741
Active Religious Surrender	4	.221	.787
Passive Religious Deferral	4	.004	.721
Pleading for Direct Intercession	5	.011	.714
Religious Purification/Forgiveness	10	.054	.923
Spiritual Discontent	5	.000	.903

Table 3
Differences between RFT Participant Characteristics for TOP v 4.1 and RCOPE Totals

Participant Characteristics		TOP Total Pre-	TOP Total Post-	RCOPE Total Pre-	RCOPE Total Post-	Positive RCOPE Pre-	Positive RCOPE Post-	Negative RCOPE Pre-	Negative RCOPE Post-
		n =60	*n* = 49	*n* =60	*n* = 49	*n* =60	*n* = 49	*n* =60	*n* = 49
RCI-10	*U* =	258	236	194	247	345	249	292	245
<41, 41+	*p* =	**.009**	.429	**.000**	.771	.150	.813	**.024**	.746
Gender		231	213	250	189	225	185	281	166
M/F		.214	.834	.321	.721	.149	.650	.660	.365
Age		270	272	321	23	377	261	264	260
<40, 40+ yrs		.055	.885	.173	.496	.620	.845	**.023**	.829
Ethnicity		217	143	266	167	259	132	214	131
NZ Euro/ Other		.179	**.015**	.478	.971	.395	.288	.089	.275
Education		171	157	186	165	256	156	212	189
Pre-grad/ Grad		.070	.340	.110	.527	.803	.397	.273	.975
Religion		22	20	23	0	18	3	25	13
Pente-Charis /Other Christ.		.715	.851	.828	**.044**	.638	.156	.862	.644
No. sessions		11	42	67	87	95	68	68	85
<5, 5+		**.011**	**.014**	.234	.360	.922	.115	.280	.334
Homework		134	176	159	152	182	192	163	139
God Space use daily/other		.074	.516	.188	.198	.465	.835	.225	.102
Previous		19	13	29	21	23	17	29	19
Hosp Yes/No		.557	.089	1.000	.883	.800	.766	1.000	.740
No. Presenting		126	148	122	155	206	181	127	140
Problems		.057	.224	**.025**	.314	.974	.759	**.034**	.154
Helpfulness		125	179	147	207	209	187	112	163
Extremely/ Other		**.044**	.411	.107	.933	1.000	.547	**.010**	.219

Note: Mann-Whitney *U* analyses are used for all tests

Table 4
Differences between PC Participant Characteristics and TOP v 4.1 and RCOPE Totals

Participant Characteristics		TOP Total Pre-	TOP Total Post-	RCOPE Total Pre-	RCOPE Total Post-	Positive RCOPE Pre-	Positive RCOPE Post-	Negative RCOPE Pre-	Negative RCOPE Post-
		n =22	*n* =13	*n* =22	*n* =13	*n* =22	*n* =13	*n* =22	*n* =13
RCI-10	*U* =	38	12	50	9	48	10	33	9
<41, 41+	*p* =	.277	.662	1.000	.548	.926	.690	.221	.548
Gender		37	5	32	4	31	8	40	3
M/F		.195	**.028**	.283	.073	.265	.315	.655	**.033**
Age		42	9	35	10	38	14	43	8
<40, 40+ yrs		.224	.086	.269	.429	.380	.931	.615	.229
Ethnicity		21	8	21	8	25	8	26	10
NZ Euro/ Other		.457	.624	.571	.730	.865	.624	.955	1.000
Education		48	8	27	9	30	3	38	9
Pre-grad/ Grad		.751	.236	.239	.630	.321	.085	.764	.576
Religion		32	11	17	5	15	6	29	7
Pente-Charis /Other Christ.		.409	.507	.137	.667	.075	.889	.751	.972
No. sessions		4	6	8	3	7	2	10	12
<5, 5+		**.015**	**.009**	.291	.067	.215	**.038**	.503	1.000
Previous Hospitalisation		34	12	10	23	21	11	21	11
Yes/No		.865	.554	.776	.777	.671	.921	.669	.885

Note: Mann-Whitney *U* analyses are used for all tests

Table 5
Chi-Square Differences between Participant Characteristics

Participant characteristics	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.
1. RCI-10 <41, 41+	-									
2. Gender Male/Female	4.13 **.048**	-								
3. Age <40, 40+	6.86 **.012**	2.00 .212	-							
4. Ethnicity NZ Euro/Other Euro	7.07 **.009**	.06 1.000	.17 .791	-						
5. Education Pre-grad/grad	5.62 **.031**	.91 .392	3.05 .115	.15 1.000	-					
6.Religion Pente-Charis Christ. /Other Christian	1.18 .390	.22 .752	5.13 **.040**	.95 .489	.15 .696	-				
7. No. sessions <5/5+	4.76 .063	3.49 .097	.54 .496	.214 .495	5.53 **.039**	.721 .590	-			
8.Previous Hosp Yes/No	3.32 .097	1.72 .337	.08 1.000	2.03 .314	.35 .622	4.23 .074	.274 .507	-		
9. No. Present. Problems <5/5+	.32 .756	2.81 .151	4.82 **.037**	.50 .512	4.92 .051	.839 1.000	4.7 .053	-[a]	-	
10.Helpfulness Extremely/Other	.04 1.000	.22 .759	.47 .577	1.86 .220	.62 .500	6.64 **.015**	.017 1.000	2.88 .141	.04 1.000	-

[a] not calculable due to no previously hospitalised participants reporting their presenting problems
Note: for cells with less than five, Fishers exact significance is used

Table 6
Correlations between Participant Characteristics and Pre-Therapy TOP v 4.1 Scores

