2001

Spiritual Coping and Well-Functioning Among Psychologists

Paul W. Case

Mark R. McMinn
George Fox University, mmcminn@georgefox.edu

Spiritual Coping and Well-Functioning Among Psychologists

Paul W. Case and Mark R. McMinn
Wheaton College

The work of psychologists can be stressful and demanding, which calls for an understanding of how psychologists cope with the stress of their work and how they prevent distress by establishing habits of well-functioning. Previous studies on psychologists' well-functioning and coping behaviors have not considered the role of spiritual practices in the life of the professional. 400 psychologists (69% response rate) returned questionnaires rating their levels of distress, coping behaviors, methods of well-functioning, and religious coping. No overall differences were observed in levels of distress between more religious and less religious psychologists. Spiritual practices, especially attending religious services and prayer/meditation, were among the most frequently endorsed for a religious subset of the sample. Spiritual practices also appear to play an important role in the prevention of distress for religious psychologists, in that spiritual practices appear to be the first line of defense against distress and are considered to play a very important role in functioning well as a professional.

During the past two decades mental health professionals have devoted an increasing amount of attention to the personal life of the psychotherapist (Farber, 1985; Guy, 1987; Hellman, Morrison, & Abramowitz, 1987; Laliotis & Grayson, 1985). Specifically, researchers have examined the prevalence and types of psychological distress among psychotherapists (Deutsch, 1985; Elliott & Guy, 1993; Thoreson, Miller, & Krauskopf, 1989), clinician-reported perceptions of the rewards and stresses of psychotherapeutic work (Farber, 1985; Hellman et al., 1987; Kramen-Kahn & Hansen, 1998), coping strategies used by mental health professionals to manage stress (Kramen-Kahn & Hansen, 1998; Mahoney, 1997; Norcross, Prochaska, & DiClemente, 1986), and factors associated with well-functioning among psychotherapists (Coster & Schwebel, 1997; Schwebel & Coster, 1998). The relevance and magnitude of these professional concerns are supported by findings that 60% of surveyed psychologists from APA's Division 29 (Psychotherapy) reported working "when too distressed to be effective," despite the fact that 85% of the respondents believed this was unethical practice (Pope, Tabachnick, & Keith-Spiegel, 1987).

The authors would like to thank Dr. Joan Brody and Dr. Robert Watson for their suggestions regarding this article. Requests for reprints may be sent to Paul W, Case, PsyD, P.O. Box 159, Warm Springs, MT 59756. Electronic mail may be sent to pcase@state.mt.us

Stress, Impairment, and Coping

The stresses associated with psychotherapeutic work are numerous and varied. Using Maslach's (1986) categorization, clinician-reported stress may be divided into personal, interpersonal, and organizational stresses. At the personal level, psychotherapists face stresses such as depression and other mental illness (Deutsch, 1985; Guy, Poelstra, & Stark, 1989; Mahoney, 1997), physical illness, (Guy et al., 1989; Thoreson et al., 1989), financial problems, alcohol or drug abuse, loneliness, exhaustion and fatigue, and a sense of enormous responsibility associated with work (Deutsch, 1985; Guy et al., 1989; Hellman et al., 1987; Kramen-Kahn & Hansen, 1998; Mahoney, 1997; Thoreson et al., 1989).

At the interpersonal level, psychotherapists most frequently report conflicts with either a marital partner or a lover and managing stressful client behaviors (Hellman et al., 1987; Mahoney, 1997). Examples of stressful client behavior include expressions of negative affect, psychopathological symptoms, suicidal threats, and passive-aggressive behaviors. There may be resistance to insight and change on the part of clients, which requires psychotherapists to be patient and flexible in their treatment interventions

(Freudenberger, 1986). Additionally, psychotherapists may experience interpersonal stress from the demands placed upon them by both colleagues and consumers (Hellman et al., 1987; Kilburg, 1986; Kramen-Kahn & Hansen, 1998).

Psychotherapists have also reported experiencing distress due to organizational and work-environment factors. In his study of 314 psychologists, Farber (1985) found that nearly half (48.1%) of those working in either hospitals or clinics reported being frustrated by administrative demands. Likewise, he found that 59.7% of his sample reported stress due to budgeting considerations, and 59.7% reported feeling "disheartened by their working conditions" (p. 13).

Though most studies on the prevalence of distress among psychotherapists have indicated that the majority of professionals are able to effectively manage the stress from their work and personal lives, a small percentage identify themselves as impaired. Impairment has been defined as "a decline in quality of an individual's professional functioning that results in consistently substandard performance" (Coster & Schwebel, 1997, p. 5). Reported rates of impairment among mental health practitioners vary from quite low (Farber, 1985 reported 2-6%) to alarmingly high (Guy et al., 1989, reported that 74.3% of their sample reported experiencing personal distress during the past three years, and 36.7% of these indicated that it impaired their work).

How do psychotherapists cope with the various stresses that they encounter? Mahoney (1997) reported the following most frequently endorsed coping behaviors: engaging in a hobby; pleasure reading; taking pleasure trips or vacations; attending movies, artistic events, or museums; engaging in physical exercise; participating in peer supervision; playing recreational games; and practicing prayer or meditation. The least commonly endorsed coping strategies among his sample included personal therapy, attending church services, receiving massage or chiropractic care, and keeping a personal diary. When the stress reaches a level of impairment, most psychotherapists seek some form of intervention or career change. Guy et al. (1989) found that 70% of distressed psychotherapists attempted to manage the stress through individual therapy (26.6%), reducing client load (17.2%), family therapy (10.7%), temporarily quitting (10%), medication (4.1%), self-help groups (3.4%), hospitalization (2.2%), or other ways of coping (13.2%). Deutsch (1985) reported that approximately 47% of her sample had sought therapy at some point in their lives for relationship problems, and 27% had sought therapy for depression. Similarly, Thoreson et al. (1989) found that 27% of their sample of psychologists sought treatment from a private psychologist for emotional or personal problems; 14% reported seeking help from a private psychiatrist, and 14% reported seeking help from a private physician.

