Couple and Family Psychology: Research and Practice
2014, Vol. 3, No. 2, 83–98

2160-4096/14/$12.00 http://dx.doi.org/10.1037/cfp0000019

Efficacy of Religion-Accommodative Strategic Hope-Focused Theory Applied to Couples Therapy

Jennifer S. Ripley
Regent University

Cynthia Leon
Compass Youth and Family Services, Charlottesville, Virginia

Everett L. Worthington, Jr.
Virginia Commonwealth University

Jack W. Berry
Samford University

Edward B. Davis
Wheaton College

Amy Smith and Audrey Atkinson
W. G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina

Tabitha Sierra
Regent University

Religion-accommodative psychotherapy has developed with trends toward equal or improved outcomes compared with psychotherapy that pays no attention to spirituality or religion (Worthington, Hook, Davis, & McDaniel, 2011b; Worthington, Hook, Davis, Gartner, & Jennings, 2013). Research on religion-accommodative psychotherapy in couples contexts is sparse, with a few studies of enrichment and prevention and only 1 study of couples therapy. The current study used a clinical trial design of 92 community couples seeking counseling to determine whether religion-accommodative hope-focused couples psychotherapy would differ from standard hope-focused couples treatment (Worthington, 2005). Results indicate that the 2 types of treatment demonstrated improvement for couples over time but were not different from each other on most comparisons. Implications for accommodating religion for couples therapy in an ethical and diversity-sensitive way are discussed (Hathaway & Ripley, 2009).

Keywords: couple therapy, hope-focused couple approach, religion accommodative, spirituality, clinical trial

A review of empirically supported couples enrichment programs found that Strategic Hope-Focused Enrichment was one of four approaches that met criteria for classification as *efficacious* (Jakubowski, Milne, Brunner, & Miller, 2004). This strategic approach was deemed efficacious because it was supported by at least two published controlled outcome stud-

Jennifer S. Ripley, Clinical Psychology Department, Regent University; Cynthia Leon, Compass Youth and Family Services, Charlottesville, Virginia; Everett L. Worthington, Jr., Counseling Psychology Department, Virginia Commonwealth University; Jack W. Berry, Psychology Department, Samford University; Edward B. Davis, Clinical Psychology Department, Wheaton College; Amy Smith and Audrey Atkinson, Psychology Department, W. G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina; Tabitha Sierra, Clinical Psychology Department, Regent University.

This research was supported by the Regent University Faculty Senate Grant awarded to Jennifer S. Ripley. The persons identified herein are employees of the Department of Veterans Affairs; however, the views expressed in this article do not necessarily represent the views of that Department, the Secretary or of the United States.

Correspondence concerning this article should be addressed to Jennifer S. Ripley, Department of Clinical Psychology, Regent University, 1000 Regent University Drive, VA Beach, VA 23464. E-mail: jennrip@regent.edu

ies, conducted by independent research teams (Chambless & Hollon, 1998). Indeed, Strategic Hope-Focused Enrichment has demonstrated efficacy in improving couples' overall relationship satisfaction (Worthington et al., 1997), communication behaviors (Ripley & Worthington, 2002), and quality of life (Burchard et al., 2003). It has demonstrated efficacy with parents (Kiefer et al., 2010) and couples in transition to parenthood (Worthington, Hook, Davis, & McDaniel, 2011a). It has been adapted into a couples-therapy format, as presented in a book (Worthington, 2005) and a treatment manual (Ripley, Davis, Leon, & Worthington, 2008; see also http://www.hopecouples.com). However, the religion-accommodative and therapy versions of Hope-Focused Couples Approach (HFCA) have not been empirically investigated. In this article, we present the findings of the first study toward that end—a randomized clinical trial.

Religion-Accommodative Couples Intervention

There is a long tradition of religious accommodation in psychotherapy. In fact, Norcross (2011) headed a joint task force by Divisions 12 (Clinical Psychology) and 29 (Psychotherapy) to examine relationship factors in psychotherapy. Meta-analyses were conducted in each case, and the task force evaluated the strength of the evidence supporting the relationship factors by classifying them as demonstrably effective, probably effective, and promising but with insufficient evidence to judge. Four matching variables received the highest level of support: reactance/resistance level, client preferences, culture, and religion–spirituality. Those classified as probably effective were stages of change and coping style, and those considered to be promising but without sufficient evidence were client expectations and attachment style. The meta-analysis on which this judgment was based was by Worthington et al. (2011a). They concluded that religion-accommodative psychotherapy was superior to weak controls in mental health outcomes, better than alternative treatments unless the alternative treatment was strictly a dismantling design, which we are attempting in the present study. In strict dismantling designs, secular and religion-accommodative psychotherapies were equal in mental health but religion-accommodative therapies had more change on spiritual measures.

The literature on religion and couples has developed several important themes including marriage as sacred, perception of God as agency in marriage, and forgiveness in marriage. Research by Mahoney, Pargament, Tarakashwar, and Swank (2008) demonstrated in a meta-analysis the importance of the sense of the sacred in marriage relationships. The number of people identifying with a religion has dropped from historical highs, but most Americans do identify with a religion with 15% reporting they have no religion (Harris, 2009). Religious couples tend to see God as having agency in their relationship indicating that the couple relationship may be more relevant to religion than other issues addressed in therapy (Mahoney et al., 2008). In contrast, research on forgiveness of a violation of the sacred, including sacred marriage, may demonstrate increased challenges for couples (Mahoney, Rye & Pargament, 2005). HFCA has proposed that an emphasis on forgiveness is necessary for relationship repair efforts, and may be more necessary with couples who view their relationship as sacred (Worthington et al., 1997).

A small collection of research on religion-accommodative couples interventions is supportive of accommodating religion in treatment (Worthington et al., 2011b). A religion-accommodative version of the Prevention and Relationship Enhancement Program has been used in church settings with positive results comparing trained graduate students, clergy, and ministry leaders (Markman et al., 2004). In addition, research on prayer with couples is supported with a conceptual framework for intervention (Beach, Fincham, Hurt, McNair, & Stanley, 2008), research in support of prayer as an intervention (Fincham, Beach, Lambert, Stillman, & Braithwaite, 2008), and a special issue on prayer in couples intervention in the *Journal of Social and Clinical Psychology* in 2008. This line of research has delineated numerous issues relevant to ethical and empirically informed religion-accommodative couples treatment specific to prayer.

Hook, Worthington, Davis, and Atkins (2014) reported a naturalistic study that examined religion and couples therapy with Christian couples. At three time points during therapy, the 68 couples entering explicitly Christian therapy completed measures of relationship satisfaction, working alliance with the therapist, and satis-

faction with therapy. Religious techniques were used in about half of the sessions, and the religious commitment of clients was positively related to the number of religious techniques used. Preliminary evidence revealed that clients improved over time in relationship satisfaction and working alliance, and reported a high level of satisfaction with couples therapy.

Unique Aspects of Hope-Focused Theory and Approach

Hope-focused theory (Snyder, 1994) has developed an impressive collection of research in social psychology and basic research as a theory of motivation and goal attainment (Bailey, Eng, Frisch, & Snyder, 2007). As an application of hope-focused theory, the HFCA is squarely located in the positive psychology movement as it draws from positive psychology principles. There are two aspects of hope: agency and pathways. Agency is the cognitive motivation to begin and maintain movement toward a goal. Pathways are the knowledge and confidence of what is needed to reach the goal. Hope-focused theory is applied to strategic couples therapy by working on cognitions and skills in treatment that increase agency and pathways thinking toward specific goals for the improvement of the relationship.