Participant Characteristics		TOP TOT	TOP LQ	TOP INT	TOP SLP	TOP WK	TOP VIO	TOP SEX	TOP PAN	TOP DEP	TOP MAN	TOP SUI	TOP PSY	TOP AL
RCI-10	r_s=	.42	.20	.34	.20	.23	.19	.17	.32	.45	23	.42	.39	.43
	p=	**.000**	.068	**.002**	.081	**.046**	.095	.144	**.004**	**.000**	**.038**	**.000**	**.000**	**.000**
Gender	τ =	-.17	-.11	-.12	.01	-.26	-.39	-.11	-.18	-.16	-.21	-.11	-.22	-.07
M/F	p=	.065	.267	.220	.935	.007	.000	.275	.053	.078	.023	.280	.021	.531
Age	r_s=	.13	.14	.09	-.10	.34	.12	-.07	.14	.16	.07	.13	.15	.08
	p=	.235	.224	.402	.395	**.001**	.291	.549	.222	.164	.532	.232	.188	.494
Ethnicity	τ =	.09	-.20	.12	.11	.08	-.04	.15	.05	.09	.11	.03	.10	.20
NZ Euro/Other	p=	.363	**.023**	.246	.287	.437	.715	.145	.601	.346	.260	.785	.353	.081
Education	τ =	.19	-.00	.16	.19	-.10	.15	.01	.18	.18	.18	.21	.21	.17
Pre-grad/grad	p=	**.040**	.991	.088	**.046**	.314	.158	.906	.064	**.049**	.054	**.036**	**.027**	.100
Religion	τ =	-.07	.12	-.04	-.07	.22	-.08	-.10	-.07	-.09	-.24	-.03	-.13	.03
Pente-Charis /Other Christ.	p=	.412	.203	.702	.449	**.019**	.437	.282	.472	.303	**.010**	.727	.818	.750
No. sessions	r_s=	-.10	-.08	-.14	-.22	.04	-.08	-.16	-.23	-.25	.02	-.18	-.15	.09
	p=	.624	.671	.487	.108	.774	.572	.248	.091	.067	.906	.344	.292	.500
Homework	τ =	.23	.23	.19	-.01	.32	.19	.02	.240	.20	.11	.24	.16	.06
God Space use Daily/Other	p=	.057	.063	.128	.956	.009	.156	.893	.048	.089	.381	.053	.195	.656
Previous	τ =	-.13	-.03	-.22	.01	-.11	-.02	-.09	-.04	-.15	-.13	-.11	-.03	-.09
Hosp Yes/No	p=	.168	.768	**.019**	.885	.263	.888	.376	.657	.112	.176	.247	.751	.369
No. Presenting	r_s=	.04	.06	.12	-.11	-.11	-.01	-.10	-.10	.04	.10	-.03	.07	.08
Problems	p=	.758	.619	.280	.354	.354	.928	.371	.368	.743	.386	.760	.517	.474
Helpfulness	τ =	-.11	.18	.04	.06	-.24	-.15	-.03	-.08	-.04	.02	-.20	-.14	-.12
Extremely/Other	p=	.336	.112	.721	.616	**.037**	.256	.825	.489	.728	.837	.088	.229	.334

Note: Spearman's rho correlations are used for continuous data and Kendall's tau correlations are used for continuous with dichotomous data

Table 7
Correlations between Participant Characteristics and Post-therapy TOP v 4.1 Scores

Participant Characteristics		TOP TOT	TOP LQ	TOP INT	TOP SLP	TOP WK	TOP VIO	TOP SEX	TOP PAN	TOP DEP	TOP MAN	TOP SUI	TOP PSY	TOP AL
RCI-10	r_s=	.17	.09	.11	.01	.29	.11	.05	.01	.15	.08	.22	.17	.30
	p=	.208	.487	.405	.926	**.029**	.428	.692	.931	.248	.546	.102	.194	**.023**
Gender	τ =	-.15	-.07	-.09	-.10	-.27	-.40	-.12	-.20	-.08	-.04	-.11	-.22	-.12
M/F	p=	.163	.524	.404	.371	.017	.001	.288	.073	.482	.721	.332	.048	.352
Age	r_s=	.07	-.05	.19	-.08	.22	.25	.01	.31	.18	.17	.08	.18	.17
	p=	.600	.684	.145	.562	.086	**.047**	.919	**.013**	.154	.176	.545	.154	.188
Ethnicity	τ =	.04	.01	.15	.00	.32	-.03	.10	-.02	-.01	-.09	-.05	.09	.06
NZ Euro/Other	p=	.747	.908	.214	1,000	.010	.819	.454	.879	.950	.469	.730	.484	.672
Education	τ =	.12	.19	.00	.15	-.04	.13	-.06	.10	.03	.03	.06	.03	.33
Pre-grad/grad	p=	.247	.080	.993	.166	.701	.279	.963	.392	.782	.761	.615	.826	**.009**
Religion	τ =	-.11	.01	-.01	-.12	.01	-.14	-.05	-.13	-.19	-.11	-.20	.01	.03
Pente-Charis /Other Christ.	p=	.308	.949	.928	.277	.920	.258	.672	.229	.081	.318	.087	.905	.817
No. sessions	r_s=	-.26	-.25	-.12	-.09	-.08	-.17	-.15	.05	-.06	-.21	-.05	-.20	.02
	p=	.056	.066	.362	.911	.557	.222	.258	.743	.756	.130	.798	.146	.894
Homework	τ =	-.12	.02	-.23	-.09	-.12	-.27	.23	.15	.17	.17	.09	.24	.06
God Space use Daily/Other	p=	.297	.895	.062	.500	.351	**.050**	.081	.228	.160	.165	.487	.059	.681
Previous Hosp Yes/No	τ =	.05	.05	.11	.06	.15	.05	.01	.09	.13	.02	.13	.03	.05
	p=	.663	.634	.341	.606	.171	.701	.947	.409	.225	.874	.257	.786	.688
No. Presenting Problems	r_s=	.01	-.04	-.04	.17	.05	.02	-.08	-.08	.01	-.11	.10	-.07	-.01
	p=	.921	.661*	.680*	.075*	.585*	.875*	.438*	.446*	.911*	.266*	.354*	.468*	.939*
Helpfulness	τ =	.11	.02	.05	.33	.14	-.11	-.06	-.00	.09	.02	.12	.15	.01
Extremely/Other	p=	.323	.879	.692	**.003**	.233	.386	.608	.973	.425	.826	.312	.198	.971

Note: Spearman's rho correlations are used for continuous data and Kendall's tau correlations are used for continuous with dichotomous data

Table 8
Correlations between Participant Characteristics and Pre-therapy RCOPE Scores

