The Relationship of Decline in Spiritual Struggles to Psychotherapy Outcomes: Evidence from a Large Scale Survey of Psychotherapy Clients

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The relationship between spiritual struggles and mental health symptomology has received increased attention in recent years. The majority of research has shown that spiritual struggles are often linked with negative psychological functioning, such as increased depression, anxiety, and PTSD symptoms. Psychotherapy effectiveness is a field that has also been heavily researched. This study examines the relationship between decreases in spiritual struggles and psychotherapy outcomes. We hypothesized that there would be a positive relationship between decreasing spiritual struggles and improved psychotherapy outcomes. Utilizing a questionnaire developed by A Collaborative Outcomes Research Network, we compared the self-reports of 1,729 individuals. 474 of those studied experienced decrease in spiritual struggles as therapy progressed. The hypothesis was supported by a total effect size of 1.18. Those whose spiritual struggles decreased through the course of therapy were more likely to experience a reduction in their negative psychological symptoms.

Keywords: spiritual struggles, religious coping, psychotherapy outcomes, religion, spirituality, psychological symptomology, depression, anxiety, Post-traumatic Stress Disorder

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CHANGES IN SPIRITUAL STRUGGLES AND PSYCHOTHERAPY OUTCOMES

Psychology and religion, although different in approaches, are both highly interested in the human condition. In fact, there are several aspects of religion that intersect with psychology. According to James (1985), both psychology and religion acknowledge there are forces that work in bringing redemption to human life. They are both generally concerned with understanding human nature and work towards bringing positive change in a person's life. In addition, both psychology and religion are developmental processes. Sisemore (2016) writes, "religion and spirituality develop and change across lifespan thus interacting with the developmental process" (p. 2). As a person grows and develops, so do his or her religious and spiritual beliefs.

However, despite the commonalities between religion and psychology, the integration of the two fields was considered taboo for much of the 20th century (Shermer, 2003). Some early theorists tried to use weak science to dismiss and even pathologize people of strong religious convictions. Sigmund Freud, for example, insisted that "neither philosophy nor religion had a place in the science of psychoanalysis" (Frie, 2012, p. 106). Another reason psychology has attempted to distance itself from religion is that many leaders in the field were trying to validate psychology as a "hard science." Thus, any involvement with religion or philosophy was seen as discrediting. Religion was equally at fault in ostracizing itself from psychology. Some Christian authors even referred to psychotherapy as "psychoheresy" (Bobgan & Bobgan, 1987). If counseling were needed, it was believed that it would have to be solely based on the Bible since psychology was seen as contradictory to Christian belief. Thus, it can be assumed that the fields of psychology and religion did not share the same views as to what makes for human flourishing.

However, recent decades show a shift in this perspective with psychology showing more attention to religion. "Research in the areas of psychology and spirituality have flourished, and religious writers have addressed psychology more openly for the most part" (Sisemore, 2016, p.2). There has also been an increase in the utilization of spiritually-based practices

in psychotherapy. For example, mindfulness practices, which originate in Buddhism, have gained popularity among many clinicians (Baer, 2003). Another sign that psychology has become less rigid in its approach to spirituality and religion is the emergence of several humanistic psychotherapy theories, such as Motivational Interviewing (Miller & Rollnick, 2012) and Emotion Focused Therapy (Greenberg & Watson, 2005) that view spirituality to be an important aspect of a person. The American Psychological Association and the American Counseling Association published books that provide information for the clinician on how to address client spirituality in therapy (Aten & Leach, 2009; Miller, 1999; Richards & Bergin, 2000; Kelly, 1995). Gradually, the fields of psychology and religion are beginning to develop a better relationship with one another.

Despite this recent change, psychologists, as a group, still appear to be skeptical about integrating religion into psychology, perhaps because they themselves are less religious than the general population. According to a series of surveys conducted by Shafranske (2001), roughly 26% of a sample of clinical and counseling psychologists considered religion to be fairly important, a number that is considerably lower than the general population. Approximately 58% of people worldwide claim religion as an important factor in their lives. Thus, there appears to be a disparity among the two. Scientists as a group are significantly less religious than the subjects they study. On the applied side, further progress in this area is hampered by the fact that many therapists lack education in ways to integrate psychology and religion. However, given the role religion plays in the majority of people's lives, it is almost inevitable that the topic of religion will appear in therapy. Oftentimes, clients with medical issues will seek out alternate forms of therapy that actually incorporate prayer, rituals, and traditional healers (Lukoff, Lu, & Turner, 1992).

