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An Outcome Evaluation of Marble Retreat's Brief, Intensive Psychotherapy Program

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by

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Abstract

Marble Retreat is an interdenominational psychotherapy treatment facility dedicated to 'eating clergy in crisis. Its mission is to facilitate healing and restoration to those who are in ocational Christian ministry through a Christ-centered approach to *brief, intensive sychotherapy*. The doors of Marble Retreat have been open since 1974. Over the past 33 years, Iarble Retreat has worked with over 3000 clergy in crisis. Recently, Marble Retreat has hanged directorship for the first time in its operation. In 2003, the Board of Directors of Marble :etreat officially appointed Steven Cappa, PsyD and his wife Patti Cappa, MS, LMFT, CAC II) oversee ministry operations.

In an attempt to assess both the strengths and areas of growth in the current treatment ıodality employed by Marble Retreat, an outcome evaluation was conducted using a quasi-xperimental pre-test/post-test and 6-month follow-up research design. In particular, the esearch assessed the treatment outcomes of clients who enrolled at Marble Retreat from January 006 thru February 2007. Included are a brief history of Marble Retreat and its philosophy of

eatment, as well as a review of the existing empirical research on the individual functioning of ergy.

At posttest Marble Retreat participants showed significantly reduced psychological istress, improved marital adjustment, and increased spiritual well-being. It is also concluded iat at a 6-9 month follow-up the effects of treatment were sustained in psychological inctioning and spiritual well-being, but not in marital adjustment. No differences were found in ffects of 8 and 12 day treatment programs, which supports the decision to move to an 8 day eatment model.

Acknowledgments

This research project would not have been possible without the support and assistance of ıe staff of Marble Retreat. I am thankful for their patience with me as I navigated through the ıallenges that accompany a project of this magnitude. I am also grateful for the financial ıpport of the Richter Grant. Their financial support enabled me to be creative in the data ɔllection process. Most of all, I am indebted to my wife. She has faithfully stood by my side as have navigated my way through graduate school. I am so thankful for the constant love and ıpport she graciously offers.

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Chapter 1

Introduction

Members of the clergy have naturally assumed the responsibility of helping their ›ngregants navigate the difficult terrain of life. They are typically admired and respected in eir communities. They are highly regarded as messengers of God, esteemed as models of ›iritual health and well-being, sought after for spiritual direction, and expected to counsel dividuals and couples in distress. Because of these idyllic perceptions, members of the clergy ·e often perceived as being above the common struggles of humankind and not susceptible to /eryday stresses of life. However, a quick look below the surface reveals a different reality. his realization is based on two basic observations: as humans, members of the clergy are ısceptible to emotional problems, just like anyone else, and pastoral work is quite stressful Spilka, Hood, Hunsberger, & Gorsuch, 2003).

Clergy face unique challenges not often experienced in other professions. These unique :ressors present various occupational hazards. In fact, recent psychological research on the ınctioning of clergy suggests they are susceptible to burnout (Grosch & Olsen, 2000), rofessional misconduct (Berman, 1997), and emotional impairment (Meloy, 1986; Von Stroth, lines, & Sharon, 1995). When the heroes of the faith fall, a suitable curative option is needed to ssist them in the process of healing and restoration.

Marble Retreat has been in the business of specialty care for clergy in crisis for 33 years. ocated in Marble, CO, Marble Retreat is an organization dedicated to healing and restoring

ɛrgy by providing *brief, intensive psychotherapy*, primarily in a small group format. As a ıilblazer in caring for the needs of clergy, Louis McBurney, MD, founded the ministry with a ɜion to offer healing and restoration for clergy in crisis. After serving this ministry for over 30 ars Louis McBurney and his wife, Melissa, have turned over the directorship of Marble Retreat to the capable hands of Steven Cappa, PsyD and his wife, Patti Cappa, MS, LMFT, CAC II, ho assumed leadership in June 2003.

Due to the recent transition in leadership, as well as a desire to substantiate the fectiveness of the Marble distinctives, the Board of Directors (BOD) of Marble Retreat have ıdorsed an outcome evaluation, conducted by this researcher. The research evaluated the ɛatment gains and maintenance of the subjects who participated in Marble Retreat's brief eatment modality from January 2006 to February 2007. A brief description of the historical ıots of Marble retreat and its current treatment approach are presented. In addition, to help the ɜader understand the unique issues facing clergy in crisis, a review of the literature on individual ınctioning of clergy is provided.

'istory of Marble Retreat

Louis McBurney, MD and his wife, Melissa, founded Marble Retreat in 1974, believing ·od was leading them to provide specialty mental health care for clergy in crisis. Marble etreat pursues three basic goals at each retreat: (a) allow each participant to safely unburden the ıurts and pressures of life and ministry, (b) assist them in understanding themselves more ɔmpletely as their life patterns have developed, (c) encourage and enable development of new ɜvels of self-acceptance as well as more effective relational skills, including reordering riorities, applying more effective communication skills, and bringing balance into life (Marble .etreat, 1999).

Marble Retreat's therapeutic model resembles the Mayo Intensive Psychotherapy Center ogram (Swenson & Martin, 1976). The key factors of success of this program are its tensity—the participants spend a total of three to four hours in session daily for a period of ght to twelve days, and the use of several different psychotherapeutic modalities, including oup and individual psychotherapy. Marble Retreat's distinguishing feature is its utilization of nall groups of four to eight participants and, if married, the mandatory inclusion of spouses in e therapeutic process. Group psychotherapy is its primary modality, highlighted by twenty- ur to thirty hours of group process; individual therapy is an adjunct, which consists of three ıe-hour sessions of individual therapy (Marble Retreat, 1999). Marble Retreat promotes its odel as a rough equivalent to six months of traditional individual therapy.

Traditionally, Marble Retreat has exclusively served clergy. However, in 2006 the BOD)proved a transition that increased the breadth of treatment to include other Christian clients. he primary focus remains on treating clergy. The term "clergy" is used here to include anyone ıgaged in part-time or full-time ministry. This includes missionaries, church staff members, hristian educators, and para-church affiliates. The cost of participation is $3,000.00 per ıdividual, including accommodations and most meals. Health insurance may cover some of the ıerapy charges, which account for $2100.00 of the total expenses. The remainder of the charges :e reserved for the aforementioned accommodations. Marble Retreat offers a limited :holarship fund for its participants who may have such a need. The "retreat" atmosphere :moves the stigma of therapy, eliminates distractions, and promotes a relaxed atmosphere, 'here participants eat together, live together, and enjoy times of recreation together. This forms unique distinctive that is a staple in the Marble Retreat experience (Marble Retreat, 1999).

'dividual Functioning of Clergy

The study and treatment of clergy in crisis has emerged in the research literature in recent ɛars (Hall, 1997). The literature has harmoniously echoed one thing: Life in ministry is ɛcoming more challenging (Larsh, 1994). Despite the vocational minefields, some clergy are nding ways to survive, even thrive, in their positions (Meek et al., 2003). The exemplar clergy ɪn offer insight into healthy functioning in this profession (McMinn et al., 2005). Nevertheless, ɪental health professionals remain mostly interested in identifying and treating maladaptive ɪnctioning, which means most of what is known about the overall functioning of clergy comes 'om this perspective.

The personal functioning of clergy has gained attention from mental health professionals ɔr two specific reasons (Hall, 1997). First, clergy work under the extraordinarily high xpectations of parishioners (Hall, 1997; Ostrander, Henry, & Fournier, 1994). This is further omplicated by the fact they hold positions that are highly visible, which make them easy targets f anonymous criticism. Yet, they are also intimately involved in the emotional and spiritual ves of their congregants. As a result, clergy are susceptible to loneliness, isolation, spiritual ryness due to providing services without much in return, marital dissatisfaction, and vocational urnout (Ellison & Mattila, 1983).

The second reason for the growing interest in the personal functioning of clergy is the ɛalization that personal maladaptive behaviors of clergy can directly impact ministry outcome Hall, 1997). Unresolved issues can reduce a clergy's ability to facilitate healing and emotional nd spiritual growth in his or her congregation. Interpersonal awareness skills are an admitted veakness in pastoral training (Ellison & Mattila, 1983). The personal health and dysfunction of member of clergy has a significant impact on his or her ministry.

The thought that clergy are immune to psychological distress is outdated. The church has :en a rise in the divorce rate for clergy and the percentage of clergy who leave the ministry. It now more pertinent than ever to establish treatment options that address their unique needs. It encouraging to hear that many in church leadership positions have implemented strategies to ıre for the emotional needs of their staff members (Nishimoto, 2002). Specifically, there seems) be a movement toward helping clergy who commit sexual offenses (Earle, 1994; Houts,)77). Despite the emerging awareness of the treatment needs of clergy, the empirical evidence ır treatment outcomes for programs helping clergy is currently lacking. This lack of empirical /idence further supports the need for the present study.

reatment Concerns of Clergy

The church is beginning to expose the myth of infallible clergy and realistically adjusting s expectations. The recent move towards integrating the disciplines of psychology and ıeology has helped uncover unique treatment concerns for clergy. The most common ıerapeutic model used for counseling clergy emphasizes a process of restoration, which seeks to nburden the hurts and pressures of life and ministry as well as to help the member of clergy and is/her spouse develop new and hopefully healthier habits and coping skills. While, clergy seem) internally accept that they are not perfect, they also seem to live with the realization that eople expect that of them (Nishimoto, 2002). It has been proposed that this thought process ften traps clergy, and prevents them from seeking help when needed (Frey, DeVries, Exley, & lcBurney, 1992).

The increase in awareness of clergy distress is probably most apparent in the Catholic 'hurch. Due to the recent allegations of sexual misconduct, church leaders are reviewing clergy are (Ciarrocchi & Wicks, 2000). As a result, there is an increasing awareness of the signs of urnout and the thin layers of defense against such temptations (Nishimoto, 2002). In fact, a

ıdy on burnout among priests revealed a resistance to intimacy as a positive predictor of ırnout (Chiaramonte, 1983). To fully understand the clinical implications of treating clergy in isis, a broad understanding of clergy life is necessary.

notional Distress

Several studies have evaluated the psychological adjustment, self-concept, and vocational ›ngruence of clergy (Hall, 1997). One such study examined the struggles Christian leaders face ıd how they develop coping strategies (Ellison & Mattila, 1983). Ellison and Mattila surveyed 38 respondents, 80% of whom were senior or associate clergy from a variety of denominations. he data suggests that senior clergy of churches with multiple staff members responded with gnificantly less difficulty in dealing with the rigors of ministry than senior clergy without other aff members. Churches with multiple staff members appear equipped to lighten individual ‹pectations as well as absorb the flood of unrealistic expectations. Other findings have ighlighted trouble areas for clergy, such as anxiety, disappointment, and feelings of inadequacy, ress, and spiritual dryness. The perceived difficulties recorded by the participants propose nrealistic expectations and constant time limitations as the undercurrent of the abovementioned ·eas (Hall, 1997).