Well-Functioning and Spiritual Practices

The majority of practitioners, while encountering stressors, do not experience impairment as a result. This has led several researchers to explore what characteristics or behaviors appear to be associated with a psychotherapist's ability to be resilient to the variety of stressors that may be encountered (Coster & Schwebel, 1997; Kramen-Kahn & Hansen, 1998; Schwebel & Coster, 1998). Well-functioning has been defined as "the enduring quality in one's professional functioning over time and in the face of professional and personal stressors" (Coster & Schwebel, 1997, p. 5). Coster and Schwebel (1997) reported factors contributing to well-functioning such as peer support, personal values, family relationships, friendship, helpful supervision or personal therapy, a balanced lifestyle, continuing education, vacations and rest, and spirituality. Kramen-Kahn and Hansen (1998) reported the top five career-sustaining behaviors in their sample to be maintaining a sense of humor, perceiving client problems as interesting, feeling renewed from leisure activities, not avoiding case consultation for fear of criticism, and engaging in leisure activities.

To date, research on distress, coping, and well-functioning among psychotherapists has not studied the effect of spiritual practices. Though the field of scientific psychology has sometimes taken an adversarial role towards religion, several recent studies have reported that psychologists appear to value the religious dimension more than once thought (Bergin & Jensen, 1990; Lannert, 1992; e.g., Shafranske & Malony, 1990). A sizable portion of psychologists identify themselves as religious or spiritual (Shafranske, 1996), and there are an increasing number of graduate training programs designed explicitly for integrating religious beliefs and values into the practice of psychology. For some professionals, spiritual practices associated with their religious tradition may be a compelling source of resilience because

religion is embedded in their guiding framework for living (Pargament, 1997).

Religious traditions speak to the alleviation of pain and suffering by providing meaning and significance to the stresses of human experience (Pargament, 1997). Therapists encounter human suffering on an almost hourly basis in their work, and much of what is required to function well within that role is the ability to instill hope within the client and maintain faith in the process of human growth and change (Alterman, 1998). To this end, religious beliefs and practices may promote a therapeutic posture that allows experiences of suffering to be viewed as opportunities for growth through wrestling with issues laden with meaning. Pargament, Smith, Koenig, and Perez (1998) have suggested that the patterns of coping that flow from a religious orientation may be positive or negative. The positive pattern appears to include coping methods such as seeking spiritual support, religious forgiveness, collaborative religious coping, spiritual connection, religious purification, and benevolent religious appraisal. From initial studies, these authors have shown that a positive pattern of religious coping appears to be related to benevolent outcomes from stress, fewer symptoms of psychological distress, and reports of psychological and spiritual growth. In contrast, the negative pattern of religious coping appears to include coping methods such as spiritual discontent, punishing God reappraisals, interpersonal religious discontent, demonic reappraisal, and reappraisal of God's powers. The negative pattern of religious coping has been associated with emotional distress, depression, poorer quality of life, and callousness towards others.

The present study was designed to compare the self-reports of religiously oriented psychologists with those of non-religious psychologists on three dimensions of well-functioning: rates of distress, coping behaviors utilized in response to stress, and practices associated with well-functioning.

METHOD

Participants

Questionnaire packets were mailed to 600 psychologists randomly selected from APA membership with the following qualifiers: 300 were psychologists who had indicated an interest in psychotherapy, and 300 were psychologists who had indicated an interest in religious issues. The sample was divided equally by gender. Of the 600 questionnaires sent, 9 were undeliverable and 13 were returned incomplete because of retirement of the respondent. Of the 578 who could have responded, 400 returned completed questionnaires, resulting in a return rate of 69%. Of the 400 respondents, 202 (51%) were males and 198 (49%) were females. Respondents ranged in age from 30 to 79, with an average age of 52. Three hundred and seventy-nine (95%) of the respondents were White, 4 (1%) were African-American, 3 (.8%) were Asian-American, 3 (.8%) were Hispanic, 1 (.3%) was Native American, and 8 (2.1%) were biracial. Seventy-five percent were married, 12% were single, 9% were divorced, 2% were widowed, and .5% were separated. The majority of respondents were Ph.D. psychologists (88%), while 8% held a Psy.D. and 4% an Ed.D. degree. Sixty-three percent were employed in independent practice, 13% in hospitals, 10% in university settings, 4% in community mental health centers, and 10% in other settings such as prisons, corporate settings, and churches. The average number of years in practice since licensure was 16, and the average number of hours per week in direct service was 26.

Measure

The Psychologist Professional Functioning Questionnaire is an 88-item self-report inventory developed for the purposes of this study. It contains five sections: demographics, well-functioning, distress, coping behaviors, and religious coping style. The demographics section asks for the participant's gender, age, ethnicity, marital status, highest degree earned, years in practice as licensed psychologist, primary employment setting, and average number of hours per week in direct service.

