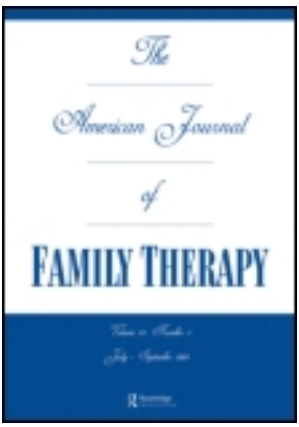

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The Effects of Religiosity on Preferences and Expectations for Marital Therapy Among Married Christians

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Highly religious couples constitute a substantial portion of marital therapy clients in the U.S. Married Christian individuals (N = 211) completed a survey of demographics and religiosity (religious values and Christian beliefs). They rated preferences and expectations for one of four marital therapy situations: Christian therapist using Christian practices (e.g., prayer or reference to Scripture), Christian therapist using psychological practices only, non-Christian therapist willing to use Christian practices, and non-Christian therapist using psychological practices only. High religious values and high Christian beliefs predicted ratings of marital therapy situations, where high was defined as one standard deviation above the mean of standardized norm groups. Low to moderate religious values or Christian beliefs did not predict ratings of marital therapy. It was concluded that highly religious couples present a special situation where the marketing, assessment, and practice of marital therapy might differ from therapy with other types of couples.

In this postmodern society, multicultural sensitivity to values and preferences of significant population groups is necessary for clinicians (Richards & Bergin, 1997; Shafranske, 1996). The U.S. is religiously diverse, including many people who adhere to no particular religion (Barrett, 1996). Researchers and clinicians must understand the influence of religion in shaping clients' preferences. Worthington, Kurusu, McCullough, and Sandage (1996) reviewed the status of religion in individual therapy and found that there has

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been considerable progress in understanding the role of religion and individual therapy during the last 10 years. Many highly religious people see the world through their religious worldview. Although many highly religious couples also seek therapy from secular therapists, many seek explicitly religious therapists—either clergy or religious mental health practitioners—when they have psychological problems. As a result of the religious worldview of both religious clients and religious therapists, religiously based therapies have developed, particularly in the Christian, Jewish, and Muslim traditions (see Thoresen, Worthington, Swyers, Larson, McCullough, & Miller, 1998).

Research has investigated the preferences and expectations that religious individuals have for individual therapy—whether they would prefer to meet with a similarly religious therapist and how they would like their religion handled in either secular or religious therapy (for a review, see Worthington, et al., 1996). Worthington et al.'s review indicates that those religious people who are highly committed to their religiosity tend to prefer to meet with a similarly religious therapist, rate therapists more favorably if they are labeled as religious, and might use religion as a litmus test for their reaction to therapy. However, results have varied depending largely on the way religiosity has been measured (Worthington et al., 1996).

Religiously based treatment has extended into marital therapy. In fact, in the U.S., religious marital counseling through churches and synagogues was widely practiced before the mental health community offered widespread couple therapy (Broderick & Schrader, 1981). Currently, religiously based marital interventions—largely drawing from the Christian tradition—are common. They are recognizable by their explicitly religious therapists, integration of religious interventions such as prayer into treatment, and matching of religious interventions to clients who share the religious values, beliefs, and behaviors on which the interventions are based.

Religious people differ substantially within their religion as a function of religious beliefs (e.g., theologically conservative or liberal) and values (e.g., high versus moderate or low value placed on religion). Measures of religious beliefs assess religiosity based on an individual's agreement with orthodox religious propositional statements. Religious values are superordinate organizing statements of what one considers important in life (Rokeach, 1968). Highly religious persons are considered to be those rating their religiosity as very valuable, engaging in religious behaviors often, and tending to have well-defined religious beliefs.

The value placed on one's religion has been particularly useful in predicting client responses to individual therapy and potential clients' expectations and preferences for individual therapy. Worthington et al. (1988) hypothesize that those who value their religion highly would react differently in therapy than would those who placed moderate-to-low value on religion. Specifically, it is hypothesized that highly religiously committed people would prefer

(a) therapists whose values were similar to their own,
(b) therapists who employed explicitly religious interventions characteristic of the clients' religion,
(c) form faster and stronger working alliances with such therapists,
(d) are less likely to drop out of therapy with such therapists, and
(e) expect better outcomes from such therapists, and relative to clients whose religious values were moderate or lower.

Highly religious clients were hypothesized to have a perceptual screen that sensitized them to be likely to perceive the world according to religious categories; whereas, people with no, low, or moderate religious values might respond to religious stimuli but would rarely perceive secular stimuli in religious terms. In a variety of tests by several investigators, some of those hypotheses have been supported (for a review of the research, see Worthington et al., 1996). Alternatively, religious beliefs (as opposed to religious values) have not always been found to predict preferences for therapy (Keating & Fretz, 1990; McCullough & Worthington, 1995; McCullough, Worthington, Maxie, & Rachal, 1997; Morrow, Worthington, & McCullough, 1993).