Warner and Carter (1984) studied the quality of life in male clergy and their spouses in ›ntrast to parishioners. After controlling for theological and doctrinal beliefs, they found that lergy tend to experience a greater degree of loneliness. Warner and Carter suggested that clergy ›neliness is caused by both burnout and reduced marital satisfaction, and both are intensified by ıe demands of ministry (Hall, 1997). Celeste, Walsh, and Raote (1995) contended that the motional well-being of clergy is positively correlated with vocational congruence, as measured y the Strong Interest Inventory (SII) Minister Scale and psychological adjustment, measured by ıe MMPI-2, among male clergy (Hall, 1997). Clergy with vocational congruence exhibited

gher energy levels, greater interest in relationships, and were more sensitive to the needs of eir parishioners, while incongruent clergy displayed depressive tendencies, anxiety, and social troversion.

Much remains to be learned about the emotional well-being of clergy and how it impacts astoral ministry. However, it is evident that the more relational maturity clergy embody the eater personal fulfillment and vocational success (Hall, 1997). Therefore, it is strongly ggested that clergy training should include educational opportunities in interpersonal and trapersonal skills. In addition, more research is needed to fully understand the relationship etween emotional well-being and spirituality of clergy (Hall, 1997).

tress and Coping

Constant demands, unrealistic expectations, and intrusions of family boundaries are ommon occupational hazards of pastoral ministry (Blackmon, 1984). Blackmon reported that 0% of the clergy he sampled had experienced periods of major stress, and 33% had strongly onsidered leaving the ministry. Morris and Blanton (1994) administered the Clergy Family Life nventory (CFLI; Blanton, Morris, & Anderson, 1990) to 136 clergy husbands and their wives or their study on work-related stressors. They found two significant work-related stressors for lergy: intrusiveness and lack of social support. These results suggest that infringement upon mily boundaries, lack of social support, and job related tasks are significant stressors that npact the parental, marital, and quality of life for couples in ministry (Hall, 1997).

Hatcher and Underwood (1990) observed the relationship between trait anxiety, self-oncept, and stress among Southern Baptist clergy. Their findings show that a poor self-concept nd low satisfaction in one's relationship with God related to high degrees of trait anxiety in lergy, as indicated by scores on the State-Trait Anxiety Inventory.

Recent research supports the conclusion that clergy display high levels of occupational ress and vocational strain (Hall, 1997). The work-related stressors include parish conflicts, aintaining a conservative lifestyle, motivating congregational involvement, and crisis work Iall, 1997). Furthermore, intrusion of family boundaries and lack of social support are sociated with poorer marriages and family relationships. Knowing the stressors and developing anagement strategies helps to reduce the impact of stress. Those successful in navigating the ressful demands inherent in ministry have been intentional in setting personal and professional oundaries. Helpful boundaries include adequate rest and relaxation, never bringing work home, id avoiding "extra" duties, when possible ((Meek et al., 2003).

larriage Strength and Affair Prevention

Numerous variables contribute to marital dissatisfaction among clergy. Clergy couples iat struggle in the following areas are more likely to experience marital dissatisfaction: role onfusion, poor communication, poor conflict resolution, perceived family stress, and sexual ustration (Hall, 1997). In addition, financial stress, lack of family privacy, inconsistent chedules, crisis management, and lack of support are causes for additional stress in marriage. eft unaddressed, these issues can provide the impetus to marital dissatisfaction, affairs, and/or ivorce.

Steinke (1989) described common characteristics of 65 male clergy who had been ivolved in affairs. He presented four dynamics that increased the probability of clergy affairs, ney are: projective identification, sexual dissatisfaction, need for love, and unhealthy narcissism. urthermore, Brock and Lukens (1989) suggest that invulnerability and gullibility contribute to lergy affairs. The most significant problem among clergy couples is the pastor's time ommitment to work. Lack of attention to spousal and family needs often leads to emotional istance and may contribute to seeking other forms of emotional support, e.g. pornography,

'fairs, addictions. Certain ministerial personality types can increase the susceptibility to an 'fair. Six personality types were indicated by Brock and Lukens (1989): (a) The Avoidant ɛrsonality, (b) The Dependent Personality, (c) The Narcissistic Personality, (d) The Antisocial ɛrsonality, (e) The Passive-Aggressive Personality, and (f) The Compulsive Personality. Not ıly are certain ministerial personality types susceptible to having an affair, there are certain ırishioner personalities that can potentially tempt clergy. These personalities are described as, ı) The Overly Affectionate Parishioner, (b) The Advice Seeker, (c) The Weeper, (d) The Fragile over, and (f) The Histrionic Counselee.

A survey administered by Fuller Institute of Church Growth describes some noteworthy atistics among clergy. For instance 70% of minister's report not having a close friend Headington, 1997), suggesting an epidemic of pastoral isolation. Because of the unrealistic ɛmands of parishioners, clergy often rely on their spouse and/or families to be their primary ıpport system (Meek et al., 2003). If the primary support system is not healthy, the risk for an ffair increases. Therefore, it has been proposed that the most effective strategy for preventing lergy affairs is greater connectedness with the primary support system. Connectedness is ɔcomplished by engaging in explicit spiritual activities together, such as praying together, ɛading Scripture together, and praying for one another (Meek et al., 2003). Connectedness can lso be achieved through emotional support. Clergy couples who play together and are intimate 'ith one another increase their connectedness. A final way clergy couples can increase onnectedness is by providing a life outside of work (Meek et al., 2003).

Furthermore, personal accountability decreases the risk of an extra-marital affair Steinke, 1989). Clergy should be accountable for self-knowledge and appropriate self-care. elf-knowledge leads to interpersonal awareness, which in return, increases the well-being of a

ıstor. Appropriate self-care entails participating in activities that promote rest, reflection, and lfillment.

ɹmily Adjustment

Ostrander, Henry, and Fournier (1994) studied stress, coping, and adaptation in 135 ergy families from several Protestant denominations. They found when stress from work :mands increases, family operations and harmony decrease. In addition, family hardiness (the ɔility to put things in perspective) and family coherence (trust, loyalty, etc.) were positive dicators of healthy family dynamics. In light of the results in his study, Hall (1997) :commended that clergy couples should limit the exposure of their families to stressful ɹcumstances, and at the same time provide them with healthy resources in order to handle the resses appropriately. Family loyalty and trust alleviate the pressure of stress within the family.

A lack of clear boundaries between family and work can also complicate healthy family ynamics (McMinn et al., 2005). The infringement of family boundaries upon clergy and their ɔouses has been associated with reduced marital and parental satisfaction (Morris & Blanton, 994). Furthermore, clergy families commonly talk about how they have a "fishbowl" existence, ʼhere the drama of their family life is played out in front of their congregations. This sense of ulnerability and exposure creates a sense of loneliness and isolation and limits the amount of ɔcial support available.

ʼurnout

The concept of burnout was first used by Freudenberger (1974) to describe the emotional tate of young social workers that worked with substance abusers. Freudenberger believed their motional distress was influenced by increased feelings of powerlessness. This simple bservation initiated the development of the burnout phenomenon, now commonly referred to as

ı occupational hazard for all helping professions. Burnout is most commonly defined (Maslach)93) as:

> A psychological syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who work with other people in some capacity. Emotional exhaustion refers to feelings of emotional overextension and depletion of one' emotional resources. Depersonalization refers to a negative, callous, or excessively detached response to other people, who are usually the recipients of one's service or care" (pp. 20-21).

urnout is associated with physical symptoms such as weight loss, fatigue, sleeplessness, eadaches, and gastrointestinal disturbances (Daniel & Rogers, 1981). It also manifests itself in ehaviors such as dysregulation of mood, quick temper, low-tolerance, increased anxiety, and ıspiciousness. A review of the research indicates that burnout symptoms in clergy strongly esemble the burnout symptoms of other helping professionals (Hall, 1997). However, clergy urnout has been empirically connected to time demands (Ellison & Mattila, 1983), role onfusion (Hall, 1997), unrealistic expectations (Ellison & Mattila, 1983), loneliness, spiritual ryness, and years in ministry (Prout, 1996).

Research indicates a positive relationship between the number of hours spent in ministry-elated activities and levels of burnout (Hall, 1997). The interpersonal factors associated with urnout are passive-aggressiveness, conflict avoidance, introversion, a lack of relational control, n inability to express affection, and emotional unawareness (Hall, 1997). Lower levels of urnout were reported by clergy who take family vacations, develop a professional support ystem, and create a flexible schedule (Hall, 1997).

To prevent ministry burnout one must first be able to recognize the symptoms (Evers & omic, 2003). An increase in clergy competencies through schooling and vocational training

ıay alleviate some burnout symptoms. Providing young clergy with mentors so that they may ɛceive appropriate support and guidance has also been shown to prevent burnout (Evers & 'omic, 2003).

npairment

Hall (1997) writes, "Significant psychopathology appears to be quite prevalent among ıbgroups of clergy referred for evaluation or treatment" (p.250). However, it is also noted that ıore research in this area is needed. Clergy in residential treatment have been diagnosed with orderline personality, neurotic disorders, psychotic disorders, passive-aggressive and arcissistic personalities (Hall, 1997). Clergy seeking psychological treatment often display ɡidity and a lack of insight in interpersonal complications, an exceedingly over-intellectualized rientation, and complaints involving issues of sexuality (Hall, 1997).

