COMPARING THE EFFICACY OF RELIGIOUSLY INTEGRATED COGNITIVE BEHAVIOURAL THERAPY ON LIFE SATISFACTION AMONG THREE CHRISTIANS DENOMINATIONS IN ANAMBRA, NIGERIA

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ABSTRACT
Religiously Integrated Cognitive Behavioural Therapy has been found to be efficacious in improving levels of life satisfaction among Christians. Whether any particular denomination benefits more than others from the psychotherapy still remains uninvestigated. This study therefore tried to compare the efficacy of religiously integrated cognitive behavioural therapy on life satisfaction among three key denominations in Nigeria: Anglican, Catholic and Pentecostal; hypothesizing that denomination would have significant effect on the efficacy of religiously integrated cognitive behavioural therapy on life satisfaction of Christians.
Adopted for the analytical framework of this research was Diener's theory on life satisfaction. A true-experimental design was used. Thirty Christians from 3 denominations: Anglican (26.7%), Catholic (43.3%) and Pentecostal (30.0%) participated in the study. A multistage sampling technique was adopted in gathering the participants: purposive sampling was used to select the Sea and denominations; accidental sampling was used to select participants therefrom. The ages of the participants ranged from 24 to 62 years with mean age of 38 (SD=8.9). Female constituted 50% of the sample. For data collection, Satisfaction with Life Scale (α=0.80) was used.
The results of data analyses using one-way analysis of covariance (ANCOVA) showed that there was significant interaction effect of Christian denomination and religiously integrated cognitive behavioural therapy on life satisfaction ($F (2, 22) = 3.93$, $p < .05$, $\eta^2_{partial} = .26$). Further analyses revealed that the Catholics have higher life satisfaction ($\bar{x} = 22.48$) than the Pentecostal (($\bar{x} = 17.58$) and the Anglican members (($\bar{x} = 20.95$) after exposure to the religiously integrated cognitive behavioural therapy.
The study concludes that denomination has effect on the efficacy religiously integrated cognitive behavioural therapy has on Christians' life satisfaction. The research recommends a denomination-specific religiously integrated cognitive behavioural therapy among Christians. Clinicians, psychotherapists, general mental workers, and religious leaders should be aware of the role denomination plays when using religiously integrated cognitive behavioural therapy in improving the life satisfaction of their clients.

Keywords: *Christians, Denomination, Life satisfaction, & Religiously integrated cognitive behavioural therapy*

INTRODUCTION:

Life satisfaction is an aspect of positive psychology which shows the level of calmness, peace and happiness a person places on his/her existence according to his/her chosen criteria. It is the degree to which an individual judge his or her overall life to be meaningful in reference to personal standard; which in reality, is also affected by the societal/cultural and/or religious standards. It is a cognitive and evaluative indicant of wellbeing showing the subjective level of an individual judgment of his or her wellbeing. It is generally defined as personal measure of conscious cognition and emotional evaluations of a person's life in relation to his or her set standards. Diener, Lucas, & Oishi, (2002) see life satisfaction as the degree of experiencing pleasant emotions, the extent of low levels of negative moods, and a high level of happiness. According to Garcia & McCarthy (1994), life satisfaction refers generally to an individual judgment of his/her condition, in comparison to a set standard, or to one's personal aspirations. Rapley (2008) holds that life satisfaction is not truly 'social' in overall sense, but in the sense that they are collections of an individuals' 'declared facts' of particular personal judgments, usually satisfaction or happiness. Seifert (2005) sees life satisfaction as a multi-dimensional concept.

