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Spiritual Wellbeing and Depression in Psychotherapy Outpatients

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Abstract

In a quasi-experimental intact groups design the effects of psychotherapy on spiritual wellbeing and depression were assessed in

two groups of adult psychotherapy outpatients. Both groups showed significant gains on the Spiritual Wellbeing Scale (SWB), and significant decreases on the Beck Depression Scale. Further, both casual and committed Christians showed similar effects. The BDI and Existential Wellbeing (EWB) were significantly negatively correlated, but BDI and Religious Wellbeing (RWB) were unrelated. While causal effects cannot be firmly established, results are consistent with the hypothesis that successful psychotherapy increases spiritual wellbeing, including religious wellbeing. The SWB scale appears useful as a treatment outcome measure; in particular the RWB may add a unique component not currently assessed in treatment outcomes.

Spiritual Wellbeing and Depression in Psychotherapy Outpatients[1,2]

Psychotherapy outcome research has come a long way since Eysenck (1952) concluded that psychotherapy was ineffective. Numerous studies and reviews in the interim have generally drawn more favorable conclusions (Garfield & Bergin, 1994). Among the most recent reviews is the meta-analytic review of Lipsey and Wilson (1993), who state: "there is good reason to conclude that well-developed psychological, educational and behavioral treatment is generally efficacious" (p. 1181). Although brief therapy has been the focus of most studies, there is some evidence that outcome is positively related to length of therapy (Howard, Kopta, Krause, & Orlinsky, 1986; Orlinsky & Howard, 1986). Length of therapy, type of therapy, and presenting problem interact in affecting treatment outcomes (Koss & Shiang, 1994).

While psychotherapy generally has been found effective, much less is known about its effects on religious functioning, effects in religious populations, and especially about the effectiveness of approaches derived from or practiced within the context of Christian religious traditions. Johnson claims that only five studies have compared the effects of traditional and Christian approaches (Johnson, 1993; Johnson & Ridley, 1992). More work is clearly needed in these areas.

Largely independent of the investigation of psychotherapy outcomes, in the 1960's systematic investigation of quality of life (e.g., Campbell, Converse , & Rodgers, 1976; Campbell, 1981) emerged as an area of basic and applied research. Eventually, subjective wellbeing emerged as an area of major concern (e.g., see Diener, 1984). Early investigation of spiritual wellbeing as an aspect of subjective wellbeing was conducted by Moberg (Moberg, 1971; 1979a, b; Moberg & Brusek, 1978). Based on Moberg's preliminary work, Paloutzian and Ellison developed the Spiritual Wellbeing Scale (SWB) to measure this dimension (Ellison, 1983; Paloutzian and Ellison, 1982). Extensive research has been conducted on spiritual wellbeing using the SWB scale; Bufford, Paloutzian, and Ellison (1991) conclude that the SWB "is a good general measure of wellbeing" (p. 65). The SWB scale may also

prove useful for assessing the effects of psychotherapy on spirituality. Given the limited data on the relationship between spiritual wellbeing and psychotherapy outcomes, a preliminary investigation using quasi-experimental methods seems warranted (Paul, 1967).

The present study had two objectives: (a) to examine the effectiveness of outpatient psychotherapy on depression in this sample; (b) to evaluate the utility of the SWB as a measure of spiritual outcomes in psychotherapy.

Method

Participants

The participants were volunteer adult outpatients at two psychology clinics in the Pacific Northwest, one in Portland OR (Group 1) and the second in Vancouver WA (Group 2). All persons initially seeking therapy at each center during the period of the study were invited to participate. Persons who were acutely psychotic and those seeking treatment for substance abuse were subsequently removed from the sample. Group 1 consisted of 14 participants, 12 female and 2 male; Group 2 consisted of 11 participants, 7 female and 4 male. All but one participant were Caucasian; mean ages were 30.4 and 31.8 years for Groups 1 & 2 respectively; median incomes were in the $20-30,000 range for both groups. Marital status for Groups 1 and 2, respectively, were: never married, 14.3%, 36.4%; first marriage, 35.7%, 27.3%; separated/divorced, 42.9%, 9.1%; remarried, 7.1%, 27.3%. Because initial agreements to participate were handled by the treatment centers, it is not possible to report how many persons declined to participate.

Instruments

Instruments included a demographic questionnaire, the Beck Depression Inventory (BDI), the Spiritual Wellbeing Scale (SWB), and a Religious Belief Questionnaire (RBQ). The demographic questionnaire gathered data on age, gender, marital status and income.

The BDI is a 21-item self-report measure of depresive symptoms which are rated from 0-3 for severity. It has adequate internal consistency (Corcoran & Fischer, 1986) and test-retest reliability

(Gallagher, Nies, & Thompson, 1982). Extensive validational study supports its use as a measure of depression (Beck & Steer, 1987). It is widely used to assess depression in normal and clinical populations (Piotrowski, Sherry, & Keller, 1985; Steer, Beck & Garrison, 1985).

