COURSE #91983 — 5 CONTACT HOURS/CREDITS RELEASE DATE: 05/01/21 EXPIRATION DATE: 04/30/24

The Role of Spirituality in Health and Mental Health

HOW TO RECEIVE CREDIT

- Read the enclosed course.
- Complete the questions at the end of the course.
- Return your completed Evaluation to NetCE by mail or fax, or complete online at www.NetCE.com. (If you are a physician, behavioral health professional, or Florida nurse, please return the included Answer Sheet/Evaluation.) Your postmark or facsimile date will be used as your completion date.
- Receive your Certificate(s) of Completion by mail, fax, or email.

Faculty

Alice Yick Flanagan, PhD, MSW, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families. (A complete biography appears at the end of this course.)

Faculty Disclosure

Contributing faculty, Alice Yick Flanagan, PhD, MSW, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for social workers, mental health counselors, physicians, nurses, and other allied health professionals who work in a clinical practice setting.

Accreditations & Approvals

JOINTLY ACCREDITED PROVIDER™
INTERPROFESSIONAL CONTINUING EDUCATION

In support of improving patient care, NetCE is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

As a Jointly Accredited Organization, NetCE is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. Regulatory boards are the final authority on courses accepted for continuing education credit.

NetCE has been approved by NBCC as an Approved Continuing Education Provider, ACEP No. 6361. Programs that do not qualify for NBCC credit are clearly identified. NetCE is solely responsible for all aspects of the programs.

This course, The Role of Spirituality in Health and Mental Health, Approval #07012022-28, provided by NetCE, is approved for continuing education by the New Jersey Social Work Continuing Education Approval Collaborative, which is administered by NASW-NJ. CE Approval Collaborative Approval Period: July 12, 2022 through August 31, 2024. New Jersey social workers will receive 5 Clinical or Social & Cultural Competence CE credits for participating in this course.

NetCE is recognized by the New York State Education Department's State Board for Social Work as an approved provider of continuing education for licensed social workers #SW-0033.

This course is considered self-study, as defined by the New York State Board for Social Work. Materials that are included in this course may include interventions and modalities that are beyond the authorized practice of licensed master social work and licensed clinical social work in New York. As a licensed professional, you are responsible for reviewing the scope of practice, including activities that are defined in law as beyond the boundaries of practice for an LMSW and LCSW.

A complete Works Cited list begins on page 30.

Mention of commercial products does not indicate endorsement.

A licensee who practices beyond the authorized scope of practice could be charged with unprofessional conduct under the Education Law and Regents Rules.

NetCE is recognized by the New York State Education Department's State Board for Mental Health Practitioners as an approved provider of continuing education for licensed mental health counselors. #MHC-0021.

This course is considered self-study by the New York State Board of Mental Health Counseling.

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This course is considered self-study by the New York State Board of Marriage and Family Therapy.

Designations of Credit

NetCE designates this enduring material for a maximum of 5 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Successful completion of this CME activity, which includes participation in the evaluation component, enables the participant to earn up to 5 MOC points in the American Board of Internal Medicine's (ABIM) Maintenance of Certification (MOC) program. Participants will earn MOC points equivalent to the amount of CME credits claimed for the activity. It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of granting ABIM MOC credit. Completion of this course constitutes permission to share the completion data with ACCME.

Successful completion of this CME activity, which includes participation in the evaluation component, enables the learner to earn credit toward the CME and Self-Assessment requirements of the American Board of Surgery's Continuous Certification program. It is the CME activity provider's responsibility to submit learner completion information to ACCME for the purpose of granting ABS credit.

Successful completion of this CME activity, which includes participation in the activity with individual assessments of the participant and feedback to the participant, enables the participant to earn 5 MOC points in the American Board of Pediatrics' (ABP) Maintenance of Certification (MOC) program. It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of granting ABP MOC credit.

Through an agreement between the Accreditation Council for Continuing Medical Education and the Royal College of Physicians and Surgeons of Canada, medical practitioners participating in the Royal College MOC Program may record completion of accredited activities registered under the ACCME's "CME in Support of MOC" program in Section 3 of the Royal College's MOC Program.

NetCE designates this continuing education activity for 5 ANCC contact hours.

This activity was planned by and for the healthcare team, and learners will receive 5 Interprofessional Continuing Education (IPCE) credits for learning and change.

NetCE designates this continuing education activity for 6 hours for Alabama nurses.

AACN Synergy CERP Category B.

Social workers completing this intermediate-to-advanced course receive 5 Clinical continuing education credits.

NetCE designates this continuing education activity for 3 NBCC clock hours.

Individual State Nursing Approvals

In addition to states that accept ANCC, NetCE is approved as a provider of continuing education in nursing by: Alabama, Provider #ABNP0353 (valid through 07/29/2025); Arkansas, Provider #50-2405; California, BRN Provider #CEP9784; California, LVN Provider #V10662; California, PT Provider #V10842; District of Columbia, Provider #50-2405; Florida, Provider #50-2405; Georgia, Provider #50-2405; Kentucky, Provider #7-0054 (valid through 12/31/2025); South Carolina, Provider #50-2405; West Virginia, RN and APRN Provider #50-2405.

Individual State Behavioral Health Approvals

In addition to states that accept ASWB, NetCE is approved as a provider of continuing education by the following state boards: Alabama State Board of Social Work Examiners, Provider #0515; Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health, Provider #50-2405; Illinois Division of Professional Regulation for Social Workers, License #159.001094; Illinois Division of Professional Regulation for Licensed Professional and Clinical Counselors, License #197.000185; Illinois Division of Professional Regulation for Marriage and Family Therapists, License #168.000190.

Special Approvals

This activity is designed to comply with the requirements of California Assembly Bill 1195, Cultural and Linguistic Competency.

About the Sponsor

The purpose of NetCE is to provide challenging curricula to assist healthcare professionals to raise their levels of expertise while fulfilling their continuing education requirements, thereby improving the quality of healthcare.

Our contributing faculty members have taken care to ensure that the information and recommendations are accurate and compatible with the standards generally accepted at the time of publication. The publisher disclaims any liability, loss or damage incurred as a consequence, directly or indirectly, of the use and application of any of the contents. Participants are cautioned about the potential risk of using limited knowledge when integrating new techniques into practice.

Disclosure Statement

It is the policy of NetCE not to accept commercial support. Furthermore, commercial interests are prohibited from distributing or providing access to this activity to learners.

Course Objective

The purpose of this course is to raise practitioners' awareness about the role of spirituality in health and mental health, specifically how spirituality is utilized as a coping mechanism and acts as a protective factor toward stress.

Learning Objectives

Upon completion of this course, you should be able to:

1. Define the concepts of spirituality and religiosity.
2. Describe the historical evolution of spirituality and religiosity in the fields of nursing, medicine, social work, and mental health counseling.
3. Summarize the advantages and disadvantages of incorporating issues of spirituality into clinical practice and the challenges associated with defining and measuring spirituality.
4. Discuss the role of spirituality in the course and prognosis of health conditions.
5. Outline the role of spirituality in mental health.
6. Analyze the effects that spirituality and religion might have on coping.
7. Describe how different ethnicities or cultures define spirituality.
8. Identify spiritually sensitive assessment and intervention guidelines and possible ethical issues that might arise.

EVIDENCE-BASED PRACTICE RECOMMENDATION

Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the course material for better application to your daily practice.

INTRODUCTION

A large percentage of the population in the United States is affiliated with or adheres to a specific religion. The Religious Landscape Study, conducted in 2014, found that 70.6% of Americans surveyed identified orientation as Christians (including 25.4% evangelical Protestant and 20.8% Catholic), 1.9% Jewish, 0.9% Muslim, 0.7% Buddhist, and 0.7% Hindu. An estimated 22.8% stated they were atheist, agnostic, or did not affiliate themselves with any religion in particular [6]. An estimated 40% to 45% of Americans indicate that they regularly attend a church, mosque, or synagogue; for the past 60 to 70 years, this attendance rate has been quite consistent [1; 2; 3]. However, studies have shown that individuals in the United States are increasingly reluctant to identify with a specific religion and less likely to attend a place of worship [5]. In a 2018–2019 survey, 65% of American adults identified as Christians and 26% reported being atheists, agnostics, or nothing [19]. Religious service attendance at least once or twice every month decreased 7% between 2009 and 2019 [19]. However, a 2020 survey found that 28% of American adults reported strengthened faith during the COVID-19 pandemic [207].

There are also regional differences in religious practices and membership in churches. Research indicates that 47% of those in the West, 51% in the Midwest, 62% in the South, and 55% in the Northeast state that religion is "very important" in their lives [6].

Despite these statistics, the fields of psychology, social work, mental health, counseling, medicine, and nursing have been reluctant to introduce and incorporate religion and spirituality into professional training curricula. Consequently, practitioners are frequently ill-equipped to discuss issues related to spirituality with patients [4]. According to a 2009 meta-analysis, 66% to 89% of social workers report having obtained minimal to no instruction during their education about working with patients on issues related to spirituality and religion or how their own spirituality may influence intervention recommendations [136]. In a 2015 study, 83% of social workers surveyed indicated that they did not

complete any coursework on religion/spirituality and integration in social work practice [208]. In a survey study of mental health professionals in Texas, licensed marriage and family therapists reported being the most confident incorporating religion and spirituality into their work [165]. Among all the professions, almost half reported not integrating spirituality into their biopsychosocial assessments.

SPIRITUALITY AND RELIGIOSITY

The term spiritual dates back to the 14th century to the Latin term *spiritualitas*, derived from *spiritus*, meaning soul, breath, or life force [209]. This life force was believed to drive all aspects of life. Today, spirituality refers to the belief that there is a power or powers outside one's own that transcend understanding [7]. It has been stated that there are three dimensions of spirituality [8]:

- Making personal meaning out of situations
- Coming to an understanding of self
- Appreciating the importance of connections with others

Historically, spirituality and religion were intertwined, with religious institutions facilitating spirituality. However, the concept of spirituality has evolved as a separate concept. Today, the term is used to describe being connecting to a deity or higher power and the process of searching and connecting with the "sacred" or "significant" [166; 210]. Pargament and Mahoney argue that, for many, spirituality involves searching to discover what is sacred, and this journey can take either traditional pathways (e.g., organized religions) or nontraditional avenues (e.g., involvement in 12-step groups, meditation, or retreat centers) [9]. People appear to have multiple and elaborate definitions of spirituality. Some definitions of spirituality focus on a vertical dimension, with a primary emphasis on transcendence to a higher power; for others, the horizontal dimension is considered to be a more important component, with a focus on connecting with others and the physical world [137]. More recently, there has been research on relational spirituality, or how one has a relationship with the sacred [167].

The term "religion" has Latin roots meaning "binds together" [166]. King and Crowther define religion as "an organized system of beliefs, practices, rituals, and symbols designed (a) to facilitate closeness to the sacred or transcendent (God, higher power, or ultimate truth/reality), and (b) to foster an understanding of one's relation and responsibility to others in living together in a community" [10]. Religiosity has been categorized as either nonorganizational religiosity, which consists of prayer and importance of religious beliefs, or organizational religiosity, which encompasses attendance at services and other activities [11; 137]. In either case, religiosity involves observable behaviors [210]. When researchers attempt to measure religiosity, they often inquire regarding attendance at religious services; attitudes toward religious behaviors, such as Bible reading and prayer; and involvement in religious activities [12; 137]. In most cases, religion strives to combine the institutional and personal experience of connecting to God or a higher power [166]. It is derived from a long tradition of beliefs and practices [210].

Some argue that spirituality and religiosity are interrelated, as religiosity focuses on external expressions of spirituality or faith [13]. In other words, religious practices can foster spirituality. Similarly, spiritual practices may involve aspects of religious participation. Furthermore, it is possible to experience spirituality outside the context of religious behaviors and activities [138]. Others maintain that religiosity and spirituality are distinctive. For example, one may outwardly exhibit religious behaviors (e.g., regularly attend services) but may not necessarily have a relationship with God [10]. Mattis' study of African American women found that the participants clearly differentiated religion and spirituality [14]. For these women, religion was generally defined as organized worship, whereas spirituality was described as the process of internalizing positive values. Religion was viewed as a path, while spirituality was considered an outcome [14]. More recently, religion has been perceived as restrictive, while spirituality is viewed as freeing [138].

