Chapter 12
Health Benefits of Spirituality

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Keywords Health · Spirituality · Religiousness

Key Points

- Addressing the role of spirituality in accordance with physical health symptoms and outcomes
- Highlighting potential mental health benefits of integrating spirituality into practice
- Showcasing the current integration of spirituality into communities and potential outcomes on community members
- Examining potential negative effects of the role in spirituality in the lives of individuals
- Providing techniques and challenges to the integration of spirituality into practice

Introduction

Health and religion have a long-standing relationship that can be traced back to a time when one's physician was frequently a clergy member as well [25]. Since that early period where health and religion were intertwined, we have seen a push to distance scientific disciplines from addressing religious experiences. Yet, the religiously affiliated are estimated to account for 84% of the global population, and researchers across disciplines have continued to explore the mechanisms between religion and health outcomes [52]. Evidence from decades of research on this relationship suggests a robust and mostly positive association between religion and health. However, before describing the associations, it is important to note that the majority of research that has been conducted has focused primarily on measuring religiousness, not spirituality [10, 12]. Considerable debate regarding the operationalization of these terms continues to persist [12, 17, 42, 59, 60].

Religion is described as having an affiliation with a denomination that has a structured set of beliefs with activities that are organized and reflect long-established traditions [32]. Religion can also encompass a connection to the transcendent in addition to establishing rules and laws for practitioners

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to follow. Studies frequently assess religiousness by measuring the frequency of engagement in religious activities or rituals (i.e., church attendance, prayer, and reading religious texts). Comparatively, spirituality is described as a broader concept extending beyond religious experiences. It is frequently associated with the search for connection with the sacred or transcendent [32]. Most often, studies measure spirituality by assessing positive psychological and emotional states (meaning, purpose in life, connection, inner peace, etc.), which creates significant overlap between spirituality and mental health indicators [21, 22].

In addition to the difficulties in distinguishing religion from spirituality, there are other common terms used, such as religiosity, faith, the divine, sacred, and more. There is not enough space in this chapter, nor is it the focus, to discuss the differences between the terms. However, the ongoing challenge to reach a consensus on defining and measuring the terms has implications for interpretation of research findings. In clinical settings, it is preferred to appeal to the majority of patients by using a broader term like spirituality [23]. More attention to the importance of word choice in clinical settings will be addressed in the section on integrating religion and spirituality into clinical practice. The field continues to struggle to agree upon delineations of these terms that satisfy both the research and clinical purposes. As this chapter is targeted toward the clinical purpose, we have striven to either match the research evidence's terminology or deferred to using broader terminology as appropriate.

Physical Health

Inherently within the USA, there is a connection between faith and physical health. Faith has proven itself to play an integral role in the medical field overall. Of the healthcare systems in America, there are 654 Catholic hospitals and 1634 Catholic continuing care facilities [4]. Each day, 1 in 6 patients in the USA is cared for in a Catholic hospital [1]. This means in effect that a number of the decisions being made concerning many Americans' day-to-day health are directly influenced by some faith-based structure and guidance. On a more personal level, spirituality and religiosity have been shown to be advantageous in coping with both chronic and terminal illness [31]. During times of health difficulty, many people rely on their faith to help understand their misfortune and to draw strength to weather their condition [36].

Prediabetes and Diabetes

In a sample of 30 African-American men living with type 2 diabetes, it was found that the men frequently engaged in religious behavior to aid with the management of their diabetes [40]. These behaviors included prayer and overall belief in God, turning things over to God, changing unhealthy behaviors, reading the Bible, and gaining support from religious/spiritual individuals. Through prayer, the men often asked God to help them both with managing their diabetes and with aiding them in the change of behaviors that were exacerbating their diabetes. There was also mention made by the men of God giving them diabetes in order to help keep them alive and push them to change their current unhealthy lifestyles [40]. In terms of how healthcare professionals can use this information, it was suggested that clinicians could utilize the role of spirituality in the lives of diabetes patients to help them make sense of their diagnoses. An example of this might be to have a conversation with a

spiritual patient suggesting that God had allowed them to contract their condition to help them re-evaluate their lives and their health, rather than it being a punishment.

