ASSESSMENT OF SPIRITUALITY IN COUNSELING: THE RELATIONSHIP

BETWEEN SPIRITUALITY AND MENTAL HEALTH

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ASSESSMENT OF SPIRITUALITY IN COUNSELING: THE RELATIONSHIP BETWEEN SPIRITUALITY AND MENTAL HEALTH

David Raymond Brown

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ASSESSMENT OF SPIRITUALITY IN COUNSELING: THE RELATIONSHIP

BETWEEN SPIRITUALITY AND MENTAL HEALTH

David Raymond Brown

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David Raymond Brown, son of W. Stephen Brown and Martha (McAfee) Brown, was born June 28, 1977 in Columbus, Indiana. He graduated from Columbus North High School in 1995. After graduating from Hanover College (Hanover, Indiana) in 1999 with a Bachelor of Arts degree in French and Theological Studies, he received an Associate of Science degree in Computer Technology from Purdue University (Columbus, Indiana campus) in 2002 as a part-time student. He then moved to Cincinnati, Ohio and completed a Master of Arts degree in Counseling from Cincinnati Christian University in 2005. In August 2005, David enrolled in the Counselor Education and Supervision doctoral program at Auburn University. David is a Licensed Professional Counselor in the State of Ohio, as well as a Board Certified Professional Christian Counselor. David married Lisa Michelle (Wauligman) Brown, daughter of Barry Wauligman and Deborah (Novello) Wauligman, on December 17, 2005. David and Lisa have one child, Evan Josiah Brown, born on July 31, 2007.

ASSESSMENT OF SPIRITUALITY IN COUNSELING: THE RELATIONSHIP BETWEEN SPIRITUALITY AND MENTAL HEALTH

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The purpose of this research study was to investigate the possible relationship between two spirituality variables (religious coping styles and spiritual well-being) and two psychological variables (anxiety and depression). Also studied were differences between those who self-disclosed a spiritual/religious identify and those who did not. There were 122 participants in this study, consisting of 30 males (24.6%), 91 females (74.6%), and 1 (.8%) individual whom did not specify gender. Data was collected from a small private university in the Midwest and a large public university located in the Southeast. Of the 122 participants, 26 (21.3%) were recruited from the small private university, and 96 (78.7%) were recruited from the large public university. The subscales from two spirituality assessments (the Religious Problem-Solving Scale and the Spiritual

Well-Being Scale) were compared to two mental health assessments: the Beck Anxiety Inventory and the Beck Depression Inventory-II. Multiple regression and multivariate analysis of variance (MANOVA) analyses revealed that participants endorsed an overall inverse relationship between the spirituality and mental health assessments. One specific spirituality subscale measuring existential well-being reported significant relationships with both mental health measures, as well as the greatest amount of influence on the mental health measures. The results of this research study are consistent with previous research. Limitations of this study, implications of this study, suggestions for future research, and suggestions for counselor education training are noted.

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I would like to dedicate this dissertation to my friend and Christian brother, Jonathan Edds, whose life was tragically cut short on August 17, 2002 by a terrorist's roadside bomb while serving in Iraq.

My deepest gratitude is to my loving wife, Lisa Michelle Brown. Lisa's support and encouragement has been a constant gift to me throughout the many hours of writing, editing, and revising this dissertation in seeking my academic and professional goals. Lisa is truly a blessing from God, and I am thankful every day for her love and generosity. I would also like to express my gratitude to my mentor and committee chair, Dr. Jamie Carney, for her leadership and patience throughout the process of writing this dissertation, as well as for challenging me to develop both personally and professionally. I would also like to thank my committee members, Dr. Debra Cobia and Dr. Suhyun Suh, for their commitment to this process and their interest in my professional growth. Furthermore, I would like to thank my Outside Reader, Dr. David Shannon, for his time and consideration in preparing this dissertation. I must also sincerely thank Mark Parrish and John Klem for continually raising the bar, making me laugh, and helping me to maintain my sanity in meeting numerous deadlines.

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I. INTRODUCTION

A comprehensive survey of current literature indicates an increasing interest in spirituality in the counseling profession (Kelly, Jr., 1994; Miller, 2001; Young, Wiggins-Frame, & Cashwell, 2007), which is evidenced by the development of graduate-level counseling courses (Curtis & Glass, 2002; Ingersoll, 1997; Souza, 2002), holistic wellness modeling incorporating spirituality (Adams, Bezner, Drabbs, Zambarano, & Steinhardt, 2000; Daaleman & Frey, 2004; Myers & Williard, 2003; Sweeney & Witmer, 1991), and in the development and validation of assessment instruments (Hall & Edwards, 2002; Hill & Hood, Jr., 1999; Slater, Hall, & Edwards, 2001; Stanard, Sandhu, & Painter, 2000). This focus reflects the importance spirituality holds in the general population. According to data collected by the United States Census Bureau (USCB; 2006), the Association of Religious Data Archives (ARDA; 2002), Gallup polls (The Gallup Organization, 2004, 2007), the National Opinion Research Center (NORC; 2004), and the American National Election Studies (ANES; 2004), a large majority of the American population identifies and/or participates with a religious organization. Although a reported religious affiliation does not imply the practice of spiritual disciplines, it appears to indicate an acceptance of spirituality and religiosity.

Research, conducted by the Princeton Religion Research Center (PRRC; 2000), indicated that "96% of individuals living in the United States believe in God; more than

90% pray; 69% are church members; and 43% have attended church, synagogue, or temple within the past 7 days" (cited in Cashwell, Bentley, & Yarborough, 2007). More recently, a 2003 study conducted by the University of Pennsylvania reported that around 75% of surveyed Americans endorsed that spirituality and religion are important; the Gallup Organization (2007), which reported that 84% of the survey participants indicated that religion is "very important" or "fairly important" in their life, echoed this finding. This provides clear evidence that religion and spirituality are important components in the lives of many Americans. It is important to clarify that any consideration of spirituality and religion needs to recognize the differences in the conceptualization of religion and spirituality across individual, cultural, and social perspectives (Hodge, 2005). These parameters can have a bearing on the role that religion and spirituality play in an individual's life. Furthermore, many researchers distinguish between the concept of religion, more related to specific ideology, and spirituality, which is often defined in relation to personal, not institutionalized or systematic, expressions of faith (Koenig, McCullough, & Larson, 2001). However, Lease, Horne, and Noffsinger-Frazier (2005) asserted that currently the terms are often used interchangeably or as combined constructs in counseling and psychological research.

A specific area of interest in the counseling profession is how religion and spirituality relate to other dimensions of an individual's life such as mental and physical well-being. Idler and George (1998) reported that as early as the late nineteenth century, French sociologist Émile Durkheim suggested the importance of religiosity in preventing suicide in its promotion of the consideration of others ahead of personal self-interest. McCormick (2004), as well, asserted that "Francis Galton, the father of differential

psychology, published pioneering works 30 years earlier in his book *Hereditary Genius* (Galton, 1869/2000) and in a paper titled 'Statistical Inquiries Into the Efficacy of Prayer' (Galton, 1872)" (p. 52). Richmond (2004) agreed that spirituality and religiosity are not new areas of research in the counseling profession: "The truth is that many people in the respective fields of mental health counseling, pastoral counseling, and counseling psychology have been researching and publishing in this area consistently since the 1970s" (p. 52). Despite the accounts that spiritual and religious issues have been researched for over a century and a half, they have received little recognition and shown only a small impact in the counseling and psychology professions (Miller & Thoresen, 2003).

While research is limited, the research that does exist indicates that religion and spirituality may directly and indirectly influence mental and physical well-being (Hodges, 2002; McCurdy, 2003; Miller & Thoresen, 2003; Seybold & Hill, 2001; Westgate, 1996). This relationship is apparent in much of the counseling research on wellness (Sweeney & Witmer, 1991). Wellness models, such as those described by Adams et al. (2000), Daaleman and Frey (2004), Myers and Williard (2003), and Sweeney and Witmer (1991), have included spirituality as a vital component of wellness. These wellness models emphasized the important link between spirituality, mental health, and physical health, as each play an equally vital role in the well-being of an individual. However, Adams et al. indicated that although medical science has demonstrated the requirements for physical wellness, psychological and spiritual wellness are much less well defined. This assertion is echoed by Miller and Thoresen, who recommended that more research was needed in this area.

Similarly, there is some agreement within counseling and psychology about the roles of religion and spirituality in mental and physical health. There is evidence that participation in religious activities such as weekly religious services may act as a coping mechanism in improving health (Powell, Shahabi, & Thoresen, 2003). Moreover, Mahoney and Pargament (2004) reported that religious conversion is often accompanied by "greater feelings of personal satisfaction, lower depression and anxiety, and a greater sense of serenity and forgiveness" (p. 490). This relationship seems even stronger for elderly individuals; elderly persons are more likely to report higher levels of religious participation than younger individuals (Chatters & Taylor, 1989; Levin & Taylor, 1993), with increased religious participation and a stronger spiritual foundation linked to better coping mechanisms with illness and improved physical health (Krause, 1992; Krause & Van Tran, 1989; Miller & Thoresen, 2003).

Few research studies have focused upon determining the relationship between mental health and spirituality or religion. Miller and Thoresen (2003) have asserted that this relationship exists and that it is generally positive. This assessment has been supported by other studies suggesting that higher levels of spirituality and religion in individuals may also correspond to more positive levels of mental health (George, Larson, Koenig, & McCullough, 2000; Levin, Markides, & Ray, 1996). Some of the benefits have included decreasing depressive symptoms, providing coping strategies, or instilling hope (Larson & Milano, 1997; Lease et al., 2005; Levin et al., 1996). However, Kier and Davenport (2004) suggested that there have been significant problems with many of these studies; one being that they have often focused on groups that are self-identified as religious versus groups of the general public. In addition, the authors argued

that while the relationship between physical health and spirituality has been well documented, there is limited empirical research to support this relationship with mental health. Kier and Davenport named several variables that have influenced this limitation in the research, including problems with defining the variables and limitations in assessment measures.

Assessing and Defining Religion and Spirituality

Slater et al. (2001) stated that attempts to assess spirituality have remained complex and unresolved because of the following reasons: "lack of precision in definitions, illusory spiritual health, ceiling effects, social desirability, and bias" (p. 4). Another obstacle to operational definitions of spirituality is, according to Hodge (2005), the description of spirituality through a cultural context, in which the individual perception of spirituality becomes a worldview. From this context, it would be practically impossible for the counseling profession to define spirituality, as each individual creates a unique worldview. As a singular worldview represents only the individual, an individual worldview cannot be generalized to a larger population.

Despite these complications, the design of spirituality assessments is becoming increasingly rigorous and specialized, denoting a desire for improved definitions and higher reliability and validity. Richards and Bergin (1997) encouraged the evaluation of spirituality to gain a more complete diagnostic understanding. This would allow the assessment of a client's spirituality to be more clearly linked to the establishment of prevention techniques and therapeutic interventions. These techniques are designed to promote a healthy balance of behaviors and practices (i.e., *wellness* or *well-being*) and to

prevent psychological, emotional, spiritual, and/or physical problems from developing in clients (Ellison, 1983; Hall & Edwards, 1996, 2002; Hathaway & Pargament, 2000; Hill & Hood, Jr., 1999; Paloutzian & Ellison, 1982, 1991; Pargament et al., 1988; Slater et al., 2001; Stanard et al., 2000). However, this need is balanced against the reality that few measures or assessment studies address mental health and spirituality. For example, in a comprehensive review of spirituality assessment instruments, Hill & Hood, Jr. located only a few references to published spirituality instruments designed to measure the relationship between spirituality and mental health.

Moberg (2002) echoed the need for the use of empirically based measures that assess the spiritual domain. He asserted that "Evaluations of the degree of spiritual maturity and tests for spiritual growth can help to reveal the effectiveness of counseling, pastoral care, psychospiritual therapy, religious education, and other endeavors to improve spirituality as a part of whole-person care for the always-linked body, mind, and spirit" (p. 47). This becomes essential as one considers the inclusion of religion and spirituality into existing counseling models of wellness. Some studies (Adams et al., 2000; Chandler, Holden, & Kolander, 1992; Reid & Smalls, 2004; Seybold & Hill, 2001; Sweeney & Witmer, 1991; Westgate, 1996) have focused upon including spirituality into a wellness model, which is then used to assess mental health, as well as spiritual health. If spirituality is to be presented as a vital aspect of wellness models, as suggested by Adams et al. and Chandler et al., then empirical evidence should support the inclusion of spirituality into a wellness model as it pertains to mental health. Gartner's (1996) research indicated that such empirical evidence does exist, and he reported "positive associations between religion-spirituality and well-being, marital satisfaction, and general

psychological functioning" (cited in Seybold & Hill, p. 23). In addition to these positive outcomes of spirituality, Gartner also reported negative association between spirituality and suicide, delinquency, criminal behavior, and drug and alcohol use. Moreover, as Miller and Thoresen (2003) have asserted, issues in spirituality are beginning to take a predominant role in professional literature.

Overall, current research has established on a limited basis, a mostly positive relationship between mental health and spirituality (Miller & Thoresen, 2003), and a variety of assessments have been developed to evaluate multiple dimensions of spirituality. There is also a greater need to more specifically examine the relationship between mental health and spirituality in an empirical manner, especially across clearly identified diagnostic categories of mental health (Richards & Bergin, 1997). This research could help address whether a relationship exists, as well as to help define the characteristics of this relationship.

Purpose

Although current literature supported the importance of integrating spirituality in mental health (Benes et al., 2000; Burke et al., 1999; Degges-White et al., 2003; Pargament et al., 1988; Souza, 2002; Stanard et al., 2000), there was limited empirical research clearly establishing the strength and characteristics of this relationship. The purpose of the current study was to examine the relationship between constructs of spirituality and mental health, or, more specifically, to understand the relationship between spirituality and specific diagnostic indicators of mental health, which, in this study, were measures of anxiety and depression. This addressed a call to link

measurements of spirituality to specific diagnostic categories and areas of mental health (Richards & Bergin, 1997) with empirical data.

Furthermore, there was an increased need to more clearly elucidate or define what is meant by the term *spirituality*. One important part of this process in assessment was more clearly delineating between aspects of spirituality and religious identity or behavior, a problem noted by Speck (2005). An additional purpose of the current study was to examine the relationship between mental health and two dimensions of spirituality and religious identity. This included assessing religious problem-solving. Research indicated that religion may be involved in how people make decisions and that having this problem-solving and coping style may relate to improved mental health (Thurston, 1999; Pargament et al., 1988). Certainly, the knowledge of an additional empirically-supported and beneficial coping strategy will be useful for clinicians in the allied health professions.

Another aspect of spirituality considered in this study was spiritual well-being. This is a more global concept that relates to one's own perception of spirituality and well-being, including one's sense of quality of life. It is important when examining spirituality and mental health to understand the role spirituality plays in an individual's life and how that influences his/her own sense of life quality. In the current study, this aspect of spirituality, spiritual well-being, or spiritual wellness, was examined, in addition to religious problem-solving (specifically religious coping styles), to determine their relationship to indicators of mental health. Furthermore, it was the intent of the current study to compare across these spirituality measures to determine if either had a more significant relationship with measures of mental health (*anxiety* and *depression*).

Significance of Study

Because of the importance placed upon spirituality and religiosity by the majority of the American population (ANES, 2004; ARDA, 2002; The Gallup Organization, 2002, 2007; Jones & Carroll, 2007; NORC, 2004; Newport, 2007; PRRC, 2000; University of Pennsylvania, 2003), as well as the researched relationship between spirituality and physical health (Alexander et al., 1989; Cole, 2005; Hodges, 2002; Idler & George, 1998; Townsend et al., 2002) and holistic wellness (Adams et al., 2000; Chandler et al., 1992 Ingersoll & Bauer, 2004; Moberg, 2002; Myers & Williard, 2003), the perceived relationship between spirituality and mental health cannot be ignored by the counseling profession. Additionally, the assessment of spirituality is becoming a significant issue in counseling, as described by Stanard et al. (2000), Hall and Edwards (1996, 2002), and Hodge (2005).

This study was designed for the potential to provide more information about the relationship between mental health and spirituality and religion. This included consideration of specific categories or indicators of mental health (*anxiety* and *depression*) as well as a greater focus on specific aspects of religious and spiritual identity (*religious problem-solving* and *spiritual well-being*). This provides critical information for counseling professionals about this relationship, as well as how it relates to psychological and mental health concerns.

In addition, while not the specific focus of this study, the results provided information to counselor educators about the relationship between these variables and the potential importance of understanding this relationship. This may influence training concerning these issues, recommendations related to models of wellness that incorporate

these variables, and potentially intervention and prevention models that incorporate an awareness of the role of religion and spirituality in individual's mental health.

Research Questions

To examine the relationship between spirituality and mental health, four assessment instruments (Religious Problem-Solving Scale [RPSS], Spiritual Well-Being Scale [SWBS], Beck Depression Inventory II [BDI-II], and Beck Anxiety Inventory [BAI]) were used to empirically assess two spirituality constructs (*spiritual well-being* and *religious problem-solving styles*) and two mental health constructs (*depression* and *anxiety*). This study was helpful in determining that a relationship exists between spirituality and mental health, and it suggested which spirituality construct more significantly impacted mental health. This research study consisting of these four assessment instruments involved the following research questions.

1. What is the relationship between religious coping styles, as measured by the Religious Problem-Solving Scale, and spiritual well-being, as measured by the Spiritual Well-Being Scale?

2a. What is the relationship between depression, as measured by the Beck Depression Inventory-II, and religious coping styles, as measured by the Religious Problem-Solving Scale?

2b. What is the relationship between depression, as measured by the Beck Depression Inventory-II, and spiritual well-being, as measured by the Spiritual Well-Being Scale?

3a. What is the relationship between anxiety, as measured by the Beck Anxiety Inventory, and religious coping styles, as measured by the Religious Problem-Solving Scale?

3b. What is the relationship between anxiety, as measured by the Beck Anxiety Inventory, and spiritual well-being, as measured by the Spiritual Well-Being Scale?

4. What is the relationship between the spirituality measures (Religious Problem-Solving Scale and Spiritual Well-Being Scale) and the mental health measures (Beck Anxiety Inventory and Beck Depression Inventory-II)?

Operational Definitions

Spirituality: For the purposes of this research study, spirituality was defined according to the suggestions of Burke et al. (1999). Burke et al. defined spirituality as an appreciation of human life and existence, as well as a sense of connectedness to a higher power and openness to the infinite beyond human existence and experience. This definition allowed for an understanding of spirituality in a larger and more diverse audience, especially those who do not align themselves with a specific religious organization or religious group (Souza, 2002).

Religion (Religiosity): Religion appeared to be more easily distinguished than spirituality. According to Burke et al. (1999), religion has come to represent "an institutionalized set of beliefs and practices by which groups and individuals relate to the ultimate" (p. 252). Religion, as Burke et al. suggested, may embody to some as a set of dogmatic beliefs that must be implicitly followed. A

distinction between spirituality and religion allows those who dislike organized religious groups to continue to experience a connectedness to others and to a higher power.

Spiritual Well-Being (Spiritual Wellness): Spiritual well-being was and has been defined in a variety of ways. However, for the purposes of this study, spiritual well-being was defined as the following: being content with current life situation and having a sense of purpose and meaning in life; a sense of balance and control in life; a sense of peace and serenity; a relationship with a higher being or higher power that is greater than oneself; and a sense of hope for the present and future (Adams et al., 2000; Chandler et al., 1992).

Depression: Depression is characterized by a variety of symptoms (American Psychiatric Association [APA], 2000). The *Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition, Text Revision* (*DSM-IV-TR*) categorized depression as a Mood Disorder and provided a list of numerous variations of mood disorders as well as the diagnostic criteria for evaluation. Because this study was not designed to assess or diagnose depression, use of the term *depression* was limited to describe the following symptoms: 1.) feelings of overwhelming sadness and/or fear; 2.) change in amount of interest in or pleasure in activities; 3.) change in appetite with marked weight loss or gain; 4.) disturbed sleep patterns; 5.) fatigue; 6.) loss of energy; and 7.) intense feelings of guilt, helplessness, hopelessness, worthlessness, and isolation.

Anxiety: Anxiety is also characterized by a number of symptoms in the *DSM-IV-TR* (APA, 2000). Anxiety is categorized as an Anxiety Disorder in the *DSM-IV-TR*,

and it is manifested in variety of ways. For the purposes of this study (and because this study did not intend to assess or diagnose any anxiety disorders), use of the term *anxiety* was limited to describe the following general symptoms: restlessness, being easily fatigued, difficulty concentrating, difficulty sleeping, irritability, the feeling of being "keyed up," and muscle tension.

Religious Problem-Solving (Religious Coping Style): According to Pargament et al. (1988), "religion may serve important functions in helping people understand and cope with life events by offering guidance, support, and hope" (p. 91). In addition, Pargament et al. (1992) reported that "religion operates in coping when generalized resources are translated into situation-specific activities" (p. 505). In this study, especially as it related to the use of the Religious Problem-Solving Scale, three styles of religious coping styles are measured. Therefore, for the purposes of this research study, religious problem-solving and religious coping style were used synonymously to indicate the use of a religious/spiritual activity or practice, or any demonstration of an individual's faith, to cope with a negative and/or stressful life event.

Wellness: Wellness was originally defined by Dunn (1961) as "an integrated method of functioning which is oriented toward maximizing the potential of which the individual is capable" (p. 4). More recently, Myers, Sweeney, & Witmer (2000) defined wellness as "a way of life oriented toward optimal health and well-being, in which the body, mind, and spirit are integrated by the individual to live more fully within the human and natural community" (p. 252). For the purposes of this

research study, use of the term *wellness* was limited to the definition proposed by Myers et al.

Mental Health: Mental health is a subjective term that describes healthy cognitive functioning. For the purposes of this study, mental health was best defined by the United States Surgeon General. Mental health is “a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity. Mental health is indispensable to personal well-being, family and interpersonal relationships, and contribution to community or society” (United States Public Health Services [USPHS], 1999).

Summary

Because of the increasing importance of spiritual issues in counseling, this study measured the relationship between spiritual well-being and religious problem-solving styles with depression and anxiety. Because spirituality is a reportedly important dimension in holistic wellness models (Adams et al., 2000; Chandler et al., 1992; Ingersoll & Bauer, 2004; Sweeney & Witmer, 1991) and has been identified as a significant predictor of positive coping with and recovery from physical illness (Idler & George, 1998), it is important to understand the relationship that exists between spirituality and mental health. Additionally, since spirituality can be separated into numerous constructs, as illustrated by Hill and Hood, Jr. (1999), this study also evaluated which spirituality construct (of the two utilized in this study) accounted for the greatest significance in mental health between the two constructs measured. This study should be

of interest to counselors and counselor educators who seek to utilize spirituality in counseling theory and practice. Furthermore, this study provided empirical evidence to evaluate the relationship that exists between spirituality and mental health, which is a useful assessment method to the counseling profession in practice, training, and research.

II. REVIEW OF LITERATURE

Introduction

Over the past few decades, spirituality has become increasingly important in the counseling profession (Kelly, Jr., 1994, 1997; Miller, 2001; Young, Wiggins-Frame et al., 2007). Increased interest has been evidenced in a variety of methods and through an interest in studying the physical, emotional, and psychological effects of spirituality and religiosity has been demonstrated in professional literature for almost two centuries (Idler & George, 1998). According to McCormick (2004), one of the first published works studying the effects of spirituality and religiosity, came from the work of Francis Galton, "the father of differential psychology" (p. 52). Galton published numerous books and articles that researched the effects of prayer in life expectancies, the occurrence of mental illness, and the ability to avoid financial ruin. Two of the most influential written works of Galton, concerning the study of prayer, include a book entitled *Hereditary Genius* (1869/2000) and a paper entitled "Statistical Inquiries into the Efficacy of Prayer" (1872). This research indicates an early interest in studying the potentially positive effects of involvement in spirituality and religion and offers comparisons between religious and non-religious individuals, focusing specifically on the life expectancies of religious persons compared to the non-religious, as well as percentages of stillborn babies between those two groups (McCormick).

