ABSTRACT

Title of Thesis: THE INFLUENCE OF RELIGIOSITY ON RELATIONSHIP SATISFACTION AND THERAPEUTIC OUTCOME AS MEDIATED BY COMMITMENT LEVEL

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The purpose of this study was to examine the common factor and client characteristic of religiosity in order to determine its effect on relationship satisfaction and therapy outcome, as well as to determine whether commitment level was a mediator of those associations within a clinical sample of couples who had experienced mild/moderate psychological, verbal, or physical abuse. Results indicated several trends. For males, a non-significant positive trend was found suggesting that their religiosity was positively associated with relationship satisfaction at the initiation of therapy. Another trend was for more religious females to be more committed to their relationships. Both females and males' commitment level was significantly correlated with their relationship satisfaction. A trend towards a negative association between religiosity and relationship satisfaction was found for females when commitment level was controlled for, and for males there was a trend towards a negative association between commitment level and therapy outcome.

THE INFLUENCE OF RELIGIOSITY ON RELATIONSHIP SATISFACTION AND THERAPEUTIC OUTCOME AS MEDIATED BY COMMITMENT LEVEL

by

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"No man is an island." ~John Donne

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TABLE OF CONTENTS

Table of Contents ii

List of Tables v

List of Figures vi

Chapter I: Introduction 1

Statement of the Problem 1

Purpose 6

Chapter II: Review of Literature 8

Couple Therapy 8

Why Couples Seek Therapy 9

The Common Factors Framework of Therapeutic Efficacy 10

Religiosity 13

Commitment 15

Relationship Satisfaction 16

Variables for the Present Study 18

Hypotheses 21

Hypothesis 1 21

Hypothesis 2 21

Hypothesis 3 21

Hypothesis 4 21

Research Question 22

Chapter III: Methodology 23

Sample 23

Procedure 25
Measures 27
Chapter IV: Results 31
Overview of the Analyses 32
The Sample's Scores on the Measures 33
Tests of Hypotheses 35
Analysis for Hypothesis 1 35
Analysis for Hypothesis 2 36
Analysis for Hypothesis 3 38
Analysis for Hypothesis 4 38
Analysis of Research Question 40
Chapter V: Discussion 44
Findings 44
Consistency of the Findings with the Hypotheses and Research Literature 45
Limitations of the Study 51
Implications for Research 53
Implications for Clinical Practice 54
Summary 55
Appendix A 57
Appendix B 61
Appendix C 63
Appendix D 68
References 70

LIST OF TABLES

Table 1: Summary of Variables and Instruments Used to Measure Them 20

Table 2: Demographic Characteristics of the Sample..... 24

Table 3: Means and Standard Deviations for the Sample Scores on the Measures.....34

LIST OF FIGURES

Figure 1: The Framework of Common Factors 13

Figure 2: Hypothesis 1 31

Figure 3: Hypothesis 2 31

Figure 4: Hypothesis 3 31

Figure 5: Hypothesis 4 32

Chapter I: Introduction

Statement of the Problem

All family therapists seek to provide effective and successful therapy to the clients they serve (Schultz & Leslie, 2004). However, what makes therapy effective is an issue that has been studied for many years. There is a body of research that has focused on common factors which are found across all models of successful therapy, such as the warmth of the therapist (Blow & Sprenkle, 2001, 2004). Other studies have investigated common factors involving characteristics of the clients that predict effective therapy, such as being less distressed at the beginning of therapy (Bray & Jouriles, 1995). In order for family therapists to provide beneficial therapy to their clients, it is helpful for them to be aware of these common factors that are predictors of successful therapy. That knowledge will help therapists increase therapeutic effectiveness.

Blow and Sprenkle (2001, 2004) have explored the common factors that promote successful therapy. They found common aspects that contribute to therapeutic outcome. These are client/extra therapeutic factors; relationship factors; technique/model factors; and expectancy, placebo, and hope factors. Of particular interest to the present study is the area of client factors. "Client factors are characteristics or qualities of the client (such as level of motivation and commitment to change, inner strength, and religious faith)" (Blow & Spenkle, 2004, p. 120). Considering that these client factors have been found to be an important component of change in the therapeutic process, the question is which client factors contribute specifically to therapeutic success.

The current study examines the specific client factor of religiosity and seeks to determine whether clients' degree of religiosity could be a predictor of successful couple

therapy. The concept of religiosity has been defined as "an organized belief system with set rituals and practices, which are acquired in places of worship" (Zullig, Ward, & Horn, 2006, p. 255). A couple's religiosity would consist of the level of devotion or importance the couple places on that religion. Religiosity is a common factor of particular interest because a belief system can provide social support, comfort, and strength for people. It is also very common for people to be religious. In recent surveys conducted in the United States with a nationally representative sample, over 93 % of Americans reported a belief in a higher power, 59% of all Americans stated that they believe religion can solve all or most of today's problems, and over 50% indicated that religion was very important to them (Pargament, Rosmarin, & Robb, 2010; Gallup Poll, May 8-11, 2008). People tend to rely on their belief system when they experience distress (Pargament et al., 2010). Individuals may feel that they can find peace by believing in a higher power. Some people feel that religion or spirituality provides them with a sense of purpose in life, despite any bad situation in which they find themselves. Utilizing religious resources like ones beliefs during difficult times is referred to as religious coping (Pargament, 1997). Religious coping has been shown to predict "lower rates of depressive symptoms, anxiety, and increased levels of self esteem and life satisfaction" (Eme-Akwari, Harrison, Hays, Koenig, & Pargament, 2001).

Some of the ways in which religiosity is measured "include denominational identification, frequency of participation in religious services, the degree of religion's meaningfulness to an individual, and the degree of the individual's closeness to members of a religious group" (Allen & Lo, 2010, p. 433). In order to evaluate degree of religiosity, it is necessary to measure how meaningful religion is to the individual and

how often he/she participates in religious activities. It has been suggested that both factors of religiosity must be included in order to fully assess commitment level to religion or religious beliefs; this is especially true considering that religious participation has been found to play a greater role in marital stability than any of the other measures of religiosity alone (Call & Heaton, 1997; Glenn & Supanic, 1984).

Religiosity can be especially important to explore as a potential client common factor in therapy outcome, considering that research studies have provided evidence that in community samples of couples a higher degree of religiosity is associated with a higher level of marital satisfaction (Call & Heaton, 1997; Curtis & Ellison, 2002; Marks, 2005). The authors of these studies provide several possible explanations for this finding. First, religion may strengthen or promote an emotional bond between husband and wife that can enhance marital satisfaction (Call & Heaton, 1997; Robinson, 1994). A second possible reason for the link between religiosity and marital satisfaction is "if a couple's religion emphasizes the importance of marriage, spouses may feel greater commitment to their marriage" (Call & Heaton, 1997, p. 383). Lastly, many religions state that nonmarital sex is unacceptable, and this policy may provide a barrier against divorce because before and after divorce individuals' access to sex may be limited or prohibited (Call & Heaton, 1997). This current study not only investigated whether religiosity is a predictor of a successful therapy outcome, it also investigated whether or not their commitment to the relationship contributed to greater marital satisfaction. Call and Heaton (1997) found that the facilitation of the partners' higher religiosity promotes their commitment to the marriage. That explanation was explored in this study.

Commitment may be a mediator between religiosity and relationship satisfaction, as suggested by Call and Heaton (1997). However, no studies were found that have been conducted in order to support or refute this assertion. Intimate partner commitment includes the actions of staying with one's partner over time and the belief that the relationship is beneficial to both parties involved (Clausell, Goldberg, Kuvalanka, & Oswald, 2008; Rusbalt, 1983). On the other hand, Stanley (1992) found in his studies that while some people are committed to their relationship for the joint benefit of the parties involved, others have outside forces that compel them to stay regardless of their personal dedication to the relationship. Johnson, Caughlin, and Huston (1999) found that there are three different sources of commitment: personal, structural, and moral. Aside from personal dedication, Johnson et al. (1999) found two other forces or reasons why couples may be committed, which supports Stanley's (1992) assertion. Johnson, et al. (1999) stated that partners may be committed to their relationship for personal reasons, (e.g., love), for structural reasons, (e.g., financial security), and/or for moral reasons, (e.g., a vow, "til death do us part"). Clausell et al. (2008) studied the sources of commitment, as found by Johnson et al. (1999), and found that when an individual is committed to a relationship for moral reasons, it refers to their desire to be in the relationship because they feel that they 'should be' in the relationship. Clausell et al. (2008) also found that when commitment is moral in origin, it has been found to be "highly correlated with religiosity for both husbands and wives" (p. 412). Thus, although there are several sources of intimate relationship commitment, at least one of these sources, namely moral reasons, has been found to be strongly associated with religiosity.

Relationship commitment has also been found to be related to relationship satisfaction. According to Johnson, Morrow, and Rusbult (1986), there is a strong positive correlation between intimate partner commitment and relationship satisfaction. The relationship has been so strong that researchers at times seem to overlook the fact that there is a difference between satisfaction and commitment. However, even though the satisfaction of individuals in a couple may be significantly correlated with their level of commitment to the relationship, this does not mean that these concepts are equivalent (Rusbult, 1983; Rusbult & Buunk, 1993; Sprecher, Metts, Burleson, Hatfield, & Thompson, 1995). For instance, an individual may be dissatisfied with their relationship, yet believe that it is important to continue the relationship for various reasons such as religious beliefs or concerns about negative effects of divorce on their children (Larsen, 2004). Even though religiosity has been shown to be related to commitment level and to relationship satisfaction, the relationships among the three have not been expressly studied simultaneously. Also, although prior research confirms that religiosity and marital satisfaction are related, it has not addressed whether higher religiosity is a predictor of higher relationship satisfaction among couples seeking therapy for relationship problems. Another aspect of the topic of religiosity that has been omitted in previous research is the prospect of its being a predictor of a positive therapeutic outcome. This study addresses the possible relationship of religiosity and relationship satisfaction as mediated by intimate partner commitment. This study also examines if religiosity is a predictor of a greater increase in marital satisfaction over the course of therapy. It explores the concept of couple therapy being more successful for more religious individuals and if that relationship is mediated by commitment level as well.