Sexual misconduct is a substantial problem for clergy, according to research. Different tudies report as many as 14-25% of clergy have engaged in inappropriate sexual behavior and stimates of the incidence of adultery range from 9 to 12%. Predictors of inappropriate sexual ehavior include unmanageable relational stress (marriage, family, and isolation), exposure to nd consumption of pornography, marital dissatisfaction, and emotional distance from spouse Hall, 1997).

ummary

The needs of clergy often go unnoticed. There appears to be a failure to acknowledge the ersistent pressure they feel to be continuously joyful, surprisingly insightful, and content in ıeir relationship with God. Clergy deserve a place where they can reconnect with their original ılling into the ministry (Meek et al., 2003). Creating this space gives clergy the opportunity to ɛestablish a sense of calling. It also validates the pain and sorrow they have accumulated along ıe way. If appropriate, clergy in crisis also need to be empowered to reenter ministry. Clergy

ed an outlet where they can be accepted without judgment. This is where mental health ofessionals can help. Mental health professionals that want to help clergy in crisis need to derstand their unique set of circumstances as well as accept the enormity of God's call on a inister's life. To this end, the need is great and the work is rewarding. They deserve our tention.

roposal for Study

For 33 years Marble Retreat has been addressing the needs of clergy in crisis by listening their stories, recognizing their pain, and reconnecting them with the calling God has in their fe. This study is the second step in the process of understanding effectiveness of treatment at Iarble Retreat. A previous outcome evaluation was conducted in 2000 (Nishimoto, 2002). In iis follow-up, research will look specifically at treatment effects and their stability and urability. Permission has been granted by Marble Retreat to participate in a study that ocuments the outcome of treatment and further contributes to the process of healing and estoration in clergy in crisis. It was hypothesized that participants in Marble Retreat's sychotherapy program will have significant treatment gains as measured by the Outcome)uestionairre 45.2 (OQ45.2), Revised Dyadic Adjustment Scale (RDAS), and the short-version piritual Well-Being Scale (SWB), and will be able to maintain them at a six-month follow-up.

Chapter 2

Method

This study was designed to measure the impact of Marble Retreat's psychotherapy rogram upon participants' primary treatment concerns. The participants, instruments, design, ıd unit of analysis for the data are presented below.

'articipants

A convenience sample of 68 participants was used for this study ($N = 68$). Informed onsent was obtained for each participant by explaining the rationale of the study and the nportance of monitoring his or her emotional and spiritual well-being as well as their marital djustment before and after treatment and at 6-month follow-up. The participants consisted of redominately clergy and their spouses; a small portion of the sample was non-clergy ($N = 4$); all articipated in treatment at Marble Retreat from January 2006 through February 2007. The ollow-up sample consisted of 18 participants.

An equal number of males and females participated; however one female participant ropped out after completing her pre-treatment measures. The participants were predominately aucasian ($N = 64$; 94%), while the other four participant's ethnicity (6%) was un-identified. he participants represented a wide variety of denominations, but were mostly evangelical. The ample population had spent an average of 22.65 years in ministry with a *SD* of 9.34 years.

Participants presented a variety of symptoms, including, but not limited to, ministerial urnout, depression, anxiety, marital conflict, infidelity, grief, loss and sexual addiction. On a

cale of 1 to 5, with 5 being the highest, participants identified the intensity of their presenting roblem on average at 4.32 with a *SD* of .95. It appears the participants in Marble Retreat sychotherapy program were in a considerable level of emotional and marital distress prior to eatment.

Aaterials

Four instruments were used in data collection: a demographic questionnaire, the Outcome)uestionaire-45.2 (OQ45), Revised Dyadic Adjustment Scale (RDAS), and Spiritual Well-Being cale (SWB) short version at pre-test, post-test, and at follow-up. The selection of criteria of hange was given serious consideration. Acknowledging the inherent difficulties that measures ave in identifying the moderators of change, selection was based on relevant domains Emotional, Marital, and Spiritual) for the population Marble Retreat serves, and the measure's sychometric features, specifically two estimates of reliability, test-retest and internal onsistency, and validity. Another important feature in selecting the measures was their user-riendly format. The demographic questionnaire included questions related to age, gender, inistry experience, primary concern, future ministry goals, indicators of self-efficacy including trategies to prevent levels of exhaustion and stress.

Outcome Questionnaire 45.2. The OQ 45.2 is a 45-item self-report scale designed to be n indicator of change using repeated measurement through the course of therapy and at ermination. It has high internal consistency (.93) and test-retest reliability (.84). It also lemonstrates moderate to high validity coefficients with other psychometrically sound measures f depression, anxiety, and global adjustment, such as the Beck Depression Inventory, Taylor Manifest Anxiety Scale, and the SCL-90-R (Lambert et al. 1996). Factor analysis was nsuccessful in establishing construct validity between the three subscales (individual, nterpersonal, and social role functioning). According to research, the variance is attributed to a

ngle symptom, distress (Mueller, Lambert, & Burlingame, 1998). Thus, only the global score 'as used. For this research the OQ45.2 pre-test internal consistency was .92 and the post-test 'as .93.

Revised Dyadic Adjustment Scale. The Revised Dyadic Adjustment Scale (RDAS) is a rief 14-item scale intended to measure the quality of relationship in couples. It is usually dministered to couples for the purpose of establishing current levels of marital distress. It's utoff score (47 and below) is typically used to ascertain clinical significance (Crane, Middleton, : Bean, 2000). The RDAS is believed to have adequate validity and is used extensively as a ıeasure of marital satisfaction. Busby, Christensen, Crane, and Larson (1995) reported an ıternal consistency coefficient of .90 for the global scale. The internal consistency coefficients or the measure used in this study were .80 at pre-test and .83 at post-test. No test/re-test data ould be found (Combs, Bufford, & Campbell, 2000). The RDAS was chosen for this study ecause of its face validity, easy administration as a motivator to increase participation, and its ensitivity to the relationship between perceived outcome and relationship satisfaction.

Spiritual Well-Being Scale. The Spiritual Well-Being (SWB) was developed by 'aloutzian and Ellison (Paloutzian & Ellison, 1982; Ellison, 1983). The SWB has adequate ıternal consistency (.89-.94) and test-retest reliability (.82-.99). The question of structure alidity has inconsistent results, but studies support convergent, divergent, predictive, and oncurrent validity (Genia, 2001). There appears to be a ceiling effect on the scale with some roups exhibiting scores that cluster on the high end, such as highly committed Christians Bufford, Paloutzian, & Ellison, 1991). However, distressed groups tend to show significantly ower scores (Bufford et al., 1991).

A short version of the SWB, developed by Bufford (2007), was used as the measure of piritual well-being in this study. It consists of 4 items, two of which measure the vertical

imension of relationship with God and include overt references to God and two that measure elationship to other humans and the world. These two scales are identified as Religious Well-eing Scale (RWB) and Existential Well-Being Scale (EWB), respectively. The 4 self-report ems are scored in a 6-point Likert Scale format ranging from "strongly agree" to "strongly isagree". Bufford (2007) reported alphas of .65, .66, and .78 for clinical members of the hristian Association for Psychological Studies, Air National Guard members, and a Pacific lorthwest community sample respectively using the 4-item version of the SWB; the 4-item ersion correlated with the full SWB .90, .94., and .90 respectively in those samples. The internal onsistency coefficient for this research was .69 for the pre-test and .84 for the post-test. These alues are considered good for a 4-item measure.

rocedure

A quasi-experimental one-group pre-test/post-test design was used (Cambell & Stanely, 963) with a six-month follow-up. Marble Retreat admits a total of eight people at a time; each roup includes four couples. The eight people participate in an 8- or 12-day intensive sychotherapy experience, which includes individual (4 hours) and group counseling (24 or 30 ours). Each day consists of three hours of group therapy as well as one hour of individual herapy on alternate days. Immediately upon arriving at Marble Retreat, participants were asked o complete and return the following pre-test measures: demographic questionnaire, OQ-45.2, DAS, and the SWB. Participants then received the 8- or 12-day treatment and were again dministered the OQ-45.2, RDAS, and SWB. Data were collected and returned to the Clinical Director of Marble Retreat.

Once data were collected and organized into cohorts, results were sent to the researcher or analysis. Six months following treatment, participants were mailed the OQ-45.2, RDAS, and WB and urged to complete and return the instruments within two weeks. A letter from the

oard of Directors of Marble Retreat Center encouraging participation was included as well as a
›ver letter explaining the objective of the follow-up procedure.

'nit of Analysis

This research is substantially exploratory in nature. There are a few expectations and
›me weak hypotheses. However, this research is meant to evaluate the program's effectiveness
ı relation to a number of variables. Data collected by the measures were analyzed using
escriptive statistics and tests of significance for variables that influence program effectiveness
nd client symptom relief. Descriptive statistics were used to compute the variables elicited on
ıe OQ-45.2, RDAS, and SWB. Measures of central tendency (mean, skewness, and kurtosis as
ppropriate) and standard deviation were provided for continuous variables. Gain scores were
omputed for each individual at posttest and follow-up. A 2tx groups x(2times) repeated
ıeasures ANOVA was used to determine differences between clergy and spouse and 8-day and
2-day treatment. The alpha level used for determining significance was .05.

Chapter 3

Results

Results include descriptive data, tests of mean changes over time, and subsequent nalyses. Among subsequent analyses are comparisons of those who completed follow-up testing nd those who did not, comparison 8-day and 12-day treatment programs, and comparison of lergy and spousal outcomes. Each will be discussed in turn.

)escriptive Data

Descriptive statistics for the selected measures are provided in Table 1. When compared o a clinical population, the participants in this study scored similarly at pre-treatment to that of a linical population. For example, on the OQ-45.2 the mean score for participants in an utpatient clinic was 83.09 with a standard deviation (*SD*) of 22.33 (Administration and Scoring *A*anual for the OQ45.2, 1996), while the mean score of Marble Retreat participants was 77.39 vith a *SD* of 11.17.

In the normative sample on the RDAS non-distressed couples had a mean score of 52.3 vith a *SD* of 6.6, while distressed couples had a mean score of 41.6 and a *SD* of 8.2 (Busby et l., 1995). At pre-test this sample population had a mean score of 46.43 with a *SD* of 7.12. Accordingly, the participants at Marble Retreat are in the distressed category. At post-test the nean score was 48.72 with a *SD* of 6.42, moving the participants closer to the non-distressed ategory.

The mean score of Christian psychologists taking the short version of the SWB was 22.10 ;ith a *SD* of 2.42 (Adams, 1993). At pre-treatment this sample population had a mean score of 7.81 with a *SD* of 3.75. At post-treatment the mean score was 19.72 with a *SD* of 4.39. The)wer mean scores suggest a slightly lower sense of well-being than might be expected for this opulation.

An outlier in the sample was identified in the follow-up data. The researcher made the ecision to include the participant because it was not detrimental to the study, and by including ıe subject the data remains most accurate.

'able 1

)escriptive Statistics for Participants in Marble Retreat Outcome Evaluation

	N	Mean	Std. Dev	Skewness/Std. Error	Kurtosis/Std. Error
)Q45.2t1	67	77.39	11.17	-0.73*/0.29	-0.12/.57
)Q45.2t2	67	70.67	8.95	-0.56/0.29	0.24/0.58
)Q45.2t3	17	65.35	10.91	-2.14*/0.54	4.81*/1.04
;DASt1	68	46.43	7.12	-0.73/0.29	-0.12/0.57
;DASt2	67	48.72	6.42	0.56/0.29	0.24/0.58
;DASt3	18	46.50	14.95	-2.14*/0.55	4.81*/1.06
;WBt1	63	17.81	3.75	-0.61/.30	.92/.59
;WBt2	65	19.72	4.39	-1.38*/0.30	1.58/.59
;WBt3	18	18.61	3.88	-0.44/0.54	-.92/1.04

Jote. * = significant skewness or kurtosis. OQ45.2 = Outcome Questionnaire. RDAS = Revised)yadic Adjustment Scale. SWB = Spiritual Well-Being Scale. t1 = Pretest. t2 = Posttest. t3 = 'ollow-up.