In Western societies, there is a greater dichotomy between spirituality and religion [211]. In Western cultures, spirituality is perceived more positively as a dimension that emphasizes the private, while religion is devalued more often and is viewed as formal and institutionalized. However, in other cultures, spirituality and religion are less polarized.

The term faith is defined as the manifestation of an expectation from God and is very subjective [212]. Faith is described as a vital element to coping, dealing with crises, and handling illnesses. It can facilitate spiritual and religious growth [211].

HISTORICAL ROOTS

In the medieval period in Europe, there were no formal government-sponsored social care or healthcare systems in place to care for those in need. Instead, feudal societies, along with the churches, assumed primary responsibility in the provision of services to the poor, sick, and needy [15]. During this time, male and female religious orders worked with the sick, and purgings, emetics, blood cleanings, and prayers were common nursing interventions [16].

During the Age of Enlightenment in the 1700s, the intellectual climate was marked by two movements: rationalism and empiricism [17]. Rationalism emphasized that the primary authority for truth is rationality or logic; spirituality, faith, and religion were considered outside these rational boundaries [17]. Empiricism focused on the idea that knowledge stems from direct, first-hand observations or sensory experiences [17]. Ultimately, these two intellectual movements challenged the authority of the church and affected the provision of general health and mental health care.

When the feudal system was abolished, the existing agrarian society transitioned to an industrial society, and social conditions ultimately deteriorated. Families and children worked long hours under deplorable conditions. Religious institutions again assumed much of the responsibility for the provision of social care [15].

The 20th century marked a major move toward professionalism and scientific inquiry in many of the helping professions. In psychology, for example, Freud had little regard for religion and viewed it as a neurosis and an "illusion," and as behaviorism became more prominent, religion as a topic in psychology diminished [18; 139; 213]. Behavioral theorists such as B.F. Skinner emphasized determinism and that phenomena should be measurable and observable in order to be scientific, and consequently, spirituality and religiosity were no longer considered rational explanations for health and mental health conditions [18]. For the next 50 years (i.e., 1920–1970), psychology moved toward behaviorism and the cognitive sciences. Overall, there was a negative bias towards the incorporation of religion and spirituality in counseling, psychotherapy, and mental health [213].

In the 20th century, there was more interest in the incorporation of religion and spirituality in the mental health fields. Many have argued that religion and spirituality can have both negative and positive effects, including human growth and behavioral change [213]. In the 1950s, humanism emerged in the psychology landscape, primarily guided by the work of Abraham Maslow [18]. His theoretical constructs of self-actualization and the hierarchy of needs included a spiritual component. Later, humanist psychologists such as Viktor Frankl and Rollo May shifted the discussion of spirituality to focus more on individual values rather than a supreme being, leading to the label "secular humanists" [139]. During this same period, spirituality and religiosity became more prominent in the counseling professions [18]. The division of Catholic Counselors in the American Personnel and Guidance Association (APGA) emerged in the 1950s. In 1974, this group became known as the Association for Religious Values in Counseling (ARVIC), and in 1993, ARVIC changed its name to the Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC) [18].

In the 1960s, the field of nursing moved toward a more holistic view of patient needs, including religious and spiritual arenas [16]. Although much of the early literature regarding nursing discusses religion, it was not until the 1960s that there was actual discussion of spirituality in nursing [16; 20]. Since 2000, there has been an increased interest in religion and spirituality in nursing. This may be partially attributed to the overall focus on holistic health and the self-help movement. Since 2001, the Joint Commission has required spiritual assessment in nursing care [210].

Into the 1990s, there was a focus on diversity issues in many of the social sciences. The 1994 revision (fourth edition) of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) included a new category for religious or spiritual problems. Conditions that may be a focus of clinical attention as religious or spiritual problems according to the fifth edition of the DSM include loss or questioning of faith, problems with religious conversion, or questioning of spiritual values [21]. The impetus for the consideration of a new diagnostic category came from a proposal from the Spiritual Emergence Network, which had concerns regarding how the field of mental health pathologized religious and spiritual problems [22]. Some individuals, for example, might experience distress as a result of questioning their faith. When taken out of context, the symptoms can mimic a psychiatric disorder when, in fact, the reactions are "normal" [22].

Though social work was built on religious underpinnings, over the decades, it has maintained ambivalence in incorporating religion and spirituality into the field [140]. In the latter part of the 20th century, social work's interest in spirituality and religion were rejuvenated [168]. This interest was aligned with the profession's attention to diversity and emphasis on viewing individuals holistically [168]. In the 1990s, the "strengths perspective" was becoming more popular, with its emphasis on acknowledging patients' attributes, strengths, worth, and potential. Social workers began to embrace their role in helping patients enhance their capabilities [23; 24]. This was a concerted move away from a pathology-based model. There was also a move toward using the term "spirituality" (rather than "religion"), which was considered to be more inclusive [168]. Today, the Council on Social Work Education (CSWE) has formulated nine competencies as accreditation standards for Master's in Social Work programs. Of these nine competencies, five touch on religion and spirituality [169]. The CSWE has mandated spirituality and religion in social work curricula to ensure that students appreciate these elements of diversity [214].

INCORPORATING SPIRITUALITY/ RELIGIOSITY INTO PRACTICE

POSSIBLE BENEFITS OF INCORPORATING SPIRITUALITY

Many supporters believe that the need to incorporate spiritual and religious attention into professional practice is based on the concept of spiritual and religious pluralism being fundamental in a multicultural society [25]. Gilligan and Furness argue that an emphasis on cultural competency means that practitioners should understand and appreciate how faith, religion, and spirituality are intertwined with the cultural values and belief systems of ethnic minority groups [26]. This is particularly important due to increased globalization and the intersection of culture and ethnic identity with other identities, such as religion, spirituality, worldviews, disability, and political affiliation [27]. In a 2019 study, counselors acknowledged the importance of considering religious and spiritual issues with clients as a core component of multiculturalism [215]. Similarly, practitioners argue that it is within a profession's ethical mandate to consider religion and spirituality because they are important factors of human experience. Not considering these issues would lead to insensitive assessment and treatment [22]. Furthermore, many would not argue that discussions about religion and spirituality are inevitable within certain contexts, such as bereavement, illness, and palliative care [170].

Others note that the symptoms resulting from spiritual distress are similar to the symptoms of depression [25]. Addressing potential problems of spiritual or religious origin may be an important aspect of treating depression and, potentially, other mental and health conditions. A 2016 systematic review found that higher levels of religious practice were correlated with decreased suicide ideations and attempts [171]. However, more research in this area is necessary to determine the impact of spiritual/religious interventions on overall well-being. Incorporating spirituality and religion into practice aligns with the strengths-based perspective and theories that advocate for empowering and fostering resilience [141]. In health care, it also aligns with the notion of providing patient-centered, holistic care [170; 216].

Worthington and Sandage have identified several ways whereby spirituality and religion may become an issue in clinical practice [28]. First, a patient might specifically request therapy that incorporates religious components and question the practitioner's religious/spiritual background. Alternately, a patient might request that religion and spirituality not be discussed. If spirituality and/or religiosity are vital dimensions of a patient's life but this is not explicitly articulated, disagreements or misunderstandings may develop between the practitioner and patient regarding the course of treatment. Such a situation can ultimately hinder the practitioner from effectively treating or helping the patient. Finally, spirituality is often intertwined with culture. It is important to remember that patients are a part of a larger social system (i.e., family, neighborhood, community, religious institutions, school, employment). It is not possible to disentangle these social forces from patients' lives.

Part of scientific advancement is openness to divergent perspectives as a means to mitigate bias [217]. Avoiding discussions of religious and spiritual issues impedes science and can result in confirmation, reinforcement, and perpetuation of homogenous and potentially erroneous views.

POSSIBLE DISADVANTAGES OF INCORPORATING SPIRITUALITY

One of the key attributes of any profession is that it possesses a unique set of competencies meant to facilitate problem solving based on scientific theory and technique [29]. In Western society, scientific theory is based on empiricism and rationalism, with a focus on measuring and observing phenomena. Because spirituality is an intangible concept, it is not easily subjected to measurement. Therefore, proponents of the empirical science of health and mental health care maintain that it is vital for professionals to remain objective and distant in order to maintain appropriate boundaries [30; 170; 216; 218; 219].

There are also concerns that incorporating spirituality into practice may exacerbate symptoms, particularly in the case of psychiatric symptoms, which then would adversely affect recovery [172]. This is a particular issue when symptoms may be linked to religion or spirituality in some way.

Another area of concern is with practitioners' levels of competence and confidence [215]. Connelly and Light assert that most practitioners are generally not well trained to address faith-based aspects of care despite the fact that more electives on spirituality and religiosity are being offered in nursing, medical, counseling, and social work curricula [31]. A study of a random sample of baccalaureate nursing programs indicated that there was sparse teaching on spirituality and religiosity in most nursing curricula [32]. Spiritual and faith-based interventions and reflective practice were not covered in depth. Consequently, many health and mental health professionals were not comfortable with their role in raising spiritual questions to patients and expressed fear or reluctance to invade a patient's private space [33; 219]. On the other hand, a cohort of nursing students who received teaching on the spiritual dimension in care overwhelmingly found the instruction to be both personally and professionally beneficial [34]. In general, healthcare providers report feeling inadequately equipped in addressing spiritual issues with their patients while also maintaining professional boundaries [173].

Providers who use tools addressing religion/spirituality should refer to the available evidence-based practice literature to assess the efficacy and define progress [142]. Religion should not obscure what has been defined as markers of progress [142]. There is also controversy regarding the use of public funds to study spirituality and religiosity [35]. Some contend that it is not appropriate to use public funding to study religious phenomena because of the notion of separation of church and state [35]. This discussion is ongoing, and it is unclear to what extent it will help or hinder the provision of care. Finally, some practitioners fear that they will be viewed as violating boundaries or proselytizing if religion is incorporated into clinical practice [216; 219].

Overall, the issue of autonomy is at the heart of the decision of whether or not to incorporate spirituality into practice. It is not a matter of what the provider wants; the patient's preferences should be honored [141]. The question of whether or not to incorporate spirituality or religion ultimately rests with the patient [170].

CHALLENGES IN DEFINING SPIRITUALITY AND RELIGIOSITY

One challenge related to the incorporation and study of spirituality and religiosity is related to the measurement of this complex and multifaceted concept. Because religion and spirituality have varied meanings for different people, these concepts pose definitional challenges [168].

The majority of instruments that assess spirituality and religion are quantitative, consisting of closed-ended question items. Quantitative instruments are based on the premise that there exists one defined objective reality of spirituality and religiosity that can be measured [23]. However, when these instruments are utilized, the subjective and intangible human experience of spirituality, religion, and faith are lost [23].

Another challenge when measuring spirituality and religiosity stems from the varied definitions. Hill and Pargament reviewed available quantitative instruments and found that existing instruments assessed different dimensions of spirituality and religiosity [36]. Aspects of spirituality that may be addressed include [36; 37; 38; 39; 40; 41; 168]:

- Perceived closeness or connection to God or higher power(s): Questions related to this dimension assume that individuals who are spiritual or religious value a connection to God or a transcendent being. For example, some instruments ask individuals to rate how closely they feel or experience God. There are other instruments that instruct individuals to describe to what extent they turn to God or a higher power in times of need or challenges. There is some disagreement, however, of whether this transcendent dimension is a necessary component in the definition of spirituality.
- Sustaining force: Some individuals view spirituality and religiosity as a force or motivation that provides direction and guidance for living. An instrument attempting to measure this aspect would inquire about the role of spirituality or religion in the patient's framework or approach to life.
- Religious support: Some researchers measure spirituality or religiosity by examining the notion of religious support, whereby individuals derive their social support from church, their faith community, and a group of other individuals who share the same values and worldview. Perceived religious support may also derive from knowing that others are praying on their behalf.
- Struggle with religion and spirituality: As with any worldview, there will be times when individuals challenge their faith or spirituality. Presence of this struggle may be an indication that the patient requires additional support.