People who prefer religious therapy consonant with their own beliefs, values, or practices might differ according to what they would actually consider appropriate religious therapy. For example, some people might be content to receive therapy from a therapist whom they know to share their religious beliefs or practices. Others might prefer to have explicitly religious techniques (e.g., prayers, religious homework, Scriptural integration) employed in therapy.

The research that has investigated the match between client and therapist religiosity has typically used a therapist label (e.g., "Christian therapist" versus "not a Christian therapist") or a description or other external stimuli (i.e., displaying a crucifix or wearing a yarmulke) as the index of therapist religiosity. While several studies have found that explicitly religious therapists frequently use explicitly religious interventions (e.g., Ball & Goodyear, 1991; Worthington, Dupont, Berry, & Duncan, 1988), studies have not investigated perceptions by potential *clients* of the use of religious interventions by either similarly religious therapists or therapists dissimilar to the potential clients' religion.

Most research on explicitly religious clients has investigated Christians—probably because of the size of that subpopulation within the U.S. First, most people in the U.S. describe themselves as Christian (Barrett, 1996; Gallup, 1981). Second, most therapists who describe themselves as religious are Christian (Shafranske & Maloney, 1990). Third, many Christian clients request (or demand) therapy from therapists who profess Christianity—whether the therapist has an explicitly Christian or secular practice. Christians as a group seem to value the permanency of marriage more than do many other subgroups (Thornton, Axinn, & Hill, 1992), so the preference for explicitly

"Christian marital therapy" with explicitly "Christian therapists" is particularly relevant. These factors have spawned

(a) large organizations such as the 17,000-member American Association of Christian Counselors (AACC)—over half of whom describe themselves as marital therapists,
(b) professional journals (e.g., *Marriage and Family: A Christian Journal*), and
(c) clearly articulated explicitly Christian interventions with marriages.

Worthington (1996) collected essays on eight approaches to Christian marital therapy. Other, nontherapy, intervention programs include Marriagebuilders (Harley, 1996), Saving Your Marriage Before It Starts (SYMBIS; Parrott & Parrott, 1996), Marriage Encounter (Silverman & Urbaniak, 1983), and Christian Prevention and Relationship Enhancement Program (Christian PREP; Stanley, Trathen, & McCain, 1996; Stanley, Trathen, McCain, & Bryan, 1998).

Research in marital therapy with couples professing to be Christians (or those professing any other religion) is virtually nonexistent (for reviews, see Ripley & Worthington, 1996, 1998). Studies have not investigated married Christians' preferences and expectations for marital therapy, should the need arise. Considering the widespread existence of Christian-based marital interventions, might some married Christians prefer to meet with an explicitly Christian marital therapist and might some prefer to have interventions drawn from Christian ecclesiastical practices integrated into marital therapy? If that is so, what distinguishes those who would prefer religious marital therapy from those without such preferences or from those who would prefer *not* to have a Christian-based marital therapy? In the present study, married Christian individuals' preferences for marital therapy and expectations of the effectiveness of marital therapy were investigated relative to the following conditions:

- Christian marital therapist or one who is not a Christian
- A marital therapist who is willing to use Christian techniques such as prayer and Scripture reading in treatment or one who uses standard psychological techniques only.

Based on previous research with individual therapy, it was expected that religious values, but not Christian beliefs, would predict ratings of the four situations of marital therapy (Keating & Fretz, 1990; McCullough & Worthington, 1995; McCullough et al., 1997; Morrow et al., 1993). Because marriage is highly valued by most Christians and many have strong beliefs about it, it is necessary to investigate responses of *married* Christians to explicitly Christian or secular marital therapy. The main hypothesis concerned the interaction between participant religiosity and rating of marital therapy situations.

METHOD

Design and Independent Variables

The study used a 2 × 2 × 2 (participant religiosity × religiosity of therapist × use of religious techniques) quasi-experimental design. Participants of higher and lower religiosity were randomly assigned to one of four conditions as described below (religiosity of therapist × use of religious technique).

PARTICIPANT RELIGIOSITY

Participants were divided into high versus low to moderate in their religiosity measured two ways: Christian beliefs and religious values. Participants who scored one standard deviation higher than the standardized mean based on the standardization statistics of the Shepherd Scale (Bassett, Camplin, Humphrey & Door, 1991) and the religious values scale (Worthington, Hight, et al., 1998) were considered high in Christian beliefs or religious values; all others were considered low-to-moderate in their Christian beliefs and religious values.

