Religious Distress and Coping With Stressful Life Events: A Longitudinal Study

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Objective(s): Hypothesis: Religious strain would mediate the relationship between stress symptoms at baseline and stress symptoms 1 year later. **Method:** Seventy-nine people with a history of stressful life events (55 women, 23 men, one unknown gender, average age 58 years) from community churches reported stressful life events, spiritual adjustment, and posttraumatic stress symptoms at initial assessment and 1-year follow-up. **Results:** Religious strain mediated the relationship between baseline and follow-up posttraumatic stress symptoms. **Conclusions:** Because religious distress contributed to prediction of stress symptoms over time, it appears that religious distress is related to adjustment to stressful life events. J. Clin. Psychol. 68:1276–1286, 2012.

Keywords: stress and coping; religion; religious coping; psychology of religion; prayer

While theories related to stressful life events and posttraumatic stress symptoms have emphasized intra-personal processes (such as changing assumptions or dysfunctional cognitions; Foa & Rothbaum, 1998; Janoff-Bulman, 1992), much less attention has been paid to important factors that may play a role in the development, maintenance, and course of reactions to stressful life events (Dekel, Ein-Dor, & Solomon, 2012). Religious functioning, which involves both internal (spirituality) and external (religious activities) components, is a potentially important area of functioning with implications for distress after exposure to severe stressors.

For many people, religious functioning is part of coping with stressful life events (Schuster et al., 2001). Some find their faith helpful in coping, some find it ineffectual, and still others describe it as a hindrance in recovery (Falsetti, Resick, & Davis, 2003; Fontana & Rosenheck, 2004; Pargament, Koenig, Tarakeshwar, & Hahn, 2004). These mixed findings mirror the pattern of results found in general studies of mental health and religious functioning, and may be due to a failure to measure the complexity of religiosity/spirituality (Chen & Koenig, 2006). Recently, multidimensional measurement of religious functioning has identified aspects of religiosity/spirituality that predict mental health outcomes, including positive and negative religious coping, religious comforts and strains, and active versus passive prayer coping (Ano & Vasconcelles, 2005; Exline & Rose, 2005; Harris et al., 2008; Pargament, Koenig, Tarakeshwar, & Hahn, 2004). Indicators of religious distress, including negative religious coping, religious strain, and passive prayer coping have been associated with posttraumatic stress symptoms in cross-sectional study (Harris et al., 2008; Ogden et al., 2011).

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Common Long-Term Reactions to Stressful Life Events

Long-term reactions to stressful life events are varied and include normal functioning, or problems with anxiety, depression, and substance abuse (Bonanno, 2004). Much of the research on responses to stressful life events has focused on "Criterion A traumas" such as rape, combat, or other threatened loss of life (American Psychiatric Association, 2000). However, there is a growing body of evidence that symptoms of posttraumatic stress disorder (PTSD) can occur in response to a wide range of stressful events, ranging from job loss to divorce to medical conditions (e.g., Gold et al., 2005; Long et al., 2008; Mol et al., 2005). While expressions of posttrauma distress are diverse, there is a substantial literature on the link between stressful life events and the reexperiencing (e.g., nightmares, intrusive memories, or flashbacks), avoidance (including avoidance of event-related reminders and general numbing and withdrawal), and arousal (e.g., irritability, hypervigilance, and exaggerated startle response) symptoms of PTSD (Bonanno, 2004; Ozer, Best, Lipsey, & Weiss, 2003). Both mental health providers and other community resources, such as religious institutions, can better facilitate recovery from stressful life events if relationships between religious distress and adjustment to such events were better understood.

Multidimensional Models of Religious Coping

Religious coping (i.e., how one uses religion to manage stressful experiences) is one aspect of religious functioning that can have positive or negative relationships with mental health. Positive religious coping strategies include seeking support and a closer relationship with the Deity, forgiving others and seeking forgiveness for one's own failings, working together with one's Higher Power to solve problems, and viewing the stressor as an opportunity for spiritual growth (Pargament et al., 1998). Negative religious coping strategies include appraising one's Higher Power as punishing or abandoning, appraising one's community of faith/clergy as unsatisfactory, attributing the stressor to a demonic force, and questioning the power of the Deity (Pargament et al., 1998). Negative religious coping predicts distress, posttraumatic stress symptoms, poorer cognitive functioning, and poorer quality of life (Ano & Vasconcelles, 2005; Harris et al., 2008; Pargament et al., 2004).