The SWB is a 20-item self report measure designed to measure wellbeing in terms of both vertical and horizontal dimensions. It has two subscales: odd-numbered items assess wellbeing in relationship to God and comprise the Religious Wellbeing Scale (RWB); even numbered items assess wellbeing in relationship to other persons and the world, comprising the Existential Wellbeing Scale (EWB). Responses are made on a six-point Likert continuum from strongly agree to strongly disagree, with no midpoint. Research has shown that the SWB scale has adequate reliability, that it is a good measure of general wellbeing (Bufford, et al, 1991), and that it correlates positively with self-reported Christian profession, importance of religion, frequency of church attendance, spiritual maturity, and other indicators of spiritual health.

The RBQ gathered self-report responses to several questions about religious beliefs and practices: frequency of church attendance and of personal devotions, profession of faith, length of time a Christian, importance of religion, and time spent in religious service.

Procedure

A project assistant on the staff of each clinic served as Intake Coordinator. During the study period, the Intake Coordinator at each center handed each new incoming patient a packet with a cover letter explaining the study and informing the person that she/he had the freedom to participate or decline. Also included in the packet was a demographic questionnaire, the BDI and the SWB. Each packet was numbered to identify the center and participant; a master list was kept by the Intake Coordinator in each clinic, then destroyed following completion of the study. Sixty days after intake, the posttest materials were given to each participant by the Intake Coordinator at the respective treatment clinics. Posttest packets included the BDI, SWB, and RBQ. Completed packets were transmitted to the investigators by the Intake Coordinator. Materials transmitted to the investigators

were identified only by the identification numbers, thus insuring anonymity for participants. All data were gathered during the Spring of 1990.

Results

Because of the clinical population used in the study, a number of participants did not complete the posttest. For many this was due to completing or discontinuing treatment prior to the elapse of 60 days; others declined to complete posttest forms. Altogether, 13 participants dropped out of each group; thus 49% of the original participants actually finished the study. The first analysis compared drop-outs with those who completed the study. Results showed no differences in SWB or BDI scores between drop-outs and those who completed the study; also, no differences were found on any of the demographic items.

The effects of therapy on BDI and SWB were examined by analyses of variance. Results indicated that SWB ($F_{(1, 21)} = 11.98$, $p = .002$), RWB ($F_{(1, 21)} = 5.92$, $p = .020$), and EWB ($F_{(1, 21)} = 14.90$, $p = .001$) changed significantly from pretest to posttest; no groups effects were found, however, and no interaction, indicating that the two groups changed equally. BDI results mirrored those for SWB: a significant decrease in BDI scores was found ($F_{(1, 21)} = 16.63$, $p = .000$), but no difference was found between the two groups, and no interaction.

On the RBQ Group 1 reported greater religious involvement and importance than Group 2. Results for the two groups were respectively: attend church less than once/year, 7.1 and 45.5% ($p = .06$); personal devotions less than once/week 28.3 and 54.6% ($p = .41$); profess personal salvation 78.6 and 18.2% ($p = .01$).

Finally, one tailed correlational analyses revealed that the BDI, at pretest and posttest respectively, was negatively correlated to SWB ($r_{(24)} = -.42$, $p \leq .05$; $r_{(24)} = -.53$, $p \leq .01$) and EWB ($r_{(24)} = -.76$, $p \leq .001$; $r_{(24)} = -.68$, $p \leq .001$), but not related to RWB ($r_{(24)} = .02$, NS; $r_{(24)} = .-.17$, NS).

Discussion

The effects of outpatient psychotherapy on depression and spiritual wellbeing were examined for the first 60 days of treatment in

two groups of outpatient psychotherapy patients in a quasi-experimental study. Taken together, results show significant treatment effects on both BDI and SWB, with no differences between Groups 1 and 2.

Participants were clinical patients seeking outpatient psychotherapy. The sample is smaller than desirable in part due to this factor. Despite being recruited from two different clinics, no significant differences were found between the two groups in demographic characteristics, pretest, or posttest scores. The groups differed in their responses to the RBQ, although only profession of faith was statistically significant. Group 1 appears highly religious, while Group 2 is more nominally religious. It is somewhat surprising that no other significant differences were found between the two groups. The small sample size may play a role in this unexpected finding, although the groups are of fairly good size for a clinical sample.

Pretest scores on SWB in Groups 1 and 2 were similar to scores of counselees reported in prior studies, while posttest results are more comparable to those reported for religious groups (Bufford, et al, 1991). Significant gains in religious and existential wellbeing were found for this sample, with no differences between the two groups.

On the BDI, as with the SWB, no group differences were found, but there was a significant treatment effect. Participants reported less depression at the posttest after 60 days of outpatient treatment. The SWB and BDI were negatively correlated, as were EWB and BDI, but RWB was not related to BDI scores. This suggests that RWB measures a spiritual or religious dimension of treatment effects not tapped by the BDI. Participants showed gains in religious wellbeing which are independent of reduced depression.