Cardiovascular Disease

For those experiencing cardiovascular disease, the role of spirituality has been found to have tangible health benefits. Faith in the lives of those with cardiovascular disease has played a role in advanced autonomic cardiac control, reduced blood pressure, and reduced pain [3, 15, 33]. Spirituality, defined as a closeness to and satisfaction with one's relationship with God, was found to be significantly related to parasympathetic and sympathetic cardiac control in middle- and older-aged adults [3]. Further, being more intrinsically religious was also found to be related to experiencing lower blood pressure levels in response to stressors [33]. In a sample of African-American women, prayer was found to be an adaptive strategy for pain management. One example of such highlighted a woman praying to God to remove the pain associated with a heart condition she was facing [15]. Additionally, spirituality can also be used to divert attention from the effects of chronic illness, including heart disease [15]. As an added health benefit for cardiovascular disease patients, engaging in spiritual self-care has been found to mediate the relationship between heart failure and quality of life in African-American adults [57]. Realistically, this means that those who practice more spiritual self-care have a better quality of life despite also having heart failure. These spiritual self-care techniques included practicing yoga or Tai Chi, attending religious services, reading religious texts (e.g., the Bible), praying, meditation, and/or enjoying/cultivating a relationship with nature [57]. Overall, religiousness is associated with lower risk of cardiovascular disease because it is connected to effective coping skills to deal with stressors and rules for engaging in healthy behaviors [25].

Chronic Kidney Disease

Depression has been found to consistently contribute to the reduction of quality of life in those with chronic kidney disease (CKD) and end-stage renal disease (ESRD) [5, 7]. In the context of a high prevalence and severity of depression on those with CKD, it seems necessary that a coping strategy be present to enable successful continuation of life in spite of illness. One of these beneficial coping strategies is spirituality. Darrell [8] found that in a sample of 12 African-American adults living with ESRD, all of the participants endorsed the role of spirituality within their lives. Spirituality was described as having faith that God cares, including utilizing faith to support coping and using prayer to develop strength [8]. Prayer, specifically, was identified as an avenue for participants to come to terms with their ESRD diagnosis, to seek guidance on decisions regarding their treatment (e.g., the use of dialysis), and to generally cope with their illness.

As a special note, some research has called into question the distinction between religion and spirituality in its relation to health outcomes. It has been proposed that religious measures in their relation to health outcomes might be biased, due largely to the fact that most religious outcome measures are predicated on religious service attendance [58]. For those who are more physically impaired, religious service attendance might not be as feasible, thereby those with the physical ability to attend religious services might inherently be healthier than those who cannot, rather than it being a true measure of religion's role in health [58].

Mental Health Benefits

Psychological Distress

Across the most commonly researched diagnoses related to mental health, the evidence suggests inverse relationships between faith and psychological distress. More than 444 studies have reported findings on the relationship between faith and depression; 61% of those studies found significant inverse relationships. Furthermore, 63% of 30 clinical trials found faith interventions produced better outcomes than treatment as usual or control groups [25]. In addition, a review study found that at least 141 studies have assessed the relationship between suicide and religiousness with 75% of the studies reporting inverse relationships. Of the 40 most methodologically rigorous studies, 80% found more religious individuals associated with fewer attempts and more negative attitudes toward suicide [25].

The relationship between religion and symptoms of anxiety is complex. A general trend indicates faith is associated with lower symptoms of anxiety and highlights how people turn to faith to mitigate their anxiety (i.e., fear of death, sense of not being alone, and more). Simultaneously, religious beliefs have the potential to increase anxiety symptoms due to threat of punishment or judgment for sins. It is possible that the increase in anxiety found in some studies may be due to use of the cross-sectional methodology. The evidence from a limited number of longitudinal studies suggests anxiety from religious beliefs may diminish over time, but additional research is needed to confirm this assertion [25].

Religiousness has also been researched as it relates to symptoms of schizophrenia. Many people diagnosed with schizophrenia report delusions and hallucinations that involve religious figures or beliefs. It can be difficult for clinicians to distinguish clinical symptoms of schizophrenia from deeply held religious beliefs. Moreover, the research findings on the relationship between faith and psychotic symptoms suggest no consistent pattern. Religious coping is common among patients with schizophrenia, but the ongoing challenge is to differentiate healthy religious coping behaviors from psychosis [23]. In clinical practice, it is recommended to consider a patient's faith during treatment planning and consult with practitioners of the same faith to clarify the severity of psychotic symptoms.