Senreich argues for a definition that is inclusive and captures all belief systems. He defines spirituality as [143]:

> ...a human being's subjective relationship (cognitive, emotional, and intuitive) to what is unknowable about existence, and how a person integrates that relationship into a perspective about the universe, the world, others, self, moral values, and one's sense of meaning.

One of the strengths of having a broad and inclusive definition of spirituality is that it allows individuals to create their own meanings. However, when a definition is so expansive, it can end up being meaningless and inconsistent [174; 220].

The definition of spirituality can lead to a bias. For example, if spirituality is defined as a personal search for meaning and purpose but a patient with depression has lost his or her sense of purpose, is that patient void of spirituality? Using emotional well-being as part of the definition may be dangerous because the outcome is intertwined with the concept of spirituality itself [144].

When differentiating religion and spirituality, some make the distinction that religion is characterized by structure, doctrine, rituals, and worship, while spirituality pertains to one's relationship with a transcendent being, being connected to a force beyond themselves, and soul seeking [168].

OVERVIEW OF THE ROLE OF SPIRITUALITY/ RELIGIOSITY IN HEALTH

The relationship between spirituality/religiosity and health is complicated in part because of the various definitions and research limitations. A discussion of some empirical studies conducted in this area is provided here as a basic overview.

A survey found that 52% of respondents had prayed for their own health [42]. Prayer was defined as "an active process of appealing to a higher spiritual power" [42]. Overall, prayer has been identified as the most commonly used form of complementary and alternative medicine in the United States. Other techniques with spiritual or religious basis include meditation, yoga, tai chi, qigong, and Reiki [42].

Studies have also shown that physicians regularly underestimate the degree to which their patients would like their concerns regarding spiritual or religious issues addressed [43; 44; 45]. Because spiritual well-being has been recognized as an important part of many patients' lives, practitioners should be aware of available resources and refer patients to the appropriate spiritual leader or advisor (e.g., chaplain) or support groups when necessary.

Health issues may arise that are specific to certain religious groups, and knowledge of major ideology specific to these groups is necessary in the provision of culturally competent care (***Table 1***). For example, health issues related to fasting may arise among Buddhists, Hindus, Muslims, and some Christian patients, as well as persons of other faiths. This may particularly become an issue during extended fasts, such as the Muslim observance of Ramadan, which continues for one month [46]. Fasting is done during Ramadan as a spiritual exercise and is mandatory for all healthy adults. Those exempt from Ramadan fasting include children (prior to the onset of puberty); developmentally disabled individuals; the elderly; those who are acutely or chronically ill, for whom fasting would be detrimental to health; travelers who have journeyed more than approximately 50 miles; and pregnant, menstruating, or breastfeeding women [46]. Practitioners should advise all patients for whom fasting would prevent healing or adequate care (e.g., inability to take medication) to postpone or abstain from the ritual, if possible [46].

AN OVERVIEW OF MAJOR RELIGIOUS IDEOLOGY AS IT RELATES TO HEALTH CARE[a]						
Topics	**Buddhism**	**Catholicism**	**Hinduism**	**Islam**	**Judaism**	**Protestantism**
Birth	As part of the reincarnation cycle, birth may be viewed as an opportunity for the spirit to attain enlightenment in this life. Although there are no Buddhist rituals specific to the birth of a child, some practitioners may engage in a naming ceremony.	Infants are usually baptized 40 days after birth.	At birth, the sacrament of jatakarma is performed, in which the father smells and touches the child and whispers religious passages. Om symbols may be placed on or around the child to ward off evil. A naming ceremony takes place 10 to 12 days after birth. The time of birth is of special astrologic importance.	Infants are usually bathed immediately after birth, prior to being given to the mother. The call to prayer is whispered in the child's ear, so it is the first sound heard. Male children are usually circumcised within seven days of birth.	A rite of passage in the Jewish community, birth is celebratory and is marked by a bris (circumcision ceremony) and a naming ceremony. Circumcision usually takes place eight days after birth.	Infants may be baptized in a symbolic ceremony, although this often takes place later in life.
Birth control	Preconception birth control is acceptable.	The official Church stance is against artificial birth control.	Birth control is generally accepted.	Preconception birth control that has no negative health consequences and does not lead to permanent sterilization is generally acceptable.	Birth control is considered a private issue, between a woman, man, and their particular faith.	There are diverse opinions regarding this subject among Protestant denominations.
Death	It is very important that everything be done to provide a quiet and calm environment for patients for whom death is imminent, as it is believed that calmness of mind at death translates to a better rebirth.	A priest should be called to give the sacrament of the sick if death is imminent. Last confession may be made to any person, although the patient may prefer a priest. Cremation is allowed; scattering of ashes is not.	A Hindu priest or Guru may be summoned for last rites. As the soul (*jiva*) is reincarnated until karmic absolution, death is seen as an opportunity to continue the spiritual journey.	Dying patients may request to face Mecca. Burial usually takes place as soon as possible, and there are special washing and shrouding procedures.	It is believed that one should not go into death alone; therefore, the dying individual will receive as much attention as possible. A confessional and shema (statement of faith) is read when death is imminent.	Traditions regarding death are also diverse. Some traditions require prayer and liturgies.

Table 1 continues on next page.

AN OVERVIEW OF MAJOR RELIGIOUS IDEOLOGY AS IT RELATES TO HEALTH CARE[a] *(Continued)*						
Topics	**Buddhism**	**Catholicism**	**Hinduism**	**Islam**	**Judaism**	**Protestantism**
Bereavement	Prayers for an auspicious rebirth are said for the 49 days following an individual's death. Meditation on impermanence is also important.	The presence of a priest may be necessary for support during this time. Prayers for the deceased soul may be said, informally and/or formally (Mass and/or the Rosary).	Remorse for the deceased is believed to inhibit the spirit from leaving the body. Therefore, excessive mourning is discouraged, though not always avoided.	The head should be covered when speaking of the deceased. Continuous prayers are recited in the home for three days following an individual's death. Guilt is a common component of grieving.	Bereavement does not formally begin until the burial, after which there is generally a seven-day period of mourning.	Among Protestants, bereavement is less structured than in other religions. Each person should be individually assessed.
Common religious objects	Prayer beads, images of Buddha and other deities	Bible, crucifix, rosary, images of the Holy family or saints, saint medallions	Prayer beads, incense, images/ statutes of deities	Prayer rug, Koran, amulet	Yarmulke or kippah (head covering), tallit (prayer shawl), siddur (prayer book), tefillin or phylacteries, candles	Bible, images of Jesus Christ or Biblical figures, religious jewelry
Major holidays	Wesak/Buddha Day, Losar, Parinirvana/ Nirvana Day, Asalha/Dharma Day, Bodhi Day	Christmas, Ash Wednesday, Lent, Palm Sunday, Maundy Thursday, Good Friday, Easter	Makar Sankranti, Holi, Diwali, Mahashivratri, Vasant Panchami, Rama Navami, Janmashtami/ Krishna Jayanti	Al-Hijra, Milad un Nabi, Ramadan, Eid al-Fitr, Eid al-Adha, Day of Ashura, Laylatul Qadr, Hajj	Shabbat, Rosh Hashanah, Yom Kippur, Purim, Passover, Shavuot, Sukkot, Hanukkah	Christmas, Ash Wednesday, Palm Sunday, Good Friday, Easter

[a]This overview is meant only to give a simple, brief summary of general ideology of each religion. By no means are all of the rites, beliefs, or holidays described practiced by all members of each religion; likewise, not all religious rites, beliefs, or holidays are listed for each religion. As always, individualized assessment is encouraged.

Source: [131; 132; 133; 134] *Table 1*

Circumcision is also common among some religious groups, and complications related to circumcision should be reviewed, as necessary. Sharing of razors, as in the case of ritual hair removal, or any other possible means of transmission of bloodborne pathogens (e.g., piercings, tattoos) should be considered, and risk minimization strategies should be discussed with patients [47].

CARDIOVASCULAR HEALTH

Masters et al. examined the relationship between religious orientation (intrinsic vs. extrinsic) and blood pressure reactivity among adults older than 60 years of age and younger adults, 18 to 24 years of age, when exposed to hypothetical stressful vignettes that described interpersonal confrontations [48]. Individuals were identified as intrinsically religiously oriented if they internalized their religious beliefs, while those who were extrinsically religiously oriented associated outward activities, such as attendance at

religious services, to their level of religious beliefs [48]. The study found that older and more extrinsically religiously oriented individuals showed higher blood pressure reactivity compared to younger and more intrinsically religiously oriented individuals. The researchers were cautious in generalizing the results to the larger population, but it appears that religious orientation in particular could in some way be linked to cardiovascular reactivity [48].

Studies show that attending religious services may serve as a protective buffer for coronary heart disease. In a large-scale study with 5,442 Canadians, those who attended religious services more than once per week had a lower odds of having diabetes or hypertension than those who attended less often or never [145]. Similarly, a study with Seventh-day Adventists found that higher levels of church attendance predicted lower levels of hypertension [175]. However, this relationship was no longer statistically significant when the participants' diet was considered. In a study of Muslim participants in Iran, researchers found an inverse relationship between levels of religiosity/spirituality and coronary heart disease (i.e., increased levels of religiosity/spirituality correlated with decreased likelihood of coronary heart disease) [221].

There is conflicting evidence, albeit in small studies, of the positive effects of intercessory prayer, or prayer on behalf of another person, on cardiovascular health. Two studies of patients admitted to coronary care units (CCUs) examined the effects of remote, directed prayer by an outside group of Christians [49; 50]. The authors of the first study found that those who were the subjects of an intercessory prayer group required less ventilatory assistance, antibiotics, and diuretics than the control group; researchers in the second study determined that those who had been recipients of prayer had significantly lower CCU course scores [49; 50]. However, a study completed in 2006 found no difference in cardiac bypass patients who were recipients of intercessory prayer [135]. In fact, patients who were certain that intercessors would pray for them had a higher rate of complications compared to patients who were unsure. The authors hypothesize that there are several potential reasons for this finding differing from earlier studies: the effect was smaller than the 10% difference the study was designed to detect, the measurement (complications within 30 days of coronary artery bypass graft surgery) was not appropriate, or intercessory prayer has no effect on outcomes in patients undergoing bypass graft surgery [135].

It has also been suggested that cardiovascular benefits may be derived from chanting or prayer recitation [51]. In one small study, recitation of six Hail Mary prayers or yoga mantras per minute was associated with a significant increase in baroreflex sensitivity and enhanced heart rate variability [52]. The authors of the study concluded that engaging in the prayer or mantras provided cardiovascular benefits because it slowed "respiration to almost exactly six respirations per minute, which is essentially the same timing as that of endogenous circulatory rhythms" [52]. Consistent Buddhist meditation has also been found to be correlated with decreases in blood pressure, pulse rate, and serum cortisol [53]. In a systematic review of 19 studies, 63% found an inverse relationship between religion and spirituality and coronary heart disease [146]. Ultimately, in all these studies, inferences regarding causation cannot be made.

HEALTH PROMOTION AND WELL-BEING

There also appears to be a relationship between religion and health-promoting types of behaviors. In other words, religious orientation may play a role in decreasing the tendency to engage in health compromising behaviors, such as substance misuse and sexual risk-taking [210]. In one study conducted with 211 African American college students, researchers found that students with proreligious, intrinsic, or extrinsic religious orientations were more likely to engage in health-promoting behaviors, including eating well, reporting symptoms to a physician, and using stress management techniques [54]. When religion/spirituality is conceptualized as a bond or attachment to God, paralleling human experiences with attachment to a key caregiver figure, religious attachment predicts psychologic well-being and life satisfaction [176].