There are three unique aspects to the HFCA: (a) an emphasis on assessment and feedback, (b) incorporation of forgiveness interventions, and (c) a focus on strategies to reduce recidivism. While all clinical research on the HFCA has included assessment and feedback, two moderate-size studies conducted component analyses of assessment and feedback (Ripley & Worthington, 2002; Worthington et al., 1997). They both found moderate effect sizes of around .3 for such a simple and brief intervention. Thus, over time, assessment and feedback has been an important and necessary component of HFCA. Assessment procedures have typically included validated self-report measures such as the Dyadic Adjustment Scale (Spanier, 1976) or the Revised Dyadic Adjustment Scale (RDAS; Busby, Crane, Larson, & Christensen, 1995) and forgiveness measures (McCullough et al., 1998). In research application, observational measures of the couples have demonstrated couple improvement (Kiefer et al., 2010; Ripley, & Worthington, 2002).

The HFCA draws heavily from forgiveness intervention research (Fincham, Hall, & Beach, 2006) as a central modality of intervention with couples. These interventions are not necessarily religious, and can be readily used with any couple open to the concept of forgiving. Gordon, Baucom, and Snyder (2000) proposed that the lack of integration of forgiveness theory with couples theories is one of the greatest shortcomings in the literature.

Investigations of couple interventions to promote forgiveness are rare. The basic research in couples forgiveness is fairly well developed at this point, demonstrating the importance of forgiveness as a central positive aspect of couples intimate relationships (Fincham, Hall, & Beach, 2006), with some early indications of the limitations in forgiveness (McNulty, 2010; McNulty & Fincham, 2012). Greenberg, Warwar, and Malcolm (2010) studied 20 couples demonstrating that emotion focused couple therapy (EFCT) was effective for most couples in improving forgiveness and relationship functioning after treatment. Two studies (DiBlasio & Benda, 2008) with a total of 57 couples in explicitly Christian therapy found step-by-step forgiveness intervention promoted forgiveness, increased satisfaction, and decreased depression. Gordon, Baucom, and Snyder (2004) have conducted a pilot study of forgiveness with infidelity, which used a model that combined couples theory, trauma theory, and forgiveness theory and found good outcomes. Their three-stage theory of forgiving, impact, meaning making and moving on, is similar to the five-stage model from the hope approach (Worthington et al., 1997).

A third unique emphasis of the HFCA is the use of strategies to reduce recidivism. Some research indicates that effects fade about 6 months after couples treatment (Christensen, Atkins, Yi, Baucom, & George, 2006). The line of research on behavioral couples therapy (Christensen et al., 2006) demonstrates that recidivism appears to particularly be a problem for couples therapy more than other types of psychotherapy. Unlike other types of problems, couples relationship problems are generally expected to be difficult to change, to maintain negative patterns of interactions, and to slip back into negativity across time. Therefore, HFCA uses simple and memorable mnemonic devices throughout the intervention, experien-

tial exercises in therapy, take-home reminder cards, worksheets, and homework to make interventions memorable after therapy. In this way, even if couples do not use the skills and concepts immediately in homework, they are more likely to remember the concepts and can use them *as they are needed*.

The Current Study

We report the results of an experimental study evaluating the HFCA in a therapeutic context implemented in a university training clinic. Participants who were willing to receive religious intervention as part of treatment were blindly and randomly assigned to one of two interventions: religion-accommodative or standard approach. The training clinic where the study was conducted was housed in a religious (nondenominational Christian) University with therapists of various religious traditions.

The primary hypothesis was that HFCA in two formats (standard and religion-accommodative) was effective with couples in couples therapy, similar to previous research that investigated couples enrichment formats. A secondary nondirectional hypothesis was whether the standard and religion-accommodative interventions differed. Finally, exploratory moderator variables were tested to determine whether the approach was equally effective with various participants.

Method

Participants

Sample demographics were similar to the surrounding community in southeast Virginia, although slightly more likely to identify as Christian. Participant mean age was 43.78. Racial composition was 19% African American, 2% Asian, 71% Caucasian, and 8% Hispanic. Modal household income was in the US$50,000/year category. Marital status was 9% never married, 70% were in their first marriage, 18% in their second marriage, 2% of participants were in their third marriage, and 1 person in their fourth and 1 fifth marriage. The sample mean length of current marriage was 8.96 years. The sample was largely Christian, 94%, with two atheist, five agnostic, and eight who indicated "other" for religion. Among Christian participants, 53% indicated Christian with no denomination, 41% were from a Protestant tradition, and 5% from a Catholic tradition.

Measures

Due to its wide use, comprehensive content coverage, and established psychometric properties, the RDAS (see below) was considered the primary outcome measure for the present study. All other scales were considered secondary outcomes of interest. Descriptive data for the measures are located in the Appendix.

Revised Dyadic Adjustment Scale. The RDAS is a 14-item version of a classic relationship research measure (Busby, Crane, Larson, & Christensen, 1995). Busby et al. reported the RDAS as improvement over the classic version by being 18 items shorter, having acceptable construct validity and internal consistency. Item anchors were from 0 to 5, with several different anchor terms. The range of scores for the measure is from 0 to 70. The baseline mean score for the standard group was 42.70 (std = 9.69) and 42.17 (std = 8.94) for the religion-accommodative group. The score of 48 is the established criterion score for distress for the RDAS (Crane, Middleton & Bean, 2000), meaning this sample was somewhat distressed at baseline. Cronbach's alpha for this sample for the baseline measure was .85.

Relationship Commitment Scale (RCS): Four-item Dedication subscale. This brief Relationship Commitment Scale is a four-item measure of each person's level of commitment to their partner and their relationship with a range from 4 to 20 (Stanley, Amato, Johnson, & Markman, 2006). Items used a five-point rating scale from 0 = *none* to 4 = *complete*. Items were derived from Stanley and Markman's (1992) study and demonstrate excellent reliability and validity. Cronbach's alpha in the current study was .82. The baseline mean score for the standard group was 17.80 (std = 2.91) and 17.24 (std = 2.60) for the religion-accommodative group. This indicates high commitment for this sample at baseline.

Gordon–Baucom Forgiveness Inventory. The Gordon–Baucom Forgiveness Inventory is a 23-item measure of a person's process of forgiveness in an intimate relationship (Gordon & Baucom, 2003). Items used a five-point rating scale from 1 = *almost never* to 5 = *almost*

always. It draws its stages from trauma models: the impact stage, the search for meaning stage, and the moving on stage. The inventory has received preliminary support for use from the original creators (Gordon & Baucom, 2003) but has not been used for clinical outcome research for couples. Cronbach's alpha for this sample was impact stage = .87, meaning stage = .84, moving on stage = .90.

Interactional Dimensions Coding System Observational Behavioral Rating. The Interactional Dimensions Coding System (IDCS; Kline et al., 2004) is a global coding system designed to assess how couples interact with each other while discussing problem areas in the relationship. The couple discusses a difficult topic with each other for 8–10 minutes on videotape. The clinician divided the videotaped interaction into three equal segments and coded major dimensions of behavior. Research support for the IDCS as a brief behavioral observation measure has been strong. Couples were scored using the entire system, which includes two affect codes (positive and negative), three content codes (problem solving skills, denial, and dominance), four combined codes (support/validation, conflict, withdrawal, and communication skills), two dyadic combined codes (positive escalation and negative escalation), and three dyadic dimensions (commitment, future satisfaction, and stability). Most measures are individual-level but the three dyadic dimensions (last three codes in Table 1) are measured and analyzed in a dyadic format.

