Health, Happiness, and Well-Being: Better Living Through Psychological Science

Integrating Religion and Spirituality Into Treatment Research and Practice

Contributors: Emily A. Padgett, Katherine G. Kusner & Kenneth I. Pargament
Edited by: Steven Jay Lynn, William T. O'Donohue & Scott O. Lilienfeld
Book Title: Health, Happiness, and Well-Being: Better Living Through Psychological Science
Chapter Title: "Integrating Religion and Spirituality Into Treatment Research and Practice"
Pub. Date: 2015
Access Date: June 3, 2020
Publishing Company: SAGE Publications, Inc.
City: Thousand Oaks
Print ISBN: 9781452203171
Online ISBN: 9781483385822
DOI: http://dx.doi.org/10.4135/9781483385822.n16
Print pages: 272-295

Integrating Religion and Spirituality Into Treatment Research and Practice

Emily A. PadgettKatherine G. KusnerKenneth I. PargamentBowling Green State University

Although healthcare professionals and social scientists have long kept their distance from the realm of religion and spirituality, the past 50 years has witnessed a surge of research on the role of religion and spirituality in a number of areas of human life, such as health, well-being, relationships, and coping with life stressors (Koenig, King, & Carson, 2012; Pargament, 1997). Overall, the literature indicates that religion and spirituality can significantly relate to mental and physical health, and some research suggests that many people would like their healthcare providers to address spirituality in their journey to achieve better health. Medical patients commonly express a desire that their physicians inquire about religious and spiritual beliefs as well as pray for them during routine visits (MacLean et al., 2003). Similarly, many psychotherapy clients express a desire to discuss such topics in therapy (Rose, Westefeld, & Ansley, 2001) and would like their therapists to pray audibly for them (Weld & Erikson, 2007). Furthermore, multiple studies highlight the utility of integrating spirituality into medical and psychological interventions to improve overall well-being (Hook et al., 2010; Pargament, 2007).

Our goal in this chapter is to describe current efforts to integrate religion and spirituality more effectively into physical and mental healthcare. We begin by considering the meaning of religion and spirituality. We then provide a brief review of research linking religion and spirituality to healthy functioning. This is followed by an overview of what we believe to be exciting efforts to bring religion and spirituality into programs to enhance health and well-being, and we describe one such program in detail. This chapter concludes with research and practice recommendations to foster a spiritually integrated approach in advancing health and well-being.

The Meaning of Religion and Spirituality

The terms *religion* and *spirituality* can evoke countless cognitions, emotions, and reactions. For some, they bring to mind a grandmother praying with her rosary, sharing a sacred moment with a child in the quiet of the woods, or attending synagogue. Others may think of protestors marching to advocate for their prolife sentiments or clergy sexual abuse scandals. When someone dares to broach such topics at family or social gatherings, reactions may be positive or negative, flexible or rigid, angry or apathetic. This is likely due to the concepts of religion and spirituality meaning different things to different people.

Indeed, scholars of the psychology of religion and spirituality have struggled to define these concepts, and the meanings of religion and spirituality have changed in important ways in the past 40 years (Pargament, 2007). William James (1985), considered the founding father of the field, defined religion as “the feelings, acts, and experiences of individual men in their solitude, as far as they apprehend themselves to stand in relation to whatever they may consider the divine” (p. 32). Religion has traditionally been viewed as a broad construct including individual beliefs, thoughts, and feelings and outward behaviors that could be both helpful and harmful, but current trends in society have altered this perspective. Nowadays, however, religion is increasingly viewed as “static, institutional, objective, and belief-based” and essentially, “bad”; conversely, spirituality is seen as “functional, dynamic, personal, subjective, and experience-based” and essentially, “good” (Zinnbauer & Pargament, 2005, p. 24). This trend toward the polarization of religion and spirituality has serious social, intellectual, and academic implications (for discussion see Pargament, 1999; Zinnbauer & Pargament, 2005). It is important to note, though, that most people in the United States (74%) identify as both religious *and* spiritual, suggesting that the general population sees these concepts as broadly overlapping (Zinnbauer et al., 1997).

Though challenging, it is necessary to draw some boundaries around the concepts of spirituality and religion by providing working definitions. We define spirituality as “a search for the sacred” (Pargament, 1999, p. 12) and define religion as “the search for significance that occurs within the context of established institutions that are designed to facilitate spirituality” (Pargament, Mahoney, Exline, Jones, & Shafranske, in press). Embed-

ded in the term *search* is the idea that spirituality is a process or a journey. Spiritual journeys are dynamic and fluid as opposed to fixed and frozen in time; they involve a process of discovering, maintaining, and transforming one's relationship to the sacred. The search begins with the discovery of the sacred through revelation, intuition, or socialization. Once discovered, the search continues as people try to maintain and sustain their relationship with the sacred. However, when personal or environmental changes push individuals beyond their ability to preserve and protect their understanding of the sacred, a transformation may occur. Transformations may involve a temporary or permanent disengagement from the sacred or a change in how the sacred is understood or experienced. Once this transformation unfolds, the individual's search returns to the process of sustaining this now-changed relationship to the sacred, and the journey continues.

Spirituality is set apart from other human processes in that the ultimate destination of the spiritual journey centers on the human need for a connection to something larger than the self—something sacred. The term *sacred* encompasses traditional notions of God, divinity, and higher powers but also other aspects of life that are imbued with divine qualities through an association with, or representation of, the sacred (Pargament & Mahoney, 2005). Through this process of *sanctification*, people can perceive God's direct involvement in their relationships, possessions, or experiences and can also imbue the same aspects of life with sacred qualities such as transcendence, ultimacy, and boundlessness (Pargament & Mahoney, 2005).

The search for the sacred can unfold within or outside of traditional religious contexts. Many begin their spiritual journey by taking age-old paths of established religious institutions and through engagement with organized religious communities. Indeed, religious institutions are designed first and foremost to facilitate the individual's search for the sacred. Many other individuals, however, create new trails, stepping into areas distinct from traditional religious life. For example, some may practice meditation as a spiritual exercise without following Buddhism, or may have dietary restrictions that are similar to some religions, but are followed due to sacred beliefs about the humane treatment of animals or about living a healthy life.

Spirituality is a rich and complex process. People understand the sacred in many different ways. Similarly, they can take many different pathways—composed of diverse beliefs, practices, emotions, and relationships—in their search for the sacred. It follows that spirituality is not necessarily good or bad in and of itself. It is, instead, multivalenced. Some find solace and comfort in their spirituality when faced with the death of a loved one that facilitates peace and healing; others may resent or blame God and in turn experience psychological distress and negative feelings. People can imbue destructive ends (e.g., violence, child abuse) with sacred qualities or take destructive pathways (e.g., drugs, alcohol) in the pursuit of sacred destinations. Whether spirituality is good or not depends on the kind of spirituality we are talking about. In sum, spirituality involves a potentially dynamic, fluid, multidimensional, multivalent, lifelong journey of discovering, conserving, and transforming one's relationship to the sacred. As mentioned previously, most people see themselves as both religious and spiritual; henceforth, we shall refer to both religion and spirituality as R/S to conserve space.

