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Abstract

Understanding the role of religion in mental illness has always been complicated as some people turn to religion to cope with their illness, whereas others turn away. The overarching purpose of this study was to draw on quantitative and qualitative information to illuminate ways in which religiousness might be associated with changes in depressive symptomatology in a spiritually integrated inpatient treatment program. This repeated measures mixed method study examined the relations among religious comfort (RC), religious strain (RS), and depression in an inpatient psychiatric sample. Adult inpatients (N=248; M_{age} = 40.78 years; SD = 18.97) completed measures of RC, RS, and depression at pre- and post-treatment. Focusing on patient responses to open-ended questions regarding spiritual perspectives on their mental illness, qualitative themes were deduced via content analytic coding procedures to further clarify quantitative findings. Autoregressive cross-lagged panel models were used to test potential reciprocal influences among RC, RS, and depressive symptomatology between admission and discharge. Scores on RS decreased, whereas scores on RC increased. At both intake and discharge, depression was inversely associated with RC and directly correlated with RS. In addition, RC on admission was inversely associated with depressive symptom severity at discharge, whereas RS on admission did not predict later depression. Religious affiliation was also positively associated with RC. This is the first study to document a direct association between RS and depression, along with an inverse association with RC, in an inpatient psychiatric sample.

KEYWORDS: religious comfort; religious strain; depression; inpatient; spirituality.

Understanding the Role of Religious Comfort and Strain on Depressive Symptoms in an Inpatient Psychiatric Setting

Research has illuminated the potential associations between religion, spirituality, and mental/physical health (Koenig, McCullough, & Larson, 2001). Although there are varying definitions for religion and spirituality, "religion" generally connotes specific behavioral, doctrinal, and institutional features, whereas "spirituality" represents one's subjective experiences in attempting to understand life's ultimate questions and find meaning/purpose (Pargament, 2013). Despite the overlap between the constructs, religion captures instances in which one's search for sacredness or transcendence (i.e., spirituality) is guided by teachings, doctrines, and institutions that have been developed to facilitate peoples' relationships to the sacred (Pargament, 2013). The Fetzer Institute (1999) has stated that "religiousness has specific behavioral, social, doctrinal and denominational characteristics because it involves a system of worship and doctrine that is shared within a group'' (p. 2). Recent efforts have moved beyond associations with global measures of religiousness and spirituality to obtain a more complex and nuanced understanding of religiousness and spirituality and health correlates that have crucial implications for clinical practice (Hill & Edwards, 2013). Whereas early psychological research in this area emphasized maladaptive aspects of religion, recent work has focused on both its adaptive dimensions and the challenges associated with religious life. This focused inquiry raises the key question:

> How helpful or harmful are particular religious (and spiritual) expressions for particular people dealing with particular situations in particular social contexts according to particular criteria of helpfulness and harmfulness? (Pargament, 2002, p. 178).

Consistent with Pargament's (2002) question, the overarching purpose of this study was to draw on quantitative and qualitative information to clarify ways in which religiousness might be associated with changes in depressive symptomatology in an inpatient treatment program.

Religiousness and Depression

According to the National Institutes of Mental Health, an estimated 16.1 million adults (6.7%) in the United States (US) had at least one major depressive episode in the past year. Religiousness often represents a resource and a source of strain for individuals suffering from depression and other psychiatric difficulties. As a resource, religiousness may provide a sense of comfort and connection with God (or the divine) as well as other persons during stressful periods. For example, results from 93 cross-sectional studies revealed that in 66% of these studies, religiousness was associated with fewer depressive symptoms (Koenig, 2009). Results from 22 longitudinal studies revealed that participants who endorsed greater religiousness reported fewer depressive symptoms at follow-up assessments in 68% of this set (Koenig, 2009). However, beyond the imprecise endorsement of religiousness, religious strain (RS; e.g., feeling alienated from God) has been positively associated with depressive symptom severity and other life difficulties (e.g., Exline, Yali, & Sanderson, et al., 2000). Clearly, the relationship between religiousness and mental health is complex. Understanding the specific impact of religious comfort (RC) and RS on mental health outcomes may have significant implications for improving clinical and spiritual care in therapeutic contexts that emphasize multicultural competence in this life domain.

Religious Comfort and Strain

RC and RS have gained increasing attention in research on health-related correlates of religiousness. For example, in a study of patients who were undergoing open-heart surgery, the

absence of strength and comfort from religion was associated with increased mortality rates (Oxman, Freeman, & Manheimer, 1995). In order to identify which aspects of religion are adaptive and maladaptive, Exline et al. (2000) developed the Religious Comfort and Strain Scale (RCSS). RC refers to a feeling of being loved by God, a sense of belonging to a religious community, and a sense of being forgiven. RC may buffer the negative effects of stressors such as depressive episodes (Cook, Aten, Moore, Hook, & Davis, 2013) and contribute to perceptions of posttraumatic growth (Ogden et al., 2011). For example, in a study of Mississippi university students following Hurricane Katrina, RC was associated with positive outcomes (e.g., physical health and perceived posttraumatic growth; Cook, et al., 2013). In addition, other evidence from Cook et al.'s work suggested that RC buffered the negative impact of material losses on students' emotional health (i.e., relationship between resource loss and emotional health was less strong for students who had more RC).

