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**The Effectiveness of Focusing and Christian Contemplative Meditation  
on Trust Development in Intimate Relationships**

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**24 March 1997**

**A thesis submitted to the School of Graduate Studies of the University of Ottawa in partial fulfilment of the requirements for the degree of Master of Arts in Pastoral Studies (Pastoral Counselling).**



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## ABSTRACT

This study examined the efficacy of two interventions practised by pastoral counsellors. Christian Contemplative Meditation (CCM) and Focusing were administered to people presenting with indications of low trust. Low trust was defined by low scores on the FIRO-B Wanted Control subscale (Schutz, 1967).

Twenty-four volunteers were randomly assigned to one of three groups: CCM, Focusing, or a no treatment control group. Attempts to control for age, gender and therapist effects were made by counterbalancing. Measurements were taken at baseline, two weeks after the five sessions and three months post counselling. It was anticipated that the Relationship Trust Scale (Boon & Holmes, 1990) would be sensitive enough to perceive any changes. Other measures indicating change in trust comprised the Inventory of Interpersonal Problems: Hard to be Intimate subscale, and a self-reported Degree of Improvement measure (Meier, 1993).

The literature suggested that the degree of client satisfaction, changes in mood, self-esteem, self-efficacy, and faith maturity would also indicate changes in trust. Several religious factors that could affect outcome were considered. These comprised three religious orientations, religious problem solving style, and mystical experiences.

There was no effect among the groups on any of the trust scales and no significant changes were detected in self-esteem or self-efficacy among the groups. The significant effects that were found were quite robust. Both treatment groups reported a significantly higher Degree of Improvement as compared to the control group. The CCM group reported higher client satisfaction than the Focusing group. Improved moods in the measures of Anger-hostility and Fatigue-inertia for the CCM group were also detected. Christian contemplative meditation

improved the scores of faith maturity, whereas Focusing did not. The results indicated that Christian contemplative meditation had a more robust effect and was longer lasting than Focusing. A history of mystical experiences was positively correlated with significant outcome findings.

These results indicated a need for more research. A replication study with increased power, treatment fidelity, and better instrumentation is recommended. Future areas of research could examine the parameters of procedural administration (i.e., duration, length and frequency of sessions), the relationship between different interventions and of the stages of change, and the impact of religious orientation, experiences and coping styles on outcome measures.

## INTRODUCTION

Trust is an important component in the fulfilment of intimate relationships. The failure to develop trust often leads to isolation, loneliness and lack of satisfying relationships. Inappropriate trust in relationships can be manifested by a fear of letting go of previously held perceptions and a resulting reluctance to be influenced by others (Frost, Stimpson and Maughan, 1978; Schutz, 1966). Schutz (1966), and Rempel, Holmes and Zanna (1985) noted that inappropriate trust in relationships can be identified as the behaviour of over-controlling others. Letting go of perceptions and control over others can be conceived as skills that may be acquired and these skills are important in overcoming personal difficulties involving trust (Wallas, 1926; Batson, Schoenrade, & Ventis, 1993 ). Furthermore, difficulties in trust might be modified in the same way that phobias were modified. Bandura (1977) has demonstrated personal difficulties such as snake phobias can be over come by specific skill acquisitions through successful situational experiences.

It is hypothesized that pastoral counselling giving the client a successful experience of letting go of control may facilitate the situational components of trust development as identified by Boon & Holmes (1991). Techniques utilized in the general practice of pastoral counselling to address a variety of presenting issues include Focusing (Gendlin, 1981) and Christian Contemplative Meditation (Harris, 1993). Although these procedures are hypothetically well suited to address the problem of mistrust, little outcome research on their efficacy exists. This lack of investigation is consistent with a paucity of research of pastoral counselling in general (Arnold and Schick, 1979; Hyman and Wylie, 1987; Worthington, 1986; Payne, Bergin, & Loftus, 1992; Hood, 1992). This study starts to address that paucity.

The goal of this study is to compare the effectiveness of Gendlin's Focusing (Gendlin, 1981) and Christian Contemplative Meditation (CCM) (Harris, 1993) to facilitate trust development for those not open to the positive influences of others. The effectiveness of the procedures will be measured against a no treatment control group.

Chapter one reviews the theoretical considerations of trust, the indicators of changes in trust, stages of change, and empirical evidence related to theoretical considerations of trust. The literature regarding Focusing and CCM, and outcome studies involving spiritually-orientated interventions are reviewed. Chapter two presents the research methodology of the study, the ethical considerations, the instruments used, and the statistical procedures used to analyse the data. The specific questions of this inquiry are outlined in the second chapter. Chapter three presents the results and includes the analyses of variance, covariance, and retrospective power analyses. Chapter four discusses the results and recommends areas for further investigation.

## CHAPTER 1

### REVIEW OF THE LITERATURE

The first task of chapter 1 was to review the trust literature including definitions of trust, early childhood experience influencing predisposition to trust, and Boon and Holmes' (1991) concepts on situational factors of trust development in adult relationships. This review included Batson, Schoenrade and Ventis' (1993) analogy between change within a religious experience and creative change, and Bandura's (1977) theory of change. The literature regarding the relationships among trust, self-esteem, religious maturity, and competency was also considered. Secondly, the empirical evidence, which is not extensive, supporting the theoretical relationships was reviewed. Finally, the outcome studies of counselling interventions involving spirituality were reviewed.

#### Trust: Theoretical Considerations

Research suggests that lack of trust is problematic to successful relationships. The lack of trust impedes the development of successful interdependent relationships (Deutsch, 1958) because trust is fundamental in the formation of healthy personalities (Erikson, 1950, Bowlby, 1973; Boon et al, 1991). Other research has shown that mistrusting dyads are less efficient than trusting dyads (Deutsch, 1960; Young, 1978; Lendenmann and Rapoport, 1980), and that high trust groups outperform low trust groups (Zand, 1972; Golembiewski & McConkie, 1975; and Boss, 1978) .

Although trust has been conceived as important in mental health, its study remains difficult. Trust is complex and operationally difficult to define. Most operational definitions

define trust as a belief that others will not harm another and/or will be beneficial (Couch & Jones, 1995). Resultant studies of trust tends to deal with generalized trust although trust can be defined as both general and specific to individuals. Couch et al (1995) conceptualized trust across three different levels of relationship involvement: general, social network (ie. family other than partner, friends, colleagues) and partner. Further, levels of trust vary not only in accordance with the relational object but also in accordance with the subject matter. For example, a husband who expresses feeling safe on the city streets may trust his wife not to have sex with another man, and yet not trust his wife with a credit card. Generalized measures of trust may indicate this man's generalized trust, but not predict the specific trust problem in his intimate relationship (Holmes, 1991). Various attempts have been made to conceptualize trust in terms of behaviours, cognition, and affective states relative to trust.

In the behaviour literature, trusting has been defined as an appropriate letting go of control over others (Schutz, 1966). Using this definition Schutz (1966) developed the Fundamental Interpersonal Relationship Orientation (Behaviour) scale. One dimension measured was the level of a persons's wish to control others. Another dimension was the level of a person's openness to the benign influences of others. The issue of appropriate control behaviour has been examined by others. Seligman (1975) suggested that exercising no personal control (helplessness) is a central part of depression. Low scores of ego strength measures, indicating little sense of inner control, have been used to predict poor response rates in psychotherapy (Barron, 1953). Boon et al (1991) conceived trust as actions in relationships indicating a favourable outcome within an indifferent and capricious world perception. This study defined low levels of trust based on the behavioral definitions presented by Schutz (1966). The selection of

participants was based on the ego strength as predictor of positive response and on behaviour indicating resistance to the influences of others. Further, it was reasoned that improved trust could be measured by actions in relationships that indicated a letting go of control over others while expecting a favourable outcome (Boon et al, 1991).

Trust, in the cognitive literature, has been defined as the belief that one safely and appropriately can be open to the influence of others (Frost et al. 1978; Schutz, 1966). Social psychologists (Adorno, Frenkel-Brunswik, Levinson, & Sanford, 1950; and Rokeach, 1960) stress that mental health is positively correlated to openness to new experiences and information. These authors perceive that openness and flexibility indicate the more psychologically healthy mind. Ellis (1980), and Harvey, Hunt, and Sullivan (1961) similarly indicated that people can significantly disturb themselves by their rigid closed mindedness. This study examined counselling procedures that could provide participants with the opportunity to be open to experiences of trust and self-focus. It was speculated that such new experiences, successfully mastered, could effect cognitive changes about trust. These changes may be measured by examining cognition about relationships (e.g. the perception about degree of a partner's caring), self-esteem and self-efficacy, and the degree of improvement in the interpersonal presenting problem.

Affectively, trust has been characterized as having low anxiety about partner dependability, sufficient security to be open to the influences of the partner, little concern about the positive outcome during conflict, and higher levels of confidence in the partner as an object of trust (Schutz, 1966; Boon & Holmes, 1991; Rempel, Holmes, & Zanna, 1985). Horney (1951) identified positive mental health as freedom from anxiety. Rogers (1951) emphasized a similar freedom would result from self-acceptance. If trust can be altered in this counselling, one would

expect changes in affect state. This study examined the effects of treatment on moods such as fatigue and anger-hostility.

### **Theory of Trust Development**

A variety of authors have made some attempt at the study of trust in generalized and partner relationships. This literature can be divided into two categories: early development theory and current situational theory. Early developmental theory (Erikson, 1950) considers that generalized trust is a result of positive early childhood experiences. Situational theory (Boon et al, 1991) considers that trust development between partners may also be influenced by specific situational experiences.

Erikson (1950) developed a socially orientated theory of Freud's psychosexual stages of development. He identified eight basic psycho social conflicts that must be confronted. While these conflicts are never completely resolved, they become more prominent during particular stages of life. The first development stage, occurring during the first year of life, is called the oral-sensory stage. It's here individuals first deal with the conflict of trust versus mistrust. If the infants needs are sufficiently met, a deep-seated trust will develop. Successful mastery of the basic trust is indicated by the infant's willingness to let the mother go out of sight without undue rage or anxiety. Bowlby (1973) emphasized the importance of the quality of care during infancy as the determining factor in the development of trust. If needs are consistently gratified by a primary caregiver during the formative period, then positive working models (or schema) about the nature of self and others develop. This schema tends to be resilient and shapes the development of personality.

Boon et al (1991) argue that early experiences impact only on a person's predisposition to trust. Thus, not only early trust experiences, but subsequent situations and relationships determine trust (Deutsch, 1958; Kelley and Stahelski, 1970; Boon et al, 1991). Holmes (1991) identified four main issues that must be addressed in the development of trust. These situational components are dependability, responsiveness, conflict resolution, and faith. According to Boon et al (1991), there are two core concepts within each of these components: interdependence and risk. Increasing interdependency implies increasing openness to be influenced by each other in a trusting dyad. The greater the level of interdependence, that is the greater the level of mutual influence, the more crucial is the state of trust. (Deutsch, 1958; Kelley, 1979; Schutz, 1966). Risk exists because there exists the probability that a favourable outcome may not be forthcoming. Risk is a function of the subjective meaning attached to an outcome and the probability that the other will positively influence an outcome.

The fundamental situational component, according to Holmes (1991) is dependability. Individuals seek dependability in partners as the foundation for trust. This is belief that the partner will behave consistently and reliably in the best interests of the individual (Boon et al, 1991).

Appropriate responsiveness to particular individual needs, aspirations and fears forms a second situational component that individuals observe in trust development. More trust is ascribed to those who appear motivated by an genuine interest in meeting the others needs (Kelley, 1979; Boon et al, 1991). Rempel and associates (1985) hypothesized that the attribution of motivation has critical influences in trust development. For example, people who attempt to exert control over others are perceived to have self-centred motivations in their personal

relationships (Frost, Stimpson and Maughan, 1978; Butler, 1986; Stack, 1978), inhibiting trust development.

A third component is expectation of positive outcomes during conflict (Collins and Read, 1990; Bowlby, 1973; Rempel et al, 1985; Boon et al, 1991). Couples need to know that they have the capability to confront conflict in a creative manner, and expect favourable resolutions.

The fourth component is faith. Faith is defined by Boon et al (1991) as the behaviour in a relationship which suggests the partner is held in positive regard and is trustworthy even though there remains a lack of supporting evidence. Generally, faith in a partner promotes security in a world that is often experienced as indifferent if not capricious (Boon et al, 1991).

#### Variables Correlated with Trust

Boon et al, 1991; Altman and Taylor, 1974; Rubin, 1973; Rempel et al, 1985 have theorized that positive responsiveness in time of need, and demonstrative positive regard engenders increased trust characterized by (1) improved mood state, and (2) increased self-esteem. Empirical evidence supporting this correlation will be discussed in a following section.

Other research (Meier, 1993) suggests mood states, self-esteem, and competency are correlated suggesting that competency is another indirect measure of trust. Meier (1993) developed an integrated model of competency by combining Bandura's (1977) "self-efficacy" theory and White's (1959) "effectance motive" theory. According to Meier, both influence the development of competency. His model comprises four components: (1) the drive for competency (effectance motive), which is a need, (2) the sense of competency (self-efficacy),

which is a cognition, (3) the actual competency is the behaviour, and (4) the positive mood state of satisfaction and self-esteem accompanying the acquisition of a skill. On that basis, Meier (1993) suggested that measures of self-efficacy, global competency, mood and self-esteem are positively co-related. Since improved mood and self-esteem have been correlated with high trust, increased competency may be another indication of increased trust.

Another indication of improving trust is suggested by the faith maturity literature.

Mature faith has observable consequences in motivation, attitude and behaviour (Calvin, 1949; Allport, 1950). Theological literature argues that God is experienced and known only inside human experience (Barry and Connolly, 1981). It is theorized that faith is observable through behaviours consistent with attitude and belief (Benson, Donahue and Erickson, 1993). Indications of mature faith are (1) trust in God, (2) accepting guidance from God, (3) acceptance of others, (4) acceptance of religious diversity and (5) a highly developed sense of self, self-acceptance and personal security (Benson, Donahue and Erickson, 1993; Spilka and Mullin, 1977).

In summary, trust is complex and difficult to define and measure. Early childhood experiences promote predisposition towards trust as a personality trait according to Erikson and colleagues. Trust development in adult relationships according to Boon et al (1991) has four situational components. Levels of trust should respond to experiences of the four components. A positive experience of trust in the therapeutic relationship involves dependability, experiencing appropriate responsiveness to need, expecting a positive outcome (hope), and taking the risk of being open to influences of the therapist (faith). Indicators of trust have included self-esteem, mood, competency and faith maturity. Trust and risk taking have been considered by a variety of writers studying stages of change towards better mental health.

### **Stages of Change**

Some writers (Wallas, 1926; Poincaré, 1913; Gheslin, 1952) suggested creative thought and change towards better mental health comprise a series of stages involving trust and risk taking. Wallas (1926) suggested creative change comprises four stages: preparation, incubation, illumination and verification.

Preparation for change occurs when an individual is frustrated in an attempt to use current cognitive perspectives, rules of comparisons and, if available, higher level beliefs (Schroder, Driver & Streufert, 1967). The second stage of this creative process has been called incubation. This is an adaptive process where an individual lets go of the problem, along with the current cognitive orientation. This implies a willingness to be open to a new cognitive perspective, different rules of comparisons and newly created higher level beliefs. Having mastered the incubation, the individual can now perceive the problem through a re-organized cognitive perspective. This reorganization, called illumination, in its most dramatic form can be sudden, often visual and allows for resolution of the problem. The process is completed with verification, which is a testing process against experience.

Batson et al (1993) noted that within the psychological literature of change there exists a parallel stage process. This is a series of stages called personal crisis, exhaustion, a new cognitive schema and improved functioning. Theorists as James (1902), Bertocci (1958), Clark (1958), Loder (1966) May (1975), and Rugg (1963) also led Batson et al (1993) to propose a parallel four stage pattern within religious experiences. A religious experience promoting change, according to this model, commence with an existential crisis, continue through the stages of self-surrender, a new vision and a new life within the new vision.

The process of change within the religious literature appears to commence when an individual's core beliefs and values no longer can be sustained in the face of new personal experiences. This initial stage, Batson et al (1993) called an existential crisis. The second stage of this process has been called self-surrender. This, like the incubation stage in creative thought theory and like the exhaustion stage in psychological literature, is an experience in which the individual lets go of the issue along with the relevant cognitive structures or schema. Successful negotiation of this stage implies the individual must be open to influence. Like the other models, the issue of trust, both in terms of being open to the influences of others and letting go control appears in this stage. Once self-surrender has been mastered, the individual moves to the third stage, that can be called the new vision stage. Here the individual may experience a new schema involving core beliefs and values. A final resolution of the presenting crisis is achieved when the individual can live the vision. Live the vision is defined as functioning function within this new schema and testing it against real experiences.

### Theories of Change

These stage theories of change, like other stage processes, must be interpreted with caution. As Silver and Wortman (1980) pointed out not all individuals experience all stages or progress through the stages in particular orders. Some can skip over stages, others may have experiences not found within the stage theory and others may never achieve the end stage. However, they remain useful in conceptualizing in short steps the possible complex processes of change.

These stage models lie within the schema-based and constructive narrative

perspectives regarding change (Meichenbaum, 1994). Common to these models is the tenet that change occurs with new interpretations or a newly constructed reality. Meichenbaum (1994) noted that this perspective is found within the writings of Immanuel Kant, Jean-Paul Satre, Alfred Adler, George Kelly, Jean Piaget and Viktor Frankl. Batson et al (1993) noted that this perspective is found in the works of William James, Alfred North Whitehead, Robert Ornstein and Max Wertheimer.