In a 2020 study, all-cause mortality rates were lower among those who were more religiously involved (e.g., regularly attend religious services) [210]. McCullough et al. found that those who were less religiously involved were more vulnerable to death at follow-up compared to those who were more religiously involved, even after controlling for demographic variables, health behavior, and social support [55]. In a longitudinal study that followed adults with cancer for more than 30 years, cancer mortality was found to be lower for those who attended church more frequently, when age and gender were taken into account [56]. However, the findings were not statistically significant after controlling for preexisting health conditions. In yet another study, spirituality was not found to be related to slowing the progression of cancer or improved recovery [57]. In a review of 326 quantitative studies that examined the relationship between well-being and spirituality/religion, 79% found a statistically significant positive relationship [146]. Studies on mortality and religion are compelling because of the large sample sizes, longitudinal nature, and ability to control for key variables (e.g., health status and functioning) [210].

Research also indicates that when health messages align with patients' religious/spiritual beliefs, they are more likely to engage in health promotion programs. This is exemplified by a HeartSmarts Program targeted to African Americans that incorporated both scriptures and evidence-based health promotion messages [177]. Another health promotion program targeted to Latinos provided information on healthy living in a Catholic religious context [178]. In both cases, participants were more likely to engage in positive health promoting behaviors when the health educational components were viewed consistent with their faith.

CHRONIC ILLNESS

HIV/AIDS

Spirituality and religion are considered important aspects of care for patients with chronic illnesses. This has perhaps been most extensively studied among patients with human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS). There have been studies of the effects of religion and spirituality on well-being, coping, and psychologic adjustment of those diagnosed with HIV. In a large-scale, national study of HIV-infected adults in the United States, 70% stated that religion was very important to them and 90% viewed spirituality as very important [58]. These findings are not surprising given the serious nature of their illness. Although this study did not find any relationship between the clinical stage of the HIV infection and level of religiosity or spirituality, a longitudinal study that examined disease progression in 100 people with HIV found that the increase in spirituality/religiousness after HIV diagnosis predicted a slower disease progression [58; 59]. Another study of 275 HIV-infected individuals residing in Wisconsin found that different dimensions of spirituality and religiosity were correlated with coping and adapting [60]. For example, those who engaged in prayer practices, utilized formal religion, and reported a higher sense of spirituality were more likely to use adaptive coping strategies. Furthermore, a profile emerged in which spirituality was associated with being female, non-White, receiving support from family members, and using active problem-solving strategies [60]. An investigation into the relationship between religious coping and health outcomes (e.g., viral load, CD4 count, HIV symptoms) in 429 patients with HIV/AIDS indicated that positive religious coping (e.g., seeking spiritual support) is associated with positive health outcomes [61]. In a study of 226 African American women with HIV, level of religiosity (e.g., prayer, attendance at religious services) appeared to buffer HIV stigma and reduce depression [222].

In one study, themes emerged related to building spiritual meaning for patients with HIV, including the concepts that purpose in life emerges from stigmatization; opportunities for meaning arise from a disease without a cure; and after suffering, spirituality frames the life [62]. This theme about a renewed sense of life also emerged in a qualitative study with Brazilian adults diagnosed with HIV. For the participants, being spiritual helped them make a concerted effort to take care of themselves and appreciate life [179]. Another qualitative study focused on individuals with HIV/AIDS who practiced Buddhism [147].

The researchers found that the individuals reported harmony with their illness and an acceptance of impermanence, which brought the participants peace. Recommended spiritual interventions for patients with HIV include promoting hope, teaching, sharing information, and creating a sense of empowerment to address spiritual issues [63].

In a meta-analysis of research published between 2000 and 2020, 62% of the studies demonstrated that greater attendance at religious services/events correlated with more condom use [223]. Furthermore, 100% of the studies found a positive relationship between religious services attendance and greater frequency of HIV testing.

Cancer

Spirituality has also been examined with regard to the course of illness for patients with cancer, though the results are mixed in terms of its role in cancer morbidity and mortality [138]. One consistent finding is that spirituality is related to positive reports of well-being among patients with cancer regardless of the stage of the illness [138]. A study of more than 8,000 cancer survivors found that participants' faith contributed to their quality of life, suggesting that religious faith can help manage anxiety, regulate emotions, and offer a sense of control when patients felt helpless [180]. In a small, qualitative study conducted by Simon et al., the experiences of spirituality among female patients in different stages of cancer were examined [64]. For many of the participants, spirituality served as a coping resource upon learning of their diagnosis. Anxiety and fear were common reactions to the cancer diagnosis; many of the women expressed the feeling that spirituality had helped them find meaning in the situation. During this initial phase, many of the women referred to a reliance on their faith in God to direct their decisions about treatment. During the treatment phase, the women stated that their faith and spirituality allowed them to maintain a positive attitude and reduced their fears. Furthermore, spirituality helped patients find a will to live. Consequently, many of these women discussed the growth of their spirituality during treatment. Finally, survivorship was linked to their higher power. In other words, many of the women believed that they had survived because of their God [64]. In a 2016 study of men diagnosed with prostate cancer, those who reported greater levels of spirituality experienced more satisfaction and less conflict with their decision-making processes [181]. A 2019 study also found that religion and spirituality contributed to positive coping and meaning-making for patients with cancer [224]. Meaning and peace, the two dimensions measured for spirituality, were found to be related to depressive outcomes in a quantitative study with an ethnically diverse sample of cancer survivors [225]. Greater levels of meaning and peace one year after diagnosis predicted fewer depressive symptoms nine years after diagnosis.

The National Cancer Institute has identified ways in which spiritual and religious well-being may improve the quality of life of patients with cancer, including [43]:

- Improved health outcomes
- Increased ability to enjoy life during cancer treatment
- Better adjustment to the effects of cancer and its treatment
- A feeling of personal growth as a result of living with cancer

Although spirituality and religiosity should be considered as part of the assessment of cancer patients, there is not sufficient evidence to recommend participation in spiritual/religious activities as part of the treatment [65]. Addressing spiritual concerns has traditionally been regarded as an end-of-life issue, even though such concerns may arise at any time after diagnosis. The National Cancer Institute recommends that inquiries into spiritual and religious concerns be postponed for patients with cancer until after diagnosis and treatment options have been discussed and considered by the patient [43].

Overall, many researchers have found links between spirituality or religion and health outcomes, but they remain cautious about the findings. First, many of these studies involve small sample sizes, nonrepresentative samples, and/or correlational research designs, whereby one cannot infer cause and effect at the conclusion of the study. Second, because spirituality and religiosity are complex, multidimensional constructs, it is difficult to derive a correlation with health outcomes [66]. Third, many studies do not control for other variables, such as socioeconomic status, age, physical mobility, and social support, all of which may also affect outcomes [67]. In some cases, when additional variables are controlled for, the significant relationships disappear altogether [66].

OVERVIEW OF THE ROLE OF SPIRITUALITY/RELIGIOSITY IN MENTAL HEALTH

Spirituality and religiosity have also been examined in the field of mental health. Because they are only part of a diverse set of variables that affect mental health, spirituality and religiosity should be assessed in addition to various other contributory factors.

DOMESTIC VIOLENCE

In the area of domestic violence, the role of spirituality/religiosity is not clear and is complicated by cultural norms and ethnic perspectives. Patriarchy and sexism, for example, are often reinforced by cultural and religious communities, in which an individual's place in society is often defined by gender. Patriarchal ideology reinforces personal and institutional sexist expectations for women and results in power differentials between men and women [68]. Many religious tenets, for example, place women in a subordinate role [69]. In Islam, marriage is considered "a means toward personal and spiritual fulfillment," and a husband is to be a "partner in faith" [70]. Muslim women may enter marriage believing that the act is an "enactment of spiritual harmony and for the greater social good" [70]. These assumptions about women's roles in the family could then affect how abuse is handled and reported. Religiosity may also influence attitudes toward the acceptability of domestic violence. In a large international study, individuals who reported greater levels of religiosity were less likely to endorse the acceptance of physical violence against wives [182]. This was particularly true in countries in which social control mechanisms were minimal or non-existent. Conservative belief systems that underlie certainly religions or practices devalue women's roles in families and societies, and this may be key in facilitating violence against women [226]. In one study, those who were more likely to attend religious services were less likely to approve of the use of violence. However, social conservativism was positively correlated with spousal violence.

Spiritual and religious involvement has also been shown to decrease the incidence of depression among domestic violence survivors. In a survey of African American domestic violence survivors, researchers found a positive relationship between religious involvement and level of social support [71]. This support then served as protective against adverse mental health outcomes, such as depression. In a separate study of Latino couples, spirituality served as a protective buffer against psychologic abuse [148].

Spirituality and religion may also be utilized as coping strategies or mechanisms for healing in cases of domestic violence. In one study of domestic violence survivors, Gillum et al. found that the majority of women identified their spirituality and the support they received from their faith community as vital to healing and recovery [72]. The extent of religious involvement influenced the level of psychologic well-being in a positive manner, decreasing the probability of depressive symptoms. In a study of Muslim women who had experienced abuse by their partners, religion was described as a source of strength and resilience and Allah was viewed as a protector and refuge from the violence [183].

SUBSTANCE USE DISORDERS

There has been increased attention to the relationship between spirituality/religion and substance misuse and dependence. In part, this can be attributed to Alcoholics Anonymous (AA), a self-help group organization founded in 1935. The AA program is based on spirituality, as it views alcoholism as a multifaceted problem affecting physical, spiritual, and mental arenas. The 12-step program utilized by AA and other support groups is a process-oriented treatment and recovery plan with a spiritual component [73; 74]. In the United States, 73% of addiction treatment programs, including 12-step programs, have some form of spirituality-based component to their treatment [227].

Neff and MacMaster argue that each of the 12 steps reflects cognitive and behavioral components, which also encompass spirituality [75]. One of the major tenets of the 12-step program is surrender to a higher power, but along with this spiritual ideology are cognitive and behavioral factors, such as obtaining a sponsor and attending meetings. Ultimately, AA's recovery process emphasizes the importance of surrendering to a higher power and the role of prayer (i.e., the Lord's Prayer and the Serenity Prayer) [76]. Interpretation of the concept of "higher power" is left to the individual to define [76]. It has been said that AA's spiritual philosophy is broad so that diverse groups can embrace its tenets [77]. In a 2020 study with a sample of 2,002 adults in the United States, spirituality and not necessarily religion facilitated recovery for alcohol and substance use disorder [228]. This was particularly true for African American participants.

It has also been surmised that spirituality and religion may reduce the risk of substance misuse [78; 79; 80; 81]. In a large-scale national study involving 17,736 adolescents, greater religiosity was protective against recreational cannabis initiation and use [184]. In another study, researchers found that positive religious coping and aspects of spirituality are protective against drinking alcohol and cannabis use [149]. Using a longitudinal design, adolescents who endorsed higher levels of religiosity were found to have lower levels of use of cigarettes, alcohol, and cannabis compared to their less religious counterparts [150]. Finally, in a systematic review of the literature from 2007 to 2013, the researchers found an inverse relationship between substance use behaviors and spirituality and religion [151]. However, it is not clear which components of spirituality and religion (i.e., commitment to substance avoidance, social support, religious involvement, or prosocial values promoted by religious affiliation) actually act as the protective factors [79]. There is also some contrary evidence that shows a positive relationship between religion and increased risk of substance misuse [79].