Exline's studies of religious comforts and strains also examine healthy and distressing religious functioning (Exline & Rose, 2005; Exline et al., 2000). Religious comforts include feeling loved and accepted by the Deity/religious community, and confidence that one has been forgiven. Religious strains include feeling alienated from the Deity, religious fear and guilt, and conflict with one's Higher Power/ faith community. Religious strains predict depression, suicidality, anxiety, and requests for assistance with spiritual problems in psychotherapy (Exline et al., 2000; Exline & Rose, 2005).

Coping through prayer has both positive and negative relationships with mental health (Harris, Schoneman, & Carrera, 2002, 2005). Active prayer coping strategies such as using prayer to accept the situation, ask for help with problem solving, or reduce arousal are associated with better adjustment, while using prayer to avoid stressors is associated with higher anxiety (Harris, Schoneman, & Carrera, 2002, 2005).

Cross-Sectional Studies of Religious Distress and Stressful Life Events

Harris et al. (2008) identified two religious factors relevant to adjusting to stressful events: (a) seeking spiritual support included positive religious coping and prayer coping functions and (b) religious strain included negative religious coping, religious fear and guilt, and alienation from G-d. Religious strain predicted posttraumatic stress symptoms. Several studies have found that psychological symptoms are related to negative religious coping among those who have survived stressful life events (Bradley, Schwartz, & Kaslow, 2005; Connors, Whiteside-Mansell, & Sherman, 2006; Gall, 2004). Most other cross-sectional studies of religious adjustment and stressful life events do not include measurement of religious distress, and use varying indicators of religious functioning and mental health outcomes, thus limiting conclusions in this field (Chen & Koenig, 2006; Krejci et al., 2004; Martz, 2004).

Longitudinal Studies of Religious Distress and Stressful Life Events

Longitudinal studies can reveal relationships between religious adjustment and adjustment to stressful life events over time. Several longitudinal studies have looked at older patients admitted to hospitals (Fitchett et al., 1999; Pargament et al., 2001; Pargament et al., 2004) or other patients in medical settings (Jim, Richardson, Golden-Kreutz, & Andersen, 2006; O'Mahoney et al., 2005; Tarakeshwar et al., 2006). Over time, those who are more religious experience less depression when factors such as illness severity and social support are controlled (Koenig et al., 1998; Pressman et al., 1990). Rehabilitation patients who report anger at their Deity show poorer recovery over time (Fitchett et al., 1999). Cancer patients with higher levels of spiritual/religious well-being were less likely to desire a hastened death (O'Mahoney et al., 2005). Cancer patients who use positive religious coping reported better quality of life over time (Jim et al., 2006; Tarakeshwar et al., 2006).

Longitudinal studies of bereaved caregivers yield mixed results. Among caregivers who later lost their partners with HIV/AIDS, discussing spirituality upon initial interview correlated with more depression and anxiety (Richards & Folkman, 1997). The participants were largely partners of gay men, and in many religions these participants may have experienced condemnation or devaluing of their relationship. These types of religious experiences are likely to affect the results of the study. In another longitudinal study of bereaved caregivers, those who were more religious were less likely to be depressed after their loss (Fenix et al., 2006).

These studies used single indicators of religious coping strategies. Studies measuring positive and negative religious coping separately found that positive coping predicted more stress-related growth and a better quality of life, while negative coping predicted poorer cognitive functioning and mortality (Pargament et al., 2001, 2004; Jim et al., 2006; Tarakeshwar et al., 2006). Furthermore, *chronic* negative religious coping predicted greater deterioration in mental and physical health, quality of life, and depression (Pargament et al., 2004). Many longitudinal studies of religious adjustment were conducted with people who have undergone stressful experiences in medical contexts (Tix & Frazier, 1998). Medical stressors are qualitatively distinct from many other stressors. Survivors of rape, combat, or serious motor vehicle accidents experience PTSD symptoms at higher rates (Copeland, Keeler, Angold, & Costello, 2007; Rasmussen, Rosenfeld, Reeves, & Keller, 2007). Further studies are necessary to examine other types of stressful life events.

