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Abstract

Interest in spiritual interventions in psychotherapy has increased dramatically in recent years as indicated by publication of at least 14 books on this topic in the past eight years, and by the offering of continuing education workshops on religious issues in psychotherapy at APA. Research and/or theorizing has begun on: religious values in psychotherapy, religious interventions (process), religiosity and mental health, graduate training in religious/spiritual interventions, and religious assessment. However, a review of the literature suggests that so far investigation of religious/spiritual outcomes of psychotherapy has been neglected, although examining such outcomes seems an obvious corollary of making the interventions. Results of two studies which show significant gains on Spiritual Well-Being following brief therapy are reported. Although causality cannot be firmly established, these results provide support for the hypotheses that psychotherapy produces favorable spiritual outcomes, and that spiritual benefits occur whether or not spiritual interventions are explicitly and consciously included.

Spiritual Changes as Psychotherapy Outcomes

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In the past fifteen years, considerable interest has developed in the relationship of religion to mental health. First, in 1980 Bergin began a discussion of the role of religious values in psychotherapy (e.g., Bergin, 1980a, b, 1991; Kelly & Strupp, 1992; Martinez, 1991; Walls, 1980; Worthington, 1993); here the emphasis was on treatment goals. Second, a growing interest has emerged regarding ethical concerns and practical strategies for addressing religions issues in psychotherapy. Several significant texts (e.g., Benner, 1987, 1988; Lovinger, 1984, 1994; Propst, 1988; Spero, 1985; Stern, 1985), and numerous articles (e.g., Bergin, 1991; DiBlasio & Benda, 1991; Propst, Ostrum, Watkins, Dean, & Mashburn, 1992; Worthington & DiBlasio, 1990) have appeared which are devoted to this topic. Third, preliminary discussion and investigation has begun of interventions which may be spiritual in nature but are used widely among therapists, such as forgiveness (Enright & Zell, 1989), and remorse (Schneiderman, 1989; Stern, 1989). Fourth, there has been initial study of interventions which are employed largely by religious therapists with religious clients, such as the use of religious imagery (Propst, 1980), and religious cognitive-behavioral interventions (Propst, Ostrum, Watkins, Dean, & Mashburn, 1992). Fifth, there has been preliminary investigation of the relationship between religiosity and mental health (e.g., Bergin, 1983; Bergin, Stinchfield, Gaskin, Masters, & Sullivan, 1988; Bufford, Paloutzian, & Ellison, 1991; DiBlasio & Benda, 1991). Sixth, a small body of literature has developed which examines the use of spiritual interventions in counseling, largely among individuals trained in the context of graduate clinical psychology programs in religious institutions (Moon, Bailey, Kwasny, & Willis, 1991; Jones, Watson, & Wolfram, 1992), and among members of the Christian Association for Psychological Studies, a professional organization of Christian mental health professionals (Adams, 1994; Stratton, 1994). Finally, Malony (1993) advocates the use of religious assessment. He argues that results of this assessment should affect treatment strategies, and concludes "religious diagnosis can play a critical role in decisions made on all five of the axes of DSM-III-R" (p. 115).

A number of writers have suggested that spiritual interventions are effective (e.g., Adams, 1970). In the face of claims by those who practice "biblical counseling" that their approaches are more effective (at least with Christian clients), Bufford (1991; 1993) proposed that documentation of these claims is needed. With the dramatic growth in interest in religious issues and interventions, the growth in training in these areas, and the emergence of studies of religious processes in psychotherapy, it seems logical that spiritual outcomes would also become a topic of interest and research. For example, Worthington (1993) states:

> evidence mounts that suggests that religious psychotherapy has no different mental health outcomes with religious clients than does secular psychotherapy. However, religious therapy may have more positive outcomes at strengthening clients' spiritual resources than does secular therapy. . . . It is incumbent on religious researchers to determine the effects of religious counseling and psychotherapy. (p. 124)

