Christian Religious Functioning and Trauma Outcomes

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While some trauma survivors find their faith helpful in recovery, others find it a source of distress, and still others abandon their faith. More complex conceptualizations of religious functioning are needed to explore its relationship with trauma. This study explores such relationships using measures of religious action and behaviors in a community sample of 327 church-going, self-identified trauma survivors. A principal components analysis of positive and negative religious coping, religious comforts and strains, and prayer functions identified two dimensions: Seeking Spiritual Support, which was positively related to posttraumatic growth, and Religious Strain, which was positively related to posttraumatic symptoms. © 2007 Wiley Periodicals, Inc. J Clin Psychol 64: 17–29, 2008.

Keywords: trauma; PTSD; posttraumatic growth; religion; prayer; religious coping

A substantial proportion of people in our society will experience a traumatic event at some point in their lives (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Decades of clinical and research findings suggest that trauma is associated with diverse outcomes, ranging from normal mental health functioning to severe psychiatric symptoms such as posttraumatic stress disorder (PTSD), depression, and alcohol abuse (Bonanno, 2004; Brewin, Andrews, & Valentine, 2000; Kessler et al., 1995; Ozer, Best, Lipsey, & Weiss, 2003). Contemporary approaches to trauma research have further broadened conceptualizations of outcome by identifying *perceived benefits* such as positive changes in self-perception and relationships with

This research was supported by a grant from the John Templeton Foundation.

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 © 2007 Wiley Periodicals, Inc.
Published online in Wiley InterScience (www.interscience.wiley.com). DOI: 10.1002/jclp.20427

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others, and more positive religious functioning (i.e., *posttraumatic growth*; Tedeschi & Calhoun, 1996). The identification of factors that may contribute to resilience or positive functioning in the face of trauma, and alleviate or avoid potential negative effects, remain a key priority in trauma research.

One area of functioning that has been implicated as both a means of coping and an outcome of traumatic events is religious functioning. Most people when confronted with trauma will use aspects of religious functioning to cope (Schuster et al., 2001). The nature and potential effectiveness of coping based on religious functioning varies as widely as do responses to trauma itself. Some authors have qualitatively suggested that religious functioning helps survivors make meaning of traumatic experiences (Hall & Johnson, 2001; Wilson & Moran, 1998). Data-based studies have shown that some survivors find their religious functioning helpful in coping with trauma, but other survivors find it hurtful and seek to reduce religious involvement or abandon their faith after experiencing trauma (Elliott, 1994; Falsetti, Resick, & Davis, 2003; Fitchett, Rybarczyk, DeMarco, & Nicholas, 1999; Fontana & Rosenheck, 2004; Pargament, Koenig, Tarakeshwar, & Hahn, 2002; Pargament, Murray-Swank, Magyar, & Ano, 2004; Strawbridge, Shema, Cohen, Rogers, & Kaplan, 1998). At this point, the reasons that individuals have such different responses to religious functioning after trauma are unclear.

This diversity in outcomes may be due in part to the challenge that traumatic events can pose to religious beliefs and faith. One important way trauma disrupts emotional, psychological, and personality processes is by shattering assumptions about safety, power/control, self, and the world (Janof-Bulman, 1992). Religious assumptions also are likely to be disrupted as beliefs in a benevolent, omnipotent G-d may appear inconsistent with traumatization, and this often precipitates existential crisis (Cadell, Regehr, & Hemsworth, 2003; Falsetti et al., 2003). Survivors must make new meaning of their perceptions of their world at physical, interpersonal, and spiritual levels (Decker, 1993; Wilson & Moran, 1998). This challenge to religious functioning may pose a great difficulty for some trauma survivors, and thus contribute to or mirror their distress.

A review of the broader literature on religious functioning and mental health suggests a similar mix of associations and outcomes. Some studies have found that religious people are less likely to divorce, use less alcohol and drugs, have more access to social support, experience less depression and anxiety, and are less likely to suicide whereas other studies have found that some religious groups are at elevated risk for depression, schizophrenia, and personality disorders, and also that "more religious" people are more likely to experience some types of anxiety and obsessive compulsive symptoms (Koenig, McCullough, & Larson, 2001).