Research on Religion, Spirituality, Health, and Well-Being

The Positive Side

The question of whether R/S is good or not can also include the question of whether R/S is good *for* us or not. In recent years, links between spirituality, religion, health, and well-being have been demonstrated through a large body of empirical research. In their extensive review of this literature, Koenig and colleagues (2012) found that aspects of religion and spirituality related to the following nonexhaustive list: (1) greater well-being, happiness, and life satisfaction; (2) lower rates of depression and suicide; (3) less anxiety; (4) lower use and abuse of alcohol and drugs; (5) lower risk of delinquent behavior and crime; (6) greater marital stability; (7)

more adaptive personality traits (e.g. altruism, optimism); (8) greater senses of self-esteem, optimism, hope, and purpose or meaning in life; (9) lower rates of cardiac difficulties (albeit a weak relationship); (10) lower blood pressure; (11) indicators of a healthy immune system; (12) improved cancer prognosis and prevention of cancer development; (13) greater longevity; (14) enhanced coping with physical disability and chronic pain; and (15) decision making related to better health, such as frequent exercise, eating healthy, and less risky sexual practices.

Although research points to significant ties between R/S and health and well-being, the literature is limited in some key respects. First, much of the research has used a cross-sectional design, limiting the understanding of causality. However, there is an accumulating body of experimental and longitudinal research that does point to benefits of certain forms of R/S. Additionally, much of the published research has depended on global, rudimentary measures of R/S consisting of only a few items, such as frequency of service attendance, frequency of prayer, or religious affiliation. While such measures may seem to be a valid way to capture R/S, such indices do not reveal how and to what level of depth individuals actually use spirituality in their lives. As R/S are complex and multifaceted constructs, researchers must move beyond global measures to identify the specific ways in which R/S play a role in well-being.

In this direction, several promising lines of research have provided an in-depth look into the workings of R/S within the lives of people (Pargament, 2002). Building on the work of Gordon Allport (Allport & Ross, 1967), studies have shown that an intrinsic religiousness, motivated by a desire to “live out” one’s faith, is associated with better mental health outcomes and less prejudice compared with an extrinsic religious orientation, motivated by the desire for personal or social gain (see Donahue, 1985). Additionally, a spirituality that is personally chosen and valued is related to lower levels of anxiety, depression, and social dysfunction and higher levels of self-esteem, whereas a spirituality founded on social pressure, guilt, or fear of social rejection is related to more emotional distress and lower self-esteem (Ryan, Rigby, & King, 1993).

The potential role of R/S in positive well-being can also be understood by examining how people use their spirituality to cope when faced with difficult decisions and traumatic circumstances: R/S appears to be especially valuable in situations that push people to the limits of their resources (Pargament, 2002). Pargament (1997, 2011) identified a variety of positive forms of religious and spiritual coping, including seeking spiritual support from others, accessing God as a loving and caring figure, working collaboratively as a team with God to handle difficulties, reframing one’s situation in a spiritually benevolent light (e.g., God is trying to teach me something through this experience), engaging in forgiveness, and seeking spiritual direction from God or spiritual leaders.

Studies of participants dealing with a range of significant life stressors, including combat veterans, widows, and abused spouses, reveal that a majority found religion to be helpful when coping with their difficulties (Pargament, 1997). Further, meta-analytic results indicate that positive religious coping is significantly tied to more optimism, happiness, quality of life, and self-esteem while adjusting to stress (Ano & Vasconcelles, 2005). Additionally, positive religious coping was predictive of better clinical and functional status in a 3-year study of individuals living with schizophrenia and schizoaffective disorder (Mohr et al., 2010) and predicted more posttraumatic growth 1 year postdivorce among adult divorcees (Krumrei, Mahoney, & Pargament, 2011).

The use of positive religious coping may also be helpful while experiencing health concerns, as it has been found to relate to better psychological well-being for individuals coping with medical difficulties such as breast cancer (Gall, 2000) and arthritis (Abraído-Lanza, Vásquez, & Echeverría, 2004). Furthermore, longitudinal designs indicate that positive religious coping predicts better postoperative functioning after cardiac surgery (Ai, Peterson, Bolling, & Rodgers, 2006); increased 5-year survival rates for those with HIV (Ironson & Kremer, 2009); and increases in mental health, stress-related growth, and cognitive functioning among medically

ill older adults (Pargament, Koenig, Tarakeshwar, & Hahn, 2004).

The tendency to sanctify aspects of life, or to see life through a sacred lens, has also been associated with health and well-being. One important area of well-being for working adults is their employment, and there is evidence that people who view their job as sacred (i.e., a vocation) experience higher job satisfaction, more commitment to their organization, and lower intention of quitting their job (Walker, Jones, Wuensch, Aziz, & Cope, 2008). Similarly, mothers who sanctify their jobs experience less role conflict between their work and parenting roles (Hall, Oates, Anderson, & Willingham, 2012). With respect to physical health, individuals who perceive their bodies as sacred report greater body satisfaction, engagement in more health-protective behaviors, and more disapproval of illicit drug use (Mahoney et al., 2005).

Sanctification also appears to play a role in sex, marriage, and parenting. A sample of married individuals who sanctified sex had greater sexual intimacy, marital satisfaction, and spiritual intimacy (Hernandez, Mahoney, & Pargament, 2011). Perceiving one's marriage as sanctified is related to greater marital satisfaction, more collaborative communication, and less negative communication behaviors (Mahoney et al., 1999), more marital commitment, and more displays of positive emotions and bonding (Ellison, Henderson, Glenn, & Harkrider, 2011). Married parents who sanctify their roles as parents show more consistent parenting, less verbal hostility toward their children (A. Murray-Swank, Mahoney, & Pargament, 2006), and more positive parenting strategies (e.g., praise, induction; Volling, Mahoney, & Rauer, 2009).

The Darker Side

Despite the large body of evidence that R/S can relate positively to well-being, empirical studies also suggest that there is a darker side to R/S. One indicator of possible trouble involves negative religious coping, more specifically the construct of religious and spiritual struggles. Major life crises not only affect individuals psychologically, socially, and physically, but can also potentially interact with peoples' spiritual lives. These events can elicit R/S struggles—tensions and conflicts about spiritual matters (Exline, in press). Pargament, Murray-Swank, Magyar, and Ano (2005) have identified and describe three types of R/S struggles: divine (e.g., feeling angry at, abandoned, or punished by God), intrapersonal (e.g., conflicts between one's higher and lower self or doubting one's beliefs), or interpersonal (e.g., spiritual tensions with family, friends, or one's religious community).