Equally significant in sociology, according to Idler and George (1998), Émile Durkheim published an influential research study concerning the positive effects of spirituality in the prevention of suicide. Durkheim's book, *Suicide*, published in 1897, studied individual characteristics of the relationship between individuals and society. Durkheim reported that increased rates of social integration resulted in decreased levels of suicide, although he also reported that both abnormally low and high levels social integration lead to suicide. Thus, the moderating effects of involvement with a spiritual and/or religious community encouraged the individual to consider others ahead of oneself. Durkheim's work in studying spiritual influences in a community is also represented by early shamanism, soul journeys, and rebirth experiences (Rayburn, 2004), indicating the rich diversity of spiritual experiences. Despite a recent resurgence in popularity, according to Rayburn, these practices are notably older demonstrations of spiritual influences in the individual and the community, and they indicate the complex nature of studying spirituality and religion.

Although Galton provided the earliest published research concerning the integration of religion and psychology (cited in McCormick, 2004), another forerunner and contributor to the modern movement of the scientific study of religion was William James, who conducted research throughout the early twentieth century (Miller & Thoresen, 2003). Religion and spirituality are first found in counseling literature within the writings of Frank Parsons (Kelly, Jr., 1994). Parson's work was concerned mainly with guidance and vocational counseling; he indicated that religion was an important aspect of searching for a vocation (Parsons, 1909/1967). Despite his noted benefits of religion, a subsequent integration of spirituality and religion with counseling did not

occur. Although a variety of speculations exist to explain this phenomenon (Speck, 2005), spirituality was not widely considered a viable aspect of the counseling profession. This perspective would persist until the 1980's when a renewed interest in integrating spirituality into counseling appeared in professional counseling literature (Richmond, 2004). In fact, Richmond states that spirituality is no longer an emerging trend in the counseling profession, "it is full blown" (p. 52).

Because of the importance of spirituality and religion to the vast majority of Americans (Kelly, Jr., 1994, 1997; United States Census Bureau [USCB], 2006), it is important that counseling professionals and others in the helping professions understand the need to integrate spirituality into the counseling process. Counseling professionals must also understand the complex nature of integrating spiritual and/or religious beliefs into the counseling process. Survey data, reporting the increasing importance of spirituality and religiosity in the lives of the majority of the American population, indicates a growing interest in matters of faith, spiritual experiences, and involvement in the community (Seybold & Hill, 2001). As such, mental health professionals must demonstrate sensitivity to the spiritual and religious beliefs of all persons. An attempt by mental health professionals to increase understanding of spirituality and religiosity is evidenced by the increasing amounts of research studies that have been conducted to study the effects of various spiritual constructs on physical health and lifestyles. According to the data collected, research has reported that spirituality is a very important aspect of many people's lives. Miller and Thoresen (2003), citing Gallup and Lindsay (1999), state the following:

> About 95% of Americans recently professed a belief in God or a higher power, a figure that has never dropped below 90% during the past 50 years, and 9 out of 10 people also said that they pray, most of them (67%-75%) on a daily basis (p. 24).

Other statistics cited by Miller and Thoresen indicate, “Many Americans have stated that their faith is a central guiding force in their lives” (p. 24). Although this research demonstrates to mental health professionals the importance of spirituality, it does not give direction for the integration of spirituality and religion into counseling practice and theory. Further research has been conducted in the form of national surveys and reports from the USCB, as well as other polling organizations and universities that receive both public and private funds to conduct research. These results also indicate that spirituality and religiosity are significantly important aspects of many individuals’ lives.

Within the past decade, numerous statistics have been reported concerning the importance of spirituality and religion in the American population, and the numbers appear to be increasing. In a 1994 study, Kelly, Jr. reported that recent Gallup polls indicated that over 80% of the American population identified with some type of spiritual/religious activity or organization. Data reported by the USCB (2006) indicated that the percentage of the American population that identified with a spiritual/religious organization had increased to approximately 86%. In fact, the *American Religious Identity Survey*, conducted by the City University of New York (CUNY; Kosmin, Mayer, & Keysar, 2001), indicated that participants reported religious identities that closely follow United States census findings (CUNY, 2001). Furthermore, other national surveys conducted by both public and private organizations concerning the importance of and experiences with spirituality and religiosity report similar trends in America.

In a 2002 survey regarding the importance of religion in the individual's life, the Association of Religion Data Archives (ARDA) reported that 63.2% of respondents indicated that religion was "very important" in their lives. An additional 24.1% of respondents stated that religion was "fairly important" in their lives. Combining these numbers indicates that 87.3% of respondents in this survey found importance in including religion in their lives, which supports the vital role of spirituality and religion. Indeed, the director of the Center for Research on Religion and Urban Civil Society (CRRUCS) at the University of Pennsylvania stated that:

> The CRRUCS/Gallup Spiritual Index, a measurement of the nation's faith and spirituality, now stands at 74.7 percent, plus or minus 1.4 points, out of a possible score of 100 percent. That is a strong indication that the majority of Americans find meaning in life through religious faith and spirituality (University of Pennsylvania, 2003, n.p.).

Although these results appear to indicate lower figures, the University of Pennsylvania survey did not report the degree of importance of religion. Moreover, as the director of the CRRUCS stated, "The level of spirituality that we discovered in the United States was much higher than expected" (University of Pennsylvania, n.p.). This statement suggests that the survey results were consistent with the statistics reported by Kelly, Jr. (1994) and ARDA (2002).

Additional survey results released by ARDA report other spiritual constructs measured by the National Opinion Research Center (NORC), such as finding comfort in religion, feeling peace or harmony, and strength of affiliation with a religious affiliation (NORC, 2004). The American National Election Studies (ANES) reported a breakdown

of the importance of religion in life according to gender, age, denomination, region, and church attendance (ANES, 2004). ANES also measured the strength of religious affiliation by gender, race, religious affiliation, age, church attendance, political ideology, and education level.

Finding comfort in religion or spirituality is related to the importance of religion and/or spirituality in an individual's life. If participating in religious activities or spiritual experiences is comforting to an individual, they will be more likely to continue to engage in those activities, and these activities may become a more significant aspect of the individual's life. NORC (2004) surveys reported that 19.3% of survey respondents reported that they find comfort in religion or spirituality "many times a day," whereas 32.0% reporting it as "every day." An additional 18.5% reported finding comfort in religion on "most days," while 9.0% found comfort in religion or spirituality during "some days." This results in a total of 69.8% of respondents finding comfort in religion or spirituality most of the time or more often. Only 10.3% of respondents indicated that they "never or almost never" found comfort in religious or spiritual experiences.

In the same study, NORC (2004) reported the responses to a question concerning the inner peace and harmony one experiences through religion or spirituality. Using the same scale, 14.7% of survey respondents stated that they felt deep peace or inner harmony "many times a day." Another 24.6% reported feeling peace or harmony "every day," and 26.3% indicated feeling this way on "most days." An additional 17.0% of survey respondents stated that they felt deep inner peace or harmony "some days." These figures result in 82.6% of participants reporting that they find inner peace and/or harmony through religion and spirituality, while only 7.1% indicated that they "never or

almost never" feel inner peace or harmony. These results correspond well with the results of how much comfort the survey participants found in spirituality and religion. However, it is important to note that this research also reported that some Americans claim to be spiritual but not religious.

Although some survey results combine both spirituality and religion (ANES, 2004; ARDA, 2006; NORC, 2004; University of Pennsylvania, 2003; USCB, 2006), the Gallup Organization reported that many Americans claim to be spiritual but not religious, some claim to be both spiritual and religious, and others claim to be neither spiritual nor religious. Kelly, Jr. (1994) discussed this phenomenon, indicating that mental health professionals have focused more on spirituality than religiosity. Many researchers, according to Kelly, Jr., consolidate both spirituality and religiosity because of the similarities, and research has demonstrated that both concepts are beneficial in counseling and counselor education. In their 2005 survey entitled *Faith and Family in America*, Greenberg Quinlan Rosner Research (GQRR) reported the following national survey results:

49.8% of survey respondents reported being religious

34.2% of survey respondents reported being spiritual and not religious

10.1% of survey respondents reported being neither spiritual nor religious

4.3% of survey respondents reported being both spiritual and religious

1.6% of survey respondents were unsure or refused to respond

These results indicate a slight preference for religiosity over spirituality. A much smaller percentage of survey participants identified themselves as both religious and spiritual or neither spiritual nor religious. This survey, however, did not provide a definition for

spirituality and religiosity, which may have influenced the results. A separate survey, conducted a year later by the Gallup Organization (2006), provided similar results:

49% of survey respondents are religious

40% of survey respondents are spiritual but not religious

3% of survey respondents are neither spiritual nor religious

7% of survey respondents are both spiritual and religious

1% of survey respondents were unsure or refused to respond

Unlike the GQRR results, the Gallup survey results indicated a nearly even split between those who report being religious but not spiritual and those who are spiritual but not religious. The additional results appeared to be congruent between the two studies. However, much like the GQRR survey, this Gallup poll did not provide definitions to spirituality and religiosity. As previously indicated, a lack of operational definitions may have affected the results. As Curtis and Glass (2002) and Souza (2002) reported, many individuals are unfamiliar with differences between spirituality and religion, which may cause some confusion to those unfamiliar with the terminology.

The Gallup Organization recently released the results of a survey entitled *Religion* (Gallup Organization, 2007). This survey reported statistics concerning a variety of spiritual constructs, such as a belief in God or a universal spirit, membership in a church or synagogue, and the frequency of attending a church or a synagogue. Similar to other surveys, this Gallup poll provided statistics involving the importance of religion in one's life. The survey reports that 57% of respondents stated that religion is “very important” and 27% stated that religion is “fairly important” in their lives. This combined 84% of participants is consistent with statistics released by ANES (2004), ARDA (2006), NORC

(2004), University of Pennsylvania (2003), and USCB (2006). As reported in other surveys, the remaining Gallup survey respondents indicated that religion was not a significant factor in life: 16% stated that religion is "not very important" and 1% elected the response of "no opinion." These national surveys consistently support the importance of spirituality and religion in America. Additionally, by studying various characteristics of spirituality and religion, such as a belief in God, feelings of happiness and peace, as well as the frequency one attends religious services, these national surveys effectively evaluate the importance of spirituality and religion in American society.

Although the numerous surveys reveal the importance of spirituality and religion in American society, very few surveys differentiate between spirituality and religiosity. However, professional counseling literature consistently delineates the differences among these constructs. Despite the intent to provide a clear understanding of the differences between spirituality and religiosity, many different definitions have been provided, and some definitions of spirituality remain ambiguous and inconsistent. This definitional dilemma demonstrates the greatest difficulty in addressing spirituality and religion. A comprehensive database search of counseling literature returns a myriad of definitions; Speck (2005) discusses how different and sometimes contradictory definitions have been published, which creates an additional challenge to understanding and comprehending spirituality and religiosity. Failure to establish an accepted definition may be a root cause preventing the creation of a method or framework to integrate spirituality and religion into counseling; if mental health professionals cannot agree upon a definition, then education, training, and practice will remain disjointed and non-standardized. Speck states that "To harmonize these definitions would be a herculean [sic] task because they

point to competing worldviews that are not always fully articulated in the literature, helping explain why the definitions rely on abstractions" (p. 4). Souza (2002) accentuates the definitional dilemma by stating, "There is no one right way to define spirituality" (p. 215). Unfortunately, spirituality is a personal issue; a consensus cannot be reached concerning a definition of spirituality.

A definition to spirituality was eventually devised at the 1995 "Summit of Spirituality," which was sponsored by the Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC) and included representatives from the American Counseling Association (ACA) divisions. This summit attempted to encompass individual definitions, address a proper understanding of spirituality, and develop a "process of fusing spirituality into counseling" (Miller, 1999, p. 500). Spirituality is described as a multifaceted concept that is not easily understood, nor easily explained. According to the ASERVIC Spirituality White Paper (n.d.), the definitional problems occur "because of the limited capacity of language" (p. 1). Other explanations state that it is a

> …capacity and tendency that is innate and unique to all persons. The spiritual tendency moves the individual toward knowledge, love, meaning, peace, hope, transcendence, connectedness, compassion, wellness, and wholeness. Spirituality includes one's capacity for creativity, growth, and the development of a value system ("Summit Results," 1995, p. 30, cited by Young et al., 2007).

Spirituality, as defined above, encompasses all aspects of life, meaning that from an existential perspective, spirituality is instrumental in helping one understand and function

as a human being. This concept becomes increasingly apparent through Teasdale's (1999) perspective (cited by Cashwell, Bentley, & Yarborough, 2007).

> Spirituality is a way of life that affects and includes every moment of existence. It is at once a contemplative attitude, a disposition to a life of depth, and the search for ultimate meaning, direction, and belonging….Spirituality draws us into the depths of our being, where we come face to face with ourselves, our weaknesses, and with ultimate mystery. Many understandably prefer to avoid this frightening prospect (p. 17-18).

According to this definition, spirituality is much more than how an individual relates with a higher power or greater being; spirituality involves an encounter with oneself – looking deep within oneself to more completely understand what one truly desires and fears. Spirituality provides an avenue for self-exploration.

An exploration of these varied definitions will not only allow one to more fully understand how spirituality changes oneself, but it will also increase the opportunity to understand oneself and thus enjoy closer relationships with others or with a higher power. Because of the similarities and differences, each definition only appears to engage one aspect of spirituality; no single definition or construct completely encompasses the whole of spirituality. Despite this challenge, professionals continue to conduct research to gain a greater understanding of spirituality and how it might be integrated into counseling and counselor education. A closer look at suggested methodologies may provide further insight.

Spirituality is currently defined by the ACA ethical code (ACA, 2005) as a multicultural issue, and it is becoming more prevalent and integrated within counseling

literature. Additionally, current Council for the Accreditation of Counseling and Related Educational Programs (CACREP) training standards also define spirituality as a multicultural issue (CACREP, 2001). Although currently undergoing revision (CACREP, 2006a), the newly drafted standards continue to reflect the definition of spirituality as a multicultural issue. Reflecting the importance of multicultural awareness and recognition in the counseling profession, ASERVIC sponsored a summit to define ways in which to integrate spirituality into the counseling process as well as in counselor education. This 1995 collaboration between ASERVIC and other ACA divisions resulted in the establishment of the following nine spirituality competencies.

> In order to be competent to help clients address the spiritual dimension of their lives, a counselor needs to be able to: 1) explain the relationship between religion and spirituality, including similarities and differences, 2) describe religious and spiritual beliefs and practices in a cultural context, 3) engage in self-exploration of his/her religious and spiritual beliefs in order to increase sensitivity, understanding, and acceptance of his/her belief system, 4) describe one's religious and/or spiritual belief system and explain various models of religious/spiritual development across the lifespan, 5) demonstrate sensitivity to and acceptance of a variety of religious and/or spiritual expression in the client's communication, 6) identify the limits of one's understanding of a client's spiritual expression, and demonstrate appropriate referral skills and general possible referral sources, 7) assess the relevance of the spiritual domains in the client's therapeutic issues, 8) be sensitive to and respectful of the spiritual themes in the counseling process as benefits each client's expressed preference, and 9) use the client's spiritual beliefs

in pursuit of the client's therapeutic goals as befits the client's expressed preference (cited in Miller, 1999, p. 500).

The development of these competencies is encouraging to counseling professionals, as it demonstrates an intentional and concerted effort to further integrate spirituality and religiosity into counseling. Unfortunately, although some current literature suggests that continued efforts are being made to infuse spirituality into counseling (Burke et al., 1999; Curtis & Glass, 2002; Fukuyama & Sevig, 1997; Ingersoll, 1997; Kelly, Jr., 1994; Miller, 2001; Souza, 2002), others appear uncertain regarding how this is occurring. McCurdy (2003) states that how "religion, faith, and spirituality are incorporated into counselor education is not clearly defined" (p. 2). Additionally, Speck (2005) and Svoboda (2005) suggest that higher education does not provide adequate training or resources to students. These statements indicate that despite the current interest in spirituality and religiosity, more research and study is necessary for their successful inclusion into counseling programs.

The integration of spirituality and religiosity can occur in many ways. Several methods of the influence of spirituality and religiosity in counseling are evidenced in the development of graduate-level coursework in counselor education training programs (Curtis & Glass, 2000; Souza, 2002), assessment instruments (Hall & Edwards, 1996, 2002; Hill & Hood, Jr., 1999; Slater et al., 2001; Stanard et al., 2000), and holistic wellness models (Adams et al., 2000; Chandler et al., 1992; Myers, Mobley, & Booth, 2003; Myers, Sweeney, & Witmer, 2000; Myers & Williard, 2003; Sweeney & Witmer, 1991; Witmer & Sweeney, 1992). Wellness literature appears to accept the inclusion of spirituality, as a variety of research has provided evidence indicating the benefits of

utilizing spirituality constructs in prevention and rehabilitation (Eliason, Hanley, & Leventis, 2001; Seybold & Hill, 2001; Slater et al., 2001).

The strongest empirical link between spirituality and mental health occurs through the wellness concept, and this relationship is graphically displayed in a variety of wellness models. A number of wellness models (Adams et al., 1999; Chandler et al., 1992; Daaleman & Frey, 2004; Ingersoll & Bauer, 2004; Myers & Williard, 2003; Sweeney & Witmer, 1991; Witmer & Sweeney, 1992) include a spiritual component, which is depicted as necessary in order to consider the whole person. Others, such as Ardell (1993, 1994, 1998, 1999) and Perrin and McDermott (1997), have strongly encouraged wellness models to remove the spirituality component, based mainly upon the difficulty in defining "spirituality." Ardell (1999) writes that "On a recent talk show, a caller said, 'My psychologist says spirituality is essential to being a 'whole' person – what do you say?' I said it depends on what the psychologist has invented about the meaning of the word 'spirituality' – the interpretations of the term are mind-boggling in variety as well as vagueness" (p. 3). Past the definitional dilemma, however, current wellness literature appears to consider spirituality a vital aspect of wellness. Chandler et al. stated that they

> …suggest that spiritual health not be conceptualized as just one of the six dimensions of wellness. Spiritual health should be considered as a component present, along with a personal component, within each of the interrelated and interactive dimensions of wellness (p. 171).

Thus, spirituality is not merely a separate and unique dimension of wellness; Chandler et al. suggested that it interacts with all other dimensions. They stated that spirituality

engages and interacts with each dimension, allowing each to be fully experienced. Removing the perspective of spirituality would decrease the optimal wellness potential for the individual.

The primary purpose of wellness modeling, as discussed by Adams et al. (2000), is to improve the quality of life and increase the duration of life. As each wellness model is designed, wellness researchers attempt to create a generalized model to fit a highly subjective and ambiguous concept. Much like the concept of spirituality, wellness is individually determined, meaning that individual wellness may differ among each individual. As previously maintained in this research study, wellness appears to be best defined by Myers et al. (2000): "a way of life oriented toward optimal health and well-being, in which the body, mind, and spirit are integrated by the individual to live more fully within the human and natural community" (p. 252). The key elements of this definition are the integration of the mind, body, and spirit – thus incorporating the impact of the psychological, physiological, and spiritual domains. Seybold and Hill (2001) reaffirm this notion by maintaining that spirituality and religion are vital elements of mental health. Citing a variety of research studies conducted within the past decade, Seybold and Hill implored health service providers to consider the positive effects of spirituality and religion in physical and mental health. Additionally, Seybold and Hill encouraged continued research to measure the implications of and relationships between spirituality and mental health. These discussions, however, depend upon a consistent understanding of the terms used within this research study. Definitions for terminology used in this research study are provided below.

Understanding the Terminology

Spirituality is a complex and ambiguous topic, and, thus, a thorough review of literature reveals a large number of definitions (Speck, 2005). Most literature also establishes the definitional and practical differences between spirituality and religion, such as demonstrated by Burke et al. (1999), Curtis and Glass (2002), Kelly, Jr. (1992, 1994), Stanard et al. (2000), and Speck. Proper definitions are important due to the necessity of providing a consistent understanding of the terms used throughout this review. These operational definitions will establish a reliable basis for the discussion purposes of this research study.

Used frequently within this research study, the word *spirituality* denotes a complex concept. Unfortunately, counseling literature has provided little assistance in defining this term, as a myriad of definitions persist according to the perspective of the author. Additionally, although some literature uses *spirituality* and *religion* (or *religiosity*) interchangeably, different definitions will be provided for each. For the purposes of this research study, *spirituality* will be defined as an appreciation of and comfort with one's existence, as well as a connectedness to a higher power that is beyond the human experience (Burke et al., 1999). Conversely, *religion* is defined as an organized group of like-minded individuals who accept an agreed-upon set of dogmatic beliefs (Burke et al.). Some, who view spirituality and religion as necessary components of the same experience, may not accept this distinction, and may, in fact, understand religion as incomplete without spirituality. However, others find this differentiation favorable due to the perceived freedom found in spiritual experiences (Souza, 2002).

The use of the term *religious problem-solving* in this research study is used to describe religious or spiritual activities in which one engages to cope with a negative or stressful life event. The problem-solving strategies that an individual uses are based upon a coping style. In this sense, a *religious coping style* provides a perspective through which an individual will develop a coping or problem-solving strategy that utilizes religious and/or spiritual practices as coping mechanisms. Newman and Pargament (1990) describe a multistep process to integrate religion in the problem-solving process. Using religious resources, such as utilizing scared texts as a “guiding framework that defines a range of acceptable solutions to problems” (Newman & Pargament, p. 391), using the examples of past religious figures for inspiration, seeking a greater religious purpose to suffering, and exploring hope for a better future, can become coping mechanisms. Pargament et al. (1988) states that the manner in which an individual copes with a negative life event are based upon two factors: “the locus of responsibility for the problem-solving process, and the level of activity in the problem-solving process” (p. 91). Therefore, the coping style is dependent upon the problem-solving strategy an individual utilizes.

Other important terms to consider, which are related to spirituality, are *spiritual wellness* or *spiritual well-being*. These terms have been used interchangeably to express peacefulness, serenity, and having sense of contentedness with one’s life, of meaning and/or purpose to life, of control in one’s life, of hope for the future, and of a relationship with a greater being (Adams et al., 2000; Chandler et al., 1992). These characteristics of spiritual well-being address a need identified in wellness literature as a necessary component of experiencing wholeness as a human. The spiritual characteristics

demonstrate a connectedness to the human experience, as well as an understanding and acceptance of the positive and negative aspects of being human. Spiritual wellness is only a single attribute of total *wellness*. The general term of *wellness* describes optimal health in all aspects of the human being. Although a variety of models have been developed by various authors, each model contains the construct of spirituality. This demonstrates the beneficence of spiritual experiences in both physical and mental health.

Mental health, much like spirituality, is a subjective term that characterizes one's ability to demonstrate psychological and emotional wellness. As such, the United States Surgeon General defined mental health as healthy cognitive functioning in which an individual is able to exhibit good mental functioning, successful relationships with others, and the ability to cope with negative life events (United State Public Health Services [USPHS], 1999). Those who do not demonstrate good mental health may express symptoms of two psychological variables that affect large numbers of the American population: depression and anxiety (Collins, 1988; Westgate, 1996). Although *depression* is distinguished through a variety of symptoms and diagnosed through a specific set of diagnostic criteria (American Psychiatric Association [APA], 2000), it can be defined in a number of ways. However, for the purposes of this research study, the term *depression* will be used to describe the following symptoms: overwhelming sadness or fear, lack of appetite, marked weight loss or gain, disturbed sleep, fatigue, lack of energy, and feelings of guilt, helplessness, hopelessness, worthlessness, and isolation (APA). Similar to depression, *anxiety* can also be defined in a variety of ways. Although the *Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition, Text Revision* (*DSM-IV-TR*; APA) names numerous anxiety disorders, the only symptoms

identified for use in this study are as follows: restlessness, irritability, difficulty concentrating, difficulty sleeping, being easily fatigued, and muscle tension. Understanding the terms used in this research study will establish a common understanding of the information outlined herein.