The well-functioning section contains 25 items, a number of which were taken from Coster and Schwebel's (1997) Well-Functioning Questionnaire. Several items were revised and additional items were added which are specific to the purposes of this study. This section asks participants to indicate the extent to which each of the following items has contributed to their ability to function well in the field. A 5-point Likert scale is used with the following anchors: 0 = none, 2 = somewhat, 4 = greatly.

The distress section lists 22 common stressors identified in the literature and asks participants to rate the extent to which they have experienced distress during the previous three years due to each

stressor. The same 5-point Likert scale is used. An additional item asks the extent to which episodes of distress during the past three years have ever negatively impacted therapeutic effectiveness.

The coping behaviors section asks participants to rate the extent to which they use various coping behaviors and the extent to which they find these behaviors effective in reducing distress (again, using the 5-point Likert scale described above). The 17 items in this section were derived from other similar questionnaires (Mahoney, 1997; Norcross & Prochaska, 1986; Thoreson et al., 1989) with several items being added to fit the purposes of this study.

Participants were also asked to complete the 14-item Brief RCOPE (Pargament et al., 1998). The Brief RCOPE items provide a 4-point Likert scale for various religious coping behaviors, ranging from 0 "none" to 3 "a great deal." This inventory differentiates between positive and negative religious coping patterns. Preliminary reliability data available on this instrument indicate internal consistency estimates of .90 and .81 for the positive and negative scales, respectively (Pargament et al., 1998).

Results

Tables 1 through 4 contain descriptive data for items from the Psychologist Professional Functioning Questionnaire. Response percentages are presented for items measuring well-functioning, distress and impairment, coping, and religious coping.

We divided the sample into two groups, based on the extent to which involvement in a church or synagogue had contributed to their ability to function well. Those choosing a 0, 1, or 2 (n = 216, 54%) were designated "less religious" (L-REL) and those choosing 3 or 4 (n = 198, 46%) were designated "more religious" (M-REL). Because this well-functioning item was used to divide respondents into L-REL and M-REL groups, it was not used as a dependent variable in any of the analyses described below. For purposes of group comparisons, a conservative alpha level of .001 was chosen to reduce the possibility of Type I error due to multiple hypothesis tests. When group differences were observed, an alpha of .05 was used for post-hoc analyses.

Using the L-REL and M-REL grouping as an independent variable, and respondent gender as a second independent variable, a 2 x 2 multivariate analysis of variance (MANOVA) was computed with responses on distress items serving as the dependent variables. The decision to include gender as a second independent variable was consistent with previous studies that have explored potential differences in self-reported distress related to gender (Mahoney, 1997; Thoreson et al., 1989). Results revealed no main effect for gender, no interaction effects, and a significant main effect for the L-REL and M-REL groups, Wilks = .87, F (22, 374) = 2.5, p < .001. Post-hoc analyses of variance revealed that the groups revealed significant differences on several items from this scale: "spiritual/religious problem," F (1, 395) = 12.4, p < .001; "financial problems," F (1, 395) = 9.6, p < .002; "occupational problems," F (1, 395) = 4.7, p < .03; "marital separation or divorce," F (1, 395) = 6.2, p < .01; and "alcohol and/or drug use," F (1, 395) = 3.7, p < .06. The M-REL reported experiencing more distress than the L-REL during the past three years related to spiritual/religious problems, financial problems, and occupational problems. The L-REL group reported more distress due to marital separation or divorce and alcohol and/or drug use. These results are summarized in Table 5. When a global distress score was computed by summing the responses on each of the items in the distress section, and a one-way analysis of variance (ANOVA) computed, no significant difference between the L-REL and M-REL groups was observed, F (2, 397) = 1.5, p = .22. A separate one-way ANOVA was computed to test whether there was a difference between the L-REL and M-REL group on the single-item measure of impairment. No significant difference was observed, F (1, 355) = 2.0, p = .16.

To test whether L-REL and M-REL psychologists differ in coping behaviors and practices associated with well-functioning, two additional MANOVAs were computed. First, in comparing the two groups on the use of 17 coping behaviors, a 2 x 2 MANOVA which again included gender as a second independent variable revealed significant differences between the L-REL and M-REL groups, Wilks = .41, F (17, 376) = 32.3, p <.001, and between male and female respondents, Wilks = .82, F (17, 376) = 4.9, p <.001. No significant interaction effect was revealed. Post-hoc ANOVAs indicated significant differences between the L-REL and M-REL groups on the following items: "sought help from clergy," F (1, 392) = 108.1, p <.001; "attended religious services," F (1, 392) = 435.9, p <.001; "meditation or prayer," F (1, 392) = 229.0, p <.001; "confession," F (1, 392) = 64.3, p <.001; and "consulted physician," F (1, 392) = 10.3,

