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The Relationship Between Spiritual Well-Being and Counselor Adaptability Among Christian Counselors

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THE RELATIONSHIP BETWEEN SPIRITUAL WELL-BEING AND COUNSELOR ADAPTABILITY AMONG CHRISTIAN COUNSELORS

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"And His name shall be called Wonderful Counselor. . ." Isaiah 9:6

"Therefore, if any man is in Christ, there is a new creation; the old things passed away; behold, new things have come. Now all these things are from God, who reconciled us to Himself through Christ, and gave us the ministry of reconciliation."

2 Corinthians 5:17-18

IN LOVING DEDICATION TO

my Father, my Savior, my Helper

that i may be a little more like You everyday

apart from You i can do nothing

with You all things are possible

To my wife

that I may love you as Jesus Christ loves the Church

To my mother, brother, and sister

that I may honor and serve you

To my extended family

that I may bless you

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Abstract

Many factors influence the abilities of counselors to assist those who seek their guidance. Perhaps no factor is more important and more often overlooked than a counselor's spiritual well-being. This research explored the relationship between the spiritual well-being of Christian counselors and one measure of their abilities to intervene therapeutically for their clients—counselor adaptability. Levels of spiritual well-being were measured by the Spiritual Well-Being Scale (Paloutzian & Ellison, 1982; Ellison, 1983) and the spiritual well-being subscale of the Mental, Physical, and Spiritual Well-Being Scale (Vella-Brodrick, 1995). Levels of counselor adaptability were measured by the Therapist Style Inventory of Adaptive Counseling and Therapy (Howard, Nance, & Myers, 1986, 1987). Statistical analysis did not find a significant relationship between both measurements of spiritual well-being and counselor adaptability for this population of Christian counselors. Although high scores obtained by this research population concerning their levels of spiritual well-being affirmed the spiritual integrity among the Christian helping professionals, the scores were, unfortunately, exceedingly high to evaluate adequately for their relationship with one measurement of their counseling ability. Further research to reevaluate the hypothesized relationship between spiritual well-being and counselor adaptability requires a strengthening of both measurements of spiritual well-being. Respective findings of correlations between spiritual well-being and counselor adaptability with other variables were presented.

Introduction

Although not necessarily speaking from a Christian perspective, Carl Rogers (1961, 1967) espoused a counselor attitude of unconditional positive regard towards all clients. He stated that the optimal attitude is for a therapist to communicate "to his client a deep and genuine caring for him as a person with potentialities, a caring uncontaminated by evaluations of his thoughts, feelings, or behaviors" (Rogers, 1967, p. 102). This attitude of non-judgmental affection finds a deeper root in the sacred principles of the Holy Bible. For example, the Apostle John wrote in his letter: "Beloved, let us love one another, for love is from God; and everyone who loves is born of God and knows God. The one who does not love does not know God, for God is love" (1 John 4:7-8, New American Standard Version [NASV]). Again he said, "And this commandment we have from him, that the one who loves God should love his brother also" (1 John 4:21, NASV). The Apostle Paul voiced a similar mandate when he said, "Brethren, even if a man is caught in any trespass, you who are spiritual, restore such a one in a spirit of gentleness; each one looking to yourself, lest you too be tempted" (Galatians 6:1, NASV). Finally, the Lord Jesus Christ himself stated succinctly, "Do not judge lest you be judged" Matthew 7:1 (NASV). Carl Rogers' personal beliefs not withstanding, when a Christian counselor learns to regard all people as created beings of God and endeavors to relate with the counseled as God would lovingly relate with unconditional love, spirituality has, in fact, entered the counseling process.

Spirituality affects who a counselor is and how he or she can and should relate with a client; even the actual techniques of counseling practiced by a counselor can be affected by his or her spiritual well-being. Carl Jung (1933) observed and

firmly advocated that the symbolism and moral teachings found in religion often parallel the fantasies and efforts made by clients as they strive toward personal wholeness.

In his popular novel Joshua: A Parable for Today, Joseph Girzone (1983) masterfully articulated that God is not as interested in religious traditions, formalities, and structures (though they have their places in personal and corporate spiritual foundations and formations) as he is in the people themselves. Similarly, although knowing and practicing appropriate therapy is necessary for the well-being of the one counseled, a successful counseling process and outcome are essentially not about applying the right theories and techniques (as important and necessary as they may be). Rather, good therapy outcome may be about establishing and exercising the right relationship between a counselor and counselee and expanding that appropriate relationship beyond the settings of the counseling office. Mark McMinn (1996) was convinced that "the value of counseling interventions is found less in one's technical training and theoretical orientation than in one's character . . . that it is not merely our flawed character that we bring into interactions with others, it is divine character revealed through us" (p. 19). Indeed, it might be said that character, especially as defined from a Christian perspective, is a reflection of one's spiritual well-being. A Christian counselor's spiritual well-being, therefore, plays a vital part in exemplifying, establishing, and building a healthy therapeutic relationship with his or her counselees as well as in affecting a positive therapeutic outcome.

The appropriateness and application of spirituality in the psychotherapeutic practices of mental health have received increasing attention, and the proposition

that spiritual well-being is an avenue through which counselors may glean insight into a client's mental health and identity is also gaining acceptance (Ortberg, 1995). The medical or disease model of psychotherapy, the cultural diversity of clients, and even the constitutional emphasis upon individual rights in the United States of America are often reasons given for the notion that counselors and therapists should remain morally neutral (Erickson, 1994). However, making moral judgments concerning a client's behavior in order to determine the necessary course of action may be unavoidable. Humphries (1982) observed, contrary to the popular notion, that to ignore or devalue the impact that a counselor's own religious beliefs have upon his or her clients might well constitute an area of potential abuse of the psychotherapeutic relationship. If the quality of an individual is defined by his or her character, and character is influenced by one's spiritual integrity, mental capacities, physical attributes, emotional makeup, and environmental inputs, then to deny discussion of the influencing forces of one's spirituality within a counseling milieu would entail a denial of an individual's opportunity to move towards completeness or wholeness even when all other factors are appraised.

A recognition of the effects of multidimensional influences upon every individual has persuaded many researchers, helping professionals, and the general public to begin to place a greater emphasis upon the role spirituality has upon each individual's overall well-being as well as upon the overall processes of psychotherapy. An acknowledgment of this multidimensional influence is evident in the revised Ethical Principles of Psychologists and Code of Conduct published in 1992. In it, religion is listed as a human difference. The guideline states that psychologists are to "obtain the training experience, consultation, or supervision

necessary to ensure the competence of their services, or they make appropriate referrals" (p. 1607). Additionally, the 1994 publication of the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV), has included a v-code (v62.89) entitled "Religious or Spiritual Problem" under the category of "Other Conditions That May Be a Focus of Clinical Attention." The criterion for diagnosis reads,

> This category can be used when the focus of clinical attention is a religious or spiritual problem. Examples include distressing experiences that involve loss of or questioning of faith, problems associated with conversion to a new faith, or questioning of spiritual values that may not necessarily be related to an organized church or religious institution. (p. 685)

Although it represents no surprise to many religious communities and professionals, spiritual well-being has now been accepted in a secular society as a vital component to the overall health of every individual. Certainly, the other components of health are, but are not limited to, mental, physical, emotional, social, existential, and environmental well-being.

Spirituality is given greater emphasis in no other place than within the walls of the church and by those engaging in the spiritual guidance of others—ministers, pastors, and Christian counselors. Yet when Todd Hall (1996) surveyed the available empirical research on the psychological and spiritual functioning of pastors, he concluded that, though numerous studies investigating pastors' personal lives were done, "there [were] virtually no studies on pastors' spirituality" (p. 250). Furthermore, while most studies focused on comparing the personal functioning of the helping professionals with the general public, Hall suggested that comparative

studies between one group of professionals and another might be more appropriate. The population of choice for this research, in part, is a response to the suggestion raised by Hall.

In a study describing the psychological problems of a group of Catholic clergy and religious people who were referred for residential treatment, Keddy, Erdberg, and Sammon (1990) observed that among other findings, pastors who had interpersonal problems also had parallel problems in their relationship with God. If this observation was the case, then the reverse could hold true: that each pastor's relationship with God (spiritual well-being) could be indicative of, or might even affect, his or her abilities to relate with people. The inference of Keddy, Erdberg, and Sammon's finding with regard to this study is that the spiritual well-being of Christian counselors could be indicative of their abilities to relate therapeutically with their clients. Indeed, these researchers also concluded that successful psychotherapy may well go hand in hand with a revitalization of spiritual life and that spiritual direction may well complement psychotherapy.

In light of the observations and conclusions drawn by these authors and researchers, the purpose of this study, then, is to measure and analyze how spiritual well-being relates with one measure of a Christian counselor's therapeutic abilities—counselor adaptability among selected Christian counselors with implications for each counselor's need to address and nurture his or her spiritual well-being. The first phase of this research was to determine each Christian counselor's general well-being by using the Mental, Physical, and Spiritual Well-Being Scale (MPS), paying particular attention to the spiritual well-being subscale of the instrument. In giving greater emphasis to spiritual well-being from a Christian perspective, each Christian

counselor's spiritual well-being was again measured by using the Spiritual Well-Being Scale (SWBS). Finally, each Christian counselor's measure of counselor adaptability was evaluated by the Therapist Style Inventory (TSI) belonging to an eclectic approach to counseling called Adaptive Counseling and Therapy. When the scales have been scored, any correlation which might exist between spiritual well-being and counselor adaptability will be analyzed. Thereafter, the corresponding relationships between counselor adaptability and religious well-being, existential well-being, mental well-being, physical well-being, age, gender, occupation, educational background, religious preferences, and worship attendance will be taken into account.

The research is essentially an investigation of the relationship between spiritual well-being and counselor adaptability. As such, the study is too limited in scope to infer causality. That is, the results of the research should not be taken to conclude whether spiritual well-being by itself would cause a Christian counselor to be more or less adaptable to the therapeutic needs of his or her clients. Also, this research is not an attempt to measure the effectiveness of Christian counseling or the efficacy of counselor adaptability in producing positive outcomes for the ones counseled. Finally, given the population of choice in this study, generalization may not be extended beyond those counselors whose spiritual beliefs lie outside the Christian faith.

For the purposes of this research, a Christian counselor is an individual engaging in counseling who also professes a faith and belief in Jesus Christ as his or her personal Savior regardless of the counseling setting or his or her professional achievements and employment. The spiritual well-being of a Christian counselor is

the level of spiritual health as measured by the SWBS and the spiritual well-being subscale of the MPS. The evaluations of spiritual well-being are based upon their personal perceptions (SWBS) and behaviors (MPS). Finally, counselor adaptability—a central construct in Adaptive Counseling and Therapy—is defined as a counselor's degree of competence to conceptualize client-behaviors and to adapt an optimal therapeutic response to the needs and readiness of his or her clients.

The first assumption is that spiritual well-being is one important facet in the overall health of a Christian counselor. A Christian counselor's personal well-being and his or her ability to relate appropriately with people and the surrounding environment—to adapt—are integrally connected. Since the Spiritual Well-Being Scale has been well established in Christian circles, an important related assumption is that the spiritual well-being subscale of the more recently developed Mental, Physical, and Spiritual Well-Being scale is also a reliable measure of Christian spirituality. The last assumption is that counselor adaptability is an important construct that points to one measure of a Christian counselor's overall proficiency; it is indicative of a Christian counselor's ability to establish a beneficial therapeutic relationship with his or her clients and to employ the most suitable therapeutic intervention.

Spiritual well-being has often been relegated to a secondary role in a person's overall well-being. While many helping professionals struggle to determine the role spiritual well-being has in the counseling milieu, those seeking guidance are often left to fend for themselves as they search for understanding and images of wholeness. Even as more and more professional counselors and therapists are

claiming some form of personal religious or spiritual orientation, and as the trend seems to indicate an increasing recognition of the beneficial role spirituality plays in the therapeutic process, spirituality and spiritual well-being have been, for the most part, reluctantly emphasized (Bergin & Jensen, 1990). This study could either confirm such reservations as justifiable, or it could serve as a beacon to counselors, particularly Christian counselors, for the importance of emphasizing the role and function spiritual well-being has not only within their personal lives, but within their counseling processes as well. In either case, this study intends to spotlight the relationship spiritual well-being has upon one aspect of a counselor's ability—counselor adaptability—to relate therapeutically with his or her clients. This study will also add a degree of confirmation to ongoing research concerning the integration of spirituality, theology, and psychology. With these thoughts in mind, the hypotheses for this research are stated as follows:

The first hypothesis is that positive correlations exist between both measurements of spiritual well-being and counselor adaptability among a select population of Christian counselors.

The second hypothesis is that, when other factors such as religious, existential, mental, and physical well-being; age; gender; marital status; occupation; highest level of education attained; ethnicity; profession of faith; religious preference; and worship attendance are considered, the relationship between spiritual well-being and counselor adaptability should prove to be the most significant.

Chapter 2

Review of the Precedent Literature

Introduction

The relationship spiritual well-being has with one measure of a Christian counselor's ability—counselor adaptability—and the impact this relationship has in intervening therapeutically with his or her clients was explored in this research. To date, no specific research has been conducted that examines the relationship between the spiritual well-being of Christian counselors and counselor adaptability. As such, this review of the precedent literature began by taking into account those empirical studies that have established the important role and function spiritual well-being has among helping professionals whose work and ministry are similar in nature to the population of choice for this research—Christian counselors. The review also examined those empirical studies that took into account the role and function spiritual well-being has in the general public's arena. The review ended with a consideration of the relationship between spiritual well-being and one characteristic that closely resembles the elements necessary in therapeutic relationships for effective intervention—interpersonal relationships. A central theme of counselor adaptability lies in the ability of a counselor to perceive accurately the level of maturity and therapeutic readiness of clients and in his or her ability to introduce the most suitable intervention. Interpersonal relationship is a characteristic that closely resembles this theme.

The direction of this review began with the establishment that spiritual well-being must be taken into account when considering personal wholeness. The second section presented studies of how levels of spiritual well-being in many people had

contributed to their ability to handle acute adversities in life and, specifically, to cope with various external and internal stresses. The third section included those findings on spiritual well-being as they pertained to potential effects upon helping professionals. The last section of the literature review highlighted the relationship spiritual well-being has with interpersonal relationship.

Spiritual Well-Being and Personal Wholeness

In the first book of the Holy Bible, Genesis, the author stated, "And the Lord God formed man of the dust of the ground, and breathed into his nostrils the breath of life; and man became a living soul" (Genesis 2:7, King James Version). From this statement, one might say that human beings are alive only because of the infusion of spirit into their bodies. In Thomas Moore's (1992) Care of the Soul, he introduced the book by saying that the soul is the quality of being which makes one uniquely human; it is the very essence of human nature and the spiritual self. Consequently, the greatest problem in modern society affecting each individual is the loss of soul which, when neglected, manifests itself through "obsessions, addiction, violence, and loss of meaning" (p. xi). According to Moore, any understanding of effective counseling must move beyond the idea of fixing or correcting the individual or the problem and move into listening and nurturing the spiritual side of each human being. He further elaborated that those symptoms a person experiences may not only be physical and emotional cries for help, but they may also be cries of the soul. Therefore, symptoms may be misdiagnosed and individuals given the wrong care if their personal wholeness was assessed without a focus also on the spiritual side of humanity.

Ellison and Smith (1991) have also elaborated upon this spiritual or soul nature of a human being, which they described as a psychospiritual entity. They stated that this entity has its source from the Spirit of God, who "does not exist as an elementalistic entity on its own, but is integratively interwoven with the body and soul of the individual, comprising the person" (p. 37). In considering what constitutes personal wholeness, therefore, one must also consider the dimension of spiritual well-being. Earlier, Craig Ellison (1983) conceptualized spiritual well-being as follows:

> It is the spirit of human beings which enables and motivates us to search for meaning and purpose in life, to seek the supernatural or some meaning which transcends us, to wonder about our origins and our identities, to require morality and equity. It is the spirit which synthesizes the total personality and provides some sense of energizing directions and order. The spiritual dimension does not exist in isolation from our psyche and soma, but provides an integrative [emphasis mine] force. (pp. 331-332)

In perhaps less philosophical terms, Ross (1995) described and defined spiritual dimension as a need within people for a sense of meaning, purpose, and fulfillment in life; it encompasses the individual's hope or will to live; and a fundamental belief and faith in self, others, and God (p. 457). From the words of Ellison and Ross, it is not beyond reason, therefore, to accept that the spiritual dimension of personal wholeness comprises essentially the same definitions of well-being as those found in physical, mental, existential, or emotional dimensions.

Still, the scientific community has long struggled with the inclusion of the spiritual dimension of human experience as a valid, let alone vital, element of any

individual's total health. The desire to identify and understand the roles and functions of spirituality within human existence led to a comprehensive review of literature conducted by Hill and Butter (1995). They examined books and articles written between 1965 and 1995 on the effects of religion in the promotion of physical health. Hill and Butter suggested that a positive relationship between religion and physical health did seem to be present. However, they also asserted that the sources for claims of such a relationship were drawn primarily from theories of personality and from individual testimonies; evidences through experimental research have yet to be entirely consistent to substantiate claims of such a positive relationship. Nevertheless, the authors also acknowledged that in some research, it has been shown that general medical conditions and ailments such as cardiovascular disease, gastrointestinal disorders, many forms of cancer, and hypertension were in fact less prevalent among individuals who considered themselves religious than those who did not. Furthermore, they also noted that researchers have demonstrated an apparent inverse relationship between levels of religious commitment and the use of and dependence on legal and illegal drugs. That is, among those who profess to hold a high degree of faith and belief in God, their use or misuse of drugs was found to be minimal.

Since that report in 1995, an increasing number of empirical studies on the spiritual dimension of personal wholeness have emerged as many researchers have become more interested in the integrative effects of spiritual well-being. For example, in reviewing a number of studies that sought to relate spiritual well-being to personal wholeness, Levin, Larson, and Puchalski (1997) found that having a sense of spiritual well-being can indeed beneficially influence a patient's general

health as well as his or her clinical course of treatment and its outcome. Patients who considered themselves to have a high level of spiritual well-being tended to stay in hospitals for shorter periods and required less time for optimal healing.

In that same study, Levin, Larson, and Puchalski also found that numerous investigative studies into diseases and health status indicators have established a statistically significant association between religious belief and various measures of health among religious groups. In particular, spiritual practices have been demonstrated to promote positive health-related behaviors and lifestyles; these positive health-related behaviors and lifestyles in turn help reduce risks of diseases, enhance individual well-being, and provide social supports that subsequently buffer stress and improve coping skills. Finally, the authors reiterated the medical community's increasing recognition of the importance of tending to patients' spirituality by acknowledging that steps have already been taken by the medical community to bring spiritual awareness to the forefront of research, medical education, and clinical care. An increasing number of opportunities for students and physicians to learn how to assess, respect, and incorporate patients' spiritual perspectives into the regular treatment modality were also in the process of being created.

Coping with external factors. Personal health or wholeness is often impacted by external factors. These factors may include difficult environmental settings and traumatic experiences such as abuse and personal tragedy. Other than difficult and traumatic experiences, positive experiences such as personal accomplishments and strong social relationships can also affect the overall well-being of an individual.

In two studies, spiritual well-being was linked to a positive sense of personal wholeness within the contexts of social relationships and environment. David Trott (1996) sampled 184 workers at a Fortune 100 engineering and construction organization and found that a significantly positive relationship existed between those workers' spiritual well-being and their perceptions of the quality of relationships among peers. Those qualities of relationship identified in the study included variables such as respect, mutual trust, and fair treatment. In his discussion of the findings, Trott observed that workers who possessed high levels of spiritual well-being tended to view their work environments as friendly, open, and accommodating. This perception allowed workers to integrate into their working environments more successfully and to possess higher levels of personal satisfaction and effectiveness in their job settings. Ultimately, workers possessing high levels of spiritual well-being were also able to offer stronger commitments toward their employer. Trott noted that "spiritual wellness provides a sense of transcendent satisfaction amidst existential circumstances" (p. 102).

Benefits of spiritual wellness are not limited to working environments. Earlier, James Gagnon (1993) discovered through a survey of 63 couples that individuals who scored high on their spiritual well-being had correspondingly high scores on their family strength. In part, Gagnon concluded that (1) a positive correlation exists between spiritual well-being and self-esteem, (2) those individuals who feel good about themselves also feel good about their spirituality, (3) those who feel good about their spirituality have greater marital satisfaction, and (4) when used in combination, marital satisfaction and spiritual well-being can serve as a significant predictor of strong family bonds. Whether within the work or home environment, the

efficacy of a high level of spiritual well-being in cultivating positive interactive environments, situation outcomes, and relationships are established.