MARITAL THERAPY SITUATION

Participants read one of four descriptions of the conditions, supposing that they were to seek marital therapy. In each situation, the therapist was described as a male with considerable marital therapy experience, well-respected in the community, and married with two children. Each therapist was also described as someone who respected his clients' values and beliefs regarding religion. The description was then varied based on (a) the therapists' religiosity and (b) the use of religious techniques in therapy. Therapists' religiosity was indicated with a description as either a Christian who attends a local church or someone who does not believe in Christianity and does not attend church. To indicate the use of Christian techniques, the therapist was described as willing to use Christian practices such as prayer and Scripture reading in therapy or as using only standard psychological practices in therapy.

Measures

DEMOGRAPHIC INFORMATION

Demographic information was obtained as part of the assessment. Individuals reported their gender, age, race, educational attainment, and they completed a measure of marital adjustment. Marital adjustment was measured by the Dyadic Adjustment Scale (DAS, Spanier, 1976). The original study was conducted with 400 subjects from rural Pennsylvania. Factor analysis of the Dyadic Adjustment Scale using oblique rotation, with a loading of at least .30, found four factors: dyadic satisfaction, dyadic cohesion, dyadic consen-

sus, and affectional expression (Spanier, 1976). For the present study, only full-scale scores were used to measure marital adjustment because the subscales have not been found to be as reliable and valid as the entire scale (Cohen, 1985). Content, criterion-related, and construct validity were established by Spanier (1976). Total sample correlation with the Locke–Wallace Marital Adjustment Scale was .93. A total reliability score of alpha = .96 was established as well (Spanier, 1976). Subsequent tests of reliability, utilizing similar samples, have repeatedly supported Spanier's Dyadic Adjustment Scale to be an adequate measure of marital adjustment (Spanier & Filsinger, 1983). The Dyadic Adjustment Scale has been evaluated as a better measure of marital satisfaction than was the Locke–Wallace (1959) Marital Adjustment Scale (Cohen, 1985). A score of less than 100 on the DAS is considered to be clinically troubled.

RELIGIOSITY

Religiosity was measured in two ways. First, Christian beliefs were assessed using the Shepherd Scale (Bassett et al., 1981). The Shepherd Scale is a 38-item instrument, derived from Christian Scripture references, to survey subjects' traditional (theologically conservative) Christian beliefs and practices. The Shepherd Scale has produced a reasonable split-half reliability when corrected using the Spearman Brown procedure, $r = .91$ (Bassett et al., 1981). In addition, Bassett et al. (1981) reported good 3-week test-retest reliability, $r = .82$. Internal consistency was estimated by Cronbach's alpha at .86. In a subsequent study, Bassett et al. found that among participants who identified themselves as Christians, the mean score was 131, while non-Christians' mean score was 91 (standard deviation was 8.7). In studies with random sampling, distributions on religious beliefs and values tend to be bimodal more often than normal (Kelly & Strupp, 1992). For the present study, people categorized as having high Christian beliefs scored at least one standard deviation above the mean in the Christian standardized sample (Bassett et al., 1991).

Second, the construct of religious values was measured using the Religious Commitment Inventory-10 (RCI-10; Worthington et al., 1998). The RCI-10 is a 10-item nonsectarian measure of an individual's values regarding commitment to religiosity such as "religious beliefs influence all my dealings in life. The RCI-10 was found to have strong internal consistency (Cronbach's alpha = .94; Worthington et al., 1998), and 3-week test-retest stability (.87; Worthington et al., 1998). Construct and criterion validity were established against a variety of criteria. Confirmatory factor analyses on two university samples and one community sample supported a consistent factor structure (CFI = .90, .94; Worthington et al., 1998). A score of 42 was one standard deviation greater than the mean and was used as the score beyond which individuals would be classified as high in religious values (Worthington et al., 1998).

PREFERENCES AND EXPECTATIONS FOR MARITAL THERAPY DESCRIPTIONS

After participants read one of the descriptions of a marital therapy situation, they rated the following questions (a) "if you were to seek marital therapy how likely would you be to visit the therapist described in the vignette," and (b) "how effective do you believe the therapist would be in improving your marriage." Participants answered each question on a 7-point Likert-scale from "definitely would not" (1) to "definitely would" (7). These scales have been used in many previous research studies except for the modification to stipulate "marital therapy" rather than "therapy" (e.g., Dougherty & Worthington, 1982; Morrow et al., 1993; McCullough & Worthington, 1995; McCullough et al., 1997; Worthington & Gascoyne, 1985; Worthington & Scott, 1983). Although the different measures of religiosity are conceptually different, they are usually highly correlated.