Table 1
Response Percentages for Items Measuring Well-Functioning

	Extent Contributing to Ability to Function Well				
Well-Functioning Item	0	1	2	3	4
Self awareness/self-monitoring	0.5	0.8	5.5	24.5	68.5
Balancing personal/professional lives	2.0	2.0	11.5	29.0	55.3
Personal therapy	228	13.8	16.3	17.0	30.3
Pleasure trips/vacations	4.5	11.0	24.8	33.0	26.8
Having a mentor	21.0	18.5	23.3	21.8	15.5
Informal peer support	5.5	10.3	24.0	39.8	20.5
Peer supervision	24.3	19.3	29.3	19.8	7.5
Financial stability	4.0	6.8	25.0	38.8	25.5
Relaxation program	29.0	16.0	26.0	19.3	9.8
Diversity of professional roles	9.0	11.5	18.3	34.3	27.0
Involvement in a church/synagogue	30.3	12.3	11.5	17.3	28.8
Meditation or prayer	23.8	10.8	16.0	16.8	32.8
Involvement in professional organizations	15.5	28.5	28.8	19.3	8.0
Personal values	0.8	0.5	5.0	22.3	71.3
Relationship with spouse/partner/family	5.0	3.5	10.5	27.0	54.0
Relationship with friends	1.8	4.0	19.3	43.8	31.3
Professional identity	3.5	5.5	20.0	40.3	30.8
Guidance from clergy	55.5	18.8	14.3	7.8	3.8
Paid supervision	58.3	14.0	10.3	8.8	8.8
Physical exercise	9.5	12.3	25.3	29.0	24.0
Confession	0.8	11.3	7.8	6.8	3.5
Continuing education	5.8	13.8	30.5	34.8	15.
Steady referral source	14.5	13.8	19.5	32.8	19.5
Relationship with family of origin	17.8	20.8	25.3	21.5	14.8
Graduate courses	21.0	15.3	30.8	23.5	9.5

Notes: Rating Scale: 0 = none, 2 = somewhat, 4 = greatly.
Some response percentages sum to less than 100% because of missing data.

p <.001. On each of these items, M-REL group reported greater use of these coping behaviors in times of distress (see Table 5). Post-hoc analyses of variance indicated significant differences between male and female respondents on the following items: "socializing with friends," F (1, 392) = 16.9, p <.001; "massage/chiropractic care," F (1, 392) = 16.4, p <.001; and "recreational games," F (1, 392) = 12.2, p <.001. Females reported greater use than males of socializing with friends and massage/chiropractic care, while males reported greater use of recreational games than females.

In the second comparison between the groups on the 24 items of the well-functioning section (1 item was omitted that was used to divide respondents into groups), a 2 x 2 MANOVA revealed significant effects for the religiousness variable, Wilks = .48, F (24, 371) = 17.1, p <.001, and gender, Wilks = .82, F (24, 371) = 3.4, p <.001. No interaction effects were observed. Post-hoc analyses of variance indicated differences between the L-REL and M-REL groups on the following items: "relaxation program," F (1, 394) = 14.1, p <.001; "diversity of professional roles," F (1, 394) = 16.8, p <.001; "meditation or prayer," F (1, 394) = 265.8, p <.001; "guidance from clergy," F (1, 394) = 195.1, p <.001; "confession," F (1, 394) = 97.1, p <.001; and "relationship with family of origin," F (1, 394) = 11.4, p <.001. On each of these items, the M-REL group indicated a greater contribution to their ability to function well

Table 2

Response Percentages for Items Measuring Distress and Extent to Which Distress Impacted Therapeutic Effectiveness

	Extent of Distress during Past Three Years				
Distress Item	0	1	2	3	4
Death of family member or friend	46.8	10.0	15.0	16.3	12.0
Marital separation or divorce	89.5	2.3	1.5	1.8	5.0
Difficulties with sleep	36.3	28.0	23.0	8.8	4.0
Doubts about therapeutic effectiveness	26.5	39.0	24.3	9.8	0.5
Financial problems	46.0	24.5	16.3	8.8	4.5
Personal illness/health problems	43.3	20.5	18.8	12.8	4.8
Episodes of depression	46.8	29.5	16.3	5.5	2.0
Occupational problems	41.3	25.0	20.0	8.8	5.0
Problems in intimate relationships	47.8	24.3	15.3	7.3	5.5
Spiritual/religious problem	73.3	16.3	8.5	1.5	0.5
Chronic fatigue	57.3	20.0	15.3	4.3	2.5
Episodes of anxiety	47.5	34.0	12.5	4.3	1.0
Disillusionment with work	26.0	33.5	20.5	14.0	5.3
Caseload uncertainties	32.3	28.5	24.0	9.8	4.8
Alcohol and/or drug use	91.8	5.5	1.5	0.3	0.3
Concerns about growing older	33.3	30.0	24.8	10.5	0.8
Emotional depletion	28.0	32.3	21.3	14.5	3.3
Suicidal ideation	92.0	6.0	1.0	0.3	0.0
Feelings of loneliness or isolation	49.5	24.8	16.3	6.8	2.0
Moving/relocation	79.0	5.0	7.0	4.5	3.8
Legal problems	87.3	7.3	2.0	2.0	0.8
Changing health care environment	22.0	14.8	19.5	24.8	18.3
Extent to which distress negatively impacted therapeutic effectiveness	15.8	43.5	24.3	4.5	1.3

Notes: Rating Scale: 0 = none, 2 = somewhat, 4 = greatly.

Some response percentages sum to less than 100% because of missing data.

in the field (see Table 5). Post-hoc analyses of variance indicated differences between male and female respondents on the following items: "personal therapy," $F(1, 394) = 11.2$, $p < .001$; "pleasure trips/vacations," $F(1, 394) = 16.2$, $p < .001$; and "relationship with friends," $F(1, 394) = 18.4$, $p < .001$, with females endorsing each of these more than males.

The items on the Brief RCOPE which measured positive religious coping were summed to produce a positive religious coping score. Likewise, those items measuring negative religious coping styles were summed to produce a negative religious coping score. The sum of the items from the distress scale was also computed to produce an overall distress score. The one item rating impairment in therapeutic effectiveness during episodes of distress was used as the impairment score. Pearson product-moment correlations are listed in Table 7. A significant correlation was observed for distress and negative religious coping, as well as for impairment and negative religious coping. Distress was slightly, but significantly, correlated with positive religious coping. Impairment ratings were not significantly correlated positive religious coping style. As would be expected, distress and impairment were correlated, but it was somewhat more surprising to see positive and negative religious coping positively correlated.