### Mastering Self-surrender

In this research, participants experienced risk-taking, being open to the influence of another, and letting go of control. This experience, theoretically, facilitates the movement through the self-surrender stage. The learning mechanism leading to the mastery of self-surrender can be conceptualized using Bandura's (1977, 1986, 1990) social learning theory.

Bandura (1977) proposed a model of change to explain the positive outcomes of a variety of diverse modes of interventions. He hypothesized that psychological interventions could alter an individual's perception about self-efficacy. Self-efficacy is defined as the belief that a particular skill can be acquired. Using this concept of self-efficacy, Bandura (1977) analysed successful treatment of phobic behaviour. Increased self-efficacy, he demonstrated, correlated with improved adaptive behaviour and decreased defensive behaviour. Four sources of information regarding self-efficacy were identified. These are, according to Bandura, from most to least influential: performance accomplishments, vicarious experience, verbal persuasion and emotional arousal. Each of these sources can be associated with specific modes of interventions.

Performance accomplishments are personal mastery experiences. Associated

theoretical interventions are the behavioral modification techniques (flooding, participant modelling, and performance desensitization). He further argues that once established for a specific issue, self-efficacy will generalize to other situations where performance was adversely affected by negative self talk. Vicarious experiences occur in those therapies where clients learn from watching the behaviour, and experiencing the associated thoughts of others who successfully achieve therapeutic goals. Seeing that others can overcome adversity suggests that the individual can be as equally successful. Associated treatment models include live and symbolic modelling. Verbal persuasion techniques help clients perceive self-efficacy through suggestion and argument. Emotional arousal techniques use imagery (implosion) to provoke strong anxiety laden thoughts. Repeated in vivo experiences in a safe place can lead to a reduction in the level of anxiety associated with the thoughts.

Bandura's theory of change through self-efficacy was further developed by Meier (1993) by combining Bandura's theory of change with White's (1959) concept of a drive for competency. Meier (1993) postulates that the basic goal of therapy is the development of competent behaviour and a belief of self-competency. Competency is complex and is comprised of at least four components: drive, self-efficacy, actual competency and a positive feeling of competency. These concepts may be applied to the mechanism leading to mastery of self-surrender.

Self surrender commences with awareness of a lack of competency. This has been noted particularly by the psychoanalytic writers as having the potential for significant personality growth (Batson et al, 1993). Awareness of deficiency may challenge and thus initiate an innate drive to overcome. Meier (1993) would argue that this activated drive can conspire with a belief

in one's ability to adapt, leading to a successful experience of self-surrender.

In summary, the self-surrender stage of a change process involves letting go of the issues, and being open to the influences of others. Social learning theory, combined with an innate drive to adapt, suggest that increasing openness to outside influences can be achieved through repetitive successful positive experiences. Thus, therapeutic interventions, providing positive and successful experiences of self-surrender, should, according to this model of change, improve the belief that one can let go control and, without harm, be influenced by others. The behaviour of letting go of control and the belief in the value of others have been conceived as components of trust. The change in trust may be observed by measures of trust, self-esteem, mood state, self competency, and religiosity, .

### Empirical Literature

Empirical studies regarding trust and its correlates are not extensive. This section reviews the relatively few studies that have attempted to operationally define and measure trust and its correlates. Most of these studies rely heavily on Schutz's (1966) concepts of behaviour and trust such as being open to the influences of others or over-controlling behaviour.

Several researchers have found correlations between letting-go-control, being open to the influences of others, trust, self-esteem, and religiosity. Stack (1978) argued that trust and controlling others (expressed control) could be characterized as polar opposites. Frost et al, (1978) defined trust as the belief that the behaviour of another would be in the individual's best interests and be altruistic. They studied 7 group dynamic classes comprised of 6-10 mixed gender undergraduate students (N=59) in order to identify personality and behavioral correlates of trust.

Dimensions of power, locus of control, and self-esteem were compared with the six dimensions of the FIRO-B (Schutz, 1966). The dimensions of power were measured using a questionnaire regarding the perceptions of the subjects regarding influence over others, influence by others, and level of trust. Four power variables were defined as 1. the amount of influence the group felt over an individual, 2. the amount of influence the group felt each individual had over them, 3. the amount of influence each individual felt he had over the group, and 4. the amount of influence each individual felt the group had over him. Locus of control was measured using Rotter's (1966) internal-external form, and self-esteem was measured using Janis and Field self-esteem inventory (Hovland & Janis, 1959). Trust was found to correlate with all four power variables. A person with an internal locus of control was found to be trusted more by group members than one with an external locus of control. Frost and colleagues (1978) found that people with an internal locus of control were higher in self-esteem, did not express a need to control others, and were perceived by others as both influential and open to being influenced. High self-esteem was negatively correlated to expressed control. Those not open to being influenced by others scored low in the wanted control scale (Pearson  $r = 0.47$ ,  $p < .01$ ). This study concluded that increased trust correlated with an increased perception that a partner is more motivated by a genuine care for others than by self gain.

Butler (1986) examined 20 engaged, 67 married and 11 divorced male-female dyads using Rosenberg's (1965) Self Esteem scale and the FIRO-B Scale (Schutz, 1966). He hypothesized that trust between partners is affected by 10 variables. These comprise reciprocity, locus of control, expressed control, wanted control, control expressed by one's partner, control wanted by one's partner, self-esteem, social desirability, duration of the relationship, marital

status, and the existence of a partner's children. Butler concluded (1) that trusted people were high in self-esteem, (2) that the perception of expressed control significantly reduces trust, (3) that, for women, the perception of one's partner's wanted control has a negative effect on trust in that partner, and (4) that trust is reciprocated between partners.

Collins and Read (1990) developed an adult attachment measure based on adult attachment theory (Bowlby, 1973; Ainsworth, Blehar, Waters and Wall, 1978). In a study of 118 undergraduates, Collins et al (1990) found that adults who believed that others would help them scored higher in self-esteem on Rosenberg's (1965) self-esteem scale.

Researchers of the psychology of religion have found a variety of religious factors that potentially play an important role in self-esteem, mental health, coping, problem-solving, and believe in a trustworthy God and world. Pargament and colleagues have found that religion may serve an important orientation and coping role during stressful situations (Pargament, 1987; Pargament & Hahn, 1986). Religious problem solving styles that embrace the locus of responsibility (God or self) may impact self-esteem and coping (Pargament, Kennell, Hathaway, Grevenegoed, Newman, & Jones, 1988). Spilka et al (1977), examining 689 subjects, found evidence suggesting religious orientation and psychological factors such as self-esteem, sense of powerlessness, and trust in others were related. Intrinsic faith orientation appeared to be related to higher self-esteem, higher levels of trust in others and God, whereas extrinsic orientation tended to be affiliated with a less favourable orientation to self, others and God. Hood (1992) reviewing the literature regarding self-esteem and intrinsic/extrinsic religious orientations summarizes that it is generally accepted that intrinsic religiosity and positive conceptions of God are associated with positive self-esteem and that extrinsic orientations are associated with low

self-esteem. For a more complete review see Spilka et al, (1985).

In summary, this research suggests that there is a positive correlation between letting go of control, openness to the influences of others and improved trust. Increased openness, the acquisition of the skill of letting-go-control, and trust development have been positively correlated to measures of increased self-esteem, elevated mood state, religious problem solving style, intrinsic faith orientation, and maturation of faith. Effective therapeutic interventions aimed to improve trust may be measured through trust measures and through these correlations. The next section reviews the literature of the counselling interventions of interest.

### Counselling Interventions

The two interventions investigated in this study comprise Focusing (Gendlin, 1981) and Christian Contemplative Meditation (Harris, 1993). Focusing is a skill that provides the participants with the opportunity to capitalize on an existential crisis. CCM provide the participants the opportunity to let go of control, and risk being open to new influences.

#### Gendlin's Focusing

The psychologically based technique to be used in this study is Gendlin's Focusing. Gendlin (1981) describes Focusing as a problem-resolving skill or technique to be used to facilitate change. It was a technique that developed from the observation that clients who did not responded to therapy tended to externalize and blame (Gendlin, 1962). Gendlin and others speculated that a necessary fundamental skill in the change process was the ability to focus on self, and taking seriously what one senses. It's a technique based on the philosophy that enabling

the mind-body awareness allows the body and mind to experience resolution. Central to the Focusing experience is the identification of a "felt sense" (Gendlin, 1981). By attending specifically to this felt sense, clients are encouraged to articulate it and reflect on its meaning. Such steps leads to change. Gendlin, Beebe, Cassens, Klein and Oberlander (1968) demonstrated that Focusing is a skill important, if not essential to successful outcome of psychotherapy. In the same study Gendlin et al produce (1968) evidence supporting Focusing as a necessary step in the creative process.

Few outcome efficacy studies have been conducted. Katonah and Flaxman (1992) evaluated the usefulness of Focusing in reducing depression, improving body image and increased use of more adaptive coping mechanisms of cancer patients. Depression was measured using L and Depression Scales from the MMPI. Coping mechanisms were measured using a Hardiness Scale (Maddi, Kobasa, and Hoover, 1979). Body image measurements comprised the Secord and Jourard Body Cathexis Scale (Secord & Jourard, 1953) and the Grindler Body Image Scale designed for the Focusing and cancer study. Katonah et al (1992) studied the outcome results of applying Focusing as an adjunct treatment to 12 people who had been diagnosed with cancer within the last five years. They found a significant decrease in depression and a significant improvement of body image at both post Focusing and at six months follow-up when compared to a wait list control group.

### Christian Contemplative Meditation (CCM)

Meditation is practised by a wide variety of people from several different value and belief systems. According to Batson et al (1993), two concepts emerge readily from the

meditation literature. First, there is an enormous variety of meditation formats across and within cultures and religious belief systems. Secondly, there are frequent claims of change resulting from meditation. The psychological literature on meditation, while inconclusive, suggests that this practice facilitates the critical stage of self-surrender or incubation involved in change. The disciplined focus of attention facilitates the breaking down of the present reality of those who practice meditation (Batson et al 1993, Goleman, 1977; Naranjo, 1971; Ornstein, 1971; and Deikman, 1966). Two studies (Seeman, Nidich, and Banta, 1972; and Nidich, Seeman, and Dreskin, 1973) found evidence that meditation facilitated self-acceptance and self-actualization. Several EEG studies found that the brain wave patterns of people in meditation approximated those that are normally associated with the incubation stage of creative processes (Kasamatsu and Hirai, 1966; Anand, Chhina, and Singh, 1961, Johnston, 1974; Wallace, 1970).

Personal testimonies about the effects of meditation include (1) experiencing a giving up of deception, self-interest, and revenge; (2) letting go of control in palliative care; (3) trusting wholly in God; and (4) increased listening, trust and compassion skills (Freeman, Felicioni, Harris and Peralta, 1992). In summary, the effects of the discipline are reported to be improved interpersonal relationships, deepening trust, increased sensitivity and caring towards others (altruism). These changes are thought to occur because the meditation leads one into the experience of love at the centre of self. (Freeman, 1992).

### **Effectiveness of Spiritually Originated Interventions**

Several psychological researchers have emphasized the importance of values, beliefs, client satisfaction, and client-respect in brief psychotherapy (Rogers, 1951; Beck and Weishaar, 1989; Ellis, 1973). Studies have hypothesized that therapy is more robust when it is specifically conducted using the client's values and beliefs (Strupp, 1978; Talley, 1992; Propst, 1980, 1992; Pecher and Edwards, 1984; and Carlson, Bacaseta and Simanton, 1988). There are several studies comparing the efficacy of spiritually originated techniques with psychologically originated techniques. These are based on the hypothesis that outcome is enhanced if the values of the client are incorporated into the interventions.

Rebecca Propst (1980) argued in favour of parallels between cognitive restructuring and pastoral counselling. Examining the style of Christian counsellors, Propst argues that this approach approximates that which was developed by Beck (1976), except that the counsellors use Scriptures to correct erroneous cognition.

She compared the outcome of the cognitive restructuring psychotherapy with several spiritual approaches on depressed persons with moderate to strong religious beliefs. Dependant variables included several self-reported measures and a group interaction measure. Behaviours measured included (1) observation of initiations, (2) reactions, action and reactions, (3) behaviour towards subject and (4) range of interaction. Four treatment modalities were tested: (1) religious meditation, (2) non-religious meditation, (3) non-directive therapy and (4) wait listed clients. Only the religious meditation group showed a significant lower proportion of depressed individuals than either the wait-list or the non-religious meditation group. The religious-meditation group out performed the non-religious meditation therapy group in four of the five

levels of interactions tested. The results suggested that theologically based techniques are efficient and a legitimate means of therapeutic change.

A second comparison of efficacy of secular and religious versions of cognitive therapy was conducted in 1984 by Pecher and Edwards. They hypothesised that efficacy of cognitive therapy would be enhanced by using religious meditation as a modification for religious patients. They applied two modes of therapy to Christian college students suffering from depression, assigning participants to either: (1) secular cognition-behaviour modification, (2) religious cognitive-behaviour modification or (3) a wait list. Results demonstrated that cognitive therapy, both secular and religious, were equally effective in treating depression in Christian college students. While this did not legitimize pastoral counselling, it did suggest that the use of theological images can be as effective as other images.

Carlson, Bacaseta and Simanton (1988) attempted to determine outcome resulting from Christian devotional meditation (DM) and secular progressive relaxation (PR). Thirty-six undergraduates from a Christian liberal arts college were assigned to one of three conditions: (1) devotional meditation, (2) progressive relaxation and (3) a wait list. Devotional meditation was defined as a period of reading of scriptures and praying about the development of Christian virtues. As predicted, psychological (anxiety) and physiological (muscle activity) responses were significantly reduced in both DM and PR subjects. Results indicated that devotional meditation and progressive relaxation have a similar impact among persons of a Christian background.

The fourth study was conducted by Propst, Ostrom, Watkins, Dean and Mashburn (1992). They assigned depressed subjects to one of four treatment modalities: (1) religious cognitive therapy, (2) non-religious cognitive therapy, (3) pastoral counselling therapy and (4) a

wait-list. The pastoral counselling therapy consisted of 75% non-directive listening and 25% discussion of pertinent scriptures and religious themes. Depression was measured using the Beck Depression Inventory and the Hamilton Rating Scale for Depression. Results indicated that religious cognitive therapy, standard cognitive therapy and pastoral counselling therapy significantly lowered depression scores. There was some indication that the religious cognitive behavioural therapy was more efficient. Measures of depression indicated that pastoral counselling outperformed standard cognitive behaviour therapy at post treatment. Further, the two year follow-up indicated that the pastoral counselling treatment continued to outperform the other treatment modalities in the BDI scores and the Global Severity Index of SCL-90-R scores. All three scores of the Social Adjustment Scale were similar in the two year follow up. The robust outcome of the pastoral counselling condition was not explained. However, the result suggested that pastoral counselling is at least as effective as that provided by cognitive-behaviour counselling in cases of depression. These studies suggest that theologically originated treatments can be as effective as psychologically originated treatments for depression and physical tension.

Other evidence indicates that spiritual benefits occur regardless of intervention planned. Toh, Tan, Osburn & Faber (1994) using a variety of psychological instruments and the Spiritual Well-Being Scale (SWBS) (Ellison, 1983) evaluated the efficacy of a church based lay counselling program. Two treatment modalities were evaluated. Treatment groups differed in the number of sessions. No significant difference was found between the groups, however when combined, outcome results indicated a significant reduction in complaints and symptoms. The SWB Scales indicated an overall significant increase in well being. The study did not identify intervention or presenting problem types.

Bufford (1995) found evidence in two studies that spiritual benefits may occur in the absence of explicit spiritual interventions. In the first study Bufford examined the outcome of outpatient psychotherapy on depression and spiritual well-being. Two treatment groups from different clinics completed pre and post-treatment tests. Tests comprised the SWB scale and Beck's Depression Inventory. No difference between the two groups was found and no interaction. Both the BDI scores and the SWB scores changed significantly, indicating improved health and well being. Intervention type was not discussed.

In the second study, Bufford compared two groups of adolescents. Group one comprised inpatients with acting out problems, substance abuse and major affective disorders. The control no-treatment group comprised of residents of a juvenile detention centre. Comparison of post-test data showed the treatment group scored significantly higher on the SWB Scales. Treatment and diagnostic criteria were not controlled.

These six studies provided limited evidence that spiritual and psychological interventions can be equally effective. Further, explicitly non-spiritual interventions can effect changes in spirituality. Although there is some evidence that spiritual interventions are effective, and that psychological interventions effect spiritual well-being, there is a paucity of information regarding efficacy of pastoral counselling, specific to presenting problems and planned interventions. Are specific interventions effective in improving mood, interpersonal relationships, and spirituality for people presenting to pastoral counsellors with personal non-pathological issues? Are there differences in outcome due to intervention? Are there different outcome due to the differences between Focusing and CCM? The purpose of this study is to examine these questions in a specific way. The study considered the outcome efficacy of two counselling

procedures found in the practice of pastoral counselling: Focusing and CCM. These procedures were applied to people presenting with problems of relationships due to inadequate trust.

Outcome measures comprised relationship trust, level of distress due to intimacy problems, client satisfaction, mood, self-esteem, competency and faith maturity. These measures were applied at baseline, two weeks after the counselling and at a three month follow-up time point. Outcome measures of each treatment group were compared to measures of a control group. Covariate influences such as previous mystical experiences, religious orientation, and religious problem solving style were studied using a variety of instruments at baseline.