To some extent, these mixed findings may be due to overly simplistic views of religious functioning. Some studies simply have assessed whether a person is religious, for example, rather than examining specifics of their religious practices or beliefs (Cadell et al., 2003; Elliott, 1994; Falsetti et al., 2003; Fontana & Rosenheck, 2004). Recent work in the field has begun to examine diverse aspects of religious functioning, and the advances that these more sophisticated models have achieved should inform the study of trauma and religion. Three sets of findings converge on aspects of religious functioning that may be particularly fruitful to explore within the context of psychological trauma.

Pargament, Koenig, and Perez (2000) identified 17 religious coping strategies that could be classed as "positive" or "negative" based on their relationships with mental and physical health outcomes. Positive religious coping strategies included searching

for spiritual purification, looking for a new religious direction, providing spiritual support for others, seeking spiritual support from others, using G-d as a partner in problem solving, using religion as a distraction from a stressor, actively giving G-d control of the situation, redefining the stressor as G-d's benevolence, seeking a stronger connection with G-d, and deliberately maintaining religious behavioral standards. These coping strategies have been related to stress-related growth and better religious outcomes (Pargament et al., 2000; Pargament, Smith, Koenig, & Perez, 1998).

Negative religious coping strategies included feeling dissatisfied in one's relationship with G-d, attributing the stressor to the devil, passively waiting for G-d to change the situation, feeling dissatisfied with relationships with the clergy and others in one's faith group, redefining G-d as other than omnipotent, identifying the stressor as punishment from G-d, and asking G-d for a miracle or direct intercession. These coping strategies have been related to higher levels of distress, poorer physical health, PTSD, reduced quality of life, and poorer cognitive functioning (Bjorck & Thurman, 2007; Pargement et al., 2000; Pargament et al., 2002; Pargament et al., 1998). A meta-analysis of 49 studies on religious coping indicated that in general, positive religious coping is associated with better adjustment to stress, and negative religious coping is associated with poorer adjustment to stress (Ano & Vasconcelles, 2005).

Along similar lines, Bade and Cook (1997) identified four coping functions of prayer: actively seeking help, seeking to increase one's ability to accept the stressor, seeking help to focus coping efforts, and deferring or avoiding the stressor. The first three prayer functions predict lower anxiety levels and higher levels of posttraumatic growth while the deferring/avoiding prayer function predicted higher levels of trait anxiety (Harris et al., 2006; Harris, Schoneman, & Carrera, 2002, 2005).

Finally, Exline (2002a, b) identified several aspects of religious functioning that have positive and negative relationships with mental health. Positive aspects of religious involvement include social support (both from people in the faith group and from G-d), improved meaning, purpose, and direction in life, and the support of virtues. These in turn, support better relationships with others and better social role functioning (Exline, 2002b; Exline & Rose, 2005). Negative aspects of religious involvement include interpersonal conflict (with peers in the faith group, authorities in the faith group, and G-d), religious doubts or perceived failures of faith, guilt associated with failures of virtue, fears of condemnation (i.e., hell), and difficulty resolving conflict with G-d (Exline, 2002b; Exline & Rose, 2005; Exline, Yali, & Lobel, 1999). Exline (2002a; Exline & Rose, 2005) noted that elements of religiosity associated with negative affect may, in some cases, include adaptive negative affect: for example, appropriate guilt leading to efforts to make amends. Exline and colleagues (2005; Exline et al., 1999) provided support to these conceptualizations by showing that those having difficulty resolving anger toward G-d reported higher levels of anxiety, depression, and anger, and those reporting religious strains such as alienation from G-d, religious rifts with other people, and religious fear and guilt reported higher levels of depression and suicidality (Exline & Rose, 2005; Exline, Yali, & Sanderson, 2000). Those reporting higher religious strain levels more often desired help with religious struggles in psychotherapy (Exline et al., 2000).