Cross-sectional and longitudinal research has shown a consistent association between measures of R/S struggle and negative psychological adjustment, including depression, paranoia, bodily symptoms, anxiety, substance abuse, serious mental illness, and posttraumatic stress (see Exline, in press). For example, in a study of adolescents diagnosed with depression, loss of faith predicted less improvement in self-reported depression symptoms over 6 months (Dew et al., 2010). Spiritual struggle has also been linked to interpersonal difficulties, including childhood sexual abuse, caregiving, grief, and divorce (Exline, in press). One such example is that viewing one's divorce as a sacred loss or desecration predicted more depressive symptoms and dysfunctional conflict tactics with the ex-partner a year later (Krumrei et al., 2011). R/S struggle also has significant ties to poorer health status of patients dealing with cardiovascular disease, cancer, chronic pain, HIV/AIDS, diabetes, lung disease, and end-of-life issues (Exline, in press). For instance, longitudinal research among medically ill older adults showed that spiritual struggle not only predicted declines in mental and physical health (Pargament, Koenig, Tarakeshwar, & Hahn, 2004), but also predicted mortality (Pargament, Koenig, Tarakeshwar, & Hahn, 2001).

It is interesting to note that, although R/S struggles have been robustly tied to harmful outcomes, a few studies indicate that R/S struggle results in spiritual and posttraumatic growth. For example, researchers have related R/S struggle to stress-related growth in individuals who view their romantic relationships as being a sacred

loss and desecration (Magyar, Pargament, & Mahoney, 2000), and individuals closely impacted by the Oklahoma City bombing experienced both stress-related and spiritual growth (Pargament, Smith, Koenig, & Perez, 1998). Additionally, in the previously mentioned longitudinal study of older adults with medical difficulties, although spiritual struggle predicted declines in physical and mental health, it also related to greater spiritual growth (Pargament, Koenig, Tarakeshwar, & Hahn, 2004). The current findings are consistent with clinical views that struggles can be a source of growth and positive transformation. Similarly, the sacred literatures from all over the world contain powerful stories of religious exemplars who encountered R/S struggles as a vital part of their spiritual journeys (Pargament, 1997). Thus, it appears that R/S struggle is essentially a fork in the road, with one path leading to despair, pain, and psychospiritual decline, and the other path resulting in positive development, growth, and potential transformation (Pargament, 2006).

Theorists and researchers have proposed a number of psychological and social mechanisms that might explain the links between religion, spirituality, health, and well-being, albeit many of them are reductionistic and overly simplified in nature. For example, Freud (1927/1961) saw religion as a way to manage anxiety; others assert that beliefs in God represent a way to achieve a secure relational attachment (Kirkpatrick, 2004). Some propose that spiritual experience is simply a product of brain structures (Persinger, 1983) and neurochemical processes (Griffiths, Richards, McCann, & Jesse, 2006), whereas others see R/S as a form of social cohesiveness and control (Durkheim, 1951) and as a way of binding people together into communities through shared morality (Graham & Haidt, 2010).

Whereas each of these explanations may help to account for the ties between R/S and health, R/S may not be fully reducible to psychological and social mechanisms. Instead, R/S may offer something special to health and well-being. The search for the sacred may rest on a distinctive human yearning and bring distinctive ingredients to the most fundamental challenges of living. Perhaps most importantly, with their focus on the sacred, R/S offer unique ways of helping people come to terms with human limitations, finitude, and frailty (Pargament, in press). That is the distinctive function of R/S, and it is worth researching and understanding in its own right. The remainder of this chapter discusses specific ways to help people integrate the sacred more fully into their lives.

The Roles of Religion and Spirituality in Healthcare

To integrate R/S into healthcare, the provider must be equipped with several key skills. Because spirituality is a highly personal topic, providers must create an atmosphere of safety and acceptance if they are to be invited into the R/S worlds of their clients. Toward this end, providers must demonstrate spiritual self-awareness, sensitivity to and respect of others' spiritual perspectives, and knowledge about R/S. First, it is important to recognize that providers, like their clients, may have a spiritual dimension to their lives that affects their worldview and understanding of health problems; thus, it is vital that they have spiritual self-awareness. Given the power differential inherent in the relationship between providers and clients, providers without self-awareness may inadvertently exert inappropriate influence on their clients (e.g., subtly or overtly manipulate the client with their own spiritual viewpoints). Second, providers should strive to convey openness, tolerance, and sensitivity toward their clients' perspectives. This does not mean having to affirm or hold to clients' beliefs; rather, this means respecting the clients' right to choose their spiritual path and most deeply held values (Pargament, 2007). Third, providers should strive to gain basic fundamental knowledge and understanding of traditional and nontraditional spiritualities and religions, especially those that are popular in or specific to the geographic region in which they practice. Most importantly, providers should know how to assess and address the spiritual dimension of clients' lives.

Spiritual Assessment

Although most clients do not schedule medical or psychological appointments due to overtly R/S problems, R/S in healthcare contexts should still be discussed with clients since their R/S may be woven into their understanding of, and means of coping with, difficulties. Talking with clients about R/S is both a learned skill and a conversational art. The process of understanding a client's R/S begins with an initial assessment. Just as providers assess clients' medical and family history, social and adaptive functioning, cognitions, behaviors, and emotions during initial appointments, providers should conduct an initial assessment of R/S. Often this includes a few basic questions, such as "Do you see yourself as a spiritual or religious person? If so, in what way?" and "Are you affiliated with a religious or spiritual denomination or community? If so, which one?" (Pargament, 2007, p. 211). Following these questions, providers should inquire about the possible role R/S plays in the clients' problems and means of coping. Through this first dialogue, clients' responses will provide a glimpse into the R/S dimension of their lives and open the door for future assessment.

Implicit Spiritual Assessment

Further assessment includes both implicit and explicit conversations about the sacred (Pargament, 2007). Implicit spiritual assessments have two critical components. First, they involve asking questions that allude to a deeper and richer dimension of life that draw on psychospiritual language to elicit spiritual exploration. When queried about where they find peace and solace, what they put their faith and hope in, and their deepest moments of despair, often clients respond with their own spiritual language. The second component in implicit R/S assessments involves the provider's keen awareness of the subtle ways clients may communicate about their R/S. Clients may end up discussing R/S without direction from the provider, spontaneously using spiritual or psychospiritual language (e.g., "This peace came over me," "It was the deepest despair"), describing spiritual emotions (e.g., awe, wonder, profound sorrow), or explaining spiritual-like experiences, beliefs, or practices (e.g., "I felt transformed, made new," "I finally forgave him and let it go"). Perceptive providers may recognize these disclosures as opportunities to help clients identify and elaborate on their R/S. Such implicit spiritual assessments sometimes provide opportunities for clients to explore and express their deeper selves. However, assessment does not end here.

Explicit Spiritual Assessment

In explicit spiritual assessment, the provider broaches R/S topics more directly. There are three goals in this process. First, the provider attempts to identify where clients are in their spiritual journey. Have they recently discovered the sacred? Are they in the midst of an R/S struggle? Or are they on the verge of transforming their understanding of the sacred? Second, the provider seeks to understand the integration and development of the client's R/S. The provider may ask questions to elicit the client's "vision of the sacred; the place of the sacred in the client's strivings; the breadth, depth, and flexibility of the client's pathways; and the fit between the client's pathways with his or her destinations, problem, and social context" (Pargament, 2007, p. 223). However, questions are not the only means to this information, and the provider should remain attentive to the client's nonverbal and emotional reactions to R/S material. Providers may consider implementing R/S assessment measures in their practice, as a promising set of such tools for use in healthcare settings is now emerging (see Aten, O'Grady, & Worthington, 2012, for examples). Finally, the provider should evaluate the quality and effectiveness of the client's R/S for the degree to which his or her spirituality leads to "valuable outcomes" (Pargament, 2007, p. 224). In what ways has the client's R/S changed his or her life for the better? What about for the worse? How has the client's R/S been a source of pleasure? What about pain and struggle? Questions such as these can help orient and guide the clinician's evaluative thinking process. The provider should be attentive to potential constructive and destructive spiritual means or ends in the client's

life.