Participant Characteristics		Total	POS	NEG	BEN	COL	PUR	ACT	PAS	PLD	DIS	PUN
RCI-10	r_s=	.42	.23	-.29	.44	.59	-.08	-.06	.06	-.1	-.41	-.36
	p=	**.000**	**.040**	**.009**	**.000**	**.000**	.489	.616	.588	.255	**.000**	**.001**
Gender	τ =	.01	.06	.06	.08	.01	.03	.06	.04	.06	.01	.14
M/F	p=	.885	.552	.544	.388	.926	.749	.519	.702	.610	.949	.164
Age	r_s=	.18	.06	-.16	.14	.15	-.02	.03	-.16	.02	-.12	-.21
	p=	.106	.612	.150	.226	.187	.894	.820	.159	.854	.305	.066
Ethnicity	τ =	.01	-.09	-.15	.05	.09	-.16	.01	-.01	-.17	-.11	-.05
NZ Euro/Other	p=	.893	.384	.129	.647	.367	.124	.919	.919	.097	.285	.654
Education	τ =	.02	-.04	-.06	-.04	.14	-.07	-.08	.17	-.12	-.11	-.12
Pre-grad/grad	p=	.846	.663	.525	.654	.144	.442	.414	.080	.230	.248	.264
Religion	τ =	.22	.21	-.03	.12	.06	.27	.00	-.18	.05	.01	.01
Pente-Charis /Other Christ.	p=	**.015**	**.025**	.731	.202	.508	.004	.967	.064	.606	.915	.955
No. sessions	r_s=	.03	-.04	-.13	-.07	-.24	.00	-.06	-.32	-.14	.08	-.07
	p=	.803	.751	.355	.633	.222	.976	.667	.371	.481	.573	.597
Homework	τ =	.22	.13	-.23	-.10	-.33	.06	-.04	-.03	-.13	.22	-.27
God Space use Daily/Other	p=	.066	.268	.061	.421	.008	.627	.741	.800	.303	.088	**.035**
Previous	τ =	.06	.04	.01	.11	-.05	.08	-.04	.03	.01	.11	.04
Hosp	p=	.538	.669	.952	.247	.594	.421	.665	.757	.918	.253	.690
Yes/No												
No. Presenting	r_s=	-.07	.00	.06	-.02	.03	-.02	.07	.12	.03	-.05	.05
Problems	p=	.439	.968	.457	.855	.742	.823	.408	.169	.741	.584	.612
Helpfulness	τ =	-.17	.02	.26	.02	.11	-.01	.05	.16	.26	.14	.14
Extremely/Other	p=	.124	.894	**.022**	.883	.358	.912	.658	.175	**.029**	.233	.262

Note: Spearman's rho correlations are used for continuous data and Kendall's tau correlations are used for continuous with dichotomous data

Table 9
Correlations between Participant Characteristics and Post-therapy RCOPE Scores

Participant Characteristics		Total	POS	NEG	BEN	COL	PUR	ACT	PAS	PLD	DIS	PUN
RCI-10	r_s=	.13	.04	-.05	.09	.30	-.12	-.03	-.00	.04	-.14	-.23
	p=	.335	.753	.687	.515	**.023**	.366	.828	.992	.767	.301	.083
Gender	τ =	-.17	.01	.22	-.10	-.25	.13	.21	.27	.19	.07	.20
M/F	p=	.117	.903	**.050**	.350	**.025**	.233	.068	**.017**	.093	.522	.097
Age	r_s=	.18	11	.00	.23	.20	-.05	.06	.04	-.02	-.12	-.22
	p=	.165	.418	.994	.079	.122	.727	.678	.754	.906	.341	.102
Ethnicity	τ =	-.03	-.12	-.10	-.03	-.02	-.11	-.16	-.11	-.03	.03	-.07
NZ Euro/Other	p=	.798	.331	.417	.839	.898	.376	.202	.379	.796	.834	.583
Education	τ =	-.01	-.06	-.06	-.06	.11	-.13	-.12	-.09	-.01	-.06	-.00
Pre-grad/grad	p=	.934	.589	.602	.614	.321	.227	.299	.452	.919	.588	.992
Religion	τ =	.08	.28	.29	.13	.07	.34	.14	-.01	.37	.27	.33
Pente-Charis /Other Christ.	p=	.463	**.008**	**.008**	.251	.521	**.002**	.206	.938	**.001**	**.018**	**.006**
No. sessions	r_s=	.38	.43	.10	.26	.28	.25	.18	-.05	-.09	.10	-.14
	p=	**.044**	**.020**	.609	.173	.148	.193	.350	.812	.649	.598	.384
Homework	τ =	-.15	.03	.17	-.10	-.23	.12	.19	.15	.08	.26	.19
God Space use Daily/Other	p=	.210	.815	.181	.411	.073	.336	.138	.231	.521	**.047**	.178
Previous	τ =	.03	.05	.12	-.02	-.15	.15	.09	.09	.22	.08	.10
Hosp	p=	.803	.628	.286	.890	.196	.162	.436	.415	.052	.479	.399
Yes/No												
No. Presenting	r_s=	.07	.02	-.07	.06	.08	-.02	-.07	.05	-.23	-.08	.02
Problems	p=	.487	.857	.466	.516	.429	.851	.469	.650	**.023**	.466	.891
Helpfulness	τ =	.06	.05	.07	.10	.25	-.01	.01	.18	.02	-.02	-.06
Extremely/Other	p=	.605	.630	.556	.362	**.030**	.929	.943	.139	.857	.874	.609

Note: Spearman's rho correlations are used for continuous data and Kendall's tau correlations are used for continuous with dichotomous data

Table 10
Correlations between Participant Characteristics

Participant characteristics	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.
1. RCI-10	-										
2. Gender Male/Female	-.099 .282	-									
3. Age	.254* **.021**	-.070 .435	-								
4. Ethnicity NZ Euro/Other	.230 **.020**	-.028 .811	.044 .709	-							
5. Education Pre-grad/grad	.206 **.026**	-.103 .344	-.094 .294	.045 .705	-						
6.Religion Pente-Charis Christ. /Other Christian	-.048 .597	.058 .586	.189 **.033**	-.148 .157	-.173 .105	-					
7. No. sessions <5/5+	-.259 **.014**	-.071 .561	.087 .515	-.218 .128	-.397 **.001**	.102 .398	-				
8.Homework God Space use	-.171 .156	.107 .478	-.203 .175	.063 .644	-.059 .698	-.088 .534	.170 .269	-			
9. Previous Hosp Yes/No	.144 .119	-.142 .192	.021 .817	.167 .159	.064 .559	-.208 .051	-.173 .164	.041 .772	-		
10.No. Present. Problems <5/5+	.135 .105	-.141 .195	-.077 .480	.126 .237	.204 .059	-.283 **.003**	-.107 .424	.063 .605	.263 **.015**	-	
11.Helpfulness Extremely/Other	.113 .309	-.106 .441	-.107 .436	.184 .194	.074 .589	-.241 .060	-.138 .318	.064 .659	.287 **.036**	.311 **.006**	-

* Spearman's rho correlation, all the remainder are Kendall's tau correlations

Table 11
Stated Presenting Problems of RFT Participants

Problem	Total $N = 178$	
	n	%
Fear/Anxiety/Stress	29	17
Seeking Guidance for Future	26	15
Relationship Difficulties	24	14
Poor Sense of Personal Identity	22	12
Low Self-Esteem	17	10
Sadness/Grief	16	9
Problems in Relationship with God	10	6
Physical Problem	9	5
Demonic Problems	8	5
Addictions or Unhealthy Behaviour	7	4
Sexual/Emotional/Physical Abuse	7	4
	3	2