When considering the influence of spiritual well-being upon general life experiences, Ann Pritt (1998) conducted a study in which she affirmed that, when dealing with traumatic events, an individual's sense of spiritual well-being is highly related to a sense of personal healing and wholeness. Using Mormon women from the Church of Jesus Christ of the Latter-Day Saints who had received counseling, Pritt conducted an exploratory study comparing 115 women who reported having been sexually abused as children with 70 women who reported no such abuse. In the study, the author found that the sexually abused group's spiritual well-being scores were significantly more negative than the scores of the non-abused group. In order to promote recovery and healing from such trauma, Pritt suggested that results of the study strongly infer the relevance and efficacy of addressing spiritual issues with survivors of child sexual abuse on the part of caregiver and helping professionals.

Another traumatic experience that many people are forced to confront is suicide. Not only do survivors of suicide have to deal with the loss of their loved ones, but social stigmas unnecessarily associated with suicide often produce stress which, very frequently, impairs a sufferer's ability to handle adequately the many uninvited consequential interactions and dialogues surrounding the suicide. The state of spiritual well-being among those who are forced to contend with such deep loss also plays an important role in helping them deal with the consequences and emotions surrounding the suicide of their loved ones. In 1997, Fournier completed a study on the effects of spiritual well-being as a resource for reducing such stress and for improving the capacity to adapt to the demands of trauma among survivors of

suicide. Those survivors of suicide who undertook the examination numbered 509. Independent of other coping resources tested such as self-mastery, social support, employment, support group attendance, and time, Fournier found that spiritual well-being did have a significantly positive effect upon survivors of suicide. Primarily, he determined that spiritual well-being contributed to a reduction in the level of stress endured by survivors of suicide; as such, they were better able to adapt to and heal from the gravity of the loss.

In another study, which was developed to understand better the causes for individuals to commit suicide and the strategies for prevention, Ellis and Smith (1991) also found similar benefits among those possessing a high level of spiritual well-being. In the study, 100 undergraduate students took part in an evaluation to explore the relationship between spirituality and reasons for living. Ellis and Smith found that there was a positive correlation between the levels of spiritual well-being and the scores obtained from the Reason for Living Inventory. The strong implication from this and the earlier mentioned study is that spiritual well-being must be given due consideration along with other more tangible interventions (e.g., medication and social support groups) when striving for or promoting personal wholeness, healing, and in recovering from difficult events in life. The efficacy of having a high level of spiritual well-being within people to cope successfully with, and rise above, external factors influencing life is strongly evident.

Coping with internal influences. In the same study, Ellis and Smith also found significant connections among spiritual well-being, cognitive beliefs (personal reasons given for not considering suicide), and existential beliefs (personal beliefs reflecting general satisfaction toward life that tend to, in this case, give stronger

reasons for not considering suicide [p. 61]). The authors identified various internal factors such as negative feelings of anxiety and despair, as well as positive sentiments such as hope and a sense of satisfaction toward life (existential well-being) as characteristics that often contribute to either a sense of personal debility or wholeness. For each factor, spiritual well-being has consistently been shown in the study to affect a positive influence both in strengthening an individual's personal resolve to resist emotional breakdown and in the empowerment of an individual to rise above what could be overwhelming circumstances.

Ellis and Smith were not the first to link spiritual well-being with existential well-being. Two years prior, Geraldine Landes (1989) had investigated the relationship between life satisfaction and spiritual well-being within a population of senior adults. She found that, where general life satisfaction was concerned, spiritual well-being ranked second after existential well-being for the group of senior adults studied. In a poignant observation of the results obtained through the study Landes said, "If one desires to increase life satisfaction, a relevant way is to increase one's spiritual well-being. If the goal is to increase spiritual well-being, this may be readily achieved by enhancing existential well-being" (p. 97). In other words, spiritual well-being and an internal sense of general well-being or life satisfaction are intricately connected; factors that affect the well-being of one will indelibly affect the well-being of the other. Together, spiritual and existential well-being represent essential elements to be nurtured and developed in achieving personal wholeness.

As further confirmation of the positive impact spiritual well-being has upon internal influences, Poloma and Pendleton (1990) interviewed 560 individuals to evaluate their general sense of well-being. Items for rating included their residence

in Akron, Ohio; employment status; responsibilities or work at home; religious involvement; education; friends; household members; marital status; standard of living; and physical health. The authors concluded that the spiritual or religious dimension was consistently strong in accounting for individual well-being. That is, for this population, no consideration of a sense of general well-being could be complete without the inclusion of the spiritual or religious dimension of health. Christopher Ellison (1991) also examined the relationship between religious involvement and an individual's subjective sense of well-being. He concluded that the positive influence of religious certainty on individual well-being was found to be direct and substantial. That is, individuals with strong religious faith reported higher levels of life satisfaction, enjoyed greater personal happiness, and suffered fewer negative psychosocial consequences amidst traumatic life events.

Most internal senses or feelings of anxiety and despair are often associated with some external predicament or catastrophe. Even so, spiritual well-being, as B. J. Landis (1996) discovered, can be an important internal resource for persons who are forced to adjust to the feelings and uncertainties associated with predicaments associated with, for example, long-term health problems. Her conclusion came as a result of assessing spiritual well-being as an internal coping resource among people with diabetes mellitus in buffering the effects of uncertainty surrounding the disease. Because uncertainties surrounding the effects of diabetes affect the sufferers' abilities to make necessary psychosocial adjustments, the presence of some internal enabling mechanism would do well in helping those individuals face the many restrictions caused by the disease and to make necessary decisions throughout life. One such internal enabling mechanism identified was an individual's spiritual well-

being. Landis found that as spiritual well-being increased, problems related to living with diabetes decreased. Furthermore, spiritual well-being had a significant inverse relationship with feelings of uncertainty; this inverse relationship meant that as one's spiritual well-being increased, the negative impact of uncertainties surrounding diabetes and its looming effects decreased. The findings of Landis firmly suggested that spiritual well-being could indeed be an important internal resource for persons who are forced to adjust to uncertainties associated with long-term health problems such as, in the case of her study, diabetes mellitus.

Great personal fortitude is also required among those affected by cancer; it is another long-term health problem that requires individuals to make immense psychosocial adjustments. Using a population of women living with breast cancer, Jacqueline Mickley (1990) examined one measure of psychological well-being—hope—and, among other variables, the relationship spiritual well-being has with an individual's sense of hope. Consistent with contemporary studies, Mickley's study showed that spiritual well-being is indeed positively associated with a sense of hope among patients suffering with breast cancer. Much like Landis, Mickley also called upon health care professionals such as doctors and nurses to foster both spiritual well-being and psychological well-being by addressing the patients' internal sense of wholeness or existential concerns. Additionally, she also stated that

> It is imperative that spiritual well-being be explored in both client and nurse. The idea that health care professionals should be impartial and value-free may not only be impossible to carry out but also be of less benefit to patients. Therefore, exploration of spirituality in nurses could promote spiritual well-being in both nurses and patients. (p. 131)

Another internal factor influencing personal wholeness that has seen beneficial effects by spiritual well-being is self-esteem. In a study on Chinese-Americans in the Northwest who have, at times, wrestled with the uncertainties and apprehensions surrounding the merging and assimilation into the popular culture, Elsa Wong (1990) found that as an individual's sense of spiritual well-being increased, so too did his or her sense of self-esteem. Although her study was limited to the Chinese-American population, the correlation is significant because it also implies that the effects of spiritual well-being upon a personal sense of wholeness goes beyond cultural boundaries and ethnic origins.

Spiritual Well-Being and the Caregiver

Often, stress is not endured by those directly affected by illness or predicaments alone. Caregivers, whether family members, friends, even the helping professionals, are frequently shaken by the pains and sufferings of those with whom they come in contact. For these caregivers, spiritual well-being also goes hand in hand with other facets of health and integrity in providing caregivers with the strength necessary to attend to those in need. In 1985, Wright, Pratt, and Schmall explored the role of spiritual support as a coping strategy for family caregivers of dementia patients. The researchers noted that as the disease progressed, patients could become increasingly dependent on their families for care, thus placing the caregivers in roles that were often difficult and demanding. The authors emphasized that in situations such as this, "the spiritual dimension of health care is an integral part in the total well-being of both the dementia patient and the caregiver" (p. 36). They further emphasized that where the nurturance of spiritual well-being can be integrated with medical and psychosocial needs, other helping professionals such as

clergy or those within the patients' spiritual community also have an integral role in lending support to those families rendering care as well as to the patients themselves.

In recent years, an increasing number of researchers have begun focusing upon the spiritual well-being of the helping professionals. In trying to delineate the specific qualities of spirituality found among counselors and psychotherapists, James Newton (1997) surveyed a number of counselors in a Midwestern city using a subscale—religious well-being—of the Spiritual Well-Being Scale developed by Paloutzian and Ellison (1982). In reviewing the survey Newton found that (1) female counselors scored higher than their male counterparts in the Religious Well-Being Subscale score, (2) master's-level counselors scored higher than those with a doctorate, and (3) those with a conservative evangelical Christian belief system scored higher than those whose belief systems were other than those of conservative evangelical Christians.

In a study investigating occupational stress among clergy, Miguel Valdivia (1998) sought to relate age and tenure with spiritual well-being. One hundred forty-three clergy from the Seventh-Day Adventist Church completed the required instruments. The study showed that stress and strain were inversely correlated with spiritual well-being. That is, a high sense of spiritual well-being may be associated with low levels of occupational stress. Also, though the difference was not statistically significant, the study showed that young-adult clergy (those between the ages of 20 and 40 years) seemed to score somewhat higher than mature-adult clergy (those above 40 years old) in the stress and strain measure. In other words, younger clergy who might be less spiritually mature might also feel more stressed about their work.

Along the line of evaluating for demographic variables that influence spiritual well-being among professional helpers, James Young (1993) examined the demographic, religious, and retirement issues among retired United States Army chaplains. The factors he found to be predictive of spiritual well-being included (1) a conservative religious belief, (2) a personal sense of job satisfaction upon retirement, (3) success in adjusting to civilian status, and (4) the amount of time spent in daily devotion. Although the population of this study has limited inference value to nonmilitary helping professionals, some findings in this study are consistent with results from other research involving a more general population of helping professionals. Albeit these attempts to catalog demographic profiles of counselors and psychotherapists possessing high levels of spiritual well-being were by no means comprehensive, they nevertheless did provide important insights to who the spiritually healthy might be and what they do.

Aside from demographic factors, existential factors contributing to spiritual well-being, such as marital satisfaction, job satisfaction, life satisfaction, and perceived social support, among helping professionals have also been explored. For example, to assess existential elements influencing levels of spiritual well-being, Lisa Jo Moree (1998) surveyed 400 women in ministry as well as those in other occupations who graduated from a theological seminary in the eastern United States. Women in this sample scored high in their levels of spiritual well-being. More significantly, their levels of spiritual well-being were associated positively with existential factors such as job and life satisfaction, with one noted exception being that spiritual well-being did not correlate with perceived social support from families and friends. Factors considered non-contributory to spiritual well-being

included age, marital status, educational degree, number and ages of children, socioeconomic status, size of church in which the women were employed, employment position, years in ministry, and hours of work per week.

As mentioned earlier, a higher sense of spiritual well-being has been associated with a lower level of occupational stress (e.g., Valdivia, 1998). Other studies have also shown similar findings. In 1997, Verdell Marsh sought to connect the relationships among job stress, spiritual well-being, and burnout in nurses. Her study showed, among other results, that spiritual well-being has a direct negative effect on burnout and a direct positive effect on hardiness (the apparent capacity to resist illness after exposure to stressors) among nurses. For this group of helping professionals, higher levels of spiritual well-being significantly correlated with higher capacities to resist occupational stress and to buffer illness and burn-out. David Prout (1996) also made a similar conclusion in his 3-year analysis of variance study that related, among other factors, spiritual well-being to burn-out among Lutheran clergy. In his study, Prout stated his finding "that burn-out scores were significantly higher among ministers with lower levels of spiritual well-being" (p. 54). That is, among Lutheran ministers who possess a high level of spiritual well-being, tendencies to succumb to occupational burn-out were minimal.

Finally, a study was done that measured the levels of narcissism and spiritual well-being among Lutheran clergy who had committed sexual misconduct. Francis & Baldo (1998) determined that the number of clergy who self-reported having committed sexual misconduct and who had low levels of spiritual well-being was significantly different from the number of those clergy who self-reported not having committed sexual misconduct and who had high levels of spiritual well-being. A

strong implication was that a high level of spiritual well-being can be attributed to clergy's ability to resist illicit sexual urges and misconduct. The results of this study demonstrated the possible positive effects of a presence of a high level of spiritual well-being and the possible detriments of an absence thereof among helping professionals.

While these studies have focused upon the general state of spiritual well-being among helping professionals and the efficacy of being spiritually well as it pertains to personal wholeness, a limited number of studies have considered whether the helping professional's spiritual well-being has any affect upon his or her abilities within a counseling milieu. A few studies were completed which focused upon the relationship between spiritual well-being and its effects upon the therapeutic experience. Other studies explored the contributions spiritual well-being might make to the therapeutic relationship between caregivers and their clients.

Spiritual Well-Being and Interpersonal Relationships

Elaborating upon the spiritual or soul nature of a human being, Ellison and Smith (1984) stated their belief that Christian psychologists are the ones most able to conceptualize human beings as psychospiritually integrated entities. Interpersonal relationships, particularly the therapeutic relationships between counselors and counselees, are intricately connected with each individual's spiritual well-being.

In a pretest-posttest study, Thomas Renfroe (1993) sought to assess the effectiveness of psychotherapy upon spiritual well-being and depression among some outpatient adults. He suggested that even though psychotherapy by itself cannot be proven to be the causal agent of change, the positive effect psychotherapy has upon the patients' spiritual well-being and in diminishing depression was

indeed evident. In the same year, Dennis Henderson (1993) postulated the possibility that high frequencies of counseling and support group involvement could account for the absence of impaired spiritual well-being. In both cases, an important corollary between spiritual well-being and counseling relationships was demonstrated.

A significant proof of the substantial role spiritual well-being has in influencing a helping professional's ability to offer assistance is found in Sarah Cimino's (1992) investigation of the spiritual well-being of nurses and their relationship to attitudes in providing spiritual care. In the study she stated plainly that if nurses are to commit to the care of the whole person, they must include spiritual care in their practice. Cimino's study focused in part on whether a positive correlation existed between nurses' spiritual well-being and their attitudes in providing care as well as the degree of comfort in providing spiritual, religious, and existential care for patients. The results indicated that a high level of spiritual well-being was in fact associated with a nurse's positive attitude and his or her high degree of comfort in providing care at all levels. In other words, as this group of helping professionals felt more comfortable with their personal spiritual well-being, the integration of spirituality in the care of patients became extensions of their personality and professionalism.

In 1991, Patricia Broten conducted a similar study concerning the care provided by nurses. Unlike Cimino's study, however, her study was done to explore the patients' perception of care as given by the nurses. The study also included an examination of the relationships and levels of spiritual care provided in the hospital setting which led to beneficial effects upon the patients' spiritual well-being. Among

professional helpers mentioned by patients as having given spiritual care are nurses, clergy, and pastoral care representatives. The study showed that where spiritual care was provided, patients also scored well on the spiritual well-being scale. At least 50 percent of the patients reported having received some type of spiritual care and intervention. Among those who did not receive spiritual care, one third to one half reported their belief that it was important for professional helpers to provide such care. Implications of Cimino's and Broten's studies are particularly apropos to the premise of this present research that spiritual well-being is significant in affecting a counselor's ability to intervene therapeutically for this clients.

Another interesting study was conducted by Richards and Davison (1989) which shed light on the appropriateness of professional helpers connecting at a spiritual level with their patients or clients. Forty-nine Mormon persons receiving psychotherapy at a Mormon counseling clinic and 51 Mormons who held church leadership positions completed a scale on how much their trust for a counselor would be influenced by the counselor's theistic or atheistic values. The study indicated that within this sample of counselees, trust levels toward counselors were affected multidimensionally by both groups' religious orientations. In short, the authors noted that where religious orientations and orthodoxy were similar, the therapeutic relationship possessed the highest level of trust. The significance of this finding as it relates to the counseling process is that where the clients can feel that their counselors can empathize with them at a common spiritual level, the therapeutic relationship can be more readily established. Subsequently, results of this and numerous other studies have suggested that having an established therapeutic relationship is essential to an effective nurturance of the clients' mental, physical,

emotional, psychological, and spiritual needs; and there is a strong beneficial relationship between spiritual well-being and the building and nurturing of interpersonal relationships.

In conclusion, Thomas Inui (1996) defined health as a capacity for present and future functional and substantial achievement; it is a capacity found in various states of well-being that includes physical, emotional, social, economic, and spiritual health. He stated that the aim of health care professionals is to improve one or more states of well-being. In the process of providing care, perspectives of patients and practitioners are brought together through interrelationships and interactions between the helping professionals and patients: between the practitioners who serve the community and the patients' community of origin and between members of the community of practitioners themselves.

Establishing an appropriate relationship implies the ability on the part of the counselor to perceive accurately a client's problems and to tailor a treatment plan that matches the needs of the client. In 1987, Howard, Nance, and Myers composed Adaptive Counseling and Therapy (ACT) to assist counselors in selecting the best-matching therapeutic approach for their clients based upon their clients' developmental needs within the counseling process. Heavily influenced by the values of situational leadership in organizational settings, a model developed by Hersey and Blanchard in 1987, the authors applied the principle of matching broad-range leadership styles and techniques with various situations and workers in applied business settings to the needs in the field of counseling and psychotherapy. The Therapist Style Inventory (TSI) was developed to assess (1) therapist style preference, (2) therapist style range, and specific to this study, (3) counselor

adaptability. A central construct to ACT, counselor adaptability is a counselor's ability to relate therapeutically with the client in order to implement the most appropriate therapy approach (Gabbard, Howard, & Dunfee, 1986). Thus, using the SWBS and the spiritual well-being subscale of the MPS to measure a Christian counselor's spiritual well-being and the TSI to measure counselor adaptability, insights to the significance spiritual well-being may have in association with one measure of a counselor's ability to relate therapeutically to the client can be analyzed. Spiritual well-being is an important dimension to personal wholeness which can no longer be minimized, particularly as it relates to the well-being of professional counselors as they attempt to nurture the souls of those who seek their guidance.

Chapter 3

Methodology

Participants

Participants were solicited through the membership of the Christian Association for Psychological Studies (CAPS). Members of CAPS included guidance counselors, marriage and family therapists, pastoral counselors, professional counselors, professors and researchers, psychiatrists, psychiatric nurses, psychologists, social workers, and students and professionals in training. Approximately 1,500 members from the United States of America and other countries were listed in the 1998-1999 CAPS membership directory. This research was limited to those members residing within this country.

Five hundred sets of the test instruments—the Spiritual Well-Being Scale; the Mental, Physical, and Spiritual Well-Being Scale; and the Therapist Style Inventory—were mailed via the United States Postal Services (USPS) to randomly selected members of CAPS. The USPS returned as undeliverable 58 (11.4%) sets of instruments. Of the remaining 442 sets of instruments, 37.6% or 166 members responded to the study; and of the 166 responses, 41 (24.7%) sets of instruments were not usable and 125 (75.3%) were usable for this research. Those sets of instruments which were returned by the members of CAPS as unusable were due to the participants having given either incomplete or multiple responses to the instrument questions. In all, 125 of 442 or 28.3% of the surveys mailed, and presumed to have reached their destinations, were returned usable for this research.

Among the surveys usable for this study, distributions of respondents with regard to gender were 63 (50.4%) males and 62 (49.6%) females. Their ages ranged

from 23 to 65 with a mean age of 47.2 years (SD = 9.7). Forty-two (33.6%) respondents identified themselves as psychologists; 31 (24.6%) as marriage and family therapists; 15 (12%) as pastors or pastoral counselors; 11 (8.8%) as Licensed Professional Counselors or Licensed Professional Clinical Counselors; 5 (4.0%) as educators, professors, or teachers; 3 (2.4%) as social workers; 3 (2.4%) as students; and 15 (12.0%) as having other occupations. The highest educational level completed included 54 respondents (43.2%) with doctorates, 66 (52.8%) with master's, 2 (1.6%) with some master's-level education, and 3 (2.4%) with baccalaureates.

At the time of the survey, a majority of the respondents (91 or 72.8%) had been married once and were remaining so. Seventeen (13.6%) had remarried, 9 (7.2%) had yet been married, 7 (5.6%) were single-again, and 1 person was cohabiting. With regard to ethnic backgrounds, although the membership of CAPS included people from all ethnic origins, 120 (96.0%) respondents identified themselves as Caucasians. Others included two Asians, two Latinos, and one person listed as other.