These recent studies, which examined religious behavior and action and not just religious belief and commitment, are a clear step forward. Tsang and McCullough (2003) discussed this as a distinction between operational and dispositional religious variables. Operational religious variables may be more strongly related to other behaviors and outcomes, and are more amenable to change than are dispositional, or traitlike, religious variables. Specific religious practices and behaviors aid in dealing

with adversity and others add strain or distress. Although these practices and behaviors may overlap, those associated with support (either from others or a higher power), belonging to a community, approach behaviors or collaborating with G-d as part of coping, and identifying higher levels of purpose or meaning associated with stressors are associated with positive outcomes. Those practices and behaviors associated with avoidance in relationship with G-d, doubt, shame, guilt, blame, or rifts from the community or G-d are associated with negative outcomes (Ano & Vasconcelles, 2005; Exline et al., 2000; Harris et al., 2006; Harris et al., 2002, 2005).

The present study has two goals: (a) to explore the relationships among religious practices, behaviors, and adjustment in a trauma-exposed community sample; and (b) to identify two religious factors: one reflecting positive mental health functions of religiosity and another reflecting negative mental health functions of religiosity.

Hypotheses

H1: "Seeking Spiritual Support" will emerge as a higher order dimension of religiosity. Variables defining this factor will include positive religious coping strategies, religious comfort, and seeking assistance, acceptance, and calm and focus in personal prayer.

H2: "Religious Strain" will emerge as a higher order dimension of religiosity. Variables defining this factor will include deferring/avoiding prayer, negative religious coping, alienation from G-d, and religious fear and guilt.

H3: "Seeking Spiritual Support" will predict lower levels of psychological symptoms and higher levels of positive outcomes (growth) while "Religious Strain" will predict higher levels of psychological distress and lower levels of positive outcomes.

Methods

Participants

We recruited a sample of 327 participants, including 95 males, 228 females, and 1 transgendered participant (Three participants did not provide information on their gender) who self-reported having experienced at least one traumatic event and were attending church services. A total of 286 participants identified as Caucasian, 15 as African American, 16 as Native American, 6 as Hispanic, 1 as African, and 1 as Asian (Two participants did not provide information on ethnicity.) Denominational affiliations included Catholic ($n = 96$), generic "Protestant" ($n = 55$), Lutheran ($n = 44$), Presbyterian ($n = 14$), United Church of Christ ($n = 12$), Reformed Church of America ($n = 16$), Baptist ($n = 17$), Church of Christ Scientist ($n = 11$), Episcopal ($n = 22$), Independent Evangelical ($n = 3$), Metropolitan Community Church ($n = 16$), United Methodist ($n = 13$), Church of the Nazarene ($n = 14$), Unity Church ($n = 1$), and other affiliations ($n = 9$). Several participants reported multiple denominational affiliations. The average age was 55 years, the average level of education was 17 years, and the median income was $35,000–45,000 per year. Most participants described a history of multiple types of trauma, including natural disasters (133), motor vehicle accidents (129), other accidents (91), war or combat (29), sudden death of a loved one (274), life-threatening or disabling accident, assault, or illness (203), being present during a robbery (66), being assaulted by a stranger (68), witnessing an assault by a stranger (52), being threatened with death (124), physical child abuse (71), witnessing domestic violence (100), spousal or

partner assault (99), childhood sexual abuse (197), adult sexual assault (60), sexual harassment (144), being stalked (77), miscarriage (85), abortion (53), and other traumatic events (124). Time since the identified "most distressing traumatic" event ranged from less than 1 year to 65 years, with a modal interval of 1 year. The median number of types of traumatic events reported (7) and the prevalence of specific traumatic events were higher than were findings from community surveys (e.g., Breslau et al., 1998). This is to be expected as participants were self-selected based on their histories of difficult or traumatic experiences.

Procedures

Research staff met with diverse Christian congregations in the northern Midwest to invite them to participate in a survey on religion and trauma in exchange for lunch and $10. Trauma was defined for these congregations as

> 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.

Church members who had experienced at least one trauma and were interested in participating were asked to stay after services and complete consent and survey forms. The survey forms included a demographic questionnaire requesting information on age, gender, ethnicity, history of trauma, time since trauma, frequency of church attendance, frequency of prayer, and present and past religious affiliations.