Generally, life satisfaction measure scores are used to reveal whether one is happy or not. When one is judged to be happy, reporting associative positive signs in clinical interview and scoring high on measures of life satisfaction, he/she is said to be satisfied with life. Positive judgments of life satisfaction are linked generally with high sense of happiness/eudaimonia, which is an affective indicant of wellbeing. More often than not, successes, sense of fulfillment, enthusiasm, peace, high self-esteem, joy and achievement of one's desires dispose one to

positive judgment about one's life satisfaction level, (Diener, et al. (2002). This, however, is not always the case; for despite possessing most of these disposing factors, some individuals still report very low life satisfaction level. Negative evaluations of perceived life satisfaction is generally recorded when one scores low on life satisfaction measure and reports negative signs in clinical interview; the person is said to be dissatisfied with life or have low life satisfaction. The predisposing conditions for this include sadness, anxiety, fear, lack of enthusiasm and motivation, disappointments, restlessness, shyness, depression, hopelessness, frustration, distress and low self-esteem. Persons with records of low life satisfaction constitute lots of dangers to themselves, families and societies at large.

Many factors, like good health, achievements, successes, puritan values, have always contributed to the achievement of a sense of wellbeing, especially, of life satisfaction or happiness in the lives of individuals. Frijns (2010) observed that Life satisfaction can be affected by many spheres of human existence. Furthermore, most researchers have accepted that healthy psychological status, such as eudaimonia/life satisfaction and general wellbeing, are always presumed to be the result of social, spiritual, psychological, and economic treasures and success (Diener, Lucas, & Napa, 2006). For some other researchers however, this healthy psychological state lies more with personal positive cognitive evaluation of non-material values, such as virtues and healthy relationship with one's supreme Being and general sense/feeling of fulfillment, (Ellison, Boardman, Williams, & Jackson, 2001; Francis, Ziebertz and Lewis, 2003). Determinants of life satisfaction, according to Veenhoven (2009), can be generally found at any of two levels: the external conditions (like socio-economic statues and general wealth) and inner psychological processes (as in values and virtues); and both approaches have long traditions. Some persons find satisfaction in materialism, their social connections, success records; while some other seek satisfaction in things not generally material, like the level of their spirituality and their prayer life. Some individuals enjoy *extrovertism* while others love *introvertism*. In common parlance, one man's meet can be another man's poison in matters that determine individuals' life satisfaction.

Religiously Integrated Cognitive Behavioral Therapy, on the other hand is about helping clients in creating rational and better alternatives through their religious values/resources to replace the old irrational accepted choices acting as stuck points that keep them bound. It can be viewed as a *sociopsychoreligious* therapeutic technique that involves the use of a client's religious resources to improve on the conventional Cognitive Behavioural Therapy (CBT) technique aimed at producing a renewed mind for the client. As the name suggests, religiously integrated cognitive behavioural therapy (RCBT) can be adapted to any particular religion (Judaism, Hinduism, Islam, Christianity, etc.) according to the very religion of the clients. Here, it is adapted to the Christian religion since the participants are Christians. While being shaped by the analytic tools and interventions devised by secular psychotherapeutic theories of CBT, the RCBT takes place within the moral and religious assumptive world associated with religious environment. It is therefore not only meant to address cognitive errors but also helps to fasten the accumulation of desired behaviours. Pearce et al., (2015) reported that RCBT is unique because it makes an explicit use of the religion of the client as the main tool to find and challenge unhealthy thinking and behaviours in reducing symptoms of unhealthy conditions. These main tools include charity works, intercession, gratitude, reflection, meditation, memorization, show of love, and other religious treasures and values like writings, teachings, testimonies, challenges, practices, rights obligations, promises, demands and rewards stemming from the client's religious beliefs. RCBT seeks meaning beyond ordinary appearance through these tools to address the human person holistically providing answers to such disturbing and sickening questions like 'who am I'; 'Is there life after death?'; 'Why should I be the one?; 'Is God really existing?'. RCBT is an interdisciplinary approach based on the science of psychology, clinical issues and religious morals, focusing on complete restoration of the human person. Situating this in the context of the society can help readers achieve more elucidation. Ejiofo, et al., (2019) attempted to demonstrate this with the diagram as seen in figure 1.