Purpose

There is substantial evidence that regardless of the therapy model used, there are common factors of successful therapy, and that it is necessary to recognize and evaluate these factors in an effort to increase therapy effectiveness (Bergin & Lambert, 1994; Blow & Sprenkle, 2001, 2004). It has been shown that of the common factors, those associated with clients and their personal qualities and characteristics are an area neglected by researchers and an especially integral part of potential therapy effectiveness (Duncan, Hubble, & Miller, 1997; Blow & Sprenkle, 2001; Lambert, 1992). One possible personal characteristic or client factor to explore is the degree of religiosity with which a client presents. Religiosity has been shown to be associated with relationship satisfaction, in that the level of marital satisfaction is higher with a greater degree of religiosity (Call & Heaton, 1997; Curtis & Ellison, 2002; Marks, 2005). This relationship has been hypothesized to be a result of a stronger relationship commitment (Call & Heaton, 1997). However, a study in which this possible relationship has been examined is not currently available. The current study investigates this relationship among a clinical population. The purposes of this study include testing whether or not partners' degrees of religiosity are related to their level of relationship satisfaction at the initiation of therapy as possibly mediated by their commitment level. Another goal is exploring whether the level of religiosity at intake effects the success of their couple therapy as measured by an *increase* in relationship satisfaction. The specific aims of the study are to determine: (1) whether relationship satisfaction in clinical couples is associated with their levels of religiosity; (2) whether commitment is a mediator of that relationship; and (3) whether higher

religiosity predicts a greater increase in partners' relationship satisfaction, as mediated by the level of commitment, over the course of therapy.

Chapter II: Review of Literature

Couple Therapy

Couple therapy is a form of psychotherapy that helps couples improve their relationships by helping them recognize and resolve conflicts. It assists couples in improving their marital satisfaction by means of the therapist's interactions with the couple. According to Gurman's *Clinical Handbook of Couple Therapy* (2008), couple therapy is especially important because of the significant cultural changes that have taken place during the last half-century. These changes have had a considerable impact on society's views of marriage, or long term relationships. Some of the changes have included reforms of divorce law, more liberality in sexual expression, increased availability of contraceptives, and the expansion of women's power (Gurman, 2008). Also, the primary cause for the termination of marriage has shifted from "death to divorce" (Pinsof, 2002, p. 139). Regardless of the cause of this marital disintegration, large consequences of this shift have been found. "Compared to other important aspects of life such as work, health, friends, economy, social life, leisure time, and family life, positive marital life promotes positive global well-being" (Lundblad & Hansson, 2005, p. 40). Thus, when marital life is stressful and negative, a wide variety of problems in individual functioning have been found to occur. In fact, as Gurman (2008) states, "partners in troubled relationships are more likely to suffer from anxiety, depression and suicidality, and substance abuse; from both acute and chronic medical problems and disabilities, such as impaired immunological functioning and high blood pressure; and from high risk behaviors, such as susceptibility to sexually transmitted diseases and

accident proneness" (p. 3). Consequently the development of interventions to reduce relationship distress and avoid relationship dissolution is a high priority.

Why Couples Seek Therapy

Couples seek therapy for a variety of reasons, mainly due to distress in their relationship. In fact, one study by Christensen, Doss, and Simpson (2004) found that there are some reasons why couples seek therapy that are more common than others. The study surveyed 147 heterosexual married couples who were originally recruited for a larger study on marital therapy. The couples were asked to answer an open-ended prompt which asked, "Please list the main factors that led you personally to seek marital therapy" (Christensen et al., 2004, p. 609). The participants were then asked to complete the 150-item Marital Satisfaction Inventory-Revised (MSI-R; Snyder, 1997). This measure is comprised of 12 subscales assessing qualities that are important to romantic relationships (e.g., communication, satisfaction, and specific aspects of the relationship such as sex). The findings indicated that communication problems and a lack of emotional affection were the two greatest reasons why couples seek treatment. Christensen et al. (2004) also examined possible gender differences with regard to the importance of areas of relationships for which members of couples seek therapy, and it was found that differences do indeed exist. They found that women were more likely than men to report communication as the reason they are seeking therapy. Men, on the other hand, report a lack of emotional affection as their main reason for getting treatment. The study's results also indicated that "when an individual couple presents for marital therapy, the husband and the wife are likely doing it for very different reasons" (p. 611). This study focused attention on the reasons couples seek therapy, and this knowledge is essential to the

success of the therapy provided (Christensen et al., 2004). Indeed, the specific reason for which couples seek therapy has been shown by at least one study to account for 35% of the variance in client outcome (Crane, Griffin, & Hill, 1986). For instance, if clients seek therapy for a specific reason and they feel that treatment addresses that expectation, then therapy will be more successful. However, there is one limitation to the study; any couple seeking therapy who did not meet the criteria for being clinically distressed was excluded from the research. This could be an issue considering that Christensen et al. (2004) stated, "it is possible that couples are also motivated to seek therapy to recapture or enhance relationship strengths in addition to ameliorating specific problems" (p. 608). Therefore, it is not only distressed couples who may seek out therapeutic services, and the study does not cover the experience of those couples who are not significantly distressed.

The Common Factors Framework of Therapeutic Efficacy

The success of therapy has been studied at length, especially with regard to specific models of treatment. However, the common factors framework as outlined by Blow and Sprenkle (2004) proposes that the effectiveness of therapy is actually due to common factors that appear across all models of successful therapy. This is the framework which provides the theoretical base for the proposed study. In the research by Blow and Sprenkle (2004), they found that little attention has been paid to the idea of common factors within the field of family therapy. In fact the framework of common factors has been designated "the overlooked foundation for effective practice" (Davis, Lebow, & Sprenkle, 2009). Blow and Sprenkle (2004) stated that the lack of focus on these factors is changing due to the field becoming more evidence-based. The common factors framework of therapy efficacy has been studied somewhat more often in the area

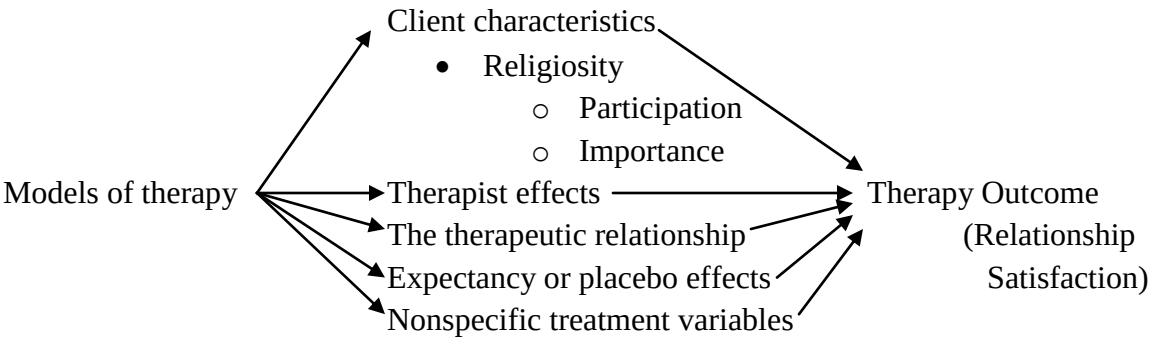
of individual therapy (Drisko, 2004; Thomas, 2006), but Blow and Sprenkle (2004) have studied it with regards to couples as well. The common factors framework states that general or common factors are "those variables that contribute to change in psychotherapy that are not the province of any specific theoretical approach or model" (Blow & Sprenkle, 2004, p. 114). In other words, it argues that the effectiveness of one model may be dependent on aspects that are also common to other forms of treatment. Drisko (2004) found in his meta-analysis of common factors in individual therapy that the most important "active ingredients" were actually the similarities between the various therapies. The common factors between therapy models, therapists, etc. were found to be the most important aspect of therapy (Drisko, 2004). In fact, it was found that the client is the most important common factor in the success of therapy (Davis, Lebow, & Sprenkle, 2009; Duncan, & Miller, 2000).

The types of common factors identified by Blow and Sprenkle include characteristics of the client, the effects the therapist has, the relationship between the client and therapist, the effects that the client's expectations have, and nonspecific treatment variables. Nonspecific treatment variables may include behavioral regulation, cognitive mastery, and emotional experiencing. Blow and Sprenkle (2004) also present common factors that are unique to the practice of marriage and family therapy: relational conceptualization, the expanded direct treatment system, and the expanded therapeutic alliance. Relational conceptualization refers to the translation of an individual's problems into relational concepts, such as how an issue affects the couple relationship. The expanded treatment system signifies the tendency of family therapists to include all members of a family, not only the identified patient, and would include both partners

when the individual is a part of a dyad. The third factor that Blow and Sprenkle (2004) found to be unique to marriage and family therapy is the expanded therapeutic alliance, which refers to the therapist forming an alliance not only with each member of the family individually, but also with each member of the family or dyad and with the system as a unit. This alliance would signify that the therapist will have a personal bond with each individual, and they will also feel this bonding "in their roles as part of subsystems as well as the whole family" (Davis, Lebow, & Sprenkle, 2009, p.43).

Of specific interest to the present study is the common factor of client characteristics. "The research literature makes it clear that the client is actually the single, most potent contributor to outcome in psychotherapy" (Blow & Sprenkle, 2004, p. 120). It is believed that the reason many therapy models appear to work equally well is because clients apply relevant aspects of therapy to themselves based on who they are and the characteristics they bring to therapy (Tallman, & Bohart, 1999). These characteristics which clients bring to therapy are called client factors. According to Lambert (1992), some important client factors include the clients' inner strength, their commitment to change, social support, level of motivation, community involvement, the number of stressful events that have occurred in their lives, and their religious faith. This study focused explicitly on the client factor of religious faith, or religiosity.

Figure 1: The Framework of Common Factors



Religiosity

Religiosity has been defined as "an organized belief system with set rituals and practices, which are acquired in places of worship" (Zullig, Ward, & Horn, 2006, p. 255). Because religiosity varies by individual, many of the clients who seek therapy might have very different levels of religiosity, and thus religiosity may constitute one of the client factors that lead to successful therapy. However, religiosity is a complex, multidimensional construct (Allen & Lo, 2010), and thus it is not easily measured. However, some "common measures of religiosity include denominational identification, frequency of participation in religious services, the degree of religion's meaningfulness to an individual, and the degree of the individual's closeness to members of a religious group" (Allen & Lo, 2010, p. 435). It has also been shown that in order to gain a true perspective on religiosity it is necessary to include a measure of the individual's attendance at religious services and activities (Call & Heaton, 1997; Glenn & Supanic, 1984). It was also suggested by Call and Heaton (1997) that this may be due to the effect that attendance has on the "amount of indoctrination a person receives in a particular theology" (p. 383).