Pearson's correlations are provided in Table 2 for the mean scores on the three measures. ll three measures are moderately to strongly correlated at pre-test/post-test and follow-up.

able 2

'orrelations of Means on the OQ-45.2, RDAS, and SWB at Pre-test, Post-test, and Follow-up

	OQt1	OQt2	OQt3	RDASt1	RDASt2	RDASt3	SWBt1	SWBt2
)Qt2	0.56* [a]							
)Qt3	0.67* [b]	0.41 [b]						
.DASt1	-0.14 [a]	0.024 [a]	-0.20 [b]					
.DASt2	0.04 [a]	-0.24* [a]	-0.013	0.52* [a]				
.DASt3	0.36	0.33	0.24	0.57*	0.43 [b]			
WBt1	-0.42* [a]	-0.35* [a]	0.09 [b]	0.07 [a]	0.17 [a]	-0.09 [b]		
WBt2	-0.35 [a]	-0.55* [a]	-0.15 [a]	0.05 [a]	0.25 *[a]	-0.36 *[b]	0.68* [a]	
WBt3	-0.63* [b]	-0.43 [b]	**-0.47** [b]	0.33* [b]	0.19 [b]	0.33 [b]	0.57* [b]	0.48* [b]

lote. * $p < .05$; [a] n = between 63 and 66 subjects; [b] n = between 17 and 18 subject

Measuring Mean Changes Over Time

The first research question sought to ascertain treatment gains over time for the three measures employed. As expected, Marble Retreat treatment was found to have positive significant effects on the OQ45.2 scores, RDAS scores, and SWB scores. Effect sizes were also calculated for each of the dependent variables. In the case of the OQ45.2, statistically significant improvement in psychological functioning was met when analyzing change scores from pre-test to post-test, t (65) = 6.45, $p < .01$. Its effect size was moderate, Cohen's d'=.63.

The RDAS showed a statistically significant improvement in marital distress when nalyzing change scores from pre-test to post-test, t (66) = -3.43, $p < .01$.

Inlike the OQ45.2, the RDAS yielded a small effect size, Cohen's d' = .34.

'he SWB scores also displayed statistically significant improvement, t (62) = -5.00, $p < .01$. A ıoderate effect size is supported on the SWB, Cohen's d = .51. Table 3 presents the paired amples test.

'able 3

'he Effects of Marble Retreat Treatment- Paired Samples Test

	Pre-test scores			Post-test scores						
)ependent Measures	Mean	*N*	*SD*	Mean	*N*	*SD*	*t*	*df*	*p* (2-tailed)	Cohen *d*
)Q45.2	77.33	66	11.24	70.44	66	8.81	5.82	65	.000	.63 (mod)
:DAS	46.40	67	3.88	48.72	67	6.42	-3.43	66	.001	.34 (sm)
;WB	17.81	63	3.75	19.86	63	4.32	-5.00	65	.001	.51 (mod)

Jote. OQ45.2 = Outcome Questionnaire. RDAS = Revised Dyadic Adjustment Scale. SWB = ;piritual Well-Being Scale. For Cohen *d*, mod = moderate effect size and sm = small effect size.

;ubsequent Analysis

The second research question sought to discover if treatment gains due to Marble :etreat's psychotherapy program were maintained at a six to nine month follow-up. The esearch supports the assumption that Marble Retreat would have sustainable benefits. Due to he natural course of participant attrition, it was necessary to employ a t-test for Equality of Aeans. It was determined that there were no significant differences in pre-test and post-test cores of those who provided follow-up data and those who did not, as detailed in Table 4. 'herefore, it is suggested that those who did not provide follow-up data would have similar

utcomes at follow-up as those who did provide the follow-up data. The assumptions of equal ariances were met for each measure at each time with the exception of the RDASt2.

'able 4

)ifferences of Participants who Provided Follow-up Data and Those who did not

	Levene's Test for Equality of Variances		*t*-test for Equality of Means		
	F	Sig.	*t*	*df*	Sig. (2-tailed)
)Q45.2t1	0.34	0.56	0.93	66	0.36
:DASt1	2.43	0.12	-1.52	66	0.13
;WBt1	0.14	0.71	-1.89	61	0.06
)Q45.2t2	0.24	0.59	2.29	65	0.03
:DASt2*	4.22	0.04	-0.87	21.98	0.39
;WBt2	3.33	0.07	-2.57	63	0.01

Jote. t1 = pre-test responses on each particular measure. t2 = post-test responses on each ›articular measure. * = equal variances not assumed.

With respect to the OQ45.2, its scores were not only maintained, but they continue to mprove at follow-up. The sphericity assumption was met, Mauchly's $W(2) = .69, p = .06$. The)Q45.2 scores significantly improved over time, $F_{(2, 32)} = 15.66, p < .001$. In addition, a ›lanned comparisons showed that pre-treatment is significantly different from follow-up, $F_{(1, 16)} = 41.00, p < .001$. Planned comparisons also showed that post-treatment and follow-up scores ›n the OQ45.2 are significantly different, $F_{(1, 16)} = 7.54, p = .014$, suggesting the scores :ontinue to improve six months following treatment at Marble Retreat.

The RDAS treatment effects were not maintained at follow-up. The Sphericity ssumption was not met, Mauchly's $W(2) = .36, p = .001$. Thus, the Greenhouse-Geisser orrection was employed. The RDAS scores are not significantly different over time, $F(_{1.22,}$ $_{3.68}) = 0.55, p = .50$. Planned comparisons showed that pre-treatment is not significantly ifferent from post-treatment, $F(_{1, 17}) = 0.26, p = .62$. Planned comparisons show that post-reatment is not significantly different from follow-up, $F(_{1, 17}) = 0.70, p = .41$.

The data revealed that the SWB treatment effects were maintained at follow-up. The phericity assumption was met, Mauchly's $W(2) = .91, p = .48$. The SWB scores are ignificantly different over time, $F(_{2, 32}) = 3.91, p = .03$. Planned comparisons show that pre-reatment scores are significantly different from follow-up scores, $F(_{1, 16}) = 7.43, p = .02$. Iowever, planned comparisons show that post-test scores are not significantly different from ollow-up scores, $F(_{1, 16}) = 0.37, p = .55$. Thus, the treatment effects were retained, but they did ıot continue to improve.

Comparison of 8-day Treatment to 12-day Treatment

In an effort to learn how 8-day treatment and 12-day treatments effects compare to one ınother, a 2tx groups x(2times) repeated measures ANOVA was implemented. There was no nain effect of length of treatment on the OQ45.2 and the SWB measures. However, on the RDAS there is a main effect of length of treatment, $t(66) = 2.50, p = .015$. Upon further ınalysis, there was a pre-existing difference in score means at pre-test between the participants in he 8-day treatment compared to the 12-day treatment that was confounding the effect of reatment. Therefore, a 2 x (2) ANOVA with the pretest scores covaried was implemented, and he main effect for session length was not significant. Accordingly, no evidence was found to ıupport that Marble Retreat's psychotherapy program's effectiveness is dependent upon length ›f treatment.

In particular, the OQ45.2 scores show no effect of session length. The sphericity ssumption was met, Mauchly's $W(2) = 1.00$. There is a main effect for time, $F(_{1,64}) = 31.35, p$: .001. However, there is no main effect for session length, accordingly 8-day and 12-day :eatments did not differ overall, $F(_{1,64}) = .24, p < .63$. There was no interaction of session :ngth and time suggesting subjects in 8-day and 12-day treatments have similar scores at pre nd post-treatment, $F(_{1,64}) = 0.48, p < .49$.

RDAS scores show no effect of session length. Sphericity assumption was met, Mauchly's $W(2) = 1.00$. There was a main effect for time, $F(1.65) = 7.48, p < .01$. There was o effect for session length, $F(1,65)\ 8.54, p < .01$. There also was no interaction of session :ngth and time, $F(1,65) = .12, p < .74$.

SWB scores showed no effect of session length. The sphericity assumption was met, Maunchly's $W(2) = 1.00$. There was a main effect for time $F(_{1,61}) = 24.57, p < .001$. There vas no main effect of session length $F(_{1,61}) = 0.09, p < .76$. Furthermore, there was no nteraction of session length and time; 8-day and 12-days behave comparably at pre-test and ›ost-test, $F(_{1,61}) = 0.88, p < .35$.

Comparison of Clergy and Spouse

In an effort to explore the response differences between clergy and spouse a 2tx groups :(2times) repeated measures ANOVA was conducted. No main effect was found between clergy nd spouse on two of the three measures used. Consequently, clergy and spouse do not differ ›verall in how they responded to treatment. Clergy status is confounded with gender in this tudy because a positive identification of clergy status was synonymous with being male. The ame conclusion can not be made about being female and the spouse because the sample ncludes four non-clergy couples. Those four participants were included in the spouse category.

On the OQ45.2 the sphericity assumption was met, Mauchly's $W(2) = 1.00$. There is a ıain effect for time $F(_{1,64}) = 33.72, p < .001$. There was no main effect of clergy status, $F(_{1,64})$ $0.27, p < .61$. There was no interaction of session length and time signifying that clergy and pouse behaved comparably at pre-test and post-test, $F(_{1,64}) = 0.37, p < .55$.

When considering the RDAS the sphericity assumption was met, Mauchly's $W(2) =$ .00. There was a main effect for time, $F(_{1,65}) = 11.88, p < .001$. There was no main effect of lergy status; clergy and spouse do not differ overall, $F(_{1,65}) = 1.75, p < .19$. There was no ıteraction of session length and time, again indicating that clergy and spouse behave omparably at pre-test and post-test, $F(_{1,65}) = .56, p < .46$.

With respect to the SWB, the scores show no effect of clergy status. Sphericity ssumption was met, Mauchly's $W(2) = 1.00$. There was a main effect for time (SWB scores for ll improve= same as #2 hypothesis test of SWB) $F(_{1,61}) = 24.19, p < .001$. There was no main ffect of session length, suggesting that clergy and spouse do not differ overall, $F(_{1,61}) = 0.15, p$ $< .70$. Finally, there was no interaction of session length and time, suggesting that clergy and pouse behave comparably at time 1 and time 2, $F(_{1,61}) = 0.01, p < .92$.