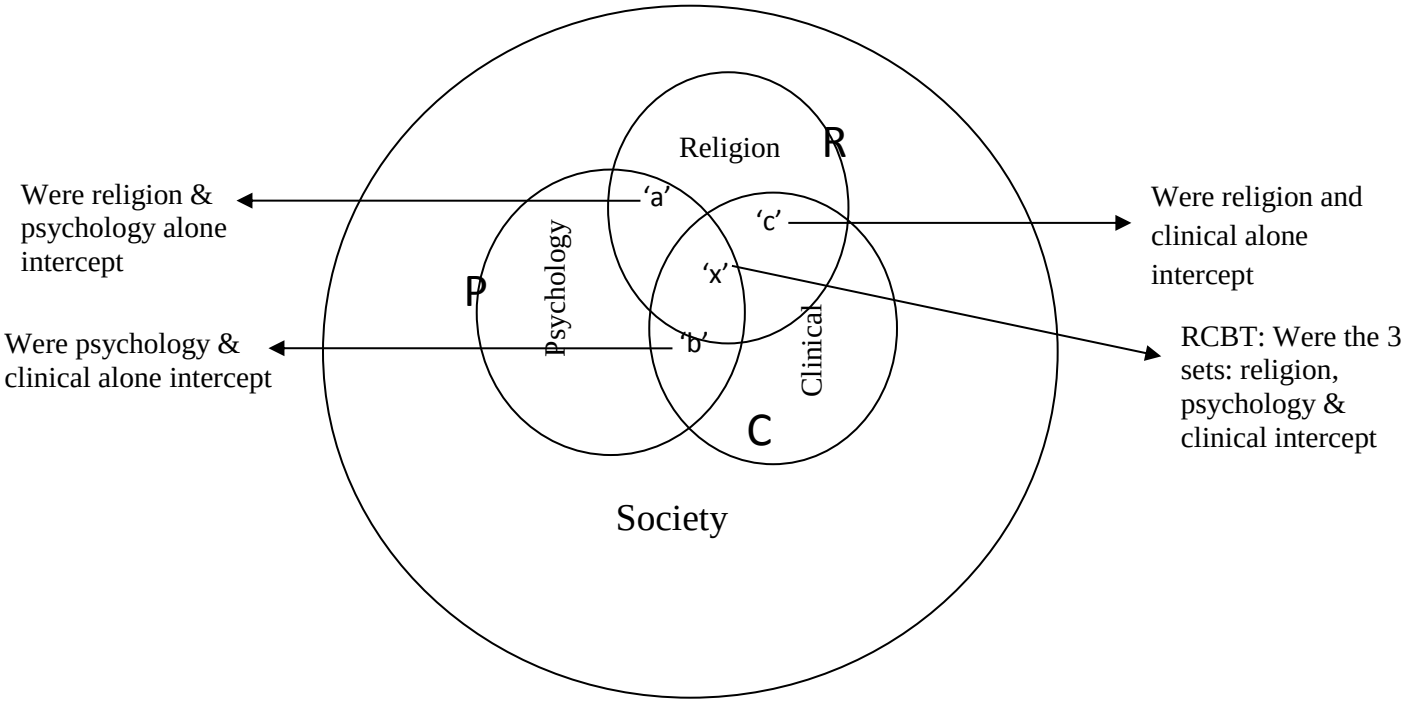


Figure 1: Situating Religiously Integrated Cognitive Behavioural Therapy in the framework of the society.

Here, the society is represented by a very large circle 'S' which contains other smaller circles that hold other three sectors relevant to the study: psychology, 'P'; clinical, 'C'; and religion, 'R'. Each of these 3 sectors within the society is interconnecting with others forming intercepts of different degrees. However, while some of these intercepts are unique to 2 of these sectors, ('a', 'b' & 'c'), the 'x' intercept is common to the 3 sectors. This point 'x', where 'R', 'P' and 'C' meet is described as the zone, area or scope of RCBT. Note that 'R' stands for any religion in the world.

The term denomination explains different categories or sets of any religious group, with slight differences from each other. Specifically, denominations as used here imply Christian sets that have some specific values and practices slightly differentiating them from each other as Christians. In this study 3 major denominations were involved: Anglican denomination (1),

Catholics (2), and Pentecostals (3). The denominations of the participants were determined according to what they filled in the gap provided for it.