Call and Heaton (1997) studied the influence that religiosity has on marital stability. Their analyses were based on the National Survey of Families and Households panel data (Bumpass, Call, & Sweet, 1988). Within this survey, there were two instances, also called "waves," in which participants were asked to respond. The first "wave" was in 1987/1988 and the second was in 1992/1994. During the first wave, personal interviews were conducted. During these interviews, participants were also given a self-administered questionnaire. This questionnaire focused on the respondent's personal attitudes and behaviors. During the follow-up, the original participants were again interviewed and another self-administered questionnaire was completed. The analyses were based on the responses of 4,587 couples who participated in both waves of interviews. The findings of the study indicated that those couples with no religious affiliation had higher marital dissolution rates than any other group. Church attendance was found to be "positively associated with marital stability for both men and women" (p. 385).

Call and Heaton (1997) also concluded that their findings suggested that marriages, when characterized by higher levels of religious attendance, are more stable because the spouses have higher levels of satisfaction and stronger attitudes opposing non-marital sex. In fact, many studies indicate that those couples who regularly attend religious activities such as church, state that they have a higher level of marital satisfaction, and they may be less likely to divorce than couples who are less religious (Arnett & Scanzoni, 1987; Call & Heaton, 1997; Curtis & Ellison, 2002; Glenn, 1982).

Religiosity may also be related to marital satisfaction, because the individuals are more committed to their relationship (Call & Heaton, 1997; Goltz & Larson, 1989). Goltz and Larson (1989) conducted a study in which they found a significant relationship

between religious participation and marital satisfaction. This study examined the associations between religious homogamy, religious affiliation, church attendance, and marital commitment, using 260 couples in Edmonton, Canada. Commitment was measured by degree of agreement or disagreement with several statements. An example of one statement is "I couldn't continue to live with my spouse if I didn't love him/her." Goltz and Larson (1989) reported that commitment was found to be "positively correlated to the church attendance of both husbands and wives" (p. 392), the higher the attendance, the higher the marital commitment. The author proposed that a possible reason for this finding is that, "religious orientation is a strong influence on the development of family commitment in giving the family a sense of purpose and values oriented to the needs and welfare of others" (p. 388).

Commitment

Intimate relationship commitment may be defined as a psychological and emotional state that is representative of a decision to develop and continue a long-term attachment to another person (Floyd & Wasner, 1994; Larsen, 2004; Rusbult & Buunk, 1993; Stanley, Markman, & Whitton, 2002). This concept also includes remaining with one's partner over time and believing that the relationship promotes the well-being of both parties (Rusbult, 1983).

Clausell, Goldberg, Kuvalanka, and Oswald (2008), found that commitment may be divided into three aspects: personal, structural, and moral commitment. Clausell et al. (2008) defined personal commitment as the desire individuals have to be in their relationship, whereas structural commitment referred to external factors such as finances that prohibited an individual from leaving the relationship. Moral commitment, on the

other hand, “refers to the sense that one ‘should’ be in a given relationship and was highly correlated with religiosity for both husbands and wives” (p. 412). The authors only addressed the ideas of structural and moral commitment to a relationship in their research. The study surveyed 190 lesbian, gay, bisexual, and transgender individuals across Illinois. Participants were asked questions regarding their demographic characteristics in addition to close-ended questions and four open-ended questions. The questions included queries about their partner, friend relationships, religious beliefs, and workplace, as well as questions like, “What is the best thing about your life?” In order to measure commitment, “structural commitment was operationalized as the execution of legal documents, and moral commitment was operationalized as having a commitment ceremony” (p. 411). One of the important findings from the study that can be applied to the current investigation is the link that was established between moral commitment and religiosity.

Relationship Satisfaction

The concept of marital satisfaction has been studied by many researchers over the decades (Anthony, 1993; Boden, Fischer & Niehuis, 2009; Bradburn & Orden, 1968; Burgess & Cottrell, 1939; Hamilton, 1929; Locke & Williamson, 1958; Rusbult, 1986; Spanier, 1976; Terman, 1938). Thus, due to the plethora of research that has examined marital satisfaction, “descriptive phrases such as 'marital happiness,' 'marital stability,' 'marital cohesiveness,' and 'dyadic adjustment,' are used almost interchangeably throughout the literature” (Anthony, 1993, p. 98). Even though these terms are sometimes used with no specified distinction, the measurements used to assess them are actually examining the quality of marriage and similar dyads (Spanier, 1976). However, marital

satisfaction is considered a component of the broader term of marital adjustment, which refers to the characteristics of a relationship that promote a congruous and well-functioning marriage (Boden, Fischer, & Niehuis, 2009). "Typically, an adjusted marital relationship has been defined as one in which partners agree on important issues, have few conflicts and resolve them when they occur, communicate effectively with one another, feel satisfied with the marriage and with each other, share common interests, and engage in the same activities" (Boden, Fischer, & Niehuis, 2009, p. 123). However, marital satisfaction is a component of this concept, and it refers specifically to the attitudes and feelings that the individuals in a marriage have toward each other (Boden, Fischer, & Niehuis, 2009; Sabatelli, 1988; Spanier, 1976). For the purposes of this study, the term relationship satisfaction was used to include marital satisfaction but also encompasses all other couple relationships. As previously noted, religiosity has been linked to relationship satisfaction as well as commitment. In fact, a variety of studies emphasize the significance of religion in strengthening emotional intimacy, which has been associated with increased marital satisfaction and stability (Call & Heaton, 1997; Robinson, 1994; White & Booth, 1991).

Anthony (1993) conducted a research study in order to identify the relationship between religious orientation and marital satisfaction. The participants included 400 married couples from four major Protestant denominations. In order to measure marital satisfaction, couples were given the Dyadic Adjustment Scale (DAS; Spanier, 1976), a widely used measure of marital satisfaction, to complete. The couple's religious orientation was determined using the Religious Orientation Scale (ROS) developed by Allport and Ross (1967). One of the levels of religious orientation it measures is the level

of intrinsic orientation, defined as the degree of "subordination of one's religious practices and beliefs to the satisfaction of personal needs and motives" (p. 104). The study found that those individuals with a high level of intrinsic religious orientation, meaning that they lived according to their faith, scored the highest in marital satisfaction.

Variables for the Present Study

The independent variable in this study was the individual's degree of religiosity. The individual's level of commitment to their couple relationship was examined to determine if it was a mediating variable between religiosity and initial level of relationship satisfaction at the time when the couple enters therapy. Relationship commitment was also explored as a possible mediator between religiosity and the success of therapy as measured by the magnitude of improvement in relationship satisfaction at the conclusion of therapy. In the current study, the degree of religiosity was defined as the degree of importance that an individual places on their chosen religion in combination with their level of participation in organized activities of a church or religious group. This was assessed by each partner's self-reported rating of each topic; i.e., the combined sum of how often they participate in religious activities, and how important their religion or spirituality is to them.

The mediating variable was the individual's level of commitment to their relationship. Commitment level was also examined as a possible mediator between the amount of religiosity and the level of marital satisfaction, both at the onset of therapy and in the degree of improvement in levels of marital satisfaction after the termination of therapy. Commitment level within a relationship was defined as a psychological and emotional state that is representative of a decision to develop and continue a long-term

attachment to another person. Commitment level was assessed using the Marital Status Inventory-Revised (MSI-R; Epstein & Werlinich, 2001).

The dependent variables that were measured and examined during this study were (a) the initial relationship satisfaction level that members of couples report when they begin couple therapy and (b) success of therapy, as measured by an increase in relationship satisfaction after the conclusion of therapy. Relationship satisfaction is defined in this study as a general feeling of having one's needs and wants met within a close relationship as measured by the individuals' initial scores on the Dyadic Adjustment Scale (DAS; Spanier, 1976) during their pre-therapy assessment. A comparison of the individuals' DAS scores before therapy to their scores immediately following therapy was used to assess the success of therapy. Therapeutic success was defined within the study as a favorable or desired outcome within the therapeutic process and was measured as an increase in DAS scores.

Table 1: Summary of Variables and Instruments Used to Measure Them

	Variables	Measures
Independent	Religiosity	Couple Information and Instructions (Combined Score of Questions #22 & #23) 2= lowest possible religiosity 12= highest possible religiosity
Mediator	Intimate Partner Commitment Level	MSI-R (total score) 0= very committed to the relationship 18= not very committed to the relationship
Dependent	Relationship Satisfaction (Pre)	DAS (item #31) 0= extremely unhappy 6= perfect
	Therapy Outcome	DAS (#31 Post – #31 Pre) 6= largest possible improvement in relationship satisfaction over therapy -6= largest possible decrease in relationship satisfaction over therapy

Hypotheses

Based on the research cited in the preceding review, in this study there were four hypotheses:

Hypothesis 1

An individual's religiosity will be positively associated with their level of relationship satisfaction. The higher an individual's religiosity, the higher their relationship satisfaction will be. This association was measured separately for both male and female partners.

Hypothesis 2

Intimate partner commitment level will mediate the relationship between religiosity and relationship satisfaction. When religiosity is high, the level of intimate partner commitment will be high, which will in turn be associated with higher satisfaction with the relationship. This association was measured separately for both male and female partners.

Hypothesis 3

Individual religiosity will predict a successful therapeutic outcome, as measured by an increase in the level of relationship satisfaction from the beginning of therapy to the termination of therapy. This association was measured separately for both male and female partners.

Hypothesis 4

Intimate partner commitment will mediate the relationship between religiosity and degree of therapeutic success. A higher degree of religiosity as mediated by commitment level will be associated with a greater increase in relationship satisfaction

from pre- to post-therapy. This association was measured separately for both male and female partners.

Research Question

In addition to the above hypotheses, a research question was also explored.

1. Are there gender differences in the relationships between religiosity, commitment level and relationship satisfaction between male and female partners who receive couple therapy, with regard to:
    a. The relation between religiosity and relationship satisfaction when entering therapy?
    b. The association between religiosity, commitment level, and relationship satisfaction when entering therapy?
    c. The relation between religiosity and therapy outcome?
    d. The relation between religiosity, commitment level, and therapy outcome?

Chapter III: Methodology

Sample

Data for this study were taken from a research project on treatment for abusive behavior in couple relationships, called the Couple's Abuse Prevention Program (CAPP). It uses the assessments of couples who qualified to be a part of that study. In order to be included, participants must have met the following criteria: 1) they were each 18 years or older, 2) neither partner had a alcohol or substance abuse problem that was not being treated, 3) one or both of the partners reported mild / moderate levels of verbal, psychological, or physical abuse and 4) each of the partners felt safe to complete therapy with the other. Information on the qualification process is outlined in the following section.

The current study utilized data that were collected from a diverse sample of 53 heterosexual couples who voluntarily sought therapy from 2000 to 2008 at the Center of Healthy Families, an outpatient clinic at the University of Maryland. Couples were not excluded due to marital status, and thus may have been cohabitating, married, dating but not living together, or separated. The included participants sought help from the clinic for a variety of relational problems, and they came from an ethnically diverse community surrounding the University of Maryland, College Park campus. Of the included female subjects, 54.7% were White, 20.8% were African American, 13.2% were Hispanic, and 11.4% were of other races. The males included 66% White males, 18.9% African American males, and 15.2% were of other races. Respondents included in this study completed a set of assessment forms before beginning therapy and at the conclusion of 10 double sessions of therapy.