An opposite pattern of findings has emerged in research focusing on RS. RS is characterized as experiencing alienation from God and one's religious community, pervasive feelings of fear and guilt, and perceived or actual rifts with other religious individuals and beliefs (Exline et al., 2000). Inverse associations have been found between RS and psychological well-being in a number of cross-sectional studies (e.g., Exline et al., 2000; Harris et al., 2008; Harris et al., 2012). For example, in a college student and outpatient clinic sample, Exline et al. (2000) documented that RS was related to a greater risk of depressive symptomatology and suicidal thoughts/behavior. In a sample of 286 church attendants, Harris et al. (2008) similarly found that RS was positively related to posttraumatic stress symptoms at the time of the study. In addition, other findings suggest that people with high levels of RS are more likely to seek help with religious concerns in therapy (Exline et al., 2000).

Notwithstanding these findings, a more nuanced picture of RS emerged from Wilt and colleagues' study (2016) of God's role in suffering in college undergraduates and a web-based adult sample. They found that participants who viewed suffering as part of God's benevolent plan had higher well-being whereas those who believed a nonbenevolent God causes suffering had lower well-being and greater divine struggle. The unexpected finding was that participants who believed that suffering was part of God's benevolent plan also experienced more divine struggle. Wilt and his colleagues (2016) explained this finding by drawing on an emerging perspective that experiencing anger toward God and divine struggle are important features of a maturing faith in many cases (Exline, Pargament, Grubbs, & Yali, 2014; Exline, Park, Smyth, & Carey, 2011). This more nuanced understanding of suffering highlights the importance of models that might account for this more multi-valenced view of faith. In addition, given this complexity in quantitative results, scientific understanding might be advanced with inclusion of qualitative questions to parse out potential differing themes related to RS.

Selected Religiousness and Spirituality Models

The role of religion in coping with mental illness has been complicated as some people turn to religion to cope with their illness, whereas others turn away (Pargament, 1997). Although longitudinal studies offer promise for clarifying this picture, Sherman and his colleagues (2005) noted that studies have yielded mixed findings for religious coping (e.g., Abernethy et al., 2002; Carver et al., 1993; Filipp et al., 1990). For example, ethnicity or religious affiliation have been shown to moderate results on religious coping (Alferi et al., 1999; Tix and Frazier, 1998). In addition, most models of religious coping and spirituality do not take into account a trajectory of adjustment over time (Sherman and Simonton, 2001). Longitudinal research that includes models of religiousness may more fully explain complex trajectories that highlight the ebb and flow of

religious life. Sherman and colleagues (2005) argued for inquiry regarding religiousness not only as a coping resource, but also as relevant to one's illness perspective. In order to address these concerns, we asked two questions in the current study: one related to coping and another related to the effects of mental illness on religiousness.

Several stress and coping models have been proposed to explain the impact of religiousness on coping with mental illness. Nelson (2009), in his stress-buffering model, posited that religiousness might serve as a moderator, suppressor, or mediator of mental health symptoms. He argued that religiousness has the greatest effect as a moderator when stress levels are high. When individuals experience greater difficulty, they may engage in more religious practices: these practices suppress the effects of stress associated with mental illness. As a mediator, religiousness leads to improved coping; this reduces the effects of stress. Similarly, individuals may seek RC in response to difficulty or increased stress.

The spiritual transformation model (Sandage & Shults, 2007) similarly allows for varied responses (i.e., positive, negative, and ambivalent) that individuals might experience in their spiritual lives as well as in response to illness. Sandage and Shults (2007) defined spiritual transformation as "profound, qualitative or second-order changes in the ways in which a person relates to the sacred" (p. 264). Their model provides a psychospiritual lens for understanding the process of spiritual transformation by emphasizing the role of relationality or interpersonal processes. They highlighted the relational dynamics of how people relate to one another and the sacred. Sandage and Shults (2007) identified key advantages of their relational model of spiritual transformation. The first is the emphasis on the reciprocal influence of spirituality and interpersonal relationships. This reciprocity also may be applied to the mutual influence between spirituality and a patient's illness experience. That is, spirituality influences one's experience of

illness, but illness may also influence one's spirituality. Second, they emphasized a wide range of spiritual experiences including negative ones. Finally, the most important contribution of their relational model is that it accounts for the tensions in spiritual life between seeking (e.g., a process of search that often includes anxiety, risk, and growth) and dwelling (e.g., a more stable place of comfort that also may include disappointment and spiritual complacency). Using this model, RC may be understood as a dimension of dwelling that is associated with a sense of stability and comfort in one's relationship with God. In contrast, RS may be more strongly associated with seeking and an increased sense of anxiety and concern in response to one's spiritual life that may also lead to growth.