Psychological Well-Being

In addition to the effect of religion on clinical diagnoses, evidence connecting religion with positive emotional states has also emerged. Most studies have found positive correlations between religious involvement and positive emotions like well-being, happiness, purpose in life, and self-esteem. Based on a systematic review, researchers found that 93% of the 45 studies included reported a positive correlation between faith and sense of purpose in life [23]. Similarly, a review article reported a positive correlation between faith and well-being in 79% of the 326 articles included in the analysis [25]. These results demonstrate the increase in studies devoted to exploring the effects of faith on positive psychology concepts [2]. However, the majority of this evidence comes from cross-sectional studies; thus, it remains unclear as to whether high religiosity precedes psychological well-being or if greater psychological well-being increases religiosity. More complex and longitudinal study designs are being conducted to continue addressing this area of research.

Underlying Theories

Overall, the research on faith and mental health illustrates how religious and spiritual beliefs indirectly contribute to mental health. Evidence suggests that religious involvement influences multiple factors that contribute to mental health, such as chronic inflammation from stress, coping styles, attachment styles, social support, childhood environment, decision-making, and self-control. Further,

these factors feed off of one another and amplify the effects of religious involvement. There are 3 primary pathways that religious involvement is associated with positive mental health: (1) religious coping provides a sense of meaning to traumatic experiences; (2) most religious belief systems have rules that protect their believers from risky health behaviors; and (3) most religious belief systems propagate feelings of love toward others, which increases our prosocial behaviors [25, 45]. Given the variety of factors involved, a life span approach offers an encompassing framework to identify the pathways that connects faith and mental health.

Religion and Spirituality in Communities

Health Promotion

Faith communities often act as contexts where spiritual support can give way to the provision of health services through the spread of health information and health promotion [37]. People are often more likely to seek, comprehend, and implement health information when it is framed in accordance with their spiritual beliefs and coming from within their spiritual institutions [37]. It is also the case that healthcare professionals are better able to spread their message when going through faith communities.

Through the socially supportive aspect of religious environments, it has been suggested that having companionships with fellow church members can lead to encouragement of the adoption of positive health behaviors [27]. This is speculated to be due to significant others (including close companions) prompting and/or persuading their loved ones to engage in behavior to enhance their health [54]. Religious involvement has been linked to the tendency to have better health due to engagement in positive health behaviors (e.g., following a healthy diet) and avoidance of negative health behaviors (e.g., excessive alcohol use) [16]. Further, it has been found that those who are more religiously involved (defined by the frequency of church attendance) had significantly better engagement in exercise (including walking), seat belt use, vitamin use, sleep, and usage of preventive healthcare services (e.g., dental and physical checkups) than those who attended church less frequently [16]. It has been suggested that these heightened health behaviors are due largely to religious tenets associating the body with being a temple of God [16].

An applied example of the role of faith-based organizations in health promotion highlights a study conducted on the health information shared over the Internet by four African-American Christian churches in the Atlanta area [14]. In terms of the health resources found on the churches' websites, the themes of (1) online health education, (2) athletic programs, (3) fitness training, (4) fitness facilities, and (5) community outreach and health emerged. Making mention of one specific subheading, under the theme of health education, many of the websites included information for congregants pertaining to certain diseases and illnesses (including obesity and diabetes). Along with provision of general information on these diseases, there were resources on how to manage those diseases and illnesses, tied in conjunction with scripture and teachings from the Bible [14]. In practice, it could be helpful to either assess what types of health information patients living with chronic illnesses could be receiving from their faith communities, and it could be helpful to attempt to establish programs within local faith institutions pertaining to healthy lifestyle factors.

Deleterious Effects of Religion and Spirituality

Negative interactions in the church can come through multiple avenues. A few of the more highlighted examples of negative interactions are unfavorable social interactions with fellow church members, providing excessive help and/or providing ineffective help [53]. Unfavorable social interactions can

include disagreements, criticism, rejection, and violations of privacy by other church members [53]. Because it has been found that negative interactions in nonreligious settings can cause adverse health outcomes physically and psychologically [26, 41], it has been suggested that negative social interactions affecting health also extend to religious settings where a wealth of social interaction takes place [27]. As an example of this, having a higher number of negative interactions with other church members is linked to higher endorsement of depressive symptomology and lower endorsement of positive well-being [28]. Further, a larger number of negative interactions within the church have led to members' reporting less overall satisfaction with their health along with greater anxiety [30, 47]. Overall, the resulting effects of negative interactions in the church were found to be greater than the effects of positive interactions [30]. Specifically, excessive demands from other churchgoers are more likely to affect depressive symptoms than other forms of negative interaction such as criticisms [9].