## CHAPTER 2

### RESEARCH METHODOLOGY

This chapter details the methods followed in this study. The first section is devoted to the research participants: procedures for recruiting, selecting, screening, testing, assignment, and counselling. Secondly, the screening and outcome instruments used are reviewed. Thirdly, the procedures for therapist training are outlined. The fourth section presents the questions posed in this research study and the procedures used in the data analyses. A final section covers the ethical issues that were considered.

#### Research Participants

Volunteers were recruited through newspaper advertisement, posters in educational institutions, in hospitals, churches, community centres, and on the local Internet. Recruits were offered short term counselling free of charge. The advertisement (Appendix A.) for volunteers offered the opportunity for counselling specifically aimed to improve interpersonal relationships. Out of the 40 responses, 9 failed to meet the selection criteria and 7 either did not return for continued counselling or failed to complete the questionnaires, leaving three groups of eight participants (N=24), 8 male, and 16 females, with a mean age 31.3 ( $M=31.3$ ,  $SD=6.9$ ). The sample for the study comprised volunteers selected for counselling by applying the following criteria:

1. The following scores on the Psychological Screening Inventory (Lanyon, 1978): Alienation less than or equal to 70 ( $AI \leq 70$ ), Social Non-conformity less than or equal to 65 ( $Sn \leq 65$ ), Anxiety Discomfort less than or equal to 40 ( $Di \leq 40$ ), Defensiveness between 40 and 65

( $40 \leq De \leq 65$ ), and Extroversion Expression between 5 and 20 ( $5 \leq Ex \leq 20$ ). This profile excluded participants needing long term counselling or referral to another facility.

2. A score on the K-scale of MMPI between  $T=55$  and  $T=70$ . This implies capacity to respond to short term therapy (Graham, 1987).
3. A score of 4.0 or less on the Wanted Control subscale of the FIRO-B (Schutz, 1967), indicating resistance to benign influences by others.
4. Age between 18 to 45, English speaking, and Caucasian
5. Absence of any current counselling, use of an antidepressant or major tranquillizer and life-threatening disease.

Out of the total number of participants, four dropped out prior to the collection of the three month follow-up data. The number of participants in the control group was 8 at pre and post period. For the CCM and Focusing groups. Data for 16 participants (8 per experimental group) was collected at pre and post counselling points, and for 12 participants (6 per experimental group) at the three month follow-up.

### Processing Participants

Participants responding to the advertising were telephoned and initially screened using a telephone administered questionnaire (Appendix B.). Volunteers meeting initial criteria were invited to a screening interview. This interview comprised three parts: obtaining informed consent (Appendix C.), a standardized interview with a questionnaire (Appendix D.) and the three screening tests (Schedule 1). The interview and questionnaire were used to obtain demographic information (age, gender, occupation, education, marital status, and religion) and the

presenting difficulties related to trust.

Volunteers who met all selection criteria were administered the pretests (Schedule 2), and were given the name of their counsellor. Counsellors were responsible to arrange for five weekly counselling sessions. Appendix E. comprises the procedures for counsellors. Between one to three weeks of the end of counselling participants wrote the posttests (Schedule 3). Three months after the end of counselling a three month schedule of tests was administered (Schedule 4).

The twenty-four participants meeting the selection criteria were randomly assigned to one of the three groups: the Christian Contemplative Meditation group (CCM), the secular Focusing Group (FG) and the Control Group (CG). Participants were unevenly distributed across three therapists: one therapist applied Focusing only, the second applied CCM only and the third applied Focusing to four participants, and CCM to a different four participants. Attempts were made to match across treatment for gender and age within six years. The composition of the groups are shown in Table 1. In order minimize experiment demand characteristics participants in this study were not informed of the different possible procedures prior to their counselling experience (Seligman, 1995).

Table 1

<b>Group Composition, Gender and Age</b>			
<b>Group</b>	<b>Males (N)</b>	<b>Females (N)</b>	<b>Mean Age</b>
CCM	2	6	31
Focusing	4	4	30
Control	2	6	33

All testing and interviews were conducted at St. Paul University. Initial telephone interviews were conducted by the primary researcher and faculty advisor. All initial interviews and administration of screening tests were conducted by the primary researcher and the faculty advisor. A research assistant, supervised by the faculty advisor and the primary researcher, helped administer the pre, post and three month follow-up tests. The effects of time were addressed by staggering the dates of the baseline data collection and the consequent post counselling collection points. The baseline data is shown in Appendix F. Analysis of variance showed no differences between groups on baseline data.

### Measurements

Four schedules of instruments were designed. They comprised: Schedule 1, screening; Schedule 2, pre-counselling; Schedule 3, post-counselling; and Schedule 4, three month follow-up. The outcome measures assessed the states of client satisfaction, mood, religiosity, self-esteem and competency. Due to the brevity of the counselling and the resulting need for sensitivity of measurement, instruments that measure personality state were chosen. Table 2 lists the measures used and outlines the composition of each schedule.

Table 2

Use of Instruments and Composition of Schedules

Test Name	Screening (Schedule 1)	Pre-counselling (Schedule 2)	Post-counselling (Schedule 3)	Three month follow-up (Schedule 4)
PSI (screening)				
MMPI-K (ego-strength)				
FIRO-B (control)				
Religious Orientation Scale				
RPSS (problem-solving)				
Mysticism Scale				
RTS (trust)				
RTQ (trust)				
IIP (Problem type)				
CSI (satisfaction)				
POMS (mood state)				
RSES (self-esteem)				
RSECS (self-efficacy)				
MF Scale (Faith)				

## Screening Measurements

### Psychological Screening Inventory (PSI)

The PSI (Lanyon, 1978) is a brief, mental health, non-threatening screening device composed of 5 scales. It comprises 130 personal items to be answered true or false. The Alienation scale (Al) indicates the degree of alienation from society and high scores are common among hospitalized psychiatric patients. The Social Nonconformity Scale (Sn) indicates the degree of social non-conformity and high scores are common among incarcerated prisoners. The Discomfort Scale (Di) indicates the degree of social discomfort and high scores are common to those with a perceived maladjustment. These specific scales were used in the screening process. Participants with the following scores were selected:  $Al \leq 70$  (alienation),  $Sn \leq 65$  (social non-conformity), and  $Di \leq 40$  (anxiety discomfort). This profile excluded participants needing long term counselling or referral to another facility.

### Minnesota Multiphasic Personality Inventory: K-scale (MMPI)

The MMPI (Graham, 1987) is a widely accepted, standardized tool used to measure personality profile by self report. The K scale, given alone, was particularly useful to this study because it indicates a client's potential to respond favourably to brief psychotherapy. The K-scale which measures ego strength is composed of 29 items. Participants with scores between 55 and 70 were selected since this range indicates adequate ego defence (Graham, 1987).

### Fundamental Interpersonal Relations Orientation-Behaviour (FIRO-B)

The FIRO-B (Schutz, 1967) scale is used to measure a person's characteristic behaviour of control, inclusion and affection toward others. The FIRO-B measures each of these three traits in two ways: wanted and expressed. The Wanted scales measures the behaviours

indicating a desire to be controlled by others, to be included by others, or to be liked by others. The Expressed scales measure the behaviours indicating a desire to influence others, to include others, or to be affectionate to others. It is a 54 item instrument scored between 0 and 9 (ten-points), and was scored in accordance with the Guttman method.

Control was defined as the need to establish and maintain a satisfactory relationship with others with respect to control and power. Over-control behaviour was defined by Schutz (1966) as dominance, power and authority. Schutz (1966) stated that reciprocated distrust lies behind the behaviour. The particular interest of this study was the Wanted Control scale. Wanted control behaviour was defined as tendencies of submission, abdication of power and responsibility in interpersonal relationships. Schutz (1966) claimed that behind this behaviour lies anxiety, hostility and lack of trust. Norms were not available due to the great occupational differences. Scores of the Wanted Control scale across a variety of subjects, differentiated by occupation, ranged from 3.1 to 5.5 ( $M=4.3$ ). Reliability and validity studies were favourable. Participants with scores of 4.0 or less, indicating resistance to benign influences from others were selected.

### Treatment Measurements

#### Relationship Trust Scale (RTS)

The Relationship Trust Scale (RTS) (Boon and Holmes, 1990) is a thirty item direct state measure of trust, specific to adult intimate relationships. The scale is scored on a 7 point Likert scale. The five subscales comprise: Dependability-reliability, Partner Responsiveness, Conflict Efficacy, Dependency Anxiety, and Faith in Partner's Caring. Reliability and validity studies (Rempel et al, 1985; Boon and Holmes, 1990) are favourable. While test norms are not

available, issues of trust according to attachment style and gender were identified: for women, feelings of anxiety were associated with loss of homonymy, whereas for men, insecurities were associated with loss of autonomy. From an analysis of 226 married subjects, the five subscales were developed out of the theoretical constructs of attachment style, emotion, and interpersonal trust in relationship to marital adjustment and insecurity.

The Dependability-reliability subscale measures the strength of beliefs about the partner reliability, honesty, consistency, even during difficult times. While this is an important factor, the next subscale Partner Responsiveness goes beyond dependability. This subscale measures the perception that the partner truly cares for, is considerate of, and appropriately responsive to a partner's needs. The Conflict Efficacy subscale reflects perceptions about the efficacy of the resolution abilities of the couple together. The fourth subscale, addressed Dependency Anxiety. The items of this subscale assess concerns about becoming dependent on a partner and the degree of vulnerability. The Faith in Partner's Caring subscale has items measuring the strength of one's belief that a partner will continue to care in the future, even though future is itself uncertain.

Boon et al (1990) identified three levels of trust: distrust, uncertainty, and trusting. People without trust score low on the subscales. Low scores indicate the state of not being open to the influences of others and will resist taking the risk of letting go of control which Boon et al (1990) argues is a necessary component in trust development. Scores from the subscales were used to measure changes of trust over time by treatment conditions.

### Relationship Trust Questionnaire

Meier (1993) combined the concepts of self-efficacy, level of determination and the gravity of specific problems to develop the relationship trust questionnaire. The RTQ is a three/four item, repeat measure instrument designed to follow three stated presenting problems regarding trust. The pretest items comprise a Determination scale (eg. determination to resolve issues of trust) measured from 0 to 100, a Belief in Self-efficacy scale (eg. strength of the belief that the trust issue can be resolved) scored from 1 to 5, and the relative degree of Problem Difficulty, scored from 1 to 5. Post-test items follow the same stated problems, asking respondents to rate the same scales plus a Degree of Improvement scale, scored from 0 to 5.

No validity, reliability or internal consistency studies have been conducted on this questionnaire. This questionnaire was used to measure the client rated perception of success in resolving a trust related difficulty.

### Inventory of Interpersonal Problems (IIP)

The IIP (Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988) is a self-report instrument designed to measure distress due to interpersonal problems. The full instrument consists of six subscales, measuring distress as a result of difficulties in Assertiveness, Sociability, Intimacy, Submissiveness, Responsibility, and Control. Horowitz et al (1988) demonstrated high internal consistency and test retest reliability. A comparison study with the SCL 90-R (Derogatis, 1977) demonstrated the IIP was as sensitive to changes after 10 sessions of therapy, and was more sensitive after a second ten sessions. The instrument is easily administered, reliable and sensitive to changes during the course of counselling.

Two subscales were used in this study: The Hard to be Intimate and Over Controlling

subscales were combined to form a 27 item instrument. Twelve items comprised the Intimate subscale, ten the Controlling subscale, and five items were unassociated. Items were scored on a five point Likert scale, end points 0 (not at all) to 4 (quite a bit). These subscales were used to measure changes in the participants' perception of their presenting problem.

#### Rosenberg's Self-Esteem Scale (RSE)

The RSE (Rosenberg, 1965) is a six item Guttman scale. Respondents answer the ten positive or negative statements across a 4 point Likert scale, end points: strongly agree and strongly disagree. The statements were arranged for alternate valance to reduce the danger of a respondent set. Three scale items were contrived from the combined responses of grouped questions (one group of 3 items and 2 groups of 2 items). Three items were stand alone scale items. The RSE measured the degree to which a client considered him/herself a person of worth. Low scores implied self-acceptance and a desire to overcome deficiencies. High scores implied a lack of self-esteem. Final scores could range from 6 (high self-esteem) to 50 (low self-esteem). Validity and reliability scores were considered adequate.

A participant's self esteem was defined by the RSE. The scale was used to measure changes in self esteem.

#### Profile of Mood States (POMS)

The POMS (McNair, Lorr and Droppelman, 1981) is a 65 item self-rating instrument designed to measure change of mood states in subjects 18 years or over. Factors measured are Tension-anxiety, Anger-hostility, Vigour-activity, Fatigue-inertia, Depression-dejection, and Confusion-bewilderment. Reliability, validity and sensitivity studies are favourable. Descriptive adjectives are marked on a five point Likert scale, end points 0 (not at all) to 4 (extremely).

Subscales are calculated using scoring templates.

Normative data is available for college students and psychiatric patients (male and female) for all items. The norms are considered tentative. The mood state of participants was measured using all subscales at the baseline, post and three month follow-up time points.

#### Mature Faith Scale (MFS)

The Mature Faith Scale (Benson, 1993) is a 38-item true false questionnaire designed to measure the extent of religious development. The instrument is considered to be reliable and to have construct validity. The MFS was moderately to strongly correlated with other religiousness measures. The mean score reflects the eight criteria deemed to measure faith maturity: 1. trusts and believes, 2. experiences the fruits of faith, 3. integrates faith and life, 4. seeks spiritual growth, 5. experiences and nurtures faith in community, 6. holds life-affirming values, 7. advocates social change and 8. acts and serves.

The adult average score was  $M = 4.63$  ( $n = 3040$ ) with a mean range from 1.6 to 6.8. The scale is scored as the mean of 38 items, with a potential range from 1 to 7. Scores tend to increase with age and professional church workers tended to score higher. Changes in faith maturity due to treatment over time were considered using this instrument.

#### Religious Orientation Scale (ROS)

The religious orientation scale used for this research comprised three main sub-scales: Intrinsic/Extrinsic-Revised, religion as Quest scale and the religious problem solving scale. These scales were combined to form a 44 item questionnaire, which was rated on a 7 point Likert scale with end points strongly disagree to strongly agree.

### Intrinsic/Extrinsic Measurement-Revised (I/E-R)

The 14 item revised I/E scale of Gorsuch and McPherson (1989) is divided into three sub-scales: Intrinsic, Extrinsic-personal and Extrinsic-social. Extrinsic (religious) orientation is defined as being utilitarian, whereas intrinsic orientation perceives faith as a supreme value in its own right, striving to transcend self-centeredness. Allport and Ross (1967) originally conceptualized religious measures along orientations they called intrinsic and extrinsic. Considerable research and refinement of the original scales followed. Gorsuch et al (1989) perceived the need to further refine the extrinsic subscale into two smaller subscales, thus developing the I/E-R items used in this study.

Validity and reliability tests are considered moderate to strong (Donahue, 1985 and Gorsuch et al, 1989). Gorsuch et al (1989) found that for college students the means for I and E were 37.2 and 25.6 respectively. Items are rated by using a six-point Likert scale (1=strongly disagrees; 6=strongly agrees).

### Religion as Quest Scale

The 12 item Religion as Quest Scale (Batson, & Schoenrade, 1991) measures the degree to which an individual's religion involves an open-ended, responsive dialogue with existential questions raised by life's complex contradictions. Three aspects were examined: the readiness to face existential questions without reducing their complexity, the openness to see self-criticism/doubt as positive and openness to change.

No norms were provided. Evidence for validity remains moderate (Batson and Schoenrade, 1991) and evidence for internal consistency and test-retest reliability is acceptable. Questions are rated on a six-point Likert scale (1=strongly disagrees; 6=strongly agrees).

### Religion Problem Solving Scale

The RPS scale, short version (Pargament, Kennell, Hathaway, Grevengoed, Newman, & Jones, 1988) measures three styles of problem solving relative to the place of God in their belief system. The first style involves active efforts by the individual to solve problems without the help of God (Active Person/Passive God), the second style involves a passive approach to personal problems with reliance on God (Passive Person/Active God), and the third style involves a collaborative effort for problem solving (Active Person/Active God). These styles are called Self-directed, Deferring and Collaborative respectively.

These subscales are measured on three six item scales. Pargament et al (1988) demonstrated, high stability, and internal consistency. Items were scored on a six point Likert scale (1=strongly disagrees; 6=strongly agrees). The baseline measures of the religious orientations and the problem solving style were studied to determine if they influenced significant changes in trust, mood, self-esteem, self-efficacy, or faith maturity.

### Mysticism Scale

Hood's Mysticism Scale (Hood, 1975) is the most widely used instrument to assess mystical experiences. This 32 item, self-report instrument was derived from Stace's (1960) 8 categories of mysticism. The categories measured comprise ego quality, unifying quality, inner subjective quality, temporal spatial quality, noetic quality, ineffability, positive affect, and religious quality. Internal consistency and preliminary construct validity were demonstrated by Hood (1975). Items are scored on a four point Likert scale: -2 (definitely not true), -1 (probably not true), 1 (probably true), and 2 (definitely true). Respondents may also indicate not knowing with a question mark.

Participants' religiosity were defined using the scores of MFS. The ROS and the Mysticism Scale scores will be examined as covariates.

#### Relationship Self-efficacy and Competency Scale (RSECS)

The RSECS was developed by Meier and Boivin (1990) to measure levels of client self reported control behaviour in relation to a significant other and their motivation/expectation to overcome these behaviours. The questionnaire requests that the client study 20 items of interpersonal behaviour. The client is then requested to complete five different tasks with regard to the items. Tasks include choosing those items presenting the most difficulty, choosing the ones most likely to be changed by therapy, ranking according to (1) difficulty, and (2) certainty of change, and rating current competencies with regard to each of the 20 items. This score defines the participants' competency.