Integrating Spirituality Into Treatment

Initial and ongoing spiritual assessment that results in a deep and rich understanding of a client's R/S can provide a strong foundation for integrating spirituality into treatments. There are two main ways that spirituality tends to be addressed within the context of healing professions. First, healthcare providers may help clients draw on spiritual resources to cope more effectively with physical or psychological disorders, and second, providers may help clients anticipate, address, and resolve spiritual problems, such as R/S struggles. Promising results have emerged from innovative research-based psychospiritual interventions designed to help clients access and strengthen their spiritual resources and address R/S struggle. Meta-analytic studies and scholarly reviews show that spiritually integrated treatments are as effective as secular treatments and more effective in terms of R/S outcomes (McCullough, 1999; Smith, Bartz, & Richards, 2007); further, many clients prefer spiritually integrated counseling (Stanley et al., 2011). Although spiritually integrated interventions are in early stages of development and research, many of these innovative programs show great potential. We now turn to further discussion about these interventions that span a range of psychological and medical problems (e.g., eating disorders, heroin addiction), treatment modalities (e.g., individual, group, couples), clients (e.g., African American, women), and spiritual resources (e.g., prayer, meditation, spiritual beliefs). We conclude this section with an in-depth overview of one spiritually integrated program designed to help individuals with HIV explore spiritual issues related to their medical condition as well as access spiritual resources to cope with the associated R/S struggles.

Spiritual Renewal

Richards, Hardman, and Berrett (2000) created "Spiritual Renewal: A Journey of Faith and Healing," a manualized 10-session theistic-centered approach to treating females with eating disorders, one of the most challenging medical and psychological disorders, with the goals of spiritual growth and living more harmonious lives. This focused intervention includes sessions on identifying and addressing deep issues such as the spiritual purpose the eating disorder replaces, exploring a guiding life vision, and creating a plan and commitment to realizing clients' vision. Additionally, clients explore and practice psychospiritual concepts and exercises involving understanding their divine worth, creating a balanced life, forgiveness of self and others, gratitude, and spiritual responsibility for the behaviors within their control. A controlled randomized research study provided preliminary evidence that the Spiritual Renewal intervention may be as or more effective in treating eating disorders than a cognitive-based intervention or emotional support group (Richards, Berrett, Hardman, & Eggett, 2006).

Spiritual Self-Schema Therapy

Avants and Margolin (2003), in an effort to help treatment-resistant heroin addicts, created the "Spiritual Self-Schema Therapy" (3S) program. This 8-week group program helps clients understand how their "addict self," the part of them driven by cravings and avoidance, does not represent their authentic self. Instead, it teaches that they have a true, authentic "spiritual self" that can be identified and reinforced as a replacement for the "addict self." To this end, the program uses meditation, prayers, Buddhist teachings, spiritual reframing, and discussions about spiritual beliefs and virtues. In a sample of 29 cocaine- and opiate-dependent treatment-

resistant clients, program completion was related to a significant decrease in illicit drug use and increases in spiritual coping, religious service attendance, and private religious and spiritual experiences (Avants, Beitel, & Margolin, 2005).

Spiritually Integrated Couples Treatment

Research on spiritually integrated treatments has expanded beyond serious mental and physical health issues and has begun addressing the spiritual dimension in interventions focused on family relationships. For example, "Prayer-Focused PREP," a spiritual version of one popular secular marital program, PREP (Prevention and Relationship Enhancement Program), incorporates prayer to help reduce marital distress and improve marital functioning in African American marriages (Beach et al., 2011). In addition to focusing on building communication, problem-solving, and listening skills, praying for one's partner is emphasized throughout the program. Prayer-Focused PREP provides spouses with illustrative prayers and also encourages spouses to create their own prayers focused on selfless love for their partner. A randomized treatment-outcome study found that African American wives, but not husbands, in the Prayer-Focused PREP group experienced more improvements in relationship satisfaction than those in the culturally sensitive version of PREP group or those in the control group that received no training.

Addressing Spiritual Struggles

As mentioned previously, the second significant way that healthcare providers incorporate spirituality into treatment involves helping clients anticipate, address, and resolve R/S struggles. Arising from challenging life events, R/S struggles may represent a fork in the road for people, leading either to growth or to psychological distress (Exline & Rose, 2005; Pargament et al., 2005). A few promising psychospiritual intervention programs have emerged within the past decade to help clients move toward psychological and spiritual growth, rather than distress, when faced with spiritual struggles.

Solace for the Soul.

Nichole Murray-Swank's (2003) "Solace for the Soul: A Journey Toward Wholeness" is an eight-session psychospiritual intervention aimed at helping female sexual abuse survivors address and resolve spiritual struggles. This intervention employs diverse spiritual methods including prayers to enhance spiritual connection, spiritual reframing, meditation and focused breathing, spiritual visualization (e.g., God's love is a waterfall within), two-way journaling to God to express emotions, and spiritual rituals to reduce feelings of shame and self-loathing. Solace for the Soul demonstrated potential as an effective intervention through an N of 1 time-series design with two participants; both women evidenced significant positive changes in their self-reported religious coping, spiritual well-being, and positive images of God (N. Murray-Swank & Pargament, 2005).

Winding Road.

Researchers more recently designed "Winding Road" to address the R/S struggles of college students (Oemig Dworsky et al., in press). This 9-week group intervention is inclusive of a variety of spiritualities; it is not affiliated with a particular religion. Goals of the intervention include helping students accept their spiritual ques-

tions, doubts, and conflicts; identify and explore their spiritual struggles; broaden and deepen their spirituality; and increase their flexibility in addressing their struggles. Using the metaphor of "a winding road," the program views R/S struggles as a natural part of one's spiritual journey that can be openly explored and considered. Sessions include sharing spiritual autobiographies, creating spiritual genograms, discussing one's current and future spiritual self, forgiveness, spiritual acceptance, and meaning making. The sessions implement resources such as meditation, visualization, and ritual exercises. Results from a small open-trial study suggest that the process of addressing R/S struggles is psychologically and spiritually helpful for students (Oemig Dworsky et al., in press).

Case Study: "Lighting the Way"

We now turn to a description of one spiritually focused intervention to exemplify how spiritual struggle can be addressed in the mental and physical health treatment of those facing a difficult medical diagnosis. "Lighting the Way: A Spiritual Journey to Wholeness" is an eight-session group intervention originally inspired by interviews with African American urban women with human immunodeficiency virus (HIV; Pargament, McCarthy, et al., 2004). Both African Americans and women are subgroups of HIV sufferers who tend to use and rely on spirituality in their day-to-day life (Mattis & Grayman-Simpson, in press). We first briefly describe each of the sessions (for more thorough descriptions, please see Pargament, McCarthy, et al., 2004) and then review empirical results from a slightly modified version of the program.