When positive religious coping was controlled with partial correlation, the relationship between negative religious coping and distress remained

Table 3

Response Percentages for Items Measuring Coping Behaviors

	Used?					Effective?				
Coping Behavior Item	0	1	2	3	4	0	1	2	3	4
Personal therapy	51.3	6.8	12.5	9.0	19.8	50.3	2.0	8.3	14.5	24.0
Movies/artistic events/museums	17.3	18.3	24.8	26.0	13.0	20.0	13.5	25.3	25.5	15.0
Physical exercise	9.3	11.8	18.8	25.5	34.0	10.8	7.0	15.0	28.3	38.3
Peer supervision	30.3	20.0	22.8	16.3	10.0	0.5	8.0	21.5	24.8	14.5
Sought help from clergy	73.0	10.8	5.8	5.3	4.5	73.5	4.8	6.0	8.0	6.8
Reduced client load	53.8	10.8	16.8	11.8	6.3	54.3	5.0	13.0	15.5	11.3
Attended religious services	35.8	9.0	11.0	13.5	30.0	38.3	9.3	12.8	16.5	22.3
Consulted physician	52.8	14.0	17.8	9.5	5.3	54.8	11.5	17.5	9.3	6.3
Socializing with friends	4.8	9.8	26.3	37.8	20.8	5.8	5.0	22.0	39.0	27.5
Pleasure trips/vacations	6.5	11.5	26.3	32.3	22.8	7.3	7.0	15.5	32.5	37.0
Hobby or reading	3.3	7.0	19.0	34.3	35.8	3.8	6.8	13.5	36.0	39.3
Meditation or prayer	26.5	7.5	14.8	19.5	31.0	26.0	4.5	14.3	18.0	36.3
Recreational games	42.8	21.3	19.5	10.8	5.0	44.5	15.3	18.5	14.0	7.0
Alcohol and/or drugs	76.0	14.8	6.0	1.8	0.8	80.5	10.8	6.3	1.3	0.5
Confession	78.3	9.8	5.5	3.5	2.3	78.8	4.3	5.3	5.3	5.5
Self-help groups	89.5	3.3	3.0	2.5	1.0	88.8	3.5	2.5	2.3	2.0
Massage/chiropractic care	59.0	11.3	13.3	11.0	4.8	58.5	5.8	11.3	14.0	9.5

Note: Used? = Rating on the extent to which respondents have used this coping method to cope with distressing circumstances. Effective? = Extent to which this coping method has been effective in helping the respondent cope. Rating Scale: 0 = none, 2 = somewhat, 4 = greatly. Response percentages sum to less than 100% because of missing data.

about the same (from $r = .43$ to $r = .40$), as did the relationship between negative religious coping and impairment ($r = .21$ in both cases). When negative religious coping was controlled with partial correlation, the relationship between positive religious coping and distress disappeared (from $r = .15$ to $r = .01$), and the relationship between positive religious coping and impairment remained insignificant (from $r = .04$ to $r = -.04$).

Discussion

Distress, Impairment, and Religious Behaviors

Overall, the majority of psychologists in this sample report only minimal distress during the past three years. This is consistent with previous findings that psychologists generally report being a rather healthy group (Mahoney, 1997; Thoreson et al., 1989). Among this sample of practitioners, the most distressing events over the past three years are primarily work-related: specifically, the changing healthcare environment and feelings of disillusionment with work. Further, as indicated by written comments from a number of respondents to this survey, much of the distress surrounding these changes in the field is related to significant reductions in earning potential. Spiritual practices do not appear to impact the reported distress related to these stressors.

Differences were observed between the L-REL and M-REL groups in their responses to specific distress items, but the groups did not differ in the overall severity of experienced distress. The M-REL group reported more distress than the L-REL group related to spiritual or religious problems, a finding that is consistent with other empirical studies showing religiousness to be associated with increased guilt and anxiety (Pargament, 1997; Pressman, Lyons, Larson, & Gartner, 1992; Spilka, Hood, & Gorsuch, 1985). However, it should be kept in mind that, as a group, the M-REL psychologists report only minimal distress due to a spiritual or religious problem (mean of 0.5 with a maximum possible score of 4.0). The M-REL reported less distress than the L-REL group related to marital separation or

Table 4

Response Percentages for Brief RCOPE items

Brief RCOPE Item	Endorsement of Religious Coping Behavior 0	1	2	3
Looked for a stronger connection with God	27.8	12.3	16.3	41.8
Sought God's love and care	33.0	10.5	17.0	37.5
Wondered what I did for God to punish me	85.0	8.0	3.8	1.3
Tried to put my plans into action together with God	40.3	12.8	17.0	28.0
Questioned God's love for me	84.0	9.3	3.3	1.5
Tried to see how God might be trying to strengthen me in this situation	40.0	14.3	22.0	21.8
Wondered whether God had abandoned me	82.5	10.3	3.0	2.3
Sought help from God in letting go of my anger	42.0	19.3	17.3	19.5
Asked forgiveness for my sins	41.5	16.0	15.3	25.3
Focused on religion to stop worrying about my problems	56.0	12.0	15.8	14.3
Felt punished by God for my lack of devotion	89.8	6.3	2.0	0.0
Decided the devil made this happen	90.3	5.0	2.0	0.8
Wondered whether my church had abandoned me	89.3	5.3	1.8	1.8
Questioned the power of God	84.0	9.3	3.3	1.5

Notes: Brief RCOPE items use scale with the following anchors: 0 = none, 3 = a great deal.
Response percentages sum to less than 100% because of missing data.