Study Aims

A relational model emphasizing "negative, positive, and ambivalent" processes in RC and RS (Sandage & Shults, 2007) may more fully explain the complexity of individual responses to mental health crises. Importantly, this model assumes that all aspects may be important responses in the process of one's spiritual life. The central question in this study was whether RC and RS would be associated reciprocally with levels of depressive symptomatology over the course of an inpatient hospitalization at a spiritually integrated behavioral health center. We hypothesized that RC at admission would be associated with reduced depressive symptomatology at discharge, whereas RS would be associated with more depressive symptomatology at discharge. We also anticipated that both RC and RS would be present for religious individuals and would be evident in their descriptions of their illness at admission.

Method

Setting and Participants

This current study was part of a larger research project that examined the role of forgiveness and spiritual distress in recovery from mental illness. This study focused on 248 patients who completed an acute psychiatric hospitalization at Pine Rest Christian Mental Health Services (PRCMHS), a non-profit behavioral health center in Grand Rapids, Michigan. Table 1 outlines the demographic and diagnostic characteristics of the sample. Although the behavioral health center that houses these units offers spiritually integrated mental health care within a Christian framework, the units provide services to persons of all faith backgrounds and are accredited by both the Joint Commission on Accreditation of Healthcare Organizations and the Commission on Accreditation of Rehabilitation Facilities.

The increased emphasis on multicultural competence in mental health professions has heightened many clinicians' awareness of the importance of addressing the spiritual and religious beliefs and practices (SRBP) of patients. Saunders, Miller, and Bright (2010) have identified four approaches to addressing SRBP that range from avoidance of spiritual concerns to what Tan (1996) has termed "explicit integration" of spiritual practices. These include: 1) spiritually avoidant care (e.g., avoiding SRBP), 2) spiritually conscious care (e.g., respectful assessment of SRBP in terms of its importance and relevance to the problem and treatment), 3) spiritually integrated care (e.g., focusing on SRBP to address therapy goals such as alleviating distress), and 4) spiritually directive care (e.g., explicit focus on SRBP that might include addressing negative dimensions of SRBP). The present study was conducted in a setting in which spiritually integrated care was available to every person, with the option for patients also to self-select a religiously integrated care approach if desired.

Spiritually integrated mental health care at PRCMHS refers to an approach that understands patients as whole persons and mental health care that is a bio-psycho-social-spiritual. The spiritual dimension of a person's life is acknowledged, respected, and engaged throughout the treatment process from understanding patients' diagnoses, caring for their needs, and supporting their healing process. Spiritually integrated mental health care is implemented by an interdisciplinary team that includes Chaplains and other traditional behavioral health providers. Chaplains attend treatment teams, contribute to treatment planning, receive spiritual care referrals from other staff members, and are available for consultation with other caregivers regarding spiritual care affecting patient health and well-being. Namely, each patient, upon admission, is screened for their religious preference and asked whether they would like to have a Chaplain visit them. If a patient requests care from a Chaplain, the unit Chaplain follows up within forty-eight hours. Chaplains offer an interfaith ministry, so are non-sectarian in their patient care. Chaplains respect each patient's religious commitments and spiritual lives, and they work within the religious framework of each patient.

The present sample was recruited from six adult inpatient units between 2013 and 2015. The patients ranged in age from 18 to 80 (M = 40.78; SD = 18.97). The average length of stay was 7.19 days (SD = 3.89; range = 2 to 32). These psychiatric units provide short-term psychotherapeutic and medical care via a multi-disciplinary team of professionals (i.e., psychiatrists and other physicians, psychologists, social workers, nurses, and chaplains). In terms of treatment interventions, PRCMHS's inpatient units provide a structured schedule of treatment programming for the day. In addition to medication management, patients participate in individual and group-based interventions. A typical daily schedule includes the following: goal setting, group therapy (let by an LMSW), activity therapy, wellness groups, meetings with their

psychiatrist and case manager, and other medical personnel appointments as indicated. Optional experiences include the spiritual growth groups, chaplain-led 15-minute daily devotions, visits from religious leaders of patient's faith communities, chaplain visits, and Sunday Christian worship.