TERMINOLOGY: SPIRITUALITY VERSUS RELIGION

Before reviewing the literature on spiritual struggle and psychotherapy outcomes, it is important to provide clear definitions of religion and spirituality. Religion and spirituality are two terms that are often used interchangeably when discussing religious topics. However, despite the similarities in meaning, religion and spirituality are distinctive in some important respects. Spirituality is a newer term that has emerged during the later decades of the 20th century (Pargament Mahoney, Exline, Jones, & Shafranske, 2013). It derives from the Latin word *spiritus*, meaning "breath" or "life" (Hill et al., 2000). The current study will follow Pargament's (1999) definition, which views spirituality as a person's "search for the sacred" (p. 12), the "sacred" being used in this definition broader than a god or higher power; it is used in reference to anything that is considered divine or has divine-like qualities (Pargament & Mahoney, 2005). When considering spirituality, it is important to realize that spirituality is a highly individualized term, meaning that it manifests itself differently from person to person.

Religion, on the other hand, has become more of an organizational and institutional term. Religion can be defined as "the search for significance that occurs within the context of established institutions that are designed to facilitate spirituality" (Pargament et al., 2013, p. 15). This "significance" refers to possible psychological, social, and physical goals, such as identity, belonging, meaning, and health (Sisemore, 2016). If spirituality is the connection of a person to a higher power then religion can be thought of as the boundaries within which that connection happens. Religion, like spirituality, is complex in meaning. In the 21st Century, there appears to be a trend towards viewing spirituality in a positive light and religion in a negative one (Hill & Pargament, 2003). However, as Hill and Pargament (2003) explain, this is problematic because religion and spirituality are two interrelated, rather than independent, constructs. Religion and spirituality are not two opposing factors, but instead, depend and rely on each other. For the purpose of the current research, the reader can assume that the term religion will be used to include both the organizational aspects as well as the individual, inclusive aspects which are now associated with spirituality.

RELIGIOUS COPING: THE ROLES RELIGION PLAYS IN LIVES OF INDIVIDUALS

As mentioned earlier, the majority of the general population claims that religion plays an important role in their daily lives. It makes sense to assume that many people use religion to cope with life stressors. However, because of varying beliefs and religious styles, individuals differ in the ways they experience and express religion in their lives. Allport and Ross (1967) write, "To know that a person is in some sense 'religious' is not as important as to know the role religion plays in the economy of his life" (p. 442). Pargament (1997) thus coined the term "religious coping" to describe the ways people use religion to buffer life's stressors. Religious coping can be defined as "the use of religious beliefs or behaviors to facilitate problem-solving, to prevent or alleviate the negative emotional consequences of stressful life circumstances" (Koenig, Pargament, & Nielsen, 1998, p. 513). Researchers have identified two types of religious coping: positive and negative.

Positive religious coping is expressed through methods that reflect an intimate relationship with God or another form of the sacred who is benevolent, loving, forgiving, and engaged (Bradshaw, Ellison,

& Marcum, 2010). These views of God or a higher power revolve around the concept of the divine as a protector, guiding figure, and/or provider. Positive religious coping rests on beliefs that God will protect and provide during the challenging events. According to McConnell and Pargament (2006), examples of positive religious coping include: "trying to find a lesson from God in the event, seeking spiritual support, and providing spiritual support to others" (p. 1470).

While some people use religious coping as a source of strength and comfort during difficult times, for some, religion can also exacerbate and compound the stress. This is referred to as negative religious coping. Negative religious coping can be defined as "an expression of a less secure relationship with God, a tenuous and ominous view of the world, and religious struggle in search of significance" (Pargament et al., 1998, p.712). In contrast to positive religious coping, those who utilize negative religious coping measures tend to view the stressful life events as an abandonment or punishment by God. Examples of behaviors associated with negative religious coping include "punitive religious appraisals, demonic religious appraisals, reappraisals of God's power, spiritual discontent, self-directed religious coping, and interpersonal religious discontent" (Pargament et al., 1998, p. 712). Negative religious coping methods are not a comfort, but rather a source of additional stress.