There is also evidence to suggest that going through a religious or spiritual struggle can lead to a greater risk for mortality [46]. This struggle was described as the feeling of being abandoned by God, the questioning of God's love and care, or feeling that malevolent supernatural forces were at work in one's illness. Among those encountering these religious or spiritual struggles, there was a 19–28% increased risk of mortality [46]. Further confirmation of this trend comes from the finding that individuals who have more doubts regarding their faith also report being less satisfied with their health [29]. For clinicians, it is important to be cognizant of the fact that having a patient report on their faith might not always mean it is acting as an advantageous factor in their lives.

Integration into Practice

Given the scope of the research findings presented throughout this chapter, it may seem daunting to integrate clients' religiousness and spirituality into practice. First and foremost, it is recommended to include a spiritual history assessment in your clinic's standard intake procedures across clinical settings. While this should be presented from a neutral perspective (i.e., not implying that one "should be religious"), collecting a spiritual history creates space for patients to share their personal beliefs, preferences, and the value they attribute to faith in their life. The number of items in the assessment may differ based on time constraints and clinical settings. Collecting a spiritual history sets the foundation for the clinician to be able to respect the patient's beliefs simply by taking the time to ask about them. Currently, there is no standardized tool for spiritual histories; but several have been suggested to guide clinicians in choosing a set of questions that fits their clinical needs and the treatment setting [11, 18, 19, 24, 34, 39]. For many people, it may be beneficial to spend smaller amounts of time over several sessions to fully explore the role their faith plays in their life. In particular, this can help patients feel more comfortable if they desire to share a religious struggle or a behavior they feel ashamed of because of their faith.

In addition to conducting a spiritual assessment, treatment professionals can support patients' religious beliefs, and, when appropriate, practitioners can sparingly challenge beliefs that seem to be acting as barriers to reaching treatment goals. Being supportive of a patient's faith can be accomplished by encouraging that individual to continue engaging in religious activities that are effective coping strategies. Also, clinicians can consider using treatment approaches that are adapted to fit a patient's faith, such as cognitive behavioral therapy that has been developed to integrate the Bible into treatment [6, 49, 51]. Professionals can also support patients' faith by praying with them; however, this is a very controversial practice that requires consideration of the power dynamic [23]. Similar to the ethics concerning physical contact with clients, praying with patients can be a powerful tool if appropriately timed and if initiated by the patient. If the clinician suggests praying together, it could put the patient into a position where they feel coerced into praying. For those who are interested in further study of this practice, guidelines have been developed [50].

Integrating a client's faith into practice in a supportive way can simply involve matching the patient's terminology and illustrating your openness to discussing the importance of their faith. In contrast, determining appropriate times to challenge a client's belief system because it is impeding treatment goals or exacerbating symptoms is more difficult. For some, reaching out to family members, religious community members, or religious leaders can help with the identification of such patients and serve to lend credibility to the treatment approach from the patient's perspective. This is especially true when trying to lessen the rigidity of a patient's beliefs by demonstrating other practitioners of the same faith tradition are open to modifying certain beliefs to remove the barrier to treatment. Therefore, it is possible to intervene when a client's faith is serving to exacerbate symptoms or disrupt therapy; however, the practitioner should approach this cautiously and strive to maintain good rapport with the patient.

Lastly, knowing when to refer a patient to another clinician can be challenging, especially for those who are less familiar with integrating faith into their practice. Familiarizing oneself with the different types of clergy that can provide counseling can be a useful first step. For example, knowing the differences between a pastoral counselor and a chaplain can help determine which clergyperson would be better fit for a particular patient. Similarly, clergy may find it difficult to know when to refer a medical or mental health practitioner; it is equally as important for them to familiarize themselves with the differences in training across health professionals to make appropriate referrals. The spiritual history assessment can help the clinician to identify patients who should be referred based on exploring the following factors: severity of the symptoms, conflict between the patient's religious beliefs and treatment goals, depth of rapport built with the patient, pervasiveness of the patient's faith influencing treatment, and the availability of clergy members for referral [23].