Measures

The Traumatic Life Events Questionnaire (TLEQ; Kubany et al., 2000) is a 24-item self-report measure that assesses for a history of multiple types of trauma, including natural disasters, life-threatening accidents, auto accidents, violent victimization, sexual assault, and combat. The total number of traumatic experiences reported by each participant was calculated and used as an index of lifetime trauma. Participants were asked to select their most distressing traumatic event to use as a referent for answering the remaining measures, including measures of prayer functions and religious coping.

The PTSD Checklist-Civilian Version (PCL; Weathers, Litz, Herman, Huska, & Keane, 1993) is a 17-item Likert-scale measure that includes the reexperiencing, avoidance, and hyperarousal symptoms that define PTSD. Alpha's range from .89 to .97. Validity is supported via significant positive correlations with other validated PTSD measures, general measures of pathology, and clinician-administered structured interviews for PTSD (Blanchard, Jones-Alexander, Buckley, & Forneris, 1996; Weathers et al., 1993).

The Posttraumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996) is a 21-item Likert scale with five factor-analytically derived subscales. The subscales are Relating to Others, New Possibilities, Personal Strength, Spiritual Change, and Appreciation of Life. Internal consistency reliability (α) for the subscales range from .67 to .85, and the alpha for the full scale is .90 (Tedeschi & Calhoun, 1996). Consistent with theoretical predictions, scores have not been found to correlate with social desirability but do correlate with optimism and extraversion (Tedeschi & Calhoun, 1996). The total score, indicating the overall level of positive change and growth attributed to a traumatic experience, was used as the index of posttraumatic growth for this study.

The Religious Comfort and Strain Scale (RCSS) is a 20-item Likert measure of religious beliefs as they relate to comforts and strains in relationship to the religious community and G-d (Exline et al., 2000). It includes one subscale for religious comfort, and three subscales of religious strains, including alienation from G-d, fear and guilt, and religious rifts. Subscale alphas range from .67 to .87. Higher scores on religious strain subscales predict increased depression and suicidal ideation, and elevated fear/guilt and religious rifts subscales predict seeking assistance with religious issues in psychotherapy (Exline et al., 2000).

The Brief RCOPE (Pargament et al., 1998) is a 14-item Likert-type item measure yielding two religious coping subscales predictive of adjustment. Concurrent validity has been demonstrated in studies showing that positive coping predicts fewer psychological symptoms while negative coping predicts more stress-related and other psychological symptoms. Subscale alphas are .90 for positive religious coping and .81 for negative religious coping (Pargament et al., 1998).

The Prayer Functions Scale (PFS; Bade & Cook, 1997) is a Likert scale assessing how often prayer is used for specific coping functions: Provides Acceptance (seeking peace with stressful circumstances, seeking G-d's will; 7 items, $\alpha = .94$), Provides Calm and Focus (asking for help to stay calm or using meditative practices; 11 items, $\alpha = .89$), Deferring/Avoiding (asking G-d to change the situation or otherwise take action independently of the individual praying; 4 items, $\alpha = .86$), and Provides Assistance (requesting specific assistance such as forgiving others, maintaining strength; 14 items, $\alpha = .92$; Bade & Cook, 1997).

The MOS Social Support Survey (Sherbourne & Stewart, 1991) is a 19-item Likert scale measuring functional social support (i.e., the individual's perception of and satisfaction with available instrumental and emotional support from others). Internal consistency reliability (α) is .97 (Sherbourne & Stewart, 1991). Higher MOS scores predict fewer trauma symptoms when degree of trauma exposure is controlled. This instrument was included to address the potential influence that shared variance with social support may play in inflating the relationship between religious activities and posttraumatic growth or low levels of posttraumatic distress (Cadell et al., 2003; Erbes, Harris, Winskowski, Olson, & Engdahl, 2006; Keane, Marshall, & Taft, 2006; Koenig, 2001).

