AN ABSTRACT OF THE THESIS OF

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in Psychology presented on November 2, 1999

Title: The Choice of Religious or Secular Counselors Based on Faith Development and Topic of Therapy

Abstract approved:

This study examined the effects of faith development and topic of therapy on the preference for a religious or non-religious counselor. Past research on religiosity has shown that different preferences exist between groups of people who have differing levels of religiosity. This study examined three hypotheses. First, the overall preference for a religious counselor was hypothesized to be higher than the preference for a non-religious counselor. Second, it was expected that people with higher faith development would choose a religious counselor for each of the four topics of therapy that were examined. The four topics of therapy presented were marriage and family counseling, alcohol and drug counseling, depression and anxiety counseling, and severe mental illness counseling. The third hypothesis tested was that there would be no difference of preferences between genders. There were 151 participants in this study. Eighty-two were women and 69 were men. The participants were given the Fowler Religious Attitudes Scale to measure their level of faith development and also completed a counselor preference survey to measure their preferred type of counselor for each topic of therapy. A 2 x 4 x 2 repeated measures analysis of variance was used to analyze that data. The test for the first hypothesis showed a strong overall preference for non-religious counselors. The second hypothesis test showed a significant interaction between faith development

level and topic of therapy. This test also confirmed the third hypothesis as no difference existed between genders. The Tukey-Kramer procedure was used to detect the true differences between means. The results of the first hypothesis are in contradiction to past research. In this study, there was a strong preference for non-religious counseling. The results did not support the second hypothesis. It was found that people who were lower in faith development preferred religious counseling more than the higher faith developed group. A limitation of this study was that the faith development scale that was used measured a conceptualized notion of faith development and not religiosity as other studies have done. Suggestions for further research would be to use measures of intelligence in making comparisons between groups and also comparing results of the Fowler Religious Attitudes Scale to those measuring moralistic thinking.

THE CHOICE OF RELIGIOUS OR SECULAR COUNSELORS BASED ON FAITH DEVELOPMENT AND TOPIC OF THERAPY

A Thesis

Presented to

the Division of Psychology and Special Education

EMPORIA STATE UNIVERSITY

In Partial Fulfillment

of the Requirements for the Degree

Master of Science

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by

Jason P. Jones

December, 1999

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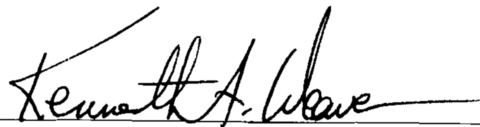

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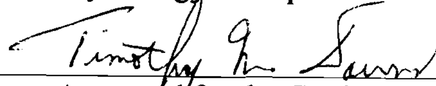

Approved for the Graduate Council

ACKNOWLEDGMENTS

My thanks go out to Dr. David Dungan, Dr. Kurt Baker, and Dr. Edmund Hansen for their guidance and support in this process. I would also like to say thank you to my wife who has had the patience to help me see this thesis through.

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CHAPTER 1

INTRODUCTION

Very early in the history of our field, explanations for psychological phenomena were given in religious terms. Demons and possession were once accepted explanations for someone's problems. Unfortunately, these explanations caused some of the people that were affected with these disorders to be persecuted and even killed in some of the more extreme cases. Today, psychology has certainly advanced far beyond those early interpretations of psychological problems. Still, there are some important questions that need to be answered in relation to our religious beliefs. Should religious beliefs be incorporated into therapy? Do therapeutic approaches that incorporate religiousness into therapy become valuable to the positive outcome of therapy? The answer to these two questions could be valuable in advancing our present therapeutic techniques.

Research in the area of religious counseling is not as abundant as many other areas of psychology. Most training programs for religious counselors seem to have little emphasis on research methods and design, therefore, these programs do not turn out a great deal of empirical data to reinforce their instructional method.

The purpose of this study is to examine preferences in choosing therapists when given the choice of religious or secular counselors. A general question that should be answered is which type of therapy, religious or non-religious, is most preferred. This is of importance because success in therapy very much depends on client attitudes and perceptions. Motivation to work in therapy should increase with personal preference for a therapist. More specifically, this research should outline some general preferences among different subgroups in choosing a therapist. These subgroups will be represented by dividing participants based on a self-rated level of religiosity and also by the

participant's choice of therapist based on the topic of therapy.

With very little empirical research on the topic of religiously oriented counselors and their effectiveness, this study may prove useful in gaining new information that can be used in the critical evaluation of pastoral and religious counseling. It will allow for a better understanding of how religiousness plays a part in different goals of therapy. In academic psychology, new information gained about pastoral and religious counseling could be looked at and scrutinized in order to restructure future research and make applications to the therapeutic community at the present time. As already noted, empirical studies are not abundant in this particular area. Therefore, more research and much more energy should be involved in developing the field of research on pastoral or religious psychology.