Table 5

Mean Scores and Effect Sizes for Group Differences on Distress, Coping Behavior, and Well-Functioning Items

	More Religious			Less Religious			Cohen's
	M	*SD*	*n*	*M*	*SD*	*n*	*d*
Distress Items							
Spiritual/religious problems	0.5	0.8	184	0.3	0.7	216	0.4
Financial problems	1.2	1.3	184	0.9	1.1	216	0.3
Occupational problems	1.3	1.3	184	1.0	1.1	216	0.2
Marital separation or divorce	0.2	0.8	184	0.4	1.1	216	0.3
Alcohol and/or drug use	0.0	0.3	182	0.1	0.5	215	0.2
Coping Behavior Items							
Sought help from clergy	1.1	1.4	182	0.0	0.4	215	1.0
Attended religious services	3.3	1.1	182	0.8	1.2	215	2.1
Meditation or prayer	3.3	1.0	182	1.3	1.5	215	1.5
Confession	0.8	1.2	182	0.0	0.4	215	0.8
Consulted physician	1.2	1.3	182	0.8	1.2	215	0.3
Well-Functioning Items							
Relaxation program	1.9	1.3	184	1.4	1.3	216	0.4
Diversity of professional roles	2.9	1.1	184	2.4	1.3	216	0.4
Meditation or prayer	3.3	1.0	184	1.3	1.4	216	1.6
Guidance from clergy	1.6	1.3	184	0.3	0.6	216	1.4
Confession	1.1	1.4	184	0.2	0.5	216	1.0
Relationship with family of origin	2.2	1.3	184	1.8	1.3	216	0.3

Note: Items used a Likert scale with 0 = "none," 2 = "somewhat," and 4 = "a great deal."

divorce, and substance use. This may reflect core behavioral values within many religious traditions. Involvement with a church or synagogue may provide greater exposure to teachings against divorce or inappropriate substance use that make these behaviors less likely options. Again, it should be kept in mind that, among this sample of psychologists, reported distress related to marital separation or divorce or substance use is quite minimal.

The other two item differences, financial problems and occupational problems, are more difficult to interpret based on religious orientation. Both the M-REL and L-REL groups reported very minimal distress related to these problems, but a significant difference was found between the groups. One possible explanation may be that some of the M-REL psychologists experience value conflicts in their practice of psychology or may feel less accepted within certain professional settings because of their religious orientation. Perhaps, there are fewer career positions available within organizations that value a religious approach to mental health. Certainly, more research is needed in order to understand these differences.

Another important finding relates to impairment of therapeutic effectiveness. From this sample of 400 psychologists, just over 1 percent reported their therapeutic effectiveness being impaired a great deal during the past three years, and 33% reported being impaired at least somewhat. No differences were noted based on religious grouping. Similar to our findings, Guy et al. (1989) reported that 36.7% of their sample acknowledged that distress had impacted their provision of psychotherapy services. Given the magnitude of impairment acknowledged in two independent studies separated by over a decade, continued attention to the issue of impaired psychologists seems warranted.

Spiritual Practices and Coping

Table 6 summarizes the top-ranked coping behaviors used among the M-REL and L-REL groups. Not surprisingly, religious psychologists tend to use spiritually-oriented means of coping, but it is striking to note spiritual practices are among the most important coping methods for religious psychologists. The two highest-ranked coping behaviors used by M-REL psychologists are "prayer or meditation" and "attended religious services." As Pargament (1997) has suggested, church members may find that they have important resources for coping available to them such as a sense of belonging and connection with a community of believers where they may find support for dealing with the vicissitudes of life. With the exception of the top two religious coping behaviors for the M-REL group, the ranked means for the two groups are almost identical.

As would be expected, M-REL and L-REL groups also differed significantly in their endorsement of seeking help from clergy and confession. These two coping behaviors are used rather infrequently, even among the M-REL group. Perhaps this lack of use reflects reluctance toward the help-seeking role among psychologists. Psychologists may experience dissonance in seeking help from clergy because their advanced training and years of reflection upon human behavior may lead them to have different explanations of various human behaviors than some clergy may hold, and psychologists may have different epistemologies for seeking answers to problems. The infrequent use of these forms of religious coping might also indicate a preference for a more autonomous and private religious experience rather than one characterized by submission to a public authority figure such as a pastor, priest, or rabbi.

Spiritual Practices and Well-Functioning

Spiritual practices also appear to account for differences in practices associated with functioning well as a professional psychologist. Significant differences were observed on each of the items that were spiritual in nature, with the M-REL group indicating a greater contribution of these items in their ability to function well. Meditation or prayer appears to contribute a great deal to the M-REL psychologists' sense of well-functioning, while guidance from clergy and confession appear to contribute only minimally. The top-ranked mean scores for both groups are nearly identical (see Table 6) with the exception of prayer or meditation being ranked highly by the M-REL group. M-REL psychologists also reported that a diversity of professional roles, relationship with family of origin, and relaxation programs contributed more extensively to their ability to function well than did L-REL psychologists, though the effect sizes of these differences were modest.