Procedure

Participants were recruited from eight churches (n =162). Denominations included Episcopalian, Presbyterian, Baptist, Nondenominational, Assemblies of God, and Christian Missionary Alliance. Married Christian students from introductory psychology classes at a public university were also recruited (n = 49). The church population was used to ensure that the specific group of highly religious individuals sought for this study were obtained and to increase the ecological validity. University students were included to increase the generalizability. Participants were presented with the opportunity to participate with an in-person request and given packets of the questionnaires to return within 2 weeks. Each participant was assessed on all of the demographic, marital adjustment, and religiosity measures. Participants were randomly assigned one of the four marital therapy situations according to their packet of questionnaires (i.e., the combinations of the 2 × 2 design) which were randomly distributed.

RESULTS

Equivalency of Conditions

Demographic information by condition is reported in Table 1. In Table 2, the means and standard deviations are reported of preferences and expectations for marital therapy for people at each level of religiosity assigned to rate each marital therapy situation. Among this sample 86% (n = 181) had used resources to improve their marriage. Among these, 70% (n = 147) had read a book to improve their marriage, 64% (n = 135) had premarital counseling, 45% (n = 93) had attended a marital enrichment workshop or seminar, and 28% (n = 57) had attended marital counseling with a mean of 7.3 sessions.

Participants were randomly assigned to one of the four marital therapy situations; several analyses were conducted to insure the equivalency of the

TABLE 1. Distribution of participants with different demographic characteristics across different stimulus conditions

	Non-Christian Therapist		Christian Therapist	
	Psychological Techniques	Christian Techniques	Psychological Techniques	Christian Techniques
Gender (*n*)				
Male	21	23	22	20
Female	36	24	33	30
Education (*n*)				
Less than H.S.	0	1	2	0
High School	24	16	21	20
College	21	16	19	20
Graduate Degree	12	14	13	10
Race (*n*)				
African–American	9	6	7	8
Asian	0	3	3	2
Caucasian	40	45	35	46
Hispanic	0	1	0	0
Native American	0	0	1	1
Christian Beliefs (*n*)				
Low to Moderate	17	10	14	12
High	40	36	41	38
Religious Values (*n*)				
Low to Moderate	21	18	20	10
High	36	29	35	38

Note: Unequal *n* are due to missing data. For each condtion, Dyadic Adjustment Scale Score was as follows: For non-Christian therapist using psychological practices (M = 114.40, STD = 15.5); for non-Christian therapist willing to use Christian practices (M = 113.40, STD = 17.2); for Christian therapist using psychological techniques (M = 110.12, STD = 20.7); for Christian therapist using Christian techniques (M = 112.44, STD = 16.1). For each condition age mean was as follows: For non-Christian therapist using psychological practices (M = 39.9, STD = 11.30); for non-Christian therapist willing to use Christian practices (M = 39.44, STD = 13.49); for Christian therapist using psychological techniques (M = 39.94; STD = 13.17); for Christian therapist using Christian techniques (M = 41.82, STD = 11.95).

conditions. For categorical variables, Chi-square analyses were conducted, which found no differences (all $p < .05$) across conditions by gender, X^2 (1) = 1.67; education, X^2 (9) = 30.84; race/ethnicity, X^2 (1) = .54; or high versus moderate to low Christian beliefs, X^2 (1) = .81; high versus low to moderate religious values X^2 (1) = 4.44. For continuous variables, one-way (four marital therapy situations) analyses of variance (ANOVAs) were conducted on marital adjustment, F (3, 205) = .55, p = .65, and age, F (3, 205) = .40, p = .75. It was concluded that random assignment to the four conditions resulted in equivalency.

Preliminary Analyses

The intercorrelation was examined (see Table 3) and ANOVAs were conducted to determine whether any demographic variables or the marital ad-

TABLE 2. Means and standard deviation of dependent variables by conditions

	Non-Christian Therapist		Christian Therapist	
	Psychological Techniques	Christian Techniques	Psychological Techniques	Christian Techniques
Christian Beliefs				
Preferences for Description of Marital Therapy Situation				
High Christian Beliefs	1.88 (1.07)	4.33 (1.84)	5.48 (1.43)	5.71 (1.41)
Low-Moderate Christian Beliefs	3.41 (1.77)	3.70 (1.70)	3.64 (1.86)	4.42 (2.35)
Anticipated Efficacy of Descriptions of Marital Therapy Situations				
High Christian Beliefs	2.28 (.91)	3.92 (1.52)	5.00 (1.52)	4.97 (1.55)
Low-Moderate Christian Beliefs	3.47 (1.33)	4.00 (1.33)	3.64 (1.69)	3.92 (1.68)
Religious Values				
Preferences for Description of Marital Therapy Situation				
High Christian Beliefs	1.76 (.91)	5.00 (1.92)	5.41 (1.64)	5.86 (1.33)
Low-Moderate Christian Beliefs	2.93 (1.72)	3.62 (1.47)	4.52 (1.76)	4.65 (2.08)
Anticipated Efficacy of Descriptions of Marital Therapy Situations				
High Christian Beliefs	2.21 (.77)	4.48 (1.60)	5.07 (1.65)	5.11 (1.59)
Low-Moderate Christian Beliefs	3.07 (1.36)	3.54 (1.21)	4.16 (1.57)	4.00 (1.45)

Note: On a scale from 1 (not at all) to 7 (very).

justment variable were related to the dependent variables. None of these variables were related to the dependent variables.