Even on a basic level, patients' spiritual concerns can begin to be addressed by asking a question as simple as: "is there anything about your spiritual beliefs you think it is important for me to know in order to help me care for you better?"

Challenges to Integrating

One relevant challenge to the integration of faith with health could be the role of the faith institution, including its clergy, in the lives of spiritual patients. Mentally and emotionally, there is evidence to suggest that about one-fourth of people primarily look to clergy for aid when encountering psychological difficulties [56]. Clergymen have been shown to frequently reference mental health disturbances such as anxiety, depression, and worry within their sermons [35]. Specifically, these illnesses can often be described in sermons as being the result of external supernatural forces (e.g., the devil) or the result of internal spiritual shortcomings (e.g., not being in adherence to one's faith or the biblical teachings) [35]. Presumably, for individuals who turn to religious leaders for help with mental disturbances and received a message that partially placed blame for their disturbance on the individual's own religiosity, this could increase the individual's resistance to seek treatment from mental health professionals.

In similar manner, the receptiveness of the clinician to engage in discussions on the patient's faith could hinder the integration of faith in clinical practice. There seems to be an overall trend indicating a lack of receptiveness by professionals to gather spiritual histories of patients. While most healthcare professionals feel they should be aware of patients' spirituality, an additional majority said they would not directly ask about spiritual topics unless the patient was dying [38]. Thereby, clinicians and practitioners should be aware of how their own receptiveness (or lack thereof) to the conversation of spirituality might be a barrier to addressing and meeting patients' spiritual needs.

Clinicians' personal religious or spiritual beliefs can also serve as a barrier to providing competent treatment that involves faith. People commonly turn to their religious or spiritual beliefs to aid in decision-making processes, which can similarly be extended to apply to treatment providers [25].

For example, personal faith beliefs on topics like abortion may influence physicians' and other healthcare professionals' comfort with performing procedures or prescribing medications. The influence of personal beliefs on providing clinical care can become particularly problematic when there is a significant difference between the provider's faith and that of the patient. Further, psychologists are more likely to identify as religiously unaffiliated (agnostic, atheist, and none) when compared to the general public [13, 20]. Thus, there is an even higher chance the psychologist may have little personal experience with the benefits of religion and be less inclined to recognize the significance of faith in a patient's life. In a study with members from the Association for Behavioral and Cognitive Therapies (ABCT), 64% of respondents indicated that they felt mostly or very comfortable addressing faith in practice [55]. Based on social desirability and respondents self-selecting to participate in studies like these, investigators have likely underestimated the discomfort clinicians feel when addressing religion or spirituality in practice. Therefore, it can be challenging for practitioners to integrate faith into their practice due to conflicts between their personal belief system and that of their patients. Tenets of cultural competency and ethical practice indicate the need for treatment providers to identify potential biases related to religious beliefs. Through increased awareness and client-centered practice, practitioners can find ways to integrate religion and spirituality into their practice and respect patients' beliefs.

An additional challenge to integration addresses the nature of the individual's style of religious coping. It has been proposed that there are three styles by which people utilize their relationship with a higher being to cope with stressors in life (including illness): collaborative religious coping, active religious surrender, and passive religious deferral [43–45]. Collaborative religious coping is the notion by the individual that they are in partnership with God in resolving their problems and that both the individual and God have active problem-solving roles [43–45]. This style has been associated with better physical health in individuals when facing stressors. The active religious surrender coping style involves the individual initiating efforts to aid with their stressors; however instead of working collaboratively with the higher being, they manage some aspects of their situation and then leave the rest for the higher being to control [43–45]. While active religious surrender has also been found to be positively associated with well-being, the associations are weaker than with the collaborative coping style [45]. In the passive religious deferral coping style, the individual leaves the responsibility of full resolution of the situation to the higher being. This style has the weakest associations of all three styles with well-being. Contrary to the benefits that are associated with religious coping, negative religious coping styles and spiritual struggles have been correlated with increasing psychological distress [48]. For integrating faith with practice, it is important to note which of these relational styles the client might be engaging in and to understand how their religious coping style might affect their willingness to engage in prescribed treatments such as taking medicine or compliance with other medical interventions.