Within the research study, doctoral students were trained using the training manual and videos supplied by the University of Denver couples research team. Once raters passed the training, they were randomly assigned videotapes to code. Of the videos, 10% were randomly assigned to a second coder with an overall ICC of .81.

Couples self-rating of video interaction. The couple watched the tape of their own 10-min "difficult discussion" in an effort to focus research on client observation of change as important voice in the research (Duncan, Miller, Wampold, & Hubble, 2009). Each person rated him/herself with instructions from the IDCS for just the positive affect and negative affect subdomains. Individual scores for self and partner were utilized. The video was sectioned into 3-min sections, with scaling from +9 to −9 with −9 being "unmistakenly clear consistent and intense signs of negative feelings throughout the entire time," 0 being "neutral," and +9 being "unmistakenly clear consistent and intense signs of positive feelings throughout the entire time."

Spatial distance scaling of intimacy. A space in room scaling that is a short exercise with a 72 in. tape measure on the floor that assesses how the couple perceives degree of closeness in their relationship. Partners stand and face each other on this tape measure as an indicator of their dyadic sense of intimacy. The couple's toe to toe distance in inches was recorded as a dyadic measure.

Religious Commitment Inventory-10. A measure of participant religious commitment was used that has demonstrated good validity in previous research (Worthington et al., 2003). The 10-item measure is measured on a 5-point rating scale as an ecumenical measure of religious commitment with a focus on religious attitudes. Items used a five-point rating scale from 1 = *Not at all true of me* to 5 = *Totally true of me.* The sample mean for this study was 36.44 (std = 10.33), with 30% of the sample scoring in the highly religiously committed range of over 42. Based on the previous research (Worthington et al., 2003), this indicates that the sample was fairly typical for the general population of adults in the United States. Cronbach's alpha for this sample was .89.

Weekly clinical feedback. The couples completed a weekly clinical feedback form while waiting for their session to begin that indicated their completed homework, status of their relationship at the time, and any concerns they wanted to discuss that week. Counselors used that form for clinical purposes to maintain an open and active feedback loop during treatment (Duncan, Miller, Wampold, & Hubble, 2009).

The Manualized HFCA Protocol

The HFCA (Worthington, 2005) uses a strategic, short-term approach to treatment. The current version followed a manual (Ripley, Davis, Leon & Worthington, 2008) starting with a comprehensive multimethod clinical assessment that was used to tailor couples treatment plans.

Table 1
Fixed Effects Estimates From Multilevel Models of Self-Report Outcomes and IDCS Video Ratings

	Time			Time^2			Group × Time			Group × Time^2			Pre–Post effect size	Pre–Follow-up effect size
	Est.	*SE*	*t*	Est.	*SE*	*t*	Est.	*SE*	*t*	Est.	*SE*	*t*		
Dyadic Adjustment	3.29	0.57	5.75***	−0.31	0.07	−4.69***	−1.06	0.77	−1.37	0.09	0.09	1.01	S = .99	S = .98
													R = .70	*R* = .57
Relationship Commitment	0.52	0.22	2.39*	−0.06	.03	−2.16*	0.17	0.29	0.56	−0.02	0.03	−0.63	S = .38	S = .28
													R = .51	*R* = .23
Forgiveness Impact	−2.12	0.49	−4.25***	0.20	0.05	3.45**	1.19	0.68	1.77+	−0.16	0.08	−2.01*	S = .81	S = .89
													R = .34	*R* = .86
Forgiveness Meaning	0.77	0.44	1.75+	−0.11	0.05	−2.16*	−0.00	0.59	0.01	−0.02	0.07	−0.18	S = .14	S = .28
													R = .32	*R* = .25
Forgiveness Moving On	1.84	0.41	4.49***	−0.18	0.05	−3.76***	−0.52	0.55	−0.94	0.07	0.06	0.99	S = .91	S = .91
													R = .54	*R* = .52
Spatial Distance	−6.17	2.33	−2.65*	0.69	0.27	2.54*	1.02	3.09	0.33	−0.16	0.36	−0.46	S = .84	S = .19
													R = .50	*R* = .46
Video Rating of Self	5.93	1.31	4.52***	−0.62	0.15	−4.05***	−1.58	1.76	−0.89	0.23	0.21	1.11	S = .68	S = .68
													R = .45	*R* = .72
Video Rating of Partner	6.51	1.27	5.13***	−0.67	0.15	−4.52***	−1.48	1.71	−0.87	0.24	0.20	1.18	S = .80	S = .86
													R = .50	*R* = .77
IDCS Positive Affect	0.68	0.17	3.98***	−0.08	0.02	−4.00***	−0.33	0.24	−1.38	0.05	0.03	1.72+	S = .59	S = .34
													R = .37	*R* = .55
IDCS Negative Affect	−0.41	0.18	−2.28*	0.05	0.02	2.31*	0.04	0.25	0.17	−0.01	0.03	−0.52	S = .31	S = .15
													R = .39	*R* = .51
IDCS Problem-Solving Skills	0.66	0.15	4.39***	−0.07	0.02	−3.99***	0.07	0.21	0.36	−0.01	0.02	−0.37	S = .70	S = .50
													R = .81	*R* = .62
IDCS Denial	−0.35	0.11	−3.03**	0.04	0.01	3.06**	0.12	0.16	0.75	−0.02	0.02	−1.01	S = .58	S = .26
													R = .36	*R* = .52
IDCS Dominance	−0.39	0.15	−2.62**	0.04	0.02	2.20*	0.08	0.21	0.38	−0.01	0.02	−0.31	S = .43	S = .49
													R = .32	*R* = .35
IDCS Support Validation	0.78	0.16	4.41***	−0.08	0.02	−4.32***	−0.65	0.23	−2.86**	0.07	0.03	2.73**	S = .67	S = .49
													R = .14	*R* = .18
IDCS Conflict	−0.49	0.18	−2.64**	0.06	0.02	2.72**	0.19	0.26	0.74	−0.03	0.03	−1.08	S = .36	S = .22
													R = .30	*R* = .41
IDCS Withdrawal	−0.24	0.12	−1.93+	0.02	0.01	1.59	0.23	0.17	1.32	−0.02	0.02	−1.18	S = .29	S = .03
													R = .61	*R* = .14
IDCS Communication Skills	0.51	0.11	4.55***	−0.05	0.01	−3.89***	−0.11	0.15	−0.72	0.01	0.02	0.47	S = .74	S = .62
													R = .65	*R* = .55

Table 1 (*continued*)

	Time			Time^2			Group × Time			Group × Time^2			Pre–Post effect size	Pre–Follow-up effect size
	Est.	*SE*	*t*	Est.	*SE*	*t*	Est.	*SE*	*t*	Est.	*SE*	*t*		
IDCS Positive Escalation	0.54	0.21	2.51*	−0.06	0.02	−2.60*	−0.53	0.29	−1.77+	0.07	0.03	2.11*	S = .45 *R* = .04	S = .23 *R* = .60
IDCS Negative Escalation	−0.39	0.21	−1.89+	0.04	0.02	1.89+	−0.06	0.28	−0.22	−0.00	0.03	−0.07	S = .39 *R* = .63	S = .20 *R* = .86
IDCS Commitment	0.30	0.09	3.31**	−0.03	0.01	−2.95**	−0.11	0.12	−0.86	0.01	0.01	0.96	S = .63 *R* = .33	S = .75 *R* = .58
IDCS Future Satisfaction	0.34	0.12	2.67*	−0.03	0.01	−2.30*	−0.11	0.17	−0.63	0.01	0.02	0.63	S = .59 *R* = .40	S = .60 *R* = .54
IDCS Future Stability	0.26	0.10	2.62*	−0.02	0.01	−2.17*	−0.12	0.13	−0.91	0.01	0.02	0.61	S = .53 *R* = .27	S = .52 *R* = .20

Note. Est. = Slope estimate (units per month); *SE* = Standard error of estimate. Effect size is Cohen's d calculated using Morris and DeShon's (2002) equation 8 for within subjects designs, taking correlation of means into account. S = Standard Hope Focused couples intervention; R = Religious accommodative Hope Focused couples intervention.
+ $p < .10$. * $p < .05$. ** $p < .01$. *** $p < .001$.