Past research by Privette, Quakenbos, and Bundrick (1994) has shown that a higher level of religiosity, based on the frequency of church attendance, does increase the likelihood that a person will prefer a religious counselor for all types of problems. This study will examine this relationship by measuring faith development instead of religiosity. This faith development will be measured by self-report on the Fowler Religious Attitude Scale (Leak, Loucks & Bowlin, in press). The results of this scale will then be used to classify each participant into different groups.

Review of Literature

Past research on therapeugenic factors has been very abundant. From within therapy variables to client and therapist variables, much study has been conducted in this area. In a meta-analysis on perceived therapist credibility, Hoyt (1996) describes the focus of research in this area. He notes that the focus of studies has included reputational cues (i.e., evidence of training, title; expertness and experience), therapist characteristics

(i.e., age, weight, physical attractiveness, attire, and office decor), verbal cues (i.e., use of jargon, type of talk, and type of intervention), nonverbal cues (i.e., attentiveness, organization, amount of talk, posture, and eye contact), and client-therapist matching (i.e., same vs. different gender, same vs. different ethnicity, etc.). Very few of the variables mentioned above have been reflected in the literature on pastoral or religious counseling. Some of these topics are also related to the current study. Topics that will be reviewed are within therapy variables and psychotherapeutic orientation. Preferences for different therapists and religious counseling will also be discussed.

Within Therapy Variables

Some variables that have been examined in the therapeutic process are those that occur during the therapy session. In a study by Beutler, Cargo, and Lafferty (1989), these types of variables were examined by comparing therapist's variables between two groups of therapists: less effective vs. more effective. Beutler et al. (1989) pointed out that, "those variables that are specific to or are developed within a given treatment relationship are more potent in determining outcome than are global variables such as therapeutic orientation or demographic background that are developed independently of the therapy"(p. 76). These factors, including empathy during sessions and the personal motivation of the therapist, are especially important when looking at therapeutic relationships between a client and therapist in a religious counseling setting. Using trainees in a therapy program, Beutler et al. defined less effective therapists based on ratings that their patients had given them before and after the therapeutic process. Those therapists that had patients who rated themselves in less distress after therapy were placed in the more effective group, whereas those therapists that had patients who rated themselves in more distress after therapy were placed in the less effective group. What

they found was that the in-therapy variables predict effectiveness much better than extra-therapy variables such as orientation. They also found that less effective therapists perceived clients as being more involved and making more progress during therapy. These less effective therapists also seemed to place more value on salary and stimulation than the therapists in the more effective group. They were described by Beutler et al. as being more interested in "self-involvement rather than altruism" (1989, p. 79).

Another dimension of therapist competence that has been studied is the area of complementarity or patient-therapist matching. In 1992, Svartberg and Stiles pointed out that even if competence was achieved, the "relation of the therapist competence to patient outcome is uncertain"(p. 304). Defining complementarity as general interpersonal communication strategy, Svartberg et al. examined how well initial session competence and complementarity can predict patient change. Using seventy-nine participants who were assigned to therapists based on scheduling availability, they found that, "patient-therapist positive complementarity in early sessions predicted shorter term patient change both alone and over and above therapist competence"(p. 306). This study showed that therapist competence may not be as important as other factors such as empathy, communication style, or complementing personalities in therapeutic situations. In another study, which investigated matching certain client-therapist variables, Safran (1979) found that clients preferred therapists who were very nurturing and less critical. It was also found that clients who were "psychologically minded" were more preferred by the therapists involved in the study. In a study by Knight (1991), complementarity was looked at in relation to being able to predict clients' perceptions of therapists' attractiveness, but pre-therapy role preferences were found to be a factor.

Psychotherapeutic Orientation and Pastoral Counseling

Theoretical orientation is a definite factor in therapy outcome. The way in which problems are conceptualized can sometimes be the difference between a successful therapeutic experience and an unsuccessful one. Schroeder and Bloom (1979) looked at the effects of orientation upon therapy. In their research, they examined four theoretical orientations and found that participants' perceptions of credibility were definitely affected by which theoretical orientation they were presented with. Participants rated psychoanalytic orientation as the highest, followed by Gestalt, behavioral, and then client-centered.