In instances where religious affiliations might come in clear contradiction to accepted patterns of treatment (e.g., a Jehovah's Witness patient who might refuse a blood transfusion), it is important to consider the well-being of the patient despite what accepted medical practices might be. It could be the case that imposing treatments on patients who are unwilling to comply due to religious restrictions could lead to the patient feeling defensive and denying all means of care, thereby potentially worsening their condition. It is important for the professional to potentially check his or her own biases and negative feelings related to a religious practice that might contradict the professional's scientific background, as to not adversely harm the patient by inadvertently neglecting other care options.

Conclusion

There is a growing evidence to support clinicians integrating faith into clinical practice to reach treatment goals, enhance adherence to medical treatments, and encourage engagement in healthy behaviors. It is recommended to gather a spiritual history early to guide treatment planning. Practitioners

face several challenges to integrating faith into their practice. Yet, research detailing the physical and mental health benefits associated with being religious or spiritual illustrates the powerful role faith can play in a client's life. As research on this topic utilizes more complex methodological study designs, it is expected that evidence will more comprehensively describe the relationship between faith and health.

References

1. American Hospital Association. American Hospital Association annual survey, 2016. 2016. Retrieved September 9, 2018, from https://www.aha.org/system/files/research/reports/tw/chartbook/2016/2016chartbook.pdf.
2. Barton Y, Miller L. Spirituality and positive psychology go hand in hand: an investigation of multiple empirically derived profiles and related protective benefits. J Relig Health. 2015;54(3):829–43. https://doi.org/10.1007/s10943-015-0045-2.
3. Berntson GG, Norman GJ, Hawkley LC, Cacioppo JT. Spirituality and autonomic cardiac control. Ann Behav Med. 2008;35:198–208.
4. Catholic Health Association of the United States. Catholic health care in the United States. 2018. Retrieved from https://www.chausa.org/about/about/facts-statistics.
5. Chilcot J, Wellsted D, Da Silva-Gane M, Farrington K. Depression on dialysis. Nephron Clin Pract. 2008;108:256–64.
6. CSTH. Religiously-integrated cognitive behavioral therapy (RCBT) manuals and workbooks (including training video). Durham: Duke University Center for Spirituality, Theology and Health; 2014. Retrieved from http://www.spiritualityandhealth.duke.edu/index.php/religious-cbt-study/therapy-manuals.
7. Cukor D, Peterson RA, Cohen SD, Kimmel P. Depression in end-stage renal disease hemodialysis patients. Nat Clin Pract Nephrol. 2006;2:678–87.
8. Darrell L. Faith that god cares: the experience of spirituality with African American hemodialysis patients. Soc Work Christ. 2016;43:189–212.
9. Ellison CG, Zhang W, Krause N, Marcum JP. Does negative interaction in the church increase depression? Longitudinal findings from the Presbyterian Panel Survey. Sociol Relig. 2009;70:409–31.
10. Flannelly KJ, Jankowski KB, Flannelly LT. Operational definitions in research on religion and health. J Health Care Chaplain. 2014;20(2):83–91. https://doi.org/10.1080/08854726.2014.909278.
11. Gomi S, Starnino VR, Canda ER. Spiritual assessment in mental health recovery. Community Ment Health J. 2014;50(4):447–53.
12. Hall DE, Meador KG, Koenig HG. Measuring religiousness in and health research. J Relig Health. 2008;47(2):134–83.
13. Harris KA, Spengler PM, Gollery TJ. Clinical judgment faith bias: unexpected findings for psychology research and practice. Prof Psychol Res Pract. 2016;47(6):391–401. https://doi.org/10.1037/pro0000113.
14. Harris TM, Lee CN. Health promotion from within: a platform for advancing a health agenda for and by the church body. In: Miller AN, Rubin DL, editors. Health communication and faith communities. New York: Hampton Press; 2011. p. 143–61.
15. Harvey IS. Self-management of a chronic illness: an exploratory study on the role of spirituality among older African American women. J Women Aging. 2006;18:75–88.
16. Hill TD, Burdette AM, Ellison CG, Musick MA. Religious attendance and health behaviors of Texas adults. Prev Med. 2006;42:309–12.
17. Hill PC, Pargament KI, Hood JW, McCullough ME, Swyers JP, Larson DB, Zinnbauer BJ. Conceptualizing religion and spirituality: points of commonality, points of departure. J Theory Soc Behav. 2000;30(1):51–77.
18. Hodge DR. Implicit spiritual assessment: an alternative approach for assessing client spirituality. Soc Work. 2013;58(3):223–30.
19. Huguelet P, Mohr S, Betrisey C, Borras L, Gillieron C, Marie AM, et al. A randomized trial of spiritual assessment of outpatients with schizophrenia: patients' and clinicians' experience. Psychiatr Serv. 2011;62(1):79–86.
20. Hyman C, Handal PJ. Definitions and evaluation of religion and spirituality items by religious professionals: a pilot study. J Relig Health. 2006;45(2):264–82.
21. Koenig HG. Concerns about measuring "spirituality" in research. J Nerv Ment Dis. 2008;196(5):349–55.
22. Koenig HG, McCullough ME, Larson DB. Handbook of religion and health. New York: Oxford University Press; 2001.
23. Koenig HG. Religion and mental health: research and clinical applications. San Diego: Academic Press; 2018.
24. Koenig HG. Spirituality in patient care: why, how, when, and what. Philadelphia: Templeton Foundation Press; 2013.
25. Koenig HG. Religion, spirituality, and health: the research and clinical implications. ISRN Psychiatry. 2012;2012:1. https://doi.org/10.5402/2012/278730.