Where personal beliefs and religious experiences were concerned, 121 (96.8%) professed to have received Jesus Christ as their personal Savior and Lord, while 2 had not made such a profession and 2 others claimed a belief in God but not in Jesus Christ as their personal Savior. By far, the majority identified themselves as Protestants (109 or 87.2%), 11 identified themselves as Catholics, 1 as Jewish, and 5 as having other religious preferences. In the past year, 50 participants (40%) attended church, synagogue, or other places of worship more than once a week; 57 (45.6%) attended once a week; 10 (8.0%) attended once a month; 5 (4.0%) attended less than

once a month, 2 attended once or twice a year, and one person had not attended any worship services.

Instruments

The Therapist Style Inventory. The Therapist Style Inventory (TSI) measures a central construct in Adaptive Counseling and Therapy (ACT)—counselor adaptability. ACT was developed as a response to the rise in eclectic approaches to psychotherapy; it was predicated on a belief that the expansive amount of therapeutic techniques available to counselors as well as the entire therapy process could be systematized into an organized framework of techniques and approaches to counseling. A systematized assortment of techniques and their corresponding conceptual frameworks could be most useful to therapists as they seek to apply the most appropriate intervention for their clients. Howard, Nance, and Myers (1987) used, as its guiding principle, the generally accepted model of situational leadership theory (SLT) in the field of organizational behavior developed by Hersey and Blanchard in 1977. The basic philosophy in SLT encompasses the guidance of business managers, who are in some supervisory roles, choose from various leadership approaches an appropriate leadership style uniquely suited for each worker and situation. Insofar as how SLT may have applications in psychotherapeutic processes, Howard et al. (1986) noted:

> Just as within organizations managers are trained in situational leadership to base their leadership behavior on characteristics of the follower and of the situation, so within psychotherapeutic contexts, practitioners should make intervention decisions based on characteristics of the client and on the issues brought to therapy. (pp. 372 - 373)

Adapting for use the central organizing principles from SLT, Howard et al. developed an approach to treatment that was designed to help counselors select therapy styles and the corresponding therapy approaches for their clients. The approach is called Adaptive Counseling and Therapy, and these therapy styles include telling, teaching, supporting, and delegating.

Among the basic tenets of ACT are two sets of behaviors that serve to describe what therapists do. The first is directive behavior, and the second is relationship/support behavior. Therapy approaches befitting the first behavior are, for example, behavioral and psychoanalytic approaches, each representing an extreme on a continuum of directiveness. An intermediate therapeutic approach that utilizes both thoughts and emotions while employing a high directive style might be, for example, the Rational Emotive Therapy. Carl Rogers' Client-Centered therapy and treatment programs based upon a token economy are two examples that represent the extremes on a continuum of a therapist's relationship/support behavior. By combining the two dimensions of therapist behaviors, four types of therapist styles can be delineated. Figure 1 displays the quadrants of therapist styles and their relationship with the two dimensions of therapist behaviors.

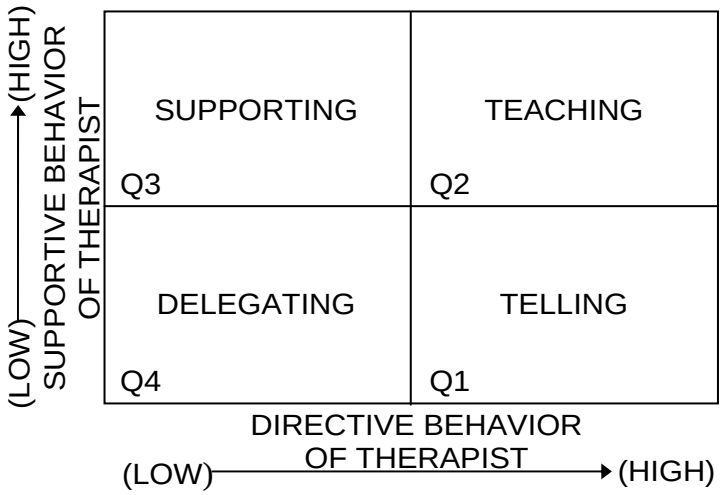

Figure 1. Types of therapist styles. TELLING = high task/low relationship; TEACHING = high task/high relationship, SUPPORTING = low task/high relationship, and DELEGATING = low task/low relationship.

Another basic tenet of ACT surrounds the concept of match and move. According to Howard et al. (1986),

> ACT conceptualizes progress in therapy as movement by the client from an unready state to a more ready state in terms of a specifically designated therapeutic task. This maturation process can also be viewed as movement from a passive to a more active stance, or as a gradual shift from a dependent to an independent position. Early in the therapeutic process, clients tend to rely more heavily upon the therapist for direction and support than in the termination phase of treatment.

It cannot be overemphasized that assessment of a client's readiness level is critical to determining what therapeutic approach will be most beneficial for that client. The optimal approach will (1) meet the client's needs at his or

> her present readiness level, and (2) encourage movement by the client to a higher readiness level. (p. 384)

Determining the appropriate therapeutic style typically follows a progression that begins with the client's initial apprehensions when he or she first enters the therapeutic process. Since most clients at the initial introduction may not be in a position or may be unwilling to make appropriate decisions, ACT prescribes a high direction/low support approach in assisting the clients. Quadrant one, telling, would be an appropriate style. For example, a strong directive may be necessary on the part of the therapist towards a client on the verge of psychotic break to be admitted to a hospital. Similarly, based upon the client's maturation and readiness level in accepting therapeutic interventions, the progression in counseling continues through the phases or quadrants necessitating the therapeutic styles of teaching (e.g., social skills training), supporting (e.g., coaching, facilitating, reflecting materials, etc.), and delegating (e.g., analyzing, commentating, etc.). The movement is one where a therapist progresses from a position of high control to a position of low control as mandated by the needs of the clients. Ideally, termination entails a trust that the client is both able and willing to direct his or her own courses through life. Table 1 provides an ordering of the four therapeutic styles and their probability of success at each of the four client readiness levels as they progress through therapy.

Table 1

Rank-Ordering of Probable Success of Therapist Styles for Clients at Each Maturity Level

Maturity Level	High Probability Therapist Style	Intermediate Probability Styles	Low Probability Therapist Styles
Low	Telling	Teaching > Supporting	Delegating
Low moderate	Teaching	Supporting = Telling	Delegating
High moderate	Supporting	Delegating = Teaching	Telling
High	Delegating	Supporting > Teaching	Telling

The central principle of ACT revolves around the ability of a counselor to adapt an optimal therapeutic style that is best suited to the developmental readiness of a client in therapy. This ability to match and move along with the client is called counselor adaptability.

The measurement of counselor adaptability is brought about by the use of the Therapist Style Inventory (TSI). The inventory consists of 12 counseling situations in which a counselor will select from 4 possible therapeutic responses. Each response corresponds to a presumed therapeutic style. Numerical scores are assigned to each therapeutic style ranging from a value of 1 for the least desirable therapist style, specific to a situation, to a value of 4 for the best choice of therapist style. Adding all the values obtained in the 12 counseling situations total the counselor adaptability score. A range of 12 to 48 is possible with a high score indicating good counselor adaptability.

Gabbard, Howard, and Dunfee (1986) conducted three studies to assess the psychometric adequacy and the construct validity of this instrument. In the first study, internal consistency was assessed by computing the part-whole correlation for a long version of Counselor Behavior Analysis Scale: CBA-Long (24 scenarios), with two shorter versions of CBA (12 scenarios). The two shorter versions were CBA-A (this is the same as the TSI) consisting of the first 12 scenarios and CBA-B consisting of the last 12 scenarios of CBA-long. The correlation for the CBA-A and CBA-B with CBA-Long adaptability scores were .78 and .77 respectively. Half of the counselors (22) who participated in the initial study were given a 3-month test-retest evaluation. Reliability was .46. No drift in ratings was observed (M Time 1 = 73.09 and M Time 2 = 72.50), t (21) = .53, p = .60. The range of the CBA adaptability score at Time 1 was 59 to 83 out of a possible range of 24 to 96. At Time 2, the range was 65 to 82. A reliability coefficient for stability style was also obtained by correlating the frequency of endorsement of each style between the first and second rating. The coefficients were .55 for telling, .76 for teaching, .70 for supporting, and .46 for delegating.

The second study used a pretest-posttest design to assess the effectiveness of the CBA in measuring change in counselor adaptability. Eleven counselors in training first completed the CBA-Long. They then participated in a 2-hour workshop on ACT theory and were subsequently given the CBA-Long again under two sets of instructions: How would you as a therapist respond to this situation (regular), and what is the correct response according to ACT theory (correct)? The mean pretest adaptability score was 73.43 (SD = 4.45; range = 66 – 81). Posttest score under regular instruction was M = 76.5 (SD = 6.65; range = 66 – 87); t (9) = 2.59, p < .05.

Under the correct instruction, M = 78.5 (SD = 4.35; range = 73 – 85); and t (9) = 5.83, p <.001.

The third study used therapist self-rating, colleague or supervisor ratings, client ratings, and judges' ratings of taped therapy sessions to assess construct validity. The measures used were the CBA-B, the Counselor Talkativeness Rating Scale, the Counselor Overall Outcome/Effectiveness Scale, and the Counselor Empathy Scale. Counseling tapes were submitted for independent scoring by raters. Each counselor was also asked to obtain various ratings from his or her supervisor or colleague and two clients each using the same instruments.

Using Jöreskog and Sörbom's LISREL V (trait x method) program for confimatory factor analysis, significance of fit of the model with observed data was supported. These tests lend support to the construct validity of counselor adaptability as a viable predictor of counseling outcome.

The Mental, Physical, and Spiritual Well-Being Scale. Developed by Vella-Brobrick in 1995, the Mental, Physical and Spiritual Well-Being Scale (MPS) is a 30-item self-reporting scale that includes three 10-item subscales of mental, physical, and spiritual well-being. The emphasis of the MPS is a balanced appraisal—wellness and illness—of the three named facets of health. According to Vella-Brodrick (1995), "The definition of well-being . . . focused on the balanced nourishment of the mind, body, and spirit. These three dimensions have commonly been referred to as the most influential dimensions of health" (p. 661). The instrument is intended to solicit behavior-oriented reports rather than expressions of feelings or opinions. The author acknowledged that the accuracy of report is dependent upon the respondent's honesty and recall. However, she contended that remembrances of behaviors are less

subjected to bias of personal thoughts, beliefs, and emotional reactions. The instrument is appropriate for the evaluation both of an individual's health complaint or the assessment of individual health status. Since the instrument has not been tested for the age groups below 18 years and above 65 years, Vella-Brobrick recommended the MPS for use among English-literate adults who are between the ages of 18 and 65. Each subscale score ranges from 5 to 50 with the higher score reflecting greater well-being.

In a study to prove concurrent validity, 140 adults completed the MPS and the General Health Questionnaire, 60 participants completed these two scales plus the Spiritual Well-Being Scale (SWBS), and 40 participants completed the MPS and the SWBS. Table 2 shows the Pearson correlation between scores on the MPS and GHQ.

Table 2

Correlations of Subscale Scores on the Mental, Physical, and Spiritual Well-Being Scale with Scores on General Health Questionnaire

		Mental, Physical, and Spiritual Well-Being Scale		
		Mental	Physical	Spiritual
General Health Questionnaire	r	-.22	-.38	-.10
	p	<.05	<.001	>.05

Brodrick and Allen explained the findings: Although scores on the mental and physical subscales were significantly correlated with those on the General Health Questionnaire, the correlations were relatively low. Scores on the Spiritual subscale were not significantly correlated. The correlations were negative because a high

score on the MPS scale reflected a good level of health, whereas high scores on the General Health Questionnaire reflected poor health.

The lack of correlation with spiritual well-being reflected the fact that GHQ was not designed to measure the spiritual component of health. To compensate for the lack of a spiritual dimension in the GHQ, the SWBS was used to correlate with the spiritual well-being subscale of the MPS. A Pearson correlation of .82 was obtained, which supported the concurrent validity of the spiritual well-being subscale of the MPS.

In testing for reliability, 100 undergraduate psychology students participated in an internal consistency experiment over a one-month interval. For each of the three subscales, coefficients alpha showed an acceptable internal consistency with a range between .75 and .85. Next, a test-retest experiment was used to determine the reliability of the MPS over time. One hundred adults who took part in the original validity test participated in the retest. Over a one-month interval, the Pearson values were .94 for the mental subscale, .87 for the physical subscale, and .97 for the spiritual subscale.

Finally, the discriminative validity of the MPS was explored in another study using three activity groups representing the three predominant subscales. Twenty-eight members of a chess club, 30 members of a weight-training group, and 30 members of a prayer group participated representing the respective characteristic found in mental, physical, and spiritual well-being. Overall, 77.3% of the cases were correctly classified into their actual activity group. Together, these tests substantiate the validity and reliability of the MPS.

The Spiritual Well-Being Scale (SWBS). The Spiritual Well-Being Scale (Paloutzian & Ellison, 1982; Ellison, 1983) is a 20-item self-report instrument designed to measure spiritual well-being from a Christian perspective. Spiritual well-being can subsequently be delineated by two subscales. These subscales are religious and existential well-being, and they are designed to measure the two dimensions of spirituality: a vertical component considering one's relationship with God and a horizontal component considering one's level of contentment towards life and relationship with others. The SWBS is intended to be a measurement of an individual's subjective state of well-being. That is, responses to the questions rest upon the respondent's perceived level of spiritual connectedness with God and life satisfaction.

The SWBS has become one of the most widely accepted and used measures of spirituality (Ellison & Smith, 1991). Developed by Ellison and Paloutizian (1982), it followed Moberg's (1971, 1979, 1984) conceptualization of spiritual well-being as having two dimensions: a vertical dimension with God and a horizontal dimension with other people. The scale also followed Moberg's indices of spiritual well-being. Each item on the SWBS is rated on a 6-point Likert Scale. The possible answer ranges from strongly disagree to strongly agree. A value of 1 to 6 is assigned to each item. The values are summed to yield three scores: religious, existential, and spiritual well-being. Scores for both the religious and existential well-being range from 10 to 60, while the score for the spiritual well-being ranges from 20 to 120 with the higher scores representing greater well-being. The spiritual well-being score is calculated by summing both the religious and existential well-being scores.

In the original analysis for reliability and validity, Ellison (1983), using a sample of 100 students, found test-retest reliability coefficients to be .93 for spiritual well-being, .96 for religious well-being, and .86 for existential well-being. Other test-retests using four different samples with 1- to 10-week intervals between tests yielded reliability coefficients ranging from .82 to .99 for spiritual well-being, .88 to .99 for religious well-being, and .73 to .98 for existential well-being (Hall, Tisdale, & Brokaw, 1994). The internal consistency of the SWBS was established based upon data from over 900 subjects across seven studies. The internal consistency reliability coefficients ranged from .89 to .94 for spiritual well-being, .82 to .94 for religious well-being, and .78 to .86 for existential well-being (Boivin, Kirby, Underwood, and Silva, 1993).

In evaluating validity, Ellison (1983) conducted a factor analysis of the SWBS. All ten items for both religious well-being and existential well-being were retained, although the existential well-being items seemed to cluster around two subfactors that alluded to life direction and life satisfaction. Nevertheless, results were generally consistent with the conceptual composition of the SWBS. Ledbetter, Smith, Fischer, Vosler-Hunter, and Chew (1991) subsequently suggested that the SWBS might be more multidimensional than the two-factor model initially proposed by Ellison. Instead, the authors suggested that additional factors, or a reorganization of items into different factors, may be helpful in investigating other possible components of spiritual well-being (p. 100). The authors also raised a concern for the possibility of some ceiling effects when using this instrument on certain religious populations (e.g., pastors). In another study, Ledbetter, Smith, Vosler-Hunter, and Fischer (1991) reiterated the psychometric limitations of the SWBS but affirmed

that “the SWBS has demonstrated an excellent ability to measure low scores . . . across a wide range of religious beliefs and practice” (p. 55). The creators of the SWBS generally concur with this observation. They stated,

> At the present time, the SWBS appears to be most useful in clinical settings to detect the presence of a significantly impaired level of well-being. Because of ceiling effects, the SWBS does not presently discriminate well among people scoring above the median (50th percentile) in evangelical samples, and thus it cannot be used to identify those persons who are functioning at the highest levels of spiritual well-being. Adding items which discriminate well among highly religious samples might solve this problem. (Bufford, Paloutzian, and Ellison, 1991, p. 66)

Although some participants in this research fall under the occupational category of pastors or pastoral counselors for which the limitations of the SWBS may apply, the majority of the participants do not fall within this occupational category. To date, no research has been done to evaluate the spiritual well-being of the population group in this study. Also, an inclusion of a second measurement of spiritual well-being (the MPS) with an emphasis upon behavioral characteristics of spiritual well-being might add strength to the evaluation. Furthermore, a valuable observation to be made would be to compare the levels of spiritual well-being among Christian counselors with those of pastors or pastoral counselors.

Nevertheless, despite some psychometric questions, the SWBS has been widely accepted and extensively used in clinical settings and research since its construction. Renfroe, Jr. (1990) compiled a list of validity studies that the SWBS

has found to correlate. The following is a limited listing of validity studies on Spiritual Well-Being Scale:

1. Spiritual Maturity Index (Bressem, 1986; Bufford, 1984; Carr, 1986; Cooper, 1987; Jang, Paddon, & Palmer, 1985; Mueller, 1986; Parker, 1984)
2. Spiritual Leadership Qualities Inventory (SLQI) (Parker, 1984; Carr, 1986)
3. Religious Orientation Scale-Intrinsic (ROS-I) (Bufford, 1984; Ellison & Paloutzian, 1979; Mueller, 1986; Quinn, 1984)
4. Supernatural Locus of Control (SLOC) (Durham, 1986)
5. Religious Fundamentalism Content (REL scale from the MMPI) (Frantz, 1985)
6. Importance of religion to an individual (Durham, 1986; Bufford, 1984; Carr, 1986; Carson, Soeken, & Grimm, 1988; Davis, Longfellow, Moody, & Moynihan, 1987; Durham, 1984, Frantz, 1985, Jang, 1987)
7. Viewing God as causal agent (Durham, 1986)
8. Frequency and/or duration of personal devotions (Bressem, 1986; Bressem, Waller, & Powers, 1985; Bufford, 1984; Carr, 1986; Clarke, 1987; Colwell, 1987; Davis, Longfellow, Moody, & Moynihan, 1987; Ellison & Economos, 1981; Huggins, 1988; Jang, 1987; Jang, Paddon, & Palmer, 1985)
9. Frequency of church attendance (Bufford, 1984; Colwell, 1987; Durham, 1986; Ellison & Economos, 1981; Frantz, 1985; Hawkins, 1986; Huggins, 1988; Jang, 1987; Mitchell, 1984; Quinn, 1984; Sherman, 1987)
10. Frequency of family devotions (Bufford, 1984)
11. Pastor/leader evaluations of present relationship to God (Bressem, Waller, & Powers, 1985)
12. RWB and one’s attitude toward charismatic practices (Bressem, 1986)

13. Religious knowledge (Bressem, Colwell, Mueller, Neder, & Powers, 1985; Carr, 1986; Davis et al., 1987; Jang, 1987)
14. Church leadership experience (Moody, 1988)
15. Feeling accepted and valued by God (Ellison & Economos, 1981; Ellison, Rashid, Patla, Calica, & Haberman, 1984)
16. Estimation of one's spiritual maturity (Davis et al., 1987)
17. Attending seminary (Bufford, Bentley, Newenhouse, & Papania, 1986)
18. Participation in religious activities (Bonner, 1988)
19. Small group participation (Huggins, 1988)

Procedures

The first phase of the research was to obtain a randomized sampling of members of CAPS residing with the United States of America. Using the table of random numbers from A Million Random Digits with 100,000 Normal Deviates by the Rand Corporation, 500 members were selected for solicitation among approximately 1,500 members of CAPS. Thereafter, packets each containing a letter of invitation explaining the general purpose of the study and procedure for confidentiality, a demographic profile questionnaire, the SWBS, the MPS, and the TSI (see Appendix A) were mailed to the subjects via the United States Postal Services.

If the members chose to participate, they were given, essentially, 6 weeks to respond (3 extra weeks were included after the stated deadline for delayed responses). All usable instruments were scored, and statistical computations were conducted using the Statistical Package for the Social Sciences (SPSS) program.

Scoring the Therapist Style Inventory. The Therapist Style Inventory was scored using the Therapist Adaptability Scale (TAS). By noting the letters that correspond to one of the four possible interventions to each situation presented in the TSI, a value is assigned according to the TAS. When the values of the respective responses are assigned, the summation of scores will yield the total counselor adaptability score. A score of 12 equates to the lowest level of counselor adaptability while a score of 48 equates to the highest level of counselor adaptability. A Therapist Adaptability Scale can be found in Appendix B.