In discussing differing theoretical orientations, pastoral counseling should be included. Based on traditional psychotherapeutic techniques and theories, pastoral counseling adds a dimension that sets it apart from the rest of the theories. In a paper entitled The Development and Practice of Pastoral Counseling, Young and Griffith (1989) discuss the history and current trends within this field. They make the argument that many religious topics come up in therapy that are not dealt with properly because of lack of training in that area. They indicate that, "a growing body of evidence suggests that secular mental health professionals lack an information base for interpreting religious ideas and beliefs"(p. 271). Young and Griffith also outline three levels at which pastoral counseling takes place. Religious counseling is the first of these levels. At this level the pastoral counselor, usually a pastor with no training in counseling, acts as an agent of change through God. The second level, pastoral mental health work, has some limited exposure to courses in mental health or counseling. At this level the counselor identifies difficulties in psychological functioning and spiritual growth. On the third level lies pastoral psychotherapy. On this level, the counselor acts very much like a

clinical psychologist or psychiatrist. The difference lies in that they stress values and view God as a main agent of change in the therapy (p. 273).

Giblin and Barz (1993) examined training programs of pastoral counseling. Using a 63 item questionnaire to assess the opinions of 26 program directors from different universities and seminaries about the adequacy of their particular programs in preparing students in pastoral counseling. Their results showed some interesting information about these programs. First, university programs were rated higher by their director than the seminaries were. This was especially true when it came to being prepared for licensure and using the DSM-III-R. Another important finding was that there were 16 of the 63 categories that did not rate above 5 on a 9 point Likert-like scale. This suggests that directors did not feel that many of their students were very prepared in these areas. These areas included, but were not limited to, preparedness to become a member of AAPC, training to do research, training in writing formal diagnostic reports, comprehension of the development of pastoral counseling, preparedness to make contributions to the literature, and training in use of personality tests (pp. 14-15). These should be areas of competence for all counselors. Giblin and Barz also found three flaws in these training programs. First, they concluded that there is a serious lack of empirical research within these training programs. Second, they found there is not much research in the area of cross-cultural training. Lastly, they found that the history of pastoral counseling is not being taught in depth. These findings suggest that this field may be seriously hindering its own development by not validating itself with any of the strengths of psychology and science. Giblin and Barz also pointed out that their study looked more at clinical competencies rather than theological concerns, and that future research should focus more on specifics of pastoral counseling (p. 20).

In 1985, Quackenbos, Privette, and Klentz reviewed pastoral counseling and looked at it from the general view of it being religious counseling. They compared religious counseling to non-religious counseling in an attempt to determine the strength of religious values in counseling and to find if there were preferences for either religious or non-religious counseling for differing problems. They developed a scale to measure participants' opinions about secular and religious counseling in Pensacola, Florida. They found that people generally preferred religious counseling over secular but noted that the geographical area that the study took place in did not offer different types of religious counseling.

Privette, Quackenbos, and Bundrick (1994) recreated this study in a different location to see if the results that were obtained in 1985 were influenced by a geographic bias towards religion. The earlier study took place in Pensacola, Florida, whereas this 1994 study took place in Appleton, Wisconsin. They found that 57% of their sample felt that both religious and non-religious were equally effective (p. 542). However, 93% of the participants felt that pastoral counseling should be available, and 81% said that religion was an important aspect of the therapeutic process. There were also definite trends in reasons people would seek out a religious counselor as opposed to non-religious counselor. Their data showed that a majority of people would rather go to a religious counselor for marriage and family problems than to a non-religious counselor. There was an equal preference for the two when it came to depression, but in cases of severe mental problems, schizophrenia, weight problems, nervousness, and alcohol and drug abuse, the preference was clearly for non-religious counselors. Another variable at which Privette et al, looked was church attendance. Those people who rated themselves as high frequency attenders were much more likely to seek a religious counselor. The results of this study

were similar to those found by Quackenbos, Privette, and Klentz in 1985. Geographic region was not a factor in the overall effect.

As a part of the research, the faith development of the participants were measured. The participants were classified accordingly. To measure their faith development, a faith development scale based on the work of James W. Fowler was used. Fowler (1981) outlined six distinct stages along which all adults should lie. After moving through infancy and undifferentiated faith, Fowler suggested that we move into the first stage of faith development. This stage, called Intuitive-Projective Faith, is characterized by "the fantasy-filled, imitative phase in which the child can be powerfully and permanently influenced by examples, moods, actions and stories of the visible faith of primarily related adults" (p. 133). Stage two, which is called Mythic-Literal Faith, is characterized by the person beginning to take on the stories and beliefs of his or her community to be the beliefs for his or herself. These stories start to give meaning and coherence to the person's life (p. 149). Stage three is Synthetic-Conventional Faith. This third stage is defined as the person forms a personal myth, which incorporates one's past and anticipated future (p. 173). The fourth stage is called Individuative-Reflective Faith. During this stage, the person makes a critical move from creating beliefs and attitudes to taking full responsibility for those beliefs and attitudes. The next stage is Conjunctive Faith, which is achieved after a person examines his or her inner self. An appreciation of other people's beliefs is also gained during this stage. The sixth, and final, stage is characterized by "leaning into the future of God for all beings" (p. 211). It is an immersement in the religious beliefs held and the feeling of community and altruism that defines this stage.