The data was analyzed using four sets of 2 × 2 × 2 (participants' religiosity × therapist's religiosity × use of religious techniques) ANOVAs. In two sets of ANOVAs, religiosity was determined by Christian beliefs and, in the other two, by religious values. Each set of ANOVAs examined the preference for the therapist first and the expectations for the outcome of therapy second. This method yields four three-way interactions and eight relevant two-way interactions. To control for Type I error a modified Bonferroni of $p < .02$ is used as the criterion for significance (Keppel, 1991). The interactions of therapists' religiosity by use of religious technique and the main effects are irrelevant to the hypotheses and were not examined.

The Effects of Christian Beliefs on Ratings of Marital Therapy Descriptions

A 2 × 2 × 2 (participants' Christian beliefs {high, low-to-moderate} × therapists religiosity {Christian, non-Christian} × use of religious techniques {willing to use Christian practices, using psychological practices only}) between subjects ANOVA was performed on the two dependent variables associated with perception of the therapist: preference for and anticipated efficacy of the therapy situation.

TABLE 3. Intercorrelation matrix of variables

	1	2	3	4	5	6	7	8
1. Age								
2. Ethnicity	.11							
3. Subject Pool	–.40*	–.08						
4. Education	.07	–.17	–.26*					
5. Marital Adjustment	.08	–.03	.04	.07				
6. Religious Values	.29*	–.04	–.47*	.16	.18			
7. Religious Beliefs	.25*	.05	–.49*	.12	.15	.58*		
8. Preference	.01	–.01	–.10	–.01	.10	.17	.14	
9. Anticipated Efficacy	.05	.01	–.10	–.03	.02	.11	.08	.83*

*Denotes $P = < .001$ (significant after Bonferroni correction).

PREFERENCE FOR THERAPY DESCRIPTION

Contrary to expectations, there were significant interactions between participants' Christian beliefs, therapist's religiosity, and use of religious techniques for preference for therapy situation. The three-way interaction of participants' Christian beliefs by therapists' religiosity by use of religious technique was significant, $F(1, 199) = 7.01$, $p = .009$. Post-hoc Tukey tests for the three-way interaction (minimum pairwise difference) = 1.99) revealed that for those with high Christian beliefs there was a significant difference between the non-Christian using psychological practices only (mean = 1.88) and all other types of therapy descriptions (non-Christian willing to use Christian techniques = 4.33; Christian with psychological techniques only = 5.48; Christian with Christian techniques mean = 5.71). There were no significant post-hoc differences for those with low-to-moderate Christian beliefs.

The two-way interaction of participants' Christian beliefs by therapist's religiosity was also significant, $F(1, 199) = 15.52$, $p = < .000$. Post-hoc Tukey tests for the two-way interaction (minimum pairwise difference = 1.33) revealed that for those with high Christian beliefs there was a significant difference between the non-Christian therapist (mean = 3.12) and the Christian therapist (mean = 5.09). However, for those with low-to-moderate Christian beliefs there were no significant differences between the non-Christian therapist (mean = 3.26) and the Christian therapist (mean = 4.09). The two-way interaction of participants' Christian beliefs by the therapists' use of religious technique alone was not significant, $F(1, 199) = 2.88$, $p = .09$.

ANTICIPATED EFFICACY OF THERAPY DESCRIPTION

The three-way interaction of participants' Christian beliefs by therapists' religiosity by use of religious technique on anticipated efficacy of therapy was not significant, $F(1, 199) = 4.78$, $p = .13$. However, the two-way interaction of participants' Christian beliefs by therapist's religiosity was significant, $F(1, 199) = 16.08$, $p = < .001$. Post-hoc Tukey tests for the two-way interaction

(minimum pairwise difference = 1.22) revealed a significant difference for those with high Christian beliefs but not for those with low-to-moderate Christian beliefs. For those with high Christian beliefs, there was a significant difference between the non-Christian therapist (mean = 3.05) and the Christian therapist (mean = 5.59). However, for those with low-to-moderate Christian beliefs there were no significant differences between the non-Christian therapist (mean = 3.67) and the Christian therapist (4.00). The two-way interaction of participants' Christian beliefs by the therapist's use of religious technique was not significant, F (1, 199) = .78, p = . 38.