Scoring the Mental, Physical, and Spiritual Well-Being Scale. Each response on the MPS is arranged on a 5-point Likert type scale with 5 indicating the highest level of well-being. In order to minimize response bias, scores on items 1, 2, 4, 6, 8, 9, 12, 13, 15, 19, 20, 24, 26, 28, and 30 are reversed. Scores for each of the three subscales are summed as follows:

1. Add items 2, 3, 7, 9, 13, 17, 19, 23, 26, and 27 for the mental subscale score.
2. Add items 5, 8, 10, 12, 15, 20, 21, 25, 28, and 29 for the physical subscale score.
3. Add items 1, 4, 6, 11, 14, 16, 18, 22, 24, and 30 for the spiritual subscale score.

A score of 10 equates to the lowest level of well-being while a score of 50 equates to the highest level of well-being in each of the subscales. A summation of the three subscale scores to attain one total score is not recommended.

Scoring the Spiritual Well-Being Scale. Each response on the SWBS is arranged on a 6-point Likert type scale with 6 indicating the highest level of well-being. For the positively worded items, a value of 6 is assigned to the response of "Strongly Agree" and a value of 1 is assigned to the response of "Strongly Disagree." For the negatively worded items, the assignment of scores is reversed.

The positively worded items are 3, 4, 7, 8, 10, 11, 14, 15, 17, 19, and 20, while the negatively worded items are 1, 2, 5, 6, 9, 12, 13, 16, and 18. A score between 20 and 40 signifies a low level of spiritual well-being, a score between 41 and 99 signifies a moderate level of spiritual well-being, and a score between 100 and 120 signifies a high level of spiritual well-being.

In a measurement of how a person views his or her sense of satisfaction and positive connection with God, a religious well-being score can be obtained by adding the odd numbered items. Adding the even numbered items will give a measure of existential well-being or how a person perceives his or her level of life satisfaction and life purpose. In each of the two subscales, a score between 10 and 20 signifies a low level of religious and existential well-being, a score between 21 and 49 signifies a moderate level, and a score between 50 and 60 signifies a high level of religious and existential well-being.

The focus of this study was to determine the nature of the relationship between spiritual well-being and counselor adaptability. In order to understand spiritual well-being in the overall scheme of influences upon a counselor's adaptability, other factors were also drawn into the evaluation: religious, existential, mental, and physical well-being; age; gender; occupation; education; ethnic background; faith and belief in Jesus Christ; religious preference; and attendance in church, synagogue or other places of worship. Setting the alpha level at .05 ($a = 0.05$), these factors were evaluated along with spiritual well-being and counselor adaptability. Then using multiple regression with counselor adaptability as the dependent variable, the relationships among the various factors mentioned were analyzed for their relative strength in accounting for variability of counselor

adaptability. Conclusions were then drawn as to the significance of relationship spiritual well-being has with counselor adaptability.

Chapter 4

Results

Descriptive Results

Demographic Profiles

The participants' age ranged from 23 to 65 with a mean of 47.19 years and a standard deviation of 9.69. The specific mean ages and their respective standard deviations between male and female participants are summarized in Table 3. Table 4 is a summary of the frequency distributions of demographic variables for this research population.

Table 3

Age Means and Standard Deviations of Male and Female Research Participants

	n	M	SD
Male	63	46.40	9.89
Female	62	48.00	9.47

Table 4

Demographic Summaries of the Research Participants

	n	Percent	Cumulative Percent
Gender			
Male	63	50.4	50.4
Female	62	49.6	100.0

(table continues)

Table 4. (continued)

	n	Percent	Cumulative Percent
Occupation			
Psychologist	42	33.6	33.6
Marriage/Family Therapist	31	24.8	58.4
Social Worker	3	2.4	60.8
Professor/Teacher	5	4.0	64.8
Pastor/Pastoral Counselor	15	12.0	76.8
LPC/LPCC	11	8.8	85.6
Student	3	2.4	88.0
Other	15	12.0	100.0
Education			
College Degree	3	2.4	2.4
Some Master's Level	2	1.6	4.0
Master's Degree(s)	66	52.8	56.8
Doctorate(s)	54	43.2	100.0
Marital Status			
Single/Never Married	9	7.2	7.2
Single Again	7	5.6	12.8
Married - First	91	72.8	85.6
Remarried	17	13.6	99.2
Living Together	1	0.8	100.0

(table continues)

Table 4. (continued)

	n	Percent	Cumulative Percent
Ethnicity			
African American	0	0.0	0.0
American Indian	0	0.0	0.0
Asian	2	1.6	1.6
Caucasian	120	96.0	97.6
Latino	2	1.6	99.2
Other	1	0.8	100.0
Christian			
No	2	1.6	1.6
Yes	121	96.8	98.4
Believe in God not Jesus	2	1.6	100.0
Religious Preference			
Catholic	11	8.8	8.8
Jewish	1	0.8	9.6
Protestant	109	87.2	96.8
Other	4	3.2	100.0
Worship Attendance in the Past Year			
None	1	0.8	0.8
1-2 Times	2	1.6	2.4
3-11 Times	5	4.0	6.4

(table continues)

Table 4. (continued)

	n	Percent	Cumulative Percent
12 Time or More	10	8.0	14.4
52 Times	57	45.6	60.0
More Than Once a Week	50	40.0	100.0

A summary of the scores obtained from the SWBS, the MPS, and the TSI is given in Table 5. This summary also delineates the two subscale scores of religious well-being (Religious WB) and existential well-being (Existential WB) in the SWBS.

Table 5

Summary of Scores Obtained for the Spiritual Well-Being Scale; the Mental, Physical, and Spiritual Well-Being Scale; and the Therapist Style Inventory

			Scores		
Scales & Subscales	M	SD	Min.	Max.	Range
Religious WB	55.44	6.07	29	60	10 – 60
Existential WB	51.96	5.66	29	60	10 – 60
Spiritual WB (SWBS)	107.40	10.88	58	120	20 – 120
Mental WB	34.54	3.59	25	43	10 – 50
Physical WB	36.82	5.80	20	48	10 – 50
Spiritual WB (MPS)	44.58	4.27	27	50	10 – 50
Counselor Adaptability	36.93	2.88	27	47	12 – 48

Scores Obtained by the Therapist Style Inventory

With respect to counselor adaptability, the TSI scores for the participants of this research fell, within a possible range of 12 through 48, between 27 and 47. A mean score of 36.93 (SD = 2.88) exceeded the midpoint score of 30 on the scale; score distribution was normal for this population of Christian counselors. The frequency distribution of mean scores obtained by research participants using TSI is displayed in Figure 2.

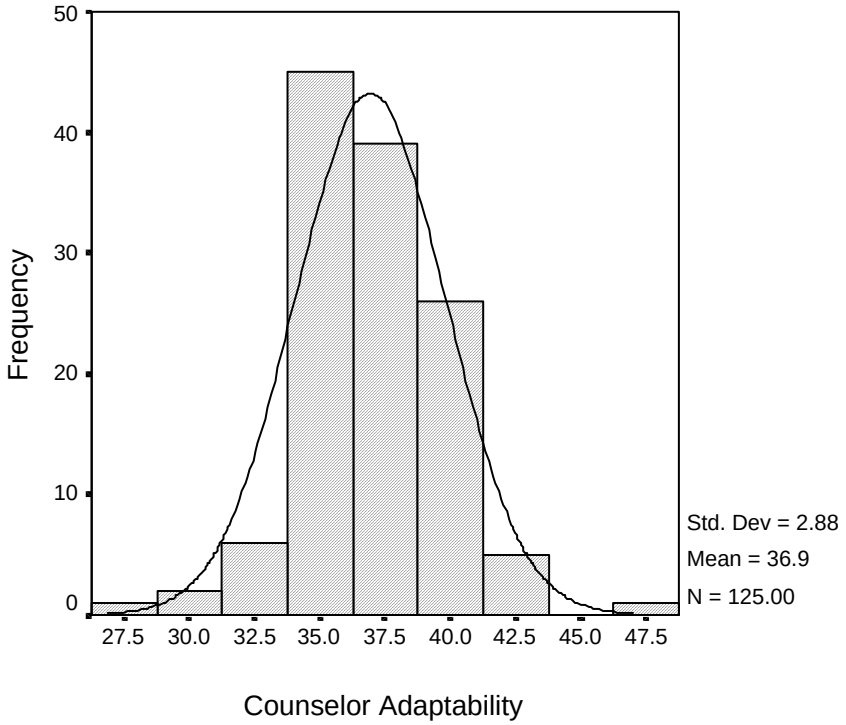

Figure 2. Frequency distribution of mean scores for counselor adaptability.

Scores Obtained by the Spiritual Well-Being Scale.

In determining spiritual well-being from the perspective of the SWBS, within a possible range of 20 through 120, the participants scored between 58 and 120. The mean score was 107.4 with a standard deviation of 10.9. Interestingly, 103 (82.4%) participants scored in the range of 100 to 120 signifying a high level of spiritual

well-being, and none scored 40 or below, which would signify a low spiritual well-being. Although the results may be expectedly high given the population at hand, they indicated that ceiling effects are also present for this population. Table 6 provides the results of the participants' scores along with selected population norms provided in the manual for the SWBS. Scores for the two subscales of the SWBS—religious and existential well-being—are also included for comparison.

Table 6

Comparison of Means and Standard Deviations Between Christian Counselor Well-Being Scores and the Norm of Selected Sample Groups

		Religious		Existential		Spiritual	
	N	M	SD	M	SD	M	SD
Christian Counselors	125	55.40	6.07	52.00	5.66	107.40	10.88
Religious Groups							
Alliance	330	53.58	6.23	49.42	7.38	103.00	12.30
Assembly of God	41	56.73	5.42	53.15	6.78	109.88	11.58
United Methodist	32	49.64	7.43	49.47	7.29	99.09	13.48
Born Again	143	55.64	5.87	52.58	6.31	108.13	11.08
Ethical Christian	33	46.76	8.30	46.67	7.78	93.42	14.63
Conservative Baptist	285	54.77	6.14	51.19	7.33	105.93	12.59
Unitarians	45	34.10	13.03	48.71	7.57	82.81	15.02
Evangelical Seminary Students	55	54.75	5.92	51.25	5.88	106.00	10.29

(table continues)

Table 6. (continued)

		Religious		Existential		Spiritual	
	N	M	SD	M	SD	M	SD
Counselees							
Combined Patients	182	44.87	10.58	38.84	9.95	83.68	17.91
Others							
Christian Convicts	27	51.10	10.40	50.10	10.40	105.50	13.15
Non-relig. Convicts	25	35.60	9.20	40.70	9.20	76.30	16.30
Caregivers	64	48.00	11.03	46.34	8.21	93.91	17.68
Medical Outpatients	56	51.50	9.67	48.50	8.38	99.89	16.01

The mean scores obtained by this group of participants on the SWBS were generally comparable to the mean scores obtained by the various religious groups. Also, with the exception of the Unitarians, the scores of this research group as well as the scores within the norm samples under the religious groups category were higher than those obtained by the combined patients under the counselees category. The higher scores of the various religious groups could be expected because they could be assumed to be more spiritually mature and, thus, be better qualified to offer spiritual directions to those needing assisting. Finally, the mean scores of this group of Christian counselors were also higher than those samples in the other category: Caregivers, Christian sociopathic convicts, and medical outpatients. An interesting sample group to note is the Christian sociopathic convicts whose mean scores indicated that they had high spiritual well-being. Figure 3 displays two frequency distributions of the mean scores of the subscales, religious and existential well-being,

in the SWBS obtained by the participants in this research. Figure 4 displays the frequency distribution of the mean scores of the SWBS, which is the summation of the religious and existential subscale scores.

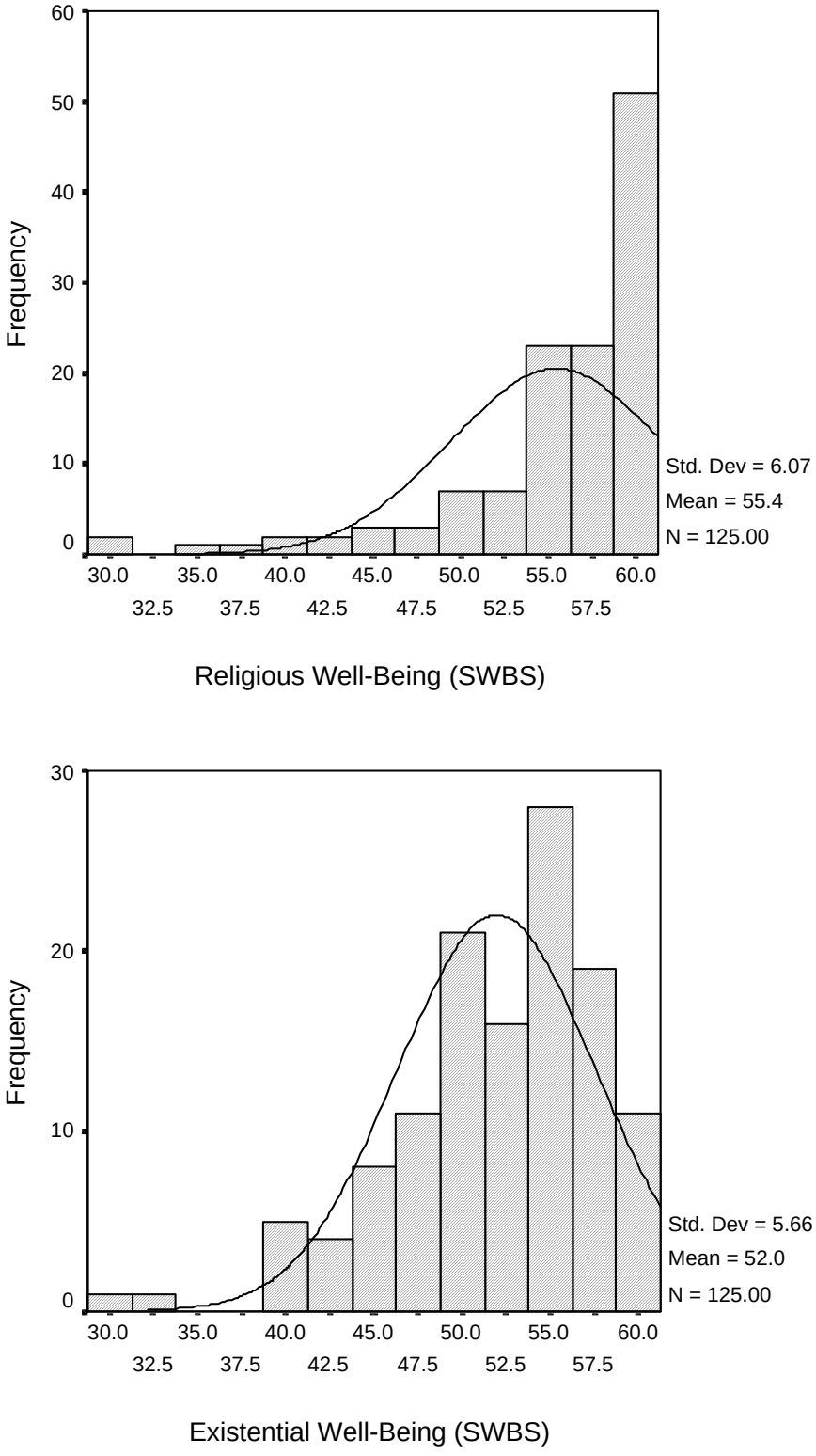

Figure 3. Frequency distributions of mean scores for the two subscales of the Spiritual Well-Being Scale: religious and existential well-being.

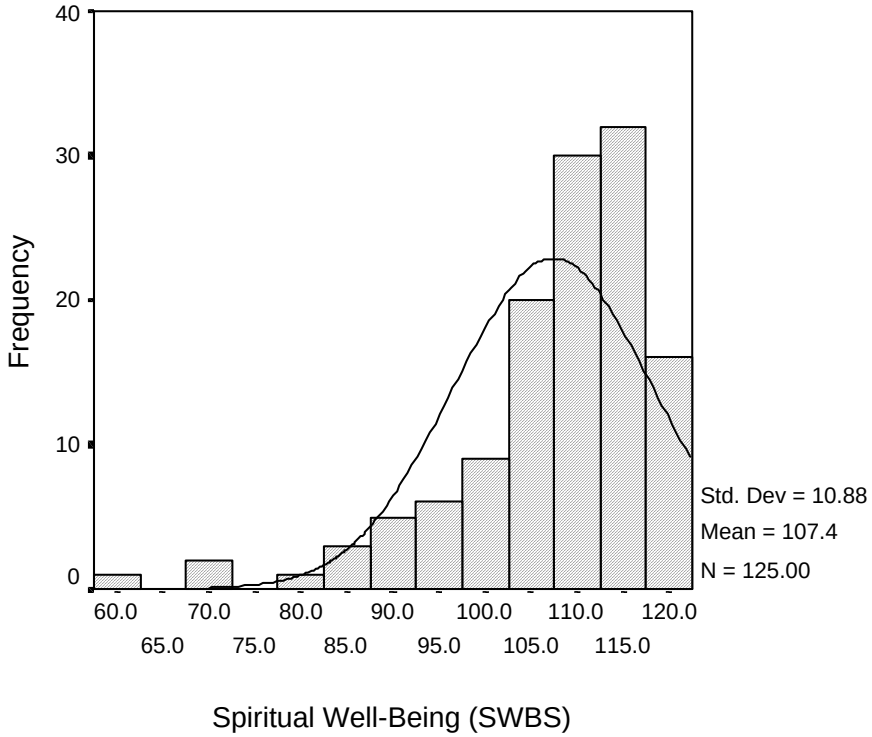

Figure 4. Frequency distribution of the mean scores of the Spiritual Well-Being Scale.

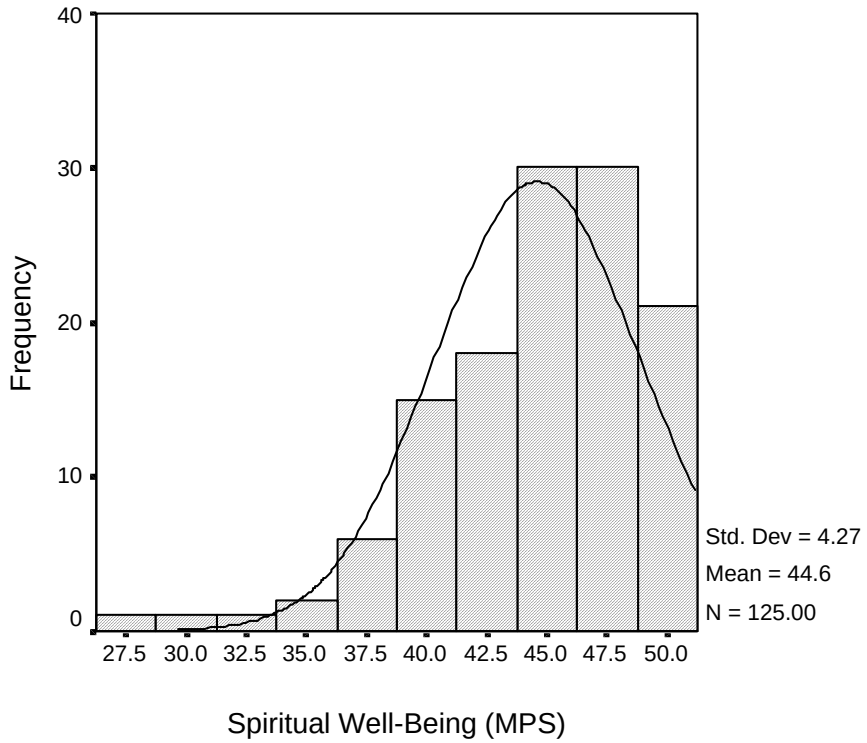

Figure 5. Frequency distribution of mean scores for the spiritual well-being subscale of the Mental, Physical, and Spiritual Well-Being Scale.

Scores Obtained by the Mental, Physical, & Spiritual Well-Being Scale

Spiritual well-being subscale scores. Looking at the spiritual well-being subscale of the MPS, out of a possible range of 10 through 50, the research participants scored between 27 and 50. The mean score was 44.58 with a standard deviation of 4.27. Figure 5 displays a summary of the frequency distribution of mean scores for the spiritual well-being subscale of the MPS.