The effect of religiosity on the relationship of client and therapist has been

studied in a variety of ways. In 1992, Moore studied the effects of a counselor's religious identification, the degree of Christian emphasis used by the counselor in the counseling situation, and the level of religiosity of the participant on the rating of the counselors' credibility. What this study found was that if a counselor was presented as religious and placed emphasis on religion during therapy, there was a significant increase in the ratings of that therapist. Hillowe (1985) found that as the religious beliefs of the therapists increased, their estimation of the number of therapy sessions needed decreased. He also found, however, that therapists in general feel that religious clients' require more therapy and that therapists prefer to work with non-religious clients.

Summary

The field of religious counseling is one that has taken on much more responsibility in the last decade in the counseling profession. Moving from churches to counseling centers these counselors can and do function as licensed psychotherapists working with paying clients. Factors that would effect the choice of a religious counselor over the more traditional psychotherapist need to be considered in order to see the full potential of pastoral or religious counseling in our mental health profession. Variables such as age, ethnicity, attire, therapeutic orientation, perceptions of clients, perceptions of therapists competency, motivation for counseling, attractiveness, and title have all been major concerns of prior research in this area.

Religious counselors bring religious issues to the forefront in therapeutic situations. Does this action benefit the clients involved? To study this question, we must better understand the motivations of the clients seeking out religious counseling for guidance and we must also understand the motivations and competencies of the religious counselor.

Research Questions:

Based on past research, the following questions were developed:

Research Question 1: Can a person's level of faith development be used to predict a better match between client and therapist for different topics of therapy?

Research Question 2: Is there any difference in the preference for a type of therapist, religious or non-religious, based on gender?

Hypotheses:

The present study investigated the following hypotheses:

Hypothesis 1: The first hypothesis was that the overall preference for therapists would be significantly higher for religious counselors than the preference for non-religious counselors.

Hypothesis 2: It was expected that people with higher faith development would choose a religious counselor over a secular counselor for each of the four therapy topics of therapy that were examined. The four topics that were examined were marriage and family problems, depression and anxiety problems, alcohol and drug problems, and severe mental illness.

Hypothesis 3: Lastly, gender was hypothesized to be equal in its effects upon the choice of a religious or non-religious counselor.

CHAPTER 2

METHODS

Participants

There were 174 participants in this study. One hundred twenty-eight of these participants were volunteers who received research credit for their participation. The remaining 46 participants were volunteers solicited from a dormitory lobby on the Campus of Emporia State University. This selection method was used because the original method did not elicit enough participation from men. All participants signed the informed consent document before data was collected from them. Twenty-three out of the total number participants scored a 4 on the Fowler Religious Attitudes Scale and were not used in the analysis. This was done to set a clear difference between those categorized as low and high in faith development. A score of 4 on the Fowler Religious Attitudes Scale represented the median score. This meant that 151 participants were used in the final analyses. Eighty-two of these participants were female, while there were 69 males. Ages ranged from 17 to 48, with an average age of 19.72. This was the age group which this research intended to study.

Demographic information gathered from items 3-6 on the Counselor Preference Survey is summarized in Table 1. Over seventy-four percent of the participants reported attending a church or temple either once a week or on holidays. Also, 58.9% of the participants reported being moderately religious. The ethnicity of the participants reflected that of the Emporia State University. Lastly, the majority of participants reported that they would prefer a non-religious counselor.

Design

To study the topic of preferences for therapists based on the level of religious development and topic of therapy, a quasi-experimental design was used. Participants were grouped according to their level of religious development as rated by the Fowler Religious Attitudes Scale (FRAS; Leak et al., in press), and their preferences rated using the Counselor Preference Survey. Surveys from participants who scored a 4 on the Fowler Religious Attitudes Scale were not used in the analysis in order to clearly separate the low and high faith developed groups.

Three independent variables were used in this study. The first independent variable was faith development. This variable had two levels. The first level was low faith development, which reflected a score of 0 to 3 on the Fowler Religious Attitudes Scale. The second level was high faith development, which reflected a score of 5 to 8 on the same scale. The second independent variable was the repeated measures variable. This second variable had four treatment levels. The first level of this variable was marriage and family counseling. The second level was drug and alcohol counseling. The third level was anxiety and depression counseling. The fourth level was severe mental illness counseling. The third independent variable was gender.

The dependent variable examined in this study was the preference level for religious counseling. This was measured by items 7 through 10 on the Counselor Preference Survey. Responses for items 7 through 10 on the Counselor Preference Survey ranged between 1 and 7 for each item.