There were three modules of the protocol typically in this order: (a) the skills module, (b) the attachment and emotion-focused module, and (c) the apology, forgiveness, and reconciliation module. Interventions were drawn from Worthington's (2005) text and previous clinical research (Ripley & Worthington, 2002; Worthington et al., 1997). The interventions were designed to increase memorability by using acronyms such as LOVE (a conflict resolution intervention focused on evaluating common underlying relationship interests) and REACH (a staged forgiveness intervention; Worthington et al., 1997). The skills module focused on teaching communication and conflict resolution skills. The attachment and emotion-focused interventions were focused on helping couples have more compassionate understanding of their partner's interpersonal pain. The forgiveness module was focused on helping develop apology skills, an empathic-altruistic approach toward forgiveness, and rebuilding trust through reconciliation efforts. For the final session, the couples created a memorial object (such as a collection of photos or a brew of their own beer) and explored the meaning of the object as part of termination.

Procedure

Conditions of treatment. The standard approach to the hope-focused intervention (Worthington, 2005) followed a dismantling protocol and only differed in religious content. The religion-accommodative version incorporated explicitly religious language (e.g., God, covenant) and practices (e.g., prayer, use of religious scriptures, and imagery). The standard version used standard psychological language and practices (e.g., a well-wishing statement and reference to nonreligious quotations). Importantly, in the standard version the therapist treated participants' religiosity with respect but did not engage in discussing religion/spirituality or using religion-accommodative interventions in treatment. Participants were randomly assigned to the treatment conditions at the point when they passed the screening by literally drawing assignments from a hat in sets of 10 (5 religion-accommodative and 5 standard).

Counselors. All of the counselors were doctoral students ($n = 22$) currently in practicum training in an APA-Accredited clinical psychol-

ogy program. Students were trained in the approach by requiring them to read the associated text (Worthington, 2005), attend a 5-hr lecture training with Worthington, and pass an open-book test on the approach. Students were supervised weekly by the lead author in group supervision when they had an active case. Students were randomly assigned to cases with an equal number of initial assignments from each condition.

Couples. Couples were recruited through a community listserv, local religious organizations, newspaper advertisement, Craig's List, online and community bulletin boards with the label "Free Couples Therapy." Interested couples were screened on the telephone and excluded if they were not married, engaged, or cohabiting, for moderate to severe domestic violence, untreated substance abuse, infidelity within the past year, currently separated, currently in couples counseling, or if they would not be in the area for the duration of the research. Before assigning to condition, couples were screened on the phone and then again in person regarding diagnostic criteria and their religiosity and willingness to receive a treatment that addresses religion. All couples were given the option, and three couples requested not to receive explicitly religion-accommodative type of interventions in their treatment and they were assigned to the nonaccommodative intervention. This modification to random assignment was deemed necessary for ethical purposes. Case review of those three couples indicated all but one of the six partners started out very close to the mean score in dyadic adjustment, and improved in scores by an average of 7 points. The one participant scored high on the RDAS at the beginning of treatment and remained high. To test equivalence between groups an ANOVA was run comparing the standard group to the religious group on the baseline RDAS, indicating no difference for men, $F(1, 88) = .18$, $p = .67$ or women, $F(1, 88) = .01$, $p = .93$.

Couples were offered 8–10 free couples therapy sessions (average length of treatment 8.91 sessions with average of 13.35 weeks). The first 56 couples were offered US$75.00 per couple for participating in the research. Due to funding limitations, payment was not available for the remaining couples but free therapy was offered. The project lasted for two years with 268 individuals who completed online screenings with interest in the study, with 184 (92 couples) participants who passed the screening and engaged in the treatment study. The screening was minimal for exclusion criteria, and then complete assessment took place at the intake session. Figure 1 describes the participation in the study across time. Couples received their follow-up data collection at the 6-month follow-up mark.

Adherence Information

To check for adherence, all treatment sessions were reviewed live or on videotape by a research assistant who used an extensive checklist of 8–20 behaviors per session to ensure that the treatment manual was followed and that therapists maintained the group assignment. Treatment validity was 98%, with the 2% resulting from clinicians not following the manual due to responding to significant client concerns such as a sudden death in the family. The therapy behavior checklist had two versions, one standard and one for religion-accommodative with prayer and religious metaphors included. There were no indications in checklists that any therapists contaminated the assigned condition of treatment.

Results

There were 22 measures of the couples' functioning (see Table 1), but the primary outcome was the RDAS. The means and standard deviations of the RDAS for the *standard* treatment were baseline 42.70 (std = 9.69), posttreatment 49.51 (std = 7.98), 6-month follow-up 50.69 (std = 8.69), and for the *religion-accommodative* treatment baseline 42.17 (std = 8.94), posttreatment 46.87 (std = 6.83), and 6-month follow-up 46.98 (std = 8.03). Detailed descriptive statistics for secondary outcomes are available on request from the authors. A score of 48 is established as the criterion for adjustment on the RDAS (Crane, Middleton, & Bean, 2000) indicating that on average couples moved from clinical scores to hovering around the criterion scores and maintained at 6 months.

Did Change Occur? Multilevel Modeling of Growth Trajectories

Multilevel growth modeling was used to model couple trajectories of relationship outcomes over time. Multilevel modeling relies on

maximum likelihood estimation of model parameters and can yield accurate and reliable results despite the presence of missing data caused by attrition or loss to follow-up (Kwok et al., 2008). The pattern of means over time suggested quadratic growth on most outcomes. Therefore, relationship outcome variables were modeled as a function of linear and quadratic time components, treatment group (standard = 0, religious = 1), and the interaction of treatment with the time parameters. In our models, time was treated as a continuous variable with baseline assessment coded 0 (so that intercepts reflect baseline status) and subsequent assessments coded as months since baseline assessment. A significant effect of time parameters indicates growth trends for both groups over time; a significant interaction of treatment with time parameters indicates differential trajectories of outcomes for the treatment groups.

Our models were based on those described by Atkins (2005) for three-level couple data. Individual intercepts within couples were treated as random effects. Couple-level intercepts and linear slopes were also treated as random effects, and a general (unstructured) covariance matrix was estimated. The spatial distance measure and five of the IDSC ratings were made at the couple (rather than individual) level, so these models did not include the individual-level intercepts. Because we had only three measurement periods, the variance of the quadratic slopes was fixed at 0 for identification of the models. In some cases, convergence problems were resolved by removing additional random components. All models were estimated with restricted maximum likelihood methods implemented with the Linear Mixed Models module in SPSS. For all effects, alpha level was set at .05 (two-tailed tests).