Session 1: Introduction. The program uses the metaphor of a journey to describe the pathway toward healing and wholeness. In this first session, the participants discuss the barriers that have impeded them from reaching the destination of healing physically, emotionally, and spiritually. They also discuss potential spiritual resources they could use to travel the pathway toward wholeness and healing more effectively (e.g., prayer, rituals). Participants are also provided with a short description of each session. This session ends with a prewritten group prayer and candle lighting ceremony, which is used in each of the following sessions.

Session 2: Body and Spirit. Clearly, HIV takes a toll on the body. This session asks participants to draw a picture of how they view their bodies and their souls. They then compare the two to demonstrate that body and soul, while connected, are separate, and HIV leaves the soul intact. Participants also discuss forms of unhealthy coping they have used to try to feed and sustain their soul (e.g., substance abuse, unhealthy relationships) as well as new and healthy ways they can nourish their spiritual selves (e.g., self-care, meditation, intimate relationships).

Session 3: Control and Surrender. It is likely that a diagnosis of HIV may leave patients feeling as if they no longer have control of their own lives. This session helps participants identify which aspects of their life are in and out of their personal control. For example, aspects within one's control could be proper diet, taking medication, and being intentional with one's time, while aspects outside of personal control could be how one's body reacts to treatment or how other people respond to their diagnosis of HIV. This session does not encourage participants to be passive about uncontrollable areas of their life but rather to actively relinquish control in such areas so they can focus their energy on spheres of their life they can actually influence. The session ends with a guided imagery exercise that encourages participants to actively surrender things beyond their control to a higher power.

Session 4: Letting Go of Anger. The diagnosis of an illness such as HIV may lead to anger at God and

questions such as “Why me?” The first goal of the session is to encourage participants to discuss and let go of their anger instead of holding on to it tightly. Second, participants identify whether their anger is directed toward appropriate targets. Third, the session normalizes and validates the anger they may feel toward God as well as affording them a safe space to discuss and experience such feelings. The session ends with an exercise designed to help participants rely on their relationship with a higher power to relinquish their anger.

Session 5: Shame and Guilt. This session focuses on the shame participants may experience regarding the choices they have made in life, which may or may not have played a role in the contraction of HIV, as well as guilt regarding how their diagnosis has impacted others. Facilitators normalize shame and guilt and support participants in sharing how shame and guilt influence their journey toward healing. Participants are encouraged to seek forgiveness from a higher power and to extend forgiveness to themselves. Participants then engage in an exercise in which they write a letter to God about their feelings of shame and guilt and then await the higher power’s response. The session ends with a guided imagery exercise in which participants imagine that they are removing shame and guilt as they approach and step into a healing lake.

Session 6: Isolation and Intimacy. The stigma attached to HIV can lead to feelings of disconnectedness from family, friends, and society. This session normalizes the experience and feeling of isolation, but it also normalizes the basic human need for intimacy and closeness. Participants hear stories of other individuals who have been successful at reaching out and finding intimacy from others, and they identify specific people who can provide spiritual and interpersonal support and intimacy. At the end, participants use string from a ball of yarn to connect to each other, symbolizing the ties they have created with one another.

Session 7: Hopes and Dreams. This session facilitates a discussion about the sacred hopes and dreams participants may feel they have lost due to their diagnosis, such as not being able to pursue certain careers or dying before they get to see their children grow up. Participants discuss the dreams they feel are attainable and unattainable and how they might achieve the sacred hopes and dreams still within their reach so they can experience meaning and purpose in their lives. They hear the story of how one quadriplegic found meaning in her life and are then encouraged to seek out their higher power to find and create their own meaning and purpose.

Session 8: A Review of the Journey. The eighth and final session reviews each of the sessions on the journey toward healing and wholeness. Additionally, group members are provided with a kit containing symbols of their journey. The kit includes items such as a compass symbolizing direction during their journey, a rock reminding them of how anger can become a burden, and a piece of yarn symbolizing the intimate connections they have made with each other and their higher power. The session ends with a poem/prayer about self-growth.

Empirical Support

One of the original developers of Lighting the Way implemented and studied the program at the Department of Epidemiology and Public Health at Yale University. A slightly modified version of the program was used with three separate groups of women (n = 5), heterosexual men (n = 4), and gay men (n = 5) all with HIV-positive diagnoses (Tarakeshwar, Pearce, & Sikemma, 2005). Over the course of the program, participants reported lower levels of depression and negative spiritual coping, higher self-rated religiosity, and use of more forms of positive spiritual coping.

According to qualitative interviews following the program, many participants appreciated the unique nature of Lighting the Way and its distinctive focus on spirituality and HIV. Although many were unsure of what to expect at the outset of the program, participants felt that the program was open to any sort of spirituality. The

participants believed that the program allowed them to reengage with their previously disconnected spiritual selves. More critically, however, participants would have preferred more sessions. While all participants were satisfied with the topics discussed in the program, women desired more focus on self-esteem issues, and men asked for more help in building more specific skills to cope with their daily stressors. Although this program is in the very early stages of establishing its efficacy and needs to be replicated and evaluated through a larger sample size, long-term follow-up, and randomized control, Lighting the Way is a fine example of spiritually integrated treatment, and it appears to be a promising program for HIV-positive adults.

Future Directions

Research

Although research in this domain is still relatively young, it suggests that R/S adds a vital ingredient to our efforts to maintain and enhance health and well-being. However, additional studies are needed to more fully understand for whom, when, and how R/S can be best integrated into healthcare to produce long-standing health benefits. There are three directions for future research that we believe will be particularly useful. First, while there is empirical evidence that there are positive gains from spiritually integrated treatments, much more research is necessary to determine the efficacy of such treatments, such as replication, random assignment, larger sample sizes, and comparison to control groups or secular treatment. Additionally, while we are proponents of the integration of R/S in healthcare, we recognize that there are other potential mediating and moderating factors that may be responsible for positive outcomes, and it is important to identify such factors to understand the true agent of change. Some possible variables to consider may be social support from a spiritual community, importance or salience of R/S in one's life, engagement in treatment, the use of secular coping resources, and quasispiritual constructs (e.g., forgiveness, gratitude, mindfulness) that are often studied in the field of positive psychology.

Second, most R/S research has been conducted in the United States with Christians, so future research should focus on the effects of R/S among diverse groups of people. For example, more knowledge is needed about those who practice nontheistic and Eastern world religions, as well as the effectiveness of spiritually integrated treatments for individuals who identify as spiritual but not religious. Creating, implementing, and testing less traditionally defined programs for such individuals would be helpful. Likewise, understanding whether and how R/S operates for marginalized and minority groups is an important aspect of multicultural sensitivity and may help facilitate the effective incorporation of R/S into healthcare for such populations. For example, research indicates that R/S may be more salient and important to African Americans (e.g., Ferraro & Koch, 1994), Hispanics (e.g., Herrera, Lee, Nanyonjo, Laufman, & Torres-Vigil, 2009), and the elderly (e.g., Neighbors, Jackson, Bowman, & Gurin, 1983). As there is no single formula for integrating R/S into healthcare, research is sorely needed to foster nuanced and effective spiritually integrated programs that meet the needs of such diverse groups.