Although all participants in this study were part of a dyad seeking couple therapy, their scores were analyzed as individuals. Table 2 includes a summary of the demographic characteristics of the sample.

Table 2: Demographic Characteristics of the Sample

Variables	Females *n*=53		Males *n*=53	
Age of partner (mean and standard deviation)	$\bar{X}$	*SD*	$\bar{X}$	*SD*
	31.64	7.74	33.30	7.43
Average length of relationship (mean and standard deviation)	$\bar{X}$	*SD*	$\bar{X}$	*SD*
	6.13	4.69	6.07	4.71
Average number of children who live in the home (mean and standard deviation)	$\bar{X}$	*SD*	$\bar{X}$	*SD*
	1.17	1.16	1.06	1.51
	n	%	*n*	%
No children living in the home	21	39.6%	24	45.3%
Average yearly gross income (mean and standard deviation)	$\bar{X}$	*SD*	$\bar{X}$	*SD*
	26,808	25,481	45,750	26,441
	n	%	*n*	%
Unemployed	10	18.9%	1	1.9%
Relationship status	*n*	%	*n*	%
Currently married, living together	30	56.6%	30	56.6%
Currently married, separated, but not legally divorced	2	3.8%	2	3.8%
Dating, living together	14	26.4%	14	26.4%
Dating, not living together	6	11.3%	7	13.2%
Domestic partnership	1	1.9 %	0	0%
Race	*n*	%	*n*	%
Native American	0	0%	1	1.9%
African American	11	20.8%	10	18.9%
Asian/Pacific Islander	2	3.8%	0	0%
Hispanic	7	13.2%	3	5.7%
White	29	54.7%	35	66%
Other	3	5.7%	3	5.7%
N/A	1	1.9%	1	1.9%

Variables	Females *n*=53		Males *n*=53	
Religious affiliation	*n*	*%*	*n*	*%*
Mainline protestant	12	22.6%	7	13.2%
Conservative protestant	8	15.1%	10	18.9 %
Roman Catholic	6	11.3%	11	20.8%
Jewish	5	9.4%	4	7.5%
Other (Buddist, Mormon, Hindu)	5	9.4%	2	3.8%
No affiliation with any formal religion)	17	32.1%	19	35.8%

Procedure

The data for this study were collected from couples who voluntarily sought therapy, and were part of a larger study on abuse treatment and prevention for couples. These couples were seen for 10 double therapy sessions and completed both pre- and post- assessment measures. The study, Couples' Abuse Prevention Program (CAPP), was designated for couples who exhibited mild to moderate violence in their relationship with the goal of preventing further violence (e.g. threatened to hit the other person, drove recklessly to frighten the other person, threw smashed, hit or kicked something in front of the person).

Therapy was initiated when couples voluntarily sought therapy and called the Center for Healthy Families requesting services. One member of each couple completed a 10-15 minute intake interview over the phone with an intake worker. The intake process includes gathering demographic information, as well as questioning about the reasons for seeking therapy and any precipitating events that may have prompted the call.

Couples are then assigned to two therapist interns who conduct an assessment session with them. During the couple's first assessment session, the partners were instructed on clinic procedures. The therapist interns then asked them a few questions to

get to know them before presenting them with a battery of assessment forms. The couple was asked to complete the forms in separate rooms to insure confidentiality and safety.

The day-one assessments explore a broad range of symptoms, beliefs, and feelings about their couple relationship and about themselves individually. The measures included 14 self-report questionnaires and an interview procedure that takes two or more hours to complete. Some of the measures included an information sheet, the Dyadic Adjustment Scale, the Marital Status Inventory-Revised (used in this study) and eleven other questionnaires. The clients were encouraged to respond genuinely and openly to all items presented. They were also informed that their answers would remain confidential, and code numbers were used in place of names on all the forms except the information sheet. The information provided on these forms was then used by the therapist interns to gain background information about the clients which can also be used for research.

The couples who participated in the CAPP study qualified for the treatment study based on their responses to specific assessments. To qualify for the study, psychologically or physically abusive behaviors must have occurred within four months of the initiation of therapy. However, if the level of abuse was high enough to cause physical injury requiring medical attention, couples were excluded from the study and were not permitted to participate in conjoint therapy for their own safety. When couples qualified for the study, the therapist gave them a description of the study and provided them with the option of participating. The couple then made the decision to participate or not. Couples who chose not to participate, and those who did not meet the inclusion criteria were still provided with treatment at the clinic, although members of couples in which injury had occurred were treated individually.

Couples received therapy for 10 ninety-minute sessions. They were then asked to fill out a battery of closing assessment forms. During the closing assessment session, clients were asked to complete the 14 questionnaires again, and were placed in separate rooms. The closing assessment measures included some of the original assessments, which were given to the clients in their opening assessment session. Therapy was not terminated until couples finished their initial and closing assessments, as well as all ten sessions.

As previously stated, this study was a secondary analysis of data that were collected prior to their use in this study. The data were accessed from a file that was located on a secure server at the Center for Healthy Families. Within this data file, names and all other identifying information have been removed. The cases have been given letter codes in order to protect client confidentiality. Approval for this study was given by the Institutional Review Board of The University of Maryland (see Appendix D).

Measures

Couples Information and Instructions. The Couples Information and Instructions (CII) form (Epstein & Werlinich, 2000) is a self-report measure used exclusively by the Center for Healthy Families at the University of Maryland. This form is a 38-item self report inventory designed to collect demographic information as well as information regarding medications, legal actions, and the purpose for which the couple entered therapy (see Appendix A).

Two questions on the CII concerning religiosity were used in the current study. Question number 22 asks, "How often do you participate in organized activities of a church or religious group?" Participants can respond on a 7 item scale, which was reverse

scored to range from 7, meaning several times per week, 6, signifying once a week, 5, being several times a month, 4, was once a month, 3, represented several times a year, 2, signifying once or twice a year, or 1, meaning rarely or never. The second question used in this study was item number 23 that asked, "How important is religion or spirituality to you in your daily life?" Clients responded on a five item Likert scale from 1. Very important, 2. Important, 3. Somewhat important, 4. Not very important, or 5. Not important at all. The second question was reverse scored, and the combined responses of couples to these two items determined their religiosity for the purposes of this study. A higher score indicated higher religiosity and a lower score indicated lower religiosity, with a possible score range of 1 to 12.

Marital Status Inventory-Revised. The Marital Status Inventory-Revised (MSI-R; Epstein & Werlinich, 2001) was used to measure the level of intimate partner commitment an individual has to their couple relationship. The original Marital Status Inventory was used as a measure of an individual's thoughts and actions taken to leave the marital partner (MSI; Cerreto & Weiss, 1980). Responses to the 14-item measure can either be "true" or "false." Statements describe the individual's level of disengagement from the couple relationship. One example is question number 3, which states: Thought specifically about separation, for example how to divide belongings, where to live, or who would get the children (MSI-R; Epstein & Werlinich, 2001). The MSI total score ranges from 0 to 14, with a score of 1 being calculated for every true answer and 0 for every answer marked false. The higher the score, the less commitment there is to the relationship. Research has shown the MSI to be both reliable and valid (Armstrong, Crane, & Newfield, 1984). Armstrong et al. (1984) calculated the Spearman-Brown split-

half reliability to be .87. Crane and Whiting (2003) found that this measure has high concurrent and discriminant validity.

The MSI-R (Epstein & Werlinich, 2001) that was used in this study is an 18-item revision of the original Marital Status Inventory. The revision was done to expand the instrument to include couples who were not married and it added four additional items. It was used for this study because the couples included in this study's sample were not selected according to marital status; they may have been cohabitating, dating, married, or separated. The MSI-R (Epstein & Werlinich, 2001) refers to an individual's partner instead of a spouse; e.g., one of the items states, "Had frequent thoughts about separating from your partner, as much as once a week or so" (MSI-R; Epstein & Werlinich, 2001).

Dyadic Adjustment Scale. To assess marital satisfaction in this study question number 31 on the Dyadic Adjustment Scale was used (DAS; Spanier, 1976). It states "The dots on the following line represent different degrees of happiness in your relationship. The middle point, 'happy,' represents the degree of happiness of most relationships. Please circle the dot which best describes the degree of happiness, all things considered, of your relationship" (DAS; Spanier, 1976). The answers range from extremely unhappy to perfect (see Appendix C).

The DAS is a 32-item measure that is widely used to assess the quality of marriage. However, the scale is "used for either married or unmarried cohabitating couples" (Spanier, 1976, p. 15). Scores can vary from 0 – 151 (Hansson & Lundblad, 2005). The scale has specifically been found to have high criterion-related validity, content validity, and construct validity. It has also demonstrated a high total scale reliability of .96 (Spanier, 1976).

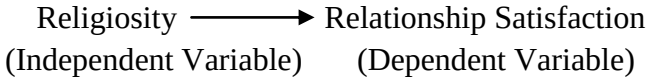
Item 31 asks the individual to rate on a scale how happy or unhappy they are in their relationship. Answers can range from 0, meaning extremely unhappy, to 7, meaning perfect. Question number 31 was used in this study in order to avoid any overlap with the questions on the MSI-R. The MSI-R measures commitment level, and many of its questions coincide with some of the items on the DAS. An example of this overlap would be item number 16 on the DAS, which states, "How often do you discuss or have you considered divorce, separation or terminating your relationship?" (DAS; Spanier, 1976). Therefore, the single direct question asking respondents to circle their degree of happiness in their relationship was used in this study.

Chapter IV: Results

The present study tested four hypotheses:

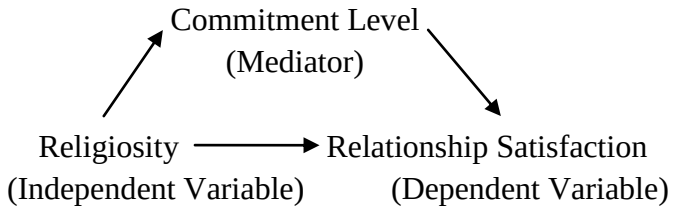
Hypothesis One: An individual's religiosity, at the beginning of therapy, will be positively associated with their level of relationship satisfaction. The higher an individual's religiosity, the higher their relationship satisfaction is expected to be.