PSYCHIATRIC DISORDERS AND MENTAL ILLNESS

Although there is an increasing emphasis on interventions that take a holistic approach to mental illness and working with patients and families toward recovery, some practitioners have expressed concern about focusing on spirituality and religiosity, particularly with patients who are diagnosed with severe mental and psychotic disorders [82]. Because patients with psychotic disorders may experience delusions and hallucinations with religious content, focusing on religion might exacerbate symptoms of disorganized thought and potentially promote injury to self or others [82; 83; 185]. Furthermore, rigid religious beliefs associated with guilt or sin may have the potential to aggravate major depression [82; 146]. An extreme version of this is moral or religious scrupulosity, an obsessive concern with one's sins and moral behavior. This condition is generally considered to be a type of obsessive-compulsive disorder [84]. Scrupulosity is characterized by excessive guilt or obsession related to religious issues, often along with extreme moral or religious observance [85]. Treatment of this disorder is difficult, as practitioners often feel torn between addressing the pathology of the disorder and respecting the patient's religious beliefs. However, there is no doubt that some individuals turn to spirituality and religion in times of stress. An overwhelming number of psychiatric patients stated that religion was their source of comfort [86; 87]. Religion/spirituality may be considered a mechanism of social support, positive coping and decision making, and avoidance of

substance misuse. At times, it can positively impact psychologic well-being [83; 87]. In a small study of adults with psychosis, participants reported finding religious rituals beneficial [185]. The adults chose which religious practices in which to engage, and some identified certain scriptures that communicated autonomy and control. Interestingly, many of the participants expressed a needed to take an active role in the recovery process versus a passive approach of merely relying on God. Religion was also described as a vehicle to experience hope and purpose, which was vital in the recovery process.

Safe religious and spiritual spaces have also been found useful for individuals diagnosed with schizophrenia [172]. These spaces can foster community and relationships, which then promote a sense of well-being, peace, acceptance and support. This is particularly important in light of the prejudice, stigma, and discrimination that many with schizophrenia experience.

A separate study of Catholic and Protestant students in Northern Ireland found that increased prayer frequency was associated with a better level of psychologic health in terms of Eysenck's concept of psychoticism, which is characterized by recklessness, disregard for common sense, inappropriate emotional expression, and hostility toward authority figures [88]. Corrigan et al. found that spirituality and religiousness decreased psychiatric symptoms, increased overall management of daily tasks of life, and increased psychologic well-being among those with mental illness [89]. A study conducted in Pakistan involving adults hospitalized for depression found that participants' level of religiosity predicted mental well-being [186]. A Canadian study of approximately 37,000 individuals found that higher worship attendance frequency was associated with a lower risk for the development of mood, anxiety, and substance use disorders [90]. In a 2012 meta-analysis of 444 studies dating back to the 1960s, 61% reported an inverse relationship between spirituality/religion and depression [146]. In another systematic review focusing on research published between 1990 and 2010 and including all types of mental disorders, 72% of the studies demonstrated an inverse relationship between religion/spirituality and mental disorders [152]. However, the findings were mixed when focusing solely on schizophrenia, and no relationship was found in studies examining only bipolar disorder.

In summary, as in the area of general health, there are no definitive conclusions about the precise mechanisms or correlations between spirituality and religion and amelioration of mental health outcomes, coping, and psychologic well-being. Causal statements at this point cannot be made; continued research efforts are needed.

Endorsing both mental illness symptoms and religion/spirituality can result in a double stigma [229]. Because practitioners are not always comfortable discussing religion/spirituality in relation to mental illness, patients may be reluctant to seek services. Practitioners may also fear that conversations regarding religion/spirituality could exacerbate mental illness.

COPING AND SPIRITUALITY/RELIGIOSITY

When individuals experience health or mental health problems, spirituality or religiosity may be utilized as a form of coping. Pargament identified three ways that religion might aid individuals in coping [91]. First, religion can influence the perspective an individual assumes toward the stressor; the source of stress may be viewed as part of a divine plan or acceptance of a larger life plan [153]. Second, religion can shape the coping process; that is, religion or spirituality can be employed as an inner resource to overcome the challenges associated with the health or mental health problem. Patients with mental illness often use religious or spiritual resources (e.g., prayer) to cope [229]. Finally, the coping process may strengthen an individual's spiritual or religious orientation. Three different types of religious coping have been identified [91; 92]:

- Self-directed coping: No reliance on God or higher power(s) to solve problems. ("It's my problem to solve, not God's.")

- Collaborative religious coping: Utilization of strategies within oneself and God or higher power(s). ("God helps those who help themselves.")
- Deferred religious coping: Passive attitude toward problems; waiting for God or higher power(s) to intervene. ("It's in God's hands.")

Rowe and Allen found that there were positive relationships between spirituality and coping among those with chronic illness [93]. Patients with chronic illness who measured high in terms of spirituality also measured high in areas of coping, which may reflect the role of spirituality in managing the stressors of chronic illness. In addition, intrusive positive thoughts (i.e., the ability to cope with stress through a positive outlook) predicted levels of spirituality among those with chronic illness. As a result, it was speculated that how one copes is mediated by one's outlook, which in turn may be influenced by one's spirituality [93].

However, findings do not always show a positive relationship between religion and coping. For example, a study with men diagnosed with prostate cancer found that African American men had lower religious coping scores than their white counterparts [187]. In this study, African American men were more likely to attribute their cancer diagnosis to God's punishment and to report their faith had weakened after learning of the diagnosis.

In a study of 100 adult survivors of childhood sexual abuse, spiritual coping predicted the level of current distress after controlling for various demographic factors, severity of abuse, and satisfaction with social support [94]. Adult survivors with self-directed and deferred religious coping styles were more likely to experience anxiety than those who utilized collaborative religious coping techniques. Spiritual discontent, another negative form of spiritual coping, tended to be correlated with greater distress [94]. In a 2013 study involving women with breast cancer, patients who deferred control to God were less anxious and had fewer concerns, but this also fostered a passive coping style and potentially a lower quality of life [154]. While deferring control can lead to acceptance and peace, practitioners can assist patients to implement active coping styles that are in harmony with their existing beliefs.

Spiritual coping may also increase family communication [188]. Research indicates that an individual's satisfaction with family communication can be improved by working through spiritual coping. However, it is important to note that spiritual coping is not a family phenomenon; rather, it is experienced on an individual level.

CULTURE AND SPIRITUALITY/RELIGIOSITY

Although many instruments meant to measure religion and spirituality have been developed, these instruments have been characterized by some as Eurocentric and Judeo-Christian focused [38]. Because the United States is both culturally diverse and religiously pluralistic, the role of culture, race, and ethnicity in the discussion of spirituality and religiosity should not be discounted.

Culture is defined as the beliefs, values, and prescribed ways of behaving that are passed from generation to generation, affecting cognition, structural institutions, and social, interpersonal, and political arenas of life [95]. Similarly, religion and spirituality consist of systematic patterns of beliefs, values, and worldviews shared by groups of individuals that affect patterns of behavior. Religion also influences how social relationships are organized, specifically through diverse rituals and ceremonies [27]. For many ethnic minority groups, religion and spirituality are intertwined with their cultural values and belief systems. In Asian cultures, spirit is usually conceptualized as a life energy force derived from harmony—harmony in relationships with oneself, others, the community, and the universe [230]. Spirituality and religiosity may be interconnected with issues of marginalization, oppression, and discrimination for some cultural and ethnic minority groups. In many cases, religion and spiritual beliefs may serve to buffer the life stressors caused by oppression [27].

AFRICAN AMERICAN CULTURES

Some have argued that religion and spirituality in African American culture are shaped by political and social contexts, particularly issues of race/racism, slavery, oppression, justice, and liberation [96; 231]. Notions of being freed from bondage, as espoused in Christian tenets, resonated with many slaves. However, those who became Christians were then prevented from participating in worship services by their slave owners. They had to find clandestine places to worship, which many surmise is the origin of "black churches" in America [189]. It is important to remember this historical backdrop and how it continues to influence the views of African Americans today.

Spirituality for African Americans has been referenced in the following manner [97]:

> Faith in an omnipotent, transcendent force, experienced internally and/or externally as caring interconnectedness with others, God, or a higher power; manifested as empowering transformation of and liberating consolation for life's adversities; and thereby inspiring fortified belief in and reliance on the benevolent source of unlimited potential.

God, Allah, and figures of a higher being are viewed as conquerors for the oppressed. Consequently, religious and spiritual orientations are often used among African Americans both to deal with and construct meaning from oppression and promote social justice and activism [96].

The belief that God is a deliverance from pain during times of suffering is centered on the historical legacy of slavery and its attempt to destroy African culture and families [98]. Many African Americans indicate that they derive their strength from the belief that God is in a personal relationship with them and that life's adversities will eventually liberate them [99]. Prayer is one religious practice through which they experience God's support, presence, grace, and affirmation, particularly during crises [189]. The Black church is often viewed as a place of community and refuge where congregants can ask for help and support [231].

In a national survey, 83% of African Americans stated that they believed in God with certainty, and 75% indicated that religion was very important [190]. Almost half (47%) stated they attended religious services at least once a week [190]. Religious involvement has become a source of empowerment and strength for many African Americans. According to the National Survey of American Life, which included 6,082 adults in the United States, African Americans and Afro-Caribbean participants were more likely to report attendance at religious services and affiliation to a specific religious denomination than non-Hispanic white participants [5]. In many cases, African American women play critical roles in the church [98]. Emotional expressiveness often characterizes African American churches, as emotions provide a venue for suffering and sorrow [98]. The level of religiosity may correlate with older age. For example, one study found that 89% of African Americans reported being religious, but only 52% to 55% of African American adolescents indicated that religion played a very important role in their lives [155].

JEWISH CULTURES

As noted, Judaism is the second most commonly practiced religion in the United States, following Christian denominations [1]. There are four major branches of Judaism, although smaller movements do exist worldwide. For the most part, Jewish individuals may be classified as Reform (the most liberal expression of modern Judaism); Conservative (known as Masorti Judaism outside the United States); Orthodox (the most traditional expression of modern Judaism); or Reconstructionist (the smallest and newest branch) [100; 101]. Some individuals may not practice a particular religious tradition, but because of the long cultural and ethnic history, these individuals may identify either racially or ethnically as Jews [100]. Experts often refer to this as Humanistic Judaism [103].

The major themes of Jewish values include community solidarity, fundamental social justice, and covenantal relationships [104]. These values are maintained through religious ceremonies and, especially among Reform or Humanistic Jews, through the pursuit of social justice.

ASIAN CULTURES

Many Asian cultures are predominantly influenced by Buddhism, Taoism, and Shintoism. Buddhism is based on the life and teachings of Siddhartha Gautama, who is believed to have founded Buddhism more than 2,500 years ago. The crux of Buddhist spiritual beliefs are manifested in the Four Noble Truths [105]:

- The Truth of Suffering: Conflict and tension are attributes of life.
- The Truth of the Cause of Suffering: The root of this tension stems from desire or craving.
- The Truth of the End of Suffering: In order to end tension, desire or craving must be eradicated.
- The Truth of the Path Leading to the End of Suffering: Practice of the Eightfold Path leads to nirvana and ends desire.

Shintoism involves the worship of spirits and was once the official religion in Japan. Shintoists describe humans as body, mind, heart, and spirit. The spirit leaves at death. In the living world, the goal is to take care of one another and one's ancestors, which is why ancestor worship is important [106]. Thus, there are both vertical and horizontal relationships: those with ancestors and those with other members of society.

Many Asians, both abroad and in the United States, have adopted Christianity or Islam. There was a large Christian missionary influence dating back to 19th century in Asia, and many converted to Christianity before or after immigrating to the United States, with some viewing conversion as part of the acculturation process [156]. According to the Pew Research Center, 42% of Asian American adults in the United States identify as Christians [191]. Despite the adoption of a monotheistic religion, many Asian families retain Buddhist, Taoist, or Shinto influences as part of their cultural traditions [156]. Many Asian Americans and Asian immigrants integrate traditional and Western religious beliefs without any dissonance [192].

Religiosity may be declining among second-generation Asian Americans [232]. Religiosity rates for second-generation Protestant and Catholic Asian Americans have remained steady, although they report religion being less salient. However, it appears that Buddhism and Hinduism is not retained at the same rate among second-generation Asian Americans affiliated with these religions. In fact, second-generation Asian Americans are more likely to become disaffiliated with any religion (34.7%) than the general population (20.1%) [232].