One of the greatest weaknesses of any research study is a lack of proper understanding regarding the definitions used throughout the discussion. Speck (2005) illustrates this dilemma by providing a list of the numerous definitions for spirituality that he located in professional publications. Additionally, it is important to note that differences between spirituality and religion are consistently addressed in professional literature. From this perspective, Seybold and Hill (2004) primarily focused on religion in their discussion of the efficacy of participation in religion on the spiritual, psychological, and physical dimensions of being. However, these authors also recognized the negative aspects of religion, such as those noted by Cashwell et al. (2007), McCullough (1999), Miller and Thoresen (2004), and Young et al. (2007). Although some individuals may not prefer a spiritual or religious approach to counseling, research suggests that a vast majority of the American population indicated a preference for or an interest in involving spirituality and/or religion to some degree in a counseling session (Cashwell, 2001; Kelly, Jr., 1994; McCullough; Richards, Owen, & Stein, 1993; Young et al.). To accomplish this task, counseling professionals must continue to research the effects of using spirituality in the counseling process, as well as the relationships among spiritual and mental health variables. Although previous and current research has provided intriguing results, further analysis is necessary.

Relationship to Other Psychological Variables

To be acceptable in the mental health professions, research must empirically demonstrate a positive link between spirituality and physical and psychological factors before it may be readily and easily used in the counseling process and in the therapeutic relationship. Spirituality and science have been at odds for many years, especially because of the influence and well-documented anti-religious beliefs of Sigmund Freud (Carr, 2000; Stander, Piercy, MacKinnon, & Helmeke, 1994). However, Carr reports that Freud did maintain a certain respect for religion, and a colleague of Freud (Pastor Oskar Pfister) wrote about how Freud's work contributed to his work as a pastor:

> I tried forthwith to apply these discoveries [Freud's ideas] to my ministry, and found to my joy that I could now discover facts and render help in a way which since then has not failed…. What caused my analytic labours to become the fulfillment of a long-standing dream was that while they dealt with real life they were also connected with my task as a pastor (Pfister, 1928, cited in Carr, p. 2).

Pfister, as explained above, discovered how to integrate Freud's ideas into his ministry, and he found them easy to include and beneficial to use. Stander et al. (1994) report that Freud's influence on integrating spirituality and religion into therapy created a scenario in which science viewed religion as "oppressive to individual freedom and scientific growth and progress" (p. 28). However, this rejection was not one-sided, as many religious organizations viewed science with suspicion. Currently, many research studies have identified a positive link between spirituality and psychological constructs such as depression (Srinivasan et al., 2003; Westgate, 1996) and anxiety (Bowen-Reid & Smalls, 2004; Degges-White et al., 2003; Graham et al., 2001). These research results have

impacted the counseling profession by demonstrating that many benefits may be gained from an integration of spirituality and counseling; a strong, positive relationship exists between spiritual and psychological factors. Wellness modeling provides an important link between these constructs. This relationship will be more fully explained, and two specific psychological variables will be highlighted: depression and anxiety.

Because of the ACA *Code of Ethics* (2005) guidelines, it is arguably both important and necessary to "promote the welfare of clients" (Section A.1.a., p. 4). Current research indicates that the integration of spirituality into the counseling process is beneficial to client welfare (Benes et al., 2000; Burke et al., 1999; Cashwell et al., 2007; Chandler et al., 1992; D'Souza & Rodrigo, 2004; Eliason et al., 2001; Hodge, 2005; Kelly, Jr., 1992, 1994, 1997; Larimore et al., 2002; McCullough, 1999; Miller & Thoresen, 2003; Moberg, 2002; Myers et al., 2000; Richmond, 2004; Seybold & Hill, 2004; Stander et al., 1994; Townsend, Kladder, Ayele, & Mulligan, 2002; Witmer & Sweeney, 1992; Young et al., 2007). Indeed, Miller and Thoresen assert, "A majority of patients receiving health care say that they would like their caregivers to ask about and discuss spiritual aspects of their illness, with particularly high percentages among patients who regularly attend religious services" (p. 24). This statement indicates that some clients find meaning in discussions of spiritual issues, especially as it relates to a holistic health perspective. Rose, Westefeld, and Ansley (2001) discussed strikingly similar findings:

> Although no research has specifically examined client beliefs about the appropriateness of discussing spiritual issues in therapy, there is indirect evidence regarding client preferences. A substantial proportion of health care patients

prefer that their physicians address religious issues with them and even pray with them (p. 61).

This provided another example in which research appears to support the implementation of spirituality in the counseling and healthcare process. Additionally, similar research indicated that clients approve of this implementation. However, receiving training and believing that spirituality in counseling is beneficial does not explain *why* it is beneficial. Holistic wellness models provide a link to better understand the relationship between spiritual and psychological dimensions of health, as well as how they relate to other aspects of wellness.

Relationship of Spirituality to Wellness Modeling

Wellness models strive for holistic health, which means that all aspects of an individual are balanced and fully developed. The wellness models do not focus on a single aspect of a person; instead, they view the individual as a whole, perceiving an individual as a complex being that is composed of various dimensions. For example, in the wellness model described by Adams et al. (2000), the authors have categorized six broad dimensions of wellness: emotional, intellectual, physical, psychological, social, and spiritual. These dimensions are defined by Adams et al. (p. 167) as follows:

Emotional centeredness: A secure self-identity and a positive sense of self-regard

Intellectual stimulation: Perception of being internally energized by an optimal amount of intellectually stimulating activity

Physical resilience: A positive perception of and expectation of physical health

Psychological optimism: Perception that one will experience positive outcomes to the events and circumstances of life

Social connectedness: Perception of having support available from family or friends… and perception of being a valued support provider

Spiritual life purpose: A positive sense of meaning and purpose in life

As described within the wellness model, if any of these dimensions are not fully developed, or if some deficiency exists, then the person is not holistically balanced. Adams et al. stated that in "extreme illness conditions, one or more [wellness dimensions] contract and cause either the compensatory or concomitant change in either of the other dimensions" (p. 166). This means that if a deficiency exists in any single wellness dimension, then the individual is no longer balanced and illness may result. Another example of a wellness model consists of similar dimensions, yet it defines the interaction among the dimensions in a different manner (Chandler et al., 1992). Instead of maintaining spirituality as a separate dimension, it integrates it into each of the other dimensions.

In the perspective of Adams et al.'s (2003) wellness model, the concept of "psychological optimism" appeared to be closely related to the development of strong coping skills; additionally, the concept of "spiritual life purpose" is explained in an existential manner. Pargament et al. (1988) proposed that a significant relationship exists between these two variables (optimism and life purpose) through their concept of religious problem solving. Pargament et al. defined religious problem solving skills in three ways: collaborative, deferring, and self-directing. In collaborative religious problem solving, "both the individual and God are thought to have an active, shared role

in solving problems" (Hathaway & Pargament, 1990, p. 425). In the second method, deferring religious problem solving, "the individual is viewed as passive, and responsibility for dealing with problems is deferred entirely to God" (Hathaway & Pargament, p. 425). Being psychologically optimistic indicated that an individual believes that positive change can occur and that positive outcomes can occur through improving one's life situation.

The third method of religious problem solving, defined by Pargament et al. (1988), was labeled "self-directing." Pargament et al. described this approach to problem solving as one in which the individual does not directly involve God in the problem solving process. Despite the lack of direct divine intervention, Pargament et al. claimed that this approach to religious problem solving is not anti-religious. Instead, the authors asserted that "From this perspective, it is the individual's responsibility to resolve problems. Faced with this responsibility, the individual takes on an active problem-solving stance" (p. 91). This approach to problem solving maintains that "God is viewed as giving people the freedom to and resources to direct their own lives" (Pargament et al., p. 91). Although this problem solving style relies primarily upon the individual's resources, it also concludes that God provides each individual with the skills and abilities to solve their own problems: religion may be one of several resources used.

Pargament et al.'s (1988) collaborative religious problem solving entailed the use of spiritual beliefs to create or enable positive outcomes to life circumstances. In the deferring religious problem solving, the passive individual does not actively participate in facilitating change; instead, the passive individual believes that his or her spiritual beliefs alone will create positive outcomes. Hathaway and Pargament (1990) indicated that

“personal coping literature suggests that it is generally more effective to take active, personal responsibility for dealing with problems than to be passive and deferring” (p. 426). Thus, “psychological optimism” suggests that an individual engages in “collaborative religious problem solving.” Schaefer and Gorsuch (1993) also supported this concept; they stated that “religious coping strategies have been found to be some of the ways in which people report coping with stress” (p. 136). The authors not only reported the benefits of religiously-related coping strategies, but they also indicated how these strategies may improve both physical and mental health: “Religious coping has been shown to mediate the relationship between stress and both physical and psychological health for a broad variety of stressors” (Schaefer & Gorsuch, p. 136).

As an example of this relationship, Young, Cashwell, and Shcherbakova (2000) reported research findings that support the use of spirituality in coping with stressful situations. Young et al. stated that “support was found for the moderating effect of spirituality among an adult population, particularly in providing protection against depression” (n.p.). This disclosure directly related spirituality to the psychological variable of depression. Additionally, Young et al. reported a negative relationship between spirituality and depression, indicating that increased levels of spirituality correspond to decreased levels of depression. It appeared that the research provided by Hathaway and Pargament (1990), Pargament et al. (1988), and Schafer and Gorsuch (1993) indicated how the spiritual and psychological dimensions are related, especially in the interrelationship depicted in Adams et al.’s (2000) wellness model. Additionally, the research on religious problem solving and coping skills supported the claims that spirituality is beneficial in therapy.

In another example of a wellness model, Chandler et al. (1992) suggested that wellness occurs in a different manner than as reported in the model illustrated by Adams et al. (2000). Instead of six dimensions, Chandler et al. proposed that wellness is best depicted in five dimensions: intellectual, physical, emotional, social, and occupational. In this five-point model, each of the five dimensions is composed of a personal component and a spiritual component. The five dimensions are combined to form an optimum state of wellness; the authors stated the following about optimal wellness:

> Optimum wellness exists when each of these five dimensions has a balanced and developed potential in both the spiritual and personal realm. Working to achieve high-level wellness necessitates the development of the spiritual component in each of the five dimensions of wellness. Without attention to spiritual health in each dimension, the individual remains incomplete (p. 171).

Although Chandler et al. did not define the five dimensions of wellness (as did Adams et al.), the authors did clearly define spiritual wellness and how it develops. Because spirituality was a central concept to Chandler et al.'s *Holistic Wellness Model*, it was illustrated as being fully integrated into each dimension of wellness. Spiritual wellness does not suddenly occur; according to Chandler et al., it develops over time. For the authors, each spiritual experience leads to greater spiritual development, and that ultimately results in spiritual transformation. A spiritual experience is "any experience of transcendence of one's former frame of reference that results in greater knowledge and love" (p. 170). This appeared to be a cognitive process, through which an individual utilizes a spiritual experience to change the way in which he/she interacts with others and reacts to different situations. Pargament et al.'s (1988) definition of collaborative

religious problem solving was similar to Chandler et al.'s definition of a spiritual experience; both use a spiritual experience to guide one's actions and perceptions of life events.

A third wellness model that attempted to describe holistic wellness, as well as how one responds to life events, was Sweeney and Witmer's (1991) *Wheel of Wellness*. The *Wheel of Wellness* was designed in the form of a wheel, which was very different from the models proposed by Adams et al. (2000) and Chandler et al. (1992). However, the central focus remained the same: spirituality. In addition to it appearing as the central "hub" of the wheel, Sweeney and Witmer described spirituality as one of five main themes in this model. The authors stated that:

> The characteristics of wellness are expressed through the five life tasks of spirituality, self-regulation, work, love, and friendship. These life tasks dynamically interact with the life forces of family, community, religion, education, government, media, and business/industry. Global events, both natural and human, impact and are impacted by the life forces and life tasks (Sweeney & Witmer, p. 529).

The spokes on the *Wheel of Wellness* are a sense of humor, physical fitness, and nutrition, sense of worth, sense of control, realistic beliefs, spontaneous and emotional response, intellectual stimulation, problem solving, and creativity. This portrayal demonstrated another connection to Pargament et al.'s (1988) collaborative problem solving and Chandler et al.'s spiritual experiences in that all three studies suggested a relationship between spirituality and psychological variables. Seybold and Hill (2001) reaffirmed this sentiment by reporting that "The empirical data not only suggest that religion is an

important contributor to physical and mental health, but also support the models linking social support, such as the support religious communities provide, with positive health outcomes" (p. 24). Because spirituality is conceptualized so differently among individuals, being based upon experiences, worldview, and beliefs, it becomes an aspect of an individual's self-identity (Burke et al., 1999, MacDonald, 2004; Mack, 1994; Young et al., 2000). Individuals, who draw upon that spiritual support, as suggested by Seybold and Hill, are able to create a buffer between themselves and negative life events. These coping strategies demonstrated a positive characteristic of spirituality in respect to mental health.

Although each wellness model is designed in a different manner, they all incorporated spirituality as a necessary dimension among the other dimensions of holistic wellness. A large body of research indicated that spirituality has a strong positive relationship to good mental health (Burke et al., 1999; Cashwell, 2001; Cashwell et al., 2007; Cashwell & Young, 2007; Chandler et al., 1992; Degges-White et al., 2003; Eliason et al., 2001; Frankl, 1984; Graham et al., 2001; Hall et al., 2004; Larimore et al., 2002; MacDonald, 2004; Mack, 1994; McCullough, 1999; McCurdy, 2003; Miller, 1999; Miller & Thoresen, 2003, 2004; Moberg, 1984, 2002; Myers, Mobley et al., 2003; Myers, Sweeney et al., 2000; Richmond, 2004; Rose et al., 2001; Seybold & Hill, 2001; Slater et al., 2001; Souza, 2002; Stanard et al., 2000; Townsend et al., 2002; Walker et al., 2004; Westgate, 1996; Young et al., 2000). This field of research has produced results that have been tested and re-tested, each time returning similar findings. Because spiritual experiences appeared to promote cognitive insight and produced positive results, this study focused on and thoroughly discussed two specific psychological dimensions in

close detail: depression and anxiety. Although wellness models and preventative health models identified a strong relationship among a variety of spiritual and psychological variables, this study intended to pursue only these two specific psychological constructs.

Relationship of Spirituality to Depression

Depression is currently known as one of the most common psychological problems across the world (Collins, 1988; Westgate, 1996). In his 1988 revision of a guide to *Christian Counseling*, Collins reported that depression is a "worldwide phenomenon that affects individuals of all ages, appears to be increasing among teenagers and young adults, and disrupts the lives of an estimated 30 to 40 million people in the United States alone" (p. 105). Almost a decade later in 1996, Westgate reported that the number of persons affected by depression is still growing and "Depending on the diagnostic criteria, depression affects between 5% and 30% of the U.S. population, cutting across the life span, gender, and social class" (p. 25). This purports to be a large number! The USCB (2001) estimated the 1996 (when Westgate's article was published) United States population to be approximately 266,664,000. Five to thirty percent of the 1996 population, therefore, corresponds to between 13 million and 80 million persons that suffer from depression or symptoms of depression. With numbers this large, it is imperative that the counseling profession devise effective treatment strategies, especially as research concerning the positive effects of spirituality on depression is reportedly promising (Flannelly, Weaver, Smith, & Handzo, 2003; Wachholtz & Pargament, 2005).

Depression is characterized as a mood disorder in the *DSM-IV-TR*, published by the APA (2000). Although a variety of mood disorders are defined in the *DSM-IV-TR*,

the primary differentiation among the diagnoses of depression is the length of time for which the individual has experienced the symptoms. However, for the purposes of this review, all depressive symptoms were defined according the diagnostic criteria for 296.2x Major Depressive Disorder, Single Episode. According to the *DSM-IV-TR*, the diagnostic criteria for recurrent episodes of major depressive disorder are defined as the presence of five or more of the following symptoms that have been present for the same two-week period and are considered different from previous behavior:

1.) Depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others.
2.) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
3.) Significant weight loss when not dieting or weight gain.
4.) Insomnia or hypersomnia nearly every day.
5.) Psychomotor agitation or retardation nearly every day.
6.) Fatigue or loss of energy nearly every day.
7.) Feelings of worthlessness or excessive or inappropriate guilt nearly every day.
8.) Diminished ability to think or concentrate, or indecisiveness, nearly every day.
9.) Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt, or a specific plan for committing suicide (APA, p. 356).

Although these criteria may change according to different diagnoses, they are similar components of all depressive mood disorders. All of the criteria listed above involve a

physiological, emotional, or cognitive response to the feelings the individual may experience. These symptoms may also result from any number of factors. For treatment purposes, research indicated that spirituality provides a good place to start.

Although a variety of theories have been developed to address the reasons for this significant increase in persons suffering from depression, current literature and research strongly supported the use of spirituality in the evaluation and treatment of depressive symptoms. Collins (1988) stated that current research regarding depression has revealed statistics that "have led to the conclusion that developmental, psychological, interpersonal, spiritual, and many nonphysical influences are the basis of much depression" (p. 107). Additionally, it appears that the incorporation of spirituality was an effective and beneficial therapeutic option for the counseling profession (Hodges, 2002; Miller & Thoresen, 2003; Seybold & Hill, 2001; Srinivasan et al., 2003; Townsend et al., 2002). Westgate (1996) approached the use of spirituality from an existential perspective; she contended that not only is spirituality a helpful option for counselors, but that theorists have also "questioned the impact of the lack of a spiritual perspective on mental health in general and on depression in particular" (p. 27). From Westgate's perspective, spiritual wellness was the key element in the development of an existential solution to depressive symptoms; this perspective consisted of four dimensions: meaning in life, intrinsic values, transcendence, and spiritual community. Each of Westgate's dimensions was defined according to an understanding of depression, providing possible existential solutions to symptoms of depression. Westgate contended that the search for purpose and meaning helps alleviate depressive symptoms.

According to Frankl (1984), finding meaning and purpose in one's life is vital; this became a well-established premise by existential theorists (Frankl, 1978; Maslow, 1971; May, 1975; Westgate, 1996). Finding significance in one's life essentially meant to be satisfied and fulfilled by one's life. These feelings directly contrasted the symptoms experienced by those suffering from depression. An individual experiencing the second diagnostic criteria for depression (i.e. diminished interest in activities) is suffering from perhaps the most commonly reported depressive symptom, as reported by Beck (1967). Another commonly reported symptom of depression is having feelings of worthlessness or hopelessness (diagnostic criteria #7). Feelings of worthlessness and hopelessness may develop into a pervading sense that one's life is insignificant, void of meaning or purpose. Frankl's (1984) existential perspective on finding significance in one's life was reaffirmed by Burke et al.'s (1999) stance that spirituality has the ability to promote a deep sense of meaning in life. Thus, it appeared that a negative relationship exists between spirituality and depression. This implied that spiritually engaged individuals may not be as acutely affected by depressive symptoms.

Frankl (1984) told the story of a man who visited him, reporting pain and depression from the loss of his wife. The man stated that he no longer had anything or any reason for which to live. Frankl stated that his answer was to reframe the man's questioning so that the man understood that by outliving his wife, he was saving her the same torment that he was currently feeling. Frankl summarized this experience by stating that "suffering ceases to be suffering at the moment it finds a meaning, such as the meaning of sacrifice" (p. 135). As Paulson (2001) maintained, it is an "authentic and personal" (p. 386) experience, which can be painful, as the individual opens oneself to

the reality of the situation. Finding meaning on a spiritual level to overcome that which could potentially overwhelm an individual is, in effect, a cognitive restructuring or reframing (Hutch, 2000). In Frankl's example, the symptoms of depression may be alleviated by finding meaning outside of loss. This may require restructuring the feelings of loss to gain a sense of meaning through a loving sacrifice. Seeking spiritual themes in these depressive situations will not change the situation, but it may inwardly change the perspective of the affected individual. Thus, by encouraging the man to find meaning in the loss of his wife, Frankl helped the man to change his outlook on the situation.

By effectively changing the man's perspective, Frankl (1984) demonstrated how spirituality can be used to alleviate the symptoms of depression, thus revealing a relationship between the two constructs. Frankl's example of helping a man find meaning in his life supported Westgate's (1996) four dimensions of spiritual wellness: meaning in life, intrinsic values, transcendence, and spiritual community. Hutch (2000) suggested a similar idea that "human spirituality is an individual's achieved capacity to affirm time and again that his or her great personal losses could have been far worse, in spite of the emotional turmoil and woe surrounding such events" (p. 329). For Westgate, finding meaning in life was finding hope in life, and in finding a reason to live. This ideal was directly related to several symptoms of depression in which the individual has a diminished interest in usually pleasurable activities, or may even be contemplating and/or planning suicide. By finding meaning in one's life, the individual becomes more self-aware, thus defining his/her intrinsic values.

Allport (1960, cited by Westgate, 1996) stated that intrinsic values are "the framework through which one's life is understood. They are stable and guide one's life

regardless of external consequences" (p. 29). With this definition, Westgate reported research that indicated that high levels of intrinsic values were found in religious persons who also generally exhibited lower levels of depression. This concept of intrinsic values supported Frankl's (1984) belief that love is the highest value to which an individual can aspire.

> The truth – that love is the ultimate and the highest goal to which man can aspire. Then I grasped the meaning of the greatest secret that human poetry and human thought and belief have to impart: *The salvation of man is through love and in love* (Frankl, p. 57, emphasis Frankl).

Frankl then revealed the spiritual aspect of love: "Love goes very far beyond the physical person of the beloved. It finds its deepest meaning in his spiritual being, his inner self" (p. 58). This intrinsic value of love, according to Frankl, enables an individual to rise above negative life situations to find meaning and significance in his or her life.

The idea of love going "beyond the physical person of the beloved" can be understood as transcendence. Westgate (1996) stated that "transcendence" referred to a relationship with a higher being or a higher power – a relationship with something larger than and outside of oneself. Additionally, research reported by Chandler et al. (1992) and Hodges (2002) supported this concept. Other research, such as that conducted by Baetz, Bowen, Jones, & Koru-Sengul (2006), indicated that worshipping a higher power corresponds to lower levels of lifetime depression, lifetime mania, psychiatric disorders, and social phobia, whereas Hodges suggested that relationships with and support from a like-minded community resulted in improved mental health. Even so, O'Connor (2002) indicated that persons suffering from depression are unlikely to view depression as

"spiritual challenges or an opportunity for spiritual growth" (p. 139); instead, they primarily "focus on the psychological and physiological symptoms of depression" (p. 139). These individuals appeared to be less likely to seek support from a relationship with a higher power, a relationship that was based upon one's worldview, as acknowledged by Cole (2005). Individuals exhibiting this response to depressive symptoms may engage in the religious problem solving style of "deferring," which was defined by Pargament et al. (1988). However, as reported by Hodges, relationships with a spiritual community can also provided needed support.

As described by Hodges (2002), Westgate's (1996) fourth dimension of spiritual wellness related to depression is a "community of shared values and support." The social dimension of Adams et al.'s (2000) and Chandler et al.'s (1992) wellness models indicated that a basic requirement of wellness was to develop relationships with others – a concept that was also supported by Sweeney and Witmer's (1991) *Wheel of Wellness*, in which relationships (such as those with friends and family) are a necessary component of wellness. As was reported in the *DSM-IV-TR* (APA, 2000), persons suffering from depression may tend to withdraw and report feelings of loneliness and isolation. Because an important aspect of spirituality is a connectedness with a higher power, as well as a like-minded spiritual community, it is vital that counselors use these resources to help those suffering from symptoms of depression. Westgate contended, "The natural outgrowth of intrinsic values and a transcendent perspective is the living and sharing of those values with others" (p. 31). Researchers, such as Beck (1967), reported that individuals suffering from depression may withdraw from others, and, therefore, active involvement in a community of like-minded persons can help support persons suffering

from depression. Collins (1988) concurred with Beck, suggesting that three methods of assisting persons suffering from depression would be to help them learn coping techniques, help them find support, and encourage them to reach out to others.