It is important to note that although spirituality and religion have two different meanings, we used spiritual coping and religious coping synonymously. We also used the term spiritual struggles alongside negative religious coping. Spiritual struggle is a term that has emerged in recent years in place of negative religious coping. According to Pargament (2007), spiritual struggles are "signs of spiritual disorientation, tension, and strain" (p. 112). They grow out of life stressors that throw the individual's spiritual orientation and values into question. Spiritual struggles are an attempt to transform or preserve an individual's relationship with the sacred. According to Pargament (2001), "though spiritual struggles may lead to growth, they are not always a prelude to greater well-being, for struggles may also presage pain and decline" (p. 115). Thus, spiritual struggles can be seen as a fork in the road, potentially leading to growth or emotional decline.

SPIRITUAL COPING AND MENTAL HEALTH

A number of studies have explored the relationship between spiritual coping and mental health. Some studies compare spiritual coping methods to various mental health issues, such as anxiety, depression, and Posttraumatic Stress Disorder (Gerber, Boals, & Schuettler, 2011; Lee, Roberts, & Gibbons 2011; Park & Dornelas, 2011). In one such study, Koenig, Pargament, and Nielsen (1998) examined the religious coping methods of 455 medically ill, hospitalized, older patients who were cognitively unimpaired. These methods included: attendance in religious functioning, private scripture reading, private prayer, and personal religious commitment. The results of their study showed that those patients who utilized negative religious coping methods were more likely to have poorer physical health, worse quality of life, and increased depression than those who practiced positive religious coping strategies. Gerber et al. (2011) examined the relationship between religious coping, posttraumatic growth, and Posttraumatic Stress Disorder in a large sample. Those who utilized positive religious coping were more likely to display posttraumatic growth [$F(7, 942) = 23.66$, $p < .001$, adjusted $R^2 = .14$.]. Alternately, those who used negative religious coping methods were more likely to manifest posttraumatic stress disorder [$F(7, 942) = 40.74$, $p < .001$, adjusted $R^2 = .20$].

Ano and Vasconcelles (2005) conducted a meta-analysis of 49 studies with a total of 105 effect sizes in order to summarize the relationship between religious coping and psychological adjustment to stress. Four types of relationships were investigated: (1) positive religious coping and positive psychological adjustments, (2) positive religious coping and negative psychological adjustments, (3) negative religious coping and positive psychological adjustments, and (4) negative religious coping and negative psychological adjustments, the latter including increased anxiety, distress, depression, etc. They found that there was a moderate positive relationship between positive religious coping and positive psychological outcomes (cumulative effect size from 29 Zr's = .33), as well as an inverse relationship between positive religious coping and negative psychological adjustment (cumulative effect size from 38 Zr's = -.12). They also found a positive relationship between negative religious coping and negative psychological outcomes (cumulative effect size from 22 Zr's = .22) although they did acknowledge that the 22 effect sizes in this sample displayed significant heterogeneity of variance ($Q_T = 188.35$, $p < .01$). They added that "a Rosenthal's fail-safe test indicated that 2,190.4 contradictory results from other studies would have to be added to this analysis in order to disconfirm the significant positive association obtained between negative religious coping and negative psychological adjustment" (p. 473). Overall, the majority of research synthesized in the meta-analysis showed that negative religious coping is linked with more negative psychological adjustments.

According to Pargament (2001), spiritual struggles add a "distinctive element to psychological functioning" (p. 115). Spiritual struggles have been shown to be positively related to higher levels of anxiety and depression, lower levels of quality of life, and

relational distress (Exline & Rose, 2005; Fitchett et al., 2004; & Pargament, Murray-Swank, et al., 2005). It does not necessarily follow that struggles with spirituality cause psychological pain; pain and distress can also trigger spiritual struggles. Thus, relationships between spiritual struggles and distress may be complex. As mentioned previously, spiritual struggles are often a sign of distress and conflict within a person. Given the relationships between negative spiritual coping and poor psychological symptoms, a person's spiritual coping strategies are important to consider during the course of psychotherapy.