Similar to the results found in the SWBS, 108 (86.4%) participants obtained a score of 41 or higher in the spiritual well-being category. However, this finding varied from the general norm given in the User's Guide to MPS where only 5% of the population tested obtained a score higher than 41. This difference can again be attributed to the population of choice for this research. The sample groups used by the author of MPS, Vella-Brodrick, to obtain the initial norm data were 188 university students and 129 Commonwealth Scientific and Industrial Research Organization (CSIRO) employees. Spiritual emphases between these two sample groups (from which norm data were obtained) and participants of this research may very well be different. A summary of the norms for the male, female, and combined (general) population with respect to the three MPS subscale scores is provided in Appendix C.

Mental well-being subscale scores. For the mental well-being subscale of the MPS, out of a possible range of 10 through 50, participants in this research scored within the range of 25 through 43. The mean score was 34.54 with a standard deviation of 3.59. The distribution of scores obtained for mental well-being among participants for this research was more normal than the distribution found for spiritual well-being. However, unlike Vella-Brodrick's initial findings listed in the

User's Guide for MPS, an independent samples t-test showed that the difference in mental well-being between this population of male and female Christian counselors was not statistically significant t (123) = +0.187, p > .05. A tabulated summary of means and standard deviations of scores pertaining to gender can be found in Table 16 under the section entitled Ancillary Findings: Gender. Figure 6 displays the frequency distribution of the mean scores of the mental well-being subscale of the MPS.

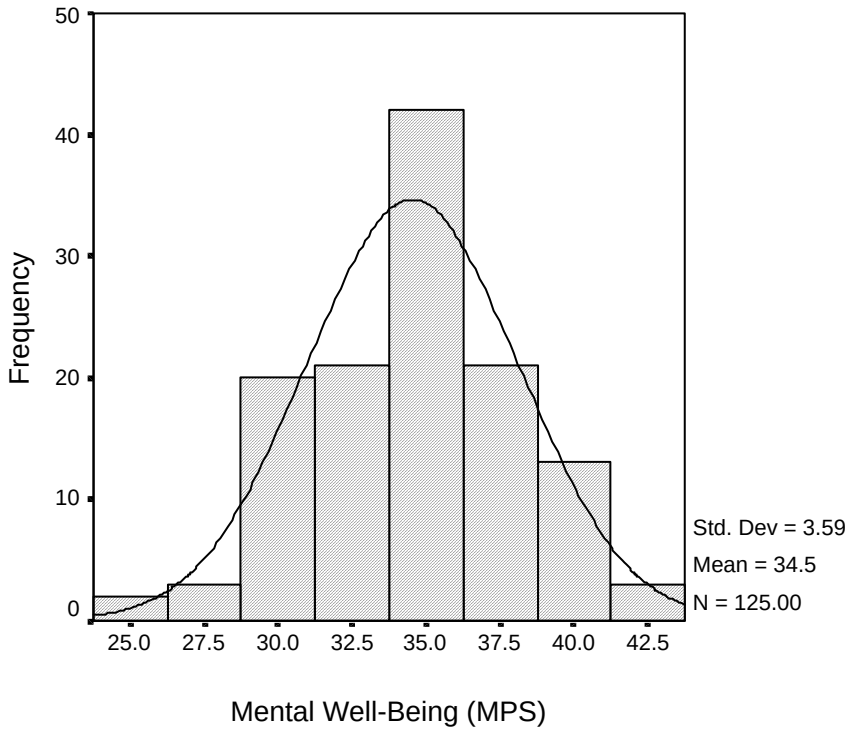

Figure 6. Frequency distribution of mean scores for the mental well-being subscale of the Mental, Physical, and Spiritual Well-Being Scale.

Physical well-being subscale scores. For the physical well-being subscale of the MPS, out of a possible range of 10 through 50, participants in this research scored within the range of 20 through 48. The mean score was 36.82 with a standard deviation of 5.80. The distribution of scores obtained for physical well-

being among these research participants did appear to skew towards the left, though it was not as much as the distribution found for spiritual well-being. Figure 7 displays the frequency distribution of the mean scores of the physical well-being subscale of the MPS.

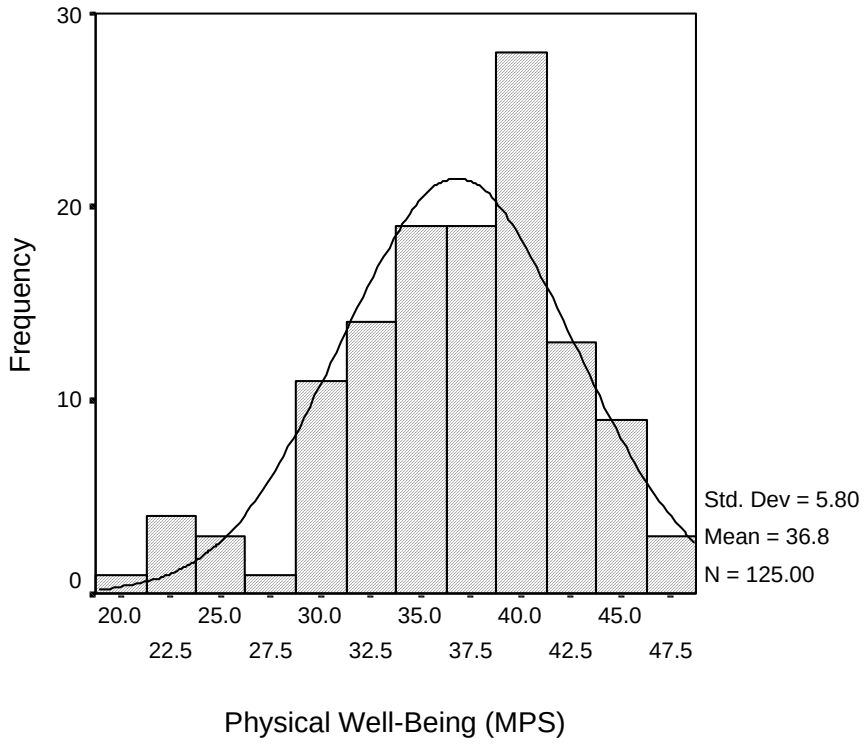

Figure 7. Frequency distribution of mean scores for the physical well-being subscale of the Mental, Physical, and Spiritual Well-Being Scale.

In the User's Guide for MPS, Vella-Brodrick stated that "norms for males and females were found to be significantly different with males tending to have higher scores indicating greater levels of well-being than did females, particularly on the physical dimension" (p. 16). An independent samples t-test did show that the difference in physical well-being between this population of male and female Christian counselors was in fact statistically significant $t\ (123) = +2.359$, $p \leq .05$. This result extends the distinction found in physical well-being between males and

females to this population of Christian counselors: male Christian counselors being more physically well than their female counterparts. A tabulated summary of means and standard deviations of scores pertaining to gender can be found in Table 16 under the section entitled Ancillary Findings: Gender.

The First Hypothesis

The first hypothesis was that a positive correlation existed between both measures of spiritual well-being and counselor adaptability among Christian counselors. Pearson correlation showed no statistically significant correlation between spiritual well-being as measured by the SWBS and counselor adaptability $r = .058$, $p = .676$, two-tailed. When spiritual well-being is evaluated through its two subscales, religious and existential well-being, neither was found to have any statistically significant correlation with counselor adaptability. The results were $r = .014$, $p = .878$, two-tailed and $r = .058$, $p = .522$, two-tailed respectively. The results from Pearson correlation also showed no statistically significant correlation between the spiritual well-being subscale of MPS and counselor adaptability $r = .023$, $p = .798$, two-tailed. The results of the Pearson correlations between counselor adaptability and both measures of spiritual well-being are summarized in Table 7. Other measures of well-being pertaining to the second hypothesis—religious, existential, mental, and physical—are also included for reference.

Table 7

Summary of Pearson Correlations Between Counselor Adaptability and Religious, Existential, Mental, Physical, and Both Measurements of Spiritual Well-Being

	r	p
Religious Well-Being	.014	.878
Existential Well-Being	.058	.522
Spiritual Well-Being (SWBS)	.038	.676
Mental Well-Being	-.133	.138
Physical Well-Being	.022	.804
Spiritual Well-Being (MPS)	.023	.798

Following the suggestion that SWBS may have more usefulness in evaluating for those individuals who obtain lower scores (Ledbetter, Smith, Vosler-Hunter, and Fischer, 1991; Bufford, Paloutzian, and Ellison, 1991), an evaluation was done to correlate counselor adaptability among those research participants who scored one or more standard deviations below the mean scores for religious, existential, mental, physical, and both measures of spiritual well-being. Results using Pearson correlation showed that none of the correlations were statistically significant and that all had either low or moderate correlations. The results of Pearson correlations are summarized in Table 8.

Table 8

Summary of Pearson Correlations Between Counselor Adaptability and Research Participants Who Scored One or More Standard Deviations Below the Sample Mean on Religious, Existential, Mental, Physical, and the Two Measurements of Spiritual Well-Being Scores

	r	p
Religious Well-Being	-.206	.444
Existential Well-Being	-.022	.928
Spiritual Well-Being (SWBS)	-.058	.818
Mental Well-Being	-.290	.242
Physical Well-Being	-.134	.574
Spiritual Well-Being (MPS)	.412	.101

The Second Hypothesis

The second hypothesis was that, when other factors such as religious, existential, mental, and physical well-being; gender; occupation; levels of education; and worship attendance were considered, the relationship between spiritual well-being and counselor adaptability should prove to be the most statistically significant. Given the apparent lack of statistical significance between either measures of spiritual well-being and counselor adaptability, attention was drawn instead to determine which variable or variables might be found to correlate significantly with counselor adaptability.

Religious Well-Being

In an analysis of the religious well-being subscale of the SWBS, a Pearson correlation showed religious well-being to have no statistically significant correlation with counselor adaptability r = .014, p = .878, two tailed (see Table 7).

Existential Well-Being

In an analysis of the existential well-being subscale of the SWBS, a Pearson correlation showed existential well-being to have no statistically significant correlation with counselor adaptability r = .058, p = .522, two-tailed (see Table 7).

Mental Well-Being

In an analysis of the mental well-being subscale of MPS, a Pearson correlation showed mental well-being to have a slightly negative correlation with counselor adaptability (see Table 7). That is, a greater level of mental well-being has an apparently minor inverse effect upon counselor adaptability for this research population. The correlation, however, was not statistically significant r = -.133, p = .138, two-tailed.

Physical Well-Being

In an analysis of the physical well-being subscale of the MPS, a Pearson correlation did not show physical well-being to have any statistically significant correlation with counselor adaptability r = .022, p = .804, two-tailed (see Table 7).

Among the descriptive variables obtained through the demographic questionnaire, four variables were not tested because the population was essentially homogeneous within those categories (see Table 4). These excluded variables were (1) marital status, where 72.8% of the participants were in their first marriage; (2) ethnicity, where 96% of the participants were Caucasians; (3) profession of faith,

where 96.8% of the participants claimed to have received Jesus Christ as their personal Savior and Lord; and (4) religious preference, where 87.2% considered themselves Protestants. The variables included for analyses were the research participants' (1) age, (2) gender, (3) occupation, (4) level of education attained, and (5) church/synagogue/place of worship attendance.

Age

An analysis was made using a Pearson correlation to determine the relationship between counselor adaptability and the ages of this group of Christian counselors. The result from a Pearson correlation showed that there was not a statistically significant relationship between counselor adaptability with respect to age $r = -.123$, $p = .171$, two-tailed.

Gender

In an analysis of the relationship between gender and counselor adaptability, using an independent samples t-test, results showed a slight difference between male and female Christian counselors where counselor adaptability was concerned with male Christian counselors being more adaptable than their female counterparts. However, the difference was not statistically significant $t\ (123) = +1.788$, $p = .076$, two-tailed. The mean scores on the TSI for male and female Christian counselors were 37.38 (SD = 2.42) and 36.47 (SD = 3.24) respectively. The section entitled Ancillary Findings: Gender provides a more in-depth evaluation on gender differences in this research. Table 16 within that same section provides a summary of the findings with respect to the independence samples t-test on gender.

Occupations

Analyses were made using Oneway ANOVA in verifying the differences between counselor adaptability and the various occupations held by Christian counselors in this research. Results from Oneway ANOVA revealed no statistically significant differences among the various occupations and counselor adaptability F (7, 117) = .833, p = .56. Table 9 provides a descriptive of the results of the participants' counselor adaptability as arranged by their respective occupations. Table 10 provides a summary of the findings of ANOVA on counselor adaptability with respect to the research participants' occupations.

Table 9

Summary of Therapist Style Inventory Mean Scores and Standard Deviations for Counselor Adaptability of Christian Counselors According to Their Occupations

				Scores (Range = 12 – 48)	
Occupations	n	M	SD	Min.	Max.
Psychologist	42	36.98	2.75	27	42
Marriage/Family Therapist	31	36.48	2.36	32	41
Social Worker	3	39.33	6.66	35	47
Professor/Teacher	5	37.00	1.87	35	40
Pastor/Pastoral Counselor	15	37.73	3.65	31	43
LPC/LPCC	11	36.82	2.48	34	43

(table continues)

Table 9. (continued)

				Scores (Range = 12 – 48)	
Occupations	n	M	SD	Min.	Max.
Student	3	34.67	5.03	30	40
Other	15	36.93	2.66	27	47
Total	125	36.93	2.88	27	47

Table 10

Summary of ANOVA Findings on Counselor Adaptability by Christian Counselors' Occupations

	SS	df	MS	F	Sig.
Between Groups	48.798	7	6.971	.833	.562
Within Groups	979.554	117	8.372		

Highest Level of Education Attained

In an analysis of the relationship between levels of education attained and counselor adaptability, Pearson correlation did not show the levels of education attained to have any statistically significant correlation with counselor adaptability $r = -.099$, $p = .272$, two-tailed.

Worship Attendance

In an analysis of the relationship between frequency of attendance at church, synagogue, or other places of worship and counselor adaptability, Pearson correlation did show worship attendance to correlate positively with counselor

adaptability. The correlation is also statistically significant r = .218, p = .015, two-tailed.

After evaluations of correlations were completed, a full-model multiple regression of counselor adaptability as the dependent variable was used to analyze some of the variables for their usefulness or relative importance in accounting for any influence upon counselor adaptability. These variables included age, gender, education level, church attendance, religious, existential, mental, physical, and the measure of spiritual well-being from MPS. Since the spiritual well-being score of SWBS is a summation of both the religious and existential subscale scores, a separate computation was done to include spiritual well-being (SWBS) as one independent variable. Results showed that only two of the independent variables (gender and worship attendance) appear to have any predictive values, and only one of the two independent variables was significantly so—worship attendance (Beta = .212, p = .03). Tables 11 through 13 provide summaries of the results of the full-model multiple regression. Model 1 represents the results of the analysis using religious and existential well-being (SWBS) as separate independent variables. Model 2 represents the results of the analysis using spiritual well-being (SWBS) as a single independent variable.

Table 11

Summary of Full-Model Regression for Models 1 and 2

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.3341	.111	.042	2.8188
2	.3252	.105	.044	2.8161

Predictors: (Constant), Age, Gender, Education, Worship Attendance, Religious, Existential, Mental, Physical, Spiritual Well-Beings (MPS)

Predictors: (Constant), Age, Gender Education, Worship Attendance, Spiritual Well-Being (SWBS), Mental, Physical, Spiritual Well-beings (MPS).

Table 12

Summary of ANOVA Findings

Model		SS	df	MS	F	Sig.
1	Regression	114.608	9	12.734	1.603	.123
	Residual	913.774	115	7.946		
2	Regression	108.422	8	13.553	1.709	.103
	Residual	919.930	116	7.930		
1 & 2	Total	1028.352	124			

Table 13

Unstandardized and Standardized Regression Coefficients

		Unstandardized Coefficients		Standardized Coefficients		
Model		B	Std. Error	Beta	t	Sig.
1	Age	-.03356	.029	-.113	-1.172	.244
	Gender	-.745	.550	-.130	-1.355	.178
	Education	-.498	.416	-.111	-1.196	.234
	Worship Attend.	.647	.295	.212	2.193	.030
	Religious WB	-.05302	.067	-.112	-.794	.429
	Existential WB	.05772	.072	.113	.806	.422
	Mental WB	-.08861	.075	-.111	-1.180	.241
	Physical WB	-.005508	.053	-.011	-.103	.918
	Spiritual WB (MPS)	.004435	.069	.007	.064	.949
2	Age	-.0348	.029	-.117	-1.219	.225
	Gender	-.727	.549	-.127	-1.324	.188
	Education	-.467	.415	-.104	-1.127	.262
	Worship Attend.	.666	.294	.219	2.266	.025
	Spiritual WB (SWBS)	-.000005	.029	.000	.000	1.000
	Mental WB	-.0781	.074	-.097	-1.054	.294
	Physical WB	.004531	.052	.009	.087	.931
	Spiritual WB (MPS)	-.00747	.068	-.011	-.110	.912

Finally, although the number of participants (N = 125) is smaller than the 400 population size preferred, stepwise multiple regression of counselor adaptability was used to determine the relative importance of the independent variables. The multiple correlation coefficient is given as .218. This is a smaller R value than the one given for full-model regression (R = .334). Nevertheless, the decision of the stepwise regression computation was that the increment in R when considering all the independent variables was not strong, and so all variables were excluded from the final equation because the p-value in the column sig. was greater than .05 except for the independent variable, worship attendance (p = .015). As such, only worship attendance appears to be a reliable predictor of counselor adaptability. When using spiritual well-being (SWBS) as one independent variable, step-wise regression computed the same result as when considering spiritual well-being (SWBS) from the perspective of its two subscales: religious and existential well-being (R = .218).

Ancillary Findings

Worship Attendance

Using Pearson correlation, an analysis of the relationship between worship attendance and variables other than counselor adaptability resulted in the finding that there were statistically significant correlations between worship attendance and the following variables: religious, existential, physical, and both measures of spiritual well-being. However, the analysis did not find a statistically significant correlation between worship attendance and mental well-being. A summary of the Pearson correlations findings is presented in Table 14.

Table 14

Summary of Pearson Correlations Between Worship Attendance and Religious, Existential, and Mental Well-Being, and Both Measurements of Spiritual Well-Being

	M	SD	r	p
Religious	55.44	6.07	.262	.003
Existential	51.96	5.66	.306	.001
Spiritual (SWBS)	107.40	10.88	.305	.001
Mental	34.54	3.59	-.049	.586
Physical	36.82	5.80	.224	.012
Spiritual (MPS)	44.58	4.27	.210	.019

Subscale Constructs of the SWBS and the MPS

The Spiritual Well-Being Scale. In reviewing the correlation between the scores for SWBS and the scores for the two subscales, religious and existential well-being, the results of the analysis indicated that, where this research population was concerned, there was no apparent distinction between the subscale constructs of religious and existential well-beings. Pearson correlations between religious and existential well-being with spiritual well-beings produced comparable results between the two pairs of variables.

A correlation between religious and existential well-being with spiritual well-being are expected since the final score for spiritual well-being is a summation of both its subscale scores. However, when a Pearson correlation between religious and existential well-being scores produced substantial strength in correlation, the uniqueness of both subscales in measuring their respective characteristics is

questioned r = .722, p < .001, two-tailed. The correlation between spiritual well-being and religious well-being (r = .933, p < .001, two-tailed) is highly comparable to the correlation between spiritual well-being and existential well-being (r = .922, p < .001, two-tailed).

The Mental, Physical, and Spiritual Well-Being Scale. When an analysis using Pearson correlation was performed for MPS, the results confirmed that, where this research population was concerned, the subscale constructs of mental, physical, and spiritual well-beings were generally distinct from one another as the scale intended. The only exception was between mental and physical well-being, where the correlation between the two was statistically significant r = .238, p = .007, two-tailed. In other words, the levels of well-being may be mutually indicative between the mental and physical well-being indices of the MPS, but the levels of well-being in neither subscale imply a corresponding well-being in the spiritual well-being index of the MPS. Table 15 is a summary of the Pearson correlation findings for the MPS.

Table 15

Pearson Correlations for the Three Subscales of Mental, Physical, and Spiritual Well-Being Scale

Correlations	r	p
Mental – Physical	.238	.007
Mental – Spiritual	.028	.754
Physical – Spiritual	.054	.550

Gender

Using an independent samples t-test, the relationships between religious, existential, mental, physical, both measures of spiritual well-beings, and counselor adaptability were evaluated. Table 16 is a summary of the mean scores and standard deviations delineated by gender. A summary of the results using an independent samples t-test is provided in Table 17.