Current literature appeared to support the efficacy of spirituality against symptoms of depression and other mental health concerns (Adams et al., 2000; Baetz et al., 2006; Chandler et al., 1992; Cole, 2005; Flannelly et al., 2003; Hodges, 2002; Hutch, 2000; Miller & Thoresen, 2003; O'Connor, 2002; Seybold & Hill, 2001; Sweeney & Witmer, 1991; Townsend et al., 2002; Westgate, 1996; Yarhouse & Kreeft-Turcic, 2003). An inverse relationship has been established between spirituality and depressive symptoms, as well as a positive relationship between spirituality and good mental health (Baetz et al.; Hodges). Because of these strong relationships, the counseling profession must consider the efficacy and benefits of using such a resource. Therefore, it is imperative that further research be completed to evaluate the use of spirituality as a treatment method for psychological issues, such as depression and anxiety.

Relationship of Spirituality to Anxiety

To further illustrate the usefulness of spirituality in the counseling profession, another psychological variable must be evaluated: anxiety. Anxiety is a common psychological response to some specific unidentified danger (i.e. fear), or it may be a result of an imaginary peril (Collins, 1988). In either manner, it produces a physiological response, which is characterized by an elevated heartbeat, elevated blood pressure, increased muscle tension, perspiration, and a release of epinephrine into the bloodstream. These physiological changes in the body are natural responses to perceived danger.

However, a psychological disorder may result when these reactions occur in response to imagined threats, or when the body seems to remain in a constant state of heightened awareness.

Collins (1988) reported that approximately 5% of the U.S. population suffers from an anxiety disorder, which, according to census data (USCB, 2001) computes to approximately 12 million persons in 1988. The *DSM-IV-TR* (APA, 2000) also reported high numbers, estimating that approximately 14 million persons (USCB) suffered from symptoms of anxiety. Additionally, six different types of anxiety have been identified: normal, neurotic, moderate, intense, state, and trait. Normal, moderate, and state anxieties refer to normal psychological and physiological reactions to perceived danger. However, neurotic, intense, and trait anxieties depict abnormal elevations of anxiety symptoms, which can persist into a psychological disorder. Collins defined these types below:

> *Normal anxiety* comes to all of us at times, usually when there is some real threat or situational danger. Most often, this anxiety is proportional to the danger.
>
> *Neurotic anxiety* involves intense exaggerated feelings of helplessness and dread even when the danger is mild or nonexistent.
>
> *Moderate anxiety* can be desirable and healthy. Often it motivates, helps people avoid dangerous situations, and leads to increased efficiency.
>
> *Intense anxiety*, in contrast, is more stressful. It can shorten one's attention span, make concentration difficult, cause forgetfulness, hinder performance skills, etc.

State anxiety often comes quickly, may or may not be of high intensity, and has a short duration.

Trait anxiety, in contrast, is a persistent, ever-present, ingrained emotional tension (p. 78).

Additionally, McCorkle, Bohn, Hughes, and Kim (2005) affirmed that thought patterns may cause significant distress to persons suffering from anxiety. These authors theorized that internal stimuli drown out the external stimuli, or other's reactions, and thus it becomes extremely difficult to rationalize the psychological and physiological responses to the stimuli. Thus, what should be a normal anxiety reaction elevates into a debilitating situation.

In these types of situations, the APA has provided numerous diagnostic criteria in the *DSM-IV-TR* (APA, 2000), by which a professional counselor may diagnose an anxiety disorder and categorize symptoms of anxiety. Although numerous diagnoses are associated with anxiety disorders, for the purposes of this research study, only the diagnostic criteria for 300.02 Generalized Anxiety Disorder were used, as it contains a wide representation of anxiety symptoms. Although this is not a complete listing, three of the following six symptoms must be present for more days than not of the last six months:

1.) restlessness or feeling keyed up or on edge

2.) being easily fatigued

3.) difficulty concentrating or mind going blank

4.) irritability

5.) muscle tension

6.) sleep disturbances (APA, p. 476)

The diagnostic criteria for other anxiety diagnoses remain consistent with most anxiety disorders. In reviewing these criteria, it is apparent that anxiety is exhibited mainly through physiological responses, as most criteria involve an involuntary response by the body. Additionally, these symptoms may occur due as the result of a wide variety of factors.

Depending upon the factors, a significant relationship may exist between spirituality and anxiety. McCorkle et al. (2005) stated that "some research suggests a link between anxiety and either religion or spirituality. The nature of this relationship is quite complex, being sometimes positive and sometimes inverse, and therefore is not easily summarized" (p. 229). This claim is further supported by Davis, Kerr, and Robinson-Kurpius (2003), who also indicated that although numerous studies report a strong inverse relationship between spiritual well-being and levels of anxiety, other research studies suggested either a slight positive relationship or no relationship at all. However, Davis et al. indicated that the discrepancy among these research findings was primarily based upon the diverse, non-standardized definitions of spirituality and/or religiosity.

> The mixed conclusions as to the nature of religion's relationship with anxiety can be partially explained by looking at the simplistic definitions of religion in past research. Different studies will have sharply different findings depending on how the spiritual variable is defined (Davis et al., p. 357).

If a higher power or transcendent being is defined according to a "fire and brimstone" perspective, it is possible that higher levels of anxiety would be reported in response to spiritual experiences. Seybold and Hill (2001) discussed such religious perspectives,

labeling them as “pathological” (p. 22), meaning that practicing spirituality or religion in this manner “can have serious implications for physical health” (p. 22). Thus, it is necessary to closely study the research results that imply that spirituality has a moderating effect on anxiety in light of the concept of spirituality in the respective studies.

Some research concerning the relationship between spirituality and anxiety has come about through studying individual resiliency to negative life situations (Connor, Davidson, & Lee, 2003; Davis et al., 2003; McCorkle et al., 2005), which is similar to Pargament et al.’s (1988), as well as Hathaway and Pargament’s (1990), studies of religious problem solving and coping strategies. Methods of resiliency included personal strengths: “The foundation of resilience is the possession of selective strengths or assets to help an individual survive adversity” (Richardson, 2002, cited in Connor et al., 2003). Some concepts of resiliency included items such as a sense of control, a sense of meaning in one’s life, a high level of self-esteem, good social skills, and the use of humor (Connor et al.). The spiritual aspects of the concepts of resiliency are evident in having a sense of meaning and significance in life, seeking a relationship with a higher power and/or with others, believing in a destiny for one’s life, and a having a realistic understanding of what one can and cannot control (Kurtz & Ketcham, 1993). McCorkle et al. also suggested that “sanctification” may also provide a direct benefit to mental health, because individuals become more invested into something they sanctify. “The process of sanctification may help explain findings that people with high levels of self-reported religiousness and spirituality tend to experience more positive emotions such as gratitude and fewer negative emotions” (McCorkle et al., p. 228). Additionally, Pargament and

Mahoney (2005) defined *sanctification* as “a process through which aspects of life are perceived as having divine character and significance” (p. 183). A belief that negative life events and dangerous situations play a divine role in one’s life may prevent negative reactions to and/or encourage resiliency against anxiety or other psychological issues.

Wellness modeling again provides an empirical link between spirituality and psychological variables, such as spiritual wellness and anxiety, respectively. Social connectedness has been previously reported as a contributing factor in achieving spiritual wellness, as well as a resiliency factor against mental illness and/or psychological issues; each wellness model includes a social dimension (Adams et al., 2000; Chandler et al., 1992; Sweeney & Witmer, 1991), a necessary component of wellness. Social interaction is suggested as a viable mechanism through which engaging in spiritually related activities and exercises is conducive to better health (Seybold & Hill, 2001). “Religious and spiritual communities provide opportunities for fellowship, involvement in formal social programs, and companionship. This kind of support can have beneficial effects by reducing both psychological and physical stressors” (Seybold & Hill, p. 23). Positive emotional behavior appeared to result in a positive physiological response, whereas negative emotions may result in illness (Seybold & Hill). Although social anxiety and agoraphobia present related disorders that produce physiological symptoms (APA, 2000), participation in spirituality and religion may establish an existential process through which an individual might find hope for the future, meaning in being, and purpose in one’s life.

Existential literature presented another construct of anxiety: *death anxiety*. This fear plagues many people, if they refuse to confront the reality of death (Cooper, 2003;

Yalom, 1980). The fear of death may become crippling, preventing an individual from fully functioning. Death anxiety may also prevent an individual from living and existing authentically. Hutch (2000) alluded to death anxiety by discussing it in terms of a reframing method called *comparative free association of loss*. In this method, one compares their future death with what will occur to others – in doing so, Hutch suggested that the individual will come to see they are not alone in facing death, nor are they worse off than others. Hutch's study provided another example in which the spiritual concept of social connectedness with a community is apparent. Spiritual belief in a transcendent power, the search for meaning in one's life, and hope for a better future, as well as social connectedness, relies upon the spiritual methods of resiliency to reduce anxiety. Through the community of like-minded persons, an individual may reduce feelings of isolation and being alone. Davis et al. (2003) stated that

> Whether through value-based vocational counseling, assisting in the exploration of one's relationship with a transcendent power, or facilitating the development of a meaningful vision of the future, counselors can help to alleviate the anxiety and intrapsychic conflict that accompany meaninglessness and lack-of-purpose (p. 363).

Research indicated that a relationship exists between spirituality and anxiety symptoms (Connor et al., 2003; Davis et al., 2003; Hodges, 2002; Hutch, 2000; McCorkle et al., 2005; Townsend et al., 2002). Although, as stated by Davis et al., the relationship is not definitive, a large number of research studies indicated that spirituality is a beneficial aspect of well-being. Further research is necessary to evaluate the strength of the relationships, if any actually exist, between constructs of spirituality (specifically spiritual

well-being and religious problem-solving) and the psychological constructs of depression and anxiety.

Assessment Instruments

Because this study intended to evaluate the relationship between two constructs of spirituality (spiritual well-being and religious problem-solving) and two psychological constructs of depression and anxiety, four different assessment instruments were used; one assessment to evaluate each construct. Each assessment was designed for a specific purpose and to measure a specific construct. The two spirituality assessments used were the *Religious Problem-Solving Scale* (RPSS; Pargament et al., 1988) and the *Spiritual Well-Being Scale* (SWBS; Ellison, 1983; Paloutzian & Ellison, 1982). The two psychological measures utilized were the *Beck Depression Inventory-II* (BDI-II; Beck et al., 1996) and the *Beck Anxiety Inventory* (BAI; Beck, Epstein, Brown, & Steer, 1998). The two spirituality measures were correlated with the two psychological measures to evaluate the relationship between the spirituality constructs and the psychological variables.

Religious Problem-Solving Scale (RPSS)

The RPSS was originally published by Pargament et al. (1988) to evaluate religious coping and problem-solving styles. The primary reason for the development of this assessment was to ascertain if a relationship exists between religious problem-solving styles and mental health (Thurston, 1999). According to Pargament et al., a large body of research exists to support the concept that spirituality and/or religion plays a

significant role in how individuals make decisions. Individuals may engage in spiritual or religious behaviors such as meditation, fasting, prayer, worship, or solitude in an effort to cope with negative life events, to make decisions, or to establish a closer relationship with God (Foster, 1998). To study this behavior, the RPSS was designed to evaluate the manner in which individuals attempt to solve problems, cope with negative events, and make decisions.

The authors (Pargament et al., 1988) identified three distinct styles (used as subscales) of religious problem-solving: *Self-Directing*, *Collaborative*, and *Deferring*. Each style also reflects the quality of one's transcendent relationship with a higher power or a higher being. The three styles are defined by Pargament et al. as follows:

> The report of a problem-solving style involving active personal exchange with God (Collaborative) appears to be part of an internalized committed form of religion, one holding positive implications for the competence of the individual. A problem-solving style in which the individual wait for solutions from God (Deferring) seems to be part of an externally-oriented religion providing answers to questions to individual is less able to resolve. This style was associated with lower levels of competence. A Self-Directing style emphasizes the freedom God gives people to direct their own lives. This approach appears to be an active coping orientation which stresses personal agency, involved lower levels of traditional religious involvement, and is part of a generally effective style of functioning (p. 90).

According to Thurston (1999), the Self-Directing subscale was "based on Fromm's (1960) notion of a humanistic religion which places the responsibility for problem

solving on people rather than God" (p. 347). Additionally, Thurston claimed that the Deferring subscale was also based upon Fromm's work, which entailed a concept of submission to an all-powerful God. Decidedly, through the definitions provided, it is obvious that Pargament et al. believed the Collaborative and Self-Directing styles to be more effective methods of problem-solving, as the individual engages in a proactive role by making decisions based upon their God-given skills and abilities. Furthermore, the Deferring religious problem-solving style appeared to be less appealing to the authors, as it suggested a total relinquishment of responsibility in problem-solving.

The RPSS consists of 36 items (12 items for each subscale) arranged in random order. A short form of this instrument may be used; it consists only of the first 18 items (6 items for each subscale). Each question is answered on a five-point Likert scale, in which item responses indicate how often the individual engages in an activity (never, occasionally, fairly often, very often, and always). Separate scores are recorded for each subscale, and each subscale is scored by calculating the sum of the answers to each item in the subscale. Scores on each subscale may range from 12-60. This instrument requires approximately 20 minutes to complete (long form) with no special instructions. This assessment was also designed to be self-administered; therefore, no special training is necessary to administer or interpret the results (Thurston, 1999).

The initial norming data consisted of 197 persons recruited from two Protestant churches, one Presbyterian and the other was Missouri Lutheran; both churches were located in the Midwest United States. Participant demographics were reported as 57% female, 69% married, primarily of Caucasian ethnicity, and a varied educational background (Pargament et al., 1988). Additionally, Pargament et al. stated that

approximately 95% of study participants reported attending a worship service at their church at least once every month.

Reliability and validity appeared to be very promising, according to Thurston (1999). Reliability estimates for each subscale were high: .94 (Collaborative), .94 (Self-Directing), and .91 (Deferring). Cronbach's alpha coefficients were also high: $\alpha = .93$ (Collaborative), $\alpha = .91$ (Self-Directing), and $\alpha = .89$ (Deferring). The means and standard deviations reported for each subscale were as follows: Collaborative ($M = 36.02$, $SD = 10.67$), Self-Directing ($M = 29.70$, $SD = 10.71$), and Deferring ($M = 25.81$, $SD = 9.19$). A test-retest reliability with a sample of 97 college students also returned promising reliability estimates: .93 (Collaborative), .94 (Self-Directing), and .87 (Deferring). These figures indicated that reliability appeared to be high. According to Pargament et al. (1988), in respect to measures of religiousness, the Self-Directing subscale correlated to a significantly negative relationship with a higher power, whereas the Collaborative and Deferring exhibited a positive relationship. Thus, it appeared that the RPSS was a promising instrument, and would collect both reliable and accurate data.

Further research has been conducted using the RPSS. Fox, Blanton, and Morris (1998) attempted to reconstruct the initial research study conducted by Pargament et al. (1988) with the development of the RPSS. However, Fox et al.'s (1998) sample consisted of 136 ordained clergy and their spouses ($n = 272$) from six Christian denominations (Church of God Cleveland, Tennessee; Seventh-Day Adventists; Episcopal Church; American Baptist Church; Lutheran Missouri Synod; and Southern Baptist Convention), and this study was conducted using the RPSS short form. Again,

Cronbach's alpha coefficients were high: .87 (Collaborative), .84 (Self-Directing), and .86 (Deferring). No other statistical data was reported by Fox et al.

In another study concerning psychological adjustment, Schaefer and Gorsuch (1991) reported high reliabilities with the RPSS: α = .91 (Collaborative), α =.91 (Self-Directing), and α = .85 (Deferring). These results appear to be consistent with those reported by Pargament et al. (1988) and Fox et al. (1998). In 1993, Schaefer and Gorsuch conducted another study with the RPSS; in the 1993 study, Schaefer and Gorsuch assessed religious coping with state and trait anxiety arranged in three vignettes (state anxiety) and a single scale for trait anxiety. Again, the RPSS performed very well, returning reliabilities on the trait anxiety scale of .90 (Collaborative), .85 (Self-Directing), and .76 (Deferring). With the state anxiety vignettes, the RPSS also returned high reliabilities: Collaborative (.92, .90, .92), Self-Directing (.93, .92, .91), and Deferring (.88, .85, .85). Thus, it appeared that the RPSS was a highly reliable and valid assessment, as is reported throughout several research studies.

Spiritual Well-Being Scale (SWBS)

The SWBS was initially published in 1982 by Paloutzian and Ellison. A year later, Ellison (1983) published a more comprehensive report of the SWBS. The users' manual for the assessment was later published in 1991 (Paloutzian & Ellison). This assessment was designed as "a general measure of the subjective quality of life. It serves as a global psychological measure of one's perception of spiritual well-being" (Boivin, Kirby, Underwood, & Silva, 1999). The SWBS was designed to evaluate individuals from a holistic perspective, not being focused on, or researched upon a single religious

community or organization. Instead, the SWBS concentrated on transcendence as it related to something beyond oneself, something that can only be understood in two ways: religious and existential. Consequently, the SWBS is constructed with two subscales: religious well-being (Religious) and existential well-being (Existential).

Although the SWBS is designed with two subscales, it provides an overall score of spiritual well-being (SWB), which is the combined scores of the Religious and Existential subscales. Boivin et al. (1999) stated that the SWBS must be viewed in both a "horizontal" and a "vertical" manner. The horizontal dimension is the Existential subscale. This subscale is considered horizontal because it is more of a "social psychological" scale, concerned with "how well the individual is adjusted to self, community, and surroundings. This component involves the existential notions of life purpose, life satisfaction, and positive or negative life experiences" (p. 382). The vertical dimension is the Religious subscale, because it is focused on the well-being of one's spiritual life as it relates to God. D'Costa and Schoenrade (1995) suggested that the two subscales are well-differentiated, making them useful for research. The users' manual (Paloutzian & Ellison, 1991) also stated that over 300 requests have been made to use this instrument in research studies, as it provided a well-designed global scale of spiritual well-being (Boivin et al.).

The SWBS is a 20-item assessment (10 items for each subscale) arranged with all even number questions assessing Existential and all odd number questions assessing Religious. Some items are scored with a higher score representing greater levels of well-being, whereas some negatively-worded items are scored in reverse. Each question is answered on a six-point Likert-type scale, with answers ranging from "Strongly Agree"

to “Strongly Disagree” (strongly agree, moderately agree, agree, disagree, moderately disagree, strongly disagree). Each scale is scored separately, as stated above; however, a total score of well-being (i.e., SWB) is calculated by summing the scores on each subscale. Scores may range from 10 to 60 on each subscale, with a total score ranging from 20-120. Higher scores represent greater levels of spiritual well-being and lower scores indicate the opposite. This assessment requires approximately 10-15 minutes to complete and may be self-administered and self-scored. According to the users’ manual, no special training is required to administer the assessment or interpret the results (Paloutzian & Ellison, 1991; Boivin et al., 1999).

The original sample used to norm the SWBS consisted of 206 college students enrolled in four universities (Biola College, Westmont College, Pepperdine University, and the University of Idaho; Ellison, 1983). Other initial studies reported using over 500 individuals, consisting of both men and women, college students, high school students, senior citizens, religious and non-religious people, and persons from towns of all sizes (rural to large city; Boivin et al., 1999). Later research also included widely diverse populations, such as people suffering from AIDS, terminal cancer patients, sociopathic convicts, and sexually-abused people.

The reliability and validity of the SWBS appeared to be high, although some potential problems do exist (D’Costa & Schoenrade, 1995; Ellison, 1983; Stanard et al., 2000). There was only a slight correlation between the two subscales (r = .32), whereas a high correlation existed between SWB (the global scale of well-being) and the Religious subscale (r = .90), as well as a moderate correlation between SWB and the Existential subscale (r = .59). However, the test-retest reliability coefficients with four samples on a

1, 4, 6, and 10 week interval resulted in high reliability: the SWB global scale ranged from .82 to .99, the Religious subscale ranged from .88 to .99, and the Existential subscale ranged from .73 to .98 (Paloutzian & Ellison, 1991). In a previous sample, Ellison (1983) reported similar results of high test-retest reliability coefficients: .93 (SWB), .96 (Religious), and .86 (Existential). Ellison reported that the Cronbach's alpha coefficients were also very high: $\alpha = .89$ (SWB), $\alpha = .96$ (Religious), and $\alpha = .78$ (Existential).

Boivin et al. (1999) reported that data based upon seven research studies consisting of over 900 subjects also returned a high reliability. Internal consistency reliability coefficients for the two subscales and the global scale reported results for SWB ranging from .89 to .94, results for Religious ranging from .82 to .94, and results for Existential ranging from .78 to .86. All of these scores indicated high internal consistency and high test-retest reliability, indicating that the SWBS exhibited high levels of reliability, as well as strong potential for further research.

Validity also appeard to be high. Boivin et al. (1999) reported that face validity was high, as the measure assessed what it was designed to assess. However, a significant psychometric difficulty exists with the SWBS: Boivin et al., Bufford, Paloutzian, and Ellison (1991), Paloutzian & Ellison (1982), and Stanard et al. (2000) reported a "ceiling effect" that develops when this assessment is used with subjects who self-report as highly religious. This can be a problem, as the assessment cannot easily measure high levels of spiritual well-being. Boivin et al. reported that this problem is especially noticeable in the Religious subscale and the SWB global scale. However, the SWBS is reportedly very sensitive with lower levels of spiritual well-being (Boivin et al.). This problem may limit

the usefulness of this instrument and certainly indicates the need for further research and revision. However, for the purposes of this research study, the limitations noted above did not adversely affect the study.

Beck Anxiety Inventory (BAI)

The BAI is an assessment designed to measure and evaluate the severity of anxiety in psychiatric outpatients (Beck et al., 1988; Dowd & Waller, 1998). Beck et al. stated that the original purpose of the development of the BAI was to create an assessment that focused specifically on anxiety – previous assessments measured both depression and anxiety. The problem faced by the researchers developing an anxiety measure is that symptoms of anxiety are considered diagnostic criteria in a variety of psychological disorders (Hewitt & Norton, 1993). The BAI was created from three anxiety assessment that already existed: the Anxiety Checklist, the Physician's Desk Reference Checklist, and the Situational Anxiety Checklist. The result of this effort, the BAI, appeared to be able to discriminate anxiety-related diagnoses (i.e. panic disorder, generalized anxiety disorder) from non-anxiety-related diagnoses, such as major depressive disorder and dysthymic disorder (Beck et al.).

Designed to differentiate between anxiety and depression and remain valid, the BAI consists of a single scale. The BAI is relatively short, consisting of only 21 items. Each question is answered on a four-point Likert scale (scored 0-3), and the answers are ranged to indicate how severe the anxiety symptom is affecting the individual, from “Not at all” to “Severely; I could barely stand it.” The BAI is scored by totaling the numerical values corresponding to the individual’s selection on each item. Scores may range from

0-63. Scores of 0-21 indicate low levels of anxiety, whereas scores of 22-35 suggest moderate levels of anxiety. Scores of 36 or greater indicate severe levels of anxiety and suggest a significant cause for concern. The BAI requires approximately 5-10 minutes to complete and may be self-administered. However, according to Harcourt Assessment, Inc., the publisher of the BAI, a C-level qualification is required to purchase and use this assessment, which indicates that advanced, graduate-level training in the field of psychology (or equivalent) is required to administer and interpret the results of this assessment.

Initial norming data consisted of 1,806 subjects collected between 1980 and 1986. All subjects were outpatients at the Center for Cognitive Therapy, located in Philadelphia, Pennsylvania. These subjects were reported as 42% men (n = 456) and 58% women (n = 630). Beck et al. (1988) stated that the first sub-sample of 810 subjects was used to "eliminate inappropriate or redundant items" (p. 894) in the development of the BAI. A second sub-sample of 116 subjects was used to eliminate further unnecessary items, and a final sub-sample of 160 subjects was used to extensively validate the final 21-item form of the BAI.