Table 12
Helpfulness of Therapy

Level of Helpfulness	RFT		PC	
	n	(%)	*n*	(%)
Extremely Unhelpful (detrimental)	0	-	1	(8)
Not at all Helpful	0	-	1	(8)
Somewhat Helpful	3	(7)	3	(25)
Very Helpful	17	(39)	7	(58)
Extremely helpful (life changing)	23	(54)	0	-

Table 13
Participants Perceptions of Helpful Aspects of RFT and PC

Category	RFT participants mentioning this aspect		Percentage of total RFT responses	PC participants mentioning this aspect		Percentage of total PC responses
	n	%	%	*n*	%	%
Experiencing God	44	(61)	(34)	3	(43)	(30)
RFT/PC Technique	41	(57)	(32)	2	(29)	(20)
Insight	33	(46)	(25)	1	(14)	(10)
Therapy Relationship	12	(17)	(9)	4	(57)	(40)

Table 14
Mann-Whitney U Tests for Differences between RFT and PC in TOP v 4.1 Scores

Scale		Mean Ranks		*U*	*z*	Asymp. Sig. (2-tailed)
Pre-therapy $N = 84$ Post-therapy $N = 59$		RFT	PC			
TOP v 4.1:						
Total	*Pre-therapy*	44	33	482	1.91	.075
	Post-therapy	36	16	118	3.47	**.001**
Life Quality	*Pre-therapy*	41	42	642	0.19	.146
	Post-therapy	34	23	209	1.91	.056
Interpersonal	*Pre-therapy*	44	35	522	1.45	.146
	Post-therapy	34	21	185	2.33	**.020**
Sleep	*Pre-therapy*	43	35	521	1.37	.172
	Post-therapy	36	14	96	3.90	**.000**
Work	*Pre-therapy*	40	43	584	0.58	.559
Functioning	*Post-therapy*	34	21	176	2.49	**.013**
Violence	*Pre-therapy*	43	35	511	1.91	.056
	Post-therapy	33	26	244	1.81	.070
Sexual	*Pre-therapy*	43	37	557	1.01	.312
Functioning	*Post-therapy*	34	23	214	1.96	**.050**
Panic	*Pre-therapy*	42	38	591	0.62	.536
	Post-therapy	34	24	220	1.76	.079
Depression	*Pre-therapy*	44	32	457	2.04	**.041**
	Post-therapy	36	15	101	3.77	**.000**
Manic	*Pre-therapy*	45	30	397	2.69	**.007**
	Post-therapy	35	20	164	2.69	**.007**
Suicide	*Pre-therapy*	43	35	508	1.53	.126
	Post-therapy	35	17	129	3.61	**.000**
Psychosis	*Pre-therapy*	44	33	483	1.78	.075
	Post-therapy	34	22	197	2.15	**.032**
Alcohol and	*Pre-therapy*	41	40	621	-.39	.699
Drug Abuse	*Post-therapy*	32	26	252	-1.59	.112

Table 15
Wilcoxon Signed Ranks Test for Changes in TOP v 4.1 Scores

Scale	Median Score Total range = 0 - 72 Subscale range = 0 – 6 RFT		PC		RFT		PC	
	Pre-	*Post-*	*Pre-*	*Post-*	*z*	*p*	*z*	*p*
TOP								
Total TOP	59.8	67.1	57.9	60.3	5.58	**.000**	1.31	.192
Subscales:								
Life Quality	3.5	4.8	3.6	4.0	4.19	**.000**	2.20	**.028**
Interpersonal	4.8	5.6	4.2	4.6	4.05	**.000**	1.35	.178
Sleep	5.3	5.5	4.8	4.5	3.37	**.001**	0.31	.758
Work function	5.2	5.7	5.3	5.2	4.16	**.000**	0.11	.915
Violence	6.0	6.0	6.0	6.0	0.83	.409	0.82	.414
Sexual function	5.5	6.0	5.3	5.0	3.74	**.000**	0.00	1.000
Panic	5.4	5.8	5.2	5.5	4.55	**.000**	2.37	**.018**
Depression	4.3	5.5	3.9	4.2	5.46	**.000**	2.15	**.032**
Suicide	5.8	6.0	5.4	5.4	3.79	**.000**	0.49	.622
Manic	4.8	5.4	4.4	5.0	3.92	**.000**	1.55	.122
Psychosis	5.3	5.8	5.1	5.5	3.89	**.000**	0.42	.677
Alcohol and drug abuse	6.0	6.0	6.0	6.0	2.35	**.019**	0.82	.414

Table 16
Differences in TOP v 4.1 Changes from Pre to Post Therapy for RFT and PC

Scale	Median Change (Total range = 0-72, Subscale range = 0-6)		*Mann-Whitney U*	*z*	Asymp. Sig. (2-tailed)
	RFT	PC			
TOP v 4.1:					
Total	4.1	0.6	167	2.09	**.036**
Life Quality	0.5	0.5	255	0.52	.602
Interpersonal	0.4	0.2	234	0.91	.364
Sleep	0.3	0.0	207	1.34	.182
Work Functioning	0.3	0.0	130	2.83	**.005**
Violence	0.0	0.0	275	0.04	.969
Sexual Functioning	0.0	0.0	196	1.63	.103
Panic	0.3	0.3	275	0.02	.985
Depression	0.6	0.5	215	1.18	.237
Mania	0.3	0.0	223	1.02	.307
Suicide	0.2	0.0	158	2.33	**.020**
Psychosis	0.3	0.1	217	1.14	.253
Alcohol and Drug Abuse	0.0	0.0	267	0.23	.817

Table 17
Mann-Whitney U Tests for Differences between RFT and PC in RCOPE Scores

Scale		Mean Rank		*U*	*z*	Asymp. Sig. (2-tailed)
		RFT	PC			
RCOPE:						
Total	*Pre-therapy*	40	43	552	0.54	.590
	Post-therapy	29	35	213	0.99	.320
Positive	*Pre-therapy*	41	39	578	0.25	.807
	Post-therapy	28	40	159	2.06	**.040**
Negative	*Pre-therapy*	39	45	514	0.96	.339
	Post-therapy	31	25	209	1.07	.284
Subscales:						
Benevolent	*Pre-therapy*	38	42	522	0.67	.502
	Post-therapy	31	25	210	1.05	.292
Collaboration	*Pre-therapy*	41	36	512	0.79	.432
	Post-therapy	32	22	177	1.71	.087
Purification	*Pre-therapy*	38	44	485	1.09	.276
	Post-therapy	28	40	150	2.22	**.026**
Active Surrender	*Pre-therapy*	40	37	523	0.66	.511
	Post-therapy	29	35	210	1.07	.286
Passive Deferral	*Pre-therapy*	41	34	466	1.33	.185
	Post-therapy	31	26	216	0.67	.338
Pleading	*Pre-therapy*	39	40	270	0.12	.904
	Post-therapy	26	46	88	3.46	**.001**
Discontent	*Pre-therapy*	39	42	551	0.46	.648
	Post-therapy	28	42	157	2.64	**.008**
Punishing	*Pre-therapy*	40	39	579	0.02	.985
	Post-therapy	28	38	181	1.86	.064