The score comprises four subscales: the Identified Problem Scale (IPS), the Self-efficacy Scale (RSECS-SES), the Specific Competency Scale (RSECS-SCS) and the Global Competency Scale (RSECS-GCS). The IPS was used to assess problem areas within intimate relationships. The RSECS-SES will be used to rate the level of self-efficacy. The scores range from 1 to 100, with high scores indicating high self-efficacy. The RSECS-SCS is rated on a 5-point scale with the higher scores indicating high competency of a specific problem area. The RSECS-GCS is calculated by summing the SCS scores for the 20 items.

#### Client Satisfaction Index (CSI)

The Client Satisfaction Index (CSI) (Talley, 1992) presented the respondent with 16 items on a ten point Likert scale with anchors 1-not at all true, 4-somewhat true, 7-quite true, and 10-extremely true. Additionally the rating of: "same", "better", or "worse" was applied to post

counselling performance in academics (for students), and quality of relationships. Correlation studies and factor analysis tentatively suggest that this is a viable instrument for measuring satisfaction in very brief psychotherapy.

Norms have not been established, however early studies indicate clients experiencing one to seven sessions reported a mean approximating 7 indicating reasonable client satisfaction. No significant satisfaction differences were found due to client gender or age, or therapist gender or experience. Talley (1992) found that client satisfaction correlated positively with client improvements in very brief psychotherapeutic models. Comparison of client satisfaction between counselling interventions was examined using the CSI.

### Therapists

Three pastoral counsellors were trained in Focusing and CCM by attending two day-long workshops. The Focusing workshop was conducted by a psychologist of the faculty of St. Paul University and the CCM workshop was conducted by the Canadian representative of the World Community For Christian Meditation. The therapists' task was to improve the openness of clients to benign influences by providing opportunities of trust through one or the other intervention. Clients in the CCM group, in each session, were exposed to the same guided meditation process, while those in the Focusing group, the same Focusing process. Therapists used the specific trust issues and experiences presented by the clients. To minimize experiment demand effect, the counsellors were kept blind to the experimental questions being posed. All sessions were videotaped. Therapy adherence was monitored by the primary researcher and a clinical psychologist.

## Counselling Interventions

### Gendlin's Focusing

The skill of Focusing involves a series of steps (see Appendix G.). These steps encourage trust of one's body, a letting go of burdens, body relaxation, awareness of body sensations, emotional sensitivity, and a deliberate attempt to focus on a single specific feeling. The description of the process matches that of the incubation stage described by Batson et al (1993).

### Christian Contemplative Meditation (CCM)

The theological intervention used for this study will be Christian Contemplative Meditation (see Appendix H.). Christian Contemplative Meditation (CCM) can be distinguished from other forms of meditation by the language employed, the specifics of the underlying belief system and the goal. The language of CCM is formed in the tradition of Christianity, influenced by the narratives of the New Testament and the central figure Jesus of Nazareth. The specifics of the belief system include mutual love between humankind and God, forgiveness through Jesus Christ, trust in God, a just God, human equality, altruism, and universality. The goal of CCM is to become face to face with God. This is different from other forms of meditation as for example a Buddhist monk seeking the dissolution of self into a sea of nothingness.

CCM is an ancient discipline of the church that comes out of the teachings of the Christian monks of the fourth century (the Desert Fathers). It is consistent with the contemplative withdrawals of Jesus Christ as reported in the Gospels. The focus of the meditation is Christ. Theologically it is considered to be an access to the inner spirit of oneself. This is where the prayer of Christ is believed to reside and may be experienced. The goal of meditation is to "set our minds on the Kingdom of God before all else" (Harris, 1993). The meditation is a way into

the stillness of spirit and body to be one with God allowing a direct experience of the Spirit of Christ dwelling in silent love within (Freeman, 1983).

Focusing and CCM are similar in that they both encourage relaxation, quiet listening, and increased awareness in a state of relaxation. The history of their development is radically different, Focusing originated from psychological experiences and CCM from spiritual experiences. They can be differentiated by their focus of listening. CCM is a deliberate attempt to listen for God, whereas Focusing is a deliberate attempt to listen to one's body. Further, CCM is a deliberate attempt to concentrate not on oneself, but rather a way to empty oneself in order to be aware only of the presence of God. Other researchers have studied the effectiveness of interventions that have originated from the experiences of counselling explicitly influenced by spiritual or religious values.

#### Control Group

A wait list condition was chosen to provide a non-treatment control group. Participants assigned to the wait list were given Schedules 1 to 3 and were advised that they would be assigned to a counsellor in six weeks. At that time they were invited in for post testing (Schedule 4 less the client satisfaction index). After this wait period, these volunteers were assigned to counselling outside of this study. The wait list non-treatment referent group is referred to as the control group.

### **Research Questions**

1. **Are Focusing and Christian Contemplative Meditation equally effective interventions for improving trust as measured by the Relationship Trust Scales (RTS), the Inventory of Interpersonal Problems (IIP), and the Relationship Trust Questionnaire (RTQ)-Degree of Improvement subscale?**
2. **Do Focusing and Christian Contemplative Meditation provoke similar levels of client satisfaction as measured by the Client Satisfaction Index (CSI)?**
3. **Are Focusing and Christian Contemplative Meditation equally effective interventions for improving mood as measured by the Profile of Mood State (POMS)?**
4. **Are Focusing and Christian Contemplative Meditation equally effective interventions for improving self-esteem as measured by Rosenberg's Self-esteem Scale (RSES)?**
5. **Are Focusing and Christian Contemplative Meditation equally effective interventions for improving self-efficacy as measured by the Relationship Self-Efficacy and Competency Scale (RSECS)-Specific Competency and Global Competency subscales?**
6. **Are Focusing and Christian Contemplative Meditation equally effective interventions for altering religiosity as measured by Mature Faith Scale (MFS)?**

### **Data Analysis**

**The instruments were scored manually and the statistical analyses was done using SPSS/PC 6.3. A preliminary analysis compared each treatment group to the control group on the FIRO-B Wanted Control selection criteria and on each dependent measure to detect any baseline differences. The baseline data was collected at staggered start points of time over the 18 months of the study. This approach controls for potential biases due to time and time related events.**

Therapist effects were addressed statistically by an Analysis of Covariance (ANCOVA) with therapist as covariate in a comparison of group means where there was a significant between subject difference.

Between- and within-subject comparisons were done to investigate the effects of counselling technique on the 5 relationship trust states, 2 types of interpersonal problems, the reported degree of improvement, the 6 mood states, self-esteem, client satisfaction, self-efficacy and faith maturity. The most important change for clients in pastoral counselling is that which may occur between the assessment data at the pre-counselling, and the immediate post-counselling time point. Analyses were done to compare the changes in measurements from baseline to the post-counselling point across all groups. Additional analyses were then completed to determine the significance of lasting effects.

Two research questions involved more than one measure. For the trust and mood sets of measures, a repeated measures Multivariate Analysis of Variance (MANOVA) was applied to determine significance of the treatment by time interaction. The MANOVA maintained the Type I error (a difference detected when, in reality, there was no difference) rate at 0.05 for these comparisons. The number of questions contained in each of these sets suggests that caution must be exercised in accepting statistical significance at  $p < .05$ . If this were not a preliminary study, it would be prudent to set statistical significance at  $p < .01$ .

Hotelling's univariate test of significance was used to determine the significance of a treatment by time specific outcome measure. Where there was only one measure (self-esteem, competency, and faith maturity), an univariate repeated measures ANOVA procedure was applied with significance set at  $p < .05$ . Where there was no repeated measures factor (Client Satisfaction

Index and reported Degree of Improvement) an ANOVA was applied to determine significance between subjects at  $p < .05$ . The pre-counselling and three month follow-up data from treatment groups was compared to the two collection points of the control group to determine if the effects were still evident three months post treatment.

For between-subject factors, significant differences between specific groups were identified using the post-hoc Student-Newman-Keuls (Keuls, 1952) procedure. Analyses of the effects of a variety of variables on the between-subject significant effects were also completed by controlling for individual covariates. These covariates comprised gender, therapist, three religious orientations scores, three Religion Problem Solving Style scores, and the Mysticism Scale score.

Within-subject significant effects were further analysed using paired sample t-tests to compare pre-counselling to post counselling group means. To determine if treatment gains were maintained paired t-tests were used to compare group means at baseline and at the 3 month follow-up time points.

An analysis of power for each measure to determine the probability of detecting a significant effect given the sample size was completed. The examination of sample size was conducted retrospectively to estimate the probability of a Type II error (no difference detected when, in reality, there was a difference). This was deemed necessary due to the small sample size ( $N=24$ ) that this project had to work with. If the power analysis revealed a larger sample size was necessary, then there was an increased probability of a Type II error. The tables and formula suggested by Streiner (1990) were used. The results of the power analysis are presented in Chapter 3 and discussed in Chapter 4 where relevant.

### **Ethical Considerations**

**Participants were informed that all the results of testing and recorded material were to be kept confidential and anonymous. Anonymity was assured by assigning subject numbers to each participant. Test results were recorded by number only. To ensure confidentiality of recorded material, client progress files and interview tapes were secured in locked cabinets. Informed consent was obtained after giving explanations of the research, videotaping, qualifications of counsellors and researchers, risks, benefits, confidentiality, right to withdraw, random assignment to the different study groups, and the procedures for referrals (Appendix C.).**

**Volunteers with difficulties beyond the capability of the study were referred to the Counselling Centre. This process included clients accepted as subjects and those screened out. Participants who dropped out were be contacted and invited to a follow-up interview to determine if need of further services or referral was appropriate.**

**Special care was taken by the researcher to ensure that wait list clients waited no more than  $54 \pm 7$  days to commence counselling outside of this study. The principal researcher and the entire research team assumed responsibility to ensure that appropriate ethical guidelines were maintained.**

## CHAPTER 3

### PRESENTATION OF RESULTS

This chapter presents the results from the analysis of the data that was collected at three time points over an 18 month period. The presentation of results is organized according to the six research questions. Appendix F. presents a table of the group means and standard deviations for each subscale.

The significance of the trust and mood score change from pre-counselling to post counselling was determined by a repeated measures Multivariate Analysis of Variance (MANOVA). Significant differences between pairs of group means were identified by univariate Analysis of Variances (ANOVA). The significance of the differences among group means were determined by a one way ANOVA with post hoc Student-Newman-Keuls tests. The significance of differences from baseline to other time points was determined using a paired t-test statistic. Outcome measures were considered lasting if there were no significant difference from post counselling to the 3 month follow-up and there was a significant difference from pre counselling to post counselling.

Before conducting the repeated measures MANOVA the treatment and control group means were analysed for homogeneity using pre-treatment scores. An ANOVA at the pre-counselling time point showed no significant difference among groups at baseline. The control group data from the tests of interest were analysed for significant differences across time using a paired samples t-test. No significant differences were found.

In order to meaningfully interpret the data, where significant between-subject differences were found therapist effects were analysed. As mentioned earlier, the original design called for

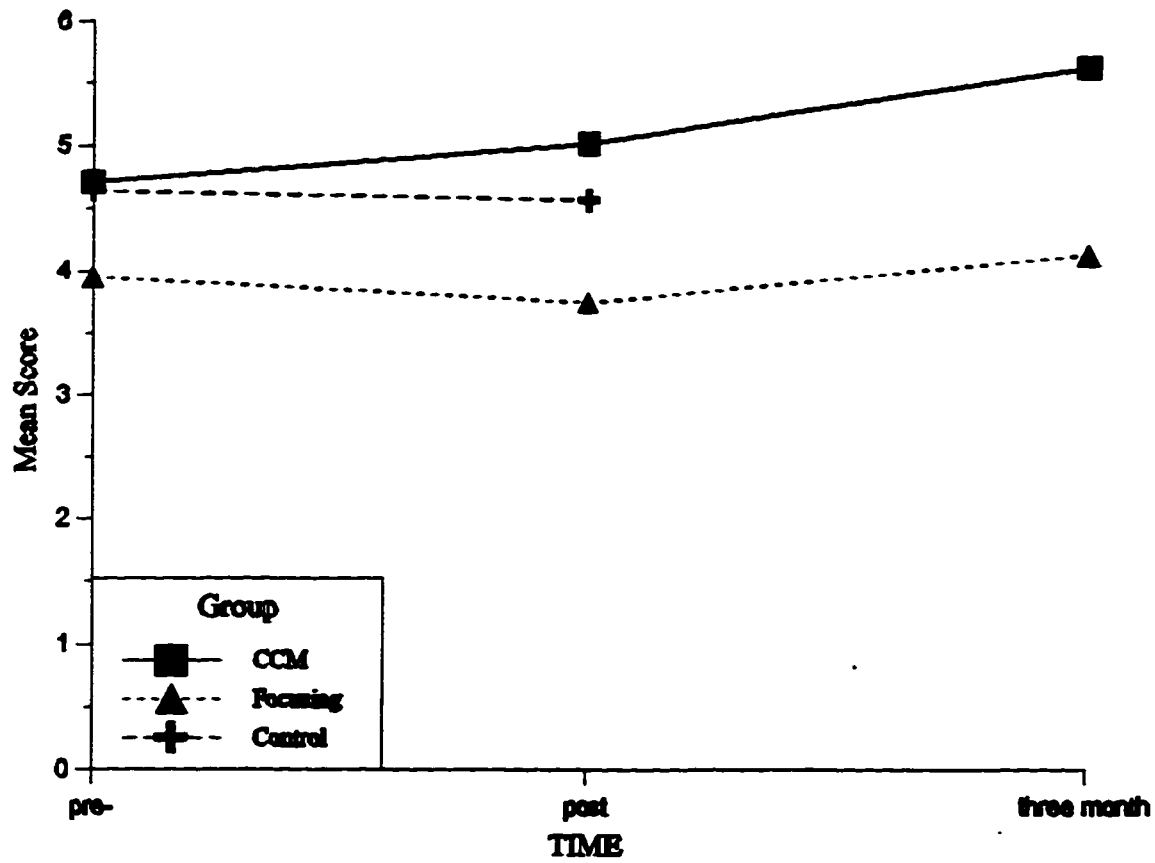
the application of both treatments by the three therapists to an equal number of research participants. Due to circumstances beyond the control of the researcher, participants were not distributed evenly across therapists. A therapist effect was detected in the CSI scores.

In the same way, gender distribution was not evenly distributed. Using the Analysis of Covariance (ANCOVA), a gender effect was detected in the CSI scores, but not the Degree of Improvement scores. There was no age effect detected in the CSI or Degree of Improvement scores.

The remaining test results and analyses are reported in the order of the research questions. When a between-subject significant difference was found, an ANCOVA was conducted in order to control for the influences, if any, of the three religious problem solving styles, the Mysticism Scale score, and the three religious orientation results. The chapter concludes with a retrospective power analysis for all measures.

### Trust Related Findings

The first research question was: "Are Focusing and Christian Contemplative Meditation equally effective interventions for improving trust as measured by the Relationship Trust Scales, the Inventory of Interpersonal Problems, and the Relationship Trust Questionnaire (Degree of Improvement subscale)?" Figure 1. shows the mean scores of the Boon RTS plotted across three time points. The repeated measures MANOVA showed no treatment, time, or treatment by time significant effects. Appendix F. shows the RTS subscale group means with standard deviations, the group mean scores and their standard deviations for the Inventory of Interpersonal Problems (IIP) Scales.



**Figure 1.** Relationship Trust Scale mean scores of groups across time. There were no significant treatment by time effects.