The Effects of Religious Values on Ratings of Marital Therapy Description

Similar 2 × 2 × 2 (participants' religious values {high, low to moderate} × therapists' religiosity {Christian, non-Christian} × use of religious techniques {willing to use Christian practices, use of psychological practices only}) between subjects ANOVAs were performed on the two dependent variables associated with perception of the therapist: preference for and anticipated efficacy of marital therapy.

PREFERENCE FOR THERAPY DESCRIPTION

As expected, there were significant interactions between participants' religious values, description of therapist's religiosity, and use of religious techniques for preference for therapy situation. The three-way interaction of participants' religious values by therapist's religiosity by use of religious technique was significant, F (1, 198) 6.16, p = .014. Post-hoc Tukey tests for the three-way interaction (minimum pairwise difference = 1.79) revealed that for those with high religious values there was a significant difference between the non-Christian using psychological practices only (mean = 1.76) and all other types of therapy descriptions (non-Christian willing to use psychological techniques = 5.50; Christian with psychological techniques = 5.41; Christian with Christian techniques = 5.86). There were no significant means differences for those with low-to-moderate religious values.

The two-way interaction of participants' religious values by therapist's religiosity was not significant, F (l, 198) = 4.36, p = .04. However the two-way interaction of participants' religiosity by therapist's use of religious technique was significant F(1, 198) = 10.08, p = .002. Post-hoc Tukey tests for the two-way interaction (minimum pairwise difference = 1.03) revealed that for those with high religious values, there was a significant difference between the descriptions with the use of psychological techniques (mean = 3.59) and use of Christian techniques (mean = 4.84). For those with low-to-moderate religious values, there were no significant differences between the descriptions with the use of psychological techniques (mean = 3.58) and use of Christian techniques

ANTICIPATED EFFICACY OF THERAPY DESCRIPTION

The three-way interaction of participants' religious values by description of therapists' religiosity by use of religious technique for the dependent variable anticipated efficacy of therapy was not significant, $F(1, 198) = 4.04$, $p = .05$. However both two-way interactions were significant. The two-way interaction of participants' religious values by therapists' religiosity was significant, $F(1, 198) = 5.93$, $p = .016$. Post-hoc Tukey tests for the two-way interaction (minimum pairwise difference = 1.30) revealed that for those with high religious values there was a significant difference between the non-Christian therapist (mean = 3.16) and the Christian therapist (mean = 5.63) for those with high Christian values. For those with low-to-moderate religious values, there were no significant differences between the non-Christian therapist (mean = 3.35) and the Christian therapist (mean = 4.58).

The two-way interaction of participants' religious values by use of religious technique was also significant, $F(1, 198) = 6.29$, $p = .013$. Post-hoc Tukey tests for the two-way interaction (minimum pairwise difference) = .95) revealed that for those with high religious values there was a significant difference between the use of psychological practices only (mean = 3.64) and the use of Christian techniques (mean = 5.49). Similar to the previous significant interactions, post-hoc Tukey tests for those with low-to-moderate religious values indicated that there were no significant differences between descriptions with the use of psychological techniques (mean = 3.68) and the use of Christian techniques (mean = 4.07).

DISCUSSION

Married Christian individuals' preferences for and anticipated effectiveness of marital therapy were examined relative to the perceived religiosity and behavioral preferences of therapists. Most of the participants were from community churches representing six denominations, but a minority were selected from married university students who rated themselves as Christian from numerous denominations. Findings inform marital therapists about two subgroups of potential clients (i.e., highly religious Christians and Christians who are of low-to-moderate religiosity).

Preferences and Expectations Stimulated by Descriptions of Marital Therapy

Some people have speculated that religious people might have some resistance to certain marital therapy contexts (see Worthington & Scott, 1983). This study found that therapist's religiosity and willingness to use religious techniques may influence whether highly religious couples would engage in therapy and anticipate positive outcomes of treatment.

As in previous research (Godwin & Crouch, 1989; Keating & Fretz, 1990; McCullough & Worthington, 1995; Morrow et al., 1993; Pecnik & Epperson, 1985; Worthington & Gascoyne, 1985; Worthington et al., 1988; cf. McCullough et al., 1997), Christians who were highly religious (one standard deviation from the mean of a Christian population) perceived therapy differently from Christians who were low-to-moderate in religiosity. In the present research, previous investigations were broadened to examine marital therapy. For the person of low-moderate religiosity, whether marital therapy was offered by a Christian or non-Christian therapist did not matter, which was consonant with research in individual therapy. Nor did the issue of whether a therapist was willing to use interventions in therapy that were derived from ecclesiastical practices, which has not previously been investigated. That is good news for most practitioners in general practice who see many Christian clients—even though the clients might not identify themselves as Christians.