Table 18
Wilcoxon Signed Ranks Test for Changes in RCOPE Scores

Scale	Median Score Range = 0-3							
	RFT		PC		RFT		PC	
	Pre-	*Post-*	*Pre-*	*Post-*	*z*	*p*	*z*	*p*
RCOPE:								
Positive	0.9	1.3	1.2	1.2	1.36	.175	1.31	.192
Negative	1.5	1.6	1.8	1.8	4.29	**.000**	0.00	1.000
Total (pos-neg)	0.6	0.4	0.6	0.5	4.33	**.000**	0.56	.574
Subscales:								
Benevolent	1.8	2.1	1.9	1.7	1.91	.056	0.30	.767
Collaborative	1.9	2.5	1.8	2.4	4.98	**.000**	1.28	.199
Purification	1.3	0.9	1.4	1.9	2.43	**.015**	0.34	.735
Active Surrender	1.5	1.3	1.1	2.0	1.87	.062	0.66	.512
Deferral	0.8	0.8	0.5	0.5	0.42	.672	0.35	.725
Pleading	1.0	0.4	1.0	1.2	4.88	**.000**	0.42	.672
Discontent	0.3	0.0	0.5	0.6	3.33	**.001**	1.27	.205
Punishing	0.2	0.0	0.1	0.2	2.86	**.004**	0.21	.833

Table 19
Differences in Pre- to Post-therapy RCOPE Changes between RFT and PC

Scale	Median Change Range = 0-3		*Mann-Whitney U*	*z*	Asymp. Sig. (2-tailed)
	RFT	PC			
RCOPE:					
Total	0.3	0.0	167	2.09	.060
Positive	0.1	0.1	216	0.21	.836
Negative	-0.2	0.0	153	1.58	.114
Subscales:					
Benevolent	0.2	-0.1	174	1.12	.264
Collaboration	0.4	0.5	197	0.62	.540
Purification	-0.3	0.0	176	1.09	.279
Active Surrender	0.0	0.1	165	1.32	.188
Passive Deferral	0.0	-0.1	202	0.51	.612
Pleading	-0.4	0.0	111	2.52	**.012**
Discontent	0.0	0.0	223	0.64	.525
Punishing	0.0	0.0	178	1.12	.262

Table 20

Spearman's rho Correlations between Pre-Therapy TOP v 4.1 and RCOPE Scores

		RCOPE Total	RCOPE POS	RCOPE NEG	RCOPE BEN	RCOPE COL	RCOPE PUR	RCOPE ACT	RCOPE PAS	RCOPE PLD	RCOPE DIS	RCOPE PUN
TOP Total	r_s =	.26	.04	-.37	.18	.36	-.21	-.04	.16	-.40	-.38	-.34
	p =	**.019**	.718	**.001**	.107	**.001**	.062	.704	.160	**.000**	**.001**	**.002**
TOP LQ		.34	.29	-.16	.34	.36	.13	.06	.07	-.13	-.18	-.19
		.002	**.011**	.158	**.003**	**.001**	.242	.622	.549	.261	.110	.089
TOP INT		.09	-.11	-.20	.04	.18	-.28	-.11	.17	-.27	-.20	-.22
		.552	.342	.076	.736	.118	**.013**	.341	.135	**.016**	.078	.057
TOP SLP		.21	.06	-.21	-.00	.27	-.01	.00	.22	-.30	-.28	-.19
		.067	.582	.066	.982	**.017**	.958	.975	.051	**.007**	**.012**	.096
TOP WRK		.16	.02	-.29	.03	.12	-.07	-.12	-.15	-.30	-.16	-.21
		.165	.889	**.010**	.787	.304	.544	.302	.195	**.007**	.166	.062
TOP VIO		.25	.09	-.32	.13	.26	-.13	.05	-.14	-.14	-.22	-.36
		.024	.429	**.005**	.259	**.022**	.257	.672	.227	.208	.053	**.001**
TOP SEX		-.03	-.13	-.10	.04	.05	-.25	-.07	-.28	-.19	-.07	-.18
		.803	.259	.400	.717	.661	**.027**	.561	**.015**	.096	.551	.113
TOP PAN		.31	.11	-.37	.22	.35	-.11	-.03	.15	-.38	-.40	-.34
		.006	.351	**.001**	.058	**.002**	.321	.828	.177	**.001**	**.000**	**.002**
TOP DEP		.32	.12	-.37	.35	.43	-.21	.04	.09	-.32	-.39	-.34
		.004	.288	**.001**	**.002**	**.000**	.061	.711	.420	**.004**	**.000**	**.002**
TOP MAN		-.02	-.15	-.24	.03	.14	-.35	-.09	.15	-.35	-.24	-.27
		.881	.176	**.036**	.815	.212	**.002**	.425	.186	**.002**	**.030**	**.015**
TOP SUI		.36	.17	-.35	.31	.39	-.11	.10	.04	-.27	-.35	-.34
		.001	.130	**.002**	**.006**	**.000**	.334	.371	.735	**.018**	**.001**	**.003**
TOP PSY		.15	-.03	-.35	.01	.31	-.21	-.13	.12	-.33	-.33	-.34
		.181	.764	**.001**	.921	**.006**	.070	.249	.281	**.003**	**.003**	**.002**
TOP AL		.18	.02	-.20	.17	.18	-.15	-.03	.01	-.28	-.21	.07
		.123	.867	.075	.130	.114	.192	.789	.956	**.013**	.062	.567