Beck et al. (1988) reported that the final 21-item form of the BAI displayed high levels of internal consistency (α = .92). The authors also tested the discriminate reliability in three separate correlational studies between subjects with *Diagnostic and Statistical Manual for Mental Disorders – Third Edition* (*DSM-III*; APA, 1980) and *Diagnostic and Statistical Manual of Mental Disorders – Third Edition, Revised* (*DSM-III-R*; APA, 1987) anxiety disorders (n = 82, 95, 114) and subjects with a *DSM-III* depressive disorder (n = 30, 49, 30). Beck et al. also reported using a control group (n =

16) with this study. Dowd and Waller (1995) reported that "Internal consistency reliability coefficients are uniformly excellent, ranging between .85 and .94. Test-retest reliability data from Beck et al. (1988) showed a coefficient of .75 over one week" (n.p.). Although a few weaknesses exist in the BAI (Dowd & Waller), this anxiety measure appeared to somewhat discriminate between clusters of anxiety disorders and other co-morbid anxiety symptoms. However, the BAI is useful as a global evaluation of anxiety (Beck & Steer, 1993a).

Further research has been conducted using the BAI. For example, Hewitt and Norton (1993) studied the overlap between the BAI and the Beck Depression Inventory (BDI), as well as to evaluate any gender differences. Hewitt and Norton's study consisted of 291 psychiatric patients (143 men and 148 women). Again, Hewitt and Norton found high internal consistency: Cronbach's alpha coefficients were $\alpha = .92$ (BAI) and $\alpha = .91$ (BDI). The authors reported that the results were consistent with symptoms of anxiety disorders. Regarding the gender differences, Hewitt and Norton discovered that women tended to report higher levels of anxiety ($M = 21.23$) than anxiety reported by men ($M = 15.72$). However, the authors also report that there was no apparent difference in the nature of the anxiety symptoms reported by men and women. This study further confirmed the reliability of the BAI as an indicator of anxiety levels.

Beck Depression Inventory-II (BDI-II)

The original version of the BDI was initially published in 1961 by Beck, Ward, Mendelson, Mock, and Erbaugh. Beck's 1967 study further elaborated on the assessment of depression through continued development of the BDI. The first revision to this

instrument occurred in 1993 when the BDI-IA was published (Beck & Steer, 1993b). Beck, Steer, and Brown published the second revision of the BDI in 1996. Additionally, Beck, Steer, Ball et al. (1996) published further studies concerning this revision. This second version of the assessment, the BDI-II, was used in this research study. The revisions came because of updates to the diagnostic criteria listed in successive editions of the *DSM-III-R* and the *Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition* (*DSM-IV*; APA, 1994; cited by Beck, Steer, Ball et al., 1996). Thus, the BDI-II was designed to accommodate changes in diagnostic criteria, as well as resolve some noted psychometric problems and gender bias reported in previous versions (Arbisi & Farmer, 2001)

The BDI-II has become the primary instrument used to detect symptoms of depression, clinical purposes, and antidepressant treatment outcomes (Arbisi & Farmer, 2001). In this latest revision, four items were dropped (body image change, work difficulty, weight loss, and somatic preoccupation) and four items were added to replace the removed items (agitation, worthlessness, loss of energy, and concentration difficulty). Revisions also suggested that individuals completing the assessment only endorse items occurring within the past two weeks, instead of a single week. This change also reflected diagnostic criteria changes in the *DSM-IV* (Arbisi & Farmer). Very few other changes were reportedly made to the BDI-II (Beck, Steer, Ball et al., 1996).

The BDI-II consists of 21 items, and each is scored on a four-point Likert scale (scored 0-3), measuring the severity of symptoms in a range from “Not present” to “Severe.” The BDI-II was revised to assess the following symptoms: sadness, pessimism, past failure, loss of pleasure, guilty feelings, punishment feelings, self-dislike,

self-criticalness, suicidal thoughts or wishes, crying, agitation, loss of interest, indecisiveness, worthlessness, loss of energy, changes in sleeping pattern, irritability, changes in appetite, concentration difficulty, tiredness or fatigue, and loss of interest in sex. Scores are reported by totaling the number associated with each endorsed item. Therefore, scores on the BDI-II may range from 0-63. Although Beck, Ward et al. (1961) originally stated that the severity of scores on the BDI were arbitrarily defined, Beck, Steer, Ball et al. (1996) reported that the severity of scores on the BDI-II have been revised and are defined as minimal (0-13), mild (14-19), moderate (20-28), and severe (29-63). The instrument requires approximately 5-10 minutes to complete, and the manual (Beck, Steer, & Brown, 1996) specifically stated that the BDI-II should not be used as a solitary diagnostic measure, as it is only an indicator that depressive symptoms are present. The publisher, Harcourt Assessment, Inc., requires a C-level qualification to purchase and/or use the BDI-II. As previously stated, the C-level qualification indicates advanced, graduate-level training in the field of psychology (or an equivalent course of study) to administer and interpret the results of this assessment instrument.

Across its lifespan, the BDI has exhibited high Cronbach's alphas (BDI, $\alpha = .80$; BDI-IA, $\alpha = .86$; BDI-II, $\alpha = .92$ [outpatients] and $\alpha = .93$ [college students]), as reported by Beck and Steer (1993b), Beck, Steer, and Brown (1996), and Beck et al. (1961). For the BDI-II, two subject samples were used to validate the instrument. The first was a clinical sample, which consisted of 500 subjects (63% female, 27% male) of primarily Caucasian ethnicity (91%). These subjects were recruited from four outpatient clinics in both rural and suburban environments. The second set of subjects was a convenience sample (n = 120) of Canadian college students. These subjects were 56% female, 44%

male and were only classified as "predominantly white." The average ages of the clinical and convenience samples were 37.2 (*SD* = 15.91; range = 13-86) and 19.58 (*SD* = 1.84), respectively (Arbisi & Farmer, 2001).

Reliability and validity data appeared to be high and suggested that the BDI-II accurately measured symptoms of depression. Reliability was measured in several methods: internal consistency reliability, coefficient alpha, and test-retest reliability. Internal consistency was measured using corrected item-total correlations for both the clinical (range = .39 to .70) and convenience (range = .27 to .74) samples. As previously reported, the Cronbach's alpha coefficients were also very high for both the outpatients (α = .92) and the college students (α = .93). The test-retest reliability, which was conducted at one clinic (n = 26), resulted in a reliability coefficient of .93. The BDI-II also correlated well with the BAI with a small subject sample (n = 297; *r* = .60). Good correlations also existed with the Beck Hopelessness Scale (BHS; n = 158, *r* = .68) and the Revised Hamilton Psychiatric Rating Scale for Depression (HRSD-R; n = 87, *r* = .71). Thus, it appears that the BDI-II accurately measured what it was designed to measure (Arbisi & Farmer, 2001; Beck, Steer, & Brown, 1996).

Further research has been completed using the BDI-II. Beck, Steer, Ball et al. (1996) conducted a research study using both the BDI-IA and the BDI-II, which returned coefficient alphas of α = .89 (BDI-IA) and α = .91 (BDI-II). The BDI-II is also reportedly useful and accurate with a variety of populations (Beck, Steer, & Brown, 1996). Other research involving the BDI-II has involved patients suffering from traumatic brain injuries (Rowland, Lam, & Leahy, 2005), in which using the BDI-II was found to be helpful in identifying symptoms of depression. The BDI-II can also be used

with diverse populations, such as the research study conducted by Alansari (2005), who used an Arabic version of this assessment to measure depression among college students in Muslim countries, as well as the development of a Persian language version (Ghassemzadeh, Mojtabai, Karamghadiri, & Ebrahimkhani, 2005). Another example would be Carmody's (2005) study of ethnically-diverse college students, in which the BDI-II was reportedly very accurate in identifying symptoms of depression. Bonilla, Bernal, Santos, & Santos (2004) used a Spanish version of the BDI, the BDI-S, to assess Puerto Rican college students. The BDI-S was also reported to produce high levels of internal consistency ($\alpha = .88$) and construct validity. Van Hemert, Van de Vijver, and Poortinga (2002) published a cross-national study, and it included subjects from twenty-five countries. Each example suggests the flexibility, accuracy, and strength of the BDI-II. These numerous studies all supported the usefulness of the BDI-II, as well as indicate that it was a useful assessment instrument in research and clinical environments.

Summary

The assessment instruments listed above provided useful tools in researching the relationships that may exist between spiritual and mental health constructs. As shown through numerous examples, each assessment instrument accurately and reliably measured the construct it was designed to measure. This accuracy suggested that these measures were useful in both research and clinical settings, thus promoting continued use and study. Seeking the relationship, if any, between spiritual and mental health constructs may provide useful information for the counseling profession; each instrument may be used as an indicator for poor mental, emotional, and/or psychological health.

However, to ensure that counseling professionals are able to integrate such constructs in counseling practice, competent training must also be provided. By producing empirical evidence supporting the integration of spirituality into counseling, thorough discussions of spiritual issues, and developing self-awareness, counselor educators may provide the necessary training to support the integration of spirituality and religiosity into counseling.

III. DESIGN AND METHODOLOGY

This research study was designed to assess the relationship between two spirituality constructs (*spiritual well-being* and *religious problem-solving styles*) and two constructs of mental health (*depression* and *anxiety*). Because this study only considered two aspects of spirituality and mental health, it was designed to neither assess nor diagnose participants with any dimension of these mental disorders, nor did it study relationships between other constructs of spirituality and mental health. This chapter reviewed the research questions, participants, data collection procedures, and data analysis procedures. The following research questions were answered through the results of this research study.

Research Questions

1. What is the relationship between religious coping styles, as measured by the Religious Problem-Solving Scale, and spiritual well-being, as measured by the Spiritual Well-Being Scale?

2a. What is the relationship between depression, as measured by the Beck Depression Inventory-II, and religious coping styles, as measured by the Religious Problem-Solving Scale?

2b. What is the relationship between depression, as measured by the Beck Depression Inventory-II, and spiritual well-being, as measured by the Spiritual Well-Being Scale?

3a. What is the relationship between anxiety, as measured by the Beck Anxiety Inventory, and religious coping styles, as measured by the Religious Problem-Solving Scale?

3b. What is the relationship between anxiety, as measured by the Beck Anxiety Inventory, and spiritual well-being, as measured by the Spiritual Well-Being Scale?

4. What is the relationship between the spirituality measures (Religious Problem-Solving Scale and Spiritual Well-Being Scale) and the mental health measures (Beck Anxiety Inventory and Beck Depression Inventory II)?

Although each mental health assessment instrument only represented one dimension of mental health, the symptoms of depression and anxiety are characterized in a number of forms in a variety of mental disorders (APA, 2000). Several studies have indicated that spirituality may be a significant factor in overcoming poor mental health (Benes et al., 2000; Degges-White et al., 2003; Pargament et al., 1988). In an attempt to assess the significance of spirituality in mental health, this research study attempted to assess the relationship between these different constructs of spirituality and mental health in order to discover the strength of the relationship between spirituality and mental health. The results of this study provided information regarding the effects of the three religious coping styles on depression and anxiety, as well as the effects of perceptions of spiritual well-being on depression and anxiety.

Participant Description

Both undergraduate and graduate students enrolled in accredited universities were recruited to participate in this study. This study targeted the recruitment of undergraduate and graduate students, because they were more likely to be easily "shaped by sociological influences," as reported by Ma (2003, p. 324). Additionally, because the "college years are among the most formative" (Holmes, 1991, cited by Ma, p. 323), undergraduate and graduate students are likely seeking an identity outside of that of parents and/or guardians. As Bryant, Choi, and Yasuno (2003) reported, "College is a critical time when students search for meaning in life and examine their spiritual/religious beliefs and values" (p. 726). A sample population that is seeking meaning and examining personal beliefs indicated individuals in transition: a good population to survey.

To accurately report the information received in this research study, a minimum of 150 and a maximum of 200 participants were recruited. Participants were located in two universities: the first university is a large public institution in the Southeast, and the second university is a small private university located in the Midwest. As a Christian seminary, a highly religious sample was sought from the private Midwestern university; whereas a more spiritually diverse sample was sought at the public Southeastern university. To ensure anonymity of the data collected, the minimum age limit was set at 19 years of age, according to the age of consent defined in the State of Alabama (1975); this minimum age limit also met age of majority regulations defined by the State of Ohio (1953). Additionally, the study was open to males and females of all ethnicities, social classes, and spiritual perspectives. This study also included students from all levels of education and academic achievement (i.e. freshman through graduate students).

Assessment Instruments

As illustrated by Hill and Hood, Jr. (1999), a vast number of spirituality measures have been developed within the past few decades. These assessments studied a variety of topics, such as measures of religious beliefs, religious attitudes, and religious orientation. Although some assessments were well-validated and have been used in many research studies, other measures have failed to provide any reliability and validity data, therefore making their use somewhat questionable. While Degges-White et al. (2003) suggested the use of spirituality from the wellness model approach as a mechanism for coping with stress and anxiety, Hill and Hood, Jr. provided reviews on several spirituality measures designed to assess coping and problem-solving. A demographics questionnaire was also used to determine the age, gender, ethnic origin, and self-determined spiritual/religious identity. All instruments or information regarding these instruments is available in the Appendices section and will be discussed in the following section.

Demographics Questionnaire

This demographic questionnaire was developed for this study to collect descriptive information about the participants including gender, age, ethnic origin, and spiritual/religious identity. In addition, the demographic measure included a self-identification of the spiritual and/or religious identity of the participants. As the Religious Problem-Solving Scale (RPSS) and Spiritual Well-Being Scale (SWBS) were developed and normed on self-identified Christian populations, an important consideration was whether the results were different for participants with other religious and/or spiritual affiliations or identities. Because the RPSS and SWBS were developed

and normed on self-identified Christian participants, the demographic questionnaire also addressed the fact that these assessment instruments only used the term "God" or "Lord." The demographics questionnaire contained an item that requested participants to indicate if this word is used in their spiritual/religious affiliation. Answers to this question allowed the researcher to determine if results were affected by the items responses from an individual with a spiritual/religious tradition that does not use the word "God."

Religious Problem-Solving Scale (RPSS)

A spirituality measure, the *Religious Problem-Solving Scale* (RPSS; Pargament et al., 1988), offered high levels of validity and reliability in each subscale: .94 (Collaborative), .94 (Self-Directing), and .91 (Deferring), as reported from the original study by Pargament et al.. The RPSS was designed to measure religious coping and problem-solving styles using three constructs of spiritual coping activity: Collaborative, Self-Directing, and Deferring. It consists of 36 items (12 items for each subscale), each marked on a Likert-type five-point scale from "never" to "always." A short form was also available for the RPSS, which consisted of the first 18 items (6 items for each subscale) of the long form. Some normative data has been collected on the RPSS, although the norms only consisted of a Judeo-Christian group (57% female, 69% married) with little ethnic diversification (Thurston, 1999). However, according to the review provided by Hill and Hood, Jr. (1999), the RPSS demonstrated high internal consistency and high test-retest reliability. Cronbach's alpha coefficients for the three subscales were very high: $\alpha = 0.91$ (Self-Directing), $\alpha = 0.93$ (Collaborative), and $\alpha = 0.89$ (Deferring). A test-retest analysis of 97 college students provided similar results:

0.94 (Self-Directing), 0.93 (Collaborative), and 0.87 (Deferring). Descriptive statistics concerning the mean and standard deviation for each subscale were as follows: Collaborative (M = 36.02, SD = 10.67), Self-Directing (M = 29.70, SD = 10.71), and Deferring (M = 25.81, SD = 9.19). These promising results indicated that the RPSS was a good selection for this research study.

Research conducted by Fox, Blanton, and Morris (1998) and Schaefer and Gorsuch (1991, 1993) have further supported Pargament et al.'s (1988) study. Using the short form of the RPSS, Fox et al.'s study consisted of 136 ordained clergymen and their spouses (n = 272). This study reported high Cronbach's alpha coefficients: α = .87 (Collaborative), α = .84 (Self-Directing), and α = .86 (Deferring). No other data or results were reported by Fox et al. Additionally, Schaefer and Gorsuch's first study using the RPSS (1991) reported high Cronbach's alpha reliabilities: α = .91 (Collaborative), α =.91 (Self-Directing), and α = .85 (Deferring). A second study, conducted in 1993, utilized the RPSS to assess state and trait anxiety with three vignettes (state anxiety) and a single scale for trait anxiety. Again, the RPSS results appeared to be valid. The trait anxiety scale provided the following reliabilities: .90 (Collaborative), .85 (Self-Directing), and .76 (Deferring). The three anxiety vignettes also provided highly reliable results: Collaborative (.92, .90, .92), Self-Directing (.93, .92, .91), and Deferring (.88, .85, .85).

Pargament et al. (1998) reported that the Self-Directing scale returned a significantly negative relationship with God, but the Collaborative and Deferring religious coping styles indicated a positive relationship. Additionally, the high reliability and validity suggested that the assessment was accurate and offered a good choice for use

in this research study, although the results did not extrapolate well into an ethnically-diverse population. Regardless, the RPSS appeared to be a good selection of a spirituality assessment with which to correlate with mental health measures.

Spiritual Well-Being Scale (SWBS)

The SWBS was first published by Paloutzian and Ellison in 1982 and Ellison in 1983 as a measure of quality of life and spiritual well-being, and it was designed to assess the individual in a holistic manner. Additional data concerning the SWBS was published by Paloutzian and Ellison (1991) in the form of a users' manual. The SWBS is measured on two subscales: Religious Well-Being (Religious) and Existential Well-Being (Existential). The Religious subscale is focused on the well-being of spiritual life, as related to an understanding of a "higher being" or God (Boivin, Kirby, Underwood, & Silva, 1999). The Existential subscale is focused upon how well the person is adjusted to life, living, and community (Boivin et al.). Additionally, the subscales were reportedly well-differentiated, which indicated that this measure was well-designed for research (D'Costa & Schoenrade, 1995).

The SWBS consisted of 20 items (10 items for each subscale) that were scored on a six-point scale, with answer options ranging from "strongly agree" to "strongly disagree." A higher point value indicated a higher level of well-being. Separate scores were given for each subscale, with a range of 10-60. The Religious and Existential subscale scores were combined to form a score of total spiritual well-being (SWB), with a score range of 20-120. The SWBS was initially developed with a sample population of 206 college students. Additional studies have reported results based upon a combined

total of over 500 individual. Participants in these additional studies have consisted of groups that are more diverse: high school students, senior citizens, religious and non-religious persons, persons living in rural and suburban areas, patients suffering from AIDS, terminal cancer patients, incarcerated individuals, and persons who have experienced sexual abuse (Boivin et al., 1999).

Reliability and validity were reportedly very high on the SWBS. A slight relationship existed between the subscales (Existential and Religious; $r = .32$). However, the authors reported a strong positive relationship between the global scale (SWB) and the Religious subscale ($r = .90$). In addition, a moderate relationship was reported between SWB and the Existential subscale: $r = .59$. Initial research, conducted with a test-retest design with three intervals, resulted in strong reliability coefficients: .93 (SWB), .96 (Religious), and .86 (Existential). Further research, which used a test-retest design in 1, 4, 6, and 10-week intervals, indicated a high degree of reliability. Reliability coefficients for the SWB (global scale) ranged from .82 to .99, for the Religious subscale ranged from .88 to .99, and for the Existential subscale ranged from .73 to .98 (Paloutzian & Ellison, 1991). Ellison also reported strong Cronbach's alpha coefficients: $\alpha = .89$ (SWB), $\alpha = .96$ (Religious), and $\alpha = .78$ (Existential). Boivin et al. (1999) reported that in seven studies, consisting of over 900 participants, returned high internal consistency reliability coefficients for each scale, ranging from .89 to .94 (SWB), .82 to .94 (Religious), and .78 to .86 (Existential). This data indicated the SWBS was a reliable measure.

Despite the strong validity and reliability, Boivin et al. (1999), Bufford et al. (1991), Ellison (1983), Paloutzian and Ellison (1991) and Stanard et al. (2000) all

reported a "ceiling effect" when the SWBS was used to assess individuals who self-identified as highly religious, especially in the Religious subscale and the SWB global scale. However, the measure was reportedly "very sensitive" at lower levels (Boivin et al.) and much research has utilized the SWBS. Additionally, the authors have claimed that over 300 studies have been completed using the SWBS (Paloutzian & Ellison). These results indicated that despite the "ceiling effect," the SWBS was valid and reliable, and a good choice for this research study.

Beck Depression Inventory-II (BDI-II)

The first of the two mental health measures was the *Beck Depression Inventory-II* (BDI-II). The original version of the BDI was published in 1961 by Beck et al., and an updated version was later published in 1993 by Beck and Steer (1993b). The second edition of the BDI was published in 1996 by Beck et al. As its name suggests, the BDI-II was designed to measure levels of depression. The BDI-II was a highly researched mental health measure that measured the severity of depressive symptoms based upon the diagnostic criteria of the *DSM-IV* (APA, 1994). Arbisi and Farmer (2001) claimed that the BDI-II has become the primary assessment to detect symptoms of depression. Consisting of 21 items on a four-point Likert scale (scored 0-3), the BDI-II was designed to provide a quick assessment of depressive tendencies, according to *DSM–IV* criteria for depressive disorders. Scores may range from 0-63, where the interpretive ranges were defined as follows: minimal (0-13), mild (14-19), moderate (20-28), and severe (29-63). It is important to note that Harcourt Assessment, Inc. requires a C-level qualification

(completed graduate work in assessment in psychology or related discipline) to administer and/or interpret the BDI-II results.

Current reliability was reportedly high (Beck, Steer, & Brown, 1996), and the BDI-II provides a high Cronbach's alpha: $\alpha = .92$ (outpatients) and $\alpha = .93$ (college students). Two sample populations were used to validate the BDI-II: a clinical population and college students. The clinical sample consisted of 500 subjects, and the college student sample consisted of 120 subjects (Arbisi & Farmer, 2001). Corrected item-total correlations ranged from .39 to .70 (clinical sample) and .27 to .74 (college student sample). The BDI-II also correlated well with the Beck Hopelessness Scale (BHS; n = 158, $r = .68$) and the Revised Hamilton Psychiatric Rating Scale for Depression (HRSD-R; n = 87, $r = .71$), which indicated that the BDI-II measured what it was designed to measure (Arbisi & Farmer; Beck, Steer, & Brown, 1996).

Further research utilizing the BDI-II has provided compelling data. Beck, Steer, Ball et al. (1996) reported that the BDI-IA and the BDI-II returned coefficient alphas of $\alpha = .89$ (BDI-IA) and $\alpha = .91$ (BDI-II). Other research indicated that the BDI-II was reliable with diverse populations (Beck, Steer, & Brown, 1996). For example, Bonilla et al. (2004) established a Spanish version of the BDI-II (the BDI-S), and reported a high degree of internal consistency ($\alpha = .88$) and construct validity. The BDI-II is also reportedly useful and accurate with a variety of populations (Beck, Steer, & Brown). Other research involving the BDI-II has involved patients who suffered from traumatic brain injuries (Rowland, Lam, & Leahy, 2005), in which using the BDI-II was found to be helpful in identifying symptoms of depression.

The BDI-II has been translated into a number of languages, such as the BDI-S (Bonilla et al., 2004) and the BDI-II-Persian (Ghassemzadeh et al., 2005). Additionally, normative data was provided for many cultural and ethnic groups, such as an Arabic version (Alansari, 2005), ethnically diverse college students (Carmody, 2005), and across nationalities (Van Hemert et al., 2002). Because of the large amount of research completed on this assessment instrument, the BDI-II returned highly reliable and valid data, and it also appeared to be a suitable mental health instrument to be used in both research and clinical environments.

Beck Anxiety Inventory (BAI)

The second mental health measure that was used in this research study is the *Beck Anxiety Inventory* (BAI; Beck et al., 1988). According to Beck et al., the BAI was originally developed to create an assessment that focused specifically on anxiety, as other mental health measures measured both depression and anxiety. The BAI was developed from three anxiety assessments: the Anxiety Checklist, the Physician's Desk Reference Checklist, and the Situational Anxiety Checklist. Therefore, the BAI, appeared able to discriminate well between anxiety-related diagnoses (i.e. panic disorder, generalized anxiety disorder) and from non-anxiety-related diagnoses (Beck et al.). The BAI consists of 21 items; responses appear on a four-point Likert scale (scored 0-3), with the answers indicating the severity of the anxiety symptoms. A BAI score was calculated by summing the numerical values corresponding to the items selected. Scores range from 0-63, where 0-21 indicates low levels of anxiety, 22-35 suggests moderate levels of anxiety, and 36 or more indicates severe levels of anxiety. Harcourt Assessment, Inc., the

publisher of the BAI, requires a C-level qualification (graduate-level training in psychology or related discipline) to administer and interpret the results of this inventory.