Results suggest that the SWB may be useful as a measure of outcome effects, and support the view that successful psychotherapy affects the patient's spiritual functioning. The inclusion of two treatment groups which exhibited similar treatment effects suggests some optimism about the generality of these findings, although the voluntary nature of the sample and the fact that 51% of initial participants did not complete the posttest limit generality. Results are most likely to

apply to persons with similar degrees of willingness to participate in experimental procedures.

Although cause-effect conclusions cannot be firmly drawn due to the quasi-experimental nature of this study, results are strengthened by the inclusion of two groups (see Lipsey & Wilson, 1993). The findings are consistent with the hypothesis that psychotherapy will enhance spiritual wellbeing. The fact that both Groups 1 and 2 showed this effect suggests that gains in spiritual functioning, as measured by the SWB, occur in nominally religious samples as well as in highly religious samples. Further, RWB taps a unique dimension not measured by the BDI. Based on these findings, it appears that further investigation of the effects of psychotherapy on spiritual wellbeing, including true experimental studies, is warranted.

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Table 1

Scores on the Spiritual Wellbeing Scale and Beck Depression Inventory at Pretest and Posttest

	Spiritual Wellbeing Scale			
	Pretest		Posttest	
	M	*SD*	*M*	*SD*
Group 1	88.93	16.30	98.27	15.50
Group 2	82.50	14.52	94.45	9.41

	Existential Wellbeing			
	Pretest		Posttest	
	M	*SD*	*M*	*SD*
Group 1	40.71	8.23	45.11	9.17
Group 2	40.73	9.62	48.96	4.83

	Religious Wellbeing			
	Pretest		Posttest	
	M	*SD*	*M*	*SD*
Group 1	48.21	10.43	52.84	6.94
Group 2	42.00	11.26	45.59	11.50

	Beck Depression Scores			
	Pretest		Posttest	
	M	*SD*	*M*	*SD*
Group 1	15.29	6.21	8.54	6.08
Group 2	10.73	6.72	5.73	4.43

Note: *n* = 14 for Group 1; *n* = 11 for Group 2.

Table 2

Treatment Effects

Scale	SS	MS	df	F	p
Spiritual Wellbeing	1145.27	1145.27	1,21	11.98	.002
Existential Wellbeing	483.50	483.50	1,21	14.90	.001
Religious Wellbeing	158.15	158.15	1,21	5.92	.020
Beck Depression	375.76	375.76	1,21	16.63	.000

Notes

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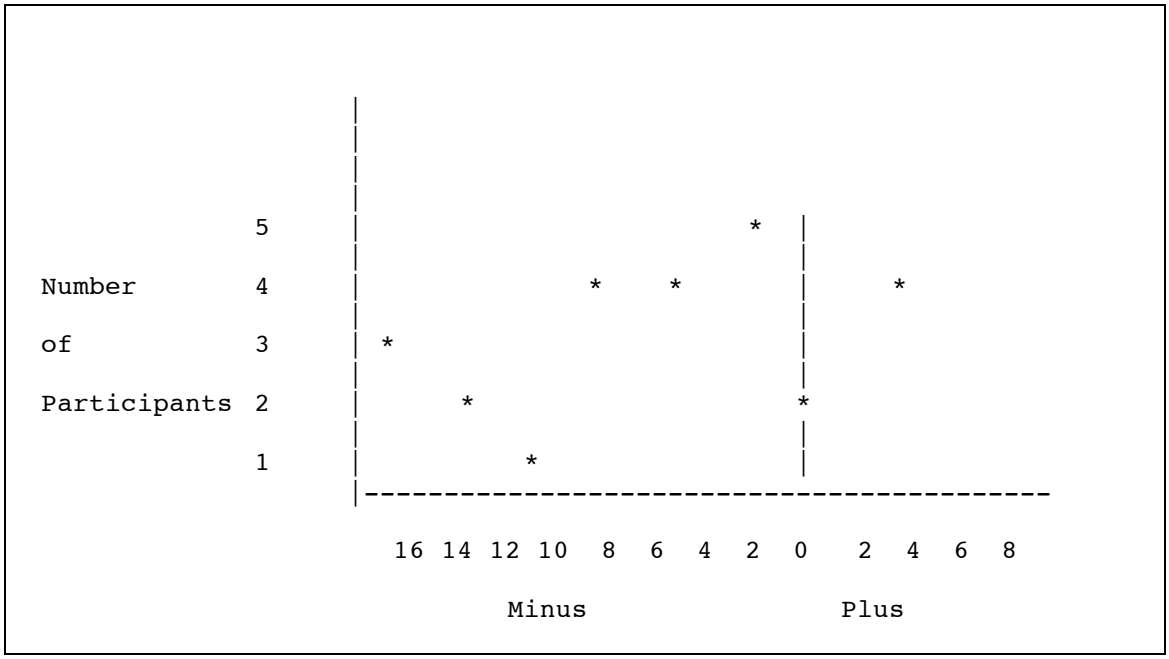
Number of Participants
5
4
3
2
1
16 14 12 10 8 6 4 2 0 2 4 6 8
Minus
Plus
BDI Change Score