Table 21

Spearman's rho Correlations between Post-Therapy TOP v 4.1 and RCOPE Scores

		RCOPE Total	RCOPE POS	RCOPE NEG	RCOPE BEN	RCOPE COL	RCOPE PUR	RCOPE ACT	RCOPE PAS	RCOPE PLD	RCOPE DIS	RCOPE PUN
TOP Total	r_s=	.38	-.02	-.49	.27	.45	-.31	-.16	-.15	-.49	-.46	-.38
	p=	**.003**	.887	**.000**	**.040**	**.000**	**.017**	.347	.246	**.000**	**.000**	**.003**
TOP LQ		.37	.14	-.29	.28	.31	-.07	-.08	-.06	-.36	-.27	-.23
		.004	.294	**.024**	**.033**	**.018**	.598	.566	.631	**.005**	**.035**	.075
TOP INT		.31	-.04	-.49	.26	.36	-.32	-.20	-.19	-.50	-.41	-.44
		.018	.743	**.000**	**.049**	**.005**	**.014**	.131	.146	**.000**	**.001**	**.000**
TOP SLP		.22	-.00	-.21	.28	.34	-.20	-.10	.05	-.39	-.27	-.07
		.093	.987	.109	**.035**	**.009**	.126	.465	.716	**.002**	**.033**	.611
TOP WRK		.24	.01	-.16	.22	.32	-.136	.006	-.038	-.22	-.066	-.24
		.074	.925	.240	.098	**.013**	.304	.961	.775	.089	.614	.074
TOP VIO		.33	-.04	-.416	.208	.34	-.26	-.20	-.20	-.42	-.35	-.37
		.010	.758	**.001**	.114	**.008**	**.049**	.124	.135	**.001**	**.006**	**.004**
TOP SEX		.24	-.05	-.40	.18	.22	-.25	-.10	-.20	-.34	-.34	-.38
		.064	.712	**.002**	.168	.098	.061	.433	.142	**.008**	**.007**	**.003**
TOP PAN		.26	-.07	-.37	.03	.33	-.27	-.05	-.05	-.35	-.46	-.38
		.044	.594	**.004**	.803	**.012**	**.040**	.700	.686	**.007**	**.000**	**.003**
TOP DEP		.33	-.11	-.55	.21	.43	-.42	-.12	-.14	-.53	-.60	-.44
		.012	.418	**.000**	.106	**.001**	**.001**	.374	.301	**.000**	**.000**	**.001**
TOP MAN		.18	-.12	-.37	.04	.26	-.30	-.15	-.08	-.38	-.38	-.36
		.179	.361	**.004**	.777	**.043**	**.023**	.243	.573	**.003**	**.003**	**.006**
TOP SUI		.44	.06	-.48	.22	.46	-.20	-.08	-.09	-.46	-.52	-.45
		.000	.640	**.000**	.094	**.000**	.129	.561	.511	**.000**	**.000**	**.000**
TOP PSY		.16	-.11	-.40	.13	.33	-.36	-.30	-.20	-.40	-.37	-.27
		.238	.423	**.002**	.329	**.010**	**.005**	**.021**	.130	**.002**	**.004**	**.040**
TOP AL		.29	.15	-.20	.22	.34	-.14	.14	.00	-.03	-.33	-.27
		.025	.249	.143	.098	**.010**	.290	.291	.993	.804	**.009**	**.040**

Table 22
Spearman's rho Correlations between TOP v 4.1 and RCOPE Changes

$N = 55$		RCOPE Total	RCOPE POS	RCOPE NEG	RCOPE BEN	RCOPE COL	RCOPE PUR	RCOPE ACT	RCOPE PAS	RCOPE PLD	RCOPE DIS	RCOPE PUN
TOP	$r_s =$	.32	.21	-.28	.37	.157	.05	.08	-.15	-.04	-.31	.02
Total	$p =$	**.033**	.166	.068	**.014**	.303	.726	.582	.340	.790	**.036**	.903
TOP		.02	.15	-.11	.15	.22	.05	.21	-.06	-.12	-.02	.06
LQ		.880	.263	.482	.269	.101	.711	.125	.644	.376	.892	.640
TOP		.07	.12	-.15	.28	.09	-.09	.01	.07	-.10	-.07	-.11
INT		.667	.385	.319	**.040**	.492	.497	.928	.577	.481	.600	.423
TOP		.29	.29	-.15	.35	.29	.06	.02	-.04	-.07	-.34	-.22
SLP		.054	**.030**	.312	**.009**	**.030**	.689	.869	.974	.634	**.011**	.102
TOP		.05	-.10	-.20	.08	-.01	-.04	-.10	.04	-.19	.02	-.11
WRK		.748	.460	.184	.541	.997	.753	.457	.780	.158	.911	.421
TOP		-.16	.02	-.16	-.09	-.17	.23	.09	-.09	.04	.05	.10
VIO		.299	.861	.299	.495	.219	.089	.530	.534	.757	.728	.951
TOP		-.06	-.01	-.06	.27	.14	-.26	-.22	.09	-.11	-.03	-.27
SEX		.714	.957	.708	**.043**	.320	.061	.113	.535	.447	.842	**.047**
TOP		.28	.22	-.26	.39	.24	-.05	.18	.13	-.01	-.37	-.07
PAN		.068	.104	.079	**.003**	.081	.714	.191	.361	.944	**.004**	.598
TOP		.41	.52	-.10	.55	.222	.25	.30	-.07	.01	-.23	-.05
DEP		**.006**	**.000**	.508	**.000**	.104	.065	**.025**	.600	.955	.090	.718
TOP		.23	.14	-.11	.38	.02	-.11	.03	.11	.01	-.30	-.16
MAN		.136	.317	.475	**.005**	.863	.410	.810	.419	.960	**.025**	.242
TOP		.41	.36	-.28	.46	.18	.16	.15	-.25	-.21	-.26	-.11
SUI		**.005**	**.006**	.058	**.000**	.201	.236	.288	.06	.123	**.048**	.438
TOP		.32	.30	-.07	.41	.246	.03	.19	.19	.14	-.30	-.17
PSY		**.030**	**.027**	.655	**.002**	.070	.856	.161	.158	.300	**.025**	.216
TOP		.17	-.19	-.24	-.02	.03	-.24	-.03	.09	-.07	-.25	-.04
AL		.270	.177	.110	.882	.828	.079	.835	.503	.614	.065	.754

Figures

Figure 1
Relationships between Attachment Style, Religious Coping Style and Mental Health