A few studies have investigated the effects of spiritual interventions on more traditional outcome measures (Johnson, DeVries, Ridley, Pettorini, & Peterson, 1994; Johnson & Ridley, 1992; Pecheur & Edwards, 1984; Propst, 1980; Propst et al, 1992). However, despite interest in religious issues in psychotherapy and the theoretical arguments for spiritual effects, a recent search was unsuccessful in identifying any published research on religious or spiritual outcomes (for purposes of this article religious and spiritual will be used interchangeably). The entire PsychLit data base was searched (1/74-6/95 for periodicals; 1/1987-6/95 for books and chapters in edited books) for the intersection of the following domains: 1) religious or spiritual; 2) psychotherapy or therapy or counseling; 3) outcome(s) or effect(s) or result(s). A second set of searches looked for: 1) religious or spiritual; 2) outcome(s) or effect(s) or result(s). In all, 48 searches were made in each of the three sections of the data base. Only one study was identified (Groves & Peterson, 1987), but it proved irrelevant to the topic at hand, examining student perceptions of leisure education outcomes. It is possible that this approach to the search is inadequate. Similarly, it seems likely that data exist which bear on the question of religious/spiritual outcomes of psychotherapy which are not indexed under these headings. One such study (Toh , Tan, Osburn, & Faber, 1994) will be discussed later. However, it appears that the question of religious/spiritual outcomes of psychotherapy remains in need of investigation.

The Spiritual Well-Being Scale was designed by Ellison and Paloutzian (Ellison, 1983) as an indicator of spiritual health. It has been studied quite extensively, and has been shown the correlate with a wide variety of spiritual measures, including the Religious Orientation Scale--intrinsic religious orientation in particular, the Spiritual Maturity Scale, the Spiritual Leadership Qualities Inventory, self report of importance of religion, frequency of attendance, frequency and duration of personal devotional activity, and profession of Christian faith (Ellison & Smith, 1991). Bufford, Paloutzian, and Ellison (1991) report descriptive data for several groups on the Spiritual Well-Being Scale. They concluded that in addition to being an effective measure of spirituality, the Spiritual Well-Being was also a good measure of general wellbeing, and could be used to identify individuals likely to currently experience emotional or physical problems.

In studies of the relationship of spiritual wellbeing and mental health, Sherman (1986) showed that eating disorder inpatients and eating disorder outpatients scored significantly lower on Spiritual Well-Being, Religious Well-Being and Existential Well-Being than a group of medical outpatients. Similarly, Rodriguez (1988) found that a group of sexually abused women currently in outpatient treatment for childhood sexual abuse, or who had been seen for outpatient treatment involving this problem during the past year, scored higher on Religious Well-Being

than eating disorder inpatients or outpatients, higher on Spiritual Well-Being than eating disorder inpatients, but lower on Spiritual Well-Being, Religious Well-Being and Existential Well-Being than medical outpatients, seminary students, and Youth for Christ staff members. In light of the Sherman and Rodriguez results, it seems likely that the Spiritual Well-Being may be sensitive to mental health treatment effects.

Toh, Tan, Osburn, and Faber (1994), in a preliminary investigation of the effectiveness of a lay Christian counseling program conducted through a church in La Canada, CA examined 18 participants at intake and after either 10 or 20 sessions of lay Christian counseling. Since no differences were found between the two groups, all data was reported for the combined groups. They found significant improvement in all self-report measures, including Target Complaints, the Global Severity Index, Positive Symptom Distress Index, Positive Symptom Total on the Brief Symptom Inventory (DeRogatis & Spencer, 1982), and in a counselor rating, the Global Rating Scale. Improvements on measures of psychopathology suggest mental health benefits from this treatment. In addition, and most significant for our purposes, they included the Spiritual Well-Being Scale (Ellison, 1983); scores on the Spiritual Well-Being Scale, and on both the Religious Well-Being and Existential Well-Being subscales, all improved significantly as well. While causal inferences are not warranted from the Toh et al data, they are consistent with the hypothesis that
Spiritual Well-Being was enhanced by lay Christian counseling. Insofar as spiritual wellbeing is correlated with mental health, spiritual changes may parallel psychological improvements. Such a finding is significant since there appear to be no existing data documenting spiritual gains as a results of psychotherapy. However, to the extent that the Spiritual Well-Being Scale measures aspects of spiritual functioning which are independent of mental health, gains on this scale suggest that lay Christian counseling may also produce spiritual benefits in addition to, or independent of, mental health gains. Confirmation of such findings would have major theoretical and practical significance.