Results

Normalizing data transformations were applied to all variables with problematically skewed or kurtotic distributions. Means and standard deviations are shown in Table 1; interscale correlations are in Table 2. For all analyses, missing data were addressed through listwise deletion. Posttraumatic symptoms were negatively correlated with religious comfort, and positively correlated with alienation from G-d, fear and guilt, religious rifts, negative religious coping, and the Defer/Avoid prayer function. Posttraumatic growth was positively correlated with religious comfort, positive religious coping, the Provides Acceptance prayer function, the Provides Assistance prayer function, the Provides Calm and Focus prayer function, and the Defer/Avoid prayer function.

A principal components factor analysis was completed using the dimensions of religiosity measured for this study: the four prayer functions (PFS), religious comforts and strains (RCSS), and positive/negative religious coping (RCOPE). In the initial analysis, the Religious Comfort scale of the RCSS loaded positively on one factor and negatively on the other; to avoid reporting on redundant variance, this subscale was

Table 1
Means and SDs for Major Variables

Variable[a]	*M*	*SD*	α
Positive Religious Coping	13.31	5.72	.86
Negative Religious Coping	3.84	4.61	.85
PFS Acceptance	62.67	14.59	.95
PFS Assistance	57.60	11.28	.86
PFS Calm and Focus	40.88	9.14	.83
PFS Defer and Avoid	14.14	4.23	.84
Alienation From G-d	6.47	6.77	.82
Religious Rifts	12.77	7.55	.58
Fear/Guilt	6.43	6.00	.70
Total PCL Score	36.43	8.11	.99
Total PTGI Score	66.54	23.00	.94
Functional Social Support	74.10	17.38	.99
Trauma Exposure	7.31	1.18	N/A

Note. PFS = Prayer Functions Scale; PTGI = Posttraumatic Growth Inventory; PCL = PTSD Checklist.
[a]$N = 327$ for all variables.

eliminated from subsequent analyses and factor score calculations. Scree plots were examined, and factors with a minimum eigenvalue of 1 were retained. Two principal components emerged, and were interpreted using a promax rotation. The factors converged in three iterations. Factor loadings are presented in Table 3.

Factors 1 and 2 were consistent with the hypothesized factors "Seeking Spiritual Support" and "Religious Strain." Factor 1 (Seeking Spiritual Support) had an eigenvalue of 3.57 and accounted for 39.7% of the variance among the religious variables. Factor 2 (Religious Strain) had an eigenvalue of 1.97 and accounted for 21.9% of the variance among the religious variables. Variables with significant loadings on Factor 1 (Seeking Spiritual Support) included positive religious coping (.81) and all four prayer functions (Provides Acceptance: .91, Provides Assistance: .91, Provides Calm and Focus: .85, and Defer/Avoid: .68). Variables with significant loadings on Factor 2 (Religious Strain) included alienation from G-d (.78), fear and guilt (.67), religious rifts (.59), and negative religious coping (.72). Scores for Factors 1 and 2 were calculated by the regression method of summing weighted scores of the component scales. The correlation of Factors 1 and 2 was −.04.

The relationship between these religious factors and traumatic stress symptoms was analyzed using hierarchical multiple linear regression analysis, with PCL scores as the dependent variable. Trauma Exposure was entered in Step 1. Because social support has the potential to act as a confound, it was entered in Step 1 as well. Seeking Spiritual Support and Religious Strain were entered in Step 2. The religious factors predicted 9% of the variance in trauma symptoms. In the full model, trauma exposure ($\beta = .29$, $p < .001$), social support ($\beta = -.26$, $p < .001$), and Religious Strain ($\beta = .32$, $p < .001$) emerged as significant predictors of trauma symptoms (see Table 4).