PSYCHOTHERAPY OUTCOMES

It is clear that religious coping strategies are important for clinicians to consider during the course of treatment. However, while the relationship between spiritual coping and mental health has been explored, the roles that spiritual coping strategies play in psychotherapy have not been as carefully researched. Psychotherapy, in a broad sense, can be defined as "the utilization of resources, wisdom, and guidance of a helper in order to lift up the spirits of the person who seeks help, so that he or she would be able to cope with the demands of his/her social role and make his/her contribution to society" (Ting, 2012, p. 762). Psychotherapy utilizes the science of psychology in order to help decrease negative psychological symptoms. It has generally been proven to be effective (Smith, & Glass, 1977). By the time Lipsey and Wilson conducted their meta-analysis in 1993, there were more than forty meta-analyses of psychotherapy in general or of particular therapy models for specific issues; these were generally lending support to the effectiveness of psychotherapy. Thus, with the prevalence of research on effectiveness of psychotherapy, current research has focused on more specific questions, such as whether a specific treatment is efficacious and, of particular relevance here, what factors may facilitate effective treatment outcomes (Wampold & Imel, 2015).

Thus, the purpose of this study was to examine the relationship between changes in spiritual struggles and psychotherapy outcomes. Given the relationship between spiritual struggles and negative mental health symptoms, it was hypothesized that a decrease in spiritual struggles (negative religious coping) would be associated with positive psychotherapy outcomes. It was expected that clients who reported declines in spiritual struggles over the course of therapy would also report better therapy outcomes as reflected in reports of fewer symptoms.

METHODS

Measures

The main measurement device used in this study was a questionnaire developed by A Collaborative Outcomes Resource Network (ACORN, 2007). This questionnaire consists of twenty-three empirically-derived items which measure subjective experience, such as anxiety and depression, therapy alliance, trauma effects, and spiritual struggles. People respond to the questions on a five-point Likert scale. The questionnaire measures spiritual struggle through two items adapted from the RCOPE scale, which are the two highest factors of religious coping on the RCOPE (Pargament, Koenig, & Perez, 2000). The two questions are: "Wonder what you did for God to punish you?" and "Wonder whether God has abandoned you?" There was also a trigger question: "Believe in God or a Higher Power?" which qualified the person for the study. In addition to the questionnaire developed by ACORN, registration forms were completed by the researchers for each new client, which provided sex, ethnicity, age, and diagnosis of the individual. Seventeen of the items that compose the questionnaire were known to load on the global distress factor found in patient self-report measures of psychiatric symptoms and complaints, giving the questionnaire high construct validity. These items assessed a variety of negative psychological symptoms which included: feelings of sadness/hopelessness, loss of energy, difficulty with attention and/or sleep, feelings of tension or nervousness, thoughts of self-harm, difficulty controlling emotions, substance abuse, and intrusive thoughts/memories. Global distress was expected to change over time, so in order to test for reliability, Cronbach's coefficient alpha was used. For this study, the reliability is approximately .91.

Participants

Participants in this study consisted of individuals who sought psychotherapy or counseling from a network of four faith-based counseling centers throughout the United States. From the base sample of 9,044 participants, a total of 1,729 individuals qualified. In order to qualify for the study, the subjects had to complete a total of two questionnaires, acknowledge a belief in God, and have a global distress scale (as determined by ACORN) in the clinical range. Clinical range was measured by client intakes that exceeded the clinical cutoff score, which is a score that represents the boundary between the normal and clinical range (Jacobson & Truax, 1984). Of the 1,729 individuals who qualified, 70% were female. Due to spotty completion of registration forms (which provided additional demographic information), information on age and ethnicity were not provided.

Procedures

Prior to his or her initial appointment with a therapist, the client was asked to complete an intake packet that included the informed consent to participate in the study. If the client agreed to participate, he or she was given the questionnaire before each subsequent

Table 1
Descriptive Statistics for Primary Study Variables

Pre-Post NRCOPE	N	Mean Effect Size	No. of Assessments	No. of Weeks
High/high	471	0.47	6.0	12.7
High/low	412	1.18	8.0	17.5
Low/high	78	0.33	5.3	12.6
Low/low	768	0.95	6.9	16.2

Table 2
ANOVA for Effect Sizes Based on Groups

Source	N	DF	Sum of Squares	F Value	P Value
Model	1826	3	146.67	75.51	<.0001
Error		1822	1179.71		

appointment with the therapist, though some clients did not complete the questionnaire every time. The client would complete the questionnaires by responding with "always," "often," "sometimes," "hardly ever," or "never" to the questions being asked, these being coded from 0 to 4 for analysis, depending on the direction of the wording of the response, with 0 being no problem to 4 being considerable concern. The forms would then be gathered by the researchers and faxed to ACORN for data processing. The client continued completing forms for the duration of his or her therapy. The client's confidentiality was maintained through assignment of a random ID number. ACORN posted the information online for therapists and researchers both to access. The therapists and researchers could monitor the change of client's symptomology and religious coping as therapy progressed.