HISPANIC/LATINO CULTURES

According to the Hispanic Churches in American Life Survey, the vast majority of Hispanics/Latinos self-identified as Christians [157]. The Hispanic/Latino culture is heavily influenced by Roman Catholicism. It is estimated that Roman Catholicism plays a predominant role in the lives of approximately 90% of Hispanic/Latino Americans [107; 193]. Roman Catholics strongly adhere to religious values that are centered on marriage and family, and condemnation of premarital sex, abortion, and the use of contraception is stressed [107]. In addition, the concepts of penance and redemption are key for practicing Catholics. While the main figures of Christianity are foremost (i.e., God, Jesus, and the Apostles), the Virgin Mary and canonized saints play a large role in the creation of spiritual relationships.

Practicing Catholics often pray almost daily, believing God is an active part of their lives. A crucifix and other religious symbols are commonly displayed in their home [233]. However as with the general population, religiosity may also be declining among Hispanics/Latinos. In a study with 5,000 Hispanic participants in the United States, 24% are now former Catholics [234]. Those born in the United States are more likely to be unaffiliated with any religion than those born outside the United States [234].

While many persons of Latin American descent practice Catholicism, for some, Santería and Espiritismo blend with their spiritual beliefs [98; 148].

Both Santería and Espiritismo have their roots in African and Catholic beliefs [108]. When enslaved Africans were brought to the Caribbean, they were exposed to Catholicism [108]. The blending of the traditional African religion of Ifa and Roman Catholicism resulted in Santería. Orishas, the potent forces or spiritual energies that are the foundation of the universe, are the central tenet of Santería [109].

Espiritismo is another spiritual belief system practiced among Hispanics/Latinos. The central focus of Espiritismo involves the existence of both good and evil spirits that can affect health [148]. According to the doctrine of Espiritismo, spirits are reincarnated in order to progress spiritually and all humans have benevolent spirits that guide them through the daily activities of life. However, evil spirits may be encountered, which can have adverse and negative influence [108]. One of the goals in Espiritismo is to achieve harmony and balance in relation to self, others, and the spirits [108]. Some have termed these belief systems as "healing cults" [157].

Familismo is an important Hispanic cultural value emphasizing family respect, loyalty, and mutuality, and in Hispanic/Latino cultures, family, religion, and spirituality are deeply intertwined [194; 195].

EVIDENCE-BASED PRACTICE RECOMMENDATION

The American Academy of Child and Adolescent Psychiatry recommends clinicians consider consulting and collaborating with traditional healers (e.g., *curanderos*, *santeros*, or shamans) and including rituals and ceremonies in psychotherapy with children from more traditional backgrounds.

(https://www.jaacap.org/article/S0890-8567(13)00479-6/fulltext. Last accessed April 19, 2021.)

Level of Evidence: Consensus Statement/Expert Opinion

NATIVE AMERICAN CULTURES

There are 574 federally recognized Native American nations, and as such, the concept of Native American spirituality does not capture the diversity represented among all these groups [110]. However, there is a set of core values that serves as the foundation for Native American spirituality, including an emphasis on community, sharing, harmony, extended family, attention to nature, relationships, and respect for elders [102; 111]. Spirituality is deeply woven into these cultures [235]. Locust summarized the following tenets as being central to Native American spirituality [112; 158; 196]:

- There is a higher being or power, referred to as Creator, Great Spirit, or the Great One.
- Spirits exist, but they are considered "lesser" than the higher being.
- Humans are a part of creation, and all living things (e.g., people, animals, plants, nature) are related. The notion of "all my relations" encompasses all these dimensions and reflects a deep sense of responsibility to all living things.
- All living things, such as plants, animals, and humans, are part of the spirit world, which exists side by side with the physical world. Humans are comprised of three interconnected elements: spirit, mind, and body.
- Physical and emotional well-being are the result of harmony of the body, mind, and spirit.
- When illness occurs, it is believed that there has been a disruption within the natural order or interaction with those with evil motives (i.e., "witchcraft").
- Every human is responsible for maintaining harmony with the self, others, the environment, and the universe.

For many Native Americans, their cultural identity is connected to spiritual beliefs, rituals, and activities [235]. Spirituality may be practiced through learning the sacred drum, dancing, talking circles, and other ceremonies [197].

CLINICAL ASSESSMENT AND INTERVENTIONS

ASSESSMENTS

Using spirituality and religion as a framework in the biopsychosocial assessment assists to identify the role they play in the patient's worldview. Incorporating spirituality and religion into assessments gives a more comprehensive understanding of patients' realities [198]. Alternatively, not addressing spirituality and religion can violate individuals' rights to self-determination.

There are a variety of assessments for spirituality and religion. The National Cancer Institute recommends that healthcare providers consider the following before selecting an assessment method [43]:

- The focus of the evaluation (e.g., religious practice, spiritual well-being/distress)
- The purpose of the assessment (e.g., screening for distress)
- The modality of the assessment (e.g., interview or questionnaire)
- The feasibility of the assessment (e.g., staff, patient burden)

Quantitative assessments entail a questionnaire with closed-ended questions, whereby the question items are predetermined and do not allow for diversity of experience or practice [23]. On the other hand, qualitative approaches to measuring spirituality are similar to taking a personal history. The qualitative approaches are generally considered more useful and comprehensive, although incorporation into daily practice may be difficult.

The Joint Commission, which evaluates and accredits healthcare organizations in the United States, mandates that practitioners in health organizations and agencies conduct an initial, brief assessment about spirituality. They require that, at a minimum, three areas be explored: denomination or faith, spiritual beliefs, and spiritual practices [113]. It may be that the practitioner merely conducts this initial assessment and finds that neither spirituality nor religiosity plays a dominant role in a patient's life. If the practitioner finds that either spirituality or religiosity is a key dimension, a more comprehensive assessment would be required. However, The Joint Commission has not developed clear guidelines as to the extent of an appropriate comprehensive assessment [114].

The Joint Commission provides the following questions that may be included in an assessment of spirituality; however, discussion need not be limited to these questions [113]:

- Who or what provides the patient with strength and hope?
- Does the patient use prayer in their life?
- How does the patient express their spirituality?
- How would the patient describe their philosophy of life?
- What type of spiritual/religious support does the patient desire?
- What is the name of the patient's clergy, ministers, chaplains, pastor, rabbi?
- What does suffering mean to the patient?
- What does dying mean to the patient?
- What are the patient's spiritual goals?
- Is there a role of church/synagogue/mosque in the patient's life?
- How does faith help the patient cope with illness?
- How does the patient keep going day after day?
- What helps the patient get through this healthcare experience?
- How has illness affected the patient and his/her family?

Open-ended questions give patients the opportunity to tell their stories, and it can be helpful to determine the emotional aspects of these stories [236]. The following open-ended questions can be helpful when assessing spirituality [237]:

- Where do you find your support?

- What gives you ...
  - Strength?
  - Hope?
  - Peace
- Where do you find meaning in your life?

The rationale in conducting an initial, brief assessment is to determine if the patient's spiritual beliefs will serve as a barrier to service delivery [114]. An individual may be reluctant to participate in certain interventions, and understanding the patient's spiritual or religious background would contextualize the patient's responses and behaviors. For example, a Muslim patient or Hasidic Jew might be reluctant to participate in mixed-gender groups or be treated by members of the opposite sex [114].

Koenig and Pritchett assert that it is vital to provide patients with the opportunity to engage in a dialogue about the role of spirituality and religion in their lives [115]. For example, they urge clinicians to ask: Is religion or faith an important part of your life? How has faith influenced your past and present? Are you part of a spiritual or faith community? Are there any spiritual needs you would like to explore or discuss? These questions are similar in many respects to those provided by The Joint Commission.

Curtis and Davis offer a slightly different approach [116]. They suggest an initial closed-ended question, such as: "Do you have any spiritual or religious beliefs?" With such a question, the patient can simply answer yes or no. If the patient indicates a simple "no," the practitioner can then move on without the patient feeling guilty or uncomfortable [116]. Curtis and Davis assert that if practitioners initially inquire regarding patients' spiritual or religious views with an open-ended question, then patients may feel pressured to indicate that they do have spiritual or religious beliefs, even if they do not consider them important [116]. Practitioners can respond by encouraging the patient to express any thoughts or questions related to spiritual or religious matters during the session. Such statements convey to patients that while the practitioner is receptive to talking about such matters, it is acceptable not to talk about them as well. If the patient responds in the affirmative to the initial closed-ended question, then the practitioner can continue with more open-ended questions. When time is of the essence and a rapid assessment is necessary, two questions might be helpful: "Are you particularly religious or spiritual?" and "What helps you most when things are difficult or when times are hard?" [199].

Inclusive language should be employed and is viewed more favorably by patients [159]. Instead of asking if a patient goes to church, ask if he or she is part of a faith community. It is also important to distinguish between explicit and implicit assessments of spirituality and religion [160]. Some patients prefer not to touch on spirituality and religiosity until they are comfortable with the practitioner's level of competence. In such cases, the practitioner may assess spirituality and religiosity indirectly by inquiring about beliefs or ideas that give meaning (or purpose) to the patient's life. It is important to remember that it is possible to be spiritual without being religious. It can be telling to also assess where the patient perceives meaning is lost rather than simply focusing where the patient places future meaning [200].

Spiritual histories, genograms, and life maps may also be useful assessment tools. A spiritual history consists of an open-ended interview that explores the patient's and his/her family's religious and spiritual beliefs, practices, and traditions. The public and private experiences of religion and spirituality are explored along a developmental life cycle [23]. Spiritual genograms are family trees that focus on religious and spiritual traditions, events, experiences, family orientation, and rituals that shape the patient's worldview and spirituality [23]. Spiritual life maps are pictorial illustrations of the patient's spiritual journey. Like a road map, the life map indicates where the patient has come from, where the patient is now, and what the patient is moving toward [117]. When creating this map, Hodge encourages practitioners to ask patients to "highlight the trials they have encountered and the spiritual resources they have used to cope in the course of their journey" [117].

Practitioners should also be in tune with the terminology and language patients use that may indicate that he or she is receptive to incorporating religiosity or spirituality into the conversation. For example, if a patient says "it is in God's hands" or "counting my blessings," this may suggest a spiritual worldview and an openness to discussing the role of spirituality in one's health and wellness [161].

Since 2010, more than 40 spiritual assessment tools have been developed [198]. Most of them, however, were developed for a specific field. Instead of developing more assessment tools, the best option may be to revise and improve existing tools and best practices.

INTERVENTIONS

Studies show that practitioners who use spiritual interventions, such as prayer, discussing religious concepts, and forgiveness, tend to combine them with traditional therapeutic frameworks [118]. Richards and Potts highlight several practice guidelines for those considering the use of spiritual interventions [119]:

- A trusting relationship between the patient and practitioner should exist before using spiritual interventions.
- Obtaining the patient's permission to discuss spiritual or religious issues is crucial. This is the heart of informed consent and self-determination.
- The practitioner should assess the patient's understanding of his/her religious doctrines or spiritual beliefs before utilizing spiritual interventions.
- Spiritual interventions should be used within the patient's value system, not universally.
- Spiritual interventions should be used carefully, with much thought and planning.
- It is important to assess the patient's mental status, as there is some concern that spiritual interventions may not be amenable with psychotic patients.
- Spiritual interventions should be employed cautiously, particularly if spiritual issues are at the heart of the patient's problems.

A small study of physicians identified several practices that improved the provision of providing spiritually sensitive care [201]:

- Practitioners must be comfortable and confident in their own spirituality and mortality before being able to incorporate into their practice.
- Practitioners should be aware that spirituality is vital as a guiding force, and therefore, it is crucial to respect patients' spiritual beliefs.
- Practitioners should be willing to acknowledge that spirituality positively affects coping and functioning.
- Practitioners should allow patients to signal when they want or are ready to talk about spirituality.
- Practitioners and patients who share similar spiritual beliefs and backgrounds find it easier to talk about spiritual matters.
- Practitioners should not feel rushed to talk about spirituality.