Figure 2: Hypothesis 1



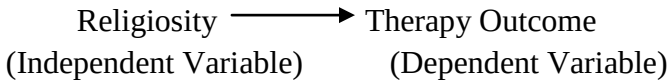
Hypothesis Two: Intimate partner commitment level mediates the relationship between religiosity and relationship satisfaction. When religiosity is high, the level of intimate partner commitment will be high, which will in turn be associated with higher satisfaction with the relationship.

Figure 3: Hypothesis 2



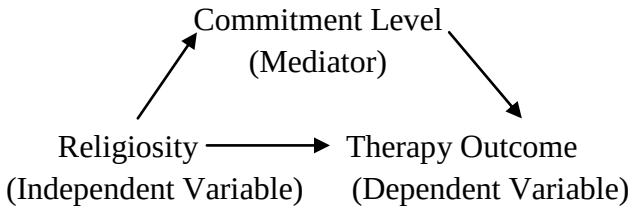
Hypothesis Three: Individual religiosity will predict a successful therapeutic outcome, as measured by an increase in the level of relationship satisfaction from the beginning of therapy to the termination of therapy.

Figure 4: Hypothesis 3



Hypothesis Four: Intimate partner commitment mediates the relationship between religiosity and the therapy outcome. A higher degree of religiosity as mediated by commitment level will be associated with a more significant positive difference between the post and pre relationship satisfaction scores.

Figure 5: Hypothesis 4



Overview of the Analyses

In order to acquire an overview of the present sample's levels of religiosity, commitment, relationship satisfaction, and therapy outcome, the means and standard deviations were calculated for their religiosity scores (combined religious participation and religious importance scores), their MSI-R scores (assessing the level of commitment to the relationship), their relationship satisfaction (as measured by the DAS #31), their therapy outcome scores (as measured by post DAS #31 minus pre DAS #31 scores) and their overall relationship satisfaction at the beginning of therapy (as calculated by their total pre-DAS scores). To calculate these scores, the religiosity score was measured by reverse scoring items number 23 and 24 on the CII (examining religious participation and importance) and then combining the two scores for each individual. The scores were reverse scored in order to clarify that the higher the score, the higher the level of religiosity. Therapy outcome was also calculated before any analysis could be performed, by subtracting the pre DAS #31 scores from the post DAS #31 scores.

Next, each hypothesis was tested using either a Pearson Product Moment Correlation or a partial correlation, conducted separately for males and females. Pearson's correlations determine the degree to which two variables are associated. In each of the correlations performed, religiosity was considered to be the independent variable. Commitment level was the mediating variable in two of the partial correlations, and the dependent variable in all correlations was either relationship satisfaction or therapy outcome.

Each correlation was run twice, once for each gender. This was to account for the research question that asked whether there were gender differences between males and females with regard to the relationships between variables that this study examined. It should be taken into consideration that all of the analyses performed were correlations, and therefore a causal relationship cannot be determined. The degrees of association are discovered, but any conclusions drawn with regard to causality must be purely speculative.

The Sample's Scores on the Measures

Table 3 presents the means and standard deviations comparing females' and males' results on the measures used in this study. A t-test was performed in order to determine the difference between men and women's relationship satisfaction scores. It was found that women reported significantly less satisfaction in their relationships than males ($t(103)=2.68$, $p=.008$). The findings were consistent with prior research indicating that males tend to report a greater level of relationship satisfaction than females (Bernard 1972; Fowers 1991; Gove & Tudor 1973; Mickelson, Claffey, & Williams, 2006; Shek &

Tsang 1993; Xu & Lai, 2004). A t-test also showed that there was a trend toward women reporting higher religiosity than men ($t(103)=1.72$, $p=.088$).

Table 3: Means and Standard Deviations for the Sample's Scores on the Measures

Source	***N***	**Mean**	**Standard Deviation**
Religiosity (combined total of reverse scores on CII #23 and #24; range 0 to 12)			
Females	53	6.42	2.96
Males	52	5.46	2.70
Religious Participation (CII #23)			
Females	53	5.19	2.12
Males	53	5.75	1.87
Importance of Religion (CII #24)			
Females	53	2.40	1.23
Males	52	2.81	1.39
MSI-R (total score; range 0 to 18)			
Females	50	6.52	3.99
Males	52	5.10	4.06
Relationship Satisfaction (DAS #31 Pre; range 0 to 7)			
Females	53	1.72	1.35
Males	53	2.47	1.54
Therapy Outcome (DAS #31 Post – DAS #31 Pre) - *Change in Relationship Satisfaction*			
Females	51	1.08	1.52
Males	48	1.10	1.55

Note: CII= Couples Information and Instructions, MSI-R= Marital Status Inventory-Revised, and DAS= Dyadic Adjustment Scale.

Tests of Hypotheses

Pearson correlations and partial correlations were used to test the hypotheses of the present study. One tailed tests were performed because of the directional nature of the hypotheses. The results of the analyses are presented below, in the order they were performed, by hypothesis.

Analysis for Hypothesis 1

An individual's religiosity, at the beginning of therapy, will be positively associated with their level of relationship satisfaction. The higher an individual's religiosity, the higher their relationship satisfaction.

A Pearson Product Moment Correlation was conducted to test hypothesis 1. In this analysis, the independent variable was religiosity, which varied in scores from 2-12. It combined the individual's participation in organized activities of a church or religious group (ranging from rarely or never, 1, to several times per week, 7), and the importance that the individual placed on religion or spirituality in their daily life (not important at all, 1, to very important, 5). The dependent variable was relationship satisfaction (from extremely unhappy, 0, to perfect, 6).

The results were calculated for female partners of a dyad and male partners of a dyad separately. For females, the hypothesis was not supported, in that the correlation between their religiosity and relationship satisfaction at the beginning of therapy was -.03 (p=.41, 1 tailed). For males, on the other hand, the results indicate a non-significant trend for their religiosity to be positively associated with their relationship satisfaction at the initiation of therapy (r=.19, p=.09, 1 tailed). Thus, there was a trend toward support for this hypothesis among males, but not among females.

Analysis for Hypothesis 2

Intimate partner commitment level mediates the relationship between religiosity and relationship satisfaction. When religiosity is high, the level of intimate partner commitment will be high, which will in turn be associated with higher satisfaction with the relationship.

In order to analyze the second hypothesis, a partial correlation was performed. In this analysis the independent variable was religiosity and the dependent variable was relationship satisfaction at the beginning of therapy. The variable that was hypothesized to be a mediator was commitment level, which was measured by the total score of the Marital Status Inventory-Revised (MSI-R; Epstein & Werlinich, 2001). Scores on the MSI-R could have ranged from 0-18.

To examine hypothesis two, the test for mediation as outlined by Baron and Kenny (1986) was used. First, an initial regression of the mediator, commitment level, on the independent variable, religiosity, was performed for both females and males. For females, the results showed a non-significant trend for their religiosity to be negatively associated with their MSI-R scores (r = -.22, p = .06, 1 tailed). This signified that there was a trend for more religious females to have taken fewer steps to leave the relationship, and thus be more committed to it, which indicated a positive trend between the association of religiosity and commitment level, as hypothesized. For males, the results indicated that there was no association between religiosity and commitment level (r = -.02, p = .43, 1 tailed).

Secondly, a regression of the mediator, commitment level, on the dependent variable, relationship satisfaction, was performed for each gender. The results indicated a

strong negative correlation for females between MSI-R scores and their relationship satisfaction level (r = -.58, p < 0.001, 1 tailed). When the regression was performed for males, similar results were found (r = -.65, p < 0.001, 1 tailed). These results signify, for both males and females, that there is a positive association between commitment level and relationship satisfaction.

The last step in Baron and Kenny's (1986) test for mediation is a regression of the dependent variable on the independent and mediating variables, comparing it to the Pearson's correlation initially found between religiosity and relationship satisfaction. The partial correlation between religiosity and relationship satisfaction, controlling for commitment level, was completed. For females, it was found that there was a non-significant trend towards a negative association between religiosity and relationship satisfaction when commitment level was controlled for (r = -.19, p = .10, 1 tailed). For men, the results indicated an increase from the non-significant trend toward a positive association between religiosity and relationship satisfaction initially found with the Pearson correlation when commitment level was controlled for (r = .24, p = .045, 1 tailed). Thus, instead of attenuating the association between religiosity and relationship satisfaction for men, controlling for commitment actually enhanced it.

In order for the proposed mediator to truly be a mediating factor, Baron and Kenny (1986) stated that certain conditions must be met. First, the independent variable (religiosity) must be shown to be associated with the mediator (commitment level) in the first regression; second, the independent variable (religiosity) must affect the dependent variable (relationship satisfaction) in the second step; and third, the dependent variable (relationship satisfaction) must be affected by the mediator (commitment level) in the

third regression (Baron & Kenny, 1986). Only when all of these conditions are met will the test for mediation support that the proposed mediator is an actual mediator. Since the results did not indicate the fulfillment of these requirements, the second hypothesis was not supported.

Analysis for Hypothesis 3

Individual religiosity will predict a successful therapeutic outcome, as measured by an increase in the level of relationship satisfaction from the beginning of therapy to the termination of therapy.

A Pearson Product Moment Correlation was conducted to test hypothesis 3. In this analysis, the independent variable was religiosity, which varied in scores from 2-12 and was a combination of the individual's participation in organized activities of a church or religious group and the importance that the individual placed on religion or spirituality in their daily life. The dependent variable was therapy outcome (Post DAS #31 - Pre DAS #31), which measure the change in relationship satisfaction after therapy.

The results for this hypothesis were calculated for female partners and male partners who had completed couple therapy. For females, the hypothesis was not supported, in that the correlation between their religiosity and therapy outcome was -.03 (p=.43, 1 tailed). For males, the results also did not support the hypothesis, in that they indicated a correlation of -.08 (p = .30, 1 tailed). Thus, the third hypothesis was not supported.

Analysis for Hypothesis 4

Intimate partner commitment mediates the relationship between religiosity and the therapy outcome. A higher degree of religiosity as mediated by commitment level, will be

associated with a more significant positive difference between the post and pre relationship satisfaction scores.

The analysis for the fourth hypothesis was not necessary considering that there was no significant relationship between religiosity and therapy outcome (as discovered in the analysis for Hypothesis 3). Therefore, there was not relationship to be mediated. However, for exploratory purposes, the analysis was performed for Hypothesis 4. This analysis was similar to the analysis performed for the second hypothesis. The test for mediation of commitment level on religiosity and therapy outcome was executed. In this analysis the independent variable was religiosity and the dependent variable was therapy outcome.