Unanswered Questions on Religious Distress and Stressful Life Events

Available research tells us little about relationships between religious distress and stressful life events over time. The present study sought to confirm previous cross-sectional findings on religious distress and psychological symptoms, using a longitudinal design and the religious strain dimension identified by Harris et al. (2008). We hypothesized that religious strain would mediate the relationship between trauma symptoms at baseline and trauma symptoms at 1-year follow-up, i.e., participants experiencing more religious strain would be more likely to experience increased PTSD symptoms over time.

Method

Participants

The sample was drawn from 182 participants in another study of religious functioning and stressful life events who were invited to participate in a follow-up study. One hundred and five (58%) agreed to be contacted 1 year after their initial participation. Ninety-eight provided usable addresses and 79 participants (43% of the original Time 1 sample and 75% of those who agreed to follow-up studies) returned usable follow-up surveys. There were 55 women and 23 men in the sample (one participant did not report gender). Seventy participants identified as Caucasian, one as African American, three as Hispanic, and five as Native American. Forty-one participants identified with Protestant denominations, 29 identified as Catholic, and nine identified as "Other." The mean age was 58 years old (range from 23–88, standard deviation

[*SD*] = 14.53), the mean level education was 16 years, and the median income was in the $35,000-$45,000 per year range.

Procedure

Methods for the initial study are detailed in Harris et al. (2008). As a summary, self-identified stressful life events survivors were invited to participate after religious services at 15 churches in a Midwestern metropolitan area. Individuals were asked to participate if they self-identified as having "experience with very stressful situations such as being physically or sexually assaulted or abused, being in a war or natural disaster, being in an accident, being diagnosed with a serious illness, or having someone close to you unexpectedly die or develop a serious illness." In the initial (Time 1) survey, participants completed demographic items assessing age, gender, ethnicity, frequency of church attendance, frequency of prayer, and present and past religious affiliations. In addition, they completed measures of stressful life events, postevent adjustment, and religious functioning detailed below. A follow-up (Time 2) survey including measures of postevent adjustment was mailed to those who provided valid addresses 1 year later, along with a $20 incentive. Reminder letters were mailed 2 weeks after the follow-up survey.

Measures

The Traumatic Life Events Questionnaire (TLEQ; Kubany et al., 2000) assesses trauma history including natural disasters, life-threatening accidents, violent victimization, sexual assault, and combat. It was given at Time 1 only. Participants were asked to select their most distressing traumatic event and to answer questions about symptoms, life changes, religious coping, and prayer specifically with regard to that event at both Time 1 and Time 2. When surveys were presented at Time 2, the participant was given a written cue in the survey packet to identify the traumatic experience they had previously identified as most distressing.

The PTSD Checklist-Civilian Version (PCL; Weathers, Litz, Herman, Huska, & Keane, 1993) measures PTSD symptomatology. The PCL includes 17 items that ask about PTSD symptoms. It has demonstrated good internal consistency reliability (Cronbach's Alpha from .89-.97; Weathers et al., 1993). Scores range from 17–85. Validity is supported by positive correlations with other validated PTSD measures and structured interviews for PTSD (Blanchard, Jones-Alexander, Buckley, & Forneris, 1996; Weathers et al., 1993). PTSD screening cutoff scores for the PCL vary with sample characteristics (Bliese et al., 2008). For the present sample, a score of 37 was used as a cutoff for probable PTSD based on findings from similar community samples (Cook, Elhai, & Arean, 2005). Participants were asked to respond to this measure specifically with regard to their identified most stressful event from the TLEQ. This measure was administered at Time 1 and Time 2.

The Religious Comfort and Strain Scale (RCSS) measures religious beliefs as they relate to comforts and strains in relationship to the religious community and Deity (Exline et al., 2000). It includes subscales for Religious Comfort (score range 0–49), Alienation from G-d (range 0–35), Religious Fear and Guilt (range 0–28), and Religious Rifts (range 0–35). Cronbach's alpha for the subscales range from .67-.87. Higher scores on religious strain subscales predict more depression and suicidal ideation. Elevated fear/guilt and religious rifts subscales predict seeking assistance with religious issues in psychotherapy (Exline et al., 2000). This measure was administered at Time 1. This instrument is not designed to measure adjustment to a specific stressor or event, and so participants did not respond to it regarding their identified most distressing event.

The Brief RCOPE (Pargament et al., 1998) measures two religious coping styles used in dealing with an identified stressor. Positive religious coping (score range 0–21) predicts fewer psychological symptoms, while negative religious coping (range 0–21) predicts more stress-related and other psychological symptoms. Subscale Cronbach's alpha's are .90 for positive religious coping and .81 for negative religious coping (Pargament et al., 1998). This measure was administered at Time 1. Participants were asked to respond to this measure specifically with regard to coping with their self-identified most distressing event.