Religiously Integrated Cognitive Behavioural Therapy has been found to be efficacious in reducing psychopathological symptoms, especially of anxiety and depression (Pearce, et al., 2015; Rajaei, 2010; Rehm, 2015) and in improving levels of life satisfaction among Christians, (Ejiofo, 2019). Whether any particular denomination benefits more than others from the psychotherapy still remains uninvestigated. This study therefore tried to compare the efficacy of religiously integrated cognitive behavioral therapy on life satisfaction among three key denominations in Nigeria: Anglican, Catholic and Pentecostal; hypothesizing that denomination would have significant effect on the efficacy of religiously integrated cognitive behavioural therapy on life satisfaction of Christians.

METHODS:

Literature search for efficacy of religiously integrated cognitive behavioural therapy on life satisfaction was done. Adopted for the analytical framework of the research was Diener's theory on life satisfaction. This is because within the framework of Diener's position, this study sees life satisfaction as a comparison of two conditions: life circumstances, or events, and internal standards. The research utilized a two-group pretest/posttest, evaluation/control group true-experimental design. The prefix 'true' is for clarity following the criteria that the three broad types of research designs are true-experimental, quasi-experimental and non-experimental research designs. A multistage sampling technique was adopted in gathering the participants: purposive sampling was used to select the State and the denominations; accidental sampling was used to select participants therefrom. The participants were 30 Christians drawn from 3 denominations: 8 were Anglicans, constituting 26.7%; 13 Catholics, 43.3%; and 9 Pentecostals 30.0%. Males constituted 50% and females 50%; and while the single constituted only 13.3%, the remaining 86.7% were married. Participants' age ranged from 24 to 62 years with mean age of 38.0 $\pm$ 8.9 years. 50.0% were below 41 years while 50.0% were 41 years and above. Regarding their socioeconomic status, 40.0% of the respondents were of lower socioeconomic status, 33.3% middle status while 26.6% of upper socioeconomic status. With regards to their educational status, larger percentage of the respondents (63.3%) has either obtained their OND or below; while 36.7% has obtained their first degree or above. They all could read, write and understand English language. The study was carried out in a monastic compound in Umuoji located in Onitsha Metropolitan Sea, Nigeria. This setting was chosen because of the serenity the environment provides. It was quite airy, calm, and free from environmental odors. While the 'Christian Complete Wellbeing Module' (CCWM), a set of 12 session intervention program aims at providing a treatment plan for the improvement of the Christians' perceived life satisfaction level, was used for the intervention; Satisfaction with Life Scale (α=0.80) was used for data collection. Sample items include: "In most ways my life is close to my ideal" & "If I could live my life over, I would change almost nothing". Content validity is greater than 0.60; and alpha coefficients have repeatedly exceeded 0.80, (Diener, et al 2002). Other instruments that were used in the imparting of knowledge to the participants in the treatment group included the Bible, pictures, hymn books and other worship-song books, some visual aids, and some general Christian prayers. The research was conducted through 3 major procedures: pre-management assessment, involving clinical interviews and general screening assessment; management, involving actual intervention with the treatment group; & post-management assessment, which involved a general administration of the questionnaire after the intervention, and analyses of the data and their interpretations. A brief summary of the content of the module, as followed in the intervention is presented in the appendix.

RESULTS:

The study hypothesized that the denominations of the participating Christians would influence the efficacy of religiously integrated cognitive behavioural therapy (RCBT) on their life satisfaction. The results of data analyses using one-way analysis of covariance (ANCOVA) showed that there was significant interaction effect of Christian denomination and religiously integrated cognitive behavioural therapy on life satisfaction ($F(2, 22) = 3.93$, $p < .05$, $\eta^2_{partial} = .26$). The summary of this finding is presented in the Tables and Figure below:

Table 1: Summary of one-way analysis of covariance (ANCOVA) demonstrating the influence of denominations on RCBT impact on Christian life satisfaction:

Source	Dependent Variable	Type III Sum of Squares	Df	Mean Square	F	Sig.	Partial Eta Squared
Prestest Life satisfaction	Life satisfaction	105.147	1	105.147	12.815	.002	.368
Treatment	Life satisfaction	586.233	1	586.233	71.446	.000	.765
Denomination	Life satisfaction	29.778	2	14.889	1.815	.186	.142
Treatment * Denomination	Life satisfaction	64.445	2	32.222	3.927	.035	.263
Error	Life satisfaction	180.516	22	8.205			
Corrected Total	Life satisfaction	1104.167	29				

The result in table 1 above demonstrates a significant main effect of RCBT intervention on life satisfaction ($F(1, 22) = 71.45$, $p < .001$, partial $\eta^2 = .77$). This means that religiously integrated behavioural therapy has significant effect on life satisfaction of the participants. The finding shows that there was significant interaction effect of Christian religious denomination and RCBT treatment on life satisfaction ($F(2, 22) = 3.93$, $p < .05$, $\eta^2_{partial} = .26$) among the participants. This means that denomination of the participants has effect on the efficacy of religiously integrated cognitive behavioural therapy on life satisfaction. This brings about the need to use the Mean Scores to determine the level of influence of each denomination on life satisfaction. The result of this is presented in table 2.

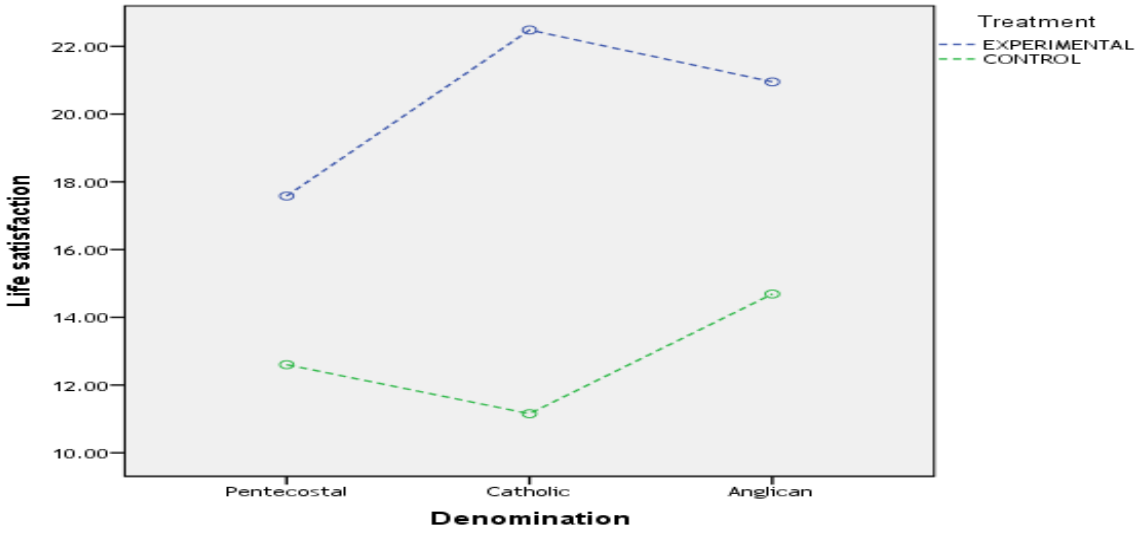
Table 2: showing the mean differences in life satisfaction based on denomination and treatment:

Dependent Variable	Treatment	Denomination	Mean	Std. Error	95% Confidence Interval	
					Lower Bound	Upper Bound
Life satisfaction	EXPERIMENTAL	Pentecostal	17.581[a]	1.938	13.562	21.600
		Catholic	22.484[a]	.958	20.497	24.470
		Anglican	20.952[a]	1.447	17.950	23.953
	CONTROL	Pentecostal	12.602[a]	1.155	10.206	14.999
		Catholic	11.154[a]	1.479	8.088	14.221
		Anglican	14.689[a]	1.225	12.149	17.229