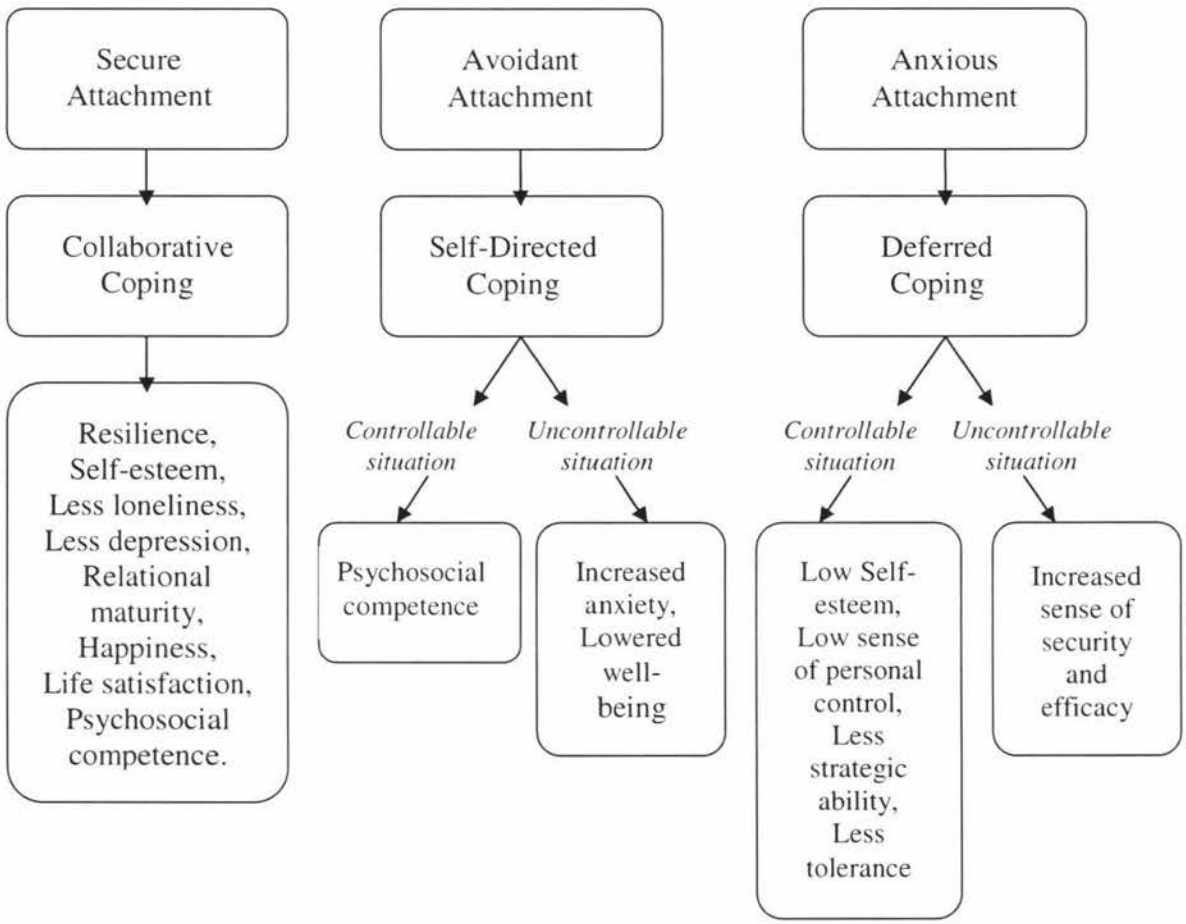

Figure 2
Proposed Pathway between Secure Attachment to God and Mental Health Outcomes

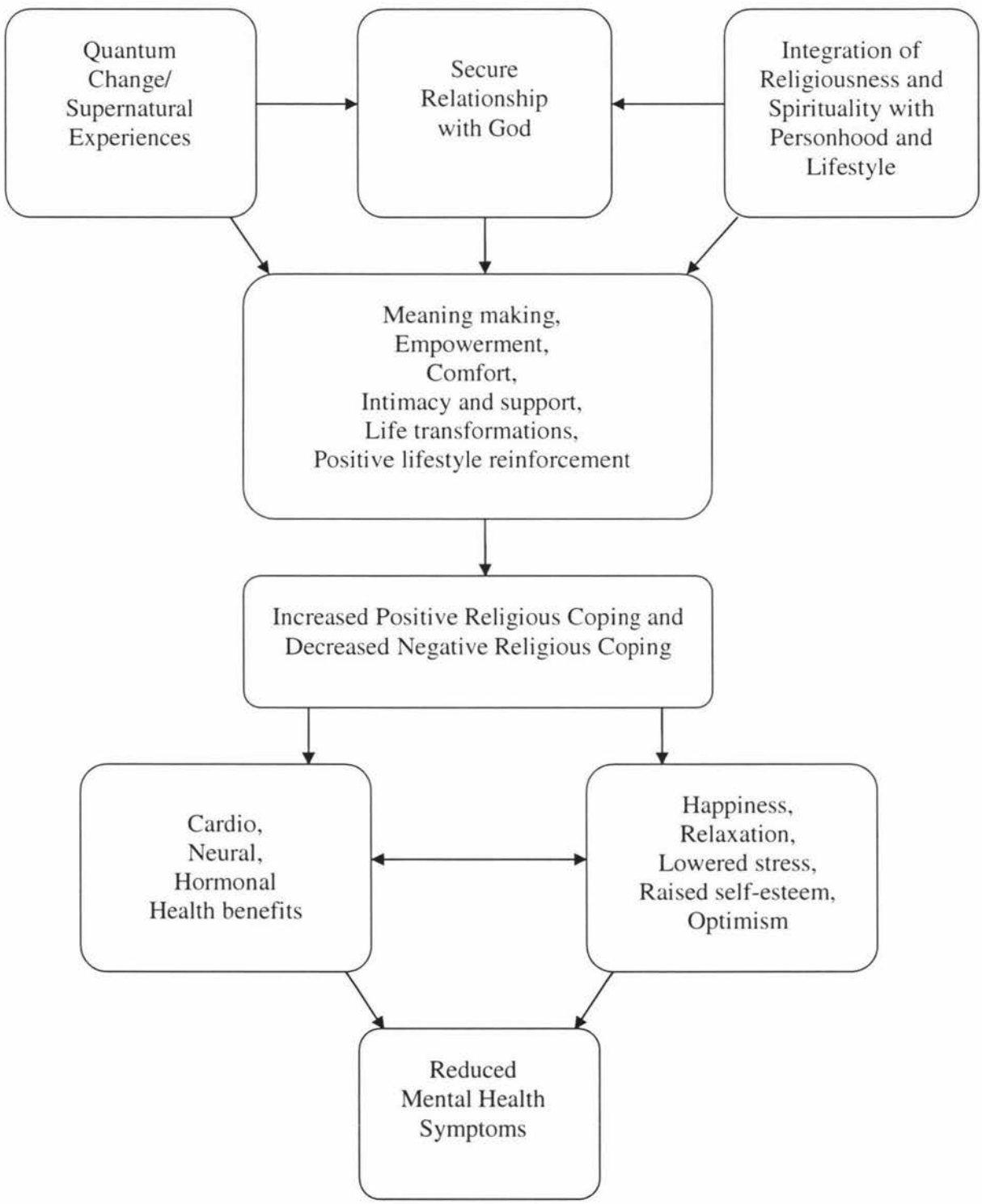

Figure 3
Refocussing Therapy Model (Derived from Divett, 2005, and Calvert, 2005)