Table 1
Means and Standard Deviations for Study Variables

Variable	Time 1		Time 2			
	Mean	*SD*	Mean	*SD*	*t*	*p*
Religious Strain	– 2.09	14.28	– 5.95	13.02	– .08	.94
Positive Religious Coping	13.31	5.72	13.71	5.37	– .24	.81
Negative Religious Coping	3.84	4.61	2.94	3.71	.53	.60
Religious Comfort	27.8	10.46	41.3	7.78	– .24	.81
Alienation from G-d	6.47	6.77	6.06	6.11	– .15	.88
Religious Fear and Guilt	6.43	5.99	5.15	5.71	– .40	.70
Religious Rifts	12.77	7.55	11.5	7.51	– .29	.77
PFS Acceptance	62.32	15.91	60.21	16.28	.92	.36
PFS Assistance	56.51	12.56	59.69	11.45	– .58	.57
PFS Calm and Focus	40.87	9.97	39.23	8.86	2.55	.01
PFS Defer/Avoid	13.65	4.41	13.19	3.85	– .31	.76
PCL	26.95	11.04	27.76	9.55	– .71	.48

Note. SD = standard deviation; PFS = Prayer Functions Scale; PCL = PTSD Checklist.
N = 79 for all variable.

The Prayer Functions Scale (PFS; Bade & Cook, 1997) identifies four commonly used means of coping with stressors through prayer, namely, using prayer as something that Provides Acceptance (score range 17–85), Provides Assistance (range 14–70), Provides Calm and Focus (range 11–55), and helps with Deferring/Avoiding (range 4–20). Subscale alphas range from .86-.94 (Bade & Cook, 1997). Participants were asked to respond to this measure, indicating how they used prayer to cope with their self-identified most distressing traumatic experience. This measure was administered at Time 1.

Results

Means and standard deviations for all variables are reported in Table 1. At Time 1, 14 participants' PCL scores were above the PTSD cutoff, and 12 were at Time 2. Both the Religious Comforts and Strains and the RCOPE scores were higher than those found in general population samples (Exline et al., 2000; Bjorck & Thurman, 2007; Pargament et al., 1998); our participants were church members and thus may be more likely to experience religious strains and more likely to use religious coping strategies.

Two-tailed *t* tests were used to compare the Time 1 data for Time 2 participants and nonparticipants. There were no significant differences for gender ($t = .64$, degree of freedom [*df*] = 179 $p = .52$), years of education ($t = .212$, $df = 180$, $p = .83$), income ($t = 1.11$, $df = 180$, $p = .27$), initial PCL scores ($t = 1.75$, $df = 175$, $p = .08$), or number of stressful life events ($t = .34$, $df = 155$, $p = .74$). Time 2 participants were significantly older ($t = –2.86$, $df = 180$, $p = .005$; 57 years ($SD = 14.23$) versus 51 years ($SD = 51.22$). Missing data were excluded listwise.

The "most distressing event" included sudden death of a loved one (22), life threatening illness (7), motor vehicle accidents (6), life threatening or disabling injury/illness of a loved one (6), abuse by an intimate partner (6), childhood sexual abuse (5), adult sexual assault (3), combat (3), natural disaster (2), accidents (2), miscarriage (2), robbery (1), assault (1), death threats (1), witnessing family violence (1), sexual harassment (1), stalking (1), abortion (1) and some other event (8). Time since the "most distressing event" ranged from less than 1 year to 64 years, with a mean of 22.35 years (SD = 17.24). Both the median and the mode were two years ago. Five participants from our sample of 79 were at the mode.