The relationship between religious factors and posttraumatic growth was similarly evaluated with hierarchical multiple linear regression, using PTGI total scores as the dependent variable. Again, trauma exposure and social support were entered in Step 1, and the religious factors were entered in Step 2. Religious factors explained about 21% of additional variance in posttraumatic growth. In the full model, Trauma

Table 2
Intercorrelations Between Major Variables

Variable	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13
1. Total Functional Social Support Score	—												
2. Total PCL Score	−.34**	—											
3. Total PTGI Score	.14*	.06	—										
4. Total Traumatic Events Reported	.14*	.39**	.23**	—									
5. Religious Alienation	−.15*	.27**	−.08	.10	—								
6. Religious Fear and Guilt	−.15*	.32**	.04	.25**	.33**	—							
7. Religious Rifts	−.16*	.17	.03	.15*	.38**	.21**	—						
8. Positive Religious Coping	−.04	.03	.37**	.08	−.06	.14*	.00	—					
9. Negative Religious Coping	−.26**	.41**	.09	.32**	.40**	.36**	.19**	.08	—				
10. PFS Acceptance	.05	−.03	.43**	.10	−.20**	.11	−.10	.66**	−.01	—			
11. PFS Assistance	.07	−.06	.35**	.03	−.25**	.06	−.09	.66**	−.07	.86**	—		
12. PFS Calm and Focus	−.02	.05	.46**	.07	−.13*	.09	−.02	.54**	.05	.77**	.73**	—	
13. PFS Defer/Avoid	−.10	.20**	.24**	.09	−.06	.21**	−.04	.48**	.22**	.47**	.49**	.46**	—

Note. PCL = PTSD Checklist; PTGI = Posttraumatic Growth; PFS = Prayer Functions Scale.
*$p < .05$; **$p < .01$.

Table 3
Factor Loadings for Religious Variables

Variable[a]	Factor 1	Factor 2
Positive Religious Coping	.81	.11
Negative Religious Coping	.10	.72
PFS Acceptance	.91	−.08
PFS Assistance	.91	−.12
PFS Calm and Focus	.85	−.02
PFS Defer/Avoid	.68	.18
Religious Rifts	−.04	.59
Religious Fear and Guilt	.20	.67
Alienation from G-d	−.18	.78
Eigenvalue	3.57	1.97
Percent Variance	39.67	21.92

Note. PFS = Prayer Functions Scale.
[a]$N = 327$.

Table 4
Multiple Regression for Religious Functions as Predictors of Posttraumatic Stress Symptoms

Variable	*B*	*SE B*	β	*p*
Step 1				
Trauma Exposure	.27	.04	.37	<.01
Functional Social Support	−.17	.04	−.26	<.01
Step 2				
Trauma Exposure	.22	.04	.37	<.01
Functional Social Support	−.11	.04	−.17	<.01
Seeking Spiritual Support	.71	.63	.06	.25
Religious Strain	3.55	.66	.32	<.01

Note. Step 1 Adjusted $R^2 = .23$, $F = 35.32$, $p < .001$. Step 2 Adjusted $R^2 = .31$, $F = 27.06$, $p < .001$. Step 2 $R^2\ \Delta = .09$, $F\Delta = 14.69$, $p < .001$.

Exposure ($\beta = .18$, $p = .002$), Social Support ($\beta = .11$, $p = .02$), and Seeking Spiritual Support ($\beta = .47$, $p > .001$) emerged as significant predictors of posttraumatic growth (see Table 5).

Discussion

As predicted, "Seeking Spiritual Support" emerged as a higher order dimension of religiosity (**H1**). Variables loading on this factor included positive religious coping and all four prayer functions (Provides Acceptance, Provides Assistance, Provides Calm and Focus, Defer/Avoid). High scorers are likely to view their relationship with G-d and others in their faith as sources of comfort and support, to work collaboratively with G-d and others in their faith group to manage trauma, and to be unafraid to use prayer to ask for many different types of specific help from G-d.

The second predicted dimension, "Religious Strain," also emerged as a higher order factor (**H2**). Variables loading on this factor included alienation from G-d, fear/guilt, religious rifts, and negative religious coping. High scorers are likely to feel that G-d is punishing them; may be angry with them; or that G-d, their church, or both have abandoned them; and are likely to have negative feelings toward G-d and others in their faith group. "Seeking Spiritual Support" and "Religious Strain" had

Table 5
Multiple Regression for Religious Functions as Predictors of Posttraumatic Growth

Variable	*B*	*SE B*	β	*p*
Step 1				
Trauma exposure	.29	.10	.25	<.01
Functional social support	.15	.08	.11	.07
Step 2				
Trauma exposure	.28	.09	.18	.00
Functional social support	.15	.07	.11	.02
Seeking spiritual support	11.19	1.32	.47	<.01
Religious strain	2.04	1.38	.09	.14

Note. Step 1 Adjusted $R^2 = .06$, $F = 8.38$, $p < .001$. Step 2 Adjusted $R^2 = .27$, $F = 22.93$, $p < .001$. Step 2 R^2 $\Delta = .21$, $F\Delta = 35.04$, $p < .001$.

a low, negative intercorrelation (−.04). This is consistent with previous findings that religious comforts and strains function independently (Exline et al., 2000).