In a second study of the effectiveness of Christian lay counseling, Toh and Tan (1995) used a wait list control group with alternate assignment of would-be counselees to treatment and control conditions. Using the same measures, Toh and Tan found significant treatment effects on all measures, and the treatment group did significantly better that the control group. As with the previous study, Toh and Tan found significant gains on Spiritual Well-Being and Religious and Existential Well-Being scores. Thus it appears that effective lay Christian counseling may result in both significant gains in symptom relief and in increased spiritual wellbeing. A number of factors, including loss of about 25% of the participants in the treatment group weaken the causal inferences which can be drawn from this study.

The findings of Toh et al and Toh and Tan suggest that Christian lay counseling may result in spiritual benefits. But what of Christian professional counseling? What if the setting is not a church-based counseling center? Might there be spiritual benefits even if the counseling

does not specifically incorporate Christian elements? The purpose of this study is to examine some of these questions. It reports the results of preliminary investigations of the Spiritual Well-Being as a measure of treatment outcome in two quasi-experimental studies using outpatient psychotherapy patients in community based clinics and a private psychiatric hospital.

Study 1

Participants

The first study examined the effects of outpatient psychotherapy on depression and spiritual wellbeing. 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). The first was associated with a baptist seminary and its entire staff was identified as Christian professionals; the second had no religious affiliation. 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 participants but one 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, the Spiritual Wellbeing Scale, and a Religious Belief Questionnaire. The demographic questionnaire gathered data on age, gender, marital status and income.

The Beck Depression Inventory is a 21-item self-report measure of depressive 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 Spiritual Well-Being is a 20-item self report measure designed to measure wellbeing in terms of both vertical (relationship to God) and horizontal (relationship to others and the world around us) dimensions. It has two subscales: odd-numbered items assess wellbeing in relationship to God and comprise the Religious Wellbeing Scale (Religious Well-Being); even numbered items assess wellbeing in relationship to other persons and the world, comprising the Existential Wellbeing Scale (Existential Well-Being). Responses are made on a six-point Likert continuum from strongly agree to strongly disagree, with no midpoint. Research has shown that the Spiritual Well-Being 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 Religious Belief Questionnaire 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 Beck Depression Inventory and the Spiritual Well-Being. 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 Beck Depression Inventory, Spiritual Well-Being, and Religious Belief Questionnaire. 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 pretests for drop-outs with those who completed the study. Results showed no differences in Spiritual Well-Being or Beck Depression Inventory scores between drop-outs and those who completed the study; also, no differences were found on any of the demographic items.

Results are presented in Tables 1 and 2. The effects of therapy on Beck Depression Inventory and Spiritual Well-Being were examined by analyses of variance. Results indicated that Spiritual Well-Being ($F_{(1, 21)} = 11.98$, $p = .002$), Religious Well-Being

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Insert Tables 1 & 2 about here

($F_{(1, 21)} = 5.92$, $p = .020$), and Existential Well-Being ($F_{(1, 21)} = 14.90$, $p = .001$) changed significantly from pretest to posttest; no groups effects were found, however, and no interaction,

indicating that the two groups changed equally. Beck Depression Inventory results mirrored those for Spiritual Well-Being: a significant decrease in Beck Depression Inventory scores was found ($F_{(1, 21)} = 16.63$, $p = .000$), but no difference was found between the two groups, and no interaction.

On the Religious Belief Questionnaire 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 Beck Depression Inventory, at pretest and posttest respectively, was negatively correlated with Spiritual Well-Being ($r_{(24)} = -.42$, $p \leq .05$; $r_{(24)} = -.53$, $p \leq .01$) and Existential Well-Being ($r_{(24)} = -.76$, $p \leq .001$; $r_{(24)} = -.68$, $p \leq .001$), but not related to Religious Well-Being ($r_{(24)} = .02$, 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 Beck Depression Inventory and Spiritual Well-Being, 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 Religious Belief Questionnaire, 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 Spiritual Well-Being 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 spiritual, religious, and existential wellbeing were found for this sample, with no differences between the two groups.