We computed scores for a previously identified religious distress factor to reduce the number of predictors. Factor scores for religious strain were derived from the subscales of the RCSS, the PFS, and the Brief RCOPE as detailed in Harris et al., (2008). Subscales with strong loadings on

Table 2
Intercorrelations of Study Variables

Variable	1	2	3	4	5	6	7	8	9	10	11	12
1) Total PCL Score T1	-											
2) Total PCL Score T2	.79**	-										
3) Religious Strain	.52**	.57**	-									
4) Positive Religious Coping	.21	.14	.02	-								
5) Negative Religious Coping	.43**	.43**	.67**	.16	-							
6) PFS Acceptance	.03	.01	−.28*	.65**	−.03	-						
7) PFS Assistance	<.01	−.02	−.24*	.70**	−.05	.86**	-					
8) PFS Calm	.07	.05	−.19	.62**	−.01	.85**	.84**	-				
9) PFS Defer	.26*	.25*	.18	.50**	.33**	.44**	.44**	.49**	-			
10) Religious Comfort	−.25*	−.30**	−.69**	.35**	−.28*	.53**	.51**	.46**	.17	-		
11) Alienation from G-d	.43**	.45**	.85**	−.06	.63**	−.16	−.20	−.17	.14	−.58**	-	
12) Religious Fear & Guilt	.55**	.58**	.65**	.08	.41**	−.04	−.02	−.01	.26*	−.21	.43**	-
13) Religious Rifts	.29**	.40**	.70**	−.01	.35**	−.26*	−.17	−.11	.08	−.36**	.41**	.37**

Note. PFS = Prayer Functions Scale; PCL = PTSD Checklist.
Spirituality Variables at Time 1 were used.
*p< = .05. **p< = .01.

the religious strain factor were Negative Religious Coping, Alienation from G-d, and Religious Fear/Guilt. Subscale scores were multiplied by the appropriate factor weight and then summed. Religious strain therefore reflects fears that one's Deity is punishing or abandoning, feeling estranged in relationship with the Deity, and feeling religious guilt.

Correlations between Time 1 scores on the spiritual variables and Time 1 and Time 2 PCL scores are in Table 2. Correlates of Time 2 PTSD symptoms included religious strain, baseline PTSD symptoms, Negative Religious Coping, Deferring/Avoiding prayer coping, Religious Comfort, Alienation from G-d, Religious Fear/Guilt, and Religious Rifts.

Following Preacher and Hayes (2008), mediation analyses were conducted using ordinary least squares regression for direct paths between variables and bootstrapping estimates for testing the mediating (indirect) effects. This approach, which has been advocated over the more traditional causal steps approach (Baron & Kenny, 1986), directly tests for the presence of mediation and does not require the assumption of normally distributed indirect path coefficients (see Preacher & Hayes, 2008, for a discussion). Analyses were conducted in SPSS version 17 using the "Indirect" macro (Preacher & Hayes, 2008). The hypothesis was tested entering Time 1 PTSD as the independent variable, religious strain as the mediating variable, and Time 2 PTSD as the dependent variable. Results indicated a statistically significant effect of Time 1 PTSD both on religious strain ($b = .670$, $t = 4.82$, $p < .000$) and on Time 2 PTSD ($b = .629$, $t = 10.20$, $p < .000$). The proposed mediator (religious strain) had an independent and significant effect on Time 2 PTSD ($b = .139$, $p = .011$).

Further, the indirect effect of Time 1 PTSD on Time 2 PTSD through religious strain (i.e., the mediating effect of religious strain) was statistically significant. The bootstrapped estimate (using 5,000 resamples) for this indirect effect was .096, with a 95% confidence interval of .013 to .197. This confidence interval did not contain 0, demonstrating significance at an alpha level of .05. In interpreting the magnitude of the indirect effect, one can consider that the regression findings indicate that for a 1 unit increase in Time 1 PTSD, there is an expected .54 unit change in Time 2 PTSD that is not mediated by Spiritual distress, and an expected .10 unit change in Time 2 PTSD that is mediated by Spiritual Distress (Preacher & Kelley, 2011).

Discussion

As predicted, religious strain mediated the severity of PTSD symptoms over time. Variables loading strongly on the religious strain factor include Negative Religious Coping, Religious

Fear and Guilt, and Alienation from G-d. The finding that religious strain mediates PTSD symptoms supports the conclusion that religious distress is related to PTSD symptoms over time. These findings are consistent with previous cross-sectional findings on negative religious coping (Ano & Vasconcelles, 2005; Exline & Rose, 2005; Harris et al., 2008; Pargament et al., 2004) and longitudinal findings (Koenig et al, 1998; Pargament et al., 2001, 2004). Distress and conflict over faith predicted poorer mental health after stressful life events over time.