Third, future studies should continue to expand beyond programs and therapies for the individual to spiritually integrated programs for families, organizations, and communities. Unfortunately, very little treatment-outcome research on the efficacy of integrating spirituality into couples and family therapy has yet to be conducted. However, researchers and practitioners alike have begun to recognize the important role of spirituality in family life. Mahoney (2010) offers a relational spirituality framework that helps put into context the last decade of faith and family research and seeks to stimulate future in-depth research in the area. Treatment that address-

es the spiritual dimension of family problems and draws on spiritual resources may offer a unique, helpful, and welcomed approach to couples and family therapy. This work may also facilitate change for organizations and communities.

Training and Practice

As noted previously, few healthcare professionals receive training and education in how to assess and address the spiritual dimension of healthcare. As a result, they may view spiritual concerns or beliefs as pathological or unhealthy, or feel ill equipped to identify and address the spiritual dimension of problems. Both formal and informal training is essential to provide clinicians with the necessary skills to integrate spirituality into healthcare. Formal training may include (1) a graduate seminar in the psychology of religion and spirituality to provide a deep and rich understanding of classic and contemporary theory and research; (2) a course in comparative religion to supply students with a foundational understanding of diverse world religions; (3) a course in spiritually integrated psychotherapy; (4) formal integration of spiritual topics and issues into graduate courses such as psychopathology, diversity, assessment, and supervision; (5) providing spiritually sensitive supervision; and (6) offering continuing education programming on spiritual topics and issues (Pargament, 2007, p. 334).

The effective integration of R/S into healthcare calls for more than formal coursework and intellectual exercises; one must cultivate an integrated perspective on R/S. This cannot be explicitly taught in the classroom but rather is developed in conjunction with informal personal experiences with R/S. Specifically, we are talking about informal experiences with traditional and nontraditional forms of spirituality that lead to greater spiritual self-awareness, increased appreciation for diverse spiritualities, and a genuine interest in the role of R/S in people's lives. Informal training may include attending different religious services (e.g., a service at a synagogue, mosque, or temple) or participating in different spiritual activities (e.g., yoga, silent retreats, meditation). Informal training may also involve spiritual self-exploration and exercises such as writing a spiritual autobiography, guided by questions that parallel those asked of clients: "What do I hold sacred? How did I discover the sacred? What have I tried to develop and sustain myself spiritually over the years? Where do I currently stand in the search for the sacred?" (for full set of questions see Pargament, 2007, p. 336). Together, these formal and informal training components can help advance the skills needed to integrate spirituality into healthcare treatment.

Conclusion

Spiritual functioning, like physical, psychological, social, and emotional functioning, is an integral part of health and well-being and should be addressed and acknowledged by helping professionals. The scientific study of the interface of R/S with health and well-being has resulted in several well established positive links between the two domains as well as a smaller but noteworthy number of negative associations. Drawing on this body of empirical research, a set of guidelines for integrating spirituality into healthcare assessment and treatment and several spiritually integrated programs to address psychological, medical, and spiritual problems has been developed (Pargament, 2007). Promising results have emerged from studies examining the efficacy of integrating spirituality into treatment in healthcare settings. In future years, we are likely to see additional developments in this important area of research and practice.

References

Abraído-Lanza, A. F., Vásquez, E., & Echeverría, S. E. (2004). En las manos de dios [in god's hands]: Re-

ligious and other forms of coping among Latinos with arthritis. Journal of Consulting & Clinical Psychology, 72(1), 91–102. doi: http://dx.doi.org/10.1037/0022–006X.72.1.91
Ai, A. L., Peterson, C., Bolling, S. F., & Rodgers, W. (2006). Depression, faith-based coping, and short-term postoperative global functioning in adult and older patients undergoing cardiac surgery. Journal of Psychosomatic Research, 60(1), 21–28. doi:http://dx.doi.org/10.1016/j.jpsychores.2005.06.082
Allport, G. W., & Ross, J. M. (1967). Personal religious orientation and prejudice. Journal of Personality and Social Psychology, 5(4), 432–443. doi:http://dx.doi.org/10.1037/0022–3514.5.4.432
Ano, G. G., & Vasconcelles, E. B. (2005). Religious coping and psychological adjustment to stress: A meta-analysis. Journal of Clinical Psychology, 61(4), 461–480. doi:http://dx.doi.org/10.1002/jclp.20049
Aten, J. D., O'Grady, K., & Worthington, E. L. (Eds.). (2012). The psychology of religion and spirituality for clinicians: Using research in your practice. New York, NY: Routledge.
Avants, S. K., Beitel, M., & Margolin, A. (2005). Making the shift from "addict self" to "spiritual self": Results from a stage I study of spiritual self-schema (3-S) therapy for the treatment of addiction and HIV risk behavior. Mental Health, Religion & Culture, 8(3), 167–177. doi:http://dx.doi.org/10.1080/13694670500138924
Avants, S. K., & Margolin, A. (2003). The Spiritual Self-Schema (3-S) Development Program. Retrieved from http://www.3-s.us/3-S_manuals/3S_general.doc.
Beach, S. R. H., Hurt, T. R., Fincham, F. D., Franklin, K. J., McNair, L. M., & Stanley, S. M. (2011). Enhancing marital enrichment through spirituality: Efficacy data for prayer focused relationship enhancement. Psychology of Religion and Spirituality, 3(3), 201–216. doi:http://dx.doi.org/10.1037/a0022207
Dew, R. E., Daniel, S. S., Goldston, D. B., McCall, W. V., Kuchibhatla, M., Schleifer, C., . . . Koenig, H. G. (2010). A prospective study of religion/spirituality and depressive symptoms among adolescent psychiatric patients. Journal of Affective Disorders, 120(1–3), 149–157. doi:http://dx.doi.org/10.1016/j.jad.2009.04.029
Donahue, M. J. (1985). Intrinsic and extrinsic religiousness: The empirical research. Journal for the Scientific Study of Religion, 24(4), 418–423. doi:http://dx.doi.org/10.2307/1385995
Durkheim, E. (1951). Suicide: A study in sociology (J. A. Spaulding & G. Simpson, Trans.). New York, NY: Free Press.
Ellison, C. G., Henderson, A. K., Glenn, N. D., & Harkrider, K. E. (2011). Sanctification, stress, and marital quality. Family Relations, 60(4), 404–420. doi:http://dx.doi.org/10.1111/j.1741–3729.2011.00658.x
Exline, J. (in press). Religious and spiritual struggles. In K. I. Pargament, J. Exline, & J. Jones (Eds.), APA handbook of psychology, religion, and spirituality (Vol. 1). Washington, DC: APA Press.
Exline, J. J., & Rose, E. (2005). Religious and spiritual struggles. In R. F. Paloutzian, & C. L. Park (Eds.), Handbook of the psychology of religion and spirituality (pp. 315–330). New York, NY: Guilford Press.
Ferraro, K. F., & Koch, J. R. (1994). Religion and health among black and white adults: Examining social support and consolation. Journal for the Scientific Study of Religion, 33(4), 362. doi:http://dx.doi.org/10.2307/1386495
Freud, S. (1961). The future of an illusion. New York, NY: Norton. (Original work published 1927)
Gall, T. L. (2000). Integrating religious resources within a general model of stress and coping: Long-term adjustment to breast cancer. Journal of Religion & Health, 39(2), 167. Retrieved from http://www.springer.com/public+health/journal/10943
Graham, J., & Haidt, J. (2010). Beyond beliefs: Religions bind individuals into moral communities. Personality & Social Psychology Review, 14(1), 140–150. doi:http://dx.doi.org/10.1177/1088868309353415
Griffiths, R., Richards, W., McCann, U., & Jesse, R. (2006). Psilocybin can occasion mystical-type experiences having substantial and sustained personal meaning and spiritual significance. Psychopharmacology, 187(3), 268–283. doi:http://dx.doi.org/10.1007/s00213–006–0457–5
Hall, E. M. L., Oates, K. L. M., Anderson, T. L., & Willingham, M. W. (2012). Calling and conflict: The sanctification of work in working mothers. Psychology of Religion and Spirituality, 4(1), 71–83. doi:http://dx.doi.org/10.1037/a0023191
Hernandez, K. M., Mahoney, A., & Pargament, K. I. (2011). Sanctification of sexuality: Implications for newlyweds' marital and sexual quality. Journal of Family Psychology, 25(5), 775–780. doi:http://dx.doi.org/10.1037/a0025103
Herrera, A. P., Lee, J. W., Nanyonjo, R. D., Laufman, L. E., & Torres-Vigil, I. (2009). Religious coping and caregiver well-being in Mexican-American families. Aging & Mental Health, 13(1), 84–91. doi:http://dx.doi.org/10.1080/13607860802154507