26. Krause N. Negative interaction and heart disease in late life: exploring variations by socioeconomic status. J Aging Health. 2005;17:28–55.
27. Krause NM. Aging in the church: how social relationships affect health. West Conshohocken: Templeton Foundation Press; 2008.
28. Krause N, Ellison CG, Wulff KM. Church-based social support, negative interaction, and psychological well-being: findings from a national sample of Presbyterians. J Sci Study Relig. 1998;40:637–56.
29. Krause N, Wulff KM. Religious doubt and health: exploring the potential dark side of religion. Sociol Relig. 2004;65:35–56.
30. Krause N, Wulff KM. Church-based social ties, a sense of belonging in a congregation, and physical health status. Int J Psychol Relig. 2005;15:73–93.
31. Larson DB, Larson SB. Spirituality's potential relevance to physical and emotional health: a brief review of quantitative research. J Psychol Theol. 2003;31:37–52.
32. Lucette A, Ironson G, Pargament KI, Krause N. Spirituality and religiousness are associated with fewer depressive symptoms in individuals with medical conditions. Psychosomatics. 2016;57:505–13.
33. Masters KS, Hill RD, Kircher JC, Benson TLL, Fallon JA. Religious orientation, aging, and blood pressure reactivity to interpersonal and cognitive stressors. Ann Behav Med. 2004;28:171–8.
34. Mathai J, North A. Spiritual history of parents of children attending a child and adolescent mental health service. Australas Psychiatry. 2003;11(2):172–4.
35. Mattox R, McSweeney J, Ivory J, Sullivan G. A qualitative analysis of Christian clergy portrayal of anxiety disturbances in televised sermons. In: Miller AN, Rubin DL, editors. Health communication and faith communities. New York: Hampton Press; 2011. p. 187–202.
36. McCombs HG. The spiritual dimension of caring for people affected by disasters. In: Dass-Brailsford P, editor. Crises and disaster counseling: lessons learned from Hurricane Katrina and other disasters. Newbury Park: Sage; 2009. p. 131–47.
37. Miller AN, Yrisarry N, Rubin DL. Introduction: health communication in, by, and through communities of faith. In: Miller AN, Rubin DL, editors. Health communication and faith communities. New York: Hampton Press; 2011. p. 1–26.
38. Monroe MH, Bynum D, Susi B, Phifer N, Schultz L, Franco M, MacLean CD, Cykert S, Garrett J. Primary care physician preferences regarding spiritual behavior in medical practice. Arch Intern Med. 2003;163:2751–6.
39. Moreira-Almeida A, Koenig HG, Lucchetti G. Clinical implications of spirituality to mental health: review of evidence and practical guidelines. Rev Bras Psiquiatr. 2014;36(2):176–82.
40. Namageyo-Funa A, Muilenburg J, Wilson M. The role of religion and spirituality in coping with type 2 diabetes: a qualitative study among black men. J Relig Health. 2015;54:242–52.
41. Okun MA, Keith VM. Effects of positive and negative social exchanges from various sources on depressive symptoms in younger and older adults. J Gerontol Psychol Sci. 1998;53B:4–20.
42. Oman D. Defining religion and spirituality. In: Paloutzian RF, Park CL, editors. Handbook of the psychology of religion and spirituality. 2nd ed. New York: Guilford Press; 2013. p. 23–47.
43. Pargament KI, Ensing DS, Falgout K, Olsen H, Reilly B, van Haitsma K, Warren R. God help me: (I): religious coping efforts as predictors of the outcomes to significant negative life events. Am J Community Psychol. 1990;18:793–824.
44. Pargament KI, Kennell J, Hathaway W, Grevengoed N, Newman J, Jones W. Religion and the problem-solving process: three styles of coping. J Sci Study Relig. 1988;27:90–104.
45. Pargament KI, Koenig HG, Perez LM. The many methods of religious coping: development and initial validation of the RCOPE. J Clin Psychol. 2000;56:519–43.
46. Pargament KI, Koenig HG, Tarakeshwar N, Hahn J. Religious coping methods as predictors of psychological, physical and spiritual outcomes among medically ill elderly patients: a two-year longitudinal study. J Health Psychol. 2004;9:713–30.
47. Pargament KI, Zinnbauer BJ, Scott AB, Butter EM, Zerowin J, Stanik P. Red flags and religious coping: identifying some religious warning signs among people in crisis. J Clin Psychol. 1998;54:77–89.
48. Park C, Masters K, Salsman J, Wachholtz A, Clements A, Salmoirago-Blotcher E, et al. Advancing our understanding of religion and spirituality in the context of behavioral medicine. J Behav Med. 2017;40(1):39–51. https://doi.org/10.1007/s10865-016-9755-5.
49. Pearce M. Cognitive behavioral therapy for Christians with depression: a practical tool-based primer. Conshohocken: Templeton Foundation Press; 2016.
50. Pearce M, Chiaramonte D. When a patient asks you to pray: what's a provider to do? Int J Palliat Nurs. 2017;23(7):316.
51. Pearce MJ, Koenig HG, Robins CJ, Nelson B, Shaw SF, Cohen HJ, King MB. Religiously integrated cognitive behavioral therapy: a new method of treatment for major depression in patients with chronic medical illness. Psychotherapy. 2015;52(1):56.