On the other hand, highly religious Christians made substantial distinctions across marital therapy situations. They did not necessarily seek highly religious Christian therapists as much as they rejected a marital therapist who was religiously different and appeared uninterested in the client's religion. They did not strongly prefer a non-Christian therapist who was not willing to use Christian techniques—despite the assurance that the therapist respected the clients' religious values. If an avowed non-Christian therapist professed willingness to use some Christian interventions, that was enough to offset the potential clients' antipathy.

Worthington (1988) suggests that in Western traditions highly religious people tend to perceive the world through a perceptual lens colored by their religious values. Why would highly religious people make distinctions among therapists based on therapists' dissimilarity to their religious values? It has been hypothesized that many religious persons (and members of other minority groups; Watkins, Terrell, & Miller, 1989) distrust mainstream American culture, which they might fear is represented by secular therapists. Highly religious clients might, therefore, prefer to stay with their own cultural group when seeking marital therapy. This may be particularly true considering the general acceptance of divorce in mainstream culture. Highly religious Christians generally adhere to traditional marital values (Glenn & Supancic, 1984; Thornton, 1989) and may believe that secular therapists are more accepting of divorce. To date, no published research has directly investigated the role of trust in influencing expectations of therapy by religious individuals for either individual and couples treatments.

In addition, in the history of psychology there have been a number of psychologists who have been less than-favorable towards Christians (Ellis, 1992; Carroll, 1988). There are also issues within psychology that many Christians would find objectionable, such as issues around sexuality (Whitehead, 1996), child-rearing practices (Bromley & Cress, 1998), and the value of self-esteem over self-sacrifice (Bromley & Busching, 1988). Many Christians hear

of these psychologists and issues and conclude that psychologists are not supportive of Christians at best and anti-Christian at worst. The call for research by the American Psychological Association in religious issues as a part of multicultural understanding should begin to send a message to this population that Christians can seek therapy without fear that their faith will be ignored, ridiculed, or attacked. In fact, it's probable that most Christians would find their faith and values supported whether or not the therapist holds the same beliefs. However, this issue has not been fully explored in research and clinicians may differ on their approach to the issue.

How important are preferences and expectations? There is some evidence that despite differences in expectations of individual therapy between highly religious and less religious people, when people actually seek therapy, the highly religious and less religious do not respond differently (Beutler & Bergan, 1991). However, that finding is opposed by substantial research (see Worthington (1991) for a review). One important study by Propst, Ostrom, Watkins, Dean, and Mashburn (1992) suggests that religious matching is important to therapy outcome. No research has investigated matching religious or nonreligious marital therapy with similarly religious couples or partners.

Apart from outcomes, preferences for and expectations of the efficacy of therapy are likely to have strong effects on whether potential clients ever set up an appointment or keep the initial appointment with a therapist. Many moderately or nonreligious therapists might have few interactions with highly religious clients simply because highly religious people usually either (a) seek therapy from clergy or their religious community, (b) seek therapy from an explicitly like-religious professional, or (c) do not seek therapy even when they need it.

Christian Beliefs or Religious Values as Predictors?

A methodological issue arose in the findings. Previous research on individual therapy found that high religious values predict preferences for and anticipated efficacy of individual therapy while high Christian beliefs do not (see Worthington et al. (1996) for a review). The present study found that religious beliefs and religious values *both* predicted preferences for and anticipated effects of marital therapy. Two potential reasons are suggested why perceptions of marital and individual therapy might differ.

First, marriage and religiosity are highly interrelated for Christians—especially theologically conservative married Christians, such as those who comprised much of the present sample (Prest & Keller, 1993; Waanders, 1987; Worthington, 1989). These people might not see their religion linked as closely to their individual mental health as to their marriage. Studies have shown there to be a positive correlation between measures of spiritual well-being and marital adjustment (Benda & DiBlasio, 1992; Dudley & Dudley, 1994; Roth, 1988; Wilson & Filsinger, 1986). Exactly how one's marriage might be intertwined with one's spirituality is a matter of debate even among

religious theorists. Nevertheless, many people in the general population, and especially among highly religious Christians, believe religion and marriage affect each other.