Hook, J. N., Worthington, E. L., Jr., Davis, D. E., Gartner, A. L., Jennings, D. J., II., & Hook, J. P. (2010). Empirically supported religious and spiritual therapies. Journal of Clinical Psychology, 66, 46–72.
Ironson, G., & Kremer, H. (2009). Spiritual transformation, psychological well-being, health, and survival in people with HIV. International Journal of Psychiatry in Medicine, 39(3). 263–281. doi:http://dx.doi.org/10.2190/PM.39.3.d
James, W. (1985). The varieties of religious experience (Vol. 13). Cambridge, MA: Harvard University Press.
Kirkpatrick, L. A. (2004). Attachment, evolution, and the psychology of religion. New York, NY: Guilford Press.
Koenig, H. G., King, D. E., & Carson, V. B. (2012). Handbook of religion and health (
2nd
ed.). New York, NY: Oxford University Press.
Krumrei, E. J., Mahoney, A., & Pargament, K. I. (2011). Spiritual stress and coping model of divorce: A longitudinal study. Journal of Family Psychology, 25(6), 973–985. doi:http://dx.doi.org/10.1037/a0025879
MacLean, C. D., Susi, B., Phifer, N., Schultz, L., Bynum, D., Franco, M., . . . Cykert, S. (2003). Patient preference for physician discussion and practice of spirituality. Journal of General Internal Medicine, 18(1), 38–43. doi:http://dx.doi.org/10.1046/j.1525–1497.2003.20403.x
Magyar, G. M., Pargament, K. I., & Mahoney, A. (2000, August). Violating the sacred: A study of desecration among college students. Proceedings of the annual meeting of the American Psychological Association. Washington, DC: American Psychological Association.
Mahoney, A. (2010). Religion in families, 1999–2009: A relational spirituality framework. Journal of Marriage & Family, 72(4), 805–827. doi:http://dx.doi.org/10.1111/j.1741–3737.2010.00732.x
Mahoney, A., Carels, R. A., Pargament, K. I., Waccholtz, A. L., Kaplar, L. E., & Frutchey, R. M. (2005). The sanctification of the body and behavioral health patterns of college students. International Journal for the Psychology of Religion, 15(3), 221–238. doi:http://dx.doi.org/10.1207/s15327582ijpr1503_3
Mahoney, A., Pargament, K. I., Jewell, T., Swank, A. B., Scott, E., Emery, E., & Rye, M. (1999). Marriage and the spiritual realm: The role of proximal and distal religious constructs in marital functioning. Journal of Family Psychology, 13(3), 321–338. doi:http://dx.doi.org/10.1037/0893–3200.13.3.321
Mattis, J. S., & Grayman-Simpson, N. A. (in press). Faith and the sacred in African American life. In K. Pargament, J. Exline, & J. Jones (Eds.), APA handbook of psychology, religion, and spirituality (Vol. 1). Washington, DC: APA Press.
McCullough, M. E. (1999). Research on religion-accommodative counseling: Review and meta-analysis. Journal of Counseling Psychology, 46(1), 92. doi:http://dx.doi.org/10.1037//0022–0167.46.1.92
Mohr, S., Borras, L., Rieben, I., Betrisey, C., Gillieron, C., Brandt, P., . . . Huguelet, P. (2010). Evolution of spirituality and religiousness in chronic schizophrenia or schizo-affective disorders: A 3-year follow-up study. Social Psychiatry & Psychiatric Epidemiology, 45(11), 1095–1103. doi:http://dx.doi.org/10.1007/s00127–009–0151–0
Murray-Swank, A., Mahoney, A., & Pargament, K. I. (2006). Sanctification of parenting: Links to corporal punishment and parental warmth among biblically conservative and liberal mothers. International Journal for the Psychology of Religion, 16, 271–287. doi:http://dx.doi.org/10.1207/s15327582ijpr1604_3
Murray-Swank, N. A. (2003). Solace for the soul: An evaluation of a psycho-spiritual intervention for female survivors of sexual abuse. Unpublished doctoral dissertation, Bowling Green State University, Bowling Green, OH.
Murray-Swank, N., & Pargament, K. I. (2005). God, where are you? Evaluating a spiritually-integrated intervention for sexual abuse. Mental Health, Religion & Culture, 8(3), 191–203. doi:http://dx.doi.org/10.1080/13694670500138866
Neighbors, H. W., Jackson, J. S., Bowman, P. J., & Gurin, G. (1983). Stress, coping, and Black mental health: Preliminary findings from a national study. Journal of Prevention in Human Service, 2(3), 5–29. doi:http://dx.doi.org/10.1300/J293v02n03_02
Oemig Dworsky, C. K., Pargament, K. I., Gibbel, M. R., Krumrei, E. J., Faigin, C. A., Haugen, M. R. G., . . . Warner, H. L. (in press). Winding road: Preliminary support for a spiritually integrated intervention addressing college students' spiritual struggles. Research in the Social Scientific Study of Religion. Psychosomatic Medicine, 57.
Pargament, K. I. (1997). The psychology of religion and coping: Theory, research, practice. New York, NY: Guilford Press.