Table 16

Means and Standard Deviations of Scores by Gender

	Male		Female	
	M	SD	M	SD
Religious WB	54.54	6.64	56.35	5.32
Existential WB	51.38	6.12	52.55	5.13
Spiritual WB	105.92	11.92	108.90	9.57
Mental WB	34.48	3.38	34.60	3.82
Physical WB	38.02	5.64	35.61	5.75
Spiritual WB (MPS)	44.13	4.77	45.05	3.68
Counselor Adaptability	37.38	2.42	36.47	3.24

Table 17

Independent Samples T-Test of Religious, Existential, Mental, Physical, Two Measurements of Spiritual Well-Being, and Counselor Adaptability by Gender

	t-test for Equality of Means		
	t	df	p
Religious Well-Being	-1.684	123	.095
Existential Well-Being	-1.155	123	.250
Spiritual Well-Being (SWBS)	-1.541	123	.126
Mental Well-Being	-0.187	123	.852
Physical Well-Being	2.359	123	.020
Spiritual Well-Being (MPS)	-1.208	123	.230
Counselor Adaptability	1.788	123	.076

Note. Spiritual well-being (SWBS) was computed separately but included for reference.

Results using an independent samples t-test showed that there is a statistically significant difference between male and female Christian counselors in their physical well-being t (123) = 2.359, p = .02. The level of physical well-being among male Christian counselors was significantly higher than their female counterparts. With regard to the mental well-being between the male and female research participants, the results indicated a lack of statistically significant difference between this group of male and female Christian counselors t (123) = -0.187, p = .852, two-tailed. Likewise, a lack of statistically significant difference was found between this group of male and female Christian counselors in the area of spiritual well-being

t (123) = -1.208, p = .230, two-tailed. That is, while a gender difference was apparent in both the student and CSIRO employee samples (from which the norm table was tallied for the User's Guide to MPS), an independent samples t-test showed no statistically significant difference in mental and spiritual well-being between male and female Christian counselors who participated in this research. Conversely, with regard to physical well-being, the results obtained for this research population were found to be consistent with the findings suggested in the User's Guide for MPS.

Finally, while the correlation between religious well-being and counselor adaptability were not statistically significant for either of the male and female populations of this research, male Christian counselors did score better than their female counterparts in counselor adaptability t (123) = 1.788, p = .076. On the other hand, results also showed that female Christian counselors had higher levels of religious well-being than their male counterparts t (123) = -1.684, p = .095, two-tailed.

Occupations

Analyses were made using Oneway ANOVA in verifying the differences between the various measures of well-being and the respective occupations held by Christian counselors in this research. Results from Oneway ANOVA revealed no statistically significant differences between the various occupations of Christian counselors and the corresponding measures of well-beings. A summary of the results using ANOVA on various occupations and well-beings is presented in Table 18. A complete statistical descriptive of the results of various measurements of well-beings by occupations can be found in Appendix D.

Table 18

Summary of ANOVA Findings on Religious, Existential, Mental, Physical, and Two Measurements of Spiritual Well-Being by Christian Counselors' Occupations

	SS	df	MS	F	Sig.
Religious Well-Being					
Between Groups	139.042	7	19.863	.525	.814
Within Groups	4427.758	117	37.844		
Total	4566.800	124			
Existential Well-Being					
Between Groups	103.730	7	14.819	.449	.869
Within Groups	3863.070	117	33.018		
Total	3966.800	124			
Spiritual Well-being (SWBS)					
Between Groups	362.199	7	51.743	.423	.886
Within Groups	14313.801	117	122.340		
Total	14676.000	124			
Mental Well-being					
Between Groups	151.161	7	21.594	1.745	.105
Within Group	1447.927	117	12.375		
Total	1599.088	124			
Physical Well-being					
Between Group	193.856	7	27.694	.815	.576
Within Group	3974.272	117	33.968		

(table continues)

Table 18. (continued)

	SS	df	MS	F	Sig.
Total	4168.128	124			
Spiritual Well-being (MPS)					
Between Group	138.293	7	19.846	1.092	.373
Within Group	2125.445	117	18.166		
Total	2264.368	124			

Chapter 5

Discussion

Summary of Results

The first hypothesis. The first hypothesis was that a positive correlation exists between both measurements of spiritual well-being and counselor adaptability. Using two instruments to measure the levels of spiritual well-being, participants for the research were asked to respond to a series of questions that were intended to measure their perceptive and behavioral accounts of spiritual well-being. Perceptions of spiritual well-being were measured by the Spiritual Well-Being Scale (SWBS), and recall of behavioral indications of spiritual well-being were measured by the spiritual well-being subscale of the Mental, Physical, and Spiritual Well-Being Scale (MPS). Statistical analysis did not lend support to this hypothesis since no correlation with counselor adaptability appeared to have existed for this group of Christian counselors.

Following the conclusions made by numerous authors who suggested the greater efficacy of the SWBS in measuring low levels of spiritual well-being, the research continued with an examination of those research participants who had scored low on both the SWBS and the spiritual well-being subscale of the MPS. Evaluations of low levels of spiritual well-being and their associating results with counselor adaptability were completed. Again, statistical analysis showed that no apparent correlation was present.

Given the fact that neither measurement of spiritual well-being was found to correlate significantly with counselor adaptability, the first hypothesis had to be rejected. Initial statistical analyses gave credence to the probability that there was no

apparent relationship between spiritual well-being and counselor adaptability within this population of Christian counselors.

The second hypothesis. The second hypothesis was that, when other factors such as religious, existential, mental, and physical well-being; age; gender; occupation; highest level of education attained; and worship attendance were considered, the relationship between spiritual well-being and counselor adaptability should prove to be the most statistically significant. Immediately, a conclusion can be made that the second hypothesis also must be rejected given the lack of statistical significance found between either measurements of spiritual well-being and counselor adaptability. As such, the direction of this research progressed toward determining which variable or variables might be found to associate significantly with counselor adaptability.

The first variable examined was religious well-being. Religious well-being is one of the two subcomponents of the SWBS, the other subcomponent being existential well-being. Statistical analysis showed that no apparent association was found between religious well-being and counselor adaptability. Next, when existential well-being was examined along with counselor adaptability, no statistical significance was found.

Following the analysis of correlations between counselor adaptability with the two subscales of the SWBS, the search for other variables with possible significance continued with an examination of the MPS. The MPS contains three subscales designed to measure the mental well-being, physical well-being, and spiritual well-being of persons. Since spiritual well-being had already been evaluated for the first hypothesis, the research moved towards giving attention to the mental and physical

subscales of well-being and their relationships with counselor adaptability. Statistical analysis showed that mental well-being has a slight correlation with counselor adaptability. The correlation, however, was a negative one and not statistically significant. Where physical well-being was concerned, statistical analysis showed that it, as with other components of well-being examined earlier, has no apparent correlation with counselor adaptability.

Where the evaluations of various measurements of well-being are concerned, statistical analyses of the relationships between religious, existential, mental, and physical well-beings with counselor adaptability indicated that none of the variables so far has any significant association with counselor adaptability. The next section explains the meanings of these findings.

Having used all the variables of well-being allowed by the SWBS and the MPS, other variables collected for evaluation were obtained through the demographic profiles questionnaire completed by the research participants. These demographic variables include age, gender, marital status, occupation, highest level of education attained, ethnicity, profession of faith, religious preference, and worship attendance.

Among those who responded to the research, it can be determined that, for the most part, they were Caucasians, most of whom were between 37.5 and 56.9 years of age. They were Protestants who have professed a faith in Jesus Christ as their personal Savior and Lord, and they were in their first marriage.

When age was considered for its association with counselor adaptability, statistical analysis showed that there was no apparent correlation between the two variables. Next, when counselor adaptability was evaluated with respect to gender, a

difference was found between the male population of Christian counselors and their female counterparts that did approach significance. With a 92.4 percent level of confidence, male Christian counselors had a somewhat higher level of counselor adaptability than their female counterparts.

Among the participants for this research, most are working as psychologists (42) and marriage and family therapists (31). A lesser number of participants are serving as pastors or pastoral counselors (15), followed by Licensed Professional Counselors or Licensed Professional Clinical Counselors (11). The rest of the participants serve in capacities such as social workers (3), professors or teachers (5), students (3), and some other professions (15). When considering the level of counselor adaptability among Christian counselors in their differing occupational capacities, statistical analyses showed that occupational differences do not account for any difference in the level of counselor adaptability. Though not statistically significant, the highest mean scores on counselor adaptability were obtained by social workers followed by pastors or pastoral counselors. The lowest mean score was obtained by students.

Even though students may have obtained the lowest mean scores in the TSI, in terms of this population of Christian counselors' highest level of education attained, statistical analysis did not show an apparent significance in the levels of education in accounting for differences in the levels of counselor adaptability. This lack of correlation substantiates the results determined previously regarding the non-significant differences of occupations in accounting for the variability of counselor adaptability.

Of all the variables examined, only one showed a statistically significant relationship with levels of counselor adaptability. This variable is worship attendance. Statistical analysis showed that a positive correlation exists between the frequency of worship attendance and counselor adaptability. A further analysis took all the variables into account and evaluated them simultaneously to determine the strongest influencing variable upon counselor adaptability. The results showed that only this variable had any influence upon counselor adaptability. Upon further analysis, when all the variables were ranked in progression from the strongest to the weakest, statistical analysis identified only one variable in the equation to account for any variability in counselor adaptability.

Ancillary findings. When all the variables had been evaluated for their relationship with counselor adaptability, an investigation was conducted into what other significant relationships might be present among these variables with one another. Since worship attendance was the only variable found to have a statistically significant correlation with counselor adaptability, evaluations were made to determine which other variables might also correlate with worship attendance.

With regard to the various measurements of well-being, the variables found to have statistically significant correlations with worship attendance were religious well-being, existential well-being, physical well-being, and both measures of spiritual well-being. All correlations were positive. The only exception where well-being was concerned was mental well-being, which was not found to have a significant correlation with worship attendance.

Age is another variable that has a positive and statistically significant correlation with worship attendance. As one increases in age, attendance at worship

services also increases. Furthermore, the male Christian counselors' higher worship attendance than their female counterparts did approach statistical significance. Male Christian counselors, it seems, frequent places of worship somewhat more than their female counterparts. On a related note, although male Christian counselors frequented places of worship more than their female counterparts, female Christian counselors obtained a higher level of religious well-being (SWBS) than their male counterparts. The difference in religious well-being between male and female Christian counselors approaches a level of significance almost equal to the difference found for worship attendance. Finally, higher levels of education attained did not correspond to a higher worship attendance.

Having examined a number of variables and their relationships with worship attendance, additional evaluations then shifted toward the other main variable in the research—spiritual well-being. An evaluation was made to focus upon some psychometric characteristics of the Spiritual Well-Being Scale and the Mental, Physical, and Spiritual Well-Being Scale. The SWBS has two subscales that relate to an individual's well-being. These two subscales are religious well-being and existential well-being. During the course of evaluation for correlations among the variables, it was observed that, where this population of Christian counselors was concerned, there was no apparent distinction between the subscale constructs of religious and existential well-being. That is, there was no measurable difference for this research group whether they were being evaluated for religious or existential well-being. The distinctions or uniqueness between the two variables were, apparently, not statistically discernible, thus making them essentially one variable.

Conversely, among the three subscales of the MPS, results in the research showed that, where this population of Christian counselors was concerned, the subscale constructs of mental, physical, and spiritual well-being were generally distinct from one another as the author of the scale had intended. The only exception was between the scales for mental and physical well-being. Results seem to indicate that there could be some overlap between these two measures of well-being. Thus, while the spiritual well-being subscale of the MPS was able to evaluate distinctly the spiritual aspects of well-being, neither the mental nor the physical well-being subscales could distinctly evaluate their respective constructs of well-being.

Having considered some psychometric characteristics of both measurements of spiritual well-being, the next set of evaluations centered on gender differences. Already some gender differences have been discussed as to their relatedness to counselor adaptability and worship attendance. The next phase of evaluation took into account gender differences in the various dimensions of well-being. Of the various facets of well-being—religious, existential, mental, physical, and spiritual—only one was found to have a statistically significant difference between genders. Where this population of research participants was concerned, male Christian counselors had a significantly higher level of physical well-being than their female counterparts.

The SWBS does not include a set of norms for possible gender differences. However, norm differences between males and females were provided by the MPS. The results obtained for this research population concurred with one of the set of norms given for the three subscales of the MPS. Similar to the MPS, this research confirmed that there is a statistically significant difference between the physical

well-being of males and females: males being at a higher level of physical well-being than females. However, unlike the MPS, no gender difference was found for the other two subscales of well-being.

A final set of evaluations took into account the various dimensions of well-being among Christian counselors and the occupations they held. Analyses showed that no statistically significant differences were discernible among the various dimensions of well-being with respect to the different occupations held by this population of Christian counselors.

Explanations for Findings

The first hypothesis. The results of the analyses between the two measurements of spiritual well-being and counselor adaptability showed that there were no statistically significant correlations between these two essential variables. However, no correlation in this case does not mean that a relationship does not exist between counselor adaptability and spiritual well-being. In the case of this group of research participants, the lack of association can be attributed to the strong probability that both test instruments of well-being were inadequate in measuring the above-normal levels of spiritual well-being present in this population of Christian counselors.

In both measurements of spiritual well-being, a majority of Christian counselors in this study scored higher than the mid-point range. In fact, if both the SWBS and the MPS had higher indices of spiritual well-being, many of the participants would have scored higher than the instruments presently allow. The possibility and potential for low ceiling effects among various religious groups had been foreseen by a number of researchers (e.g., Ledbetter, Smith, Vosler-Hunter, and

Fischer, 1991; Bufford, Paloutzian, and Ellison, 1991) particularly for the SWBS. Since the MPS is a relatively newer scale (Vella-Brodrick, 1995), this same anticipation was not prescribed. However, in testing for instrument reliability and validity, the author of the MPS used the SWBS as her scale of choice for analyzing the evaluative power of the spiritual well-being subscale of the MPS. Thus, for various religious groups, the possible presence of low ceiling effects could be suggestible for the MPS since its possibility is evident in the SWBS. Within this group of research participants, low ceiling effects appear undeniable for pastors and pastoral counselors. This finding would be consistent with other religious groups studied. However, scores obtained by other helping professionals in this research population were also comparable to those of pastors, pastoral counselors, and people in various religious groups. On the one hand, the exceedingly high scores attained by this group of Christian counselors are indeed commendable. One would expect that Christian counselors, whether they work as psychologists, psychiatrists, marriage and family therapists, social workers, professors and teachers, Licensed Professional Counselors or Clinical Counselors, or even students in training, ought to be more mature and fairly well established where spirituality is concerned. The result of this research could imply that for counselees they could impute a high level of confidence toward most Christian helping professionals to offer adequate spiritual direction as well as emotional guidance. A similar implication is that both clients and patients can also expect that most Christian helping professionals would be spiritually well-grounded in their personal lives, thus lending integrity as they intercede for their clients' and patients' welfare.

However, for this inference to be consistent, one argument may be that this group of Christian counselors would have to score as high on counselor adaptability as measured by the Therapist Style Inventory (TSI). Unfortunately, the results of the scale, unlike the results of both measurements of spiritual well-being, showed a complete bell-shaped distribution. In other words, the hypothesis again could not be true based upon this present research because while most Christian counselors in this study had attained the maximum allowable scores in the two measurements of spiritual well-being, they did not do so in the measurement of their level of counselor adaptability.

One possible reason is that the TSI did not adequately measure the skill levels and abilities of this group of Christian counselors, or else the TSI might even be too strong in evaluating for counselor adaptability and underrated these research participants. Another possible reason is that the research populations were not introduced to the model of Adaptive Counseling and Therapy. A brief introduction and training in Howard et al.'s eclectic model could allow the participants to obtain higher scores on the TSI. Nevertheless, with a range between 12 and 48 points for the TSI and the median score for the scale being 30 points, this group of research participants did score relatively high on the scale with a mean score of 36.9 and a median score of 37. As such, a positive relationship between spiritual well-being and counselor adaptability is, at the very least, suggestible. A more likely explanation for the lack of statistical correlation, therefore, is that stronger measurements of spiritual well-being are necessary for Christian population groups such as the ones who composed this research population.

In establishing the norms for the SWBS, Bufford, Paloutzian, and Ellison (1991) observed from the amalgamation of many studies that most religious or Christian groups score much higher on the spiritual well-being scale than non-religious groups. The authors concurred with other researchers that "the scale presently has no use in identifying persons who are above average in SWBS. In its present form, the SWBS is inadequate to reach this goal" (p. 65). From the results of this research, one more population group can be added to the list for which the SWBS may be inadequate. This group has been generally defined as Christian counselors within the boundary of this study. Specifically, they include Christian psychologists, Marriage and Family Therapists, Licensed Professional Counselors and Licensed Professional Clinical Counselors, professors and teachers, social workers, and students in training to be Christian counselors. The fact that the SWBS was not adequate in measuring spiritual well-being for this group of research participants was not necessarily due to the fact that they were helping professionals but that they were Christians who function at the highest levels of spiritual well-being. Consistent findings seem to suggest that Christians generally score exceedingly high on the spiritual well-being scale. This population of choice appears to conform to earlier suggestions concerning Christians, occupational positions not withstanding. A case in point may surround Agnor's (1986) study of spiritual well-being among a population of sociopathic inmates at a state penitentiary in the Pacific Northwest. The spiritual well-being scores among Christian sociopathic convicts were as high as, and sometimes even higher than, the scores obtained by various religious groups in other studies. The difference could be attributed to Christian inmates' resolution of their position and relationship with God while the non-

religious inmates did not possess such insight. On the other hand, the high scores could be nothing more than a reflection of the inmates' sociopathic arrogance and presumptuousness of their personal relationships with God. In fact, Moody (1988) suggested that the SWBS might possess some shortcomings in its ability to detect fake-good responses. Still, even though the SWBS has received extensive scrutinizing treatment, it remains a proven and strong instrument for measuring general well-being, and it is widely accepted and used in numerous clinical settings and research despite some psychometric limitations with high-functioning religious or Christian groups.

Unless the spiritual well-being subscale of the MPS is evaluated against another measurement of spiritual well-being to determine further its power in measuring the religious population, many of the observations made of the SWBS might be applied to the MPS. Where this population of Christian counselors is concerned, observations of the instrument's limitation appear generally to hold true for the spiritual well-being subscale of the MPS.

As mentioned in the summary of results, the SWBS might be more adept at measuring low levels of spiritual well-being. Evaluations of those Christian counselors in the study who scored beyond one standard deviation below the norm (within this population) also yielded no statistical significance. The primary reason for the lack of correlation spiritual well-being has with counselor adaptability is that there simply were not enough participants who scored low on the spiritual well-being scales to draw an adequate association. The lowest score obtained on the SWBS was 58, which was 12 points below the midpoint of the scale and well above the highest score (40) given to be classified as having a low level of spiritual well-being, a

difference of 18 points. Similarly, the lowest score obtained on the spiritual subscale of the MPS was 27, which was only 3 points below the midpoint of the scale. Owing to the lack of Christian counselors scoring low on both spiritual well-being scales, which limited the variability of scores, it is not surprising that no correlation of counselor adaptability could be attained with those who had obtained low scores.

The second hypothesis. The significance of the results with respect to the second hypothesis surrounds the apparent lack of correlation between counselor adaptability and all other variables except worship attendance. That counselor adaptability and worship attendance are significantly correlated do not necessarily infer causality. One certainly cannot increase the level of counselor adaptability simply by going to church, synagogue, or other places of worship. The relationship is somewhat confusing in one respect in that the frequency of worship attendance in itself is a religious act while there is no apparent religious element to counselor adaptability, yet a correlation is found between the two. On the other hand, worship attendance is presumably related to one's religious and spiritual well-being, and a correlation does exist between spiritual well-being and worship attendance. Yet, no correlation between spiritual well-being and counselor adaptability is apparent. If worship attendance is related with counselor adaptability and spiritual well-being, and if worship attendance is a relevant characteristic to spiritual well-being, then logic dictates that spiritual well-being should be related to counselor adaptability. Unfortunately, the relationship ends up being a linear model instead of a circular one. Figure 8 is a depiction of these relationships.

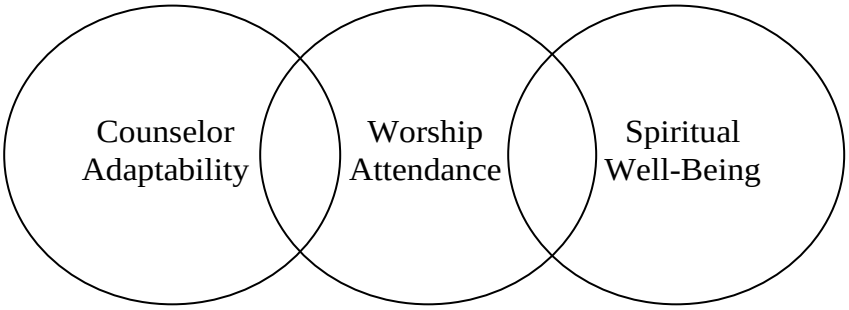

Figure 8. Relationships of Counselor Adaptability and Spiritual Well-Being with Worship Attendance.