RESULTS

The total N for the study was 1,729 individuals who qualified. The average number of treatment sessions for the clients was 6.9 sessions and the average time in treatment 15.3 weeks. The negative RCOPE data were not normally distributed due to many clients not marking any negative religious coping patterns (mode for first and last RCOPE was 0; mean was 1.0 at first session and .6 at last). Thus, based on the lack of normal distribution, parametric analysis was not appropriate.

The negative coping scores from the RCOPE were converted to categorical variables, a negative RCOPE score above .5 was considered high while a negative RCOPE score below .5 was considered low (as these marked the presence or absence of negative religious coping). Four groups were then developed based on the clients' first and last negative RCOPE measures. The first group was high/high. These individuals made use of some negative religious coping at the beginning of therapy and ended therapy continuing to use negative religious coping. This group represented greater religious struggle overall. The next group was high/low. These individuals manifested negative religious coping at the beginning of therapy and ended therapy with low negative religious coping. For this group, religious struggles declined over the course of therapy. The next group was the low/high group. These individuals began therapy with low negative religious coping but ended therapy with higher negative religious coping. This group's negative religious coping increased as therapy progressed. The final group was the low/low group. These individuals began therapy with low negative religious coping and ended therapy with low negative religious coping. For this group, negative religious coping was not an issue. Per ACORN procedures (A Collaborative Outcomes Research Network, 2016), therapy effect size (based on change in symptoms from first to last session) was computed to adjust for change in Global Distress Scale (controlling for regression effects).

Table 1 presents descriptive data for the four

groups. For the high/high group (N = 471) the mean adjusted effect size was 0.47, the average number of assessments was 6.0, and the number of weeks averaged 12.7. In the high/low group (N = 41), the mean effect size was 1.18, the number of assessments averaged 8.0, and the number of weeks averaged 17.5. For the low/high group, (N = 78) the mean effect size was 0.33, the average number of assessments was 5.3, and the number of weeks averaged 12.6. Finally, for the low/low group (N = 768,) the mean effect size was 0.95, the number of assessments averaged 6.9, and the number of weeks averaged 16.2. Overall, change in negative RCOPE score (M=0.23) correlated with change in Global Distress Score (M=0.26), r=.33, ($p < 0.0001$) supporting the hypothesis.

For those with 2 or more RCOPE measures (N=1179), the mean change in RCOPE scores from first to last session was 0.3 and the comparable change in Global Distress was 0.26, yielding r = .33 ($p<.0001$) and showing a very strong relationship between decrease in distress and decrease in the use of negative religious coping. As would be expected, the greatest change was among those who manifested higher negative religious coping to begin with and the least improvement in therapy was among those who displayed increases in spiritual struggle over the course of therapy.

An analysis of variance was then performed (See Table 2) to compare the overall effect size as a function of negative religious coping. This analysis yielded a highly significant result (N=1826, F=146.67(df = 3; $p<.0001$). A subsequent Tukey Test for the effect size (Table 3) showed significant changes ($p<.001$) for all group comparisons except between the high/high and low/high groups, reflecting that clients ending with high scores on negative religious coping did not fare as well in symptom improvement during therapy. All pairs that showed movement in the direction of less negative religious coping were superior to those that did not.

DISCUSSION

Research examining the implications of spiritual struggles for mental health has rapidly increased within recent years. This investigation sought to extend this research to the realm of psychotherapy outcome studies. We focused specifically on the relationship between a change in spiritual struggles and outcomes of therapy. We hypothesized that there would be a relationship between decreasing spiritual struggles and improvement over the course of psychotherapy. The results of this study supported the hypothesis. Of the four negative religious coping groups identified in the study, the most change in the Global Distress Scale occurred within those whose spiritual struggles decreased during therapy. Thus, reductions in spiritual struggles were clearly related to improved psychologi-

Table 3
Turkey Test for Groups of Change in Negative Religious Coping from First to Last Report

Negative Religious Coping	Group Comparison	Mean Differences
High/low	High/high	.694***
	Low/high	.851***
	Low/low	.221***
Low/low	High/low	-.221***
	High/high	.473***
	Low/high	.630***
High/high	High/low	-.693***
	Low/low	-.473***
	Low/high	.156
Low/high	High/low	-.851***
	Low/low	-.630***
	High/high	-.157***

***p<.001

cal functioning. On the other hand, the least improvement in psychological functioning occurred in the group whose spiritual struggles increased as therapy progressed.