'able 5

'ests of Significance for OQ45.2, RDAS, and SWB

	Mauchly's	*df*	*F*	Sig
)Q45.2				
Planned Comparisons				
1) Pre/Follow-up	.69	1,16	41.00	.001
2) Post/Follow-up	.69	1,16	7.54	.014
Repeated Measures ANOVA				
3) 8 vs.12 day Treatment	1.00	1,64	0.24	.630
4) Clergy and Spouse	1.00	1,64	0.27	.610
:DAS				
Planned Comparisons				
1) Pre/Follow-up	.36	1,17	0.26	.620
2) Post/Follow-up	.36	1,17	0.70	.410
Repeated Measures ANOVA				
3) 8 vs.12 day Treatment	1.00	1,65	8.54	.010
4) Clergy and Spouse	1.00	1,65	1.75	.190
;WB				
Planned Comparisons				
1) Pre/Follow-up	.91	1,16	7.43	.020
2) Post/Follow-up	.91	1,16	0.37	.550
Repeated Measures ANOVA				
3) 8 vs.12 day Treatment	1.00	1,61	0.09	.760
4) Clergy and Spouse	1.00	1,61	0.15	.700

Chapter 4

Discussion

Marble Retreat's psychotherapy program provided solid treatment gains for its participants. Significant treatment gains were attained from pre-treatment to post-treatment in all three domains; emotional well-being, marital adjustment, and spiritual well-being. In addition, the emotional well-being and spiritual well-being treatment gains were maintained at a 6-9 month follow-up, while the marital adjustment treatment gains were not maintained. No differences were found between 8-day and 12-day treatments, justifying Marble Retreat's recent transition in format. Furthermore, the treatment effects were similar for both clergy and spouse participants, although clergy participants reported more improvement in marital adjustment than the spouse participants.

The following includes a discussion of symptom severity identified by Marble Retreat participants, their symptom change and symptom maintenance, as well as treatment effects of duration and participant roles (clergy or spouse).

Symptom Severity

According to the normative means provided on the OQ-45.2 and RDAS, the sample understudy is slightly less distressed than patients in similar population groups. To reconcile the fact that those who participated in treatment at Marble Retreat identified their problems as highly intense yet the mean scores suggest they are not distressed; a closer look at the unique dynamics of this population is necessary. Members of the clergy typically hold positions of responsibility

hat require a minimal level of functioning in order to function adequately in their environment. Their congregations typically have high expectations of them; therefore their scores might nderstate levels of distress. Another way to look at it is that members of clergy and their pouses have learned to defend against admitting weaknesses because of the unreasonable xpectations to adhere to social conventions that parishioners and congregants place on them. Therefore, it may be difficult to accurately gauge how they compare to other populations.

ymptom Change

The participants in the Marble Retreat psychotherapy program showed statistically ignificant treatment gains in all three domains; psychological functioning, marital adjustment, nd spiritual well-being from pre to post-treatment, thus supporting the original research ypothesis: Marble Retreat's psychotherapy program demonstrates short-term benefits. Effect izes were moderate for stress reduction and increases in well-being and small for marital atisfaction. The general thrust of the data suggests the participants in this study experienced imilar treatment gains to those in a clinical population (Lambert, 2004).

Marble Retreat's psychotherapy modality, *brief, intensive psychotherapy*, appears to be quite effective in working with a wide variety of presenting issues, including but not limited to, motional distress, spiritual crisis, and marital adjustment. In particular, Marble Retreat appears quite adept in treating the psychological and spiritual concerns of their participants.

Maintenance of Change

Additionally, participants treated with Marble Retreat psychotherapy program have hown statistically significant treatment maintenance on two of the three domains; psychological listress and spiritual well-being. Psychological distress continues to improve over the follow-up eriod, and spiritual well-being gains were maintained.

In terms of marital adjustment, the data appears less convincing, the treatment gains in he area of marital adjustment were not maintained at 6 to 9 month follow-up. This latter finding s similar to most treatment outcomes in Couples Therapy (CT). Even in the most successful CT reatments, less than half the couples treated have significantly positive outcomes (Lambert, :004). In fact, Christensen and Heavey (1999) stated, "We can say with confidence that fewer han half of couples treated in therapy will move from distressed to non-distressed." Thus, the act that participants in the Marble Retreat psychotherapy program indicated statistically ignificant positive outcomes is an impressive finding.

In addition, the long-term sustainability (6 to 9 months) of treatment gains in CT have arely been the subject of treatment outcome research (Lambert, 2004). In those studies where ong-term follow-up for marital satisfaction was employed, the positive effects of CT leteriorated significantly beyond 6 months (Christensen & Heavey, 1999). With that said, this tudy further confirms what is already commonly accepted in CT: treatment gains and naintenance in the area of marital adjustment is difficult. Intimate dyadic relationships are all oo often unsatisfying and tainted with discord.

Duration of Treatment

In the summer of 2006, the BOD endorsed a transition from a 12-day treatment format to in 8-day treatment format. Due to this transition, the BOD were interested in knowing if there vere any treatment effects between the two formats. The data in this study substantiates the alidity of this transition. The move towards an 8-day format appears to have been a good lecision, not only because there is no noticeable difference between the groups, it is also a more ıser-friendly model that will likely attract more participants.

Participant Roles

Similarly, the BOD was curious to know if there were noticeable difference in treatment effects between clergy and spouse participants. The difference in treatment effects between these two groups were minimal, but worth discussing. The psychological distress and spiritual well-being treatment effects are similar to both groups, however the marital satisfaction paints a different picture. Clergy and spouse benefited equally in reduced distress and enhanced spiritual well-being. However, it appears as if the clergy group sees more marital improvement than the spouse group.

The difference in clergy and spouse responses makes sense in light of the outcome literature in CT. As stated above, the clergy group and spouse group are confounded with gender: clergy equals male and spouse equals female, with one or two exceptions. Using the Dyadic Adjustment Scale as a predictor of post-treatment satisfaction for couples in distress treated using Emotionally-focused Couples Therapy, Johnson and Talitman (1997) found that a wife's initial level of faith in her partner's investment increased their marital satisfaction (Lambert, 2004).

Using Johnson and Talitman's findings as a template to explain the differences in this sample, it is proposed that the member's of clergy might perceive that their level of investment is satisfactory given their involvement in treatment, thus increasing their level of marital satisfaction. However, spouses want to see evidence of continuing change once they are faced with the customary demands of everyday life and ministry. The lack of expected parallel growth is disconcerting, and may be explained in several ways. First, behavior change tends to gradually follow commitment. Therefore, it is possible that clergy were more focused on the commitment level of the relationship, while the spouses focused on behavior during follow-up. Second, the RDAS focuses on behavioral modifications in marital relationships, while the Marble Retreat's

›sychotherapy program focused more on emotional and relational functioning. Thus, the RDAS nay not adequately reflect marital change.

Clinical Implications

How does this information translate into the everyday operations of Marble Retreat? First of all, it substantiates the results that were initially reported in a utilization-focused program evaluation conducted in 2000 (Nishimoto, 2002): Marble Retreat's psychotherapy program is efficacious in treating clergy in crisis.

An important question to consider is what type of participant problems is Marble Retreat's psychotherapy program most equipped to treat? According to this study, the program s especially proficient at treating and sustaining psychological distress relief and reconnecting he participants with God and their calling in vocational clerical work. In the Nishimoto study 2002), 35% of Marble Retreat alumni identified emotional distress as their primary concern. In ıddition, the present data show an increased sense of spiritual well-being as a result of treatment. This appears to be a nice match of fitfulness between client and treatment. Therefore, it is ›roposed that Marble Retreat's psychotherapy program is well suited for clergy, and non-clergy, lealing with personal growth issues, vocational burnout, emotional distress, and spiritual crisis.

It is also suggested that Marble Retreat is somewhat successful in treating marital listress, even though the data was not as strong in this area. Results are consistent with the ›utcome literature in couples therapy (Lambert, 2004).

Given the results of the 6- to 9-month follow-up in the area of marital adjustment, it is ıuggested that the Marble Retreat staff and BOD broaden the scope of follow-up treatment for heir participants. A follow-up treatment plan helping the couples implement effective strategies ›f maintaining a healthy marriage, like establishing effective boundaries between family life and

ninistry and not accepting the expectations of maintaining an image of the "perfect family" may ıelp sustain the treatment gains at follow-up.

Marble Retreat's psychotherapy program emphasis on group therapy as the primary reatment approach, with individual therapy provided as a supplement, in a retreat setting that :reates and atmosphere of safety and acceptance (Nishimoto, 2002) looks as if it may be :xceptionally suited for the treatment needs of clergy. Treatment in a retreat setting disarms the ıegative perception of mental health care, enhances the need for privacy outside of the context of he community where clergy live and work, and decreases the distraction of daily life, all of vhich have been found helpful in working with clergy (McMinn et al., 2005).

Limitations of the Study

Given the nature of this study there are several limitations that are important to highlight. First, without a control group the researcher was not able to isolate the treatment gains and, thus, ınable to confirm that gains were solely attributable to Marble Retreat's psychotherapy program. In addition, there were no controls for additional gains following treatment. For example, the ·esearcher did not screen for continued psychological treatment following participation in Marble Retreat's psychotherapy program.

Incomplete data also complicated the analysis. Several participants did not complete one ɔr more of the measures. The rate of attrition limited the power of the follow-up analyses. The ·esearcher counted on motivation of Christian service to increase participation at follow-up.

The selection of criteria of change was given serious consideration. However, it is ıcknowledged that any measure of change has inherent weaknesses that cannot adequately :apture the complexity of the human growth process. Other measures may have found larger or ;maller treatment outcomes—or none at all. Complementing the present results, the outcome :valuation conducted by Nishimoto (2002) gives some indication of the historical perception of

›articipant satisfaction with the effectiveness of Marble Retreat's psychotherapy program, and hus helps round out this study.

Suggestions for Future Research

Much is left to uncover in the area of treating the psychological, emotional, and spiritual ıeeds of clergy. Highlighted in the research literature, and confirmed in this outcome evaluation, s the reality that marital relationships are an area of vulnerability for some clergy. Therefore, nore research should be conducted to illuminate effective strategies for treating marital elationships of clergy and their spouses.

Additional research is also needed in substantiating moderators of change for clergy. The 'acilitators of change will help us understand what forms of treatment work most effectively for his population.