On the Beck Depression Inventory, as with the Spiritual Well-Being, 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 Spiritual Well-Being and Beck Depression Inventory were negatively correlated, as were Existential Well-Being and Beck Depression Inventory, but Religious Well-Being was not related to Beck Depression Inventory scores. This suggests that Religious Well-Being measures a spiritual or religious dimension of treatment effects not tapped by the Beck Depression

Inventory. Participants in both groups showed gains in religious wellbeing which are independent of reduced depression.

Results suggest that the Spiritual Well-Being 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 Spiritual Well-Being, occur in nominally religious samples as well as in highly religious samples. Further, Religious Well-Being taps a unique dimension not measured by the Beck Depression Inventory. Based on these findings, it appears that further investigation of the effects of psychotherapy on spiritual wellbeing, including true experimental studies, is warranted.

Study 2

Participants

The second study examined the effects on Spiritual Well-Being for adolescents treated at an inpatient psychiatric hospital in the Portland area. All adolescent patients admitted to the inpatient unit at a private psychiatric hospital in Portland Oregon during a three month period in 1993 were invited to participate. This facility specializes in serving a resistant and severely disturbed population with severe acting out, substance abuse, and major affective disorders. Patients were excluded if their stay was less than two weeks or greater than six weeks. In addition, patients who did not sign the consent form for participation, or whose parents did not sign the parental consent form were excluded. In all, 28 inpatients met the inclusion criteria, while over 40 were excluded. Participants ranged in age from 12 to 17 years with a mean of 14.32 years. Twelve were male, 16 female. Education ranges from 6th to 10 grade (n = 1, 8, 8, 5, 6--3.6, 28.6, 28.6, 17.9, 21.4% for 6th, 7th, 8th, 9th, and 10th grades respectively). By race 63 percent were Caucasian, 18.5% Native American, 7.4 % Afro-American, and 3.7% Hispanic). For religion, 25.9% indicated Catholic, 3.7% protestant, 14.8% agnostic, and 55.6% other. Median income was in the $30-39,000 range. For 75% this was a first hospitalization.

The comparison group was comprised of residents in a juvenile detention facility in Tacoma Washington. This facility was chosen because the demographic characteristics of the residents were similar to those of the inpatient population. The 16 participants included 8 males and 8 females with a mean age of 15.1 years; 62.5 % were Caucasian, 25% Afro-American, and

12.5% Other. Education ranged from 6th to 11th grade (25%, 12.5%, 50%, and 12.5% were in the 6th,8th, 9th, and 11th grades respectively. On religion, 16.7% said they were agnostic; the rest marked Other or left the item blank. Median income was in the 30-39,000 range. In this group 87.5% had never been treated in an inpatient psychiatric hospital.

Instruments

Instruments included a demographic questionnaire and the Spiritual Well-Being Scale (Spiritual Well-Being). Psychiatric patients completing the Spiritual Well-Being within 24 hours of admission; post-test data was completed within three hours of discharge for those that met the inclusion criteria for the study, including two to six weeks of inpatient treatment. Residents of the juvenile detention center completed the Spiritual Well-Being on admission and after six weeks. To protect confidentiality, all data were numerically coded by a member of the treatment team, and master lists were destroyed when the study was completed; researchers did not have access to the identifying information, and treatment staff did not see the data. The research was reviewed and approved by the Human Participants Review Committee at George Fox College.

Results

Seven participants in the treatment group and 8 in the detention center group failed to complete the post-test. A comparison of drop-outs with those who completed the study revealed no significant differences between those who completed the study and those who withdrew on Spiritual Well-Being or demographic variables for either group.

Results are summarized in Tables 3 and 4. Visual examination of the data revealed that posttest scores were higher for the treatment group, and lower for the comparison group. Data

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Insert Tables 3 & 4 about here

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were analyzed first to examine for differences between treatment and comparison groups on pretest Spiritual Well-Being, Religious Well-Being (Religious Well-Being), and Existential Well-Being (Existential Well-Being); the treatment group scored lower than the comparison group on Spiritual Well-Being, but no differences were found on Religious Well-Being or Existential Well-Being. Comparison of pretest and posttest data for the treatment group revealed significant gains on Spiritual Well-Being ($t_{(27} < -2.86$; $p = .01$), Religious Well-Being ($t_{(27)} < -2.26$; $p = .03$), and Existential Well-Being ($t_{(27)} = -3.17$; $p < .01$) during treatment. To control for pre-test differences, group comparison of posttest data was completed by means of an analysis of covariance with pretest scores controlled; results showed that the treatment group scored significantly higher on the posttest for Spiritual Well-Being ($F_{(1, 42)} = 18.024$, $p < .001$), Religious Well-Being ($F_{(1, 42)} = 15.118$, $p < .001$), and Existential Well-Being ($F_{(1, 42)} = 17.959$, $p < .001$).