The premise of this research rests upon the presumed existence of a relationship between spiritual well-being and counselor adaptability, and the purpose for this research is in fact to prove that the connectedness between spiritual well-being and counselor adaptability is a significant one. That being the case, how then can the apparent linear relationship be accounted for since worship attendance is related to both counselor adaptability and spiritual well-being, but none of the other two variables are related to each other?

The answer again reverts to the weakness of the SWBS and the MPS in adequately measuring the level of spiritual well-being within this sample of Christian counselors. Had there been stronger instruments to measure spiritual well-being for religious groups such as this research population, a correlation with worship attendance might be more forthcoming. The strength or power of both instruments in measuring well-being lies in the specific questions determining spiritual wellness.

Earlier discussions have established the weakness of both scales of spiritual well-being in measuring the religious or Christian population. Upon closer examination of the specific questions asked in both scales regarding spiritual well-being, no question specifically addressed the frequency of worship attendance. One

conclusion that can be made relates to increasing the power of measurement in both instruments of spiritual well-being. That is, the frequency of worship attendance appears to be one element that can be introduced which could add to the power of both instruments in measuring this population of Christian counselors and, perhaps, in measuring other religious or Christian populations as well. Furthermore, in the final analysis, if the frequency of worship attendance is one index that can adequately determine spiritual well-being, a connected relationship between spiritual well-being and counselor adaptability remains probable.

Ancillary findings. Other than spiritual well-being and counselor adaptability, variables found to correlate significantly with worship attendance include religious well-being, existential well-being, physical well-being, and age. As mentioned in an earlier section, religious and existential well-beings appear essentially to be very similar subsets of spiritual well-being (SWBS). As such, it serves as no surprise that these two variables of well-being should correlate well with worship attendance. However, where the subscales of the MPS are concerned, that physical well-being should correlate well with worship attendance while mental well-being did not is somewhat surprising. One would assume that if a connection were present, the reverse should be true based upon the assumption that worship is more an activity of the mind than of the body.

A partial explanation of the relationship may be seen through the relationship between age and the other variables. One association not previously considered is between physical well-being and age. As this population of Christian counselors got older, their physical well-being increased, and correspondingly, their worship attendance also increased. Furthermore, a review of the relationship age

may have with other variables found that age was, in fact, significantly related with four separate variables. Church attendance and physical well-being have both been mentioned, but age also relates significantly with existential and mental well-being. In the case of worship attendance and physical well-being, age is a common denominator for both variables. This, in part, can help to explain the connectedness between worship attendance and physical well-being.

However, as this population of Christian counselors increases in age, so too do they increase in mental well-being. Yet unlike physical well-being, mental well-being has not been found to correlate significantly with worship attendance. One possible reason for this seeming discrepancy goes back to the construct of mental and physical well-being. The results of statistical analyses indicated a possible overlap between the two constructs of mental and physical well-being. Questions relating to one construct may tie into considerations for the other construct, thus blurring the two. Therefore, the fact that church attendance was correlated with physical well-being but not with mental well-being may not be due to a discrepancy in response on the part of the research population. Rather, it would suggest a variation in magnitude or definition within the construct of the mental and physical subscales of the MPS.

A fuller explanation cannot be given for this relationship without considering a more complete spectrum of activities engaged by this population of Christian counselors, and further analysis of this relationship is beyond the scope of this research. Similarly, explanations for why male Christian counselors in this research had a significantly higher level of physical well-being than female

Christian counselors involve the same expansion of analyses beyond the purposes of this research.

One significant implication regarding the constructs of mental, physical, and spiritual well-being in the MPS is the apparent relatedness between the mental and physical dimensions of well-being but not the spiritual. If the correlation between the mental and physical constructs goes beyond the specificity or mechanics of asking the right questions, then a question can be raised concerning the integration of mental, physical, and spiritual elements of the human identity.

If the human identity is in fact a psychospiritual entity (Ellison and Smith, 1991) where life proceeds from the infusion of spirit by the breath of God (The Holy Bible, Genesis 2:7), then why does the overlapping of constructs between mental and physical well-being not include the spiritual dimension? If, in fact, mental and physical traits are connected, as the analysis could imply, then is one's spiritual nature distinct from the mental and physical attributes? Answers to these questions require, in part, a clarification or strengthening of the constructs within the three subscales of the MPS.

Limitations of the Study

The most immediate limitation of the study revolves around the strength of both measurements of spiritual well-being to evaluate adequately the religious or Christian population who function at the highest level of spiritual well-being. As mentioned in previous sections, if both measures of spiritual well-being had higher indices of well-being beyond the present limits, this population of Christian counselors would surely be able to obtain higher scores.

A second limitation of the study involves the choice of research participants. This research, in part, served to address a concern raised by Todd Hall (1996) that there has been little or no study that examined the spirituality of pastors. The research participants solicited were intended to address that concern and to expand the research beyond one group of professionals to encompass a larger population of Christian helping professionals. As such, while this research did address the spiritual issues surrounding the helping professional, it was inadequate in exacting the results necessary to address the needs and concerns which might be present among Christian helping professionals. Concern for low ceiling effects raised by various authors regarding the use of the SWBS was apparently realized for this population of Christian counselors. Because the spiritual well-being subscale of the MPS was evaluated against the SWBS, limitations surrounding its adequacy for this population were also encountered.

A third limitation concerns the length of time involved when using three evaluative tools. The SWBS consists of 20 questions, the MPS consists of 30 questions evaluating for three subscales, and the TSI consists of 12 counseling scenarios for evaluation. Approximately 45 minutes is required to respond adequately to the surveys. A number of surveys that were returned without being completed might be attributed to its length. A few respondents have, in fact, indicated on the surveys that the survey was too long. Owing to the emphases desired for this research, eliminating either the SWBS or the MPS was not feasible. On the other hand, their inclusion might have excluded some participants from contributing to the outcome.

A fourth limitation concerns the nature of the instruments. All three surveys involve self-report, which may bias against objectivity. The issue of soliciting objective responses (e.g., getting respondents to indicate “I am” instead of “I would like”) in subjective or relative nomenclature such as spiritual well-being or even counselor adaptability is always a concern for creators of certain scientific instruments.

Relating to the last concern, a fifth limitation of the study concerns the relative newness of both the MPS and TSI. While the SWBS has been adopted for innumerable applications and survived many scrutinies, neither the MPS nor the TSI has been subjected to the same level of field-testing.

A final limitation of this study is the inference value or generalizability of this study in two regards. The first is that both hypotheses have yet been adequately proven or disproved because of the limitations of the test instruments discussed. There may be greater inference value in the ancillary study than the primary one. The second concerns the demographics of this population of Christian counselors. The majority of research participants are Caucasian Christian Protestants who are in their first marriage. Any generalization of results may have limited applicability beyond this demographic population. Owing to the fact that solicitation for participation was done by postal mail, the desire for demographic inclusiveness was left at the mercy of the recipients’ willingness to participate.

Future Directions for Research

This research may be among the first to examine the spiritual well-being of Christian helping professionals in the field of psychology and counseling. While many studies have focused upon the needs of those who are searching for healing

and who are in the midst of receiving help, few have given attention to the need which may be present among those helping professionals who must wrestle with and intercede for others. Further research must continue what this research has not been able to establish: the dynamic quality of spiritual well-being and its potential to influence the abilities of Christian counselors in assisting people in need. Future study must also take into consideration, whenever possible, the greater diversity needed in research participants.

Both instruments measuring spiritual well-being used in this study should be strengthened to account for the presence of higher levels of spiritual well-being among Christians such as those in this research population. Doing so would allow adequate evaluation of the level of spiritual well-being among various Christian groups in general and Christian helping professionals in specific. This research identified one possible variable that may be introduced for future consideration. In fact, frequency of church attendance has already been positively correlated with spiritual well-being as measured by the SWBS (e.g., Bufford, 1984; Colwell, 1987; Durham, 1986; Ellison & Economos, 1981; Frantz, 1985; Hawkins, 1986; Huggins, 1988; Jang, 1987; Mitchell, 1984; Quinn, 1984; Sherman, 1987); therefore, the inclusion of this variable appears most fitting.

Another area for further research involves the MPS. Further studies to solidify the distinctive constructs for mental, physical, and spiritual well-being dimensions of health will offer greater value in clinical applications and for future research. Since this present research population may have skewed results regarding spiritual well-being, further research may be necessary to specify populations where this instrument may service its optimal use.

Finally, as with the SWBS and the MPS, the TSI evaluates via self-report a subjective determinant of a counselor's ability. Outcome-based research involving evaluations by clients in conjunction with self-reports may be helpful in determining the accuracy of a counselor's perception of wellness, optimal intervention, and eventual success.

Appendix A

Luke M. Tse, M.Div.
3216 Idaho Ave. Kenner, LA 70065
(504) 469-5081 • Tseluke@cs.com

June 00, 2000

Dr. John Doe
Counseling Center
12 Local Street
New Orleans, LA 70126

Dear Dr. Doe,

The application of Christian spirituality in psychotherapeutic practices of mental health has received increasing attention. According to Ortberg (1995), an avenue through which counselors may gather insights to a client's mental health and identity may well come through an understanding of the client's spiritual well-being. Nowhere is spirituality given greater emphasis than within the walls of churches and by Christian counselors who engage in the psychological, emotional and spiritual guidance of others. Yet, research is lacking when it comes to understanding the spiritual well-being of Christian counselors and caregivers such as yourself.

The purpose of this research is to identify the spiritual well-being of Christian counselors and to understand the relationship between spiritual well-being and counseling. The enclosed questionnaire is designed to measure a counselor's spiritual well-being and his or her therapy style.

The benefits of such research may include improved educational and training programs for counseling, better counselor-client relationships, and more effective means of addressing spiritual issues and needs of Christian counselors.

Perhaps this is a busy time for you; however, your participation is vital to the success of this research. Your assistance in this research is greatly appreciated. No part of this questionnaire is coded to identify the participant and all information is confidential. At your earliest convenience, please return this questionnaire by **July 00, 2000**. If you have any questions, please feel free to contact me at the telephone number or e-mail address above.

Sincerely,

Luke M. Tse, M.Div., Ph.D. candidate
New Orleans Baptist Theological Seminary

PERSONAL INFORMATION

1. Age: ____

2. Gender: 1. Male 2. Female

3. Occupation:
   1. Psychologist
   2. Psychiatrist
   3. Marriage & Family Therapist
   4. Social Worker
   5. Educator
   6. Pastoral Counselor
   7. Other (please specify): _____

4. Your present marital status:
   1. Single (Never married)
   2. Single Again (Divorced, Widowed)
   3. Married – first marriage
   4. Remarried
   5. Living Together (not married)
   6. Other (please specify) _____

5. What is the highest level of education you have attained?
   1. High School or G.E.D.
   2. Some College
   3. College Degree(s)
   4. Some Master's-level Work
   5. Master's Degree(s)
   6. Doctorate(s)

6. Which of the following best describes your racial or ethnic background (you may circle more than one if you wish)?
   1. American Indian
   2. Asian (Pacific-Islanders, Asian-American, etc.)
   3. Caucasian (White, European-American, etc.)
   4. Latino (Hispanic, Mexican-American, etc.)
   5. Negro (Black, African-American, etc.)
   6. Other (please specify) _____

7. Do you profess to be a Christian (have you received Jesus Christ as your personal Savior and Lord)?
   1. No.
   2. Yes.
   3. I believe in God, but I do not believe in Jesus Christ as my personal Savior and Lord.

8. With which religion, or faith, do you most closely identify?
   1. Catholic
   2. Jewish
   3. Protestant (please specify; e.g., Baptist, Presbyterian) _____
   4. Other (please specify) _____

9. How frequently have you attended church/synagogue/place of worship during the past year?
   1. None
   2. 1 to 2 times
   3. 3 to 11 times (less than once a month)
   4. 12 times (once a month)
   5. 52 times (once a week)
   6. More than once a week

SECTION A

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

		Strongly Disagree					**Strongly Agree**
1.	I don't find much satisfaction in private prayer with God.	1	2	3	4	5	6
2.	I don't know who I am, where I came from, or where I'm going.	1	2	3	4	5	6
3.	I believe that God loves me and cares about me.	1	2	3	4	5	6
4.	I feel that life is a positive experience.	1	2	3	4	5	6
5.	I believe that God is impersonal and not interested in my daily situations.	1	2	3	4	5	6
6.	I feel unsettled about my future.	1	2	3	4	5	6
7.	I have a personally meaningful relationship with God.	1	2	3	4	5	6
8.	I feel very fulfilled and satisfied with life.	1	2	3	4	5	6
9.	I don't get much personal strength and support from my God.	1	2	3	4	5	6
10.	I feel a sense of well-being about the direction my life is headed.	1	2	3	4	5	6
11.	I believe that God is concerned about my problems.	1	2	3	4	5	6
12.	I don't enjoy much about life.	1	2	3	4	5	6
13.	I don't have a personally satisfying relationship with God.	1	2	3	4	5	6
14.	I feel good about my future.	1	2	3	4	5	6
15.	My relationship with God helps me not to feel lonely.	1	2	3	4	5	6
16.	I feel that life is full of conflict and unhappiness.	1	2	3	4	5	6
17.	I feel most fulfilled when I'm in close communion with God.	1	2	3	4	5	6
18.	Life doesn't have much meaning.	1	2	3	4	5	6
19.	My relation with God contributes to my sense of well-being.	1	2	3	4	5	6
20.	I believe there is some real purpose for my life.	1	2	3	4	5	6

SECTION B

All questions have a specific scale for you to mark your response. Please circle one number per question based on how close you feel you are to one of the alternatives at each end of the scale. Please answer all questions honestly. Thank you.

For example:

Are you usually a happy person?	1 Often	2	(3)	4	5 Never

---

1. During difficult times do you reach out for spiritual help (e.g., God or a higher being, church or place of worship, pray, priest, etc.)?	1 Often	2	3	4	5 Never
2. Do you watch quiz programs?	1 Often	2	3	4	5 Never
3. Do you read novels?	1 Never	2	3	4	5 Often
4. Do you engage in thoughtful discussions about ethical or moral issues?	1 Often	2	3	4	5 Never
5. Over recent months have you been lethargic or tired?	1 Often	2	3	4	5 Never
6. Do you read or study about religion or spiritual issues?	1 Often	2	3	4	5 Never
7. Do you collect as much information as possible on a subject before making judgments on it?	1 Never	2	3	4	5 Often
8. In the past year, have you suffered nausea and/or vomiting?	1 Never	2	3	4	5 Often
9. Do you engage in games which are designed for mental stimulation (e.g., bridge, crosswords, chess, etc.)?	1 Often	2	3	4	5 Never
10. In the past year, have you had stomachaches and/or indigestion?	1 Often	2	3	4	5 Never
11. Do you engage in serious self-analysis of your behavior for the purpose of improving your moral behavior?	1 Never	2	3	4	5 Often
12. Over the past year, have you suffered headaches?	1 Never	2	3	4	5 Often

13. Do you visit places of culture, art, or creativity (e.g., museums, art galleries, theaters, etc.)?	1 Often	2	3	4	5 Never
14. When you gain insights into life that others could learn, how often do you share them with people close to you?	1 Never	2	3	4	5 Often
15. Over the past year, have you been constipated?	1 Never	2	3	4	5 Often
16. Do you believe in life after death?	1 Never	2	3	4	5 Often
17. Over the past year, have you written for pleasure (e.g., letters, stories, poems, etc.)?	1 Never	2	3	4	5 Often
18. How long have you been making use of an activity for obtaining inner peace (e.g., meditation, yoga, prayer, etc.)?	1 I have not	2	3 <5 yr.	4	5 >10 yr.
19. Over the past year, have you taken steps to improve your environment (e.g., made your home or office pleasing, provided yourself with more objects of beauty, etc.)?	1 Often	2	3	4	5 Never
20. Over the past year, have you gone on a diet to lose or gain weight?	1 Never	2	3	4	5 Often
21. In recent months, do you wake up fresh and rested most mornings?	1 Never	2	3	4	5 Often
22. Do you discuss matters of the spirit (e.g., purpose in life, religion, inner peace, death, etc.)?	1 Never	2	3	4	5 Often
23. Do you think before you act?	1 Never	2	3	4	5 Often
24. Over the past year, have you tried to enhance your personal or spiritual development (e.g., meditation, yoga, praying, etc.)?	1 Often	2	3	4	5 Never
25. Do you watch, read, listen to the news?	1 Never	2	3	4	5 Often
26. Are your hands and feet warm enough, generally?	1 Often	2	3	4	5 Never
27. Do you watch documentaries?	1 Never	2	3	4	5 Often
28. Do you suffer diarrhea at least once a month?	1 Never	2	3	4	5 Often

29. Over the past year, have you experienced aches and pains?	1 Often	2	3	4	5 Never
30. Do you make use of meditation and/or prayer for the purpose of gaining inner peace?	1 Often	2	3	4	5 Never

SECTION C

In answering the following 12 questions assume that you are the therapist involved in the situation described. Think about what action you would choose in that situation, and then circle the response that most closely resembles the action you would take. Please circle only one response to each situation. Remember to answer as you think you would if you were the therapist. Please answer in order, and without spending too much time on any situation.

---

1. As an alcoholism counselor in an inpatient treatment program, you are scheduled to meet with Ann who had been given the assignment of identifying on a work sheet all the people who have been hurt by her alcoholism. The client arrives on time for the appointment and seems pleasant and willing to talk. After a few minutes of small talk you ask about the assignment. She begins to explain why she hasn't done the assignment. You would:

    A. Say, "You have not done your assignment. We have nothing to talk about until you do."
    B. Work with her to develop the list in the session.
    C. Reflect your frustration and listen to her feelings.
    D. Ignore the missing material and ask Ann what she wants to talk about today.

2. You are in the fourth session with a 15-year-old who has been sent to you for truancy problems. You have established a good relationship and have just begun to focus on the school behavior. During the session the client says, "I don't really want to go to school but I'll do it for you." Your response is:

    A. If you go to school all week, I will authorize an extra privilege.
    B. Good! It's important to continue your education; so I'm glad you'll go for me and for you.
    C. I trust your judgment about whether you decide to go to school or not.
    D. So you really don't want to go, but if you thought it would please me you would go.

3. You have seen Charlie, a middle-aged man, two times. He sought services voluntarily due to feelings of insecurity. He recently was diagnosed as diabetic and has lost some of his vision as a result of the disease. He also lost his job of 18 years due to the poor economy. He is happily married and has one son. You would:

    A. Set up a program of physical therapy in conjunction with his doctor and refer him to a competent vocational rehabilitation counselor.
    B. Discuss with the client his history of loss and begin to work out a plan with him on expanding his coping mechanisms.
    C. Encourage the client to express feelings and provide empathy and support.
    D. Make no effort to focus on his loss, to avoid increasing his pain.

4. You are seeing the father of a client, at the client's request. The client, Clint, has a history of emotional problems, due in part at least to effects of brain damage from a motorcycle accident several years ago. Clint takes medication to control some of the effects. One of the effects of the injury is that the client occasionally has delusions that a sibling is stealing from him. The client wants the father to see you, so that you can convince the father that he is telling the truth about the delusions. The father is an articulate, patient man who has gone through similar situations with this son on many occasions. He understands the chronicity of

his son's problems. He makes it clear that he is at the session "to keep peace" and that in the past this has worked. You would:

A. Further discuss the pattern of incidents with the father in an attempt to help the father to express his feelings about the injury and to provide the father a plan to deal with the delusion and to avoid recurrent situation.
B. Express to the father your understanding of his frustrating situation and encourage him to vent any pent-up emotions.
C. Review Clint's medication with the staff psychiatrist and present recommendations to the father.
D. Allow the father to direct the course of the session.

5. You are interviewing the parents of three children. The children have been removed from the home for clear indications of child abuse. The parents were referred to you as a part of the evaluation process for court determination. They both maintain that nothing is wrong with them as individuals or as a couple. The court just has it in for them and they want their kids back. You believe that they did abuse the kids and they want the kids back to save face with the family.

A. Tell them that if they maintain their "bullshit" stance they'll never get their kids back.
B. Indicate that cooperating in treatment with you may not only help them individually and as a couple but also improve their chances of the kids being returned.
C. Communicate understanding of their frustration with the system and share a frustrating parenting story of your own.
D. Wait them out by not responding to their complaints.