Instruments

There were two separate instruments in this study. The first instrument that was used was the Fowler Religious Attitudes Scale (Leak et al., in press), which is based on

James W. Fowler's book entitled Stages of Faith (1981). In this book, Fowler outlined six different stages of development of one's faith. The scale is a paper and pencil measure on which participants must chose between one of two responses. One of the responses is reflective of a more religiously developed person. This instrument has shown acceptable internal consistency (coefficient alpha = .71; Leak et al., in press). Test-retest reliability has been shown to be $r = .96$, $p < .01$. Peer ratings of participants also correlated well as the average across peers was $r = .55$. Content validity was checked by a panel of professionals in the psychology of religion field and the items were found to measure the content found in Fowler's stages of faith. This scale is found in Appendix A.

The second instrument that was used was the Counselor Preference Survey. This questionnaire was developed specifically for this research. This instrument surveyed the participant's preference for religious or non-religious counselors for different topics of therapy. The topics of therapy that were covered by this questionnaire were broad ones. They were severe mental illness, depression and anxiety, marriage and family problems, and drug and alcohol addictions. It also contained demographic questions to help describe the sample. These questions surveyed age, gender, frequency of church attendance, self-reported religiousness, ethnicity, and an overall choice of therapist. This survey can be found in Appendix B.

Procedures

Participants were sampled using two different methods. First, volunteers were taken from introductory psychology classes. These students were surveyed during scheduled testing sessions. These sessions began by asking everyone in attendance to sign in on provided sign in sheets. Next, the participants were asked to read and sign the informed consent form for this study. This form can be found in Appendix C. Each

participant was then asked to complete the FRAS and return it to the experimenter. The participants were then asked to complete the Counselor Preference Survey. When they had completed the survey they were given their class credit and allowed to leave the testing session.

The scheduled testing sessions failed to gather enough data from male participants. To help gain more data from this group, a table was set up in the campus dormitory where the experimenter asked for volunteers. This method of participant recruiting enabled the experimenter to gain a more even number of male and female participants. The participants obtained from this method of participant recruiting were asked to complete the forms in the same order as in the scheduled testing sessions. After these forms were completed, these participants were told that any questions would be answered and that they were free to leave.

CHAPTER 3

RESULTS

Three analyses were performed on the data. First, the responses on item 6 on the Counselor Preference Survey were totaled to test the first hypothesis. Second, a repeated measures three-way analysis of variance (ANOVA) was performed on the data to test Hypotheses 2 and 3. This set of hypotheses included gender as an independent variable. The third analysis was performed as a repeated measures two-way ANOVA, which excluded gender as a factor. This third analysis was performed because gender had no effect on the outcome of the second analysis, and the results of a smaller two-way ANOVA would show the interaction of the other two variables more clearly.

Statistical Design

A 2 x 4 x 2 repeated measures ANOVA was used to test for significance between the choice of religious or secular counselors based on the level of faith development and the topic of therapy. The first independent variable had two levels. People who were high in faith development were designated as anyone scoring from 5 to 8 on the Fowler Religious Attitudes Scale. People of lower faith development were designated as those who score 0 to 3 on this scale. A score of 4 on this scale excluded a participant's data from the study so that a clear division of the lower and higher faith developed groups would be established. Topic of therapy was the variable that mandated the repeated measures design. The four levels of this variable were marriage and family, alcohol and drug addiction problems, depression and anxiety problems, and severe mental illness. The third independent variable was gender. The dependent variable was the score for the desired religiousness of the counselor, which was found on items 7 through 10 on the

Counselor Preference Survey. The data from these items were entered into the ANOVA. For all statistical tests, an alpha level of .05 was used.

Test for Hypothesis 1

In order to investigate the first hypothesis, the percentage of participants who chose a non-religious counselor (psychologist, psychiatrist, or social worker) was compared to the percentage of those who chose a religious counselor (pastoral counselor, priest or minister, or clergy member). This information was found in item 6 on the Counselor Preference Survey. A significant difference in preference existed as 68.9% of the participants reported that they would prefer a non-religious counselor. This data can be found in table 1.

Tests for Hypotheses 2 and 3

The first analysis that was performed for Hypotheses 2 and 3 was a repeated measures three-way ANOVA on gender, level of faith development, and topic of therapy. The data were entered into SPSS and analyzed. In the test of between-subjects effects, the effect of gender was not significant, $F(1, 147) < .00$, $p = .99$. The level of faith development was significant, $F(1, 147) = 15.46$, $p < .001$. The observed power for faith development was .97. The interaction of gender and faith development was not significant, $F(1, 147) = .11$, $p = .75$.