Second, highly religious people's beliefs might affect their perceptions of marital therapy because both could be related to their philosophy of social relations. Christianity and marriage might both be seen as rooted in a covenantal, communal value system of human relations (Adams, Spain, & Hunt, 1998; Bromley & Busching, 1988; Browning, Miller-McLemore, Couture, Lyon, & Franklin, 1997; Witte, 1997). In a covenant, a permanent commitment is made between two parties in which each is seen as being of shared blood with the other. According to Bromley and Busching (1988), covenantal social relations can be contrasted to social relations that are seen as implicitly or explicitly contractual. Contractual social relations are those held together by mutual contract fulfillment. Whereas covenantal social relations are largely seen as permanent, contractual social relations are often more temporal and contingent on contractual performance. If Christians perceive themselves as covenantal in their marital social values and perceive their therapist as contractual in marital social values, then clients might perceive their therapist to be working at cross-purposes to the clients' goals. Thus, highly committed married Christian individuals might be seeking a therapist with values similar to their own. Their preference for a similarly religious therapist, or at least one open to their religion, might have little to do with religious faith per se.

Implications for Marital Therapy

For the Christian marital therapist, the present research indicates that the explicit identification of himself or herself as a Christian is likely to attract highly religious Christian clients, while not affecting the moderate-to-less religious Christian clients. Marketing ventures that target highly religious Christians, such as seeking referrals from ministers and word-of-mouth in religious organizations, may be a method for attracting new couples seeking therapy or promoting enrichment endeavors.

For the marital therapist whose religion is dissimilar from that of Christian clients, the willingness to use interventions consistent with their clients' religion may make the therapist more appealing to highly committed Christian clients than might refusal to use such techniques. This research implies that, similar to research in other cultural groups, many from the Christian religion may prefer respect for and incorporation of their beliefs and values in marital therapy. Therapists who are willing to explore the religious beliefs and values of their clients and then to allow for the incorporation of those beliefs into the therapy process may be meeting the needs of their clients (Richards & Bergin, 1997). The present research is limited in that it did not investigate the effect of simply not mentioning the therapists' personal Christian commitments or willingness to use Christian-consonant interventions.

An important question is, does the typical religious marital therapist feel comfortable engaging in this type of integration, not to mention the marital therapist who is less committed to religion or who is not religious? One of the marital therapy situations in the present research described a nonreligious therapist who was willing to engage in religious practices as part of the therapy. How comfortable might a nonreligious therapist feel saying a prayer in session, or referring to Scriptures that he or she may not have studied or understand, not to mention may not believe? Some therapists may be comfortable with this type of situation while others may not (Lovinger, 1990).

Beyond a therapists' comfort in using religious interventions is his or her competence at doing so. Propst et al. (1992) found that non-Christian individual therapists who followed an explicitly Christian protocol for treating depression had clients who actually improved more than did Christian therapists who followed the same protocol. However, professional ethics will play a large part in a therapist's willingness and competence relative to using explicitly religious interventions (Sanders, 1997). For example, just because a therapist *can* pray with a client who requests prayer does not mean that the therapist *should* pray, especially if the therapist does not share similar religious beliefs and values as the client. An analogy would be the suburban Caucasian therapist who suddenly adopts an African-American urban dialogue with an African-American client without understanding the experience of African-American urban life. Such an attempt to join with the client would likely be perceived by the client as insincere.

Limitations of the Present Study

The present study investigated married individuals who indicated some commitment to Christianity. Within the U.S., a majority of people self-identify as Christian (Barrett, 1996). At present, the findings are generalizable to many potential clients for marital therapy but do not apply to nonreligious clients or those of other religions.

In addition, it is also possible that except for those that market themselves as "Christian counselors" the religious beliefs and values of a therapist would not be readily available for a client when they seek a therapist. How, when, and if highly religious clients ascertain this information about their therapist would be an interesting process to observe and study. The present study cannot speak to this phenomenon because the religiosity of each therapist was described. In addition, the condition in which the therapist is a non-Christian willing to use Christian interventions is somewhat unrealistic. It's possible that a non-Christian therapist might encourage a client to use their faith and faith community as a source of strength, but the therapists' use of ecclesiastical techniques in counseling is unlikely and may have been confusing to participants.

Another limitation of the present research is that it surveyed expectations of married people who were not clinically referred to marital therapy.

In fact, many individuals reported high marital adjustment. While the vast majority of participants had sought some help with their marriage and 28% of the sample had attended marital counseling at some time, only 38 of the 211 participants had a score on the DAS of below 100 at the time of the study, a standard below which Spanier and Filsinger (1983) would consider to be clinically distressed. When couples become distressed enough to seek marital therapy, their preferences for specific therapist characteristics might change—becoming either more or less tolerant of differences in values or beliefs. Generalizations should be made circumspectly. As has been argued, expectations of marital therapy will likely affect whether couples seek therapy, and perhaps how they might respond to it. With marriages deteriorating in large numbers today, many of the people surveyed in the present study might actually be candidates for marital therapy in the future.

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