Gender, Coping, and Well-Functioning

Although there were some differences between males and females on coping and well-functioning items, no significant interaction effects with religious

Table 6
Ranked Mean Scores on the Most Frequently Endorsed Coping Behavior Items and Well-Functioning Items

More Religious			Less Religious		
Coping Behavior Items	*M*	*SD*	Coping Behavior Items	*M*	*SD*
1. Meditation or prayer	3.3	1.0	1. Hobby or pleasure reading	2.8	1.1
2. Attended religious services	3.3	1.2	2. Physical exercise	2.6	1.3
3. Hobby or pleasure reading	3.1	1.0	3. Pleasure trips/vacations	2.5	1.1
4. Socializing w/ friends	2.7	1.1	4. Socializing w/ friends	2.5	1.1
5. Physical exercise	2.7	1.3	5. Movies/art/museums	2.1	1.3
6. Pleasure trips/vacations	2.6	1.2	6. Peer supervision	1.6	1.3
7. Movies/art/museums	1.9	1.3	7. Personal therapy	1.6	1.7
Well-Functioning Items	*M*	*SD*	Well-Functioning Items	*M*	*SD*
1. Personal values	3.7	0.6	1. Self-awareness	3.6	0.7
2. Self-awareness	3.6	0.7	2. Personal values	3.6	0.7
3. Balancing personal/professional	3.4	0.8	3. Balancing personal/professional	3.3	1.0
4. Relationship w/spouse/ partner/family	3.3	1.1	4. Relationship w/spouse/ partner/family	3.1	1.1
5. Meditation or prayer	3.3	1.0	5. Professional identity	2.9	1.0
6. Relationship w/friends	3.1	0.9	6. Relationship w/friends	2.9	1.0
7. Professional identity	2.9	1.1	7. Financial stability	2.7	1.1
8. Diversity of professional roles	2.9	1.1	8. Pleasure trips/vacations	2.6	1.1
9. Financial stability	2.8	1.0	9. Informal peer support	2.6	1.1
10. Pleasure trips/vacations	2.7	1.1	10. Diversity of professional roles	2.4	1.3

Note: Items used a Likert scale with 0 = "none," 2 = "somewhat," and 4 = "a great deal."

Table 7
Correlations among Negative Religious Coping, Positive Religious Coping, Distress, and Impairment

	Negative RCOPE	Positive RCOPE	Distress	Impairment
Negative RCOPE	1.00 (*n*=390)	0.32* (*n*=390)	0.43* (*n*=390)	0.21* (*n*=351)
Positive RCOPE		1.00 (*n*=392)	0.15* (*n*=392)	0.04 (*n*=353)
Distress			1.00 (*n*=400)	0.50* (*n*=357)
Impairment				1.00 (n=357)

Note: * $p < .01$. RCOPE = Religious Coping.

orientation were noted. Females report socializing with friends as a coping behavior more than males, and females also report using massage or chiropractic care more often than males. Males report using recreational games to cope with distress more extensively than females. Similarly, gender differences were observed on items related to well-functioning, with females ranking personal therapy, pleasure trips/vacations, and relationship with friends as greater contributors to their ability to function well than reported by males.

Religious Coping Style and Impairment

A minimal positive correlation was observed between negative religious coping style and impairment. Similarly, negative religious coping style was moderately correlated with distress. Positive religious coping, however, was not significantly correlated with impairment, nor was it correlated with distress after controlling for negative religious coping scores. While these findings appear to support the conclusion that those reporting a negative religious coping style report greater impairment in therapeutic effectiveness, we urge caution in interpreting these findings. The small amount of variance accounted for with the reported correlation coefficients does not lend to conclusive interpretations about how religious coping style and impairment by distress are related.

Implications

Distress related to the changing healthcare environment and disillusionment with work appears to affect a large number of respondents and, for some, may lead to impairment of therapeutic effectiveness. Trainers need to prepare future professionals for the sometimes-harsh realities of the contemporary healthcare environment. Professionals should be prepared to be thoughtful consumers of research regarding empirically-validated treatment procedures (The Task Force on the Promotion and Dissemination of Psychological Procedures, 1995), as well as advocates for the practice of psychology with insurance companies and managed-care panels. APA and state boards should continue programming that assists psychologists in this time of challenge and change.

Another implication of these findings is the need to consider religious forms of coping in the training of psychologists. In this sample, those psychologists who found religious services an important resource also report that other spiritual forms of coping are important. In particular, meditation or prayer and attending religious services are coping behaviors used most extensively in times of distress. Certainly this could be dismissed as methodological artifact– of course, those who use one form of spiritual coping are inclined to use other forms of spiritual coping also. But the striking aspect of this finding is, for some psychologists, spiritual practices are their first resource for coping with distress. Their faith is at the center of their life and their capacity to cope with the stresses of professional work. Students entering graduate school with devout religious beliefs would do well to integrate those beliefs into their style of coping with professional work–something that will require the help of spiritually informed mentors and professors.

Future research should explore in a qualitative fashion the ways in which spiritual practices promote resilience and well-functioning among religiously-oriented psychologists. This may provide insight into why certain spiritual practices are more extensively used than others. Coster & Schwebel (1997) provide an excellent example of a qualitative design that might prove useful in researching this question. Additionally, research on the extent that training institutions are educating and emphasizing self-care in professional development would be beneficial.

REFERENCES

Alterman, S. R. (1998). *Understanding clinician self-care.* Unpublished doctoral dissertation, The Chicago School of Professional Psychology, Chicago, Illinois.

Bergin, A. E., & Jensen, J. P. (1990). Religiosity of psychotherapists: A national survey. *Psychotherapy, 27,* 3-7.

Coster, J. S. & Schwebel, M. (1997). Well-functioning in professional psychologists. *Professional Psychology: Research and Practice, 28,* 5-13.