The Wellness Groups are led by Chaplains and focus on common human spiritual needs: guilt, shame, fear, worry, self-worth, hope, healing, forgiveness, gratitude, loneliness, grief and loss, and recovery. As patients are required to attend Wellness Groups, Chaplains do not use religious material in these groups. The optional Spiritual Growth Groups are also led by Chaplains and use religious material such as sacred scripture, inspirational stories, guided meditation, hymns and poetry, and spiritual practices to address relevant topics. The group activities provide time for patients to openly process their feelings, reflect on their experiences, and draw from their religious and spiritual resources for hope, healing, and personal growth.

Procedures

Inclusion in the study was restricted to patients who were at least 18 years of age and who did not present active psychotic symptoms, cognitive impairments, or other concerns that might interfere with completing self-report measures that provided the basis for this study. All patients who met these inclusion criteria were invited to participate. Assessments of RC, RS, and depressive symptomatology were completed within 48 hours of being admitted into one of the inpatient units and at the time of discharge. The coping and illness perspective questions were administered only at pre-treatment. After being identified as a potential participant, a Chaplain or Chaplaincy Intern completed the consenting procedure and oversaw completion of study measures. In total, 251 patients completed the baseline assessment. Three patients were dropped from the study based on their inability to complete reliably the study measures. A total of 216

participants completed the post-treatment survey. When compared to the patients in this sample, the subgroup who were not included in statistical analyses (due to psychosis or cognitive impairment) did not differ in demographic/diagnostic characteristics or other variables that formed the basis of this study. Two Institutional review boards independently approved all procedures before recruiting patients.

Measures

Religious Affiliation. Participants classified themselves religiously as Protestant Christian, Catholic, Muslim, Jewish, Buddhist, Spiritual but not Religious, Atheist, None/N/A, or Other. If the participants did not feel that any of these classifications described their religion, they wrote in what they felt best described them.

Religious Comfort and Strain. Exline et al.'s (2000) Religious Comfort and Strain Scale (RCSS) was utilized to assess RC and RS at baseline and discharge. We began this 24-item measure with this statement: "People report a wide variety of experiences in their religious and spiritual lives. Please indicate the degree to which you have experienced the following in relation to how you have felt about God, a Higher Power, or a deity in your faith in the past month*."* The RCSS includes 10 items that capture comforting experiences of religion and/or spirituality (e.g., "Feeling loved by God," "See your faith as a source of peace and harmony," "Find that your beliefs give you a sense of meaning or purpose) and 14 items that assess varying ways in which people might experience distress in this domain of their lives (e.g., "Feel abandoned by God," "Disagreement with a family member or friend about religious issues," "Feeling excessive guilt for your sins or mistakes"). Items were rated on a ten-point scale from 1 (*Not at all)* to 10 (*Extremely)* with higher scores indicating higher levels of RC or RS. Internal consistencies ranged from $\alpha = .88$ to .96 for the two subscales across the two assessment points.

Depression. The Patient Health Questionnaire (PHQ-8; Kroenke, Spitzer, & Williams, 2001; Kroenke et al., 2009) was used to assess eight possible symptoms of major depressive disorder at baseline and discharge (e.g., anhedonia, depressed mood, disturbances in sleep and appetite, self-disparagement, psychomotor agitation). The PHQ-8 is a widely used instrument that asks respondents to rate the frequency of these symptoms over the past month, with scores ranging from 0 = *not at all* to 3 = *nearly everyday*. The PHQ-8 yielded internal consistencies of $\alpha = .89$ at both assessment points.

Spirituality in Mental Health Care. Pargament and Kumrei (2009) have developed several items to assess patients' view of the role of spirituality in their mental health care. Two items were included: "Has your illness affected you spiritually or religiously," and "Has your spirituality or religion been involved in the way you have coped with your problem?" The response categories for both questions were spiritually, religiously, both, or neither. For participants who endorsed a connection with spirituality or religion in coping with their mental health issue, a follow-up question of "In what way?" was included to obtain additional qualitative information.

Plan of Analysis

An autoregressive cross-lagged panel model (CLPM) was used to test potential reciprocal influences between RC, RS, and depressive symptoms in the sample. The CLPM was conducted in Mplus (version 7.1). Available data from all 248 participants were included in the analyses and conducted using full information maximum likelihood estimation with robust standard errors (FIML). Covariance coverage (i.e., proportion of available data) for RC, RS, and depression ranged from 87% to 100%. There were two times points in the CLPM (i.e., baseline and discharge), and thus the model was just identified and exhibited perfect fit to the data. This

limited the ability to conduct model comparisons; however, regression paths (e.g., path reflecting influence of RC on depression) could be estimated, which was sufficient to test the hypotheses guiding this study. Four covariates were measured at baseline and included in the model (age, gender, ethnicity [white = 1, non-white = 0), and religious affiliation [Christian = 1, other = 0]).