Table 1 provides the fixed effects parameter estimates for all outcomes. For efficiency of presentation, random effects, fixed intercepts, and treatment main effect are not shown but are available on request. There were no significant treatment main effects for any variable, which indicates that there were no significant baseline differences between treatment groups. The RDAS and most secondary outcome had significant linear and quadratic effects over time, but no significant interactions with treatment condition. For these outcomes, both groups showed significant improvement from baseline to posttreatment, followed by a stable trajectory from posttreatment to follow-up. For three secondary outcomes (forgiveness impact, support valida-

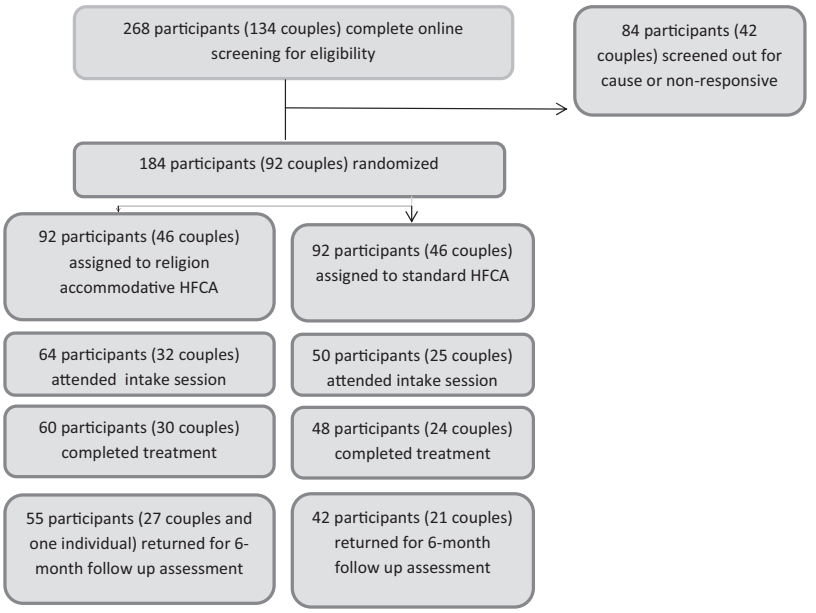

Figure 1. CONSORT flow diagram for religion-accommodative hope-focused clinical trial.

tion, and positive escalation), there were significant quadratic interactions of treatment with time (along with significant or approaching significant) linear trends. The trajectory of these trends indicated an initial stronger improvement from baseline to end of treatment in the standard treatment, followed by a greater decline from posttreatment to follow-up.

How Much Change Occurred?

The effect size for each group was calculated using Morris and DeShon's (2002) equation 8 to correct for dependence between means in within subject designs by including the correlation between the pretreatment and posttreatment scores. Table 1 includes data on the effect sizes (Cohen's *d* using equation 8) for each of the measures from pretreatment to posttreatment and from pretreatment to follow-up. Prepost and pre-follow-up effect sizes for both groups were moderate to large, over $d = 0.50$, for the RDAS and for most secondary outcomes. Out of 88 effect sizes, 47 (53%) of the measures indicated effect sizes of .50 or higher

Were Drop-Out Couples Different Than Completers?

Participation in the study was divided into four groups, those that dropped out before intake, before therapy was over, before the follow-up assessment, and those that completed all measures. A chi-square was conducted to see if condition of treatment predicted drop out, which was not significant, X^2 (3) = 1.71, $p = .64$. Separate ANOVAs were conducted to determine if drop out could predict baseline RDAS measure for each gender. Completion did not predict baseline RDAS for men, $F(3, 88) = 2.26$, $p = .09$, or women, $F(3, 88) = 1.77$, $p = .16$. Four additional baseline measures given online also indicated no significant difference for drop out level. These measures all had *F* test degrees of freedom of (3, 85) and $p > .05$. For women, RCS $F = .06$, Forgiveness impact $F = 1.42$, Forgiveness meaning $F = 1.23$, Forgiveness moving on $F = .94$. For men $F = .35$, Forgiveness impact $F = 1.96$, Forgiveness meaning $F = 1.08$, Forgiveness moving on $F = .56$. The rest of the measures were obtained in person so there were three levels. These measures all had *F* test degrees of freedom of (2, 75) and $p > .05$ unless otherwise noted. For women, spacial distance $F = .63$, self-video rating $F = 2.49$, partner video rating $F = 2.54$. Women's IDCS codings *F* tests were positive affect $F = 1.84$, negative affect $F = 1.70$, problem solving $F = .30$, denial $F = 2.71$, dominance $F = 1.02$, support/validation $F = .96$, conflict $F = .02$, withdrawal $F = .39$, communication skills $F = 4.07$, positive escalation $F = .19$, negative escalation $F = 1.51$. For men, there were some significant differences: special distance $F = .15$, self-video rating $F = 7.52$, $p = .001$, partner video rating $F = 4.13$, $p = .02$. Men's IDCS codings *F* tests were positive affect $F = 2.26$, negative affect $F = 7.64$, $p = .002$, problem solving $F = 3.23$, denial $F = 4.18$, $p = .02$, dominance $F = .75$, support/validation $F = 1.91$, conflict $F = 3.20$, withdrawal $F = 1.87$, communication skills $F = 4.00$, $p = .03$, positive escalation $F = .46$, negative escalation $F = 4.95$, $p = .01$. The three dyadic IDCS codings were not significant commitment $F = 2.30$, future satisfaction $F = 2.90$, and future stability $F = .002$.

Exploratory Moderator Analyses

For outcome variables measured at the individual partner level (16 outcomes), we conducted exploratory analyses to determine whether gender or degree of religious commitment (RCI scores) had a moderating effect on treatment trajectories. In separate analyses for gender and RCI, we entered the potential moderators as main effects and included all two-way and three-way interactions in the models. In the religious commitment moderation analyses, only two outcome variables (denial and ratings of partner videos) had interaction effects of RCI scores with time trajectories. For denial, there was a significant two-way interaction of RCI scores with both linear time (Est. = 0.03, $SE = 0.01$, $t = 2.02$, $p < .05$) and quadratic time (Est.−0.001, $SE = .001$, $t = -2.03$, $p < .05$); for ratings of partner videos, there was a significant interaction of RCI scores with linear time (Est. = −0.23, $SE = 0.19$, $t = -2.23$, $p < .05$). Graphical exploration of these findings (not shown) indicates better initial gains among participants lower in religious commitment.

In the gender moderation analyses, only two variables (forgiveness impact and dominance) had significant gender interactions with time

trajectories. For forgiveness impact, there was a significant two-way interaction of gender with both linear time (Est. = 2.37, $SE = 0.94$, $t = 2.50$, $p < .05$) and quadratic time (Est. = −0.23, $SE = 0.11$, $t = -2.01$, $p < .05$). Graphical exploration indicates that females showed more rapid declines in impact scores initially and over the follow-up period. For dominance, there was a significant there-way interaction of gender with treatment group and linear time (Est. = −0.78, $SE = 0.39$, $t = -1.98$, $p < .05$). Graphical exploration indicates substantial initial declines in husband dominance scores in both treatment groups. However, in the standard treatment, husband dominance scores increase over follow-up relative to husbands in the religious treatment group. There is no theoretical reason for these results, the primary measure of relationship adjustment (RDAS) did not differ, and since there was a large number of outcomes and parameters assessed in these moderation analyses, we caution against overinterpreting these few significant findings.