Those who construe stressful life events as related to a punishing G-d, experience alienation from their G-d, and harbor religious fear and guilt have more difficulty adjusting to stressful life events, in accord with previous findings that event-related losses and recovery resources predict adjustment (Elhai, Reeves, & Frueh, 2004; Goto, Wilson, Kahana, & Slane, 2006). Viewing stressful life events as evidence for a punishing G-d constitutes loss of a spiritual resource. Given that over 90% of the U.S. population reports a belief in G-d and 58% report that their faith is very important (Shafranske, 2001), giving up on G-d can be a significant loss. Those who lose faith in the context of stressful life events may suffer secondary losses such as available spiritual support through prayer, a relationship with G-d, and interaction with a community of faith. They may also lose social, emotional, and physical resources for recovery, as many religious communities provide these.

Limitations of this study include a modest N; better statistical analyses for longitudinal designs are available, but require larger samples. With this sample size it was not possible to control for a wide range of confounding variables, such as social support, time since the event, and chronic versus acute stressors, that may have affected results. Addressing potential confounds would be an important direction for future research in this area.

In this study, as in most longitudinal studies, attrition may have affected results. Participants who persisted to Time 2 tended to be older than those who did not. It is not known if there were other patterns among those who self-selected out of the study that may have affected results.

These variables should be studied in a variety of populations. Ours was a predominantly Caucasian, exclusively Christian community sample. The sample was well-educated, church-going, and relatively well-functioning (based on the rate of people screening positive for PTSD). Most of the sample did not exceed the PCL cutoff for a probable diagnosis of PTSD; thus, the extent to which these findings would generalize to a clinical sample is unclear. On the other hand, understanding the effects of religious functioning in nonclinical, community samples is important in its own right and has relevance for pastoral counselors, community and religious service agencies, etc.

It is possible that religious coping strategies may be more relevant to this sample of participants as they were drawn from church settings, and this is a limitation and caution in interpreting findings. However, other studies have found strong relationships between religious functioning and mental health outcomes in samples that were not drawn from religious settings and in samples in which religious commitment was controlled (Fontana & Rosenheck, 2004; Harris, Cook, & Kashubeck-West, 2008; Ogden et al., 2011), so further research is necessary before drawing conclusions in this area. Relevance of specific spiritual coping strategy may also vary based on other variables, such as severity or type of stressor, and the range of active coping options available to the individual (Harris et al., 2008)

The diversity of stressors reported in this sample may have also limited clarity of findings. Participants reported both acute stressors (such as sudden death of a loved one, accidents, or natural disasters) and chronic stressors (such as child abuse and life-threatening illnesses). There may be differences in coping with these diverse types of stressors, but given our modest sample size, more detailed analysis of this concern is not possible.

Because we did not inquire about stressful events that may have occurred between Times 1 and 2, it is possible that some who experienced increased religious strain experienced intervening stressful events, thus maintaining or exacerbating PTSD symptoms. Future studies will need to collect data on stressor exposure between time points to examine this possibility,

Implications for Practice, Research, and Training

For most people who have endured stressful life events, spiritual distress and psychological symptoms are related (Harris et al, 2008). Therefore, it is appropriate to address spiritual concerns

in practice. Those in spiritual distress may benefit from spiritually integrated psychotherapy (Pargament, 2007; Pargament, Murray-Swank, & Tarakeshwar, 2005), or referrals to clergy, chaplaincy, or similar resources consistent with the client's faith. Initial studies of spiritually integrated interventions have been promising; Murray-Swank and Pargament (2005) demonstrated that spiritually integrated interventions reduce spiritual distress in adult survivors of childhood sexual abuse. Harris et al. (2011) demonstrated reduction in PTSD symptoms among veterans who participated in a spiritually integrated intervention. These types of interventions focus on resolving spiritual distress while respecting clients' existing faith affiliations.

Given the evidence that religious distress after stressful life events is related to adjustment, further research on spiritually integrated interventions is indicated. Manualized, spiritually integrated psychotherapies are available, but research in this area is still sparse (Pargament, 2007). Outside of chaplaincy, most mental health professionals receive little training on religious functioning, and psychologists tend to be religious at lower rates than the population (Pargament, 2007). Increased professional education in spirituality would help mental health providers make appropriate use of these manualized interventions, respecting and attending to the clients' religious and spiritual foundations and concerns, while providing room for resolution of conflicts with one's Deity and community of faith, and making referrals to appropriate community faith resources, without imposing either their own spiritual beliefs or lack thereof (Pargament, 2007).

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