Our results show a strong relationship between decreased spiritual struggles and increased psychotherapy outcomes. However, we cannot assume that changes in spiritual struggle caused changes in psychotherapy outcomes. Perhaps changes in global distress led to changes in spiritual struggle. In this vein, Pargament and Lomax (2013) distinguished between primary struggles in which struggles produce distress, secondary struggles in which distress produces struggles, and complex struggles in which both factors are operating. It is also possible the findings could be explained by other variables. For example, the role of the therapists' own religious beliefs were not measured. What role would the therapist's own religious convictions play in the counseling session? Would psychotherapy outcomes differ depending upon the level of spirituality of the therapist or his or her sensitivity to clients' spirituality? In addition, the theoretical orientation of the therapist was not measured. Might certain orientations be better suited to addressing spirituality in the counseling room than others? Finally, it is uncertain if negative religious coping was specifically addressed by the counselor as part of the counseling process, since the results were solely based on self-report.

Although questions remain, these findings do have certain implications for the therapist. They suggest the importance again of addressing negative religious coping in psychotherapy. This is an area that should be addressed during the counseling session due to its clear relationship with improved psychological symptoms. Certainly, religious clients may take their spiritual concerns to pastors, clergy, and other clergy members who can be sources of support for the client. Nevertheless, clients may bring up spiritual matters within the therapeutic relationship as well. If a client reports having struggles with his relationship to the sacred then the therapist should overcome his or her hesitations and address this topic during therapy.

LIMITATIONS

The findings of this study should be interpreted in light of the following limitations. First, the inadequate completion of registration packets made it impossible to gain demographic information on the participants. Due to this information not being provided, further questions regarding the role culture and age play regarding spiritual struggles and psychotherapy outcomes are left unanswered. Second, all the results were based on self-reports from the participants. Since the clients knew the forms would be reviewed by the therapists, there is the possibility they might not have been completely forthcoming when completing the questionnaire. The data also do not identify how long each client was in therapy, but merely compare the final negative religious coping score to the first. This is, of course, correlational data and ultimately does not speak to whether changes in negative religious coping reduce symptoms, or whether a reduction in symptoms helps clients resolve their religious struggles. While the data came from four primary sites in differing parts of the United States, these were all essentially faith-based counseling centers that are more likely than average to attract counselors who are religious and clients seeking spiritually sensitive care.

CONCLUSION AND FUTURE RESEARCH

This study helps to extend the research in the following ways. Prior research has consistently shown that spiritual struggles are positively related to poorer psychological functioning, such as increased PTSD, depression, and anxiety (Ano & Vasconceles, 2005). This study supported the hypothesis that as a person's spiritual struggles decrease during the course of therapy, his or her psychological functioning is most likely to improve. In other words, the client who experiences a decrease in spiritual struggles has a better chance of gaining more from psychotherapy. This study shows that spiritual struggles have a strong relationship to outcomes in counseling. This is important for therapists to consider. Because the majority of the population reports that spirituality and religion play an important role in interpreting and dealing with life stressors, it is likely that in many cases, religion will come up in therapy session. When this occurs, the counselor should be intentional in addressing the client's religious or spiritual coping strategies.

For future research, it would be important to distinguish between the client's religious coping strategies and other variables that may account for change in psychotherapy. For example, perhaps the therapist's own religious beliefs play a key part in reducing the Global Distress Score. Other questions arise as well. What role did the therapist's theoretical approach play in the counseling relationship? How were spiritual struggles specifically addressed by the therapist? It would be important to determine whether the spiritual struggles were an explicit part of treatment goals and process or whether spiritual struggles were not explicitly addressed which might suggest that spiritual struggles decreased as a natural by-product of improvements in psychological symptoms. In addition, a more intact demographic set would be beneficial. More knowledge about demographic variables would help clarify how religious coping strategies relate to psychotherapy outcomes among various cultural groups, psychological diagnoses, and age categories. Finally, experimental designs (e.g. randomized clinical trial) that addressed spiritual struggles would help clarify the causal direction of the relationship between declines in spiritual struggles and better psychotherapy outcomes.

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