Much normative data for a variety of cultural and ethnic groups has been collected using the BAI, as the initial norming data consisted of 1,806 subjects (Beck et al., 1988). Reportedly, the BAI displayed a high degree of internal consistency ($\alpha = .92$). Dowd and Waller (1995) reported a high level of internal consistency reliability with coefficients ranging from .85 and .94. Beck et al. reported test-retest over one week: .75. Further research by Hewitt and Norton (1993) reported high internal consistency between the BDI and BAI, with Cronbach's alpha coefficients of $\alpha = .92$ (BAI) and $\alpha = .91$ (BDI). Numerous research has indicated the reliability and validity of the BAI. Because of the high reliability and validity of the BAI, it was an obvious choice for a reliable mental health measure to use in this study.

Procedures

The data collected throughout this research study was provided through four assessment instruments; the only additional data that was collected was a brief demographics questionnaire. The Institutional Review Boards of Auburn University and Cincinnati Christian University, as well as the program director or department head of each university where data was collected, reviewed the research design, these assessment instruments, and questionnaire. Permission was also provided by the course instructor.

After receiving permission from the department head and the instructor, the researcher presented the research study to the potential participants during the last five minutes of class to recruit volunteers. The course instructors agreed to provide extra-

credit to those who completed the survey packets. Those who wished to participate in the study were given a numbered manila envelope (envelope numbering will correspond with a number placed on all forms and assessments included in the envelope, which ensured that all survey packet materials from each envelope remained together). Those who chose not to participate (or could not participate) were provided with a comparable activity to complete; this activity enabled non-participants to earn an equal amount of extra-credit. Participants were also asked to complete a demographic questionnaire (included in the envelope), which asked for grouping data, such as age, ethnicity, gender, religious/spiritual affiliation, and the use of the word "God" in their spiritual/religious affiliation. The researcher presented and described each assessment (all self-administered scales). The researcher indicated the typical amount of time required to complete the assessments. Participants were required to complete the survey packet contents outside of class. The researcher collected the survey packets at the beginning of the following class session. Each participant was provided with complete anonymity. However, a small dot was marked on envelopes provided to students enrolled at Cincinnati Christian University to differentiate among survey packets given at Auburn University. No other identifying characteristics were placed on the envelopes, forms, or assessments. The researcher scored the assessments, input the data into a statistical analysis software program, Statistical Product for the Social Sciences (SPSS), and analyzed the data.

To counter-balance the presentation of measures, half of the survey envelope packets contained documents in the following order: 1.) Informed Consent information sheet; 2.) Demographics Questionnaire; 3.) Religious Problem-Solving Scale; 4.)

Spiritual Well-Being Scale; 5.) Beck Anxiety Inventory; and 6.) Beck Depression Inventory II. The second half of survey envelope packets contained documents in the following order: 1.) Informed Consent information sheet; 2.) Demographics Questionnaire; 3.) Beck Anxiety Inventory; 4.) Beck Depression Inventory II; 5.) Religious Problem-Solving Scale; and 6.) Spiritual Well-Being Scale. Counter-balancing the order of documents provided in the envelope packets was completed to prevent the document order from affecting the participant responses on the assessment instruments.

Data Analysis

The analyses that were utilized to address each research questions for this study are described in this section. This section also states the significance and purpose of each research question to this study. Each research question is reviewed below.

Research Question 1 pertained to the relationship between religious coping styles and spiritual well-being. Descriptive analyses were conducted to identify the means, standard deviations, frequencies by item, and a correlation coefficient between the scores on each assessment. The data was analyzed according to university and overall trends; this means that the data was analyzed according to the university from which participants were recruited. This question was not designed to be compared with the other research questions; it was merely created to assess the relationship between the spirituality measures.

Research Questions 2a and 2b were combined into a multiple regression analysis. Seeking the correlation coefficient with depression, Research Question 2a was designed to assess the correlation between depression and three religious coping styles, and

Research Question 2b was designed to determine the correlation between depression and spiritual well-being. The items identified through descriptive analysis included the means, standard deviations, frequencies by item, and the correlation coefficient. Question 2a identified the relationship between depressive characteristics and the use of religious identity and religious activity to cope with negative life events. Question 2b intended to address the relationship between depressive behaviors and the spiritual well-being of the participants. As the RPSS was designed to measure three distinct subscales, Self-Directing, Collaborative, and Deferring, each subscale was correlated to the BDI-II score. Each subscale was designed to report a different method of religious problem-solving, and this question determined which religious problem-solving style returned the greatest relationship with depression. Furthermore, the SWBS was designed to measure two subscales and one global scale (religious well-being [Religious], existential well-being [Existential], and overall spiritual well-being [SWB], respectively); only the two subscales were analyzed to determine which aspect of spiritual well-being resulted in the greatest relationship with symptoms of depression.

Research Questions 3a and 3b were also combined into a multiple regression analysis. Research Question 3a was developed to assess the relationship between symptoms of anxiety and styles of religious problem-solving, and Research Question 3b was designed to assess the relationship that existed between anxiety and spiritual well-being. The descriptive analyses identified the following information: means, standard deviations, item frequencies, and the correlation coefficients between scores on the BAI and the RPSS subscales, as well as between scores on the BAI and the SWBS subscales. The relationship between the BAI score was correlated to each of the three RPSS

subscales (Collaborative, Deferring, and Self-Directing) to determine which religious coping style provided the greater relationship to symptoms of anxiety. Additionally, analysis revealed the correlation between the two SWBS subscales (Existential and Religious) and the BAI to determine which type of spiritual well-being provided the greatest relationship to anxiety symptoms.

Research Question 4 determined which constructs of spirituality (measured by the RPSS and SWBS subscales) accounted for the greatest effects on the BAI and BDI-II. This question utilized a multiple analysis of variance (MANOVA) to evaluate the strength of the relationship between both spirituality assessments and both mental health assessments. Descriptive statistical analysis provided the means and standard deviations. For the purposes of this study, the three RPSS subscales, as well as the two SWBS subscales, were analyzed.

Because several research questions were combined for analysis, the following table will illustrate the relationship between the research questions and assessment instruments used in this study. The acronym *RQ* is used to refer to the research question. Information for all research questions is depicted in Table 1 (below). Note that Research Question 4 involved all spirituality subscales and both mental health assessments and will not be depicted in Table 1. Data retrieved through analysis will be provided and described in upcoming sections.

Table 1

Research Question Summary

	RPSS	SWBS	BDI-II	BAI
RPSS				
Collaborative	- -	RQ1	RQ2a	RQ3a
Deferring	- -	RQ1	RQ2a	RQ3a
Self-Directing	- -	RQ1	RQ2a	RQ3a
SWBS				
Existential	RQ1	- -	RQ2b	RQ3b
Religious	RQ1	- -	RQ2b	RQ3b

Summary

In this chapter, the design of the study and the methods of research were reviewed to reveal the intended use and direction of this research study. This chapter has also identified which assessment inventories were used to gather data and as well as how this data was analyzed. This research study was not intended to be comprehensive in nature, nor was it intended to provide a professional assessment or diagnosis of any participants. As outlined in this chapter, this research study was intended to define and assess the relationship that occurs between mental health and spirituality.

IV. RESULTS

Introduction

The purpose of this research study was to explore the strength of the relationship between spirituality and mental health. To conduct the research, four assessment instruments were used to collect data. Two assessments evaluated two constructs of spirituality: the Religious Problem-Solving Scale (RPSS; Pargament et al., 1988) measured religious coping styles, and the Spiritual Well-Being Scale (SWBS; Ellison, 1983; Paloutzian & Ellison, 1982, 1991) measured perceptions of spiritual well-being. Two more assessments evaluated two constructs of mental health: the Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1988; Beck & Steer, 1993a) measured levels of anxiety, and the Beck Depression Inventory II (BDI-II; Beck, 1967; Beck, Steer, & Brown, 1996) was designed to measure levels depression. These assessment instruments were selected based upon validity and reliability, as well as the constructs each assessment was designed to measure. It was expected that research participants indicating a higher degree of spiritual well-being and a higher use of one or more religious coping styles would indicate lower levels of symptoms of depression and anxiety. Therefore, this chapter presents the results of the data analysis for the research study detailed above. In addition, this chapter will provide information and details regarding the participants recruited for this research study, the research design, the

statistical methodologies used, and the results of the statistical analysis. This information will be provided according to the research questions examined in this study.

The research questions examined were:

1. What is the relationship between religious coping styles, as measured by the Religious Problem-Solving Scale, and spiritual well-being, as measured by the Spiritual Well-Being Scale?

2a. What is the relationship between depression, as measured by the Beck Depression Inventory-II, and religious coping styles, as measured by the Religious Problem-Solving Scale?

2b. What is the relationship between depression, as measured by the Beck Depression Inventory-II, and spiritual well-being, as measured by the Spiritual Well-Being Scale?

3a. What is the relationship between anxiety, as measured by the Beck Anxiety Inventory, and religious coping styles, as measured by the Religious Problem-Solving Scale?

3b. What is the relationship between anxiety, as measured by the Beck Anxiety Inventory, and spiritual well-being, as measured by the Spiritual Well-Being Scale?

4. What is the relationship between the spirituality measures (Religious Problem-Solving Scale and Spiritual Well-Being Scale) and the mental health measures (Beck Anxiety Inventory and Beck Depression Inventory II)?

All participants in this study were adult (19 years or older) undergraduate and graduate students enrolled at two universities; one university is located in the Midwest,

and the other university is located in the Southeast. This study sought a participant sample that would likely encounter a high degree of uncertainty and distress, as well as a population that may more easily be "…shaped by sociological influences" (Ma, 2003, p. 324). Additionally, because the years that a student spends in college are considered "among the most formative" (Holmes, 1991, cited by Ma, p. 323), undergraduate and graduate students presented as a beneficial sample population.

Participants

The sample population recruited for this study consisted of 122 undergraduate and graduate students located at two institutions. The Demographics Questionnaire, which was developed by the researcher, collected information regarding, gender, age, ethnicity, spiritual/religious identity, and if the participants' religious identity uses the word "God" or "Lord." Information gathered from the Demographics Questionnaire is provided in Table 2 according to the institution in which the participants are enrolled.

Table 2

Demographic Information of Participants by Institution

Demographic Category	Midwest University		Southeast University	
	N	*%*	*N*	*%*
Gender				
Male	10	38.5	20	20.8

(table continues)

Table 2 (continued)

Demographic Category	Midwest University		Southeast University	
	N	%	*N*	%
Gender				
Female	16	61.5	75	78.1
Not Specified	0	- -	1	1.1
Age				
19 – 25	10	38.5	85	88.5
26 – 35	5	19.2	4	4.2
36 – 45	5	19.2	5	5.2
46 – 55	6	23.1	0	- -
56 – 65	0	- -	1	1.0
Not Specified	0	- -	1	1.0
Ethnicity				
Native American/Alaskan Native	0	- -	1	1.0
African-American	2	7.7	14	14.6
Caucasian	23	88.5	77	80.2
Caucasian/American Indian	0	- -	1	1.0
Belizean/African-American	0	- -	1	1.0
Caucasian/Puerto Rican	0	- -	1	1.0
African	1	3.8	0	- -

(table continues)

Table 2 (continued)

Demographic Category	Midwest University		Southeast University	
	N	%	*N*	%
Ethnicity				
Not Specified	0	- -	1	1.0
Religious Identity				
Christian – Overall	25	96.2	87	90.6
Christian	23	88.5	73	76.0
Christian – Baptist	0	- -	4	4.2
Christian – Catholic	1	3.8	6	6.3
Christian – Church of Christ	0	- -	1	1.0
Christian – Methodist	0	- -	2	2.1
Christian – Non-denominational	1	3.8	0	- -
Christian – Primitive Baptist	0	- -	1	1.0
Agnostic	0	- -	4	4.2
Gnostic	0	- -	1	1.0
Jewish	0	- -	2	2.1
Messianic Jew	1	3.8	0	- -
Seventh-Day Adventist	0	- -	1	1.0
Not Specified	0	- -	1	1.0

(table continues)

Table 2 (continued)

Demographic Category	Midwest University		Southeast University	
	N	*%*	*N*	*%*
Use of the word "God" or "Lord"				
Yes	26	100.0	95	99.0
No	0	- -	0	- -
Not Specified	0	- -	1	1.0

Of the entire 122 subjects assessed during this research study, 30 (24.6%) were male, 91 (74.6%) were female, and one (.8%) individual did not specify gender. Although age was not grouped on the Demographics Questionnaire, for the purposes of reporting data, five groupings have been developed. The groups are as follows: ages 19 to 25 (n = 95, 77.9%); ages 26 to 35 (n = 9, 7.4%); ages 36 to 45 (n = 10, 8.2%); ages 46 to 55 (n = 6, 4.9%); and ages 56 to 65 (n = 1, .8%). One individual (.8%) did not specify an age. Ethnic origin was also reported, and the results are as follows: Native American/Alaskan Native (n = 1, .8 %), African-American (n = 16, 13.1%), Caucasian (n = 100, 82.0%), Caucasian/American Indian (n = 1, .8%), Belizean/African-American (n = 1, .8%), Caucasian/Puerto Rican (n = 1, .8%), African (n = 1, .8%), and one (.8%) individual did not report ethnicity.

The religious identity of the research participants consisted of several diverse groups; however, the large majority of respondents reportedly identified with the Christian religion. A total of 112 (91.8%) of the 122 participants self-identified with the

Christian religion, or identified with a Christian denomination. Of that number, 96 (78.7%) identified as Christian, 4 (3.3%) were Baptist, 7 (5.7%) were Catholic, 1 (.8%) was Church of Christ, 2 (1.6%) were Methodist, 1 (.8) was Non-denominational, and 1 (.8%) was Primitive Baptist. Non-Christian religious identities are as follows: Agnostic (n = 4, 3.3%), Gnostic (n = 1, .8%), Jewish (n = 2, 1.6%), Messianic Jew (n = 1, .8%), Seventh-Day Adventist (n = 1, .8%), and one (.8%) individual did not specify a religious identity. Additionally, 121 (99.2%) participants reported that the word “God” is used within their religious identity, whereas one (.8%) individual did not respond to this question.

Table 2 also reported the differences among the sample populations when location was considered. As expected, participants enrolled at the Midwestern university self-identified as almost entirely Christian (n = 23, 88.5%), as well as primarily a Caucasian ethnicity (n = 23, 88.5%), whereas the Southeastern university was both religiously and ethnically more diverse. However, even though it was decidedly more diverse, the participants at the Southern university self-identified as primarily Christian (n = 73, 76.0%) and Caucasian (n = 77, 80.2%). The mean age of the subjects enrolled at the Midwestern university was higher (M = 34.31) than participants enrolled in the Southeastern university (M = 21.81). As evidenced by descriptive statistical analysis, the mean age of participants appears to be the primary meaningful difference among the sample populations. Table 2 indicated that the other participant descriptives are similar.

Descriptive statistical analysis also reported the response frequency for the spirituality assessment subscales and mental health inventories. Although the data analysis did not separate participants according to university, participant responses

indicated differences in religious coping styles, spiritual well-being, and scores on the mental health inventories. This data is reported in Table 3.

Table 3

Mean Responses by University Enrollment

Assessment Instrument	Midwest		Southeast		Overall	
	M	*SD*	*M*	*SD*	*M*	*SD*
RPSS						
Collaborative	43.88	7.039	37.31	12.531	38.72	11.861
Deferring	30.15	7.358	29.25	10.595	29.45	9.967
Self-Directing	21.96	6.109	25.32	12.015	24.60	11.080
SWBS						
Existential	51.15	5.767	50.20	6.528	50.40	6.361
Religious	56.73	4.754	51.45	10.824	52.59	10.061
BAI	5.62	4.900	7.28	6.561	6.93	6.263
BDI-II	7.96	8.388	7.01	5.607	7.21	6.275

Data analysis revealed that the Midwestern participants reported a higher degree of spiritual well-being (*M* = 51.15, *SD* = 5.767 [Existential]; *M* = 56.73, *SD* = 6.625 [Religious]) than participants enrolled in the Southeastern university (*M* = 50.20, *SD* = 6.528 [Existential]; *M* = 51.45, *SD* = 10.824 [Religious]). Furthermore, Midwestern participants reported higher scores on the Collaborative (*M* = 43.88, *SD* = 7.039) and

Deferring (*M* = 30.15, *SD* = 7.358) subscales than Southeastern participants (*M* = 37.31, *SD* = 12.531 and *M* = 29.25, *SD* = 10.595, respectively). However, participants located in the Southeast revealed a higher level (*M* = 25.32, *SD* = 12.015) of the Self-Directing coping style, as compared to the Midwestern participants (*M* = 21.96, *SD* = 6.109). The Southeastern participants also reported a lower level of depressive symptoms (*M* = 7.01, *SD* = 5.607) than those in the Midwest (*M* = 7.96, *SD* = 8.388), whereas levels of anxiety symptoms were reportedly higher in the Southeast participants (*M* = 7.28, *SD* = 6.561) than in the Midwest participants (*M* = 5.62, *SD* = 4.900). Also depicted in Table 4 are the total participant responses on each assessment and subscale. Despite the differences between the participant locations, the overall scores indicated relatively high levels of Existential and Religious well-being (as measured by the SWBS), as well as a moderate use of the three religious coping styles measured by the RPSS. Furthermore, total scores on both the BAI and BDI-II fall within the "minimal" range.

As depicted in Table 4, the Cronbach's alpha coefficients reported a high degree of reliability. In several spirituality subscales, the alpha coefficients reported from the current study were higher than those reported in the original studies were (Collaborative: $\alpha = .96$; Self-Directing: $\alpha = .96$; Religious: $\alpha = .95$). With the remaining spirituality subscales, the alpha coefficients were comparable to the values reported in the original studies. The current study reported values of $\alpha = .92$ (Deferring) and $\alpha = .82$ (Existential), which either fall within the range of scores reported by the original study (Existential: $\alpha = .78$ to .86) or are very close (Deferring: $\alpha = .94$). Although the spirituality subscales provided high levels of internal consistency, the mental health measures did not report alpha coefficients as high as the values reported in the original studies (BAI: $\alpha = .87$;

BDI-II: α = .88). Despite the current study reporting lower alpha coefficients, the values are high and depict high levels of internal consistency.

Table 4

Cronbach's Alpha Comparison of Measures

	Original Study	Current Study
RPSS (Pargament et al., 1988)		
Collaborative	.94	.96
Deferring	.94	.92
Self-Directing	.91	.96
SWBS (Paloutzian & Ellison, 1982)		
Existential	.78 to .86	.82
Religious	.82 to .94	.95
BAI (Beck & Steer, 1993a)	.92	.87
BDI-II (Beck, Steer, & Brown, 1996)	.93[a]	.88

[a] college student sample

Correlation Analysis

Research Question One

Research question one was designed to assess the relationship between the RPSS subscales (Collaborative, Deferring, and Self-Directing) and the SWBS subscales (Existential Well-Being [Existential] and Religious Well-Being [Religious]). When

compared to the original studies, as well as other comparable research studies using these assessment instruments, the current study returned equivalent results. Descriptive statistics are provided in Table 3, and comparison of the Cronbach's alpha values are provided in Table 4. Furthermore, Table 5 provides the correlation coefficients among the assessments. These subscales appeared to have significant correlations.

As depicted in Table 3, scores on the Collaborative subscale ranged from 12 to 59 (M = 38.72, SD = 11.861), whereas scores ranged from 12 to 59 (M = 29.45, SD = 9.967) and 12 to 60 (M = 25.60, SD = 11.080) on the Deferring and Self-Directing subscales, respectively. The mean score on each subscale indicated a moderate use of each problem-solving style when faced with negative life situations or other distressing experiences. The scores on the Existential subscale ranged from 29 to 60 (M = 50.40, SD = 6.361), which indicated a relatively high perception of existential well-being. Moreover, the standard deviation resulted in a smaller variance of scores than the Religious subscale. Scores on the Religious subscale ranged from 20 to 60 (M = 52.59, SD = 10.061); these scores suggested a high level of religious well-being among participants. Analysis indicated that participants reported levels of anxiety that fit within the "minimal" range (M = 6.90, SD = 6.283), as defined by Beck and Steer (1993a). Additionally, participants reported depressive symptoms that were within the "minimal" range (M = 7.17, SD = 6.279), as defined by Beck, Steer, & Brown (1996).

Table 5 depicts the correlation coefficients among the spirituality subscales, as well as the mental health inventories. According to Cohen (1988), the strength of these correlations fall within different categories. Additionally, these subscales showed moderate to high degrees of significance, which is also noted in Table 5. It should be

noted that this study was not designed to report a correlation coefficient between the mental health inventories (BAI and BDI-II); therefore this data was not provided in Table 5. Further discussion will be provided concerning the relationship between the spirituality subscales and the mental health inventories in upcoming sections.

Table 5

Pearson Correlations between the Spirituality Subscales and Mental Health Inventories

	Deferring	Self-Directing	Existential	Religious	BAI	BDI-II
Collaborative	$.748^{***}$	$-.698^{***}$	$.358^{***}$	$.760^{***}$	-.092	-.077
Deferring	- -	$-.586^{***}$	$.283^{**}$	$.605^{***}$	-.001	-.012
Self-Directing		- -	$-.348^{***}$	$-.809^{***}$	$.117^{*}$	.196
Existential			- -	$.489^{***}$	$-.299^{***}$	$-.448^{***}$
Religious				- -	-.041	$-.212^{*}$

$^{*}\ p < .05$, $^{**}\ p < .01$, $^{***}\ p < .001$

Analysis with the Collaborative subscale resulted in high positive correlations with the Deferring subscale ($r = .748$, $p < .001$) and the Religious subscale ($r = .760$, $p < .001$). A high negative correlation ($r = -.698$, $p < .001$) was found between the Collaborative subscale and the Self-Directing subscale, whereas analysis reported a moderate positive correlation ($r = .358$, $p < .001$) between the Collaborative and Existential subscales. The Deferring subscale reported a high negative correlation ($r = -.586$, $p < .001$) to the Self-Directing subscale, as well as a relatively high positive correlation ($r = .605$, $p < .001$) to the Religious subscale, and only a small positive

correlation ($r = .283$, $p = .001$) to the Existential subscale. The Self-Directing subscale reported a moderate negative correlation ($r = -.348$, $p < .001$) to the Existential subscale and a strong negative correlation ($r = -.809$, $p < .001$) to the Religious subscale. The final correlation coefficient, between the Existential and Religious subscales indicated a moderate-to-high positive correlation ($r = .489$, $p < .001$). These results indicated that primarily high correlations and strong significance existed between the RPSS subscales and the SWBS subscales.

Research Question Two (parts A and B)

The second research question contained two subsections: the relationship between the RPSS subscales and the BDI-II (part A) and the relationship between the SWBS subscales and the BDI-II (part B). Therefore, each section of this research question was designed to assess the relationship between the spirituality subscales and the BDI-II. The same statistical analysis (multiple regression) was used to retrieve the Pearson correlation coefficients, as well as the significance. Furthermore, because the relationship strength among some spirituality subscales and the mental health appeared low, beta weights were extracted to determine which spirituality measure's subscales accounted for the greatest amount of significance.

As depicted in Table 5 (shown above), and as expected by the researcher, negative correlations were reported between the BDI-II and the Collaborative subscale ($r = -.077$) and the Deferring subscale ($r = -.012$). Although these subscales did not report a significant relationship to the BDI-II, statistical significance was reported with the Self-Directing subscale ($r = .196$, $p = .016$), the Existential subscale ($r = -.448$, $p < .001$), and

the Religious subscale ($r = -.212$, $p = .010$). Although the negative relationships were expected by the researcher, the results indicated primarily weak correlations between the spirituality subscales and the BDI-II. Furthermore, three of the five spirituality subscales reported statistical significance with the BDI-II.