Conclusion

In conclusion, although firm causal conclusions cannot be drawn due to the quasi-:xperimental nature of the study, the present data suggest Marble Retreat's psychotherapy ›rogram is quite effective in treating clergy in crisis. Specifically, participants in Marble Retreat ›sychotherapy program reported significant reductions in psychological distress with an ıssortment of presenting problems and continued improvement in this area 6 to 9 months 'ollowing treatment. Maintaining treatment gains in the area of marital adjustment was less :ffective. However, the results resemble what is commonly seen in CT outcome research. Further, clergy and spouses showed generally similar benefits in reduced psychological distress, ncrease spiritual well-being and enhanced marital relationships. During follow-up, ›sychological distress continued to diminish, spiritual well-being was maintained, but gains in narital satisfaction seemed to decline a bit. The treatment effects were similar regardless of :ight or twelve day duration of treatment.

References

Adams, S. A. (1993). Spiritual well-being, religiosity, and demographic variables as predictors of the use of Christian counseling techniques among members of CAPS, USA. University Microfilms International, 9316275.

Administration and Scoring Manual for the OQ45.2. (1996). American Professional Credentialing Services, LLC.

Berman, W. B. (1997). Ten commandments for avoiding clergy malpractice in pastoral counseling. *Journal of Psychology and Christianity, 16*, 268-272.

Blackmon, R. A (1984). *The hazards of the ministry*. Unpublished doctoral dissertation, Fuller Theological Seminary, Pasadena, CA.

Blanton, P. W., Morris, M. L., Anderson, D. (1990, November). The development of a questionnaire to measure stress in clergy families. Paper presented at the 1990 meeting of the National Council on Family Relations, Seattle, WA.

Bradshaw, S. L. (1977). Clergy in trouble: A study of 140 cases evaluated at the Menninger Foundation. *The Journal of Pastoral Care, 31*, 230-242.

Brock, R. T., & Lukens, H. C. (1989). Affair prevention in the ministry. *Journal of Psychology and Christianity, 8* (4), 44-55.

Brokaw, B. F. & Edwards, K. J. (1994). The relationship of God image to level of object relations development. *Journal of Psychology and Theology, 22*, 352-371.

Bufford, R. K. (2007). *Short version of the Spiritual Well-Being Scale for institutional research.* Unpublished manuscript, George Fox University, Newberg, OR.

Bufford, R. K., Paloutzian, R. F., & Ellison, C. W. (1991). Norms for the Spiritual Well-Being Scale. *Journal of Psychology and Theology, 19* (4), 56-70.

Busby, D. M, Christensen, C., Crane, R. D., & Larson, J. H. (1995) A revision of the

dyadic adjustment scale for use with distressed and nondistressed couples: Construct hierarchy and multidimensional scales. *Journal of Marital and Family Therapy, 21,* 289-308.

Campbell, D. T., & Stanely, J. C. (1963). Experimental and quasi-experimental designs for research. Boston, MA: Houghton Mifflin.

Celeste, B. L., Walsh, W. B., & Raote, R. G. (1995). Congruence and psychological adjustment for practicing male clergy. *The Career Development Quarterly, 43,* 374-384.

Chiaramonte, A. J. (1983). Psychological correlates of burnout in clergymen (Doctoral dissertation, Boston College, 1983). *Dissertation Abstracts International, 44 (2-A),* 433.

Christensen, A., & Heavey, C. L. (1999). Interventions for couples. *Annual Review of Psychology, 50,* 165-190.

Ciarrocchi, J. W., & Wicks, R. J. (2000). *Psychotherapy with priests, protestant clergy, and catholic religious*. Madison, CT: Psychosocial Press.

Combs, C. W., Bufford, R. K., & Campbell, C. D. (2000). Effects of Cognitive-Behavioral Marriage Enrichment: A Controlled Study. *Marriage & Family: A Christian Journal, 3*(1), 99-111.

Crane, R. D., Middleton, K. C., & Bean, R. A. (2000) Establishing criterion scores for the Kansas Marital Satisfaction Scale and the Revised Dyadic Adjustment Scale. *American Journal of Family Therapy, 28* (1), 53-60.

Daniel, S., & Rogers, M. L. (1981). Burn-out and the pastorate: A critical review with implications for pastors. *Journal of Psychology and Theology, 9,* 232-249.

Earle, R. (1994). The problem of sexual trauma and addiction in the Protestant Church. *Sexual Addiction and Compulsivity, 1* (2), 137-139.

Ellison, C. W. (1983). Spiritual Well-Being: Conceptualization and measurement.

Journal of Psychology and Theology, 11, 330- 340.

Ellison, C. W., & Mattila, W. S. (1983). The needs of evangelical Christian leaders in the United States. *Journal of Psychology and Theology, 11,* 28-35.

Evers, W., & Tomic, W. (2003). Burnout among dutch reformed pastors. *Journal of Psychology and Theology, 31* (4), 329-338.

Freudenberger, H. J. (1974). Staff-burnout. *Journal of Social Issues, 30,* 159-165.

Frey, W., DeVries, J., Exley, R., & McBurney (1992). Creating a restoration process. *Leadership, 13*, 122-134.

Genia, V. (2001). Evaluation of the Spiritual Well-Being Scale in a sample of college students. *International Journal for the Psychology of Religion, 11* (1), 25-33.

Grosch, W. N., & Olsen, D. C. (2000). Clergy burnout: An integrative approach. *Journal of Critical Psychology, 56,* 619-632.

Hall, T. W. (1997). The personal functioning of pastors: A review of empirical research with implications for the care of pastors. *Journal of Psychology and Theology, 25,* 240-253.

Hall, T. W., & Brokaw, B. F. (1995). The relationship between spiritual maturity and level of object relations development. *Pastoral Psychology, 43,* 373-391.

Hatcher, S. W., & Underwood, J. R. (1990). Self-concept and stress: A study of a group of Southern Baptist clergy. *Counseling and Values, 34,* 187-196.

Headington, G. L. (1997). *A guide to recovery for fallen pastors: The journey back from sexual misconduct*. Unpublished doctoral dissertation, Fuller Theological Seminary, Pasadena, CA.

Houts, D. (1977). Pastoral care for pastors: Toward a church strategy. *Pastoral Psychology, 25,* 186-196.

Johnson, S. M., & Talitman, E. (1997). Predictors of success in emotionally focused marital therapy. Journal of Marital and Family Therapy, *23* (2), 135-152.

Lambert, M. J. (2004). *Bergin and Garfield's handbook of psychotherapy and behavior Change*. New York: John Wiley & Sons, Inc.

Lambert, M. J., Burlingame, G. M., Umphress, V., Hansen, N. B., Vermeersch, D. A., Clouse, G. C., & Yanchar, S. C. (1996). The reliability and validity of the Outcome Questionnaire. *Clinical Psychology and Psychotherapy, 3*, 249-258

Larsh, W. G. (1994). Family types, family satisfaction, and ministry satisfaction in clergy families: A report of clergy couples in the Evangelical Free Church of America (Doctoral dissertation, Trinity Evangelical Divinity School, 1994). *Dissertation Abstracts International*, 55-06A, 1517.

Marble Retreat (1999). Brochure of ministry. Marble, CO.

Maslach, C. (DATE). Burnout: A multidimensional perspective. In W. B. Schaufeli, C. Maslach, & T. Marek, (Eds.). Professional burnout: Recent developments in theory and research. (pp.19-32). Philadelphia, PA: Taylor & Francis.

McMinn, M. R., Lish, A. R., Trice, P. D., Root, A. M., Gilbert, N., and Yap, A. (2005). Care for pastors: Learning from clergy and their spouses. *Journal of Pastoral Psychology*, *53* (6), 563-581.

Meek, K. R., McMinn, M. R., Brower, C. M., Burnett, C. M., McRay, B. W., Ramey, M. L., Swanson, D. W., & Villa, D. D. (2003). Maintaining personal resiliency: Lessons learned from evangelical protestant clergy. *Journal of Psychology and Theology*, *33* (4), 339-347.

Meloy, J. R. (1986). Narcissistic personality and the clergy. *Pastoral Psychology*, *35,* 50-55.

Morris, M. L., & Blanton, P. W. (1994). The influence of work-related stressors on clergy husbands and their wives. *Family Relations, 43,* 189-195.

Mueller, R. M., Lambert, M. J., & Burlingame, G. M. (1998). Construct validity of the Outcome Questionnaire: A confirmatory factor analysis. *Journal of Personality Assessment, 70* (2), 248-262.

Nishimoto, J. K (2002). A program evaluation of marble retreat: A psychotherapy program for clergy in crisis. Unpublished dissertation, Wheaton College.

Ostrander, D. L., Henry, C. S. & Fournier, D. G. (1994). Stress, family resources, coping, and adaptation in ministers' families. *Journal of Psychology and Christianity, 13* (1), 50-67.

Paloutzian, R. F., & Ellison, C. W. (1982). Loneliness, spiritual well-being and quality of life. In L. A. Peplau & D. Perlman (Eds.), Loneliness: A sourcebook of current theory, research and therapy (pp. 224-237). New York: Wiley.

Prout, D. L. (1996). Effects of loneliness, years of service, and spiritual well-being upon burnout. Unpublished dissertation, Loyola College of Maryland.

Spilka, B., Hood, R. W., Hunsberger, B., & Gorsuch, R. (2003). The psychology of religion: An empirical approach, 3rd edition. New York: The Guilford Press.

Steinke, P. L. (1989). Clergy affairs. *Journal of Psychology and Christianity, 8* (4), 56-62.

Swenson, W. & Martin, H. (1976). A description and evaluation of an outpatient intensive psychotherapy center. *American Journal of Psychiatry, 133* (9), 1043-1046.

Von Stroh, S. P., Mines, R. A., & Sharon, K., (1995). Impaired clergy: Applications of ethical principles. *Journal of Counseling and Values, 40* (1), 6-14.

Warner, J., & Carter, J. D. (1984). Loneliness, marital adjustment and burnout in pastoral and lay persons. *Journal of Psychology and Theology, 12,* 125-131.

Appendix A

Consent Form to Act as a Participant

Consent Form to Act as a Participant

This study is designed to evaluate the effectiveness of Marble Retreat treatment modality and its lasting effects in symptom relief and self-awareness.

_____

Name Date

I hereby authorize Scott Koeneman, M.A. of the Graduate Department of Clinical Psychology, George Fox University, Newberg, OR, and any research assistants designated by him, to gather information from me on the effectiveness of Marble Retreat treatment modality. My participation will involve:

a. Responding to one demographic questionnaire.

b. Responding to three psychological measures three different times which assess marital adjustment, spiritual well-being, and symptom distress.