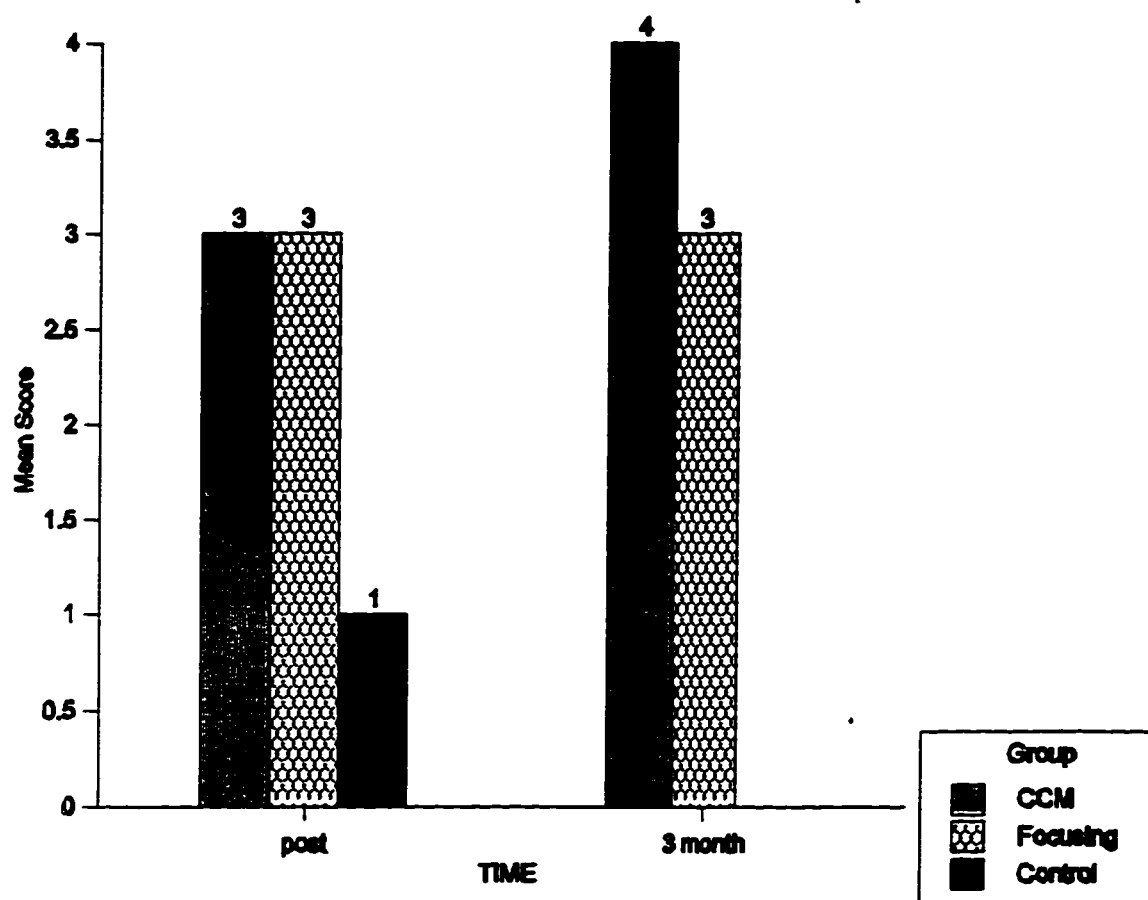
Figure 2. shows the reported Degree of Improvement across conditions at the post and three month time points. Compared to the control group, the participants of both experimental groups indicated a significant Degree of Improvement of the most important presenting problem at the post-counselling point; CCM:  $M = 3$ ,  $SD = 1$ ; Focusing:  $M = 4$ ,  $SD = 1$ ; control group:  $M = 1$ ,  $SD = 1$ . The reported significant Degree of Improvement was maintained for both experimental groups at the three month time point: CCM:  $M = 4$ ,  $SD = 1$ ; Focusing:  $M = 3$ ,  $SD = 2$ . Statistical significance was determined using a one way ANOVA across groups at each collection point. Among groups, at the post time point there was significant difference of the degree of reported improvement ( $F(2,21) = 4.1$ ,  $p=0.03$ ) and at the three month time point, ( $F(2,17)=11.5$ ,  $p<.001$ ). A Student-Newman-Keuls post hoc test with a significance level of .05 indicated both Focusing and CCM group scores were significantly higher from the control group at both time points. The group mean scores and their standard deviations for the Degree of Improvement subscale of the Relationship Trust Questionnaire are presented in Table 3.

Table 3

Mean Test Scores For Degree of Improvement Subscale of the RTQ							
Measure	Group	pre		post		3 month	
		M	SD	M	SD	M	SD
Degree of Improvement							
	Control			1.0	1.0		
	CCM			3.0	1.0	4.0	1.0
	Focusing			3.0	2.0	3.0	1.0

Significance of differences among groups at post counselling:  $F(2,21)=4.1$ ,  $p=0.03$

Significance of differences among groups at 3 months:  $F(2,17)=11.5$ ,  $p<.001$



**Figure 2.** Degree of Improvement mean scores for each group at post and 3 month follow-up. CCM and Focusing scores at both times are significantly different from the post wait period control group mean score. There was no collection of data for the control group at 3 months.

### Measures of Client Satisfaction

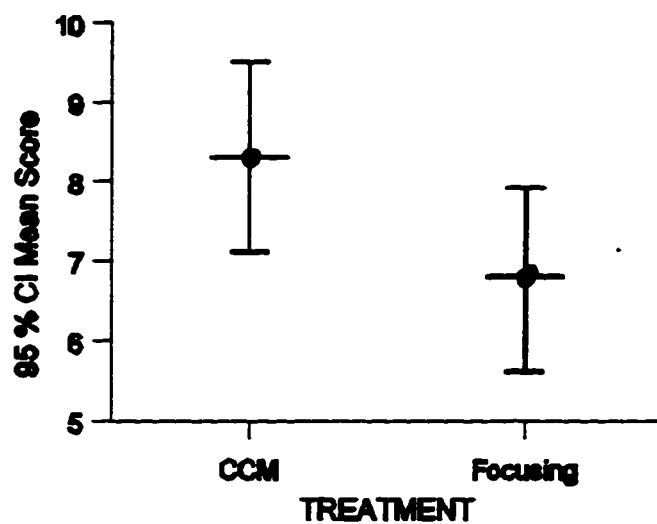
The second research question was: "Do Focusing and Christian Contemplative Meditation provoke similar levels of client satisfaction as measured by the Client Satisfaction Index?" The group means and the standard deviations of these scales across treatments are reported in Table 4 under Client Satisfaction Index (CSI).

Table 4  
Mean Test Scores For Measure of Client Satisfaction across Treatment

Measure	pre		post		3 month	
	M	SD	M	SD	M	SD
Client Satisfaction						
Control						
CCM			8.3	1.5		
Focusing			6.8	1.3		

Significance of mean differences between groups  $F(1,14)=4.8, p=0.045$

The Client Satisfaction Index scores revealed a significantly greater satisfaction for the CCM group  $M = 8.3, SD = 1.5$  than for the Focusing group  $M = 6.8, SD = 1.3$  ( $F(1,14) = 4.82, p < .05$ ). Figure 3. shows the CSI scores by treatment group with 95% confidence interval bars.



**Figure 3.** Client Satisfaction Index mean scores for CCM and Focusing groups with 95% confidence interval bars. The CCM group mean is significantly higher than the Focusing group mean.

### **Mood State Measures**

**The research question regarding mood read: "Are Focusing and Christian Contemplative Meditation equally effective interventions for improving mood as measured by the Profile of Mood State?" The group means and the standard deviations of these scales across treatments are reported in Appendix F. under the POMS mood subscales: Tension-anxiety, Confusion-bewilderment, Depression-dejection, Anger-hostility, Fatigue-inertia, and Vigour-activity.**

**The repeated measures MANOVA applied to the six mood measures from pre to post counselling among all groups showed a significant difference in the treatment by time effect using Hotelling's (Hotelling, 1933) T-value  $F(12,30)=2.21, p=.039$ . The univariate analysis showed that there was a treatment by time effect in the Anger-hostility  $F(2,21)=3.6, p=.045$  and Fatigue-inertia  $F(2,21)=6.5, p=.006$  measures. No significant treatment, time, or treatment by time effect was found for the Vigour-activity, Depression-dejection, Tension-anxiety and Confusion-bewilderment mood states. The results are reported in Table 5.**

Table 5  
Mean Test Scores of Profile of Mood States Across Three Time Points

Measure	Group	pre		post		3 month		Significance *		
		M	SD	M	SD	M	SD	df	F	p
POMS: Anger-hostility										
	Control	9	11	10	10					
	CCM	11	8	5	5	4	4	1,14	10.8	0.01
	Focusing	15	11	12	12	12	11	1,14	2.1	0.16
POMS: Fatigue-inertia										
	Control	7	7	12	5					
	CCM	7	5	7	7	2	3	1,14	4.39	0.05
	Focusing	13	11	10	9	9	8	1,14	11.78	0.01
POMS: Vigour-activity										
	Control	18	9	15	6					
	CCM	15	5	18	9	20	5	1,14	3.91	0.07
	Focusing	11	8	15	8	15	5	1,14	3.40	0.09

\* Pre post mean score difference compared to control group

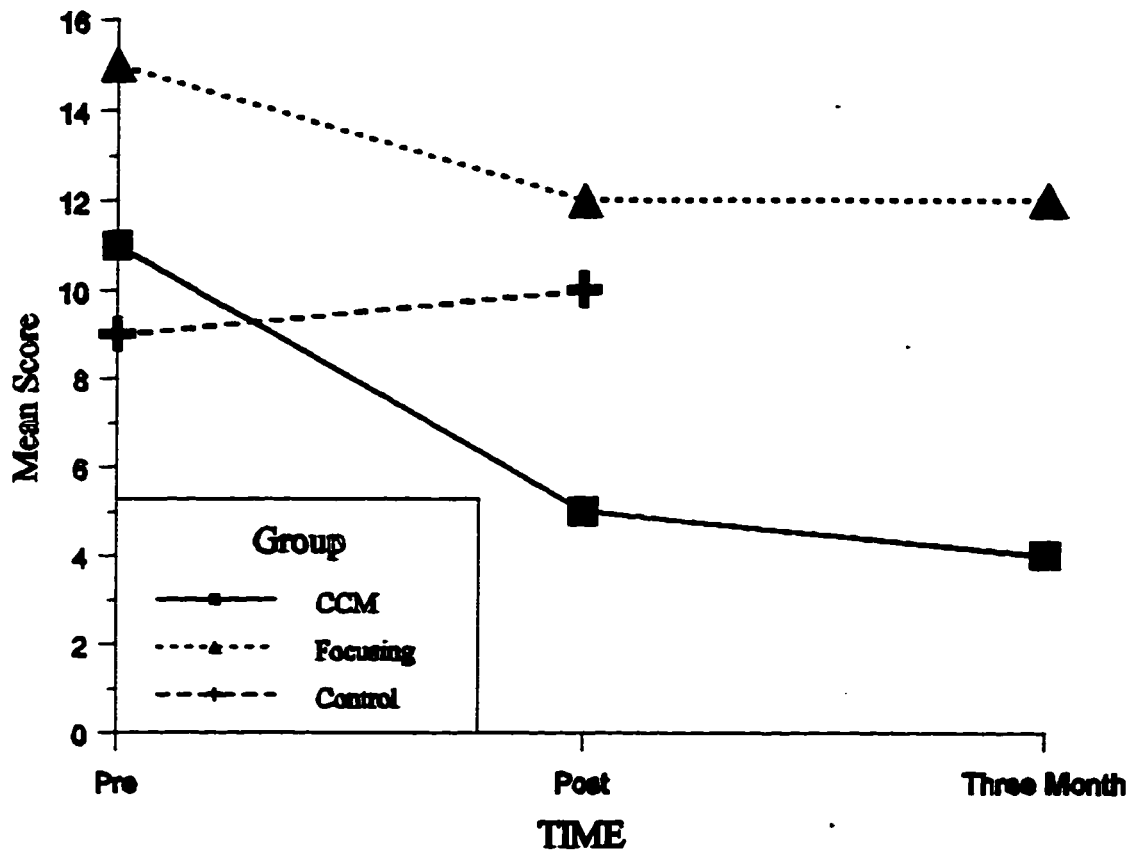
Figure 4. shows the results of the Anger-hostility mood state measures. Anger-hostility for people exposed to CCM decreased from a mean score of  $\underline{M} = 11$ ,  $SD=8$  to  $\underline{M} = 5$ ,  $SD=5$  (post). For those exposed to Focusing, the Anger-hostility scores dropped from  $\underline{M} = 15$ ,  $SD=11$  to  $\underline{M} = 12$ ,  $SD=12$  (post). The Anger-hostility difference for those exposed to CCM from before counselling to post counselling was significant ( $t(7)=3.3$ ,  $p=.013$ , two tailed) and was lasting ( $t(5)=3.73$ ,  $p=.014$ , two-tailed). Paired t-tests showed no significance in the Anger-hostility measures for the Focusing or control groups. A post-hoc analysis showed that no two groups were significantly different at any time point.

Figure 5. shows the results of the Fatigue-inertia mood state. The control group means significantly increased from pre counselling to post counselling ( $\underline{M}=7$ ,  $SD= 7$ ,  $\underline{M}=12$ ,  $SD=5$ ). Fatigue-inertia for people exposed to CCM remained the same from pre to post counselling ( $\underline{M} =7$ ,  $SD=5$  to  $\underline{M} = 7$ ,  $SD=7$  (post)). For those exposed to Focusing, the Fatigue-inertia scores dropped from  $\underline{M} = 13$ ,  $SD=11$  to  $\underline{M} = 10$ ,  $SD=9$  (post). The Fatigue-inertia difference was significant from pre to post counselling for the control group increase ( $t(7)= 2.76$ ,  $p=.028$ , two-tailed) and for the Focusing decrease ( $t(7)=2.76$   $p=.028$ , two-tailed), but the change in the CCM group was not significant. For Focusing, a paired t-test showed that this decrease was not lasting. However the decrease from pre-counselling to the three month follow-up for CCM became significant ( $t(5)=5.86$ ,  $p=.002$ , two-tailed). A post-hoc analysis showed that no two groups at any time point were significantly different.

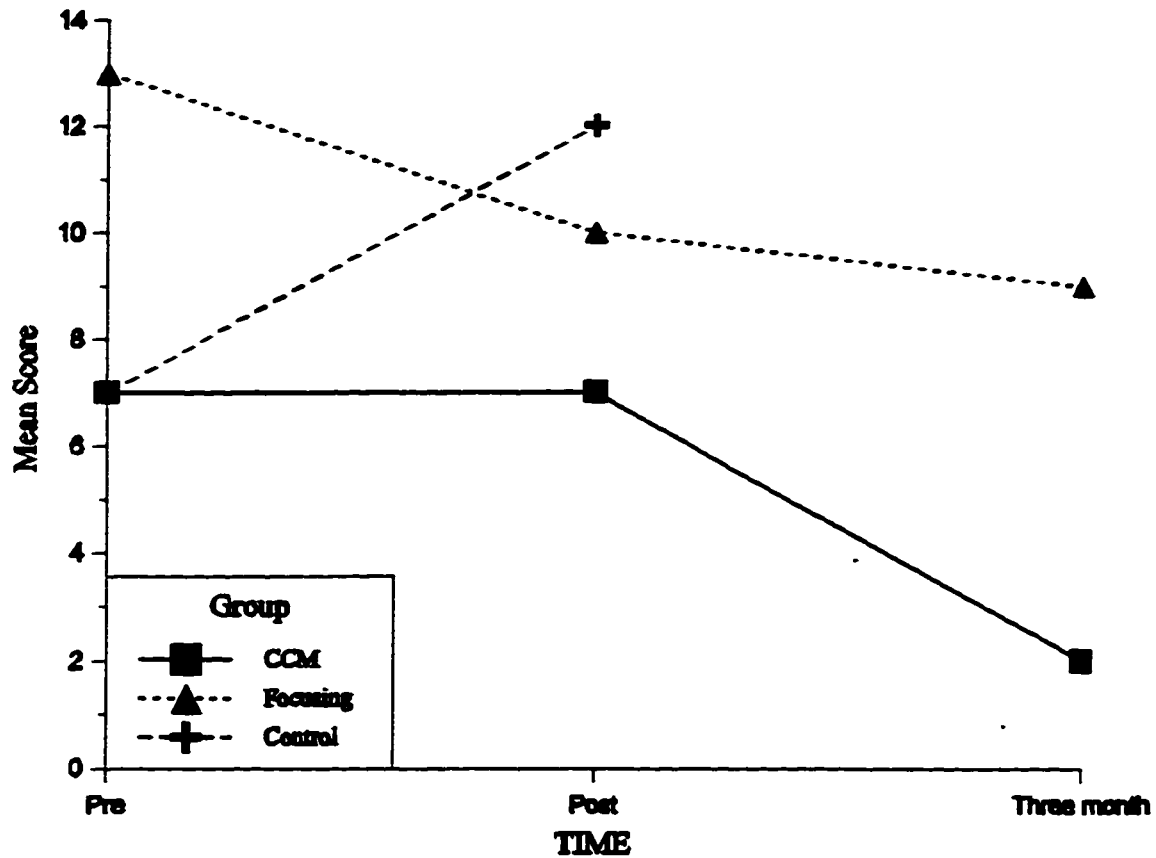
#### Measures of Self-esteem

The self-esteem research question was: "Are Focusing and Christian Contemplative

**Meditation equally effective interventions for improving self-esteem as measured by Rosenberg's Self-esteem Scale?" The group means and the standard deviations of these scales across treatments are reported in Appendix F. under the R Self-Esteem Scale. The scores of the RSES did not differed significantly over the time points for any group.**



**Figure 4.** Anger-hostility Mood State mean subscale scores of groups across time. Mean scores from base line to post counselling and to 3 month follow-up of the CCM group were significantly lower. Although there appears to be a significant difference between-subjects at baseline, analyses indicates that there is none.



**Figure 5.** Fatigue-inertia Mood State subscale mean scores of groups across time. The mean scores of the control group were significantly higher from base line to post wait period. The mean scores for the Focusing group were significantly lower from base line to post counselling, and that effect diminished at 3 months. The mean scores for the CCM group from base line to 3 month follow-up were significantly lower.