Results revealed that the Catholics have higher life satisfaction ($\bar{x} = 22.48$) than the Pentecostal (($\bar{x} = 17.58$) and the Anglican members (($\bar{x} = 20.95$) after exposure to RCBT. From the table, it is also observed that the Anglican denomination members reported higher life satisfaction than the Pentecostals at the posttest, (a line graph of this is presented in figure 3 below.) This strongly demonstrates denomination of the participants affected the levels of effectiveness of the RCBT

intervention in the improvement of life satisfaction among Christians in the study. The hypothesis is thus supported.

Fig 1: Line graph showing the posttest levels of life satisfaction based on treatment and Christian denominations:



The graph revealed that the Catholics exposed to RCBT intervention have higher life satisfaction compared to the Pentecostals and Anglicans; and that the Pentecostals have lower life satisfaction compared to the Anglicans.

DISCUSSION:

Denomination was reported to have shown significant relationship with the efficacy of RCBT on life satisfaction. This finding might be as a result of the fact that different denominations differ in their approaches and responses to the RCBT. Given the fact that denomination is part of what spells out a participant's religiosity, the result can be understood. Even on the strength of this particular result, it is justifiable to infer that denomination as part of religiosity has significant implications for RCBT. Denominations certainly enhance subjective wellbeing by providing their adherents with access to Christian values (Krause 2009); but certainly, according to their own riches, understanding and insights, for *'nemo dat non habet'*. Some decade ago, McIntosh (1995), in line with the research opinions of the time that view religion as a schema influencing human perceptions, researched on '*Religion as Schema, with Implications for the Relation between*

Religion and Coping', suggested that differences in specific religious beliefs affect how people understand and respond to events. He therefore concluded that religion acts like cognitive schema, reforming cognitive processes which include the interpretations given to stressors. It then means that different denominations, despite much of similar tenets among all Christian denominations, still have some differing beliefs, cognitive processes and behavioural consequences/expectations.

This finding on denomination supports Brañas-Garza et al. (2009), who reported that religiously-devoted Catholics trust peers and institutions more compared to non-practicing Catholics and individuals involved in practicing other denominations. This trust, they assert, increases their levels of life satisfaction and improves their wellbeing. Park et al., (1990) before this, reported that Protestants with intrinsically religiousness using religious coping more reported less psychological difficulties when coping with negative life events than the Catholics, who revealed no relationships between intrinsic religiosity and psychological distress. They judged that the differences in the specific religious beliefs in the Catholic and Protestant theologies concerning work versus faith might be responsible. Following their line of argument, specific religiousness about God and different theological ideologies in relation with cognitive and behavioural issues might be responsible for the differing influences religiously integrated cognitive behavioural therapy has on different Christian denominations.

Another possible explanation to this significant difference found with denomination and RCBT maybe as a result of experimental error, for being a Catholic, the researcher may have unconsciously given a Catholic touch to the intervention. Despite this possible negativity, it points out to something very positive: the need for denominational tuned RCBT for each denomination. If the Catholics respond more positive than other denominations in a 'synchronized Christian intervention where effort was made to remove everything 'specifically Catholic' (or of any other denomination at that); how much more positive will they respond if the rich values of the 'Catholic faith' like the sacraments are completely allowed to flow in. Following this argument then, establishing denominational tuned RCBT, where the rich values of every denomination and other specific denominational effective practices would be considered in their specific denomination RCBT is absolutely necessary.