When considering the significance of the relationships, the multiple regression analysis also reported the effects of each spirituality subscale upon the overall relationship with the BDI-II. This data is reported below in Table 6.

Table 6

Multiple Regression with the Spirituality Measures and the BDI-II

Regression Model	β	*r*
Full Model		
Collaborative	.125	-.077
Deferring	.148	-.012
Self-Directing	.205	.196
Existential	-.460	$-.448^{***}$
Religious	-.006	-.212
Restricted Model		
Existential	-.448	$-.448^{***}$

$^{*}p < .05$, $^{**}p < .01$, $^{***}p < .001$

The multiple regression analysis revealed which individual scales provided the greatest effect on the BDI-II scores. Table 6 (above) outlined the results of the full regression model, as well as the restricted model, which indicated that the Existential subscale was responsible for the greatest effect on the BDI-II. The other spirituality subscales (Collaborative, Deferring, Self-Directing, and Religious) did not report statistical significance, high correlation coefficients, or high beta weights. In referring to the unique importance of each subscale, the beta weight indicated the amount in which the individual subscale affected the correlation coefficient, when accounting for the effects of any additional subscales. In the current study, of particular significance, as previously stated, was the Existential subscale which accounted for a relatively large effect size in both the full regression model ($\beta = -.460$, $r = -.448$) and in the second restricted model ($\beta = -.448$, $r = -.448$). By itself, when controlling for the other subscales, the Existential subscale accounted for 20.1% of the zero-order correlation (r^2), 17.6% of the semi-partial correlation within the first restricted regression model, and 20.1% of the semi-partial correlation in the second restricted model. Moreover, data analysis also reported that the predictability of the restricted regression model indicated little change when variables were dropped: $R^2 = .236$ (full model) and $R^2 = .201$ (restricted model), which indicated the effect size of the Existential subscale.

Research Question Three (parts A and B)

Much like Research Question Two, the third research question also consisted of two parts: part A addressed the relationship between the RPSS subscales and the BAI, whereas Part B assessed the relationship between the SWBS subscales and the BAI. As

noted in Table 5, only small correlation coefficients were reported between the spirituality subscales and the BAI. Negative correlations were reported with the Collaborative subscale (r = -.092), the Deferring subscale (r = -.001), the Self-Directing subscale (r = .117), and the Religious subscale (r = -.041). Only the Existential subscale (r = -.299, $p < .001$) reported statistically significant results, as well as a moderate relationship with the BAI. Table 7 (shown below) provided information regarding the beta weights of the individual spirituality subscales with the BAI.

Table 7

Multiple Regression with the Spirituality Measures and the BAI

Regression Model	β	r
Full Model		
Collaborative	-.219	-.094
Deferring	.171	-.001
Self-Directing	.301	$.120^{*}$
Existential	-.387	$-.299^{***}$
Religious	.456	$-.041^{**}$
Restricted Model		
Self-Directing	.306	$.120^{*}$
Existential	-.387	$-.299^{***}$
Religious	.396	$-.041^{*}$

$^{*}p < .05$, $^{**}p < .01$, $^{***}p < .001$

Depicted in Table 7, multiple regression analysis revealed the strength of relationship between the spirituality subscales and the BAI. The correlation coefficients and significance were already reported in Table 5. Also separated into a full regression model and a restricted regression model, these results indicated the amount to which each subscale explained the correlation with the BAI. Showing the greatest beta weight in the full regression model (β = .456), the Religious subscale also reported a slight negative correlation with the BAI (r = -.041). Although the Existential subscale reported the second-greatest beta weight (β = -.387), it resulted in a moderate zero-order correlation (r = -.299). The analysis also provided results in the full regression model for the remaining subscales. The Collaborative and Deferring subscales reported small beta weights, were not statistically significant, and were dropped from the restricted regression model. The remaining spirituality subscale also reported a small beta weight, but the Self-Directing subscale was statistically significant: β = .301, r = .120.

The restricted regression model removed two spirituality subscales that reported the least amount of impact in explaining the relationship with the BAI (the Collaborative and Deferring subscales). Again, the Religious subscale appeared to be the most important variable, providing a moderate negative beta weight (β = -.396); however, this subscale also reported the smallest correlation coefficient and the least effect on the relationship. Furthermore, in the restricted model, the Existential subscale provided the second-greatest beta weight in the relationship with the BAI (β = -.387). However, having the greatest correlation (r = -.299), the Existential subscale contributes 8.9% of the relationship (r^2); with the semi-partial correlation, the relationship contribution increased to 11.3%. A summary of the multiple regression models are shown in Table 8.

Table 8

Multiple Regression Model Summary

Regression Model	IV	R	R^2	F	FΔ
Full Models					
BDI-II	5	.486	.236	7.113^{***}	- -
BAI	5	.392	.154	4.171^{*}	- -
Restricted Models					
BDI-II	1	.448	.201	29.848^{***}	2.136
BAI	3	.369	.136	6.155^{*}	.625

* $p < .05$, ** $p < .01$, *** $p < .001$

Consisting of all five spirituality subscales assessed by the spirituality measures (IV), the multiple regression models indicated which spirituality subscale contributed the most to the relationship with the mental health measure. Table 8 depicted the multiple regression coefficients for both mental health measures; analysis indicated that each measure provided moderate correlations in the full regression model: R = .486 (BDI-II) and R = .392 (BAI). The coefficients of determination (R^2) indicated that, in the full model, all five spirituality subscales significantly accounted for approximately 23.6% of the relationship with the BDI-II (F (5,115) = 7.113, $p < .001$) and approximately 15.4% of the relationship with the BAI (F (5,115) = 4.171, $p = .002$). The R^2 values in the restricted model indicated that of the relationships with all five factors, the three remaining factors significantly account for the majority of the relationship: approximately 20.1% with the BDI-II (F (1,120) = 29.848, $p < .001$) and approximately 13.6% with the

BAI ($F(1,118) = 6.155$, $p = .001$). The F Change ($F\Delta$) was not statistically significant with neither the BDI-II ($F\Delta = 2.136$, $p = .146$) nor the BAI ($F\Delta = .625$, $p = .431$), which indicated that the restricted models did not significantly decrease the effect size by removing variables. In summary, the restricted regression model contained the spirituality subscales that significantly contributed to the relationship with the mental health measures, whereas the excluded factors made negligible contributions to the overall relationship with the mental health measures.

Research Question Four

The final research question was designed to determine the overall relationship between the spirituality measures and the mental health measures. To do so, a multiple analysis of variance (MANOVA) was used. Two MANOVA analyses were run; one compared the spirituality measures to the BAI, and the other analysis compared the spirituality measures to the BDI-II. To accomplish these MANOVAs, the BAI scores and the BDI-II scores were grouped according to different levels of anxiety and depression, as defined by the authors of the inventories (Beck & Steer, 1993a; Beck, Steer, & Brown, 1996), respectively. The BAI was separated into four groups: minimal (scores of 0 to 7), mild (scores of 8 to 15), moderate (scores of 16 to 25), and severe (scores of 26 to 63). Similarly, the BDI-II was also separated into four groups, although the scoring ranges differed: minimal (scores of 0 to 13), mild (scores of 14 to 19), moderate (scores of 20 to 28), and severe (scores of 29 to 63). Although no participant scores fell within the "severe" range on the BAI, figures are provided for the remaining three groupings. The

descriptive statistics provided below in Table 9 detail the mean, standard deviation, and number of participants that fell within each grouping.

Table 9

Descriptive Statistics of Mental Health Groupings and Spirituality Subscales

	Minimal		Mild		Moderate		F
	M	*(SD)*	*M*	*(SD)*	*M*	*(SD)*	
BAI[a]							
Collaborative	38.95	(11.891)	39.24	(11.243)	35.30	(13.985)	.455
Deferring	29.11	(9.337)	31.59	(11.315)	26.00	(10.614)	1.320
Self-Directing	23.96	(11.144)	24.76	(9.913)	29.30	(13.614)	1.039
Existential	51.40	(5.466)	50.07	(6.290)	43.20	(8.967)	8.382^{***}
Religious	53.10	(9.753)	53.10	(8.898)	46.90	(14.426)	1.763
BDI-II[b]							
Collaborative	39.13	(11.885)	37.45	(11.335)	34.60	(14.741)	.418
Deferring	29.53	(10.004)	30.18	(11.044)	27.00	(9.192)	.185
Self-Directing	24.04	(11.026)	26.00	(7.483)	32.40	(17.897)	1.005
Existential	51.59	(5.313)	42.18	(7.547)	46.20	(8.228)	11.525^{***}
Religious	53.35	(9.667)	51.09	(8.396)	42.40	(16.426)	2.522

$^{*} p < .05$, $^{**} p < .01$, $^{***} p < .001$

[a] The multivariate test of significance found Wilks' Lambda = .843 ($p = .030$)

[b] The multivariate test of significance found Wilks' Lambda = .700 ($p < .001$)

When analyzed, each BAI and BDI-II scoring group in the Collaborative, Deferring, and Self-Directing subscales indicated that scores within the “minimal” and “mild” ranges were fairly consistent. Across all spirituality subscales (except for the Self-Directing subscale), mean values were reportedly lower in the mental health “moderate” group. Although a “severe” groups is defined by Beck, Steer, and Brown (1996), only one individual reported a score in that group on the BDI-II, and it was not reported. These scores indicated that these participants reported smaller use of religious coping skills and a lower degree of spiritual well-being. Analysis also revealed that the majority of participants fell within the “minimal” and “mild” mental health grouping, which indicated that participants did not report high levels of distress related to symptoms of anxiety and depression.

Also reported in Table 9 (shown above) was information regarding which spirituality subscale reported the greatest effect upon the mental health inventories. MANOVA analyses revealed a single spirituality subscale showed statistical significance. As noted in Table 9, the Existential subscale reported the only statistically significant relationship with the BAI ($F(2,118) = 8.382$, $p < .001$) and the BDI-II ($F(3,117) = 11.525$, $p < .001$). Although the Religious subscale approached a statistically significant relationship with the BDI-II ($F(3,117) = 2.522$, $p = .061$), the other spirituality subscales reported no significance with either mental health inventory. The Existential subscale also reported the greatest power in relationships with the BAI (Observed Power = .960) and the BDI-II (Observed Power = .999). These values indicated that the statistical significance of the Existential subscale was not likely due to chance. The next highest

power level (.611) reported by the Religious subscale in relation to the BDI-II did not indicate a high degree of power.

A multivariate test of significance found a Wilks' Lambda of .843 (p = .030) with the BAI. This value indicated a significant difference between the BAI and spirituality subscales; the observed power (.883) denoted these values were likely a true effect and did not result from chance. Additionally, a Wilks' Lambda of .700 (p < .001) with the BDI-II indicated a significant different between the BDI-II and the spirituality subscales. Also reporting a high observed power (.992), the effect between the BDI-II and the spirituality subscales was likely a true effect.

V. DISCUSSION

Introduction

Professional literature revealed that research studying the influence of religiosity and spirituality in physical heath dated back into the mid-nineteenth century with the work of Francis Galton (1869/2000, 1872; McCormick, 2004) and Émile Durkheim (1897/1951; Idler & George, 1998). While Richmond (2004) agreed that the study of spirituality and religiosity was not a new concept, he stated that "many people in the respective fields of mental health counseling, pastoral counseling, and counseling psychology have been researching and publishing in this area consistently since the 1970s" (p. 52). Miller and Thoresen (2003) contended that despite the research conducted in these areas, it has received little recognition within the allied health professions. For example, it was only since the late 1980s that there has been a significant focus on the issues or spirituality and religion in counseling research and training (Burke et al., 1999; Kelly, Jr., 1992; Miller & Thoresen; Richmond).

This increased attention to religion and spirituality was reflected in several areas, this included the development of undergraduate and graduate courses (Curtis & Glass, 2002; Ingersoll, 1997; Souza, 2002), the holistic health movement (Adams et al., 2000; Daaleman & Frey, 2004; Myers & Williard, 2003; Sweeney & Witmer, 1991), and with the development and validation of assessment instruments that focused on religion and

spirituality (Hall & Edwards, 1996, 2002; Hill & Hood, Jr., 1999; Slater, Hall, & Edwards, 2001; Stanard, Sandhu, & Painter, 2000). This paralleled an increasing awareness in our culture and society that religion and spirituality are important faucets of individuals' lives and how they manage their personal and emotional issues, as reported by the Princeton Religion Research Center (PRRC; 2000), the Center for Research on Religion and Urban Civil Society at the University of Pennsylvania (CRRUCS; 2003), and the City University of New York (CUNY; 2001). These organizations and the data that they reported indicated that a large majority of the American population has an interest in and engages in spiritual and/or religious activities. These organizations also reported that how individuals define religion and spirituality differed greatly across groups, religions, and individuals.

One of the challenges of studying the constructs of religion and spirituality is how these terms are defined, how they are utilized by an individual, and how they may differ in their relationship to other issues such as emotional well-being. Speck (2005) indicated that numerous and sometimes contradictory definitions for these constructs have been provided in the literature and that this created a significant challenge in the discussion of spirituality and religiosity. For example, Souza (2002) stated, "there is no one right way to define spirituality" (p. 215). The current study focused on examining both constructs.

One of the goals of the current study was to consider the relationship between religious coping styles and mental health. To accomplish this task, the Religious Problem-Solving Scale (RPSS) and two constructs of mental health (anxiety and depression), measured by the Beck Anxiety Inventory (BAI) and the Beck Depression Inventory-II (BDI-II), respectively, were examined. It was hypothesized that a higher

degree of religious problem-solving would be negatively correlated to symptoms of anxiety and depression. Specifically, persons who reported using one or more religious problem solving styles to a high degree would also report lower levels of anxiety and depression symptoms.

The second goal of the study was to determine the relationship of spirituality with mental health. Specifically, the study sought to examine if there was a relationship between spiritual well-being, as measured by the Spiritual Well-Being Scale, (SWBS) and the two mental health constructs (i.e., depression and anxiety). It was hypothesized that, similar to the religious constructs, persons who reported a high level of spiritual well-being would also report lower levels of anxiety and depression.

Discussion of Results

The findings from this study have been organized in relation to the specific research questions that were the focus. In addition, specific limitations of the study were considered, as well as implications and recommendations for future research.

Relationship between Religious Coping Styles and Spiritual Well-Being

The first research question focused on the potential relationship between religious coping styles, as measured by the Religious Problem-Solving Scale (RPSS), and spiritual well-being, as measured by the Spiritual Well-Being Scale (SWBS). The results demonstrated that there was a strong relationship between these variables. The results suggested that those individuals who are more likely to report a high use of religious coping styles are also more likely to report high levels of spiritual well-being. These

results were not surprising since the research literature indicated that these instruments were measuring constructs that were generally similar, and that both may be part of how people view their spirituality and its role in their lives (Miller & Thoresen, 2003; Phillips III, Pargament, Lynn, & Crossley, 2004). In fact, Phillips III et al. correlated the RPSS and SWBS subscales and reported results similar to those reported in this study.

One characteristic of the sample may have influenced these overall findings. In the current study, a majority of the participants reported a relatively high level of spiritual well-being and a high level of use of religious coping styles. These results were not inconsistent with previous research that has suggested that a high level religious and spiritual identification exists in the American culture, as indicated by the American National Election Studies (ANES, 2004), the Gallup Organization (2004, 2006, 2007), the National Opinion Research Center (NORC, 2004), and PRRC (2000). However, these scores were relatively high when compared to the samples upon which these two measures were normed (Boivin et al., 1999; Thurston, 1999). Overall, the mean values of the RPSS, collected in this research study, were higher than the mean values reported in the initial validation study reviewed by Thurston. This is a surprising finding because the authors of the RPSS, Pargament et al. (1988), sought participants from two Christian churches. The current study recruited participants primarily from a public university, which may indicate a highly spiritual or highly religious undergraduate population at this public university.

The RPSS subscales (Collaborative, Deferring, and Self-Directing) also reported results that differed from the initial validation study, as reported by Pargament et al. (1988). Moreover, the results from this research study also differed from Fox et al.'s

(1998) study, which supported the findings of Pargament et al. The surprising finding was that the relationship between the Collaborative subscale and the Self-Directing subscale was stronger than that between the Deferring subscale and the Self-Directing subscale. According to Pargament et al., the definitions of the Deferring (a passive approach that allows God to solve all problems) and Self-Directing (a perspective that God provides the skills and abilities and expects them to be used to solve problems) subscales appeared to be opposite, whereas the Self-Directing and Collaborative (the idea of the individual working with God to solve a problem) subscales were similar. A possible explanation might be that college students may either rely primarily upon personal strengths without the need to seek spiritual guidance in negative life situations, or because of the stresses and uncertainty found during the college years (Ma, 2003), students might feel supported through relying upon spiritual guidance. Because of the negative correlations, however, it appeared that the participants, who sought guidance from a spiritual and/or religious experience, did not fully rely upon a higher power, nor did they rely solely upon personal strengths.

Relationships between the spirituality subscales (existential well-being and religious well-being) appeared consistent with the design of the assessment (Ellison, 1983; Paloutzian & Ellison, 1982, 1991). The Existential subscale, which measured adjustment to self and community, returned moderate positive relationships with the Collaborative and Deferring subscales. As the Existential subscale was designed to focus upon the existential concerns of spirituality, it was expected that it would not be highly correlated with subscales measuring religiously oriented coping styles. The moderate negative relationship between the Existential subscale and the Self-Directing subscale

appeared to be consistent, as the Self-Directing subscale was designed to measure self-reliance through a religious perspective – meaning that a spiritual relationship is not necessary to cope with negative life events. Furthermore, the moderate to high relationships between the Religious subscale, which was designed to assess spiritual well-being as it relates to God, and the Collaborative and Deferring subscales suggested that all involve a relationship and interaction with a higher power. The high negative relationship between the Religious and the Self-Directing subscales indicated that non-reliance upon a higher power (measured by the Self-Directing subscale) is not consistent with seeking direction and wellness through involvement with a religious organization.

Relationship between Depression and Religious Coping Styles

The second research question examined the potential relationship between symptoms of depression and religious coping styles. It was hypothesized that higher scores on Collaborative and Self-Directing subscales of the Religious Problem Solving Scale (RPSS) would negatively correlate with the Beck Depression Inventory-II (BDI-II) scores. However, because the authors of the RPSS (Pargament et al., 1988) defined the Deferring subscale as a passive approach to problem solving, by allowing God to solve all problems, it was hypothesized that analysis with the Deferring subscale would reveal a positive relationship with the BDI-II scores.

The results, however, did not support this hypothesis; there was a trend toward a relationship between these variables but it was not significant. One trend suggested that those participants who reported higher levels of a collaborative approach to coping with negative life events also reported lower levels of depressive symptoms. This trend

appeared to indicate that collaborating with a higher power to solve problems also appeared to provide an additional resource to decrease symptoms of depression; however, these findings were not significant. Also reporting a slight negative correlation trend with depressive symptoms was the Deferring subscale. Participants who reported higher levels of a deferring approach to solving problems also indicated lower levels of depression symptoms; however, these findings also only suggested a trend and were not significant.

Across the religious coping style subscales, only the Self-Directing subscale demonstrated a positive correlation to scores on the BDI-II that was significant. The Self-Directing subscale measured a problem-solving approach where the individual believes that God provides skills and abilities to deal with negative life situations and, therefore, does not need to directly resolve problems for the person. According to these results, participants that reported a higher level of depressive symptoms also reported using a self-directing approach to coping with negative life events. Two possible explanations may exist for this result:

1.) Less reliance upon a higher power may increase the possibility of feeling alone and unsupported, thus leading to increased symptoms of depression, which is described by Phillips III et al. (2004) as a feeling of abandonment.
2.) Participants that reported higher levels of depression may also experience a loss of hope, which may prevent the individual from utilizing spiritual and/or religious resources, as indicated by Frankl (1984) and Hodges (2002).

Another important consideration related to these findings were the characteristics of the sample. Ma's (2003) research, which focused on spiritual growth in college students enrolled at Christian universities, reported that students connected to a social

community reported a higher degree of spiritual growth. Ma postulated that students living off-campus have a smaller social network, and, therefore, there is the possibility that students may report a strong religious beliefs but not actively participate in the self-identified religion. As an additional consideration, Ma also reported that as college students experience an increased amount of freedom and responsibility, they may rely more heavily upon oneself and not religious beliefs. These factors could contribute to or disguise the relationship with reported symptoms of depression.

Relationship between Depression and Spiritual Well-Being

The third research question examined the relationship between the level of depressive symptoms and perceptions of spiritual well-being. Across the subscales of the Spiritual Well-Being Scale (SWBS), there was a significant relationship between the Existential subscale and scores on the Beck Depression Inventory-II (BDI-II). The Existential subscale measured perceptions of adjustment to self and community, as well as notions of purpose in life and life satisfaction. Results suggested that participants who reported higher levels of existential well-being also reported fewer or less intense symptoms of depression. It is also possible that individual experiencing fewer depressive symptoms may foster a greater sense of existential well-being.

The results from this study supported previous research, which indicated that individual reporting a higher level of involvement in spiritual and/or religious activities also reported decreased symptoms of depression, especially as it relates to life satisfaction and finding meaning in life (Reinert & Bloomingdale, 1999; Wachholtz & Pargament, 2005; Westgate, 1996; Young et al., 2000). Furthermore, Baetz et al. (2006)

stated that spirituality and/or religious activities were beneficial not only with symptoms of depression, but also in the treatment of a variety of psychiatric illnesses.

The Religious Well-Being subscale, which measures spiritual well-being through a relationship with God, also demonstrated a significant negative correlation with scores on the BDI-II. These results indicated that individuals who reported lower levels of depressive symptoms endorsed a higher level of religious well-being. As with the Existential subscale, these results may indicate that persons experiencing few symptoms of depression may perceive a closer relationship with God. However, these results are also supported by research that studied a highly religious approach to alleviating symptoms of depression (Flannelly et al., 2003; Hodges, 2002; Hutch, 2000; Wachholtz & Pargament, 2005; Yarhouse & Kreeft-Turcic, 2003). Flannelly et al. and Hutch listed specific religious activities that their studies found to assist in alleviating symptoms of depression, as well as other mental health issues. These findings suggested that persons who engaged in religious activities designed to communicate or further one's relationship with God may experiences fewer or less-intense symptoms of depression.

These findings, as with many related to the BDI-II, need to be viewed cautiously since, overall, the participants reported relatively low levels of depressive symptoms, as well as high levels of religiosity. When comparing the results from this study to wellness literature, which considered the inter-connectedness of mind, body, and spirit, the impact of spirituality is similar: spirituality is an important dimension in achieving wellness. Adams et al. (2000) named six dimensions of wellness: physical, social, psychological, intellectual, emotional, and spiritual. Furthermore, other wellness research, such as that reported by Chandler et al. (1992) and Sweeney and Witmer (1991) have consistently

supported these characteristics, have demonstrated that each dimension of wellness is closely linked, and that changes in one dimension influence the others. For example, Adams et al. stated that illness results in a combination of factors: "Illness in this model is not as much a state of psychological disease as it is a perception of disconnection, poor self-esteem, poor physical health, pessimism, existential frustration, lack of intellectual stimulation, or any combination of the above" (p. 166). Indeed, Chandler et al. and Sweeney and Witmer placed spirituality as the central dimension, anchoring other factors together to achieve holistic wellness – this indicated that spirituality was a significant factor in achieving wellness. Therefore, the results of this research study, while viewed cautiously, appeared to support both mental health research and wellness literature: engaging in spiritual and/or religious activities may reduce or alleviate symptoms of depression.