### **Measures of Self-Efficacy**

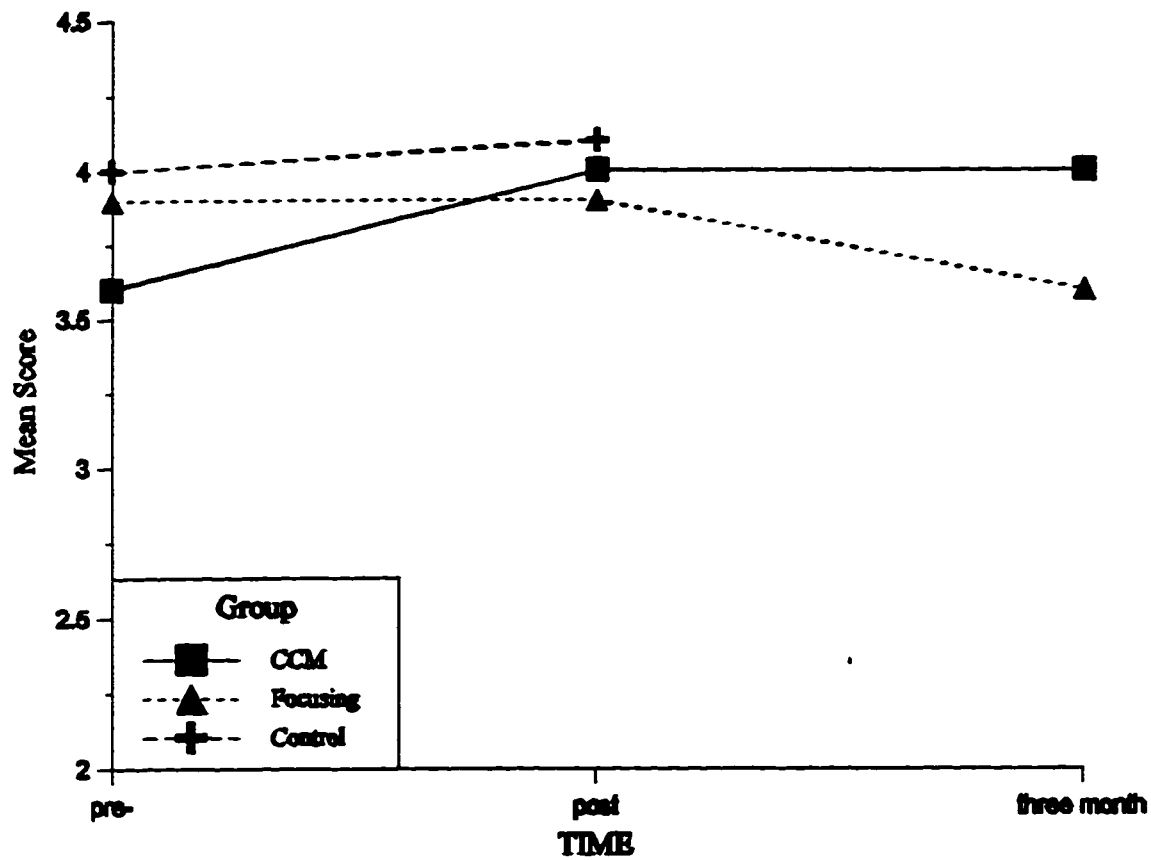
**The fifth research question was: "Are Focusing and Christian Contemplative Meditation equally effective interventions for improving self-efficacy as measured by the Relationship Self-Efficacy and Competency Scale (Specific Competency and Global Competency subscales)?"**

**The group means and the standard deviations of these scales across treatments are reported in Appendix F. under the Relationship Self-efficacy and Competency Scale and its subscales, beginning with the letters RSECS. The scores of neither the RSECS-specific competency or the RSECS-global competency subscales did not differed significantly over the time points for any group.**

### **Faith Maturity Measure**

**The faith maturity research question was: "Are Focusing and Christian Contemplative Meditation equally effective interventions for altering religiosity as measured by Mature Faith Scale?"**

**The results of the faith maturity scale are illustrated in Figure 6. For those exposed to CCM, the MFS scores significantly increased from  $M = 3.6$ ,  $SD = 0.6$  to  $M = 4.0$ ,  $SD = 0.6$  (post),  $t(7) = -9.10$ ,  $p < .0001$ , two tailed. This significant increase lasted to the 3 month follow-up. Neither the control group or the Focusing group mean scores changed significantly. The group means and the standard deviations of these scales across treatments are reported in Appendix F. under the Mature Faith Scale (MFS).**



**Figure 6.** Mature Faith Scale mean scores of groups across time. The mean scores of the CCM group increased significantly from base line to post counselling and to 3 month follow-up. Although there appears to be a significant difference between-subjects at baseline, analyses indicates that there is none.

### Measures of Religiosity

There was insufficient power in this study to examine meaningfully any changes in the religiosity measures that could result from pastoral counselling. However due to the influences of religious orientation, mystical experiences and religious problem solving style on coping and mental health (Hood, 1975; Spilka et al, 1985; and Pargament, 1987), these factors were considered by controlling for them at baseline.

The baseline measures of Intrinsic-Extrinsic Religious Orientation Scales, the Religion-as-Quest Scale, and the Religious Problem-Solving subscale are reported in Table 6. The impact of the religiosity measures were analysed using a regression analysis of the covariate within-plus-residual error term, with a 95% confidence interval of the analysis of variance (ANCOVA). This analysis was applied the reported Degree of Improvement and Client Satisfaction Index post counselling group means.

Significance of the difference among groups remained in the Degree of Improvement scores even when controlled for the religiosity measures with the exception of the Defer to God Religious Problem Solving Style. The significant differences in the Client Satisfaction Index scores disappeared when controlled for the Religion Problem Solving Styles: Collaborative and Deferring. Intrinsic-extrinsic religious orientations were found not to have significant effects on any group. When controlling for the Quest measure, the association between CSI and treatment vanished, and the association between the Degree of Improvement and treatment was maintained. When controlling for Mysticism Scale scores, the CSI and Degree of Improvement significant differences were maintained. A regression analysis of the covariate Mysticism Scale mean score in a general factorial analysis indicated that for higher Mysticism Scale scores, the CSI score was higher.

Table 6  
Mean Test Scores For Measures of Religiosity Across Three Time Points

Test	CCM <sup>1</sup>			Focusing <sup>2</sup>			Control group	
	pre	post	3 month	pre	post	3 month	pre	post
Mature Faith*								
<u>M</u>	3.6	4.0	4.0	3.9	3.9	3.6	4.0	3.9
<u>SD</u>	0.6	0.6	0.6	0.7	0.7	0.4	0.9	0.7
ROS: Intrinsic								
<u>M</u>	31			30			31	
<u>SD</u>	3			8			10	
ROS: Extrinsic								
<u>M</u>	21			17			20	
<u>SD</u>	7			5			10	
ROS: Quest								
<u>M</u>	52			49			45	
<u>SD</u>	4			11			12	
Mysticism Score								
<u>M</u>	91			103			100	
<u>SD</u>	23			30			31	
Autonomous RPSS								
<u>M</u>	30			31			28	
<u>SD</u>	9			9			12	
Collaborative RPSS								
<u>M</u>	18			16			15	
<u>SD</u>	8			9			10	
Deferring RPSS								
<u>M</u>	13			12			10	
<u>SD</u>	7			3			4	

<sup>1</sup> CCM: Pre-post Mean difference compared to the control group  $F(1,14)=8.12, p=0.01$

<sup>2</sup> Focusing: Pre-post Mean difference compared to the control group  $F(1,14)=0.16, p=0.70$

### Power Analysis

The data were analysed to determine if a sample size of  $N=24$  ( $N=8$  in each experimental group) provided adequate power for the measures of interest (Table 7). Column 1 names the instrument. Columns 2 and 3 show a minimum change for Focusing and CCM respectively. This minimum change was calculated using one half the standard deviation for that measure. Columns 4 and 5 show the sample size required to obtain a power level of 70% for Focusing and CCM respectively. Using the formula provided by Streiner (1990), with a beta level set at 0.3, which yields a power of 70% the sample size required for differences of half the standard deviation was calculated. Power set at this level means there is a 30% chance of a type II error (a false negative finding). It is not unusual to set a lower power level for power analyses when considering the probability of a type II error. Cohen(1988) defends this level on two grounds. In preliminary studies, as this one is, increased power would demand large and impractical increases in sample size. Secondly, if power is found to be less than 70%, false negative findings become probable.

The retrospective power analysis, assuming a minimum change in measure of a half a standard deviation shows that a  $N = 8$ , yields power in all cases below the 70% confidence interval. This suggests that the lack of significant difference found in many of the measurements could be explained as a false negative (type II error). For example, no significant difference was found across treatment over the three time points in the means of the relationship trust scale. For this measurement  $N=8$  in each group. Expecting change for Focusing of at least 0.6 and for CCM of at least 0.7, this would require, at 70% power, 34 and 25 subjects respectively. Having only 8 subjects each means there is less than 70% power. This implies a high probability that the lack of significant difference is a type II (false negative) error.

Table 7

## Retrospective Power Analysis Table

Measure	Focus (SD/2)	CCM (SD/2)	N(Focus) at 70%	N(CCM) at 70%
Boon RTS	0.6	0.7	34	25
RTS: Conflict Efficacy	0.7	0.8	38	43
RTS: Partner dependency	0.8	0.75	64	49
RTS: Partner's caring	0.8	0.3	14	87
RTS: Responsiveness	0.6	0.65	22	19
RTS: Dependency concerns	0.6	0.7	22	16
Anger-hostility	3.8	2.6	15	32
Confusion	3.5	3	25	34
Depression-dejection	6.4	2	23	41
Fatigue-inertia	5.5	2.5	20	96
Anxiety	5	4	31	49
Vigour	4	2.5	62	159
Hard to be Intimate	0.4	0.4	64	49
Try to Control	0.4	0.3	25	34
Self-esteem	3.5	2.5	49	96
Self-efficacy	20	18	52	64
Degree of Improvement	1	0.5	12	49
Faith Maturity	0.4	0.3	81	111

### Summary of Findings

The main findings of this study comprised:

1. Neither CCM or Focusing significantly changed the scores on the Relationship Trust Scale or its subscales. The results of these interventions on trust were not different from the no treatment control group.
2. The CCM mean scores of the Client Satisfaction Index were significantly higher than the Focusing mean scores.
3. Compared to the control group both the CCM and Focusing groups scored significantly higher on the Degree of Improvement subscale. These effects were maintained to the 3 month follow-up. No other differences were found.
4. Compared to the control group and the Focusing group, the CCM group mean score significantly decreased on the Anger-hostility subscale. These effects remained at 3 month follow-up.
5. The CCM group mean scores of the Fatigue-inertia subscale for the 3 time points were significantly reduced only at the 3 month follow up. By contrast, the control group mean significantly increased from pre to post counselling. When compared to the control group, the Focusing group mean score of the Fatigue-inertia subscale significantly decreased from pre to post counselling. This effect diminished at the 3 month follow up. No other significant differences were found in the other mood subscales.
6. Compared to the control group and the Focusing group, the CCM group mean significantly increased on the Mature Faith Scale. These effects remained at 3 month follow-up.
7. A history of mystical experiences appeared positively to impact client satisfaction.

8. **When the Quest Score, the Collaborative and the Deferring to God Religious Problem Solving Styles Scores were controlled, significant differences between treatment groups on the Client Satisfaction Index Score disappeared.**

## CHAPTER 4

### DISCUSSION OF RESULTS

This chapter discusses the eight main findings of this study in the context of the literature and concludes with recommendations for future studies. This study remains a preliminary investigation in a field where there has been little research and it has a number of limitations. Thus the results are interpreted with caution.

#### Trust Results

The results regarding trust were not robust. Based on the limitations of the study, it is not clear from this study whether the lack of change in the trust is a true result or not. The law of parsimony would suggest, however, that given the preponderance of no significant change, neither intervention as applied in this study brought about the desired improved level of trust.

The lack of robust change in the trust measures was also seen in the lack of significant differences in self-esteem and perceived competence. This would be consistent with the studies linking self-esteem and competency with trust (Frost et al, 1978; Schutz, 1966; Boon et al, 1991; Rempel et al, 1985; Meier, 1993).

#### Degree of Improvement

It was interesting that both procedures left participants with the impression that they had improved their first presenting problem and yet this improvement was not found through the use of most of the other measures. The apparently contradictory data from the Degree of Improvement measurement may be explained a placebo or a proximity effect. A proximity effect is

not indicated because the Degree of Improvement was maintained to the three month follow-up point. While it is not clear what the client perception of improvement means, it is clear that the client believed there was improvement. Whether or not this is sufficient evidence of improvement continues to be debated in the literature (see Seligman, 1995, Strupp, 1996).

### Client Satisfaction

The Client Satisfaction Index (CSI) rating indicated that CCM had a more significant impact than Focusing. Talley's (1992) studies on client satisfaction provided some indication that improvement correlates with satisfaction. Talley identified that a mean score of 7 meant a client was quite satisfied. Thus the more robust score of CCM participants ( $M=8.3$ ) as compared to Focusing participants ( $M=6.8$ ) suggest CCM had more of an impact than Focusing. In the same way that the reported Degree of improvement may be the strongest indicator of successful counselling, positive client satisfaction has been considered a very strong indicator of positive counselling outcome (Talley, 1992). The result, however, in this study must be interpreted with caution as the CSI significant differences were eliminated after controlling for therapist and age.

### Mood Results

The interventions, did however produce some interesting results as measured by the Profile of Mood State subscales. The Anger-hostility and Fatigue-inertia results suggested that CCM had a more robust effect than Focusing on trust development. The mood improvements being more robust for CCM than for Focusing were consistent with the Propst et al (1992) findings that the most robust long lasting results were found by those in pastoral counselling.

The improved lasting moods from CCM is consistent with the anecdotal reports (Freeman et al, 1992) of those who practice meditation over long periods of time. Particularly relevant to this study were the reports of the giving up of revenge and increased sensitivity to others. It is remarkable that the experience of only four meditation periods, over five weeks could produce reduced anger-hostility, fatigue-inertia (delayed) while Focusing impacted favourably on only one mood state and for only a short period of time.

The lack of improvement in other mood subscales was surprising. For example, the lack of change in the Depression-dejection subscale for both CCM and Focusing was not expected as it is not consistent with either Propst et al (1992) study of the positive effects of counselling on depression or the improved depression results as reported by Katonah et al (1992) in a Focusing outcome study.

#### **Mature Faith Results**

The finding that changes were evident in the Faith Maturity Scale scores only for those exposed to CCM was consistent with the findings of Propst (1978, 1992), Carlson et al (1988), and Pecheur et al (1978) in that they suggested that spiritual values are important to consider in designing interventions. The lack of robustness in the Faith Maturity Scale scores for the Focusing group appear inconsistent with the findings of Bufford (1995) and Toh et al (1994) who found changes in spirituality regardless of intervention type. However, those studies used the Spiritual Well-being Scale (Ellison, 1983) and so the relationship between these measures could form the object of future research.

### **Religiosity Factors**

Given the literature suggesting correlations between mental health, self-esteem, and religious orientations (Spilka et al, 1977; Masters & Bergin, 1992; Hood, 1992) it was surprising that religious orientation had little impact on the outcome measures. Quest impacted in a non-specific manner the Client Satisfaction Index. The Religious Problem Solving Styles: Collaboration with God, and Deferring to God also impacted in a non-specific way on the CSI significant differences.

The Mysticism Scale scores affected the Client Satisfaction Index mean scores in a measurable way. The data indicated that, for participants with a mystical experience history had increased client satisfaction. This finding suggests that religious orientation, and religious problem solving style are not relative to trust development by the procedures applied. However, personal mystical encounters, it appears, does effects outcome and thus could play a role in counselling planning. Future inquiries could also examine if religious variables can be predictive of successful outcomes in pastoral counselling.

### **Comparing Outcome Measures of CCM with Focusing**

CCM appears more robust and resilient than Focusing. Although both procedures are considered experiential and the literature reviewed suggested that they should represent the initial stages of change (insight and self-surrender), these procedures are quite different. Focusing involves a heightening of body awareness. It is a process of deliberately and purposefully becoming aware of a physical felt sense. CCM, on the other hand, is a process of deliberately entering of state of non-awareness of body or cognition, providing experiences of letting go and

self-surrender. This study suggests that the experience of sitting in silence, attempting not to engage oneself or ones environment is such that even a few attempts to meditate were efficacious. This study suggest future research could examine the effects of dosage, duration and frequency on the clinical effects of Christian Contemplative Meditation.

Another difference between the two processes that could account for the outcome differential was suggested by the Batson et al's (1993) model of change. Batson et al (1993) would argue that change begins with an existential crisis. Focusing is the successful awareness of the impact an issue has on self, at the physical level that Gendlin (1981) identifies as the felt sense. Gendlin would argue that recognition of or a felt sense of the existential crisis is a necessary component to change. This may be a shorter term state, which may have been detected by the short term relief of fatigue-inertia. CCM on the other hand, may be the different self-surrender process within the Batson model. This process may be longer term, and have broader affects as one experiences therapeutic change. Future studies could examine the effects of a series of planned interventions, each designed to help participants master each of the stage model steps. Focusing followed by CCM could be used to operationalize the first two stages. Other techniques could be considered for the last two stages. Variations of such a study could include leaving one of the procedures out.

### Limitations

The limitations of this study could be summarized in terms of participant effects, therapist effects, treatment and rater effects, and instrument effects.

### Participant effects

Sampling was based on volunteers, who were screened according to two measures: Psychological Screening Inventory and MMPI Ego Strength subscale. It remains unknown if these results can be generalized to include people presenting exclusively for counselling, or those screened out due to PSI or MMPI K scale instruments. Further it is not clear if there would have been a difference if participants could have been randomly selected from a much larger pool of volunteers.

### Therapist Effects

Attempts to counter therapist effects were made by planning plan to assign each therapist an equal number of participants for both interventions. These attempts were partially successful. In the analysis, when controlling for therapist effects, significant differences remained in the measure for Degree of Improvement at the 3 month collection point, and in the Fatigue-inertia mood score at both post counselling collection points. However, the significant difference across treatments in client satisfaction disappeared when controlled for therapist.

### Treatment and Rater Effects

A more significant limitation was in the use of self-report instruments only. Although for quality management purposes the sessions were taped, there were no observer rated measures to validate data from the self-report instruments, therapist competency, and client level of mastery of the procedure.