6. You are known for your work in the area of sex roles. You have helped many women develop a more positive self-concept and take charge of their own lives. A new client, Frank, with whom you are meeting is a prominent middle-aged executive in town, who has come to you and wants to get some help understanding his wife's problem. "She's just not like she used to be. She's gone back to school, lost 25 lb. of fat, and is expressing dissenting opinions at social gatherings." You would:

A. Indicate a willingness to help him look at how and why he's struggling with these changes.
B. Restate his feelings of confusion, anger, and threat.
C. Indicate that she will snap out of this phase sooner or later.
D. Tell him he had better look at himself and change before his wife starts looking around.

7. Recently a case was transferred to you from another therapist who left the community. The client and the previous therapist had been working, with a high degree of success, on expanding social skills and social relationships. The client has expressed some reluctance to get involved with a new therapist. However, the client keeps the first scheduled appointment. During this first appointment you would:

A. Get a commitment from the client to continue therapy and then assign the task of meeting one new person before the next session.
B. Indicate your interest in the client and encourage the client to discuss the course of previous therapy.
C. Discuss with the client previous therapy and recent successes and outline a new program for behavior change.
D. Suggest to the client to terminate therapy.

8. As part of your consultation practice, you are asked to evaluate a day-care center and provide the board of directors with recommendations. You have observed staff and children interacting and have interviewed parents individually. In addition, you have reviewed the program guide for the center and compared it to state and federal guidelines, which it meets without reservation. The center has been operating for 7 years with the same director. Staff turnover is low and there is a waiting list for future openings. During your 4 hours of observation you did see one staff member handle a behavior problem with one of the children in a less than desirable fashion. Otherwise, indications are that the center is above satisfactory in all areas. You would:

    A. Recommend a program on teacher effectiveness for staff members.
    B. Meet with staff as a group and praise them for their performance overall while encouraging them to come up with a program for managing behavior problems.
    C. Meet with staff and director to praise their work and have them outline their long-term goals.
    D. Circulate your findings to the board and staff.

9. You have been working with a client for more than a month around her expressed unhappiness with her current situation. Much of her content in therapy has a theme of other people just don't understand and agree with her. You have been sharing observations and making suggestions that she seems to accept but does not apply. Not much of any positive change has taken place. You would:

    A. Confront her with her unwillingness to change and use her behavior in the therapy relationship as a focus.
    B. Continue listening and reflecting.
    C. Continue listening, raise questions about her role in problem situations, but don't push.
    D. Continue to propose ways she can improve her situation, pointing out the benefits of proposed changes while appreciating her efforts in this regard.

10. The client, referred by a former client, states in an initial interview that recently he has been having problems in going to sleep at night, feeling tired all the time, has lost interest in activities, and has recurrent thoughts of death. The problems seem to have begun about 2 months ago, concurrent with new additional responsibilities at work. His brother died about this time as well. You would:

    A. Indicate a willingness to see him if he thought he needed to talk to someone.
    B. Reinforce him for coming to see you and recommend weekly therapy focused on reactive depression and grief.
    C. Recommend he talk to his friends about his new problems.
    D. Recommend he read two books, one on grief and the other on job stress. Weekly therapy session would focus on learning to apply the concept to his life.

11. You are seeing an elderly retired professional woman. She recently moved from her life-long home, several hundred miles away, to be near her youngest daughter. Her friends in the former community had all either died or moved away. She has joined two social groups and a political action group and occasionally takes group vacations. Her older daughter has been in and out of state institutions for the past 5 or 10 years and has been diagnosed as schizophrenic. She complains of occasionally waking up and feeling worthless and having lived her life for nothing, because of her older daughter's situation. She does not want to burden her younger daughter, who is empathic to her sister's situation. She and the younger

daughter have a good relationship otherwise. Client gets tearful during sessions when discussing her older daughter. You would:

A. Refer her to an older group and give her reading material on the aging process.
B. Tell her these feelings of worthlessness are quite common complaints of the elderly.
C. Indicate your understanding of her feelings and allow her to talk about her daughter in a nonjudgmental atmosphere.
D. Encourage her to examine her life for positive relationships and work with her on a plan to expand her self-worth through volunteer work.

12. You have been seeing this client for several months. Treatment has centered around improving the quality of his relationships with coworkers. He has accepted and applied insights he gained during the sessions most satisfactorily. During the current session he suggests terminating the therapy. You would:

A. Allow him to make that decision.
B. Tell him to prepare a list of benefits he believes he has gained for review in the next session.
C. Praise him for meeting the goals of his current therapy contract, reviewing the specific goals as you do so.
D. Share with him your feelings about his progress in therapy.

Thank you very much for taking the time to respond to this study. Please fold this booklet in half and mail it in the enclosed stamped envelope. God's blessings be with you.

Appendix B

Therapist Adaptability Scale

	Intervention Choices			
Situations	A	B	C	D
1	4	3	2	1
2	3	4	1	2
3	1	3	4	2
4	2	3	1	4
5	4	3	2	1
6	4	3	2	1
7	1	4	2	3
8	1	2	3	4
9	4	1	2	3
10	2	4	1	3
11	1	2	4	3
12	4	1	2	3

Subtotal: _____ + _____ + _____ + _____ = _____ (Total)

Appendix C

Norms for Males, Females and Combined (General) on the Three MPS Subscale Scores

	Male N = 191			Female N = 126			General N = 317		
Percentile	M	P	S	M	P	S	M	P	S
100	46	50	49	45	49	49	46	50	49
95	41	48	44	41	46	38	41	47	41
90	39	47	40	38	43	36	39	45	38
85	38	46	39	38	42	34	38	44	37
80	38	45	35	37	41	33	38	43	34
75	37	44	32	36	40	32	37	42	32
70	36	43	29	35	39	30	36	41	30
65	35	43	27	34	39	30	35	41	29
60	34	41	26	34	37	28	34	39	27
55	34	40	25	33	36	27	34	38	26
50	33	39	24	32	35	26	33	37	25
45	32	39	22	32	34	24	32	37	23
40	31	38	21	31	34	23	31	36	22
35	30	37	20	31	33	21	31	35	21
30	30	37	19	30	32	20	30	35	20
25	29	35	17	29	31	19	29	33	18
20	27	34	16	28	30	18	28	32	17

(table continues)

(continued)

	Male			Female			General		
Percentile	M	P	S	M	P	S	M	P	S
15	26	32	15	27	27	17	27	30	16
10	25	30	14	26	26	16	26	28	15
5	22	27	13	24	24	15	23	26	14
1	20	19	11	17	18	12	19	19	12

Note. These norms have been collected on a limited sample and should be used as guidelines only.

Appendix D

Statistical Descriptive of the Results of Various

Measurements of Well-Being by Occupations

	n	M	SD	Min.	Max.
Religious Well-Being (SWBS)				Range (10 – 60)	
Psychologist	42	54.14	6.86	29	60
Marriage/Family Therapist	31	55.61	6.34	31	60
Social Worker	3	57.67	3.21	54	60
Professor/Teacher	5	55.40	7.57	42	60
Pastor/Pastoral Counselor	15	56.67	3.64	47	60
LPC/LPCC	11	55.54	6.19	41	60
Student	3	57.00	5.20	51	60
Other	15	56.67	5.49	38	60
Total	125	55.44	6.07	29	60
Existential Well-Being (SWBS)				Range (10 – 60)	
Psychologist	42	51.57	5.55	29	60
Marriage/Family Therapist	31	51.52	5.62	39	58
Social Worker	3	52.67	6.43	48	60
Professor/Teacher	5	52.2	6.98	41	58
Pastor/Pastoral Counselor	15	4.44	1.15	44	59
LPC/LPCC	11	52.09	6.65	41	60
Student	3	57	3.46	53	59

(table continues)

(continued)

	n	M	SD	Min.	Max.
Other	15	51.73	6.58	33	60
Total	125	51.96	5.66	29	60
Spiritual Well-Being (SWBS)				Range (20 – 120)	
Psychologist	42	105.71	11.50	58	120
Marriage/Family Therapist	31	107.13	10.97	70	118
Social Worker	3	110.33	9.07	102	120
Professor/Teacher	5	107.60	14.36	83	118
Pastor/Pastoral Counselor	15	109.53	7.31	96	119
LPC/LPCC	11	107.64	12.16	82	120
Student	3	114.00	8.66	104	119
Other	15	108.40	11.70	71	120
Total	125	107.40	10.88	58	120
Mental Well-Being (MPS)				Range (10 – 50)	
Psychologist	42	34.14	4.20	25	43
Marriage/Family Therapist	31	35.74	3.08	29	43
Social Worker	3	37.00	3.46	33	39
Professor/Teacher	5	34.40	3.36	30	38
Pastor/Pastoral Counselor	15	33.13	3.23	28	40
LPC/LPCC	11	33.27	2.10	29	36
Student	3	32.00	5.29	28	38
Other	15	35.53	3.00	30	40

(table continues)

(continued)

	n	M	SD	Min.	Max.
Total	125	34.54	3.59	25	43
Physical Well-Being (MPS)				Range (10 – 50)	
Psychologist	42	37.31	5.57	23	48
Marriage/Family Therapist	31	35.71	5.31	20	46
Social Worker	3	40.33	4.16	37	45
Professor/Teacher	5	33.60	7.44	22	42
Pastor/Pastoral Counselor	15	36.47	6.07	24	45
LPC/LPCC	11	38.09	7.04	23	48
Student	3	40.33	3.21	38	44
Other	15	36.87	5.11	30	47
Total	125	36.82	5.80	20	48
Spiritual Well-Being (MPS)				Range (10 – 50)	
Psychologist	42	43.26	5.18	27	50
Marriage/Family Therapist	31	45.13	4.03	32	50
Social Worker	3	44.00	4.58	40	49
Professor/Teacher	5	43.80	4.87	38	48
Pastor/Pastoral Counselor	15	45.80	2.68	41	50
LPC/LPCC	11	46.09	2.43	43	49
Student	3	45.00	3.00	42	48
Other	15	45.13	3.98	37	50
Total	125	44.58	4.27	27	50

Appendix E

Raw Data

Legend to Columns

A	Participants
B	Age
C	Gender
D	Occupation
E	Marital Status
F	High level of education attained
G	Racial or ethnic background
H	Profess to be a Christian
I	Religion or faith
J	Church attendance in the past year
K	Religious Well-Being (SWBS)
L	Emotional Well-Being (SWBS)
M	Spiritual Well-Being (SWBS)
N	Mental Well-Being (MPS)
O	Physical Well-Being (MPS)
P	Spiritual Well-Being (MPS)
Q	Counselor Adaptability (TSI)

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
1	47	1	1	3	6	3	2	1	5	60	51	111	39	41	50	37
2	23	1	8	1	4	3	2	3	4	60	59	119	30	44	45	30
3	25	1	6	1	5	3	2	1	5	60	54	114	28	39	50	41
4	47	2	6	3	6	3	2	1	6	60	57	117	31	38	48	34
5	35	1	9	3	6	4	3	3	3	38	33	71	39	36	41	37
6	45	1	1	3	6	3	2	4	5	42	52	94	38	32	45	39
7	39	1	5	3	6	3	2	3	6	42	41	83	38	32	39	37
8	52	1	1	4	6	3	2	3	4	36	48	84	36	44	27	36
9	52	1	1	3	6	3	2	3	6	46	49	95	37	38	49	34
10	28	1	1	1	5	3	2	3	4	29	29	58	34	23	42	39
11	42	1	1	4	6	3	2	1	5	48	46	94	34	38	35	36
12	52	1	1	3	6	3	2	3	5	50	41	91	29	23	31	38
13	39	1	1	3	5	3	1	3	5	52	46	98	34	34	41	39
14	53	1	3	3	6	3	2	3	5	41	46	87	34	33	41	35
15	54	1	6	3	6	3	2	3	5	52	44	96	30	42	43	41
16	52	1	6	3	5	3	2	3	6	47	51	98	33	35	47	36
17	51	1	7	3	5	3	2	3	6	49	41	90	32	41	44	38
18	52	2	1	3	6	3	2	3	5	45	46	91	30	30	41	39
19	62	2	3	2	5	6	2	3	3	49	42	91	32	37	44	34
20	41	2	3	3	5	3	2	3	2	31	39	70	38	34	32	36
21	44	2	1	1	6	3	2	3	5	54	45	99	27	31	47	37
22	57	2	1	4	6	3	2	3	4	46	47	93	40	37	41	38
23	52	2	7	3	5	3	2	3	6	41	41	82	34	35	49	36
24	47	2	3	3	5	3	2	3	5	50	49	99	35	42	42	38
25	44	2	3	3	5	3	2	3	6	52	42	94	33	20	45	35
26	27	1	3	3	5	3	2	3	5	50	42	92	32	33	38	37
27	33	2	1	3	6	3	2	3	6	60	59	119	35	35	48	37
28	41	2	3	2	5	3	2	3	5	58	52	110	32	31	45	39
29	58	2	4	3	5	3	2	3	6	59	50	109	39	45	49	36

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
30	34	1	3	3	6	3	2	3	5	53	53	106	36	35	43	38
31	58	1	6	3	5	3	2	3	6	55	55	110	40	40	47	38
32	32	1	1	3	6	3	2	3	5	56	59	115	34	37	40	40
33	30	2	9	1	3	4	2	3	3	60	52	112	34	32	44	40
34	46	1	1	3	6	2	2	3	5	58	51	109	33	41	42	35
35	50	2	7	3	5	3	2	3	2	57	56	113	34	31	43	34
36	55	2	3	5	5	3	2	5	6	60	54	114	38	38	48	36
37	32	2	1	1	6	3	2	3	4	54	54	108	31	29	41	38
38	54	2	6	4	5	3	2	3	5	55	48	103	31	30	45	34
39	45	2	6	3	6	3	2	1	5	55	49	104	34	30	44	35
40	38	2	6	3	5	3	2	3	5	59	52	111	30	24	48	40
41	62	1	1	3	6	3	2	3	5	60	58	118	36	44	46	38
42	55	2	7	3	5	3	2	3	6	60	60	120	35	45	48	43
43	37	2	3	3	5	3	2	3	6	56	47	103	35	26	47	36
44	54	2	9	4	5	3	2	4	6	58	56	114	30	41	42	34
45	55	1	1	3	6	3	2	3	5	54	51	105	37	41	47	34
46	41	2	5	2	6	3	2	1	6	57	50	107	30	22	38	36
47	60	2	1	3	6	3	2	3	5	58	52	110	37	43	38	35
48	47	1	1	3	6	3	2	3	6	60	60	120	37	46	47	38
49	44	2	3	3	5	3	2	3	4	60	42	102	37	27	48	33
50	53	2	1	4	6	3	2	3	5	52	51	103	31	33	43	33
51	43	2	3	3	5	3	2	3	6	59	57	116	37	36	48	36
52	43	1	1	3	6	3	2	3	5	57	53	110	32	34	40	40
53	62	2	4	3	5	3	2	3	6	60	60	120	33	39	43	47
54	38	1	3	3	5	3	2	3	5	59	49	108	41	46	42	38
55	56	2	1	4	6	3	2	3	6	59	51	110	32	40	48	35
56	53	1	6	3	3	3	2	3	5	55	48	103	30	29	43	36
57	55	1	3	3	5	3	2	3	6	60	58	118	42	43	48	37
58	45	1	9	3	5	3	2	3	5	55	46	101	32	33	45	35

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
59	28	1	9	3	5	3	2	3	5	56	48	104	34	37	41	34
60	65	1	1	4	6	3	2	3	3	60	53	113	33	33	44	35
61	65	2	3	3	6	3	2	3	6	59	57	116	36	39	49	32
62	56	2	9	3	5	3	2	3	5	60	60	120	37	41	49	32
63	56	2	3	3	5	3	2	4	5	60	54	114	43	36	47	33
64	43	1	3	3	5	3	2	3	5	56	54	110	34	36	42	40
65	49	2	5	3	6	3	2	3	5	59	57	116	35	42	47	40
66	51	2	9	3	5	3	2	1	6	60	56	116	38	35	45	40
67	43	2	9	3	5	3	2	3	3	57	49	106	38	30	50	38
68	46	1	7	3	5	3	2	3	6	50	54	104	29	48	47	37
69	51	1	5	3	6	3	2	3	6	59	55	114	32	37	48	37
70	39	1	9	3	5	3	2	3	6	60	51	111	36	35	45	37
71	58	1	1	4	5	3	2	3	6	60	54	114	37	41	50	37
72	61	1	3	3	6	3	2	3	5	59	52	111	35	43	37	37
73	46	1	3	3	5	3	2	3	5	59	58	117	38	36	50	41
74	26	2	9	1	5	3	2	3	5	56	54	110	35	30	42	35
75	27	2	9	1	5	3	2	3	5	58	54	112	32	32	49	42
76	40	2	1	3	6	3	2	3	6	57	57	114	38	37	41	34
77	64	1	3	3	5	3	2	3	5	60	58	118	36	41	48	37
78	62	1	3	3	6	3	2	3	6	58	57	115	36	31	49	38
79	52	1	9	3	5	3	2	3	6	58	57	115	36	47	48	37
80	47	2	9	3	5	3	2	3	4	55	48	103	33	40	50	37
81	52	1	6	4	5	3	2	3	6	60	58	118	36	45	41	31
82	54	2	3	4	5	3	2	3	6	59	53	112	35	39	46	34
83	50	1	3	3	5	3	2	3	6	54	46	100	35	24	46	41
84	45	1	1	3	6	3	2	3	6	58	50	108	31	40	45	41
85	39	1	6	3	5	3	2	3	6	58	57	115	34	43	43	41
86	45	1	3	3	5	3	2	3	6	56	53	109	35	32	46	38
87	39	1	1	3	6	3	2	3	5	55	48	103	25	37	48	38

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
88	43	2	3	2	5	3	2	3	4	57	54	111	41	40	47	33
89	52	2	3	4	5	3	2	3	6	60	56	116	29	34	47	34
90	57	2	4	2	5	3	2	3	4	54	48	102	39	37	40	35
91	52	2	3	3	5	3	2	1	6	60	58	118	36	41	48	36
92	55	2	7	3	5	3	2	3	5	58	51	109	31	41	43	37
93	57	2	1	4	6	3	2	3	5	56	51	107	37	36	50	35
94	38	1	6	3	5	3	2	3	6	58	50	108	34	42	50	43
95	40	1	1	3	6	3	2	3	5	55	53	108	37	48	34	35
96	49	2	1	3	6	3	2	3	1	60	54	114	40	33	48	27
97	56	1	3	3	6	3	2	3	6	53	54	107	34	40	44	35
98	52	1	5	3	6	3	2	3	5	60	58	118	37	35	47	35
99	59	2	1	3	6	3	2	3	5	60	56	116	29	44	44	34
100	48	2	6	4	3	3	2	3	5	60	59	119	37	38	46	43
101	63	2	6	2	5	3	1	3	6	59	57	116	36	39	45	35
102	52	1	1	3	6	3	3	1	6	54	54	108	41	43	43	38
103	49	1	1	3	6	3	2	3	6	56	50	106	33	41	38	39
104	59	2	7	3	5	3	2	1	6	60	60	120	35	40	49	35
105	36	2	1	3	5	3	2	3	4	60	53	113	25	32	45	39
106	24	2	8	3	4	3	2	3	5	51	53	104	38	39	42	34
107	49	1	1	3	6	3	2	3	5	53	51	104	39	43	40	40
108	40	2	1	2	6	3	2	3	5	54	48	102	31	33	44	34
109	51	2	9	3	6	3	2	3	6	59	58	117	40	41	37	37
110	44	2	7	4	5	3	2	3	5	59	54	113	32	23	44	36
111	58	2	7	4	5	3	2	3	5	59	49	108	35	38	45	38
112	44	2	9	1	5	3	2	3	6	60	54	114	39	43	49	39
113	45	2	1	3	6	3	2	4	5	48	55	103	43	37	43	37
114	46	1	7	3	6	3	2	3	5	58	48	106	36	34	49	34
115	51	1	7	3	5	3	2	3	6	60	59	119	33	43	46	37
116	60	1	6	3	5	3	2	3	6	57	54	111	33	33	47	38

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
117	31	1	1	3	6	3	2	3	5	58	56	114	30	41	47	35
118	44	2	1	3	6	3	2	3	5	57	58	115	35	38	46	42
119	48	1	3	3	5	3	2	3	6	60	52	112	34	39	46	37
120	56	1	1	3	6	3	2	3	5	58	53	111	35	37	49	38
121	37	1	3	3	5	3	2	3	5	59	54	113	36	34	50	37
122	49	1	3	3	5	3	2	3	6	57	55	112	33	41	46	40
123	52	2	1	4	6	3	2	1	5	60	55	115	33	42	49	41
124	40	1	8	3	5	2	2	3	5	60	59	119	28	38	48	40
125	43	2	1	3	5	3	2	3	6	59	58	117	29	37	40	39

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