Deutsch, C. J. (1985). A survey of therapists' personal problems and treatment. *Professional Psychology: Research and Practice, 16,* 305-315.

Elliott, D. M. & Guy, J. D. (1993). Mental health professionals versus non-mental health professionals: Childhood trauma and adult functioning. *Professional Psychology: Research and Practice, 24,* 83-90.

Farber, B. A. (1985). Clinical psychologists' perceptions of psychotherapeutic work. *The Clinical Psychologist, 38,* 10-13.

Freudenberger, H. J. (1986). Chemical abuse among psychologists: Symptoms, causes, & treatment issues. In R. R. Kilburg, P. E. Nathan, & R. W. Thoreson (Eds.), *Professionals in Distress: Issues, Syndromes, and Solutions in Psychology* (pp. 135- 152). Washington DC: APA.

Guy, J. D. (1987). *The personal life of the psychotherapist.* John Wiley & Sons: New York.

Guy, J. D., Poelstra, P. L., & Stark, M. J. (1989). Personal distress and therapeutic effectiveness: National survey of psychologists practicing psychotherapy. *Professional Psychology: Research and Practice, 20,* 48-50.

Hellman, I. D., Morrison, T. L., & Abramowitz, S. I. (1987). Therapist experience and the stresses of psychotherapeutic work. *Psychotherapy, 24,* 171-177.

Kilburg, R. R. (1986). The distressed professional: The nature of the problem. In R.R. Kilburg, P.E. Nathan, & R.W. Thoreson (Eds.), *Professionals in Distress: Issues, Syndromes, and Solutions in Psychology* (pp. 13 - 26). Washington DC: APA.

Kramen-Kahn, B. & Hansen, N. D. (1998). Rafting the rapids: Occupational hazards, rewards, and coping strategies of psychotherapists. *Professional Psychology: Research and Practice, 29,* 130-134.

Laliotis, D. A. & Grayson, J. H. (1985). Psychologist heal thyself: What is available for the impaired psychologist? *American Psychologist, 40,* 84-96.

Lannert, J. L. (1992). *Spiritual and religious attitudes, beliefs, and practices of clinical training directors and their internship sites.* Unpublished doctoral dissertation. University of Southern California.

Mahoney, M. J. (1997). Psychotherapists' personal problems and self-care patterns. *Professional Psychology: Research and Practice, 28,* 14-16.

Maslach, C. (1986). Stress, burnout, and workaholism. In R. R. Kilburg, P. E. Nathan, & R. W. Thoreson (Eds.), *Professionals in distress: Issues, syndromes, and solutions in psychology* (pp. 53 - 75). Washington DC: APA.

Norcross, J. C., Prochaska, J. O., & DiClemente, C. C. (1986). Self-change of psychological distress: Laypersons' vs. psychologists' coping strategies. *Journal of Clinical Psychology, 42,* 834-840.

Pargament, K. I. (1997). *The psychology of religion and coping: Theory, research, practice.* New York: The Guilford Press.

Pargament, K. I., Smith, B. W., Koenig, H. G., & Perez, L. (1998). Patterns of positive and negative religious coping with major life stressors. *Journal for the Scientific Study of Religion, 37,* 710-724.

Pope, K. S., Tabachnick, B. G., & Keith-Speigel, P. (1987). Ethics of practice: The beliefs and behaviors of psychologists as therapists. *American Psychologist, 42,* 993-1006.

Pressman, P., Lyons, J. S., Larson, D. B., & Gartner, J. (1992). Religion, anxiety, and the fear of death. In J. F. Schumaker (Ed.), *Religion and mental health* (pp. 98-109). New York: Oxford University Press.

Schwebel, M. & Coster, J. (1998). Well-functioning in professional psychologists: As program heads see it. *Professional Psychology: Research and Practice, 29,* 284-292.

Shafranske, E. P. (1996). Religious beliefs, affiliations, and practices of clinical psychologists. In E. P. Shafranske (Ed.), *Religion and the Clinical Practice of Psychology* (pp. 149-162). Washington, DC: American Psychological Association.

Shafranske, E. P. & Malony, H. N. (1990). Clinical psychologists' religious and spiritual orientations and their practice of psychotherapy. *Psychotherapy, 27,* 72-78.

Spilka, B., Hood, R. W., Jr., & Gorsuch, R. L. (1985). *The psychology of religion: An empirical approach.* Englewood Cliffs, NJ: Prentice-Hall.

Task Force on Promotion and Dissemination of Psychological Procedures, Division of Clinical Psychology, American Psychological Association (1995). Training in and dissemination of empirically-validated psychological treatments: Report and recommendations. *The Clinical Psychologist, 48,* 3-23.

Thoreson, R. W., Miller, M., & Krauskopf, C. J. (1989). The distressed psychologist: Prevalence and treatment considerations. *Professional Psychology: Research and Practice, 20,* 153-158.

AUTHORS

CASE, PAUL W. *Address:* P.O. Box 159, Warm Springs, MT 59756. *Title:* Resident in Clinical Psychology at Montana St. Hospital. *Degrees:* MA, Clinical Psychology; PsyD, Clinical Psychology, Wheaton College. *Specializations:* Treating adults with serious and persistent mental illness, couples and marital counseling, and spiritual coping.

McMINN, MARK R. *Address:* Wheaton College Department of Psychology, Wheaton, IL 60187. *Title:* Rech Professor of Psychology. *Degrees:* PhD, Clinical Psychology, Vanderbilt University. *Specializations:* Cognitive therapy, professional ethics, church-psychology collaboration, integration of psychology and Christian spirituality.