Further, the absence of observer rated measures, precluded a clinical rating of the participants' actual experience of the interventions. The lack of a treatment fidelity measure makes it difficult to know if the procedures were successfully mastered by the participant. Taking

measurements of the intensity, duration, and frequency of the participants experience as observed by a qualified clinician (see Hendricks, 1986) would be useful in future similar research.

### Instrument Effects

The selection of instruments could also have had an impact. The literature of some of the instruments that were selected gave some indication that these were measures of state not trait and were thus more sensitive. However, it is not clear if the negative results could be a result of instrument insensitivity. Replication of this study using, for example, a variety of self-esteem instruments would help confirm these results.

### Lack of Power

Finding a lack of significant differences, however, does not necessarily mean there was no effect of treatment. In preliminary studies such as this, type II errors are not uncommon (Abelson, 1995; Cohen, 1988; and Streiner, 1990). As Talley (1992) pointed out, very brief psychotherapy can be effective, but expectations of magnitude of change should be realistic, indicating definitive conclusions can be drawn only after a series of related studies and studies with larger sample sizes. These results could indicate that the interventions of CCM and Focusing were not effective, however, the small sample size increased the probability of false negative findings.

A retrospective power analysis was completed to ascertain the sample size required for 70% power. The analyses showed that in the Relationship Trust Scale subscales, the study lacked sufficient power. The minimum number of subjects for 70% power is estimated at 3 to 4 times the N of this study. Thus, it remains unclear if the results would be different with a larger sample size. What is clear is that based on sample size, there is a better than 30% chance that one would find no significant effect when indeed one exists (type II error).

However, even with such a small sample size some significant effects were found. Finding significance with such low power indicates that the improvements found were big and very robust.

### Conclusion and Suggestions for Further Research

Although results of this study are mixed, some things are clearer. Procedures designed and/or applied by pastoral counsellors can be examined for efficacy. Meditation and Focusing applied by pastoral counsellors have a positive effect on mood and perceptions for people presenting with trust problems. A personal history of mystical experience may impact the results. The stages of change as outlined by Batson and colleagues (1993) could be used as a model to locate pastoral counselling interventions.

There remains a paucity of studies of pastoral counselling, spiritual direction, and the relationship between religiosity and psychology (Hood, 1992). This study identified a variety of future pastoral counselling research areas. This paper indicated that a replication study using a larger large sample sizes is recommended. Both the treatment fidelity and the variety of the type of outcome measures could be improved in subsequent studies by using both self-report and observer rated instruments.

More research to improve sensitivity of instrumentation, and increase the understanding of the variations of the intervention parameters (i.e. length, frequency and duration of sessions) are indicated. Studies could focus on the development of a variety of instruments more applicable to pastoral counselling objectives. Religiosity, and religious problem solving styles as predictors of successful outcome have not yet been examined. The role mystical

experiences play in the mastery of Focusing, meditation or other procedures taught in pastoral counselling is not yet well understood.

The stage model of change from Batson and colleagues (1993) could be further explored in such a way as to increase its validity with pastoral counselling. Designing a series of interventions, each attempting to improve the mastery of each stage might be a way of increasing the robustness of the results of the current study.

The results of the current study were interpreted as preliminary data of a single study. The mixed results and the lack of magnitude of effect size in key areas suggest that much more work is indicated. Generalization of the results of this study would be premature because this is a single paper in a field where there is not yet sufficient research to allow for meta-analysis. The field of pastoral counselling has not yet become a focus of scientific enquiry, although there are recent indications (Clay, 1996; Payne et al, 1992) that religiosity and spiritual beliefs are being more rigorously studied. It is hoped that this project is a preliminary contribution towards the analysis and the development of pastoral counselling science.

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**Appendix A. Advertisement for recruiting volunteers**

**DO YOU WANT TO IMPROVE  
YOUR INTIMATE RELATIONSHIP?**

We are conducting research on the difficulties men and women experience in developing and maintaining trust in close relationships and the impasses they experience trying to realize this goal.

If you are willing to discuss your relationship difficulties with a professional counsellor and try new ways to resolve them please contact us. The only requirements are that you be:

- currently in a relationship,
- English speaking, and
- between the ages of 20 and 45.

**NO FEES WILL BE CHARGED**

**ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL**

For More Information,  
Call 236-1393  
Stating Your Interest in the Zimmerman/Meier Research

Saint Paul University  
223 Main Street  
Ottawa, Ontario

### Appendix B. Telephone screening interview

Interviewer: \_\_\_\_\_

Research Participant: \_\_\_\_\_

Telephone Number: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

I am returning your call wherein you inquired about the study being conducted by Dr. Augustine Meier and George Zimmerman. Dr. Meier, a registered Psychologist, is a Professor of Psychology at St. Paul University and George Zimmerman is a MA graduate student in Pastoral Studies at St. Paul University.

My name is \_\_\_\_\_. I am a co-director of the research.

Do have any specific questions in mind? Attend to these questions and then proceed as follows:

Let me tell you a little more about the study so that you can decided whether or not it is the type of study in which you would like to participate. This research is designed to look at different methods to help people become more adept in relating to others, especially with those who are close to us. You will be offered five counselling sessions with a professional counsellor. These interviews will be videotaped. In addition to the interviews, you will be asked to complete a set of questionnaires before you begin counselling, and at the completion of counselling, two other sets of questionnaires, three months apart. But before you begin counselling, you will be invited in for an interview and some questionnaires to gather some necessary information and to see if this study will be beneficial to you. It is possible at this time that the results indicate that the counselling will not be useful given your current situation. If that is the case, we can recommend some other counselling centres, as you wish. Your confidentiality will be safeguarded throughout this study. The people involved in the study include a counsellor who will be assigned to you, a research assistant by the name of Rita Uson, Dr. Meier and George Zimmerman, the co-directors of the project.

The video tapes will be protected by the co-directors of the research and they will destroy them after five years.

You should also know that you have a one in four chance of having to wait five weeks before counselling begins. At the beginning and the end of this time period we will be gathering information for the study by asking you to fill out two sets of questionnaires.

Are you interested in participating in our research project.

No \_\_\_\_ (If the research subject says no, say to him/her) Thanks for the interest you have shown. Perhaps you will offered another opportunity in the future.

Yes \_\_\_\_ (If the research subject says yes, say) Could you tell me whether you are presently receiving professional help.

Yes \_\_\_\_; No \_\_\_\_ (Enquire about the nature of the help).

What is the nature of the help received:

therapy \_\_\_\_ counselling \_\_\_\_ group counselling \_\_\_\_

Are you currently in a relationship? How long have you been in this relationship?

Yes \_\_\_\_; No \_\_\_\_\_

If the research subject is in counselling or therapy, say:

Since you are in counselling we think that this project would not be helpful to you and might interfere with you present counselling process. Thanks for taking the time to respond to our advertisement. We appreciate your interest.

If the research subject is not in a current appropriate relationship, say:

This project is specifically designed to meet the needs of people in longer term relationships. Thanks for taking the time to respond to our advertisement. We appreciate your interest.

If the research subject is willing to participate in the research and is not in therapy or counselling, say:

We are very pleased that you are interested to take part in this project and hope that you will find it interesting and useful.

Do you have any further questions? (Take time to answer all the questions without giving away the precise nature of the research study.) When you have answered all the questions arrange for an interview by saying: Could we arrange an appointment for you now? (Give the possible time slots and record the one chosen).

Date: \_\_\_\_\_ Time: \_\_\_\_\_

The meeting will take place at the Counselling Centre here at St. Paul University, located at 223 Main Street. There is parking on the north side of the building. When you arrive, enter by the front door, descend a half-flight of stairs and walk straight ahead where you will see the sign for the counselling centre. Inform the receptionist that you are coming to take part in the research project undertaken by Dr. Augustine Meier and George Zimmerman. I will meet you in the waiting room.

## Appendix C. Information and consent forms

### INFORMATION FOR PARTICIPANTS

#### WHAT IS THE PURPOSE OF THE STUDY?

This research is designed to assess the effectiveness of different counselling methods to help persons resolve interpersonal difficulties and improve intimate relationships.

The research has two components, one a quantitative study and the other a qualitative study. The quantitative study will use as a data base the responses to the questionnaires. The qualitative study will use as data base the videotaped interviews and/or transcripts of the videotaped interviews.

#### WHO IS IN CHARGE OF THE RESEARCH PROJECT?

Dr. Augustine Meier, a registered psychologist and a professor at St. Paul University and George Zimmerman, a graduate student at St. Paul University are directing this research project. Several graduate students from St. Paul University and from the University of Ottawa are collaborators. The counselling will be provided by professionals who have completed graduate training in counselling or graduate students of counselling.

#### WHAT IS MY INVOLVEMENT IN THE STUDY?

First you will be invited to come for an interview to obtain relevant biographical information, discuss with you your interpersonal difficulties, and assess whether this research project meets your needs and is suitable for you.

Secondly, if you accept to participate in the research, you will be asked to complete a series of questionnaires. This will take from 60 to 90 minutes to complete.

Following this we will arrange for you, at your convenience, to see one of the counsellors who will provide five counselling sessions (free of charge) which focus on your interpersonal concerns. You will see the same counsellor for all of the sessions. You will see either the same counsellor or another professional for a follow-up session. All session will take place at St. Paul University. Your sessions will be videotaped.

Fourthly, we will ask you to complete a set of questionnaires after you have finished the follow-up session. About three months later, we will call you and arrange that you fill out several questionnaires.

The questionnaires comprise a series of psychological tests or inventories. The questions ask for personal information or opinions. In other research projects, participants have found them provocative and lengthy.

In total you will be asked to come for ten one-hour sessions, one of which will be for an interview to obtain background information, one to administer the questionnaires, five for individual counselling regarding the interpersonal concerns, one follow-up session, one session to administer a second set of questionnaires and one three months later for the final set of questionnaires.

### **IS THE MATERIAL I GIVE CONFIDENTIAL?**

All information, be it written or on tapes, will be held in strictest confidence. Your name will not appear on questionnaires or tapes nor will your name be used in the reports of any results. To provide this confidentiality, all material will be coded and the codes will be known only to the researchers. All team members, that is, the directors, counsellors, and research assistants, assume responsibility for confidentiality. The consent form you are signing is specific to this project only.

If the researchers decide to use your material for additional research, you will be contacted. At that time you will be advised who the researchers are and be asked to sign another consent form. All effort to protect your identity will be made.

All written and videotaped material will be safely kept for five years beginning of the date that the research was launched. After that it will be destroyed. Dr. Meier and Mr. Zimmerman are responsible for the safeguarding and destruction of all raw material such as test results and videotapes.

### **WHAT ARE THE POSSIBLE RISKS?**

It is possible that during the course of the counselling you will become aware of painful past experiences which will grip you with intense emotion. A second risk is that you might begin to work on an emotional and disturbing issue at the time of the last session. The counsellor will help you in these circumstances and, at your request, set you up with an appropriate counsellor.

Thirdly, while the literature indicates that this counselling is effective to improve trust in relationships, there is a possibility that you may not gain as much from the counselling as you initially expect.

### **WHAT IF I WANT MORE COUNSELLING?**

Should you require more counselling, we will provide you with a referral to another counsellor. As was mentioned, we will provide you with five free counselling sessions. Any counselling beyond the five sessions will be at your own expense.

### **WHAT ARE THE BENEFITS FOR ME?**

You will receive five free counselling sessions which we hope you will find a benefit to yourself. We do not promise that you will resolve your interpersonal difficulties but we hope so.

By taking part in this project you will be contributing to our understanding of the process and methods that facilitate the resolution of interpersonal difficulties and the improvement of intimate relationships.

#### AM I FREE TO QUIT?

You are free to withdraw from the research and the counselling at any time. If you choose to do so, we appreciate if you would discuss this matter with your counsellor or with one of the two co-directors of this project, namely, Dr. Augustine Meier or George Zimmerman. This interview is designed for your well being only. No pressure to continue in this project would be applied.

#### WILL I BE GIVEN FEEDBACK AND GET TO KNOW THE RESULTS?

You will be given feedback three months after the study has been completed. At this time you will be asked to complete a last series of questionnaires.

If you wish to know the results of the study, we will mail you a copy of the published article. It will be important for you to notify us of any change in your address so that we can mail the results to you.

---

I, \_\_\_\_\_ certify that I have read the document, Information For Participants, and that I understand its contents.

Signature \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_

ST. PAUL UNIVERSITY  
223 MAIN STREET  
OTTAWA, ONTARIO  
K1S 1C4

**CONSENT FORM**

I have read a written explanation of the research project (see attached document, Information for Participants) and my involvement in it has been clearly discussed with me.

I understand that my privacy will be protected and that my name will not appear in any published or unpublished papers.

I understand that I am at liberty to withdraw from the research study at any time.

I understand that there exists a risk of emotional distress and/or disappointment at the results.

I consent to participate in the study and to the use of my written responses to the questionnaires and to the video-recordings of the five counselling sessions and the one follow-up session for research purposes.

I consent to the use of my written and videotaped material for the research project under the direction of Dr. A. Meier and Mr. G. Zimmerman.

Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

### Appendix D. Screening interview and questionnaire

Interviewer: \_\_\_\_\_

Research Subject: \_\_\_\_\_ Code: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

The screening interview has three parts to it. In the first part, the nature of the research is reviewed and any questions that the research participants have are answered. In the second part, biographical data are obtained and a psycho social history is undertaken with a focus on the quality of relationships experienced by the research participant. The relationships to be explored are: parent-child, siblings, peers, friends, lovers, teacher-student, employer-employee, etc. The level of emotional disturbance is assessed as well. In the third part, the questionnaires are administered.

#### Part One

(After having greeted the research participant in the waiting room and taken him/her to the counselling room the interviewer will review again the nature of the study without giving away the essential aspects. Continue like this):

I would like once more to go over the research project with you and respond to any questions you might have concerning it so that you may know whether you still want to participate. As I mentioned to you over the telephone, this research is designed to look at different methods to help people become more adept in relating to others, especially with those who are close to us. You will be offered five counselling sessions with a professional therapist. These interviews will be videotaped.

In addition to the five interviews, you will be asked to complete a set of questionnaires before you begin counselling, right at the completion of counselling and three months later. You will also be asked to come back after the fifth counselling session for a debriefing of your counselling experience.

It goes without saying that confidentiality will be safeguarded throughout this study.

Do you have any questions? (If the research participant does, answer these as fully as possible). When the questions have been answered to ask the participant if he/she is still willing to participate in the research project. If the response is YES, hand the participant, **Information for Participants** and ask him/her to read it. Respond to any questions that might arise. Then ask the participant to sign the form indicating that he/she read the information. Following this, ask him/her to sign the **Consent Form**.

## SCREENING INTERVIEW (Page 2)

### Part Two

Following the review of the research project, and the signing of the Information for Participants and the Consent Form, the interviewer obtains the following biographical and medical information. The interviewer says: I would now like to obtain some background information which I will record on this form.

Research Subject: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Telephone Number: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Occupation: \_\_\_\_\_ Years of work \_\_\_\_\_

Education: \_\_\_\_\_

How long have you known your partner: \_\_\_\_\_

Sex of partner: Opposite sex \_\_\_\_\_ Same Sex \_\_\_\_\_

Are you living alone \_\_\_\_\_ With your partner \_\_\_\_\_

After the above information have been obtained, the interviewer explores with the research participant, the nature of his/her current relationship problems and those he/she has experienced in the past years. The goal of this exploration is to assure that the research participant is having difficulty in letting his/her partner be, that is, is experiencing a need to control the partner.



### Appendix E. Procedures for research counsellors

1. Contact the research participant within one week after receiving the file.
2. Arrange to see the research participant for counselling on a weekly basis. Limit counselling sessions from 45 or 50 minutes. Do not go over one hour unless the situation warrants it.
3. You will be informed in advance about the nature of the research participant's request for counselling (e.g. difficulty to let the other be). You should focus on this task or its variations for each of the counselling sessions.
4. Use the first session to get to know the research participant and his/her concerns. Have a good feel for the research participant before using one of the counselling techniques. In the majority of the cases, you might begin to use the specific counselling technique only in the second session.
5. You will be given six coded videocassettes for each research participant. An example code could be: 0 3 1 2 6-2. The last number of the code (to the far right) indicates the session number. Begin with videocassette with session number 1, and proceed sequentially thereafter.

When you have installed the videocassette, return the counter to zero and then record the full code (e.g. 0 3 1 2 6-2, as above) and indicate the date of the session.

Verify that the session is being well recorded by playing back the recorded code and date.

Consent for taping the sessions will be obtained before the research participant is assigned to you.

6. All the counselling sessions are to be conducted in the Counselling Centre of St. Paul University. Arrange with the receptionists (Aline, Nicole or Shirley) for a counselling room.
7. In your sessions with the research participant, adhere strictly to the counselling technique assigned to you.

8. Keep brief hand-written (or if you want, typed) progress notes of your sessions with the research participant. Indicate any difficulties that might have arisen during the course of counselling.

Indicate the extent to which the research participant cooperated (compliance) with the technique used and the effectiveness of the technique (effectiveness).

Indicate the degree of compliance by using a scale of -3 to +3, with -3 indicating poor resistance and +3 excellent compliance.

Indicate the degree of effectiveness by using a scale of one to seven with one indicating poorly effective, and seven, very effective.

You will find prepared forms on which to record this information in the envelop given to for each of the research participants.

9. Following the session, place the videocassettes on a shelf reserved in Room #19 and the written material with the envelop in the place to be designated.