52. Pew Research Center. The global religious landscape. 2012. Retrieved from http://www.pewforum.org/global-religiouslandscape.aspx.
53. Rook KS. The negative side of social interaction: impact on psychological well-being. J Pers Soc Psychol. 1984;46:1097–108.
54. Rook KS. Stressful aspects of older adults' social relationships: current theory and research. In: Stevens MAP, Crowther JH, Hobfoll SE, Tennenbaum DL, editors. Stress and coping in later life. Washington, DC: Hemisphere; 1990. p. 172–92.
55. Rosmarin DH, Pirutinsky S, Green D, McKay D. Attitudes toward spirituality/religion among members of the Association for Behavioral and Cognitive Therapies. Prof Psychol Res Pract. 2013;44(6):424–33.
56. Wang PS, Demler O, Kessler RC. Adequacy of treatment for serious mental illness in the United States. Am J Public Health. 2002;92:92–8.
57. White ML. Spirituality self-care effects on quality of life for patients diagnosed with chronic illness. Self-Care Depend Care Nurs. 2013;20:23–32.
58. Zimmer Z, Jagger C, Chiu C-T, Ofstedal MB, Rojo F, Saito Y. Spirituality, religiosity, aging and health in global perspective: a review. SSM- Popul Health. 2016;2:373–81.
59. Zinnbauer BJ, Pargament KI, Cole B, Rye MS, Butter EM, Belavich TG, et al. Religion and spirituality: unfuzzying the fuzzy. J Sci Study Relig. 1997;36(4):549–64. https://doi.org/10.2307/1387689.
60. Zinnbauer BJ, Pargament KI. Religiousness and spirituality. In: Paloutzian RF, Park CF, editors. Handbook of the psychology of religion and spirituality. New York: Guilford Press; 2005. p. 21–42.