Practitioners who adopt a relational posture that reflects an ethics of care and apply Rogerian tenets of unconditional positive regard, authenticity, and empathy will be able to develop trust with their patients. At that point, patients will feel comfortable enough to disclose to the practitioner when and how to incorporate religion and spirituality into their care [162]. When trust has been developed, practitioners can assess what services may be appropriate to meet patients' spiritual or religious needs [229].

Tanyi offers the following general guidelines to facilitate spiritually based interventions for individuals and families in the following areas [120]:

- Spiritual support: Practitioners convey respect and support to promote an atmosphere of exploration and include an individual or family's spiritual beliefs, practices, and need for spiritual growth.

- Spiritual well-being: Practitioners help individuals and families access spiritual resources within their community, sustaining discussion and desire for harmony and peace and affirming patients' desire for spiritual maturity.
- Spiritual distress: Practitioners assist patients and families to find reasons for their distress and examine their spirituality and religiosity, providing research-based evidence about the role of spirituality in health and mental health.

Lawrence and Smith introduced the EBQT paradigm, a framework that includes four principles to help practitioners determine whether they should address and incorporate spirituality in the treatment or care of a patient. These four principles are [121]:

- Evidence: What evidence dictates the use of a spiritual adjunct to therapy with this particular patient?
- Beliefs: Does sufficient congruence exist between the patient's belief, the practitioner's belief, and the relevance of therapy?
- Quality of Care: Will the spiritual adjunct to treatment improve the quality of care for the patient? Maximum quality of care is achieved when the desired outcomes are accomplished and the patient's values are preserved.
- Time: Can this intervention be implemented within the time constraints of the clinical encounter, respecting the time committed to other patients?

In general, incorporating religion and spirituality into practice should not be spontaneous [238]. It should be thoughtful and systematic. In some cases, such as when a patient feels rejected by God/higher power or has been abused by a spiritual/religious leader, attempts to include spirituality/religion can trigger trauma and anxiety [238].

Part of this paradigm is based on the belief that when both the practitioner and the patient believe that an intervention can work, this is a strong component of success. In other words, if both the patient and the practitioner believe in the importance and effectiveness of the spiritual adjunct to therapy, then success is maximized. This does not necessarily mean that the practitioner adheres to the patient's spiritual or religious value system, only that both have faith in the efficacy of the intervention.

Asking about the effectiveness of interventions is part of the ethical mandate; practitioners should only practice what is expected to produce positive outcomes. If a practitioner wishes to add a spiritual component to interventions with a depressed patient who identifies as a Christian, the empirical literature should be considered. This is the essence of the first principle of the EBQT paradigm. Although randomized clinical trials may be the criterion standard in evaluating interventions, in some cases it may be more feasible to use practice-based evidence, which focuses on conducting studies within the context of practice [202].

Hodge conducted a systematic review of 14 studies examining the efficacy of cognitive and cognitive-behavioral interventions that included a spiritual or religious component [122]. These studies addressed seven different conditions: anxiety disorder, neurosis, obsessive-compulsive disorder, perfectionism, schizophrenia, stress, and depression. Hodge's analysis found that spiritually and cognitively based interventions within an individual or group setting can be used to address a range of problems targeted at diverse groups, such as Christians, Muslims, and Taoists [122]. These interventions have been used in a range of geographic locations, including China, Malaysia, New Zealand, Saudi Arabia, and the United States. Researchers specifically found that spiritually and cognitively based interventions were effectively used in the treatment of depression in Christian patients. There was limited evidence that spiritually and cognitively based interventions might

also be effective for depression in Muslim patients [122]. In a randomized clinical study examining the effectiveness of religious cognitive-behavioral therapy vs. conventional cognitive-behavioral therapy, religious cognitive-behavioral therapy was not more effective than conventional therapy in reducing suicidal ideations among patients with major depression [203]. The authors speculated that the conventional treatment approach may have induced less guilt, especially among the less religious participants. In another randomized clinical study, there were no differences in optimism level using religious versus standard care for patients with major depression and chronic illness [204]. Overall, it is important to examine the criteria for "well-established, validated interventions," as not all of the evaluated studies utilized a true random experimental design (i.e., clinical trials) with a minimum of 30 subjects in each of two groups.

A scale to determine the suitability and the usefulness of including a spiritual adjunct to therapy has been developed. The scale ranges from appropriate to inappropriate based upon the number of principles upheld in the EBQT paradigm. An intervention is considered appropriate if the practitioner endorses all four principles. Endorsement of all four principles indicates that a spiritual adjunct might be useful and would likely be ethical given the patient's circumstances. Potential recommendations are those interventions supported by only two to three principles; the appropriateness of the action is limited to special circumstances and may not be useful for all practitioners [121]. Finally, a recommendation is inappropriate if the practitioner endorses only one or none of the principles; in these cases, a spiritual adjunct to therapy is unlikely to be useful and may not be ethical [121].

ETHICAL ISSUES

Respect is the heart of many health and mental health professions' codes of ethics. Because patients are seeking help for health, mental health, psychologic, or social problems, they are already vulnerable when they meet practitioners. Consequently, patients come into the clinical process with some degree of trust that practitioners will offer remedies to their problems [123]. Therefore, the issue of trust and respect is key to the provision of care that guarantees patients' autonomy and self-determination [213]. The issue of patient autonomy and self-determination touches upon the concept of informed consent. Informed consent refers to the communication process between the patient and the practitioner during which information about an intervention is conveyed. One main aspect of informed consent is an understanding of the information that allows the patient to make an informed decision to either voluntarily participate or not participate in the intervention [124; 125]. When addressing spirituality, the ethical question is whether an initial signed consent covers spiritual interventions (e.g., prayer, meditation) when patients may not necessarily classify spiritual interventions as treatments or interventions [31].

Incorporating spirituality into assessments and interventions is often assumed to be beneficial, without any inherent risk. Many believe that spirituality is a crucial dimension of life and ignoring it can be a detriment [163]. However, having patients discuss spirituality and religiosity either as part of the assessment process or during an intervention may exacerbate their already vulnerable state and cause additional distress [31]. For example, if a patient employs religious coping without being willing to consider other options, it can be detrimental to the process of moving forward to therapeutic change [205]. The possibility of this occurrence should be discussed with the patient. In addition, practitioners should work within their professional boundaries.

Is a nurse or counselor, when working in a healthcare or mental health agency, first and foremost a nurse or counselor or is he/she a pastoral caregiver [126]? The professional role of the practitioner to the employing organization or agency, particularly if the organization is not faith-based or religiously oriented, should guide decisions about conducting spiritual interventions. Practitioners should not practice outside their bounds of competence. If a practitioner does not feel capable of handling a patient's spiritual or religious concerns, appropriate referrals should be made [127]. Therefore, it is important to collaborate and network with clergy and religious leaders in the community. However, it remains part of ethical practice for practitioners to become familiar with the basics of the spiritual and religious beliefs of the populations they serve, as ultimately, this is a sign of respect [126; 128; 129]. Further training may be sought to enhance skills in empathy, listening, connecting theory to technique, differentiating pathology from spiritual/religious experiences, and critically examining the advantages and disadvantages of incorporating spirituality or religion into assessment and interventions [213].

Working with patients is considered a social experience. As such, practitioners may be confronted with values and beliefs that they do not understand, have conflict with, or have rejected. Practitioners should be aware of their reactions to the diverse or similar values and beliefs that may be presented by patients during interventions [114; 163]. Cultural humility should be demonstrated [213]. In addition, it is important to remember the hierarchical relationship between the practitioner and patient [218]. The patient is made vulnerable by his/her position and by the fact he/she has come into the relationship in distress or ill. As a result, it is imperative that the practitioner not advocate for spiritual/religious interventions, pray with them before asking, or use spiritual assessments in order to move toward a particular goal without explicit patient instruction [206]. Hence, clinical supervision becomes a useful tool. Bracketing, a strategy of deliberately putting aside one's own beliefs or knowledge, is also recommended [164].

Before practitioners decide to incorporate spirituality or religion into practice, they should honestly explore the following questions to gain insight into their own comfort levels and how they might respond to diverse spiritual and religious backgrounds [130]:

- Are you a spiritual or religious person?
- What ethical concerns do you have about incorporating spirituality or religion in practice?
- How knowledgeable are you about different spiritual and religious belief systems outside your own?
- How do you feel about using prayer with patients?
- What was your most painful experience with religion or spirituality while growing up? As an adult? How has it affected you?
- What are your reactions when you meet someone who has a set of spiritual or religious belief systems that are different from your own?
- What are your thoughts, experiences, and attitudes toward abortion, premarital sex, infidelity, drinking, drugs, gambling, disciplining children, etc.?

INTERPROFESSIONAL COLLABORATION

The incorporation of spirituality and religion into clinical practice lends itself well to interprofessional practice and collaboration. The emphasis on treating the whole person and patient centeredness are at the heart of interprofessional practice, and healthcare and mental health practitioners from diverse disciplines benefit from collaboration with faith leaders to formulate culturally and religiously/spiritually sensitive care plans.

Incorporation of spirituality/religion into collaborative practice can occur on multiple levels. A spiritual community may work with an organization or facility to promote sensitive practice and care. One example of this type of collaboration is a Jewish community who worked with staff at a community hospital to ensure that the care provided was sensitive to the values and norms of the Orthodox Jewish community [239].

Interprofessional collaborations can also occur on an individual level, with providers seeking consultations with religious or spiritual leaders, when appropriate. Interprofessional approaches can be introduced during professional training, with religious or spiritual leaders incorporated into simulations. In one undergraduate nursing program, student nurses are required to collaborate with chaplains in a simulation involving a patient at risk for suicide [240]. When interprofessional practice is introduced early in a professional's training or career, he or she is often more comfortable collaborating and understanding team member's roles. Interprofessional collaborations and shared decision-making are needed in many crisis situations in order to ensure that patients' and families' needs are fully met.

In all settings, the National Coalition for Hospice and Palliative Care recommends the interdisciplinary team should include professional chaplains who have evidence-based training to assess and address spiritual issues frequently confronted by pediatric and adult patients and families coping with a serious illness.

(https://www.nationalcoalitionhpc.org/wp-content/uploads/2018/10/NCHPC-NCPGuidelines_4thED_web_FINAL.pdf. Last accessed April 19, 2021.)

Level of Evidence/Strength of Recommendation: Low Quality Evidence, Strong Recommendation

CONCLUSION

In order to provide culturally sensitive services to the racially and ethnically diverse population of the United States, it is necessary for practitioners to consider the impact of spirituality and religion on health and mental health care. The relationships between spirituality/religiosity and health and mental health outcomes, although by no means definitive or clear, indicate that practitioners should be educated and sensitive to the subject. It is not possible to be completely spiritually or religiously blind when practicing in such a diverse society. Therefore, practitioners should be prepared to conduct assessments of spirituality and religiosity and to incorporate issues of spirituality into practice in an ethical and culturally competent manner.

RESOURCES

Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC)
https://aservic.org

Association for the Sociology of Religion
https://www.sociologyofreligion.com

Association of Professional Chaplains
https://www.professionalchaplains.org

Earl E. Bakken Center for Spirituality and Healing
https://www.csh.umn.edu

International Association for the Psychology of Religion
http://www.iaprweb.org

Council on Social Work Education Religion and Spirituality Clearinghouse
https://www.cswe.org/Centers-Initiatives/Curriculum-Resources/Religion-and-Spirituality-Clearinghouse.aspx

National Cancer Institute
https://www.cancer.gov/about-cancer/coping/day-to-day/faith-and-spirituality/spirituality-hp-pdq

National Alliance on Mental Illness
https://www.nami.org

National Center for Complementary and Integrative Health
https://nccih.nih.gov

Society for the Psychology of Religion and Spirituality, Division 36 of the American Psychological Association
https://www.apadivisions.org/division-36

Psychotherapy and Spirituality Institute
https://psinyc.org

Institute for Spirituality and Health at the Texas Medical Center
https://www.spiritualityandhealth.org

Implicit Bias in Health Care

The role of implicit biases on healthcare outcomes has become a concern, as there is some evidence that implicit biases contribute to health disparities, professionals' attitudes toward and interactions with patients, quality of care, diagnoses, and treatment decisions. This may produce differences in help-seeking, diagnoses, and ultimately treatments and interventions. Implicit biases may also unwittingly produce professional behaviors, attitudes, and interactions that reduce patients' trust and comfort with their provider, leading to earlier termination of visits and/or reduced adherence and follow-up. Disadvantaged groups are marginalized in the healthcare system and vulnerable on multiple levels; health professionals' implicit biases can further exacerbate these existing disadvantages.