When you have completed the fifth session with a research participant, contact George Zimmerman to inform him of the fact. George will give you further instructions regarding the sixth session with the research participant.

10. Should the research participant be unwilling to continue for the five sessions, or should any other matter of a serious nature arise, immediately contact George Zimmerman or Augustine Meier.

Although research participants have been assessed for their suitability to participate in the research, it is possible that new information might indicate that they are not suitable. In such cases, the counsellor should discuss the matter with George or Augustine. The counsellor will then continue to provide the five counselling sessions (if the research participant agrees to it) and modify therapy so as to meet needs of the research participant. In no case should a research participant be told that he/she cannot receive more counselling because he/she is not suited for the study. Once a research participant has started the sessions, he/she is entitled to the five sessions.

11. The research participants will be provided with five free counselling sessions. If they request more sessions, offer to them a list of agencies that they could contact. Include among the agencies the following: Catholic Family Services, Psychological Services at the University of Ottawa, and Ottawa Family Services.

12. If any ethical issues arise in you work with the research participant, deal with them if they are within your jurisdiction otherwise contact George or Augustine as soon as you can. In the case of ethical issues which you and the research participant resolved together, make a note of this in the progress reports.

13. **If you experience difficulty with the equipment contact Aline at the Counselling Centre.**
14. **Don't hesitate to contact George or Augustine should a need arise.**

Appendix F. Table Of Mean Test Scores For Each Condition Across Time Points With Significance

Measure Group	pre		post		3 month		Significance *		
	M	SD	M	SD	M	SD	df	F	p
<b>Relationship Trust Scale</b>									
Control	4.64	1.00	4.56	1.46					
CCM	4.71	1.36	5.01	1.45	5.62	1.39	1,14	0.72	0.41
Focusing	3.95	1.24	3.74	1.46	4.12	1.23	1,14	0.08	0.78
<b>RTS: Dependability</b>									
Control	5.0	1.4	5.0	1.4					
CCM	5.7	1.5	5.6	1.3	5.9	1.6	1,14	0.08	0.78
Focusing	4.8	1.6	4.2	1.6	4.8	1.7	1,14	1.01	0.33
<b>RTS: Responsiveness</b>									
Control	4.9	1.2	4.5	1.2					
CCM	4.6	1.6	5.2	1.6	5.8	1.4	1,14	0.07	0.80
Focusing	4.2	1.2	4.0	1.2	4.1	1.3	1,14	1.54	0.23
<b>RTS: Partner's Caring</b>									
Control	5.0	1.2	4.9	1.4					
CCM	5.2	1.5	5.0	1.4	5.8	1.4	1,14	0.46	0.51
Focusing	4.3	1.8	3.8	2.0	4.1	1.8	1,14	0.96	0.34
<b>RTS: Conflict Efficacy</b>									
Control	3.9	1.6	4.1	1.7					
CCM	3.9	1.6	4.5	1.6	5.4	1.3	1,14	1.16	0.30
Focusing	3.5	1.3	3.4	1.7	4.1	1.5	1,14	0.01	0.96
<b>RTS: Dependency Concerns</b>									
Control	4.3	1.2	4.3	1.7					
CCM	4.2	1.8	4.8	1.5	5.4	1.4	1,14	1.11	0.31
Focusing	3.0	1.8	3.3	1.6	3.5	1.7	1,14	0.39	0.55
<b>IIP Hard to be Intimate</b>									
Control	1.2	0.8	1.2	0.8					
CCM	1.2	0.8	0.9	0.6	0.9	0.9	1,14	3.60	0.08
Focusing	1.5	0.7	1.1	0.8	1.3	0.6	1,14	2.76	0.12
<b>IIP: Try to Control</b>									
Control	1.3	0.5	1.2	0.5					
CCM	0.9	0.6	0.6	0.4	0.6	0.3	1,14	2.50	0.13
Focusing	1.2	0.7	1.0	0.8	1.0	0.7	1,14	3.22	0.09

\* Pre post mean score difference compared to control group

Appendix F. Table Of Mean Test Scores For Each Condition Across Time Points With Significance

Measure Group	pre		post		3 month		Significance * (between pre and post)		
	M	SD	M	SD	M	SD	df	F	p
Degree of Improvement									
Control			1.0	1.0					
CCM			3.0	1.0	4.0	1.0			
Focusing			3.0	2.0	3.0	1.0	2,21	4.10	0.03
Client Satisfaction									
Control									
CCM			8.3	1.5					
Focusing			6.8	1.3			1,14	4.82	0.04
POMS: Anger-hostility									
Control	9	11	10	10					
CCM	11	8	5	5	4	4	1,14	10.8	0.01
Focusing	15	11	12	12	12	11	1,14	2.1	0.16
POMS Tension-anxiety									
Control	13	8	14	10					
CCM	10	8	9	8	6	4	1,14	0.35	0.56
Focusing	15	10	15	8	11	11	1,14	0.06	0.81
POMS: Depression-dejection									
Control	12	11	14	14					
CCM	14	12	10	10	5	8	1,14	1.66	0.22
Focusing	18	16	15	17	16	15	1,14	0.64	0.44
POMS: Fatigue-inertia									
Control	7	7	12	5					
CCM	7	5	7	7	2	3	1,14	4.39	0.05
Focusing	13	11	10	9	9	8	1,14	11.78	0.01
POMS: Confusion									
Control	8	5	9	7					
CCM	9	6	8	6	6	4	1,14	0.85	0.37
Focusing	12	7	11	7	10	6	1,14	0.64	0.44
POMS: Vigour-activity									
Control	18	9	15	6					
CCM	15	5	18	9	20	5	1,14	3.91	0.07
Focusing	11	8	15	8	15	5	1,14	3.40	0.09

\* Pre post mean score difference compared to control group

Appendix F. Table Of Mean Test Scores For Each Condition Across Time Points With Significance

Measure Group	pre		post		3 month		Significance * (between pre and post)		
	M	SD	M	SD	M	SD	df	F	p
R. Self-esteem scale									
Control	13	7	15	7					
CCM	7	5	13	6	8	5	1,14	1.08	0.31
Focusing	13	7	16	13	15	15	1,14	0.11	0.74
RSECS: Self-efficacy									
Control	51	41	76	27					
CCM	57	33	55	36	68	42	1,12	1.74	0.21
Focusing	54	39	58	30	54	24	1,11	0.95	0.19
RSECS: Specific Competency									
Control	3	1	3	1					
CCM	3	1	3	1	2	2	1,12	0.01	0.93
Focusing	3	2	3	1	4	2	1,12	0.37	0.56
RSECS: Global Competency									
Control	4.2	0.7	4.2	0.8					
CCM	4.3	0.5	4.4	0.4	4.6	0.4	1,14	0.87	0.37
Focusing	4.0	0.8	4.2	0.4	4.3	0.5	1,14	1.16	0.30
Mature Faith									
Control	4.0	0.9	3.9	0.7					
CCM	3.6	0.6	4.0	0.6	4.0	0.6	1,14	8.12	0.01
Focusing	3.9	0.7	3.9	0.7	3.6	0.4	1,14	0.16	0.70
ROS: Intrinsic									
Control	31	10							
CCM	31	3							
Focusing	30	8							
ROS: Extrinsic									
Control	20	10							
CCM	21	7							
Focusing	17	5							
ROS: Quest									
Control	45	12							
CCM	52	4							
Focusing	49	11							

\* Pre post mean score difference compared to control group

Appendix F. Table Of Mean Test Scores For Each Condition Across Time Points With Significance

Measure Group	pre		post		3 month		Significance * (between pre and post)		
	M	SD	M	SD	M	SD	df	F	p
Mysticism Score									
Control	100	31							
CCM	91	23							
Focusing	103	30							
Autonomous RPSS									
Control	28	12							
CCM	30	9							
Focusing	31	9							
Collaborative RPSS									
Control	15	10							
CCM	18	8							
Focusing	16	9							
Deferring RPSS									
Control	10	4							
CCM	13	7							
Focusing	12	3							

\* Pre post mean score difference compared to control group

### Appendix G. Focusing Manual

**Explain:** This procedure (condensed from Gendlin, 1981) consists of a set of instructions in a way of thinking which has been helpful to people. It is not meant to be a test. Afterwards you will be asked about what was happening for you during the process. The whole process is going to be just to yourself.

After a pause, try to break in gently with the next instruction.

#### Step One

Clear a space

Start by closing your eyes. Relax, concentrate on your breathing. Breath in through your nose and out through your mouth, evenly and continuously. Make your breathing like a wave continuous and gentle in through the nose and out through the mouth.....10 seconds

All right...now...,inside yourself. I would like you to pay attention inwardly, in your body. Perhaps in your chest or your stomach.....10 seconds

Now: see what comes to that part when you ask, "how is my life going? what is the main thing for me right now?" Sense within your body. Let the answers come slowly from this place. Let whatever comes, just come. Trust your body sense, it knows what is right and wrong, like one's body temperature: trust the body it knows. When something comes, do not go into it. Just set it aside. Stand back and say" yes, that there. I can feel that, there." Put a little space between you and that. Then ask what else is there. Wait again, and sense.....usually there are several things. Keep doing this until you have these thing lined up like books on a shelf.....30 seconds.

### Step Two: A felt sense

From among what came select one personal problem to focus on. Do not go inside it. Stay back from it. Of course there are many parts to that one thing you have selected: too many to think of each one alone. But you can feel all of these things together. Pay attention there where you usually feel things, and in there you can get a sense of what all of this problem feels like. Sometimes there is noise, arguments, your head trying to engage this problem, wait for it to clear away. Get past the noise, and feel the problem in its entirety. The feeling of the problem shifts with clarity, and clarity comes with sitting long enough in quiet and let all the other voices be still. Let go and let your self feel the unclear sense of the whole problem, of all of it.

- encourage patience
- encourage stillness
- encourage self gentleness
- what does this particular problem feel like take in its entirety? Take the time not put words to the sensation, but experience the sensation
- remind client they are very safe, friendly place
- timing 4-5 minutes

### Step Three: Find a Handle or name

What is the quality of this unclear felt sense? Let a word, a phrase, or an image come up from the felt sense itself. It might be a quality-word. like tight or sticky, or scary, stuck, heavy jumpy, or maybe a phrase or an image. Remember do not go into the problem itself, just describe the feeling it gives. As the right quality word comes, let it come, trust your body, your body will know if this handle fits. Stay with the quality of the felt sense until something fits it just right.

- when that happens the body sends a signal: client may sigh, or indicate a shift in their perception of the problem, often a lightening of the load, a relief
- let the feeling describe itself: wait for the fit
- timing 5-10 minutes

### Step four Resonating:

Go back and forth between the felt sense and the handle. Check and see how well they resonate with each other. Check your body, that place where you feel things and see if there is a little body signal that lets you know if there is a fit. To do it, you have to have the felt sense there again, as well as the handle. Let the felt sense shift and change, if it does, and also the handle go with it, until they feel just right in capturing the quality of the felt sense. (timing 5 minutes)

### Step five ASKING

Now ask: what is it, about this whole thing, this whole problem that make it this quality? Make sure the quality is sense again, freshly vividly. When it comes back, tap it touch it, be with it, asking What makes this problem this quality what it that makes it so. If your get quick answer, without any shift in the sensation of the whole problem let that answer go, wait Focusing, trusting that the answer is there: what is it, about this whole thing, this while problem that make it this quality? what is it about this problem that makes me so uncomfortable: Ask the sensation and wait for replies Finally ask: what does this sensation need in order to feel right? or What would it take for this to feel OK? Remember to wait for an answer, do not go into the problem, and solve it, let the process work. Be with the felt sense until something comes along with a shift or a slight "give" or release.

- timing 4-5 minutes
- encourage trust, patience
- watch for a sigh or other body language indicating something has occurred.

#### Step six Receiving

Let whatever answer comes regardless of content. Remember that the answers are gifts (grace). We need not understand, agree or believe the answer, just receive it. Thus we suspend judgment. And finally if during these instructions somewhere you have spent a little while sensing and touch an unclear holistic body sense of the problem you picked, then you have been successful in letting go and trusting. The body shift sometimes comes, sometimes it does not. We do not control that. Now you have a choice, you may go on Focusing a second round or you may stop and return to this room. To go on ask the body, with this answer is it all right to stop? Is there anything else to gain right now? when you are ready come back into this room. Tell me out loud whether you wish to go on or to stop.

- do not let the answer be negated by the clients mid at this stage
- timing 2 minutes
- there will be opportunity to examine the answers that come
- a second round of Focusing is now possible
- go on to repeating step 2 or
- client may conclude that they have done enough work like this and remind them they can let it go for now and come.

#### Step seven debrief with open questions:

- what happened?
- if no change then reassure client that that happens too, takes time to develop this skill, but with practice they will.
- if there are changes explore the description and the accompany descriptions of changes in the body sensations
- ask if there is anything new about the problem now that they have experienced the process? remind them they can do this themselves if they want.

## Appendix H. Christian Contemplative Meditation Manual

This procedure (condensed from Freeman and Harris, 1992) consists of a set of instructions in a way of prayer which has been helpful to people. It is not meant to be a test. I will not be watching, judging, or evaluating you during the session. Contemplative meditation is offered as a way for you to stop and get in touch with yourself at a profound and peaceful level. In this meditation there should be no expectation or goal, other than enjoyment of the experience itself. It is an ancient practice of the Desert Fathers in the early Christian church. The practice of Jesus and his disciple, John and other prophets to retreat into wilderness in order to empty themselves provides the model for contemplative meditation. It is widely held by practitioners both modern and ancient that experience facilitates trust in oneself and in one's God. During these sessions I will help you to learn and practice meditation. You may chose to practice the process at your convenience. Long time practitioners of the meditative prayer recommend that the practitioner practice twice daily and join a meditative group. I have provided you with a list of the meditation groups in the Ottawa area. However, what you chose to do in this regard is entirely up to you. This research is designed to leave that choice to you. Do you understand? Have you any questions?

Step One: Outline the procedure:

The process starts and ends with music and lasts fifteen minutes. Normally we start by sitting comfortable, loosening any tight clothing, shoes etc. Posture is important. I'll ask you to sit with your back straight, with your head squarely on your shoulders. Once you are comfortable and remember you will sitting still like that for the meditation period, I will ask you to close your eyes and concentrate on your breathing and muscle tension. When you appear relaxed and comfortable I will start the music. At that time the meditation begins. Are you with me so far?

So how do you meditate. Well its very simple to do. Meditation consists on staying still and silent both in body and mind. Normally one to meditates on a word or a sound. Some people have their own word. Unless you have a particular sound for meditation, I suggest you use this word: MARANATHA. Simply say it to yourself, slowly enunciating each syllable like this MA-RA-NA-THA. Will you try that sound?.....

Your breathing will soon fall into the rhythm of the word. This word is a mantra. Listen carefully to its sound, repeating it over and over again. Are you with me so far?

Now, several things can happen during the relaxation and meditation. Sometimes one feels tingling, in the fingers or toes, sometimes there a warmth in ones stomach, sometimes there's a little muscle spasm. Often there are itches on the skin. Sometimes people nod off, sometimes we image sights or lights or sounds. Often we become aware we have been dwelling on problems or unresolved issues from the past or planning in the future. Its best to treat all of these kinds of things as distractions. See yourself pushing them gently aside like clouds, and return to the sound of the mantra: MARANATHA. Stay with that word as long as you can, if you find yourself distracted from that word, and this is very important, do not feel bad, do not blame yourself, don't fight it, it happens, simply set it aside and return to the mantra. It's more important to return to the mantra when you become aware of it, than to stay with the mantra for the whole time. With practice the period of being free of distractions increases, however at this stage its more important that when there are distractions,

that very clear? After fifteen minutes, the music will fade in and the meditation period will be over. Any questions, so far?

#### Step two: preparation

Start with your posture, loosen your clothing, take off your shoes if you like, its important that you feel comfortable and safe. Sit straight, like this... Rotate your head a little to find where it sits naturally on your shoulders. Important not to put tension on any part of your neck. There: are you comfortable?

Counsellor discretion floor, pillow, chair.

Now close your eyes and concentrate on the tensions in your body. Where there is tension in a muscle just let it go. Check your body from head to toe, shoulders, arms hands, torso, legs, feet. Just feel yourself sinking into the chair. Take several deep breaths, and every time you breath out feel yourself relaxing. Be aware only of the chair holding you up.. Relax, feel yourself sinking into the chair. Now concentrate on your breathing. Breath in through your nose and out through your mouth, evenly and continuously. Make your breathing like a wave continuous and gentle in through the nose and out through the mouth.....1-2 minutes

When client appears relaxed and breathing move to next step.

#### Step 3: The Prayer

I'll start the music now, you can start your meditation with it. Remember to meditate by simply repeating your mantra over and over. When there are distractions, and you become aware of them, simply return to the sound of the mantra.

Start the tape. (15 minutes)

#### Step 4 Return

After 15 minutes, the music will fade in.

Fifteen minutes have now past, and we can move to the next part. Take your time and when you are ready return your attention to me and this room.

**Step 5: Reflections**

**Ask the client to tell you what was happening during the period: cognitively, emotionally, physically.**

**Examine the experience of the client where the letting-go was achieved. (Times when the chair or the room had slipped out of their awareness.) Look at the cracks, the holes of the experience, rather than the distractions. What was the stillness like? Minimize the problem of distractions. Emphasize the returning to the mantra.**

**Give sufficient time for questions and answers.**

**Step 6: Conclusion**

**Conclude the session by giving room to any last thoughts or issues the client wishes to raise. Normal pastoral counselling skills of closure of a session apply, summarize etc.**