In order to examine this hypothesis, the test for mediation, as outlined by Baron and Kenny (1986), was used. The initial regression of the mediator, commitment level, on the independent variable, religiosity, was performed for both females and males under hypothesis 2. As previously stated, for females, the results showed a non-significant trend for their religiosity to be negatively associated with their MSI-R scores (r = -.22, p = .06, 1 tailed). This signified that there was a trend for more religious females to have taken fewer steps to leave the relationship, and thus be more committed to it, which indicated a positive trend between the association of religiosity and commitment level. For males, the results indicated that there was no association between religiosity and commitment level (r = -.02, p = .43, 1 tailed).

Secondly, a regression of the mediator, commitment level, on the dependent variable, therapy outcome, was performed for each gender. The results indicated no correlation for females between MSI-R scores and their therapy outcome (r = .02, p = 45,

1 tailed). When the regression was performed for males, results indicated a non-significant trend toward a positive association between MSI-R scores and therapy outcome (r = .21, p = .08, 1 tailed). These results signify that there was a trend for males who had taken more steps to leave the relationship and thus be less committed to it, to have a more successful therapy outcome. Thus the trend indicates that there is a negative association between commitment level and therapy outcome for males.

A regression of the dependent variable on the independent and mediating variables is the last step in Baron and Kenny's (1986) test for mediation. This was accomplished by using the Pearson's correlation performed in the test of hypothesis 3 in comparison to the results of a partial correlation between religiosity and relationship satisfaction, controlling for commitment level. The results indicated no association between religiosity and therapy outcome for both females (r = .01, p = .49, 1 tailed) and males (r = -.08, p = .30, 1 tailed).

The aforementioned requirements, as provided by Baron and Kenny (1986), were not fulfilled according to the results. The independent variable was not proven to affect the mediator in the first regression. Secondly, the independent variable did not affect the dependent variable for females in the second step; and lastly, the dependent variable was not affected by the mediator for either females or males. Therefore, the fourth hypothesis was not supported.

Analysis of Research Question

The research question which was examined during this study was: Are there gender differences in the relationships between religiosity, commitment level, and

relationship satisfaction between male and female partners who receive couple therapy? Especially with regards to:

a. The relation between religiosity and relationship satisfaction when entering therapy;

    As stated earlier, the Pearson's correlations between religiosity and relationship satisfaction at the initiation of therapy differed slightly for females and males, however there were no significant differences. There was no correlation for females, as r = -.03 (p=.41, 1 tailed). For males, on the other hand, there was a non-significant trend for their religiosity to be positively associated with their relationship satisfaction at the initiation of therapy (r = .19, p=.09, 1 tailed). Neither of these results was significant, and thus no gender differences were found.

b. The association between religiosity, commitment level, and relationship satisfaction when entering therapy;

    As previously noted, although commitment was not found to be a mediator for religiosity and relationship satisfaction for either gender, there was a gender difference found through the course of the analysis. When examining the relationship between religiosity and MSI-R scores, there was no association for males (r = -.02, p = .43, 1 tailed) and a trend was found for females. For females, the results showed a non-significant trend for their religiosity to be negatively associated with their MSI-R scores (r = -.22, p = .06, 1

tailed). There was no difference for men (r = -.65, p <0.001, 1 tailed) and women (r = -.58, p <0.001, 1 tailed) in their correlations between their MSI-R scores and their relationship satisfaction. A test was performed to analyze the difference between these two correlation coefficients and it was found that any difference was not significant and therefore, there was no difference between men and women in the analysis of the correlation between MSI-R scores and relationship satisfaction (z=0.55, p=.58, 2 tailed). Lastly, some differences were found in the partial correlations performed for males and females. For females, it was found that there was a non-significant trend towards a negative association between religiosity and relationship satisfaction when commitment level was controlled for (r = -.19, p = .10, 1 tailed). Whereas for men, the results indicated an increase in the non-significant trend toward a positive association between religiosity and relationship satisfaction when commitment level was controlled for (r = .24, p = .045, 1 tailed). Gender differences found when examining the associations between religiosity, commitment level, and relationship outcome in the analysis of religiosity and relationship satisfaction when commitment level was controlled for. The analysis of the difference between men and women was found to be significant (z=2.14, p=.03). Therefore, one gender difference was found.

c. The relation between religiosity and therapy outcome;

As previously stated, the Pearson's correlations for religiosity and therapy outcome were -.03 and -.08 respectively. Thus, there were no significant gender differences in the relation between religiosity and therapy outcome.

d. The relation between religiosity, commitment level, and therapy outcome?

As noted earlier, commitment level was not found to be a mediator between religiosity and therapy outcome for males or females. The results did not indicate a correlation for females between their MSI-R scores and their therapy outcome (r = .02, p = 45, 1 tailed), but they indicated for men that there was a non-significant trend toward a positive association between MSI-R scores and therapy outcome (r = .21, p = .08, 1 tailed). However, there were no significant gender differences found between MSI-R scores and therapy outcome scores.

Chapter V: Discussion

Findings

The purpose of this study was to examine the degrees to which the religiosity of individuals who were part of a dyad was related to their intimate partner commitment level, their relationship satisfaction at the beginning of therapy, and their therapy outcome, as measured by the change in their perception of relationship satisfaction after completing couple therapy. The results of the study indicated that there were some associations between the variables. More specifically, intimate partner commitment level was found to be strongly associated with relationship satisfaction. Other trends were found that differed by gender. The results indicated that there was a non-significant trend for men's religiosity to be positively associated with their relationship satisfaction at the initiation of therapy. For more religious females, a positive trend was found to suggest that they had taken fewer steps toward ending the relationship, and thus were more committed to their relationship. In contrast, men were not found to have any correlation between their religiosity level and their commitment level. However, when the relationship between religiosity and relationship satisfaction was explored controlling for commitment level, it was found that for women, there was a trend signifying that the more religious they were, the less satisfied they felt with their relationship. Men, on the other hand, were the opposite. The trend which was found indicated that the more religious the men were the more satisfied with their relationship they were at the beginning of therapy. Further results did not find any association between religiosity and therapy outcome for males or females. When examining the association between intimate partner commitment level and therapy outcome, the results indicated that there was no

correlation for women; however, for men, a trend was found indicating that the less committed a man was the greater the increase in his perceived relationship satisfaction from the beginning of therapy to the end of therapy.

Consistency of the Findings with the Hypotheses and Research Literature

There was a statistical trend toward support for the hypothesis that an individual's religiosity would be positively associated with their level of relationship satisfaction at the initiation of therapy for males. However, there was no such support for females. The trend for men to have a positive association between religiosity and relationship satisfaction is consistent with the literature that has found that those individuals who attend more religious activities have a higher level of relationship satisfaction (Arnett & Scanzoni, 1987; Call & Heaton, 1997; Curtis & Ellison, 2002; Glenn, 1982). This prior research specifically denotes that religiosity is highly correlated with religious participation. The limited support for the association between men's religiosity and relationship satisfaction may be due to the inclusion of the importance they placed on their religion and spirituality, instead of a score based entirely on participation. This may have diluted the strength of the results, leading to weaker support for this association. However, one speculation about why there was a trend found for men and not for women may indicate the different roles for men and women within religions. Men are more likely to be placed in leadership positions within religious organizations, and this sense of power may enable them to feel more satisfied with their life overall. Religion may give the man a leadership role in the family as well, which may carry this sense of power to his relationship. This power may also provide the man with a sense of satisfaction in that relationship.

Furthermore, for both genders the results may have been limited due to the nature of the inclusion and exclusion criteria for this study. Since the sample was composed of couples who were seeking couple therapy, this may have resulted in a sample of more significantly unhappy individuals than were included in previous research. Also, in order to be included in this study, couples needed to have experienced some mild to moderate levels of psychological or physical abuse within four months of entering therapy. This level of abuse may have skewed the results and affected all aspects of the findings, especially with regard to females. Women are more likely to be the recipients of abuse and thus their unhappiness in their relationships might be enlarged due to the inclusion of abuse in this sample. For future studies, it might be important to utilize a larger sample size of all couples seeking therapy, not exclusively those who had experienced some type of abuse.

Another factor that might account for the findings with regard to this hypothesis is that only one question on the DAS was used to indicate relationship satisfaction. The question used specifically targets how the individual felt about their relationship, answers ranging from extremely unhappy to extremely happy to perfect. Although this was a straightforward measure of how satisfied the individual felt in their relationship, a more comprehensive measure showing the many aspects of relationship satisfaction might be helpful in future research.

The results did not support the second hypothesis, which stated that intimate partner commitment level mediates the relationship between religiosity and relationship satisfaction. Since an association between religiosity and relationship satisfaction was not found for females, then commitment level could not have been found to be a mediator for

women. However, when the association between religiosity and commitment level was examined, it was found that there was a trend for more religious females to be more committed to their relationship and have taken fewer steps to leave than less religious females. Males' results did not indicate any association between religiosity and commitment level.

The findings for females were in accordance with the literature (Call and Heaton, 1997; Clausell, Goldberg, Kuvalanka, and Oswald, 2008), which stated that there was a positive association between religiosity and commitment level. However, it is unusual that the association was not very strong and that there was none for men. There may be several factors contributing to these findings. One reason may be directly related to the source of the participants who were included in this sample, namely that these were couples seeking therapy. The literature includes a broader population, whereas this study focuses on a clinical one which could influence the findings. For instance, literature has found that people, in general, tend to have an attitude that problems can be resolved without the assistance of a counselor (Trump & Hugo, 2006; Adair et al., 2007). Thus, it is possible that some individuals are using couple therapy as a last effort and have already taken many steps to leave their relationship, thus demonstrating a decrease in commitment level.

For both men and women, the results indicated a positive correlation between intimate partner commitment level and relationship satisfaction. The literature is consistent with this finding, and it has found a strong positive correlation between intimate partner commitment level and relationship satisfaction (Johnson, Morrow &

Rusbult, 1986; Rusbult, 1983; Rusbult & Buunk, 1993; Sprecher, Metts, Burleson, Hatfield, & Thompson, 1995). Therefore, this finding was not surprising in any way.

Another interesting finding for females was the discovery of a non-significant trend towards a negative association between religiosity and relationship satisfaction when commitment level was controlled for. Thus, when intimate partner commitment level was kept constant and not impacting religiosity and relationship satisfaction, a relationship trend was shown. According to the findings, there is a trend for the more religious females to be more unsatisfied with their relationships. There are a number of possible explanations for this finding. For example, women who are very religious may enter into a relationship having high expectations for that relationship. When the relationship fails to meet all of the expectations, the women may feel disillusioned and thus be unhappy in the relationship. Another factor could be the sample that was included in the study. Those participants in the study had experienced some mild to moderate psychological or physical abuse. As women are often the victims of abuse, this might account for the women's greater dissatisfaction with their relationship despite their religiosity.