1. I understand there is minimal psychological risk involved as discussed in the following statements:
   a. I am aware that some people may become offended by the questionnaires used in this study.
   b. I am aware that I may not choose to answer any questions that I find embarrassing or offensive.
   c. I have been assured that I must feel free to refuse to discuss any matters that cause me discomfort or that I might experience as an unwanted invasion of privacy.
2. I understand that I may terminate my participation in this study at any time.
3. I understand that if, after my participation, I experience any undue distress that may have been evoked by my participation in this study, Scott Koeneman, M.A., or one of his associates will be available for consultation.
4. The procedures and investigation listed above have been explained to me by Scott Koeneman, M.A., or one of his associates.
5. I also understand that confidentiality of research results will be maintained by the researcher, Scott Koeneman, M.A.. No individual results will be released without my expressed written consent.
6. I also understand that feedback regarding the overall results of the research will be provided, if desired. I understand that I will be asked if I am interested in a written summary of the completed research project, prior to my initiating my participation in the project.

_____

Signature Date

Appendix B

Instructions to Clinical Director

Instructions to Clinical Director

Please read the following description and instructions about the study to <u>each</u> Cohort:

This study is designed to assess the effectiveness of the unique treatment modality at Marble Retreat. Should you consent, your participation in this study will provide valuable data to Marble Retreat. The responses you provide will be useful in helping Marble Retreat better understand the spiritual, emotional and psychological needs of clergy, and can help in establishing treatment modalities that can better target these needs.

Please remove the packet of material from the envelope and read each page, answering each question. In order to insure your confidentiality, your responses will be isolated from your identity before analyzed by the researcher.

Upon completion of the test battery, please place the packet back into the envelope, and re-seal it with the metal tabs. Please return the pre-test packet to the Clinical Director's office prior to your 1st group session and the post-test packet before leaving Marble Retreat. You will be mailed the follow-up packet 6-months following your participation please fill it out and return it to Marble Retreat.

Appendix C

Demographic Questionnaire

Demographic Questionnaire

1. Age:_____

2. Gender: Male_____

   Female_____

3. Race (check one):

   _____Caucasian
   _____Hispanic
   _____Asian
   _____African American
   _____American Indian
   _____Other (please clarify)_____

4. Current Marital Status (check one):

   _____Married
   _____Single
   _____Divorced
   _____Widowed
   _____Separated

5. Do you have children? _____ if yes, how many?_____

   Ages:_____

6. How long have you been serving in ministry? _____

7. Have you received prior psychological treatment? _____

   How many sessions?
   ____1-5
   ____5-10
   ____10-20
   ____20 or more

   In what way was it helpful? _____

8. Using a 5 point Likert Scale (1 = no social support 5=feel supported), describe your social support network:

   ____Family

____Spouse
____Colleagues
____Friend
____Mentor
____Small Group

9. How do you handle stress (please check or expand)?

_____
_____
_____

_____Read
_____Sleep
_____Clean the house
_____Talk to a friend
_____Pray
_____Eat
_____Talk to a family member
_____Exercise
_____Watch a movie
_____Organize
_____Drink Alcohol
_____Worry
_____Talk to a Colleague

10. Are you currently taking any medications?

___yes
___no

If so, what are you taking and what is the dosage? _____
_____
_____

11. Presenting Issue:_____
_____
_____
_____

How long have you been dealing with this issue?_____

Intensity of complaint on a scale of 1 to 5, 5 being the highest:_____

12. What are you hoping to change while at Marble Retreat?

Appendix D

Spiritual Well-Being Scale – Short Version

Spiritual Well-Being Scale – Short Version

For each of the following statements circle the choice that best indicates the extent of you agreement or disagreement as it describes your personal experience:

SA = Strongly Agree	A = Agree	MD = Moderately Disagree
MA = Moderately Agree	D = Disagree	*SD* = Strongly Disagree

1. I feel very fulfilled and satisfied with life ..... SA MA A D MD *SD*

2*. I don't enjoy much about life ..... SA MA A D MD *SD*

3*. I don't have a personally satisfying relationship with God ..... SA MA A D MD *SD*

4. My relationship with God contributes to my sense of well-being ..... SA MA A D MD *SD*

*Item reverse-scored.

Appendix E

Curriculum Vita

Curriculum Vita

Scott Koeneman, M.A.

18718 SW 91st Terrace Tualatin, Oregon 97062
skoeneman@mac.com
(503) 784-8995

Education

August 2003 – present	**Student in Doctor of Clinical Psychology Program** Graduate School of Clinical Psychology, APA Accredited George Fox University Newberg, Oregon -projected graduation date: May 2008
May, 2005	**Master of Arts: Clinical Psychology** Graduate School of Clinical Psychology George Fox University Newberg, Oregon
May, 2003	**Master of Arts: Counseling** Denver Seminary, CACREP Accredited Denver, CO *With Honors*
May, 1998	**Bachelor of Science: Physical Education** Oklahoma Christian University Oklahoma City, Oklahoma

Supervised Clinical Experience

Doctorate Level Training	
July 2006-Present	**Psychology Pre-Intern Student** *Northwest Occupational Medicine Center* Tigard, Oregon *Population* -Veterans, Chronic pain patients, Law enforcement employees *Clinical Duties:* • Conduct neuropsychological test administration for head trauma victims, veterans, and disability claims.

	• Assistance in neuropsychological test interpretation and behavioral observations. • Co-facilitate psycho-educational groups for chronic-pain patients; topics include sleep hygiene, problem-solving, effective communication, etc. • Co-facilitate functional biofeedback. • Co-facilitate comprehensive chronic pain evaluations. • Consult in interdisciplinary team meetings with a psychiatrist, a psychologist, physical therapist, and occupational therapist. • Observe Law enforcement post-offer/pre-employment psychological evaluations. • Observe psycho-diagnostic social security evaluations. • Observe critical incident debriefing sessions. *Supervision*: -Individual and group *Supervisor*: -Luke Patrick, Ph.D. Licensed Psychologist *Clinical Hours*: 60 direct (current)
September 2005-Present	**Psychology Practicum II/Pre-Intern Student** *Supplemental Training: Psychodynamic Psychotherapy Population* -Adult/Clergy *Clinical Duties*: • Provide long-term psychotherapy in once/twice a week object relations framework. • Provide transcripts of each session. • Evaluation of transference/countertransference issues. • Participate in psychodynamic case conceptualization. *Supervision*: -Psychodynamic group supervision, Individual psychoanalytic consultation *Supervisors*: -Kathy Reicker, LCSW, Psychoanalyst -Kurt Free, Ph.D., Licensed Psychologist *Clinical Hours*: 75 direct (current)
September 2005-June 2006	**Psychology Practicum II Student** *Portland State University Student Health and Counseling Center* Portland, Oregon *Population*

	-Adults *Clinical Duties*: • Provide comprehensive clinical interviewing. • Conduct Psycho-Educational assessment administration, interpretation, and report writing. • Received specialized training in ADHD and Learning Disorders. *Supervision* -Individual, group, weekly training sessions *Supervisor*: -Linda Fishman, Ph.D., Licensed Psychologist *Clinical Hours*: 160 direct
September 2004-June 2005	**Psychology Practicum I Student** *George Fox University Health and Counseling Center,* Newberg, Oregon *Population* -Adults *Clinical Duties* • Provide individual short and long-term therapy utilizing various treatment modalities. • Conduct comprehensive clinical interviews and dictate assessment reports. • Develop treatment plans and therapeutic goals. • Psychological/Intellectual assessment administration, Interpretation, and report writing. • Perform alcohol assessments for mandated clients. • Create feedback letters based on results of alcohol assessments. • Write termination summaries. *Supervision* -Individual, group, weekly training sessions *Supervisor*: -Bill Buhrow, PsyD Licensed Psychologist *Clinical Hours* 180 direct
March-August 2004	**Psychology Practicum I Student** *Columbia River Mental Health, Vancouver, Washington* *-Population* -Adults *Clinical Duties* • Provide individual, couples, and group therapy. • Develop treatment plans and therapeutic goals. • Provide crisis counseling and life-skills training.

	• Engage in progress note writing and file reviews. • Consultation and case presentations for diversity and special population consultations. *Supervision* -Individual *Supervisor* -Doug Park, Ph.D. Licensed Psychologist *Clinical hours* 80 direct **Psychology Pre-Practicum Student** *George Fox University Health and Counseling Center*, Newberg, Oregon *Population* College Students *Clinical Duties* • Conduct intake interviews and formulate assessment reports • Provide brief individual therapy • Engage in treatment planning with client • Consultation and case presentation with multidisciplinary mental health team *Supervision* -Individual and group, including weekly didactics *Supervisors* -Clark Campbell, Ph.D., Nancy Thurston, Psy.D, and Charity Benham, M.A. *Clinical Hours* 30 direct
January 2004 – May 2004	
Terminal Master's Training	
August 2002- May 2003	**Student Counselor** *Shepherd's Gate Counseling Center* Denver, CO *Population* Children, Adolescents, Adults, Married Couples *Clinical Duties* • Provide short and long-term play therapy with children. • Provide short and long-term individual therapy with adults. • Provide pre-marital/marital therapy. • Develop treatment plans and therapeutic goals. • Write termination summaries.

	Supervision Individual, children/adolescent group supervision *Supervisor* -Joan Winfrey, Ph.D. Licensed Psychologist *Clinical Hours* 176 direct
September 2002- May 2003	**Student Counselor** *Arapahoe/Douglas County Mental Health Services* Littleton, CO *Population* Adults/Dual Diagnosis *Clinical Duties* • Administer Clinical Intakes • Co-facilitate Drug/Alcohol relapse prevention groups • Co-facilitate Dialectical Behavioral Therapy groups • Facilitate relaxation groups • Provide progress notes and treatment planning • Provide individual therapy • Consult in a weekly interdisciplinary team meeting with a psychiatrist, social workers, nurses, and mental health specialist. *Supervision* -Individual *Supervisor* -John Layne, Ph.D., Counseling Psychologist *Clinical Hours* Group- 41 direct Individual- 50 direct
January 2002- May 2002	**Student Counselor Pre-Practicum: Denver Seminary** Denver, CO *Population* Graduate Students Children *Clinical Duties* • Individual psychotherapy skills training *Supervision* - Individual and group *Supervisors* - Joan Winfrey, Ph.D., Licensed Psychologist & Dixie Hart, M.A.