Discussion

Overall, the results indicate that the hope-focused brief couples therapy intervention is significantly and consistently improving couples relationship as measured by various self-report and observational measures. Dyadic adjustment gains are higher than Baucom, Hahlweg, and Kuschel (2003) estimated that the mean effect size for Behavior Marital Therapy ($d = 0.82$) which is higher than Shadish and Baldwin's (2005) estimate ($d = 0.59$). The treatment gains were maintained at the 6-month follow-up assessment of couples. Similar to the hope-focused couples enrichment research (Jakubowski et al., 2004), hope-focused strategic couples therapy appears to be effective in a therapeutic context, regardless of religious accommodation.

Implications for Religious Diversity in Couples Therapy

The lack of differences between the religion-accommodative and the standard version of couples counseling is important information. While many couples present for couples therapy requesting "Christian" or other religious couples counseling (Ripley, Worthington & Berry, 2001), results indicate that whether or not that treatment is religion-accommodative is not indicative of good treatment. Similar to research on race of therapist and sensitivity to racial issues (Swift, Callahan & Volner, 2011; Thompson, Worthington, & Atkinson, 1994), the current research indicates that while couples may have preferences and expectations for treatment, once the treatment is engaged in then the use of ecclesiastical techniques or religious discussion does not appear to improve general treatment outcomes.

Meta-analytic research has indicated that religion-accommodative treatment for individuals may improve religious outcomes (Worthington et al., 2011a) and this theory should be tested with couples treatment. Future couples research might explore proximal religious outcome measures such as spiritual intimacy or manifestations of God in marriage (Mahoney et al., 2008) or distal constructs such as spiritual well-being. A unique aspect of couples treatment is that partners may have varied interest and expectations for religion-accommodative treatment. The current intervention helped the couple come to agreement on whether to use religion-accommodative practices in treatment as the method of addressing any differences. Couples where religious differences are a point of concern for the couple might especially benefit from treatment that addresses religion explicitly. Couples varied preferences for treatment might be further explored as both a clinical and a predictive variable.

Given the lack of research to support therapists addressing religion in treatment, a diversity-sensitive approach seems most prudent at this time. On the one hand, it appears couples are not receiving ineffective treatment if the treatment is respectful of their religious beliefs but doesn't incorporate them directly into the treatment. Likewise if a couple and therapist agree to use ecclesiastical techniques or religious concepts in treatment, treatment was not impaired. Given this result, professional ethics and sensitivity to diversity should guide treatment.

Because there was not a significant difference, therapists should use skills similar to multicultural counseling skills where the effectiveness and perceptions around discussions of religion are processed with the couple and illuminated. Guidelines should continue to be developed intended to help clinicians who want to be sensitive to religious diversity in psychotherapy (Hathaway & Ripley, 2009).

The HFCA to couples treatment was a brief (8–10 sessions) treatment with components we believe are possibly efficacious components and worth investigating in future research studies. The components of this intervention were—

1. A focus on hope within the positive psychology tradition.
2. Assessment and written feedback with a focus on agency for change.
3. Simple strategies. In this study the techniques were constrained for research purposes as described in the method section. Future research should determine whether diverse techniques with similar strategic approach maintain good outcomes for couples.
4. Repairing bonds through emotions and forgiveness. Combining emotion-focused couples therapy technique (such as emotional softening and empty chair) with forgiveness intervention should receive future research as a component of intervention we believe may account for long-term maintenance of gains as couples face offenses and damage to their attachment bond in the future.
5. The use of couple feedback throughout treatment. Couples, therapist and a researcher provided a weekly clinical evaluation of couple improvement. There is some research indicating that simply tracking and discussing couples' feedback on improvement is an effective intervention for therapy (Duncan, Miller, Wampold, & Hubble, 2009). Though a new method, we attempted to use the couples' rating of their own video as another means of feedback to the couple and therapist. This might be useful to develop through future research.

Limitations

The study has several limitations. First, the analysis did not use a wait-list in keeping with recent recommendations (Baucom, Hahlweg, & Kuschel, 2003). While the activity of a wait-list for couples therapy groups is well-known, the lack of a wait-list does not allow for a direct comparison with this sample. The assignment of three couples to the standard treatment, at their request, is a limitation on random assignment of cases. Despite that the couples did not seem to change the outcome, we recognize this is a limitation of the study.

The intervention was relatively standardized with 8 to 10 sessions following specific types of interventions with every couple. While this allows for good comparison between groups in research design, it is not reflective of community practice of HFCA, which recommends 8 to 20 sessions. HFCA uses >100 interventions within nine modules. Only a small number were utilized in the present treatment. Future research should attempt a field study with fewer controls on intervention choices and dosage of treatment to see if the results of the study are due to tight research controls or continue to produce results in field settings. Future research on religious outcomes for couples should investigate which religious activity or discussions are most helpful to which types of couples to help guide therapists in their work with religious couples.

There was moderate dropout for a clinical lab study by the follow-up period (see Figure 1). Multilevel modeling provides unbiased parameter estimates under the assumption that missing data are either (a) missing completely at random (MCAR), meaning that missingness is not due to observed variables in the models or to the unobserved missing values themselves, or (b) missing at random (MAR), which means that missingness is not caused by the unobserved values of the missing data (Schafer & Graham, 2002). Our finding that the number of sessions completed was not related to initial observed values of the RDAS and self-report measures supports that there is not a pattern of missing data for that important variable. However, there were differences particularly for video ratings of men with more negative initial video ratings predicting drop out. Therefore, some missing data is not random. Because there is no statistical test for missingness at random (MAR), we cannot know with certainty whether our results are without bias.

In conclusion, the HFCA was effectively adapted for couples in a dismantling treatment study of standard or religion-accommodative treatment. The adaptation did not affect general relationship outcome variables. Psychotherapy outcomes were at or better than previous couples therapy outcome research (Shadish & Baldwin, 2005). Future research that investigates spiritual outcomes and component research of religious interventions for couples is recommended.

References

Atkins, D. C. (2005). Using multilevel models to analyze couple and family treatment data: Basic

and advanced issues. *Journal of Family Psychology, 19,* 98–110. doi:10.1037/0893-3200.19.1.98

Bailey, T. C., Eng, W., Frisch, M. B., & Snyder, C. R. (2007). Hope and optimism as related to life satisfaction. *The Journal of Positive Psychology, 2,* 168–175. doi:10.1080/17439760701409546

Baucom, D. H., Hahlweg, K., & Kuschel, A. (2003). Are waiting-list control groups needed in future marital therapy outcome research? *Behavior Therapy, 34,* 179–188. doi:10.1016/S0005-7894(03)80012-6

Beach, S. R. H., Fincham, F. D., Hurt, T. R., McNair, L. M., & Stanley, S. M. (2008). Prayer and marital intervention: A conceptual framework. *Journal of Social and Clinical Psychology, 27,* 641–669. doi:10.1521/jscp.2008.27.7.641

Burchard, G. A., Yarhouse, M. A., Kilian, M. K., Worthington, Jr., E. L., Berry, J. W., & Canter, D. E. (2003). A study of two marital enrichment programs and couples' quality of life. *Journal of Psychology and Theology, 31,* 240–252.

Busby, D. M., Crane, D. R., Larson, J. H., & Christensen, C. (1995). A revision of the Dyadic Adjustment Scale for use with distressed and nondistressed couples: Construct hierarchy and multidimensional scales. *Journal of Marital and Family Therapy, 21,* 289–308. doi:10.1111/j.1752-0606.1995.tb00163.x

Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology, 66,* 7–18. doi:10.1037/0022-006X.66.1.7

Christensen, A., Atkins, D. C., Yi, J., Baucom, D. H., & George, W. H. (2006). Couple and individual adjustment for 2 years following a randomized clinical trial comparing tradition versus integrative behavioral couple therapy. *Journal of Consulting and Clinical Psychology, 74,* 1180–1191. doi:10.1037/0022-006X.74.6.1180

Crane, D. R., Middleton, K. C., & Bean, R. A. (2000). Establishing criterion scores for the Kansas marital satisfaction scale and the revised dyadic adjustment scale. *American Journal of Family Therapy, 28,* 53–60. doi:10.1080/019261800261815

DiBlasio, F. A., & Benda, B. B. (2008). Forgiveness intervention with married couples: Two empirical analyses. *Journal of Psychology and Christianity, 27,* 150–158.

Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M. A. (2009). *The heart and soul of change: Delivering what works in therapy*. Washington DC: American Psychological Association.

Fincham, F. D., Beach, S. R. H., Lambert, N., Stillman, T., & Braithwaite, S. (2008). Spiritual behaviors and relationship satisfaction: A critical analysis of the role of prayer. *Journal of Social and Clinical Psychology, 27,* 362–388. doi:10.1521/jscp.2008.27.4.362

Fincham, F. D., Hall, J., & Beach, S. R. H. (2006). Forgiveness in marriage: Current status and future directions. *Family Relations: An Interdisciplinary Journal of Applied Family Studies, 55,* 415–427. doi:10.1111/j.1741-3729.2005.callf.x-i1

Gordon, K. C., & Baucom, D. H. (2003). Forgiveness and marriage: Preliminary support for a synthesized model of recovery from a marital betrayal. *American Journal of Family Therapy, 31,* 179–199. doi:10.1080/01926180301115

Gordon, K. C., Baucom, D. H., & Snyder, D. K. (2000). The use of forgiveness in marital therapy. In M. E. McCullough, K. I. Pargament, & C. E. Thoresen (Eds.), *Forgiveness: Theory, research, and practice* (pp. 203–227). New York, NY: Guilford Press.

Gordon, K. C., Baucom, D. H., & Snyder, D. K. (2004). An integrative intervention for promoting recovery from extramarital affairs. *Journal of Marital and Family Therapy, 30,* 213–231. doi:10.1111/j.1752-0606.2004.tb01235.x

Greenberg, L., Warwar, S., & Malcolm, W. (2010). Emotion-focused couple therapy and the facilitation of forgiveness. *Journal of Marital and Family Therapy, 36,* 28–42. doi:10.1111/j.1752-0606.2009.00185.x

Harris, D. (2009, March 9). *America is becoming less Christian, less religious*. Retrieved from http://abcnews.go.com/US/story?id=7041036&page=1

Hathaway, W., & Ripley, J. S. (2009). Ethical concerns around spirituality and religion in clinical practice. In J. Aten & M. Leach (Eds.), *Spirituality and the therapeutic process: A comprehensive resource from intake to termination*. APA Books: Washington DC. doi:10.1037/11853-002

Hook, J. N., Worthington, E. L., Jr., Davis, D. E., & Atkins, D. C. (2014). Religion and couple therapy: Description and preliminary outcome data. *Psychology of Religion and Spirituality, 6,* 94–101.

Jakubowski, S. F., Milne, E. P., Brunner, H., & Miller, R. B. (2004). A review of empirically supported marital enrichment programs. *Family Relations: An Interdisciplinary Journal of Applied Family Studies, 53,* 528–536. doi:10.1111/j.0197-6664.2004.00062.x

Kiefer, R. P., Worthington, E. L., Jr., Myers, B., Kliewer, W. L., Berry, J. W., Davis, D. E., Kilgour, J., Jr., Miller, A. J., Van Tongeren, D. R., & Hunter, J. L. (2010). Training parents in forgiveness and reconciliation. *American Journal of Family Therapy, 38,* 32–49. doi:10.1080/01926180902945723

Kline, G. H., Julien, D., Baucom, B., Hartman, S. G., Gilbert, K., Gonzalez, T., & Markman, H. J. (2004). The Interactional Dimensions Coding System: A global system for couple interactions. In P. Kerig & D. Baucom (Eds.), *Couple observational coding systems* (pp. 113–126). Mahwah, NJ: Erlbaum.

Kwok, O.-M., Underhill, A. T., Berry, J. W., Luo, W., Elliott, T. R., & Yoon, M. (2008). Analyzing

longitudinal data with multilevel models: An example with individuals living with lower extremity intra-articular fractures. *Rehabilitation Psychology, 53,* 370–386. doi:10.1037/a0012765

Mahoney, A., Pargament, K. I., Tarakeshwar, N., & Swank, A. B. (2008). Religion in the home in the 1980s and 1990s: A meta-analytic review and conceptual analysis of links between religion, marriage, and parenting. *Psychology of Religion and Spirituality, S*(1), 63–101. doi:10.1037/1941-1022.S.1.63

Mahoney, A., Rye, M. S., & Pargament, K. I. (2005). When the sacred is violated: Desecration as a unique challenge to forgiveness. In E. L. Worthington, Jr. (Ed.), *Handbook of Forgiveness* (pp. 57–72). New York, NY: Brunner-Routledge.

Markman, H. J., Whitton, S. W., Kline, G. H., Stanley, S. M., Thompson, H., St. Peters, M., . . . Cordova, A. (2004). Use of an empirically based marriage education program by religious organizations: Results of a dissemination trial. *Family Relations: An Interdisciplinary Journal of Applied Family Studies, 53,* 504–512. doi:10.1111/j.0197-6664.2004.00059.x

McCullough, M. E., Rachal, K. C., Sandage, S. J., Worthington, Jr., E. L., Brown, S. W., & Hight, T. L. (1998). Interpersonal forgiving in close relationships: II. *Journal of Personality and Social Psychology, 75,* 1586–1603. doi:10.1037/0022-3514.75.6.1586

McNulty, J. K. (2010). Forgiveness increases the likelihood of subsequent partner transgression in marriage. *Journal of Family Psychology, 24,* 787–790. doi:10.1037/a0021678

McNulty, J. K., & Fincham, F. D. (2012). Beyond positive psychology: Toward a contextual view of psychological processes and well-being. *American Psychologist, 67,* 101–110. doi:10.1037/a0024572

Morris, S. B., & DeShon, R. P. (2002). Combining effect size estimates in meta-analysis with repeated measures and independent-group designs. *Psychological Methods, 7,* 105–125. doi:10.1037/1082-989X.7.1.105

Norcross, J. C. (2011). *Psychotherapy relationships that work: Evidence-based responsiveness*. New York: Oxford University Press. doi:10.1093/acprof:oso/9780199737208.001.0001

Ripley, J. S., Davis, E. B., Leon, C. Q., & Worthington, E. L., Jr. (2008). *The Hope-Focused Couples Approach treatment manual*. Regent University. Available for download at http://hopecouples.com/hope-manual.php

Ripley, J. S., & Worthington, E. L., Jr. (2002). Hope-focused and forgiveness-based group interventions to promote marital enrichment. *Journal of Counseling & Development, 80,* 452–463. doi:10.1002/j.1556-6678.2002.tb00212.x

Ripley, J. S., Worthington, E. L., Jr., & Berry, J. W. (2001). The effects of religiosity on preferences and expectations for marital therapy among married Christians. *American Journal of Family Therapy, 29,* 39–58. doi:10.1080/01926180126136

Schafer, J. L., & Graham, J. W. (2002). Missing data: Our view of the state of the art. *Psychological Methods, 7,* 147–177. doi:10.1037/1082-989X.7.2.147

Shadish, W. R., & Baldwin, S. A. (2005). Effects of behavioral marital therapy: A meta-analysis of randomized controlled trials. *Journal of Consulting and Clinical Psychology, 73,* 6–14. doi:10.1037/0022-006X.73.1.6

Snyder, C. R. (1994). *The psychology of hope: You can get there from here.* New York, NY: Free Press.