Pargament, K. I. (1999). The psychology of religion and spirituality? Yes and no. International Journal for the Psychology of Religion, 9(1), 3. doi:http://dx.doi.org/10.1207/s15327582ijpr0901_2
Pargament, K. I. (2002). The bitter and the sweet: An evaluation of the costs and benefits of religiousness. Psychological Inquiry, 13(3), 168–181. doi:http://dx.doi.org/10.1207/S15327965PLI1303_02
Pargament, K. I. (2006). Spiritual struggle. Human Development, 27(3), 5–13.
Pargament, K. I. (2007). Spiritually integrated psychotherapy: Understanding and addressing the sacred. New York, NY: Guilford Press.
Pargament, K. I. (2011). Religion and coping: The current state of knowledge. In S. Folkman (Ed.), The Oxford handbook of stress, health, and coping (pp. 269–288). New York, NY: Oxford University Press.
Pargament, K. I. (in press). Searching for the sacred: Toward a nonreductionistic theory of spirituality. In K. Pargament, A. Mahoney, & E. Shafranske (Eds.), APA handbook of psychology, religion, and spirituality (Vol. 2). Washington, DC: APA Press.
Pargament, K. I., Koenig, H. G., Tarakeshwar, N., & Hahn, J. (2001). Religious struggle as a predictor of mortality among medically ill elderly patients. Archives of Internal Medicine, 161(15), 1881. doi:http://dx.doi.org/10.1001/archinte.161.15.1881
Pargament, K. I., Koenig, H. G., Tarakeshwar, N., & Hahn, J. (2004). Religious coping methods as predictors of psychological, physical and spiritual outcomes among medically ill elderly patients: A two-year longitudinal study. Journal of Health Psychology, 9(6), 713–730. doi:http://dx.doi.org/10.1177/1359105304045366
Pargament, K. I., & Mahoney, A. (2005). Theory: “Sacred matters: Sanctification as a vital topic for the psychology of religion.” International Journal for the Psychology of Religion, 15(3), 179–198. doi:http://dx.doi.org/10.1207/s15327582ijpr1503_1
Pargament, K. I., Mahoney, A., Exline, J., Jones, J., & Shafranske, E. (in press). Envisioning an integrative paradigm for the psychology of religion and spirituality: An introduction to the APA handbook of psychology, religion and spirituality. In K. I. Pargament, J. Exline, & J. Jones (Eds), APA handbook of psychology, religion, and spirituality, (Vol. 1). Washington, DC: APA Press.
Pargament, K. I., McCarthy, S., Shah, P., Ano, G., Tarakeshwar, N., Wachholtz, A., . . . Duggan, J. (2004). Religion and HIV: A review of the literature and clinical implications. Southern Medical Journal, 97(12), 1201–1209. doi:http://dx.doi.org/10.1097/01.SMJ.0000146508.14898.E2
Pargament, K. I., Murray-Swank, N., Magyar, G. M., & Ano, G. G. (2005). Spiritual struggle: A phenomenon of interest to psychology and religion. In W. R. Miller & H. D. Delaney (Eds.), Judeo-christian perspectives on psychology: Human nature, motivation, and change (pp. 245–268). Washington, DC: American Psychological Association. doi:http://dx.doi.org/10.1037/10859–013
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(4), 710–724. doi:http://dx.doi.org/10.2307/1388152
Persinger, M. A. (1983). Religious and mystical experiences as artifacts of temporal lobe function: A general hypothesis. Perceptual and Motor Skills, 57(3f), 1255–1262. doi:http://dx.doi.org/10.2466/pms.1983.57.3f.1255
Richards, P. S., Berrett, M. E., Hardman, R. K., & Eggett, D. L. (2006). Comparative efficacy of spirituality, cognitive, and emotional support groups for treating eating disorder inpatients. Eating Disorders: The Journal of Treatment & Prevention, 14(5), 401–415. doi:http://dx.doi.org/10.1080/10640260600952548
Richards, P. S., Hardman, R. K., & Berrett, M. E. (2000). Spiritual renewal: A journey of healing and growth. Orem, UT: Center for Change.
Rose, E. M., Westefeld, J. S., & Ansley, T. N. (2001). Spiritual issues in counseling: Clients’ beliefs and preferences. Journal of Counseling Psychology, 48(1), 61. doi:http://dx.doi.org/10.1037//0022–0167.48.1.61
Ryan, R. M., Rigby, S., & King, K. (1993). Two types of religious internalization and their relations to religious orientations and mental health. Journal of Personality & Social Psychology, 65(3), 586–596. doi:http://dx.doi.org/10.1037//0022–3514.65.3.586
Smith, T. B., Bartz, J., & Richards, P. S. (2007). Outcomes of religious and spiritual adaptations to psychotherapy: A meta-analytic review. Psychotherapy Research, 17(6), 643–655. doi:http://dx.doi.org/10.1080/10503300701250347
Stanley, M. A., Bush, A. L., Camp, M. E., Jameson, J. P., Phillips, L. L., Barber, C. R., . . . Cully, J. A. (2011). Older adults’ preferences for religion/spirituality in treatment for anxiety and depression. Aging & Men-

tal Health, 15(3), 334–343. doi: http://dx.doi.org/10.1080/13607863.2010.519326
Tarakeshwar, N., Pearce, M. J., & Sikkema, K. J. (2005). Development and implementation of a spiritual coping group intervention for adults living with HIV/AIDS: A pilot study. Mental Health, Religion & Culture, 8(3), 179–190. doi: http://dx.doi.org/10.1080/13694670500138908
Volling, B. L., Mahoney, A., & Rauer, A. J. (2009). Sanctification of parenting, moral socialization, and young children's conscience development. Psychology of Religion and Spirituality, 1, 53–68. doi:http://dx.doi.org/10.1037/a0014958
Walker, A. G., Jones, M. N., Wuensch, K. L., Aziz, S., & Cope, J. G. (2008). Sanctifying work: Effects on satisfaction, commitment, and intent to leave. International Journal for the Psychology of Religion, 18(2), 132–145. doi:http://dx.doi.org/10.1080/10508610701879480
Weld, C., & Eriksen, K. (2007). Christian clients' preferences regarding prayer as a counseling intervention. Journal of Psychology & Theology, 35(4), 328–341. Retrieved from http://journals.biola.edu/jpt/
Zinnbauer, B. J., & Pargament, K. I. (2005). Religiousness and spirituality. In R. F. Paloutzian, & C. L. Park (Eds.), Handbook of the psychology of religion and spirituality (pp. 21–42). New York, NY: Guilford Press.
Zinnbauer, B. J., Pargament, K. I., Cole, B., Rye, M. S., Butter, E. M., Belavich, T. G., . . . Kadar, J. L. (1997). Religion and spirituality: Unfuzzying the fuzzy. Journal for the Scientific Study of Religion, 36(4), 549–564. doi:http://dx.doi.org/10.2307/1387689
http://dx.doi.org/10.4135/9781483385822.n16