When testing the within-subject effect, topic of therapy was a significant factor, $F(3, 441) = 43.40$, $p < .001$. Likewise, the interaction of faith development and topic of therapy was significant, $F(3, 441) = 2.67$, $p = .05$. The interaction of gender and topic of therapy was not significant, $F(3, 441) = 1.50$, $p = .21$. The three-way interaction of gender, faith development, and topic of therapy was not significant either, $F(3, 441) =$

Table 1

Demographic Information from Counselor Preference Survey Items 3-6

	% of participants	n
Reported Frequency of Church Attendance		
More than once a week	9.3%	14
Once a week	43.7%	66
Holidays	30.5%	46
Never	16.6%	25
Reported Religiousness		
Very	7.9%	12
Moderate	58.9%	89
Mild	25.2%	38
Non	7.3%	11
Anti	.7%	1
Reported Ethnicity		
American Indian	1.3%	2
Hispanic	4.6%	7
Caucasian	82.8%	125
African American	5.3%	8
Asian	2.0%	3
Other	4.0%	6
Reported overall choice of therapist		
Non-religious (Psychologist, Psychiatrist, Social Worker)	68.9%	104
Religious (Pastoral Counselor, Priest or Minister, Clergy)	31.1%	47

.69, $p = .56$.

Since gender had no significance and the effect of the other two variables was suspected to be stronger when gender was removed, a second analysis was performed on the data excluding gender as a variable. Means and standard deviations for this second analysis can be found in Table 2. In this second analysis, faith development was found to be significant when testing between-subjects effects, $F(1, 149) = 16.15$, $p < .001$. Power for this test was substantial at .98. The test for within-subjects effects found that topic of therapy was significant, $F(3, 447) = 46.13$, $p < .001$. The interaction of faith development and topic of therapy was also significant with $F(3, 447) = 3.29$ and $p = .02$.

One of the assumptions made in a repeated measures analysis is that sphericity is met. This means that the variances for all pairs of repeated measures need to be equal. This assumption defines an additional class of situations where the univariate approach is valid. The sphericity requirement was met in this study with a Greenhouse-Geisser Epsilon of .89.

The treatment groups in this second analysis did differ significantly from one another. As a result of this, post hoc analysis was necessary so that the true differences between the treatment groups could be identified. The Tukey-Kramer procedure was used for this purpose. Significance, in this procedure, was based on the confidence intervals found by the procedure. For a treatment group to be significant, the confidence interval comparing the groups had to include zero as a value. Results of this follow-up procedure are summarized by subscripts in Table 2.

Table 2

Means and Standard Deviations for Analysis 2 Based on Topic of Therapy

Treatment Groups	M	SD	N
Marriage and Family Counseling			
Low FRAS	5.29	1.38	82
High FRAS	$4.01_{a, b}$	1.69	69
Drug and Alcohol Counseling			
Low FRAS	$4.29_{b, c}$	1.69	82
High FRAS	3.75_{a}	1.63	69
Depression and Anxiety Counseling			
Low FRAS	4.67_{c}	1.50	82
High FRAS	3.74_{a}	1.59	69
Severe Mental Illness Counseling			
Low FRAS	3.51_{a}	1.75	82
High FRAS	2.86	1.67	69

Note. FRAS is the abbreviation for Fowler Religious Attitudes Scale. Scores were on a 7-point scale (1 = strongly disagree that he or she would choose a religious counselor, 7 = strongly agree that he or she would choose a religious counselor). Means with the same subscript did not significantly differ when compared using the Tukey-Kramer comparison. All means tested at $p < .05$.

CHAPTER 4

DISCUSSION

Hypothesis 1

The results indicated that there was a strong overall preference for non-religious counselors. Almost 69% of the participants chose a counselor of the non-religious type. This finding was contrary to what the Quackenbos, Privette, and Klentz (1985) study found. This previous study had shown that there was a general preference for religiously oriented counseling while the present study showed that there was a strong preference for non-religious counseling. The Quackenbos, Privette, and Klentz study was replicated in 1994 and was done in a different geographic location in order to see if the result from the 1985 study were biased by this factor. They found no difference between preferences in the two geographic regions.

Hypothesis 2 and 3

The hypothesis that a higher faith developed person would choose a more religiously oriented counselor was not supported. In fact, the general trend was that the lower faith developed groups tended to prefer religious counselors more than the higher faith developed groups for all topics of therapy. When examining the differences between each of the treatment groups, only two of the groups differed significantly from all other groups. For the marriage and family topic, the low faith developed group significantly preferred religious counseling more strongly than did all other groups. On the other end of things, the high faith developed group for severe mental illness showed significantly less preference for religious counseling than all other groups.

These results show that there were differences in the preferences that people have based on whether or not they were high or low in faith development. For the marriage

and family, depression and anxiety, and severe mental illness topics, the low faith developed group preferred a religious counselor more than did the groups in those treatments that were high in faith development. This finding is contradictory to the hypothesis in question. What was hypothesized was that the higher faith developed group would prefer a more religious counselor more than the lower faith developed group.