Results

Changes Over Treatment Period

Table 2 depicts the changes in RC and RS as well as depression over the treatment period. In summary, results of paired-samples *t*-tests revealed that RC generally increased in the sample, whereas RS and depression decreased significantly from admission to discharge.

Cross-Lagged Panel Model Results

Table 3 provides a detailed accounting of the autoregressive and cross-lagged paths, within-panel correlations, and covariate regressions stemming from the autoregressive cross-lagged panel model (CLPM). All coefficients are reported in standardized form along with their associated standard errors, 95% confidence intervals, and p-values. A simplified and visual version of these results is displayed in Figure 1. Not surprisingly, autoregressive paths (e.g., RC at discharge regressed onto RC at baseline) each generated positive and statistically significant relationships. As expected, the within-panel correlations (e.g., inverse correlation between RC and RS at baseline) were all statistically significant. Several of the regressions involving covariates were also statistically significant. Perhaps the most notable of these regressions (reported in Table 3) were the two showing that religious affiliation was a significant predictor of RC at both baseline and discharge. That is, participants who self-identified as Christian had significantly higher levels of RC at both assessment points than participants from other religious or non-religious backgrounds.

Most critical to the present research were the cross-lagged paths. Each path represented the association between one of the focal variables (i.e., RC, RS, or depression) at baseline and one of the remaining two focal variables at discharge, after controlling for autoregressive effects, cross-sectional correlations, and the four covariates (see Table 3 for statistics). As depicted in Figure 1, RC and depression formed the only cross-lagged path that was statistically significant. This path was negative in direction: participants with higher levels of RC at baseline reported a significant reduction in depressive symptomatology from intake to discharge. Notably, baseline level of depression was not reciprocally associated with changes in RC. In contrast to RC, there was no evidence that RS was associated with changes in depressive symptomatology or vice versa. In addition, RC and RS did not have any mutual relationship to each other at intake and discharge.

Qualitative Responses

Two clinical psychology graduate students coded responses to the two qualitative questions into several categories via content analytic procedures (Creswell, 2013; Ponterotto, 2005). Hsieh and Shannon (2005) have defined content analysis as a "subjective interpretation of the content of text data through the systematic classification process of identifying themes of patterns" (p. 1278). The two independent coders categorized the responses and then achieved consensus on those classifications where there was disagreement. The selected quotes below illustrate some of the key concepts related to RC and RS.

In what way has your illness affected you spiritually or religiously? Of the 248 participants, 23% indicated that it affected them spiritually and religiously, 36% indicated that their mental illness affected them spiritually, 14% indicated that it affected them religiously, and 26% indicated that this did not apply or that neither was relevant to them. Participants' responses

included references to belief/faith, change/growth, decrease/lack in spiritual activities, failure, forgiveness, guilt/shame, and the power of illness. These responses describing illness effects (n = 143) were then coded into one of four higher order categories: strain, comfort, both, or neither. The category of strain was most prominent: 101 (71%) responses were categorized as strain, 21 (15%) as comfort, 11 (8%) as both, and 10 (7%) as neither (see Table 4 for examples).

Has your spirituality or religion been involved in the way you have coped with your problem? …In what way? In response to this coping question, 65% indicated "yes" and 35% indicated "no." For those participants who answered affirmatively, their responses included references to spiritual practices/disciplines, religious support/community, forgiveness, belief, spiritual intervention, and change/growth. These responses (n = 168) were then coded into one of four higher order categories: 11 (7%) responses were categorized as strain, 125 (74%) as comfort, 8 (5%) as both, and 24 (15%) as neither (see Table 5 for examples).

Expressions of RS and RC were prominent in the responses to the questions about illness effects and coping, respectively. Specifically, mental illness effects on religiousness and spirituality were predominantly associated with strain, and religious and spiritual coping with illness was predominantly associated with comfort. For 60 respondents (24% of the total sample) whose narrative expression reflected both RS and RC in response to illness effects and coping, 59 of the participant responses were categorized as both RC to the illness question and RS to the coping question, whereas only one participant reported RS to the illness question and RC to the coping question.

Discussion

Given the prevalence of depressive disorders in the US, as well as the particularly high occurrence in psychiatric populations, identifying factors that may be associated with decreased

depression in treatment settings will assist in addressing this major mental health challenge. In the current inpatient psychiatric sample in which 50% had a clinical diagnosis of unipolar depression, initial analyses revealed significant reductions in depressive symptomatology from intake to discharge. In addition, other analyses revealed that RS decreased in this spiritually integrated program whereas scores on RC increased. Importantly, at both intake and discharge, RC was inversely associated with severity of depressive symptoms, whereas RS was positively associated. These concurrent associations between RS and depression are consistent with Exline and colleagues' (2000) prior findings in non-treatment seeking samples. To our knowledge, this is the first study to document a direct association between RS and depression, along with an inverse association with RC, in an inpatient psychiatric sample.