CONCLUSSION:

Christian denomination types have significant influence on the efficacy of religiously integrated cognitive behavioural therapy among Christians. There is therefore, the need to consider denominational tuned religiously integrated cognitive behavioural therapy (RCBT) for each Christian denomination; and by extension, for other religions and their denominations or sets. This study therefore recommends a denominational specific approach to RCBT where the complete religiosity, worship behaviours and all other values specific to each denomination should also be freely considered: which for the Anglicans, as an example will be Anglican Integrated Cognitive Behavioural Therapy (ACBT), for the Catholics, Catholic Integrated Cognitive Behavioural Therapy (CCBT), and for the Pentecostals, Pentecostal Integrated Cognitive Behavioural Therapy (PCBT). The research further suggests that such denominational considerations, or rather, denominational-specific forms of RCBT would not end with Christian denominations but rather be extended to the sects in Islamism, African Traditional Religions (ATRs), and even to unidentified others. This would then include the different Islamic sects: the Sunni Integrated Cognitive Behavioural Therapy (SuCBT), where the religiously integrated cognitive behavioural therapy (RCBT) can be adapted to the Sunni (those Moslems who holds that prophet Mohammed was the very last prophet) and the Shia Integrated Cognitive Behavioural Therapy (SCBT) for those who hold that there came another prophet after Prophet Mohammed.

Finally, the research recommends that clinicians, psychotherapists, general mental workers, and religious leaders should be aware of the role denomination plays when using religiously integrated cognitive behavioural therapy in improving the life satisfaction of their clients.

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Appendix
A brief table-summary of the module sessions of the Religiously Integrated Cognitive Behavioral Therapy (RCBT):

SESSIONS	TARGET	ACTIVITIES	EXPECTATIONS
1	Rapport, Pretest Data, and Grouping	Introduction, randomization of the participants into groups, and Administration of the questionnaire	Happy environment, Pretest data of both treatment and control groups
2	Assumptions of RCBT, basic ideas of LS and mood monitoring	Teaching mood monitoring & Explaining the basic concepts of LS and the basic assumptions of RCBT	Having the elementary knowledge of RCBT, mood monitoring, and of LS
3	Practicing the 'ABCD' of RCBT	Discussing A, B, C & D of ABCDE, & making Formulations through religious treasures, the RCBT tools	Having the capacity for alternative explanation
4	Religious/Christian Cognitive errors	Explain some Christian cognitive errors about Christianity, worship *(DWS-C)*, etc., and how to overcome them	Better understanding of Christian principles/practices especially worship/religiosity
5	Dangers of irrational beliefs	Pointing out the harmful effects of irrational beliefs with *Idea Inventory*	Awareness of the dangers and harms of irrational beliefs
6	Automatic thoughts	Explaining how to watch for and stop automatic thoughts through mindfulness & understanding psychological factors.	Better control of one's mind on stressors, depression, self-esteem & social support.
7	Right self-judgment & right judgment of events, stressors/situations	Using Psalm 139, Serenity prayer & other Aids to help self – understanding & evaluation (e.g. meditation)	Better understanding & evaluation of oneself & life events/situations.
8	'*Decatastrophizing'* and Mindfulness	Teaching how to use RCBT tools to dispute irrational/awful beliefs, the behavioural aspect of RCBT/mindfulness	Power to make informed decisions; sense of awareness, and happiness
9	Altruistic nature, forgiving spirit & other Christian practices	Explaining God as altruistic, kind & forgiven; and how He wants/made Christians to be imitators of Him	Achieving altruistic nature, kindness, forgiven spirit & some other Christian virtues.
10	Christian satisfaction	Educating the participants using Jn., 14:127 & Matt, 5:1-12; 25: 14-30 on Christian LS.	Achieving better Christian understanding of LS.
11	The D & E of RCBT	Using RCBT tools to dispute irrational beliefs & automatic thoughts; general review of the sessions.	Having Effective new beliefs, new emotional & behavioral consequences
12	Posttest data & dismissal	Administration of the questionnaire, appreciation & dismissal	Post-test data of both treatment and control groups

Key to the abbreviations: A = Activating event(s), B = Beliefs, C = Consequences (emotional and behavioral), D = Disputing/'Decatastrophizing', E = Effective new belief(s) and new Emotional and behavioral consequences, LS = Life satisfaction; Jn. = Gospel of John and Matt. = Gospel of Matthew, DWS-C = Divine Worship Scale for Christians, RCBT = Religiously Integrated Behavioural Therapy.