The 1994 study done by Privette, Quackenbos, and Bundrick showed that there was a preference for religious counseling for marriage and family problems. The present study also supports this as the strongest preference was found for religious counseling when the topic of therapy was marriage and family counseling. Also, the Privette et al. (1994) study found a preference for non-religious counseling for the treatment of severe mental illness. The present study also supported this finding as the lowest preference for religious counseling was found in the results for the severe mental illness topic.

This contradiction between these similar studies may be understood by examining the instruments used to investigate the religiosity and faith development and by the concepts behind them. First, the study by Privette et al. (1994) defined the religiousness of a person as the frequency of church attendance. The more a person went to church, the more religious that person was in terms of classification for the study. In the present study, faith development was measured using the Fowler Religious Attitudes Scale. This scale was based on a philosophical idea of what people who are highly developed in faith would be like. A large part of what this scale seemed to measure was a sort of sophistication of belief, and not necessarily religiousness as it has been measured in other scales. This sophistication was measured by the participant answering questions that examined the independence of personal beliefs. The person either answered that part of their belief system was based on faith (a faith handed down by parents, friends,

established religions, etc.) or that it was based on an independent formulation of moralistic guidelines. This scale does measure faith development in terms of James W. Fowler's work, but it is not a true substitute for religiosity measures.

The third hypothesis that there should be no significant difference in counselor preference between genders was a hypothesis formulated due to the lack of this factor being examined in earlier studies. Studies dealing with religiosity and preferences do not usually do very much to test for gender differences. This study included it to document results so that future research can be planned while knowing the effects, or lack of effects, of gender. This hypothesis was strongly supported by showing no statistical difference between the two groups.

Limitations

This study had a few limitations that may have impacted the findings. First, the Fowler Religious Attitudes Scale was standardized as a continuous scale measuring the degree of faith development. In this study it was used to classify participants as either low or high in faith development by designating a division at the score of 4, which used it in a way in which it was not tested during the standardization process. A second limitation would be that the subject pool was made up entirely of college students. College students are taught to be scientific in thought and trust in what the sciences produce. Psychology would be the more scientific of the religious or non-religious counselors. Also, the volunteers from psychology classes may be biased towards psychologists from the recent exposure to psychology. Having a subject pool of college educated, high school educated, and high school drop out may be of value in future research. In fact, including G.P.A. or I.Q. test scores as reported data for each participant may provide much more insight into the question of how one's faith development can be used to aid in counseling.

Another limitation was that the sample used for this study was a very homogenous one. A vast majority of the participants were classified as being around the moderately religious designation. The result may have differed if the sample had more participants in the extremities of this classification.

Finally, the biggest limitation this study had was that the measure of faith development does not measure religiousness in pure form. What it does measure is the conformity of each participant to the faith development theory conceptualized by James W. Fowler. Other studies have used many other methods of measuring religiousness, and the Fowler Religious Attitudes Scale should not be mistaken for this type of measurement. However, it may be a measure that helps better match clients with the best counselor.

Conclusion

Although counter to the hypothesis, the finding that higher faith developed people prefer a less religious counselor may be understood by looking at socialization and degree of education. As a person in our society begins college, personal beliefs and independent thinking become more prominent than in the sheltered life of secondary school. This time of life is a time of belief formulation and the growth of ideas. This trend probably does carry over into the religious beliefs formed earlier in life and the students start to become more independent in their religious belief. This growth coincides with Fowler's later stages of faith and so faith development would be rated as high. However, our education system also emphasizes a strong belief in the sciences on which it is based. This strong belief in the sciences supports the decision of an independent thinker living in our higher education system to choose the sciences over faith beliefs. Thus, non-religious counselors would be preferred over religious counselors in this arena.

An interesting endeavor would be to survey both less and more educated people. This may lead to a more equal preference for a religious therapist. Age, years of formal education, and intelligence level could also be examined to add more control to future study in this area.

Other questions were raised by this research: Which is the best measurement for client-therapist matching on religious issues, religiosity or faith development? They each show different trends. Religiosity studies have shown that the higher the religiosity, the more likely that person will prefer a religious oriented counselor. The current study on faith development, however, seems to indicate that higher faith developed individuals will prefer a less religious oriented counselor.

This study raised several important questions. First, is religious counseling really needed? The results of this study indicated that only one of the four topics, marriage and family, show a significant preference for religious counseling. All of the other means are either around a score of 4, which is a neutral response, or lower. Second, is religiosity a measure of one's religious strength or that person's tendency to present as being a good person? Likewise, is faith development a measure of sophistication of thinking or a measure of one's strength of faith? The search for perfect client-therapist matching will possibly go on forever. However, this quest must be carried out for the improvement of treatments regardless of orientation. The better the treatment can get, the more likely it will help or even heal the client.