Discussion

While causal conclusions may not be firmly drawn from this data, the findings are consistent with the hypothesis that inpatient psychotherapy resulted in gains in spiritual wellbeing for these adolescents. A limitation of the study is that treatment was uncontrolled and is unspecified. This makes replication more difficult, but increases the likelihood that it represents the actual treatment regimen normally practiced in this psychiatric hospital. No systematic assessment of treatment outcomes was made apart from those normally used by the treatment facility to determine readiness for discharge. While it cannot be said with certainty, it is doubtful that religious issues were addressed in any great degree at this facility except in the use of 12-step approaches. Finally, this sample is not very religious; over 70% reported no religious affiliation, or described themselves as agnostic. Even so, treatment appears to have enhanced spiritual wellbeing in this group.

General Discussion

While the results of the present studies, and of Toh et al (1994), and Toh and Tan (1995) are weak in regard to support for causal inferences, together they provide significant support for the hypothesis that successful psychotherapy may have spiritual or religious benefits, at least as measured by the Spiritual Well-Being Scale. The present results show that gains in spiritual wellbeing occur not only in a religious setting with religious clients, but also in an outpatient psychotherapy setting with both highly religious and casually religious clients, and in an inpatient setting with clients who in many cases view themselves as non-religious or at least not religious in any traditional sense.

So far, all of the known data on spiritual/religious outcomes of psychotherapy have been gathered with the Spiritual Well-Being scale. Further study of the religious or spiritual benefits of psychotherapy needs to examine other populations and settings, and especially other measures. Additional attention needs to be given to further making the case for causal relationship as well. However, the preliminary data provide a strong case for the conclusion that psychotherapy produces spiritual benefits, that the benefits occur across a range of settings and clientele, and that they are not limited to persons who identify themselves as traditionally religious. Explicit address of spiritual or religious issues does not appear to be essential to these benefits. Finally, the fact that Religious Well-Being was not related to the Beck Depression Inventory in study 1 raises the possibility that changes in the spiritual wellbeing in relationship to God may be relatively independent of changes in psychological symptoms as measured by traditional measures of psychopathology. This issue also merits further study.

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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

Table 3

Scores on the Spiritual Wellbeing Scale at Pretest and Posttest

	Spiritual Wellbeing Scale			
	Pretest		Posttest	
	M	SD	M	SD
Group 1	76.30	16.19	85.20	16.96
Group 2	89.62	8.23	72.13	9.86
	Existential Wellbeing			
	Pretest		Posttest	
	M	SD	M	SD
Group 1	39.58	9.48	43.52	9.33
Group 2	44.88	6.75	35.75	6.43
	Religious Wellbeing			
	Pretest		Posttest	
	M	SD	M	SD
Psychiatric Inpatients	36.60	11.55	41.35	12.72
Detention Residents	44.75	6.23	35.75	6.43

Note: n = 28 for Psychiatric Inpatients; n = 16 for Detention Residents.

Table 4

Analysis of Covariance Comparing Psychiatric Inpatients with Detention Residents on Posttest with Pretest Controlled.

Scale	SS	MS	df	F	p
Spiritual Wellbeing	4248.81	2124.40	1,42	18.02	.000
Existential Wellbeing	1379.41	689.70	1,42	15.12	.000
Religious Wellbeing	2400.26	1200.13	1,42	17.96	.000

Note: N = 44.

In at least one study (Lewis and Epperson, 19 ?, non-Christian clients expressed a preference for non-Christian therapists. It is possible that this reflects concern that Christian professionals will

engage in efforts to influence them toward conversion, perhaps in disregard of the informed consent guidelines.