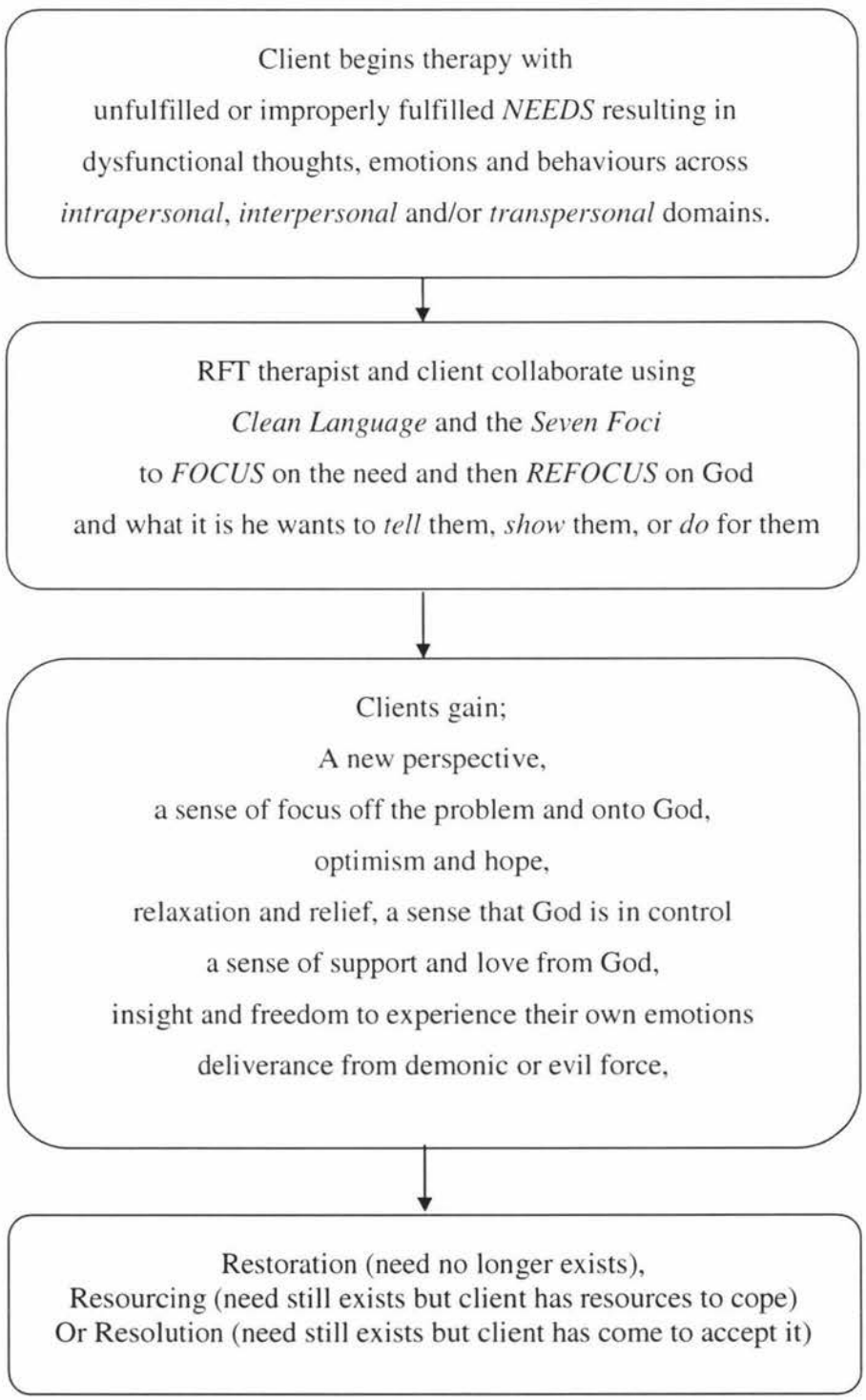

Figure 4
Graph Showing Change Occurring from Pre- to Post-Therapy for RFT and PC

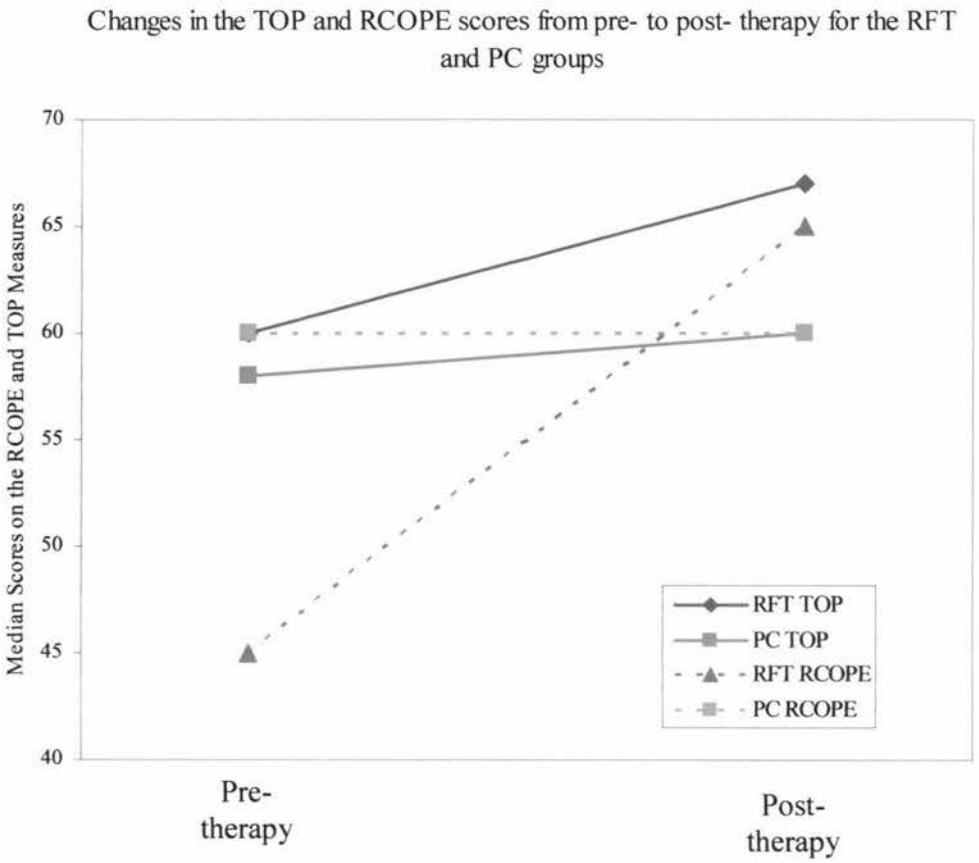

Figure 5
Proposed Religious Coping Pathways