In the process of examining the second hypothesis, an additional result for males was found indicating an increase in the non-significant trend toward a positive association between religiosity and relationship satisfaction when commitment level was controlled. This finding suggests that instead of commitment level being a mediator, it detracted from the association between religiosity and relationship satisfaction. Therefore, when the effect of commitment level was not allowed to affect the association between a man's religiosity and his relationship satisfaction, it became stronger. Thus,

when males are more religious, they are more likely to be more satisfied in their relationship; however, the source of this occurrence was not commitment level in this sample. There may be another variable accounting for the trend, beyond what this study set out to explore.

The third hypothesis, which stated that individual religiosity would predict a successful therapeutic outcome, as measured by an increase in the level of relationship satisfaction from the beginning of therapy to the termination of therapy, was not supported by the findings of this study. Although no literature was found either supporting or refuting the hypothesis, one speculation about this finding is that the sample may not have included enough highly religious individuals. In fact, 32% of females and 35% of males did not associate themselves with any religious group. Also, 45.3% of females and 54.7% of males stated that they rarely or never participated in organized activities of a church or religious group. This may be due to the tendency of religious individuals to seek counseling from a religious leader, such as a pastor or bishop. In fact, it has been found that "pastoral counseling has now become a major provider of mental health services in the USA, accounting for over 3 million hours of therapy annually in both institutional and private settings" (Woodruff, 2002, p. 94). Thus, many of the participants in the sample may not have been very religious, which would have placed a limitation on the findings.

Another speculation which might be presented is that the findings were somewhat inaccurate due to the nature of the way in which the data were measured. Self-report questionnaires were used. It is possible that some participants would have reported a higher level of religiosity than is actually the case. For instance, because of the

apprehensive subject role (Kazdin, 2003), they may have been concerned that their performance on the measure would be used to evaluate their personal characteristics and have reported answers that they felt would make them appear more favorable. This might have significantly affected the data and accounted for the results.

Lastly, the fourth hypothesis stated the intimate partner commitment level would mediate the relationship between religiosity and therapy outcome. The statistical analyses that were performed indicated that this was not the case. However, there was one finding that indicated that there was a non-significant trend for males toward a positive association between a low commitment level and a greater positive change in the level of relationship satisfaction after therapy. This finding signified that there was a trend for males who had taken more steps to leave the relationship and were thus less committed to it, to have a more successful therapy outcome. Thus, the more ambivalent a male was about his relationship, the more therapy worked for him. This finding could provide very interesting implications for therapy. Commitment to the relationship is a common factor; more specifically it is a client characteristic. It is a factor that the client brings with them to therapy. However, the results indicate that it may have the opposite relationship with a successful therapy outcome than was hypothesized in this study. For men, the less they care if their relationship succeeds or does not succeed and the more steps they have taken to leave the relationship, the more therapy will help them feel more satisfied in their relationship. It is possible that with the larger number of steps taken to get out of the relationship, such as consulting an attorney, the lower their satisfaction at the initiation of therapy will be (as was indicated by the previously stated results), and thus the greater the level of satisfaction can improve over the course of therapy.

Limitations of the Study

This study was limited in several ways. First, it utilized data which were gathered from a clinical sample. Therefore, it can only be applied to couples who are seeking therapy. In addition, each of the participants in this study reported mild to moderate levels of verbal, psychological, or physical abuse within their couple relationship. Couples who seek therapy do so mainly due to a level of distress within their relationship, as previously stated by the literature review. Also, they may be even more distressed than other couples who seek therapy because of the addition of some form of abuse. Both of these factors could also play a part in the level of intimate partner commitment. Considering that many people feel that problems can be resolved without the assistance of a counselor (Trump & Hugo, 2006; Adair et al., 2007), it may indicate that the couples may have waited a significant amount of time before seeking therapy and may not be as committed to their relationships as they previously had been. Minimally, they had had time to take steps toward leaving their relationship already. Also, the presence of abuse symptoms may indicate greater distress and thus less commitment to the relationship, notwithstanding religiosity, or it may indicate a commitment to stay, simply because one of the partners was too afraid to take any steps to leave. Fear of leaving an abusive relationship is a valid concern considering that domestic violence resulting in homicide is highly associated with relationship separation (Campbell, 2007; Eke, Harris, Hilton, Houghton, & Rice, 2011). Therefore, the sample's experience of their relationships may be very different from those in relationships where they did not present for therapy and are not currently experiencing abuse in those relationships.

An additional disadvantage to using this sample was its limited size. The number of couples who were available for use in the study was fairly small – 53 couples. The small sample size affects the generalizability of the findings and ensures that they are most applicable to individuals in couple relationships who match the demographic characteristics of the current sample. Thus, the results are not applicable to a broader population, and the statistical power would have been affected by the smaller sample size. This small sample may account for some of the varied results.

However, it must be noted that there are several advantages to working with the sample included in this study. First of all, the reason for completing this study was to examine what makes couple therapy effective and explore one of the common factors that may help clinicians lead their clients to successful results. Therapists will always be working with a clinical sample, considering that they will only provide therapy to those who present in their offices for treatment. Also, the literature suggests that couples present to therapy because of some form of distress in their relationship (Christensen et al., 2004). Couples who are experiencing mildly or moderately abusive behavior in their relationship are most likely distressed and are in possible danger. Because of this safety threat, they need therapy to be successful, perhaps even more urgently than other couples. Therefore, discovering any possible factors that could contribute to that success is essential. The sample used also contributes to the research literature by being culturally diverse; much of the prior research has not included a diverse sample. Another asset is that the sample used in the study was not recruited to be a part of this research, but rather represents the clients who are seeking help on their own initiative. Therefore, the use of the present sample adds to the existing literature by providing information on religiosity,

commitment and relationship satisfaction with a clinical, mildly/moderately abusive, culturally diverse population who have not been recruited, but sought therapy out of their own initiative.

Implications for Research

Although this study provides some valuable findings for the field of Couple and Family Therapy, there are several other ways in which this topic could be studied further that could lead to additional findings. For example, it would be interesting to examine the discrepancy between males and females in their religiosity. A discrepancy score could be found to help researchers discover if a difference in religiosity between partners could have an adverse effect on couples' relationship satisfaction.

Further studies might include more extensive measures of the various variables. For example, religiosity could be examined using a more comprehensive measure that would include various questions regarding how religious an individual was. It might include questions about participation in personal religious activities and not simply organized ones. In this study, commitment was measured using the MSI-R, which calculated the number of steps a person had taken to leave their relationship and their thoughts concerning leaving. A future study might include a measure that was broader and allowed for a more in-depth coverage of intimate partner commitment. Also, relationship satisfaction was measured using one question from the DAS. Unfortunately the DAS is highly correlated to commitment as portrayed in the MSI-R, and thus the total score could not be utilized for the purposes of this study. However, if a different measure of relationship satisfaction could be found that was comprehensive and did not correlate

with other measures being used, it would be a useful addition to any future exploration of this topic.

With reference to the variable of religiosity, a very interesting area to study might be how the different religions vary in how satisfied couples are in their relationships. Researchers could explore whether couples who are highly religious in one specific faith are more likely to be more satisfied with their relationships than couples who are highly religious in another faith. Each religion differs to some extent in the values that it places as most important. Thus it might be interesting to empirically test whether the results would differ depending on which faith the individual ascribes to.

One change that should be made is the inclusion of a larger sample size. In addition, the examination of religiosity, commitment, relationship satisfaction and therapy outcome with a non-clinical sample who had not been selected based on abuse symptoms, would be an important addition to the current research. Also, it would be interesting to compare the findings between a clinical and a non-clinical population.

Implications for Clinical Practice

The findings of this study, while limited, provide useful knowledge for clinicians working with this type of sample in therapy. The results indicated several trends that might assist clinicians when they are approaching therapy with couples who are highly religious. Therapists may tailor their approach to treatment based upon these findings. When religious females enter therapy they are more likely to be unhappy in their relationships, when commitment is controlled for. This information, coupled with the finding that highly religious men tend to be more satisfied in their relationships, may

induce clinicians to focus their initial therapeutic efforts on the religious female partners of the dyad.

Another implication of the findings refers to the results indicating that men who are more ambivalent about their relationships, may benefit more from therapy than those who are more committed. The results suggest that men who have taken more steps to leave their relationship or have more thoughts about leaving their relationship, may have a greater increase in their relationship satisfaction over the course of therapy. For clinicians, this may imply that there is more hope for males who come to therapy. It could be tempting for a clinician to believe that therapy will be difficult or that the couple will not succeed because of the low level of commitment of the male partner; however, the findings indicate that this may not be the case. The attitude that clinicians bring to therapy may differ and thus affect the method in which treatment is applied.

Summary

Overall, this study was relevant for couple and family therapists because it provides more insight for clinicians who work with religious individuals who present for couple therapy. Although previous research has suggested that higher religiosity indicates higher intimate partner commitment and higher relationship satisfaction, this study indicates that this may not be completely accurate for a clinical population. Also, the results found that there were gender differences between some of the associations. More religious females were found to be more committed to their relationships, but less satisfied when that commitment is controlled for.

Couple and family therapists are seeking to discover what makes therapy more effective, and this study failed to find support for the idea that high religiosity is one of

those factors for a clinical, mildly to moderately abusive population. However, it did raise an interesting trend for low commitment in a relationship to indicate a more successful therapeutic outcome for males. This finding may be encouraging for clinicians who work with disengaged male partners of a dyad.

Appendix A
Couple Information and Instructions (CII)

The following information is gathered from each partner separately.

Name: (Print) _____

E-mail address: _____

Phone Numbers: (h) _____

(cell) _____

Address: _____

_____Zip_____

(w) _____

(fax) _____

5. Gender: M F 6. SS# _____ 7. Age (in years) _____

8. You are coming for: a.) Family _____ b.) Couple ___ c) Individual Therapy ___

9. **Relationship status** to person in couple's therapy with you:

1. Currently married, living together
   a. **If married**, number of years married: _____
2. Currently married, separated, but not legally divorced
3. Divorced, legal action completed
4. Engaged, living together
5. Engaged, not living together
6. Dating, living together
7. Dating, not living together
8. Domestic partnership

10. Total Number of **Years** Together: _____

11. What is your **occupation** ?_____

1. Clerical sales, bookkeeper, secretary
2. Executive, large business owner
3. Homemaker
4. None – child not able to be employed
5. Owner, manager of small business
6. Professional - Associates or Bachelors degree
7. Professional – master or doctoral degree
8. Skilled worker/craftsman
9. Service worker – barber, cook, beautician
10. Semi-skilled worker – machine operator
11. Unskilled Worker
12. Student

12. What is your **current employment status** _____

1. Employed full time
2. Employed part time
3. Homemaker, not employed outside
4. Student
5. Disabled, not employed
6. Unemployed
7. Retired

13. Personal **yearly gross income**: $_____
(i.e., before taxes or any deductions)

14. **Race**: _____
1. Native American
2. African American
3. Asian/Pacific Islander
4. Hispanic
5. White
6. Other (specify)_____

15. What is **your country of origin**? _____
What was **your parent's country of origin**?
16. _____(father's) 17. _____(mother's)
How many years have you lived in the USA? _____

18. Highest Level of **Education** Completed: _____
1. Some high school (less than 12 years)
2. High school diploma (12 years)
3. Some college
4. Trade School (mechanic, carpentry, beauty school, etc.)
5. Associate degree
6. Bachelors degree (BA, BS)
7. Some graduate education
8. Masters degree (MA, MS, etc.)
9. Doctoral degree (PhD, MD, EDD, etc.)