An important contribution of this study is that, in addition to an examination of these concurrent associations, the repeated measures design afforded an opportunity to examine changes in RC, RS, and depressive symptoms over time. Despite the concurrent associations between RS and depressive symptoms, after accounting for key demographic variables including age, gender, ethnicity, and religious affiliation, cross-lagged analyses did not indicate a relationship between RS and depressive symptomatology at admission or discharge. The absence of this link is somewhat surprising given that participants endorsed RS on Exline et al.'s (2000) quantitative measure as well as in response to the coping with illness question. Clearly, although RS was relevant for this population, reductions in RS were not significantly associated with decreases in depression. In fact, because the majority of the patients endorsed high levels of RS during the study period, methodologically speaking, the absence of an association between RS and change in depressive symptoms might be attributable to a restricted range of patients who

were not struggling with their religious faith during this time of potentially heightened emotional vulnerability.

In contrast, the finding that RC upon intake was associated inversely with depressive symptoms at discharge likely represents the central finding from this study. Namely, cross-lagged results revealed that patients who were drawing on religious faith for comfort at the time of admission achieved significant reductions in depressive symptomatology. Consistent with Nelson's (2009) buffering hypothesis, RC may have helped to protect against a worsening of depressive symptoms. In other cases, RC might suggest an overall openness to positive emotional experiences in a stressful period. Given that this multifaceted inpatient treatment approach was provided in a milieu setting in the absence of experimental controls, we cannot identify what specific factors, such as treatment interventions, group process-related factors, or individual characteristics may have contributed to this buffering role of RC. Although the mechanisms of this association are not clear, pre-existing spiritual beliefs/behaviors of an adaptive nature may have provided resources for many patients' stabilization and alleviation of depressive symptomatology. These results offer preliminary support for a spiritually integrated approach with patients for whom religiousness plays a prominent role in their identity and meaning system (Saunders, Miller & Bright, 2010). Future studies might clarify the specific contributions of varied treatments on the relationship between RC and depression in inpatient settings. In particular, clinicians might affirm the importance of religiousness and incorporate ways of inviting patients to draw on their RC resources as they engage interventions with patients who are interested in doing so.

Although it has been recognized that religiousness may be a source of comfort (Oxman, Freeman, & Manheimer, 1995), the presence of RS may override these emotional benefits. This

common association acknowledges the potency of RS, but perhaps also underestimates the power of RC. In fact, self-identified religiousness in this predominantly Christian sample was also a strong predictor of RC on admission and discharge. RC may be even more prominent and a resource in this sample, in which Catholic and Protestant Christians comprised 74% of the participants. This sample also included 25% who identified either as spiritual-but-not-religious, or as having no religious affiliation. These participants were also admitted to a Christian-based psychiatric hospital and had the option of participating in more religiously oriented groups as well as chaplain visits (common to most psychiatric units). Thus, patient religious affiliation in this spiritually integrated care setting may have provided a rich context for enhancing RC as a resource in the process of alleviating patients' depression.

At pre-treatment, participants described that RC played a major role in their approach to coping with their illness, but RS was also present for those who experienced RC. Responses to the qualitative questions examining effects of mental illness and coping may illuminate this complexity. On the one hand, in response to whether their illness affected them spiritually, 76% of participants indicated that it affected them spiritually and/or religiously. Most participants described RS as feeling that God had let them down, turned away from them, forgotten about them, or was punishing them. A few referred to RC and noted the illness made them feel closer to God. On the other hand, 65% indicated they drew on their religion and/or spirituality in coping with their mental illness. A few participants identified RS, such as a sense of being punished or that religious factors fueled aspects of their illness. Most responses, however, reflected a degree of RC as participants stated explicitly that God was a source of comfort and strength, as well as a source of help, calm, and hope. Descriptions of both a sense of RC in response to illness effects and RS in how they coped with their illness, indicates that people who experience comfort from

their religion even in the midst of mental illness may also encounter more strain in their efforts to cope with their illness. These results illuminate the concurrent experience of RC and RS in a specific way. In future research, it may be helpful to inquire further about the context in which individuals experience RC and RS.

The spiritual transformation model of Sandage and Shults (2007) offers a lens for understanding these mixed responses in a sample in which RC and RS were prominent, but RC was associated with decreased depression. This model suggest the process of seeking and dwelling in one's spiritual life involves an ebb and flow in which life circumstances and experiences can move individuals back and forth through periods of strain and comfort. The descriptions of strain offered by these psychiatric inpatients at pre-treatment included clear relational expressions of feeling abandoned or forgotten by God. These results may offer one response to Pargament's question: "How helpful or harmful are particular religious (and spiritual) expressions for particular people dealing with particular situations in particular social contexts?" (2002, p. 178).