Interventions or strategies designed to reduce implicit bias may be categorized as change-based or control-based. Change-based interventions focus on reducing or changing cognitive associations underlying implicit biases. These interventions might include challenging stereotypes. Conversely, control-based interventions involve reducing the effects of the implicit bias on the individual's behaviors. These strategies include increasing awareness of biased thoughts and responses. The two types of interventions are not mutually exclusive and may be used synergistically.

FACULTY BIOGRAPHY

Alice Yick Flanagan, PhD, MSW, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families.

Previously acting as a faculty member at Capella University and Northcentral University, Dr. Yick Flanagan is currently a contributing faculty member at Walden University, School of Social Work, and a dissertation chair at Grand Canyon University, College of Doctoral Studies, working with Industrial Organizational Psychology doctoral students. She also serves as a consultant/subject matter expert for the New York City Board of Education and publishing companies for online curriculum development, developing practice MCAT questions in the area of psychology and sociology. Her research focus is on the area of culture and mental health in ethnic minority communities.

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SELF-ASSESSMENT QUESTIONS
#91983 THE ROLE OF SPIRITUALITY IN HEALTH AND MENTAL HEALTH

After reviewing the course, complete the following Self-Assessment Questions. Receive immediate feedback by reviewing the Study Guide provided on pages 42–43. Please record the number of questions you correctly answered on the Evaluation. The Evaluation must be completed in order to receive credit for this course.

This 5 contact hour/credit activity must be completed by April 30, 2024.

1. Which of the following is NOT considered a dimension of spirituality?
- A) *Coming to an understanding of self*
- B) *Making personal meaning out of situations*
- C) *Participation in activities with spiritual goals*
- D) *Appreciating the importance of connections with others*

2. Historically, rationalism emphasized that
- A) *the primary authority for truth is logic.*
- B) *spirituality and religion are logical sources of truth.*
- C) *knowledge stems from direct, first-hand observations.*
- D) *care for the needy is primarily the responsibility of religious organizations.*

3. Which movement in the field of psychology brought the issue of spirituality and religion back into the forefront of clinical practice?
- A) *Humanism*
- B) *Empiricism*
- C) *Behaviorism*
- D) *Cognitive theory*

4. All of the following are considered possible disadvantages of incorporating spirituality into practice, EXCEPT:
- A) *It would impede the provision of culturally competent care.*
- B) *Spirituality is not easily measured, placing it outside the realm of empirical science.*
- C) *Practitioners are not adequately trained in assessing and addressing spiritual concerns.*
- D) *Utilization of public funds in addressing spiritual concerns may conflict with the notion of a division between church and state.*

5. A patient is asked to describe the role of spirituality or religion in his or her approach to life. This question addresses which dimension of spirituality?
- A) *Sustaining force*
- B) *Religious support*
- C) *Struggle with religion and spirituality*
- D) *Perceived closeness or connection to God or higher power(s)*

6. What is the most commonly used form of complementary/alternative medicine in the United States?
- A) *Yoga*
- B) *Prayer*
- C) *Tai chi*
- D) *Echinacea*

7. After birth, male Muslim children are usually circumcised within
- A) *24 hours.*
- B) *3 days.*
- C) *7 days.*
- D) *40 days.*

8. Meditation on impermanence is an important part of bereavement in which of the following religions?
- A) *Islam*
- B) *Judaism*
- C) *Buddhism*
- D) *Protestantism*

Self-Assessment questions continue on next page →

9. Small studies of the effects of intercessory prayer on cardiovascular health have shown that, when compared to a control group, patients in the coronary care unit who are the subject of such prayer may require less

A) diuretics.
B) antibiotics.
C) ventilatory assistance.
D) All of the above

10. The National Cancer Institute recommends that, for cancer patients, inquiries into spiritual or religious concerns be

A) undertaken at every appointment.
B) avoided in order to prevent undue stress.
C) addressed, even if only briefly, at diagnosis.
D) postponed until after diagnosis and treatment options are discussed and considered.

11. Which of the following components of spirituality/religiosity is NOT considered a possible inhibitor of substance misuse?

A) Social support
B) Prosocial values
C) Religious involvement
D) Patriarchal gender roles

12. Religious scrupulosity is defined as

A) rigid religious beliefs.
B) preoccupation with recognizing lies.
C) an obsessive concern with one's sins and moral behavior.
D) an overwhelming need to convert others to one's own religion.

13. In a large Canadian study, higher worship attendance frequency was associated with a lower risk for the development of

A) cancer.
B) obesity.
C) anxiety disorders.
D) obsessive-compulsive disorders.

14. Self-directed religious coping is characterized by

A) participation in overt religious activities, such as Bible study.
B) a lack of reliance on God or higher power(s) to solve problems.
C) utilization of strategies within oneself and God or higher power(s) to solve problems.
D) a passive attitude toward problems while waiting for God or higher power(s) to intervene.

15. Which of the following statements is TRUE regarding African American spirituality/religiosity?

A) In many cases, women play a lesser role in African American churches.
B) There is a general belief that God is a cause of pain during times of suffering.
C) Religious and spiritual orientations are often used among African Americans to deal with oppression.
D) African American churches are often characterized by emotional restraint, as expression of emotion is believed to prolong suffering.

16. Individuals who do not practice a particular religious tradition but who identify racially or ethnically as Jews are considered to be a part of

A) Progressive Judaism.
B) Humanistic Judaism.
C) Conservative Judaism.
D) Reconstructionist Judaism.

17. Approximately 90% of Hispanic/Latino Americans practice

A) Santería.
B) Espiritismo.
C) Protestantism.
D) Roman Catholicism.

18. Spiritual genograms, one method available for assessing spirituality in an individual's life, are

A) closed-ended questions in the form of a questionnaire.
B) open-ended interviews exploring religious and spiritual beliefs and practices.
C) pictorial illustrations of patients' spiritual journeys, in the form of a "road map."
D) family trees focusing on religious and spiritual traditions, events, and experiences.

19. According to Richards and Potts, which of the following is a guideline for those considering the use of spiritual interventions?

A) Spiritual interventions should be used universally.
B) A trusting relationship between the patient and practitioner should exist before using spiritual interventions.
C) Spiritual interventions should always be used in cases when spiritual issues are at the heart of a patient's problem.
D) All of the above

20. Patient M is a man, 24 years of age, who is referred for follow-up after being diagnosed with HIV. The patient is having trouble coping with his diagnosis and has been praying for answers. Research has indicated that spiritual interventions, such as prayer, may have positive effects for those suffering from chronic illness, such as HIV infection. Therefore, two of the four principles in the EBQT paradigm are supported. Based on this information,

A) spiritual intervention is necessary and ethical.
B) a spiritual adjunct might be useful and would likely be ethical.
C) a spiritual adjunct would be inappropriate and may not be ethical.
D) spiritual intervention is limited to special circumstances and may or may not be useful for this patient.

Study Guide

COURSE #91983 THE ROLE OF SPIRITUALITY IN HEALTH AND MENTAL HEALTH

This Study Guide has been included to provide immediate feedback about your achievement for the course learning objectives. The correct answer for the Self-Assessment Questions and their locations within the text are indicated below.

1. **Which of the following is NOT considered a dimension of spirituality?**
   C) Participation in activities with spiritual goals (Spirituality and Religiosity)

2. **Historically, rationalism emphasized that**
   A) the primary authority for truth is logic. (Historical Roots)

3. **Which movement in the field of psychology brought the issue of spirituality and religion back into the forefront of clinical practice?**
   A) Humanism (Historical Roots)

4. **All of the following are considered possible disadvantages of incorporating spirituality into practice, EXCEPT:**
   A) It would impede the provision of culturally competent care. (Incorporating Spirituality/Religiosity into Practice; Possible Disadvantages of Incorporating Spirituality)

5. **A patient is asked to describe the role of spirituality or religion in his or her approach to life. This question addresses which dimension of spirituality?**
   A) Sustaining force (Challenges in Defining Spirituality and Religiosity

6. **What is the most commonly used form of complementary/alternative medicine in the United States?**
   B) Prayer (Overview of the Role of Spirituality/Religiosity in Health)

7. **After birth, male Muslim children are usually circumcised within**
   C) 7 days. (Overview of the Role of Spirituality/Religiosity in Health; Table 1)

8. **Meditation on impermanence is an important part of bereavement in which of the following religions?**
   C) Buddhism (Overview of the Role of Spirituality/Religiosity in Health; Table 1)

9. **Small studies of the effects of intercessory prayer on cardiovascular health have shown that, when compared to a control group, patients in the coronary care unit who are the subject of such prayer may require less**
   D) All of the above (Overview of the Role of Spirituality/Religiosity in Health; Cardiovascular Health)

10. **The National Cancer Institute recommends that, for cancer patients, inquiries into spiritual or religious concerns be**
    D) postponed until after diagnosis and treatment options are discussed and considered. (Overview of the Role of Spirituality/Religiosity in Health; Chronic Illness; Cancer)

11. **Which of the following components of spirituality/religiosity is NOT considered a possible inhibitor of substance misuse?**
    D) Patriarchal gender roles (Overview of the Role of Spirituality/Religiosity in Mental Health; Substance Use Disorders)

12. Religious scrupulosity is defined as

C) *an obsessive concern with one's sins and moral behavior. (Overview of the Role of Spirituality/Religiosity in Mental Health; Psychiatric Disorders and Mental Illness)*

13. In a large Canadian study, higher worship attendance frequency was associated with a lower risk for the development of

C) *anxiety disorders. (Overview of the Role of Spirituality/Religiosity in Mental Health; Psychiatric Disorders and Mental Illness)*

14. Self-directed religious coping is characterized by

B) *a lack of reliance on God or higher power(s) to solve problems. (Coping and Spirituality/Religiosity)*

15. Which of the following statements is TRUE regarding African American spirituality/religiosity?

C) *Religious and spiritual orientations are often used among African Americans to deal with oppression. (Culture and Spirituality/Religiosity; African American Cultures)*

16. Individuals who do not practice a particular religious tradition but who identify racially or ethnically as Jews are considered to be a part of

B) *Humanistic Judaism. (Culture and Spirituality/Religiosity; Jewish Cultures)*

17. Approximately 90% of Hispanic/Latino Americans practice

D) *Roman Catholicism. (Culture and Spirituality/Religiosity; Hispanic/Latino Cultures)*

18. Spiritual genograms, one method available for assessing spirituality in an individual's life, are

D) *family trees focusing on religious and spiritual traditions, events, and experiences. (Clinical Assessment and Interventions; Assessments)*

19. According to Richards and Potts, which of the following is a guideline for those considering the use of spiritual interventions?

B) *A trusting relationship between the patient and practitioner should exist before using spiritual interventions. (Clinical Assessment and Interventions; Interventions)*

20. Patient M is a man, 24 years of age, who is referred for follow-up after being diagnosed with HIV. The patient is having trouble coping with his diagnosis and has been praying for answers. Research has indicated that spiritual interventions, such as prayer, may have positive effects for those suffering from chronic illness, such as HIV infection. Therefore, two of the four principles in the EBQT paradigm are supported. Based on this information,

D) *spiritual intervention is limited to special circumstances and may or may not be useful for this patient. (Clinical Assessment and Interventions; Interventions)*