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APPENDICES

Appendix A

ID Code: ____________ Gender:______ Age:______

FOWLER RELIGIOUS ATTITUDES SCALE

This survey asks you to choose between two different ways of looking at religious issues. For items 1 through 8, both of the choices available may seem valid to you, or both may seem inadequate; however, it is important that you select the one of the two options that comes the closest to reflecting how you feel about the religious issue involved. If you think option "A" best reflects your viewpoint, circle "A"; if "B" is best, circle "B" for that particular item.

1. A. I believe totally (or almost totally) the teachings of my church.
   B. I find myself disagreeing with my church over numerous aspects of my faith.

2. A. I believe that my church offers full insight into what God wants for us and how we should worship him.
   B. I believe that my church has much to offer, but that other religions can also many religious insights.

3. A. It is very important for me to critically examine my religious beliefs and values.
   B. It is very important for me to accept the religious beliefs and values of my church.

4. A. My religious orientation comes primarily from my own efforts to analyze and understand God.
   B. My religious orientation comes from the teachings of my family and church.

5. A. It does not bother me to become exposed to other religions.
   B. I don't find value in becoming exposed to other religions.

6. A. My personal religious growth has occasionally required me to come into conflict with my family or friends.
   B. My personal religious growth has not required me to come into conflict with my family or friends.

7. A. It is very important that my faith is highly compatible with or similar to the faith of my family.
   B. It isn't essential that my faith be highly compatible with the faith of my family.

8. A. The religious traditions and beliefs I grew up with are very important to me and do not need changing.
   B. The religious traditions and beliefs I grew up with have become less and less relevant to my current religious orientation.

Appendix B

Counselor Preference Survey

INSTRUCTIONS: The following questions are intended to gather information about religiousness and psychotherapy. Please read each statement carefully and then circle or check each appropriately.

1. What is your age? _______

2. Gender: Male ___ Female ___

3. How often do you attend church? More than once a week ___ Weekly ___ Holidays ___ Never ___

4. I am: Very Religious ___ Moderately Religious ___ Mildly Religious ___ Non-religious ___ Anti-religious ___

5. What is your ethnicity? American Indian ___ Hispanic ___ Caucasion ___ African American ___ Asian ___ Other ___

6. If you were to seek therapy, you would go to a: (check choice)

___ Psychologist ___ Psychiatrist ___ Social worker
___ Pastoral counselor ___ Priest or Minister ___ Clergy member

On the following items: SD=Strongly Disagree, D=Disagree, A=Agree, and SA=Strongly Agree

7. I would choose a religious oriented counselor for Marriage and Family Problems:

1----------------2----------------3----------------4----------------5----------------6----------------7
SD D A SA

8. I would choose a religious oriented counselor for Drug and Alcohol Addictions:

1----------------2----------------3----------------4----------------5----------------6----------------7
SD D A SA

9. I would choose a religious oriented counselor for Depression and Anxiety Problems:

1----------------2----------------3----------------4----------------5----------------6----------------7
SD D A SA

10. I would choose a religious oriented counselor for Severe Mental Illness (such as schizophrenia):

1----------------2----------------3----------------4----------------5----------------6----------------7
SD D A SA

Appendix C

Informed Consent Document

Read this consent form. If you have any questions, ask the experimenter and s/he will answer the question.

You are invited to participate in a study investigating preferences for therapists based on whether or not the therapist is religious or not. You will be asked to complete two short questionnaires during this session.

Information obtained from the completed forms will only be identified by a code #. Your name will only be used to indicate that you participated in this study so that you can receive credit for participating in research. Credit will be given to those who complete both forms.

Your participation in this study is completely voluntary. Should you wish to terminate your participation, you are welcome to do so at any point during the session. Termination of participation will have no bearing on your class standing. There is no risk or discomfort involved in completing this study.

If you have any question comments about this study, feel free to ask the experimenter. If you have any additional questions, please contact Jason Jones, Division of Psychology and Special Education, 342-5056.

Thank you for your participation.

I,______________________________ , have read the above information and have decided to participate. I understand that my participation is voluntary and that I may withdraw at any time without prejudice after signing this form should I choose to discontinue participation in this study.

______________________________ ______________

(signature of Participant) (Date)

____

(signature of Experimenter)

THIS PROJECT HAS BEEN REVIEWED BY THE EMPORIA STATE UNIVERSITY COMMITTEE FOR THE PROTECTION OF HUMAN PARTICIPANTS

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Signature of Author

12-13-99

Date

The Choice of Religious or Secular Counselors Based on Faith Development and Topic of Therapy

Title of Thesis

Doug Cooper

Signature of Graduate Office Staff Member

December 16, 1999

Date Received