For some psychiatric inpatients, expressing RS and questioning God related to their illness may not be as harmful as anticipated, if these individuals also can access RC. First, Sandage and Shults's model illustrates that this questioning and challenging is an expected dimension of spiritual growth and change. Their model highlights the importance of challenging seasons in one's spiritual life as part of the process of growth. Second, given the nature of their religiousness, it may be particularly important that RC be obtained to offset this strain. In addition, experiencing divine struggle may have different meanings and salience than other dimensions of religiousness, such as preoccupation with one's own sin and guilt or negative social interactions surrounding religion, such as religious rifts in relationships. These

participants' descriptions focused on negative emotions toward God rather than the other aspects of RS. For many patients, the opportunity to experience increased RC in the midst of RS that was predominantly focused toward God may have played an important role in minimizing the negative and depressive effects of RS. In a related study, we found that these patients' use of negative emotions in describing God decreased over the course of their admission (Currier et al., 2016); this reduction of negative emotion toward God lends support to the current findings.

Limitations

This study advances empirical understanding of the complex role of RC and RS in a sample of predominantly Christian and white inpatients who were admitted on a spiritually integrated psychiatric unit. This homogeneity limits the generalizability of these findings. Eligible patients were recruited for this sample and were not randomized to treatment conditions. Given the multifaceted treatment offered on an inpatient unit, this study was not designed to assess the influence of these components parts. As such, lack of a no-treatment comparison group makes it impossible to identify which treatments or experiences may have contributed to RC for the patients. In addition, participants provided responses to the coping and illness questions only at pre-treatment. It would have been clarifying to see whether participant's qualitative post-treatment responses to these questions would have reflected the corresponding changes on RC and RS. In recent work, Exline and colleagues have developed a more refined Religious and Spiritual Struggles Scale (RSSS) Scale that includes specific subscales related to divine and interpersonal struggle (Exline, Pargament, Grubbs, & Yali, 2014). It would be helpful to examine relations among these different dimensions of religious struggle, RC, and depression in clinical samples.

Conclusion

Despite these limitations, this study replicates and extends the growing scientific literature on the varied role of religiousness and spirituality in coping with mental illness. Drawing on a sample of adults seeking inpatient hospitalization in a spiritually integrated program, findings again point to a concurrent positive association between RS and depression. However, even when accounting for the role of RS and demographic factors, we also found initial levels of RC predicted depressive symptom severity at discharge. Combined with patients' qualitative responses to open-ended questions, these results present a more nuanced picture of RC and RS than previous work. Specifically, findings underscore the utility of understanding the role of religiousness and spirituality not only with respect to coping with mental illness, but also in patients' perspectives on their difficulties and impact of mental health conditions on their belief systems. Adopting such a patient-centered approach to assessing and understanding the interplay between religion, spirituality, and mental illness might allow clinicians to make more room for complex trajectories of religiousness and/or spirituality in their patients' lives.

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Table 1

Demographic and Diagnostic Characteristics of Sample

Age in years [*M* (*SD*)]	41.01 (15.03)
Gender	
Male	43.7%
Female	56.3%
Race	
White or Caucasian	89.4%
African American/Black	4.7%
Hispanic/Latino	2.1%
Multiracial	2.1%
Other Group	1.6%
Marital Status	
Married or domestic partner	32.5%
Divorced or separated	22.5%
Single or never married	36.3%
Spouse deceased	5.0%
Religious Affiliation	
Christian Protestant	59.2%
Roman Catholic	14.6%
Buddhist	1.0%
Other religious group	1.3%
Spiritual but not religious	15.0%
No religious affiliation	10.0%
Level of Education	
Less than high school diploma	10.3%
Earned high school diploma	23.7%
Some college	50.2%
Bachelor's degree or equivalent	11.6%
Graduate school degree	4.1%
Psychiatric Diagnosis	
Unipolar depression	56.0%
Bipolar depression	35.9%
Anxiety disorder	42.6%
Posttraumatic stress disorder	14.5%
Psychotic disorder	3.3%
Alcohol-related disorder	45.5%
Drug-related disorder	53.0%

Polysubstance abuse/dependence	13.7%
Other	22.6%

Note. Sum of percentages of psychiatric diagnoses exceed 100% due to significant comorbidity in the sample. *M* = Mean, *SD* = Standard Deviation.