Spanier, G. B. (1976). Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads. *Journal of Marriage and The Family, 38,* 15–28. doi:10.2307/350547

Stanley, S. M., Amato, P. R., Johnson, C. A., & Markman, H. J. (2006). Premarital education, marital quality, and marital stability: Findings from a large, random household survey. *Journal of Family Psychology, 20,* 117–126. doi:10.1037/0893-3200.20.1.117

Stanley, S., & Markman, H. J. (1992). Assessing commitment in personal relationships. *Journal of Marriage and the Family, 54,* 595–608.

Swift, T. B. Callahan, J. L., & Vollner, B. M. (2011). Preferences. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence based responsiveness* (2nd ed., pp. 301–315). New York, NY: Oxford University Press.

Thompson, C. E., Worthington, R., & Atkinson, D. R. (1994). Counselor content orientation, counselor race, and black women's cultural mistrust and self-disclosures. *Journal of Counseling Psychology, 41,* 155–161. doi:10.1037/0022-0167.41.2.155

Worthington, E. L., Jr., Hook, J. N., Davis, D. E., Gartner, A. L., & Jennings, D. J. II. (2013). Conducting empirical research on religiously accommodative interventions. In K. I. Pargament, A. Mahoney, & E. P. Shafranske (Eds.), *APA handbooks in psychology. APA handbook of psychology, religion, and spirituality* (Vol. 2, pp. 651–669): An applied psychology of religion and spirituality.

Worthington, E. L., Jr., Hook, J. N., Davis, D. E., & McDaniel, M. E. (2011a). Religion and spirituality. *Journal of Clinical Psychology, 67,* 204–214. doi:10.1002/jclp.20760

Worthington, E. L., Jr., Hook, J. N., Davis, D. E., & McDaniel, M. A. (2011b). Religion and spirituality. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (pp. 402–420). New York, NY: Oxford University Press. doi:10.1093/acprof:oso/9780199737208.003.0020

Worthington, E. L., Jr., Wade, N. G., Hight, T. L., Ripley, J. S., McCullough, M. E., Berry, J. W., . . . O'Connor, L. (2003). The religious commitment inventory10: Development, refinement, and vali-

dation of a brief scale for research and counseling. *Journal of Counseling Psychology, 50,* 84–96. doi:10.1037/0022-0167.50.1.84

Worthington, Jr., E. L. (2005). *Hope-focused marriage counseling: A guide to brief therapy* (Expanded Ed.). Downers Grove, IL: InterVarsity Press.

Worthington, Jr., E. L., Hight, T. L., Ripley, J. S., Perrone, K. M., Kurusu, T. A., & Jones, D. R. (1997). Strategic hope-focused relationship-enrichment counseling with individual couples. *Journal of Counseling Psychology, 44,* 381–389. doi:10.1037/0022-0167.44.4.381

Appendix

Descriptive Data for Outcomes for Hope-Focused Couples Therapy

	Standard		Religion-accommodative	
	M	*SD*	*M*	*SD*
Revised Dyadic Adjustment Scale				
Baseline	42.70	9.69	42.17	8.94
Post	49.51	7.98	46.87	6.83
Follow-up	50.69	8.69	46.98	8.03
Relationship Commitment Scale				
Baseline	17.80	2.91	17.24	2.60
Post	18.85	1.78	18.36	2.61
Follow-up	18.59	2.34	17.85	2.94
Gordon Baucom Forgiveness Impact*				
Baseline	17.96	6.11	18.86	6.03
Post	13.46	4.96	16.77	5.65
Follow-up	12.90	4.41	13.87	5.43
Gordon Baucom Forgiveness Meaning				
Baseline	24.51	5.54	24.54	4.97
Post	25.15	5.18	26.07	4.49
Follow-up	22.86	5.51	23.17	4.86
Gordon Baucom Forgiveness Moving On				
Baseline	26.97	5.42	26.48	5.38
Post	30.84	3.94	28.96	3.85
Follow-up	30.92	3.23	29.70	4.44
Spatial Distance*				
Baseline	18.92	19.52	16.33	15.12
Post	8.47	13.70	8.42	14.14
Follow-up	14.30	30.00	8.76	14.72
Video Rating of Self				
Baseline	5.12	14.55	4.53	13.64
Post	15.94	9.78	11.54	11.18
Follow-up	14.05	13.24	14.17	13.00
Video Rating of Partner				
Baseline	4.60	15.28	3.47	14.35
Post	16.81	8.82	11.12	11.35
Follow-up	15.32	10.87	14.89	11.13
IDCS Positive Affect				
Baseline	4.94	1.63	4.76	1.70
Post	6.06	1.43	5.34	1.71
Follow-up	5.43	1.48	5.50	1.69

(*Appendix continues*)

Appendix (*continued*)

	Standard		Religion-accommodative	
	M	*SD*	*M*	*SD*
IDCS Negative Affect*				
Baseline	3.59	1.93	4.03	1.70
Post	2.92	1.20	3.42	1.70
Follow-up	3.29	1.24	3.19	1.36
IDCS Problem-Solving Skills				
Baseline	4.79	1.59	4.47	1.43
Post	5.83	.94	5.63	1.51
Follow-up	5.71	1.27	5.41	1.41
IDCS Denial*				
Baseline	2.85	1.40	2.97	1.24
Post	2.33	.67	2.61	.95
Follow-up	2.50	.92	2.47	1.13
IDCS Dominance*				
Baseline	3.47	1.58	3.29	1.27
Post	2.89	1.17	2.79	1.19
Follow-up	2.82	1.19	2.75	.98
IDCS Support Validation				
Baseline	4.35	1.65	4.66	1.67
Post	5.64	1.38	4.87	1.54
Follow-up	5.32	1.63	4.91	1.67
IDCS Conflict*				
Baseline	3.88	1.90	3.92	1.94
Post	3.08	1.42	3.42	1.33
Follow-up	3.57	1.55	3.25	1.46
IDCS Withdrawal*				
Baseline	2.74	1.64	2.74	1.16
Post	2.33	.76	2.71	1.35
Follow-up	2.21	.92	2.63	1.13
IDCS Communication Skills				
Baseline	5.65	1.52	5.68	1.32
Post	6.44	.77	6.32	1.09
Follow-up	6.61	1.10	6.25	1.24
IDCS Positive Escalation				
Baseline	3.12	1.2	2.79	1.17
Post	3.94	1.50	2.84	0.95
Follow-up	3.36	1.19	3.38	1.24
IDCS Negative Escalation*				
Baseline	3.18	1.53	3.21	1.38
Post	2.56	.84	2.47	.69
Follow-up	2.93	.90	2.31	.86
IDCS Commitment				
Baseline	6.71	.91	6.68	.93
Post	7.22	.72	7.00	.99
Follow-up	7.36	.83	7.19	.82
ICS Future Satisfaction				
Baseline	6.53	1.31	6.53	.95
Post	7.11	.67	6.89	.86
Follow-up	7.21	.96	7.00	.80
IDCS Future Stability				
Baseline	7.06	.95	7.16	.83
Post	7.50	.70	7.37	.75
Follow-up	7.57	1.00	7.31	.69

* indicates a scale where decreased scores reflect improvement in the relationship.

Received November 4, 2013
Revision received March 4, 2014
Accepted March 8, 2014 ■