	Clinical Hours 50 direct

Research Experience

January 2004-Present	**The Effect of Psychotherapy on Clergy in Crisis at Marble Retreat** (Dissertation In progress) Currently conducting an outcome evaluation of Marble Retreat, an organization with a long-standing tradition of working with clergy in distress. Supervisor: Rodger Bufford, PhD
January 2004 – present	**Research Vertical Team** Joined a team of graduate students at George Fox University that participates in collaborative research in psychotherapy outcomes and psychology of religion. Supervisor: Rodger Bufford, Ph.D.
January-May 2004	**Social Responsibility and Religious Experience** Studied social responsibility, altruism, and the individual's religious preference and spirituality as a possible indicator of motivation for social responsibility. Administered a set of scales to undergraduate students at two universities in the Portland area, one with a religious emphasis and the other without. Supervisor: Rodger Bufford, PhD
January 2006-Present	**Administrative Checklists for Neuropsychological Assessments** (In Progress) An experimental study exploring the educational benefits of using administrative checklists to increase the effectiveness of training clinical psychologists in test administration. Supervisor: Wayne Adams, PhD, ABPP
May 2006-Present	**Research Assistant: Evaluating Correlational Relationships among Clinical Measures of Working Memory** An empirical study examining the relationships between working memory measures from the WAIS-III, WMS-III, WRAML-II, and Stanford Binet in order to establish whether the measures are assessing the same construct. Supervisor: Ben Giesbrecht, M.A. & Wayne Adams, PhD, ABPP

Relevant Work/Teaching Experience

September 2006-Present	**Clinical Foundations of Treatment, Graduate Assistant:** Graduate School of Clinical Psychology George Fox University,

	Newberg, Oregon. • Responsibilities include lab instructions and evaluation of foundational therapy skills for 1st year PsyD students and supervising their clinical work with clients.
January 2006-May 2006	**Neuropsychological Assessment, Graduate Assistant:** Graduate School of Clinical Psychology George Fox University, Newberg, Oregon. • Responsibilities include co-facilitating lab instructions, one-to-one training on neuro-psych testing instruments, and test interpretation training.
January 2005 – May 2006	**Personality Assessment, Graduate Assistant:** Graduate School of Clinical Psychology George Fox University, Newberg, Oregon. • Responsibilities include co-facilitating lab instructions as well as grading clinical intakes and personality assessment write-ups.
January 2005 – May 2005	**Teacher's Assistant:** Graduate School of Clinical Psychology George Fox University, Newberg, Oregon. • Help Nancy Thurston, Psy.D with admissions committee responsibilities as well as coordinate service projects to students in need.
May 2001 – July 2002	**Co-Director of Student Ministries:** Centennial Community Church, Littleton, Colorado • Responsibilities include teach, equip, and counsel youth as well as train and lead a team of adult volunteers.
May 1999 - May 2001	**Associate Pastor:** Christ's Church of Highlands Ranch, Highlands Ranch, Colorado • Responsibilities include teach, equip, and counsel children, youth, and young adults as well as train and lead a small group of adult volunteers. Also responsible for quarterly teaching seminars.
January 1998-May 1999	**Activities Coordinator/Intern:** Westlink Christian Church, Wichita, Kansas • Responsibilities include planning, coordinating, and implementing sports leagues and camps for the church community.
September 2003	**Guest Lecturer:** George Fox University, Newberg, Oregon. • Introduction to Psychology

	-Lectures: Abnormal psychology and Motivation • Adolescent Development -Lecture: Psycho-social development
June 2003	**Guest Lecturer:** First Presbyterian Church, Boulder, Colorado. • Adolescent Spirituality
September 2002	**Guest Lecturer:** Young Life, Rocky Mountain Region, Winter Park, Colorado. • Adolescent Spirituality • Leadership Development
March 2001	**Guest Lecturer:** Christ's Church Highlands Ranch, Highlands Ranch, Colorado. • Parenting Seminar

University Involvement / Volunteer Experience

August 2004-Present	**GDCP Community Involvement Coordinator:** Graduate School of Clinical Psychology George Fox University, Newberg, Oregon. • Selected by faculty representative to organize and implement monthly community gatherings, including marriage seminars and other educational opportunities.
October 2003–May 2005	**GDCP Student Council Committee:** Graduate School of Clinical Psychology George Fox University, Newberg, Oregon. • Selected by classmates to serve as a student representative. Responsibilities include communicating 2nd year student concerns to student council, student advocacy, and planning spring banquet.
October 2003-May 2004	**GDCP Alumni Relations Committee:** Graduate School of Clinical Psychology George Fox University, Newberg, Oregon. • Selected by student council to serve as a liaison between current student body and local/national alumni.
Spring 2005	**Admissions Assistant:** Graduate School of Clinical Psychology George Fox University Newberg, Oregon. • Met with prospective students for interview process in graduate school of clinical psychology.
August 2004-May 2005	**Peer Mentor:** Graduate School of Clinical Psychology George Fox University Newberg, Oregon..

	• Mentor a new graduate student in the psychology department to adjustment and professional development in the program.

Honors/Grants

- **Letter of Special Commendation** (2004-2005)**:** George Fox University, Newberg, Oregon.
  -GDCP faculty extended a special commendation for accomplishments and contributions to the program. In any given year, GDCP commendations are extended to less than 5% of students.
- **Letter of Special Commendation** (2005-2006): George Fox University, Newberg, Oregon.
  -GDCP faculty extended a special commendation for accomplishments and contributions to the program. In any given year, GDCP commendations are extended to less than 5% of students.
- **Grant:** Richter Scholars Grant for Independent Student Research (2006): George Fox University, Newberg, Oregon.
  -$1100 grant extended to study the effectiveness of the treatment modalities of Marble Retreat Center, Marble, CO.

Additional Clinical Training

- Psychodynamic Therapy Discussion Group**:** George Fox University, Newberg, Oregon
  Facilitator: Kurt Free, Ph.D.
  Monthly meetings 2004-Present

- Clinical Colloquium: Motivational Interviewing: William Miller, Ph.D., University of New Mexico.
  October 2006.

- Clinical Colloquium: Healing Images of God**:** Beth Fletcher Brokaw, Ph.D., Rosemead School of Psychology.
  March 2006.

- Clinical Colloquium: Relational Cognitive Therapy**:** Mark McMinn, Ph.D., Wheaton University.
  November 2005.

- Multi-method Church-Based Assessment Process**:** Mark McMinn, Ph.D., Wheaton University.
  November 2005.

- Analytic Technique in Once and Twice Weekly Psychotherapy: A Four Week Seminar: Oregon Psychoanalytic Institute, Portland, Oregon
  Facilitator: Kathy Reicker, LCSW
  May 2005

- 2005 Annual Northwest Assessment Conference: Using the Millon Scales in Clinical Practice, Seth Grossman, PsyD, Millon Institute for Advanced Studies.

- Clinical Colloquium: Motivational Interviewing, Theory, Practice, and Evidence,
  Denise Walker, Ph.D., University of Washington
  April 2005

- Sex, Drugs, and Rock' n' Roll: The Symbolization of Adolescence
  Presented by Seth Aronson, PsyD
  January 2005
  Oregon Psychoanalytic Center, Portland, Oregon

- 2004 Annual Northwest Assessment Conference: An Overview of the WISC-IV,
  Jerome Sattler, Ph.D.
  June, 2004

- 2004 Annual Northwest Assessment Conference: Disability Assessment
  Presented by Dr. Bob Henry, Ph.D.
  June, 2004
  Newberg, Oregon

- Imaginary Gardens, Real Toads: Enactments, Memory & Working Through
  Presented by Theodore Jacobs, MD
  March 2004
  Oregon Psychoanalytic Institute, Portland, OR

- Clinical Colloquium: Dialectical Behavior Therapy, An Introduction
  Presented by Dr. Brian Goff, Ph.D.
  October, 2003
  Newberg, Oregon

- Play Therapy Discussion Group
  Denver Seminary, Denver, CO
  Facilitator: Joan Winfry, Ph.D.
  Sept. 2002-May 2003

Psychometric Testing

Assessment Instrument	**# of Administrations**	**# of Reports**
Adult Population:		
Personality Assessment		
MMPI-II	12	12
MCMI-III	2	2
16 PF	5	3
PAI	5	5
Projective Assessment		
Rorschach (Exner System)	3	2
Rotter Incomplete Sentences Test	2	2
House-Tree-Person Figure Drawing Test	2	2
Thematic Apperception Test	2	2
Intellectual-Cognitive Assessment		
WAIS-III	17	15
WCJ-COG III	7	6
WCJ-ACH III	8	7
WRAT-III	4	2
WIAT-II	3	2
WRAML-II	2	2
WRIT	3	3
WMS-III	10	7
Neuropsychological Assessment		
Halstead Reitan Standard Battery	1	0
Tactual Perceptual Test	1	1
The Booklet Category Test	1	1
Wisconsin Card Sorting Test	5	4
Rey Complex Figure Test	7	6
Trails A & B	11	9
COWA	3	2
CVLT	2	1
Grooved Pegboard	3	2
Stroop Color-Word Test	9	7
Reitan-Indian Aphasia Screening	1	0
21-Item Test	1	0

Child Population:		
WISC-IV	3	3
WRAML-II	2	2
WIAT-II	1	1
WCJ-ACH III	2	2
Rotter Incomplete Sentences Test	1	0
House-Tree-Person Figure Drawing Test	1	0
Thematic Apperception Test	1	0

Professional Affiliations and Memberships

2004 – present	American Psychological Association, Student Affiliate
2004 – present	Oregon Psychoanalytic Institute, Student Affiliate
2006- present	American Psychological Association, Division 39 Psychoanalysis, Student Affiliate

Relevant Coursework:

Theory and Practice:	
Psychopathology	A-
Ethics for Psychologists	A
Psychodynamic Psychotherapy	A
Object Relations Therapy	A
Lifespan and Human Development	A
Biological Basis of Behavior	A-
Theories of Personality and Psychotherapy	A
Social Psychology	A
Learning, Cognition, and Perception	A
An Academic Career in Psychology	A
Cognitive-Behavioral Psychotherapy	B+
History and Systems of Psychology	A
Practice of Group Psychotherapy*	A
Psychopharmacology	A-
Family & Couples Therapy	A
Supervision and Management of Psychological Services (in progress)	N/A

Research:	
*Statistical Methods	A-
Research Design and Outcome Measures	
Research in Psychology of Religion	A
	A-
Assessment:	
Psychometrics in Assessment*	A-
Intellectual-Cognitive Assessment	A
Neuropsychological Assessment	A
Personality Assessment	A
Clergy Assessment	A
Projective Assessment	A
Comprehensive Assessment	A
Diversity:	
Spiritual Formation	A
Contemporary Religious Worldviews	A-
Integration of Psychology and Religion	A-
Integration Seminar	A
Human Sexuality/Sexual Dysfunction	A
Multicultural Counseling*	A
* denotes transfer classes	**Current GPA=3.92**