Table 2

Changes on Study Variables Over Time

	Baseline [*M* (*SD*)]	Discharge [*M* (*SD*)]	Paired-samples *t*
Religious comfort - RC	64.87 (27.32)	73.78 (23.68)	7.49*
Religious strain – RS	61.48 (28.29)	47.80 (24.05)	-9.53*
Depression – PHQ-8	16.59 (6.33)	10.80 (6.22)	12.65*

Note. RCSS = Religious Comfort and Religious Strain Scales, PHQ-8 = Patient Health Questionnaire, *M* = Mean, *SD* = Standard Deviation. *$p < .001$

Table 3

Detailed Results From Autoregressive Cross-lagged Panel Analysis

					95% CI		
	Outcome	Predictor	Estimate	SE	Low	High	p-value
Cross-Lagged Paths	RC (dc)	RS (it)	.038	.050	.136	-.060	.438
		Dep (it)	.012	.043	.096	-.072	.772
	RS (dc)	RC (it)	-.052	.068	.081	-.185	.445
		Dep (it)	.028	.051	.128	-.072	.588
	Dep (dc)	RC (it)	-.189	.081	-.030	-.348	.020
		RS (it)	.021	.073	.164	-.122	.773
Autoregressive Paths	RC (dc)	RC (it)	.741	.043	.825	.657	<.001
	RS (dc)	RS (it)	.620	.060	.738	.502	<.001
	Dep (dc)	Dep (it)	.333	.075	.480	.186	<.001
Correlations	RC (it)	RS (it)	-.423	.052	-.321	-.525	<.001
	RC (it)	Dep (it)	-.322	.058	-.208	-.436	<.001
	RS (it)	Dep (it)	.316	.058	.430	.202	<.001
	RC (dc)	RS (dc)	-.398	.062	-.276	-.520	<.001
	RC (dc)	Dep (dc)	-.200	.076	-.051	-.349	.008
	RS (dc)	Dep (dc)	.317	.062	.439	.195	<.001
Covariates	RC (it)	Age	.134	.063	.257	.011	.033
	RC (dc)		.082	.042	.164	.000	.050
	RS (it)		-.135	.059	-.019	-.251	.023
	RS (dc)		-.047	.048	.047	-.141	.329
	Dep (it)		.090	.066	.219	-.039	.175
	Dep (dc)		.062	.069	.197	-.073	.366
	RC (it)	Gender	.059	.061	.179	-.061	.335
	RC (dc)		.125	.041	.205	.045	.002
	RS (it)		.059	.063	.182	-.064	.350
	RS (dc)		-.062	.052	.040	-.164	.233
	Dep (it)		-.004	.063	.119	-.127	.943
	Dep (dc)		-.019	.062	.103	-.141	.757
	RC (it)	Ethnicity	-.096	.065	.031	-.223	.136

RC (dc)		-.088	.041	-.008	-.168	.035
RS (it)		-.044	.064	.081	-.169	.490
RS (dc)		-.009	.056	.101	-.119	.878
Dep (it)		-.108	.061	.012	-.228	.079
Dep (dc)		.023	.061	.143	-.097	.714
RC (it)	Religion	.214	.065	.341	.087	.001
RC (dc)		.125	.040	.203	.047	.002
RS (it)		.095	.065	.222	-.032	.145
RS (dc)		-.083	.048	.011	-.177	.082
Dep (it)		.040	.064	.165	-.085	.534
Dep (dc)		-.028	.057	.084	-.140	.619

Notes. Path coefficient and correlation estimates are standardized; RC = religious comfort, RS = religious strain, Dep = depression, it = intake, dc = discharge

Table 4

Examples of Illness Affecting Individuals Spiritually or Religiously

Religious Strain
"Because I don't understand why God didn't answer my prayers."
"Because it makes it hard to seek God. Especially when faith is affected by my illness."
"Feel like God has let me down. He isn't with me like I felt He was."
"I began to think that God has forgotten about me."
I've felt mad at God and hurt that He seems so distant and uncaring."
"Reluctance to attend church believing God is punishing me or that I'm not doing enough."
Religious Comfort
"I have drawn even closer to God to help me. I pray more."
"I want to learn more about God and Bible with Religion."
"Accentuating the need to be open to the leading of the Holy Spirit - Much time in the Word of God – Bible"

Table 5

Examples of Spirituality or Religion in Coping with Illness

Religious Comfort
"Again, God is someone who I can always ask for help when I am in a dark place, as well as a symbol for hope."
"Ask God to come in to my life, asking for comfort and forgiveness."
"I have called upon God to comfort me and help keep me going, to calm my fears."
"I rely on God to help me and give me strength and hope."
"Spirituality has helped give a glimmer of hope and reading the scriptures I find stories of how others cope during suffering"
Religious Strain
"I believe I'm being punished."
"I feel religion has fueled my illness."
"I have cried out for His wisdom and intervention in my life... It's as if He has turned His back"
"I ran away ashamed and alone. Not thinking God would forgive me for my actions."

Figure 1. Path diagram of autoregressive cross-lagged panel model. *Notes.* Numbers are standardized regression coefficients; solid paths are significant, dashed paths are non-significant, double-headed arrow paths are bivariate correlations.