The two religious functioning factors performed in a fashion which was partially predicted. "Seeking Spiritual Support" was a positive predictor of posttraumatic growth but, contrary to **H3**, did not predict lower posttraumatic symptoms. "Religious Strain" was a positive predictor of posttraumatic symptoms and was unrelated to posttraumatic growth. For the statistically supported aspects of **H3**, the effect sizes were large (Cohen, 1992); religious factors accounted for 9% of the variance in trauma symptoms and 21% of the variance in posttraumatic growth. It is possible that "Seeking Spiritual Support" did not appear to be related to symptoms in this study because use of both positive and negative religious coping strategies increases as traumatic stressors increase (Bjorck & Thurman, 2007). While individuals may be finding "Seeking Spiritual Support" helpful in reducing symptoms, those with more trauma exposure and more symptoms may be accessing these types of coping resources with greater frequency and intensity. In a cross-sectional design such as this, such a relationship would not be detected.

It is particularly interesting that the Defer/Avoid prayer function did not load, as predicted, on the Religious Strain factor and demonstrated positive relationships with both posttraumatic symptoms and posttraumatic growth. Previous findings on this prayer function have not linked it to positive mental health outcomes (Harris et al., 2002, 2005). It is possible that the prayer function measured by this single scale may comprise multiple, as yet inadequately measured, prayer functions. For example, a prayer asking to defer distress for the duration of a necessary task may have a very different coping function than would a prayer asking that the stressor simply be avoided. Further studies in the field of prayer are likely to be useful in shedding more light on this emerging pattern of findings.

Religion's relationship to mental health has historically been questioned as though it were either positive or negative (Freud, 1927/1961; James, 1902; Jung, 1938/1969). It now seems clear, based on this and similar research (Exline et al., 2000; Harris et al., 2002; Pargament et al., 1998) that the more appropriate question is which aspects of religious functioning have positive or negative relationships with which aspects of mental health. This study also underscores the emerging importance of attending to operational religious variables rather than merely dispositional religious variables in the relationships between religious functioning and mental health (Tsang & McCullough, 2003). Operational religious variables demonstrate stronger, more

reliable relationships with mental health outcomes than do dispositional religious variables (Tsang & McCullough, 2003). Furthermore, many dispositional religious variables are not ethically appropriate targets of change in psychotherapy. It would not be appropriate for a therapist to guide a client to a different religious denomination or a different level of religious commitment; however, assisting religious clients in making changes in their relationships with others in their faith group and in their ongoing interactions with G-d through prayer respects existing religious commitments.

The sample used here reported higher levels of trauma exposure than are found in the community, and thus may better approximate individuals who may be seen in clinical settings. While these preliminary, cross-sectional findings do not support causal conclusions, they provide preliminary evidence of a relationship between religious functioning, posttraumatic growth, and PTSD symptoms. Particularly for clients who report high levels of religious strain, it may be useful to consider referrals to pastoral counseling, chaplaincy, or similar services. Further research could support development of interventions to assist trauma survivors to optimally use religious resources in their recovery. If further study in the field of religious functioning and trauma indicates causal relationships, operational religious variables would be the most appropriate targets for interventions.

These findings provide a profile of the relationships between several aspects of Christian religiosity and subsequent coping with traumatic experiences. The participants in this study were predominantly female, Christian, regular church attendees, and Caucasian. Replication with a more diverse sample would be a useful extension of these findings, as would a longitudinal study to address cause and effect relationships. Extension of these findings to faith groups outside of Christianity also would be a fruitful area for further study.

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