19. Number of people in household:_____

20. Number of **children** who **live in home** with you: _____

21. Number of children who **do not live** with you: _____

Names and phone number of **contact people** (minimum 2):

_____

_____

22. What is your **religious** preference? ____

1. Mainline Protestant (e.g., Episcopal, Lutheran, Methodist, Presbyterian, Unitarian)
2. Conservative Protestant(e.g., Adventist, Baptist, Pentecostal)
3. Roman Catholic
4. Jewish
5. Other(e.g., Buddist, Mormon, Hindu)
6. No affiliation with any formal religion

23. How often do you **participate in organized activities of a church or religious group? _____**

1. several times per week
2. once a week
3. several times a month
4. once a month
5. several times a year
6. once or twice a year
7. rarely or never

24. How **important is religion or spirituality** to you in your daily life?_____

1. Very important
2. Important
3. Somewhat important
4. Not very important
5. Not important at all

25. **Medications**: ____ Yes _____ No

If yes, please list the names, purpose, and quality of **medication**(s) you are currently taking. Also list the name and phone number of the medicating physician(s) and primary care physician:

Medications:

Primary Care Physician: **Phone:**

Psychiatrist? Yes/No Name & Phone, if yes.

Phone:

Legal Involvement:

26. Have you ever been involved with the police? Yes/No (circle)
If yes, what happened? Explain: _____

_____

27. Have formal, legal procedures (i.e., ex-parte orders, protection orders, criminal charges, juvenile offenses) been brought against you? Yes/No (circle)
If yes, what happened? Explain: _____

_____

28. If formal procedures were brought, what were the results (e.g., eviction, restraining orders?) _____

_____

Many of the questions refer to your "family". It will be important for us to know what individuals you consider to be your family. Please list below the names and relationships of the people you will include in your responses about your family. Circle yourself in this list.

29. (Number listed in family) _____.

Name Relationship

List the concerns and problems for which you are seeking help. Indicate which is the most important by circling it. For each problem listed, note the degree of severity by checking (√) the appropriate column.

	4-Severe	3-Somewhat Severe	2 – Moderate	1 - Mild
30.	31.			
32.	33.			
34.	35.			
36.	37			

38. The most important concern (circled item) is # _____

Appendix B
Marital Status Inventory-Revised (MSI-R)

We would like to get an idea of how your relationship stands right now. Within the past four months have you…

Yes __ No__ 1. Had frequent thoughts about separating from your partner, as much as once a week or so.

Yes __ No__ 2. Occasionally thought about separation or divorce, usually after an argument.

Yes __ No__ 3. Thought specifically about separation, for example how to divide belongings, where to live, or who would get the children.

Yes __ No__ 4. Seriously thought about the costs and benefits of ending the relationship.

Yes __ No__ 5. Considered a divorce or separation a few times other than during or shortly after a fight, but only in general terms.

Yes __ No__ 6. Made specific plans to discuss separation with your partner, for example what you would say.

Yes __ No__ 7. Discussed separation (or divorce) with someone other than your partner (trusted friend, minister, counselor, relative).

Yes __ No__ 8. Discussed plans for moving out with friends or relatives.

Yes __ No__ 9. As a preparation for living on your own, set up an independent bank account in your own name to protect your interest.

Yes __ No__ 10. Suggested to your partner that you wish to have a separation.

Yes __ No__ 11. Discussed separation (or divorce) seriously with your partner.

Yes __ No__ 12. Your partner moved furniture or belongings to another residence.

Yes __ No__ 13. Consulted an attorney about legal separation, a stay away order, or divorce.

Yes __ No__ 14. Separated from your partner with plans to end the relationship.

Yes __ No__ 15. Separated from your partner, but with plans to get back together.

Yes __ No__ 16. File for a legal separation.

Yes __ No__ 17. Reached final decision on child custody, visitation, and division of property.

Yes __ No__ 18. Filed for divorce or ended the relationship.

Appendix C
Dyadic Adjustment Scale (DAS)

Most persons have disagreements in their relationship. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list. Place a checkmark (√) to indicate your answer.

	Always Agree	*Almost Always Agree*	*Occasion-ally Disagree*	*Frequently Disagree*	*Almost Always Disagree*	*Always Disagree*
1. Handling family finances						
2. Matters of recreation						
3. Religious matters						
4. Demonstrations of affection						
5. Friends						
6. Sex relations						
7. Conventionality (correct or proper behavior)						
8. Philosophy of life						
9. Ways of dealing with parents and in-laws						

	Always Agree	*Almost Always Agree*	*Occasion-ally Disagree*	*Frequently Disagree*	*Almost Always Disagree*	*Always Disagree*
10. Aims, goals, and things believed important						
11. Amount of time spent together						
12. Making major decisions						
13. Household tasks						
14. Leisure time interests and activities						
15. Career decisions						

	All the time	*Most of the time*	*More often than not*	*Occasion-ally*	*Rarely*	*Never*
16. How often do you discuss or have you considered divorce, separation or terminating your relationship?						
17. How often do you or your partner leave the house after a fight?						

	All the time	*Most of the time*	*More often than not*	*Occasion-ally*	*Rarely*	*Never*
18. In general, how often do you think that things between you and your partner are going well?						
19. Do you confide in your partner?						
20. Do you ever regret that you married (or lived together)?						
21. How often do you or your partner quarrel?						
22. How often do you and your partner "get on each others' nerves"?						

How often would you say the following events occur between you and your mate? Circle your answer.

23. Do you kiss your partner?

Everyday Almost every day Occasionally Rarely Never

24. Do you and your partner engage in outside interests together?

All of them Most of them Some of them Very few of them None of them

25. Have a stimulating exchange of ideas?

Never	Less Than Once a Month	Once or Twice a Month	Once or Twice a Week	Once a Day	More Often

26. Laugh together?

Never	Less Than Once a Month	Once or Twice a Month	Once or Twice a Week	Once a Day	More Often

27. Calmly discuss something?

Never	Less Than Once a Month	Once or Twice a Month	Once or Twice a Week	Once a Day	More Often

28. Work together on a project?

Never	Less Than Once a Month	Once or Twice a Month	Once or Twice a Week	Once a Day	More Often

---

These are some things about which couples sometimes agree and sometimes disagree. Indicate if either item below causes differences of opinion or have been problems in your relationship during the past few weeks. Check "yes" or "no."

29. Being too tired for sex. Yes __ No __

30. Not showing love. Yes __ No __

---

31. The dots on the following line represent different degrees of happiness in your relationship. The middle point, "happy," represents the degree of happiness of most relationships. Please circle the dot which best describes the degree of happiness, all things considered, of your relationship.

. . . . . .

Extremely Unhappy	Fairly Unhappy	A Little Unhappy	Happy	Very Happy	Extremely Happy	Perfect

---

32. Which of the following statements best describes how you feel about the future of your relationship? Check the statement that best applies to you.

___ 6. I want desperately for my relationship to succeed, and would go to almost any length to see that it does.

___ 5. I want very much for my relationship to succeed, and will do all I can to see that it does.

___ 4. I want very much for my relationship to succeed, and will do my fair share to see that it does.

___ 3. It would be nice if my relationship succeeded, but I can't do much more than I am doing now to help it succeed.

___ 2. It would be nice if my relationship succeeded, but I refuse to do any more than I am doing now to keep the relationship going.

___ 1. My relationship can never succeed, and there is no more that I can do to keep the relationship going.

Appendix D
Institutional Review Board Protocol Approval

UNIVERSITY OF MARYLAND
INSTITUTIONAL REVIEW BOARD

To: Principal Investigator, Carol A. Werlinich, Family Science
Student, Ciara Dresser, Family Science

From: James M. Hagberg
IRB Co-Chair
University of Maryland College Park

Re: IRB Protocol: 11-0119 - The influence of religiosity on relationship satisfaction and therapeutic outcome as mediated by commitment level

Approval Date: March 07, 2011

Expiration Date: March 07, 2014

Application: Initial

Review Path: Exempt

The University of Maryland, College Park Institutional Review Board (IRB) Office approved your Initial IRB Application. This transaction was approved in accordance with the University's IRB policies and procedures and 45 CFR 46, the Federal Policy for the Protection of Human Subjects. Please reference the above-cited IRB Protocol number in any future communications with our office regarding this research.

Recruitment/Consent: For research requiring written informed consent, the IRB-approved and stamped informed consent document will be sent via mail. The IRB approval expiration date has been stamped on the informed consent document. Please note that research participants must sign a stamped version of the informed consent form and receive a copy.

Continuing Review: If you intend to continue to collect data from human subjects or to analyze private, identifiable data collected from human subjects, beyond the expiration date of this protocol, you must submit a Renewal Application to the IRB Office 45 days prior to the expiration date. If IRB Approval of your protocol expires, all human subject research activities including enrollment of new subjects, data collection and analysis of identifiable, private information must cease until the Renewal Application is approved. If

work on the human subject portion of your project is complete and you wish to close the protocol, please submit a Closure Report to irb@umd.edu.

Modifications: Any changes to the approved protocol must be approved by the IRB before the change is implemented, except when a change is necessary to eliminate an apparent immediate hazard to the subjects. If you would like to modify an approved protocol, please submit an Addendum request to the IRB Office.

Unanticipated Problems Involving Risks: You must promptly report any unanticipated problems involving risks to subjects or others to the IRB Manager at 301-405-0678 or jsmith@umresearch.umd.edu

Additional Information: Please contact the IRB Office at 301-405-4212 if you have any IRB-related questions or concerns. Email: irb@umd.edu

The UMCP IRB is organized and operated according to guidelines of the United States Office for Human Research Protections and the United States Code of Federal Regulations and operates under Federal Wide Assurance No. FWA00005856.

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