Relationship between Anxiety and Religious Coping Styles

The fourth research question examined the potential relationship between symptoms of anxiety, as measured by the Beck Anxiety Inventory (BAI), and religious coping styles, as measured by the Religious Problem-Solving Scale (RPSS). While the findings suggested a trend, there was no significant relationship reported between scores on the BAI and the three RPSS subscales (Collaborative, Deferring, and Self-Directing). While previous research has reported significant negative relationships between anxiety and spirituality (Davis et al., 2003; McCorkle et al., 2005; Townsend et al., 2002; Wachhold & Pargament, 2005), research with the RPSS has not linked religious coping style to anxiety (Phillips III et al., 2004; Schaefer & Gorsuch, 1991). The results of this

study appeared to indicate that despite the relationship between spirituality and anxiety, specific religious coping styles, as measured by the RPSS, did not influence anxiety.

Several possible explanations exist for these results. As noted above, previous research has reported an inverse relationship between spirituality and anxiety; this indicated that spirituality, in some manner, removed or reduced the intensity of symptoms of anxiety. It is possible that individuals cope with anxiety in a different manner that the three religious coping styles measured by the RPSS. Or, as analysis revealed in this study, no significant relationship exists between religious coping styles and anxiety. Other problems might exist with the assessment instrument: it was noted by Newman and Pargament (1990) that the word selection of questions on the RPSS may not fully correspond with the coping style associated with the question. Moreover, another additional consideration is that the RPSS was developed within a Judeo-Christian perspective and, therefore, may not be appropriate for participants who reported no belief in God. When considering the participant characteristics, few participants reported significant levels of anxiety, which may also have contributed to these results.

Relationship between Anxiety and Spiritual Well-Being

The fifth research question examined the potential relationship between the level of symptoms of anxiety and perceptions of spiritual well-being. A multiple regression analysis indicated that both the Existential Well-Being subscale (Existential) and the Religious Well-Being subscale (Religious) were negatively correlated to the Beck Anxiety Inventory (BAI). However, only the Existential subscale reported a significant

relationship with the BAI. Analysis revealed that the relationship between the Religious subscale and the BAI was not significant, although a slight negative trend was observed.

As previously noted, a modest negative correlation, that was significant, was found between the Existential subscale and the BAI. As a reminder, the Existential subscale of the SWBS was designed to measure perceptions of well-being related to connectedness with self and community, life satisfaction, and finding meaning in life. These findings suggested that participants who reported high levels of existential well-being also reported lower levels of anxiety symptoms. This relationship may indicate that persons reporting high levels of existential well-being are better equipped to handle stressful and anxiety-producing situations. Furthermore, this correlation may be bi-directional, meaning that a lack of anxiety could also encourage an increase in existential well-being and vice-versa; it is also important to note that these results corresponded with previous research indicating an inverse relationship between involvement in spirituality and mental health issues (Carr, 2000; Degges-White et al., 2003; Gartner, 1996; Graham et al., 2001; Miller & Thoresen, 2003; Seybold & Hill, 2001). Specifically, previous research has suggested that persons with a high level of spiritual well-being also correspondingly reported lower levels of mental health concerns.

Conversely, there was no significant relationship between scores on the BAI and the Religious subscale on the SWBS, which was designed to measure well-being related to relationship with God or a Higher Power. It should be noted, that while the findings were not significant the trend indicated by the negative correlation between these variables is consistent with previous research (Miller & Thoresen, 2003; Seybold & Hill, 2001) which has suggested that persons engaging in spiritual and/or religious activities

(i.e., prayer, meditation, reading sacred writings) are more likely to report less mental health concerns. Specifically, Graham et al. (2001) reported that “counseling students who expressed their spirituality through their religious beliefs had greater spiritual health and greater immunity to stressful situations than counseling students who identified themselves as spiritual with no set of religious beliefs” (p. 9). Furthermore, Townsend et al. (2002) and McCorkle et al. (2005) suggested that religious activity has demonstrated positive results in the treatment of anxiety and other mental health issues.

Several possible explanations for this result could be explained by the participants in this study. Primarily, a vast majority of participants reported low levels of anxiety symptoms. Furthermore, because the participants reported relatively high levels of religious well-being, this could indicate that the participants had already developed a greater array of resources to cope with negative life events. As Boivin et al. (1999) noted, the Religious subscale of the SWBS develops a “ceiling effect” with participants reporting to be highly religious, which would not accurately portray perceptions of spiritual well-being. Additionally, the results could also be explained that a lack of negative life events could increase the perception that religious beliefs and activities have positively affected one’s life and lifestyle.

Relationship between the Spirituality Measures and the Mental Health Measures

The sixth research question examined the overall relationship between the spirituality measures and the mental health measures. A MANOVA was used to analyze the data and report which spirituality subscales provided the greatest influences to the mental health assessments. Results indicated that the RPSS subscales (Collaborative,

Deferring, and Self-Directing) and the SWBS subscales (Existential Well-Being and Religious Well-Being) could explain a significant portion of the relationship with the Beck Anxiety Inventory (BAI) and the Beck Depression Inventory-II (BDI-II). The same multivariate test indicated that the RPSS and SWBS subscales also predicted levels of anxiety and depression. Remaining consistent with previous research (Adams et al., 2000; Chandler et al., 1992; Davis et al., 2003; Gartner, 1996; Graham et al., 2001; McCorkle et al., 2005; Miller & Thoresen, 2003; Schaefer & Gorsuch, 1991; Seybold & Hill, 2001; Townsend et al., 2002; Wachhold & Pargament, 2005; Witmer & Sweeney, 1991), these results indicated that the overall significance and relationship was high.

Research studies, as noted above, have consistently reported the efficacy of including spirituality and/or religiosity into the treatment of persons suffering from physical, emotional, or mental illness. Such research reported that involvement in spiritually- or religiously-related activities had an inverse relationship with depression (Baetz et al., 2006; Hodges, 2002; Westgate, 1996), anxiety (Davis et al., 2003; Graham et al., 2001; Schaefer & Gorsuch, 1991), physical health (Holt et al., 1999; Powell et al., 2003; Townsend et al., 2002), and other mental health issues (Carr, 2000; Seybold & Hill, 2001; Weber & Cummings, 2003), as well as a positive relationship with quality of life (Skevington et al., 2004) and existential concerns of purpose and meaning in life (Purdy & Dupey, 2005). Therefore, this large amount of evidence supported the findings of this research study, regarding the overall significance and relationship between the spirituality and mental health assessments.

When considering the between-subjects effects, only one spirituality subscale reported significance with each mental health assessment: the Existential subscale.

Analysis showed no significance with the other spirituality subscales. The impact of the Existential subscale was surprising but not unexpected; the concept of finding meaning and purpose in one's life is an overarching theme throughout all spirituality subscales, as spirituality demonstrated through religious activities or philosophical endeavors seeks transcendence and life satisfaction (Stanard et al., 2000). Although the RPSS subscales (Collaborative, Deferring, and Self-Directing) were designed to measure separate religious coping styles, each subscale represents a different perspective on one's relationship with God (or a Higher Power), as well as how to use this relationship to better oneself or one's environment. Similarly, the SWBS subscales (Existential and Religious) distinguished differing perspectives seeking the same goal: spiritual well-being and wholeness. Thus, although analysis revealed only the Existential subscale as a significant factor with the mental health assessments (BAI and BDI-II), these results appeared to remain consistent with previous research.

Summary of Findings

The analyses used in this research study identified two spirituality subscales that demonstrated significant relationships with the mental health assessments: the Existential and Religious subscales from the Spiritual Well-Being Scale (SWBS). A multiple regression analysis reported that the Existential subscale revealed a significant inverse relationship with both the Beck Anxiety Inventory (BAI) and the Beck Depression Inventory-II (BDI-II). These results indicated that individuals reporting higher levels of existential well-being were also reporting lower levels of symptoms of anxiety and depression; a finding that is supported by a variety of research studies (Baetz et al., 2006;

Davis et al., 2003; Graham et al., 2001; Hodges, 2002; Miller & Thoresen, 2003; Phillips III et al., 2004; Purdy & Dupey, 2005; Seybold & Hill, 2001; Wachholtz & Pargament, 2005; Westgate, 1996). Moreover, a multivariate analysis of variance (MANOVA) reported that only the Existential subscale provided significant between-subjects effects. This result indicated that the Existential subscale is the greatest predictor between the spirituality subscales and the mental health scores.

The multiple regression analysis also reported that the Religious subscale provided a significant inverse relationship with the BDI-II. These results indicated that participants reporting a higher degree of religious well-being also reported lower levels of symptoms of depression. Furthermore, these results suggested that participating in religious activities and/or seeking a closer relationship with God or a Higher Power might remove or diminish the intensity of depressive symptoms. Also supported by research (Flannelly et al., 2003; Hodges, 2002; Hutch, 2000; Wachholtz & Pargament, 2005; Yarhouse & Kreeft-Turcic, 2003), these results revealed that greater religiosity may increase well-being and decrease mental, emotional, and physical illness.

Limitations of This Study

One of the most significant limitations of this study was related to the sample characteristics. Overall, this sample reported relatively low levels of anxiety and depression. This is directly related to the characteristics of the sample in reference to age. The majority of the participants, college students, were between the ages of 19-25. Research supported that excluding a clinical population, the rate of depression and anxiety disorders among college populations is actually lower than might be found in

older populations (Beck & Steer, 1993a; Beck, Steer, & Brown, 1996; Schmitt & Kurdek, 1985). In addition, among this sample, which included both students from a Christian identified University and a non-denominationally identified University, the majority of participants self-identified as Christian or within a Christian religious denomination. Because the Religious Problem-Solving Scale (RPSS) and the Spiritual Well-Being Scale (SWBS) were primarily developed and normed on Christian populations, it would be beneficial to determine if the assessment are useful and/or valid with non-Judeo-Christian populations. It would also be important to consider the influence of other religious or spiritual identifications or perspectives on the variables identified in this study.

Another significant concern with the design of this study is related to the measure used to assess spiritual well-being. A noted limitation with the SWBS is the presence of a "ceiling effect" that may occur in the Religious Well-Being subscale (Religious) and the Spiritual Well-Being global scale (SWB) when assessing individuals reporting high religiosity (Boivin et al., 1999; Paloutzian & Ellison, 1991). This ceiling effect results in difficulty distinguishing among individual reporting high levels of spiritual well-being and individuals reporting high levels of religiosity. Furthermore, a limitation of both spirituality assessments was a Judeo-Christian context or the belief in God or a Higher Power for measurement. Stanard et al. (2000) has noted that a majority of published spirituality assessments have been developed within the Judeo-Christian context; this presents a problem to populations that do not identify with Judeo-Christian values and ideologies and may "exclude a vast realm of spiritual experiences ranging from Eastern religions to non-religious views" (p. 209). This should also be considered in reference to the sample characteristics already discussed, specifically, that the majority of the sample

reported Christian religious identification. This further emphasizes the need to look at a more diverse population in the future to determine the relationship between these variables and the need to cautiously view the finding when considering their meaning in relation to the general population.

Recommendations for Further Research

The discussion of limitations raised specific considerations for future research. One recommendation for future research is to expand upon this study but to include a more diverse population (i.e., age, ethnicity, religious identity) that may or may not include a clinical population. Other suggestions are to explore a small segment of this study, such as focusing upon a single dimension of spirituality or mental health. Although every study should ensure that potential limitations are considered, the ambiguous nature of spirituality and the difficulty in reducing marginalization of specific populations when using assessments instruments that were developed from a Judeo-Christian perspective can severely limit the results. Therefore, further research with non-Christian populations may require the use of different spirituality assessments. This limitation suggested the possibility of developing a spirituality assessment instrument that was designed from a different spiritual/religious perspective, or seeking to adapt currently published assessment instruments. The potential also exists to develop a spirituality assessment that is useful in many spiritual/religious traditions. This potential for further research will continue to support the call to integrate spirituality into counselor education, research, and practice.

Implications of This Study: Counseling and Counselor Education

Although a variety of research has been conducted on the relationship between spirituality and mental health, this research study provided further support to include spirituality and religiosity into the counseling process. Using two spirituality assessments and two mental health assessments, this research study analyzed the relationship between two constructs of spirituality (religious coping styles and spiritual well-being) and two constructs of mental health (anxiety and depression). Additionally, the majority of previous research has focused on the relationship between spirituality and physical health (Holt et al., 1999; Krause, 1992; Miller & Thoresen, 2003; Powell et al., 2003; Seeman et al., 2003; Seybold & Hill, 2001; Townsend et al., 2002), which was clearly demonstrated in the large number professional literature dedicated to holistic wellness (Adams et al., 2000; Chandler et al., 1992; Purdy & Dupey, 2005; Myers et al., 2000; Myers et al., 2003; Myers & Williard, 2003; Witmer & Sweeney, 1992). The results of the current study extend this research to considering that spiritual well-being, specifically existential well-being and religious well-being, may also correspond to mental health.

Once again, this result was not surprising when considered in relation to the extensive research in the wellness literature (Adams et al., 2000; Carr, 2000; Chandler et al., 1992; Davis et al., 2003; Degges-White et al., 2003; Gartner, 1996; Hodges, 2002; Miller & Thoresen, 2003; Myers et al., 2000; Perrin & McDermott, 1997; Powell et al., 2003; Westgate, 1996). There appears to be a growing body of literature that demonstrates that spirituality and religious identification may provide a useful resource to dealing with multiple personal, social, and health issues.

This mounting research, supporting the positive effects of spiritual and religious involvement, makes it imperative that counselors and counselor training programs begin to more effectively consider how religion and spirituality relate to the counseling process and their clients' well-being. Ardell (1993, 1998, 1999) and Speck (2005), have asserted that there is clearly sufficient evidence to support the need for counselors to understand the role of religion and spirituality in the lives of their clients. However, these authors also stated that there has been a hesitation in the profession and by some counselors to approach or even address this issue in the counseling process.

One starting point in this process may be extending research on the role of spirituality and religion in the counseling process. Richmond (2004) has claimed that research concerning spirituality has been a part of the counseling profession for well over a century, however there is a real need for additional research and study focused on addressing the negative perceptions of spirituality and religiosity as they relate to the counseling process (Miller & Thoresen, 2003; Seybold & Hill, 2001).

Summary

This research study was designed to explore the relationship between spirituality and mental health. Specifically, two constructs of spirituality (religious coping styles and spiritual well-being) and two constructs of mental health (anxiety and depression) were analyzed within this study. Of the variables studied, only the Existential Well-Being subscale of the Spiritual Well-Being Scale (SWBS) reported a significant inverse relationship with both mental health measures, the Beck Depression Inventory-II (BDI-II) and the Beck Anxiety Inventory (BAI); the subscales of the Religious Problem-Solving

Scale (RPSS) indicated trends toward a relationship with the mental health measures, but they were not significant. Additionally, the Existential Well-Being subscale was the only spirituality subscale to significantly predict the between-subjects effects with the mental health assessments. Finally, the Religious Well-Being subscale of the SWBS reported a significant inverse relationship with one mental health measure: the BDI-II. These results further supported a variety of research studies that have noted an inverse relationship between spirituality and both physical and mental health, suggesting that increased levels of spiritual well-being may decrease or remove symptoms of depression and anxiety.

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APPENDICES

APPENDIX A

RELIGIOUS PROBLEM-SOLVING SCALE

Religious Problem-Solving Scale

Presented below are some more statements concerning the role of religion in dealing with problems. Again, please read each statement carefully, think about how often the statement applies to you, and circle the number that best indicates this.

Never	Occasionally	Fairly Often	Very Often	Always
1	2	3	4	5

Item					
1. When I have a problem, I talk to God about it and together we decide what it means.	1	2	3	4	5
2. Rather than trying to come up with the right solution to a problem myself, I let God decide how to deal with it.	1	2	3	4	5
3. When faced with trouble, I deal with my feelings without God's help.	1	2	3	4	5
4. When a situation makes me anxious, I wait for God to take those feelings away.	1	2	3	4	5
5. Together, God and I put my plans into action.	1	2	3	4	5
6. When it comes to deciding how to solve a problem, God and I work together as partners.	1	2	3	4	5
7. I act to solve my problems without God's help.	1	2	3	4	5
8. When I have difficulty, I decide what it means by myself without help from God.	1	2	3	4	5
9. I don't spend much time thinking about troubles I've had; God makes sense of them for me.	1	2	3	4	5
10. When considering a difficult situation, God and I work together to think of possible solutions.	1	2	3	4	5
11. When a troublesome issue arises, I leave it up to God to decide what it means for me.	1	2	3	4	5
12. When thinking about a difficulty, I try to come up with possible solutions without God's help.	1	2	3	4	5
13. After solving a problem, I work with God to make sense of it	1	2	3	4	5
14. When deciding on a solution, I make choices independent of God's input.	1	2	3	4	5
15. In carrying out the solutions to my problems, I wait for God to take control and know somehow He'll work it out.	1	2	3	4	5
16. I do not think about different solutions to my problems because God provides them for me.	1	2	3	4	5
17. After I've gone through a rough time, I try to make sense of it without relying on God.	1	2	3	4	5

18. When I feel nervous or anxious about a problem, I work together with God to find a way to relieve my worries.	1	2	3	4	5
19. When I'm upset, I try to soothe myself, and also share the unpleasantness with God so He can comfort me.	1	2	3	4	5
20. When faced with a decision, I make the best choice I can without God's involvement.	1	2	3	4	5
21. God solves problems for me without my doing anything.	1	2	3	4	5
22. When I have a problem, I try not to think about it and wait for God to tell me what it means.	1	2	3	4	5
23. In carrying out solutions, I work hard at them knowing God is working right along with me.	1	2	3	4	5
24. When a difficult period is over, I make sense of what happened on my own without involvement from God.	1	2	3	4	5
25. When faced with a question, I work together with God to figure it out.	1	2	3	4	5
26. When I feel nervous or anxious, I calm myself without relying on God.	1	2	3	4	5
27. God doesn't put solutions to my problems into action, I carry them out myself.	1	2	3	4	5
28. I don't worry too much about learning from difficult situations, since God will make me grow in the right direction.	1	2	3	4	5
29. When I am trying to come up with different solutions to troubles I am facing, I do not get them from God but think of them myself.	1	2	3	4	5
30. When a hard time has passed, God works with me to help me learn from it.	1	2	3	4	5
31. God and I talk together and decide upon the best answer to my question.	1	2	3	4	5
32. When faced with a decision, I wait for God to make the best choice for me.	1	2	3	4	5
33. I do not become upset or nervous because God solves my problems for me.	1	2	3	4	5
34. When I run into trouble, I simply trust in God knowing that He will show me the possible solutions.	1	2	3	4	5
35. When I run into a difficult situation, I make sense out of it on my own without divine assistance.	1	2	3	4	5
36. The Lord works with me to help me see a number of different ways that a problem can be solved.	1	2	3	4	5

APPENDIX B

DEMOGRAPHICS QUESTIONNAIRE

DEMOGRAPHICS QUESTIONNAIRE

Please circle, write in, or select the response that best describes you.
Please give only one response per item.

1. **What is your gender?** Male Female

2. **What is your age?** __________

3. **What is your ethnic origin?**

   _______ American Indian/Alaska Native

   _______ African-American

   _______ Asian/Pacific Islander

   _______ Caucasian

   _______ Hispanic

   Other (please describe) ____

4. **What is your spiritual/religious identity (i.e. Agnostic, Christian, Jewish, etc.)?**

   ____

5. **Does your spiritual/religious identity use the word "God"?**

   Yes No

APPENDIX C

INFORMATION SHEET

INFORMATION SHEET
for a research study entitled
"Assessment of Spirituality:
The Relationship between Spirituality and Mental Health"

You are invited to participate in a research project designed to assess the relationship between spirituality variables of religious coping styles and spiritual well-being and psychological variables of anxiety and depression. David R. Brown is conducting the study, under the supervision of Dr. Jamie S. Carney, Committee Chair and Professor in Auburn University's Department of Counselor Education, School Psychology, and Counseling Psychology.

If you choose to participate, you will be asked to complete five assessment instruments that will take approximately 20 minutes of your time. Please complete the measures, place them in the survey packet envelope, and seal the envelope. You will then return the packets to me during the first 5 minutes of your next class session. I do not anticipate any possible risks or discomforts associated with participation in this study, but a list of counseling and psychological centers has been provide in case you experience any emotional and/or psychological discomfort during or after participation in the study. Please understand you are responsible for any costs associated with medical treatment.

Two assessments within this survey packet envelope were designed within a Judeo-Christian context. Therefore, many questions use the word "God." If your spiritual and/or religious identity does not use the term "God," I encourage you to replace the word with one that is relevant to you.

Your instructor has agreed to provide extra-credit for participating in this study. To verify participation, you will be provided with a certificate when you return the survey packet. Your decision to participate in this study is voluntary, and if you choose not to participate, your instructor will provide an alternative activity to complete for extra credit. All data collected in this study is anonymous. Therefore, once you have returned your survey packet, it will be impossible to withdraw from the study. Your decision to participate will not jeopardize your future relations with Auburn University, the Department of Counselor Education, Counseling Psychology, and School Psychology, or your class grade.

Information collected in this study will be used in a doctoral dissertation, may be published in a professional journal, and/or presented at a professional meeting.

If you have any questions, I invite you to ask them now. If you have questions later, please feel to contact me, David R. Brown, at 334-750-4183 or browndr@auburn.edu or my Faculty Advisor, Dr. Jamie S. Carney, at 334-844-2885 or carnejs@auburn.edu.

For more information regarding your rights as a research participant, you may contact the Auburn University Office of Human Subjects Research or the Institutional Review Board by phone 334-844-5966 or e-mail at hsubjec@auburn.edu or IRBChair@auburn.edu.

HAVING READ THE INFORMATION PROVIDED, YOU MUST DECIDE WHETHER TO PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, THE DATA YOU PROVIDE WILL SERVE AS YOUR AGREEMENT TO DO SO. THIS LETTER IS YOURS TO KEEP.

______________________________ _______________

David R. Brown, MA, PC, BCPCC Date

APPENDIX D

MENTAL HEALTH REFERRAL (AUBURN/OPELIKA, ALABAMA)

Referral List of
Mental Health Providers in Auburn/Opelika, Alabama

Individual/Agency	Services Available	Phone No.	Cost/Hour
East Alabama Mental Health Center 2506 Lambert Drive Opelika, AL 36801	Individual and Group Therapy	334-742-2700 334-742-2877 (after hours)	Sliding Scale Based on Income
Student Counseling Services at Auburn University 400 Lem Morrison Drive, Suite 2086 Auburn, AL 36849	Individual and Group Therapy	334-844-5123	(No charge)
Auburn University Psychological Services Center 1122 Haley Center Auburn, AL 36849-5234	Marriage, Family, and Individual Therapy	334-844-4889	$25-55 Based on income
Clinical Psychologists 248 East Glenn Avenue Auburn, AL 36849	Individual and Group Therapy	334-821-3350	Initial Appt: $130 Other App: $120
Crisis Center	Phone Counseling (only)	334-821-8600	(No charge)

APPENDIX E

MENTAL HEALTH REFERRAL (CINCINNATI, OHIO)

Referral List of
Mental Health Providers in Cincinnati, Ohio

Individual/Agency	Services Available	Phone No.	Cost/Hour
Psychiatric Emergency Services at University Hospital 234 Goodman Street Cincinnati, OH 45219	Behavioral health services, in-patient services, and mobile crisis unit	513-584-8577	Fees based upon services provided.
Counseling Center at Cincinnati Christian University 2700 Glenway Avenue Cincinnati, OH 45204	Individual, Group, Couples, Family, and Pre-Marital Counseling	513-244-8193	Sliding fee scale based upon income.
Community Mental Health Center, Inc. 285 Bielby Road Lawrenceburg, IN 47025	Individual, Family, and Group Therapy	812-537-1302 1-877-849-1248 (toll-free)	Sliding fee scale based upon services provided.
Douglas Reed & Associates 5750 Gateway Boulevard, Suite 103 Mason, OH 45040	Individual, Marriage and Family, and Pre-Marital Counseling	513-779-7400	Fees range from $75 - $150 per session.
New Beginnings Christian Counseling 6080 Camp Ernst Road Burlington, KY 41005	Individual, Career, Marriage and Family, Pre-Marital Counseling	859-426-9020	Sliding fee scales based upon income.

APPENDIX F

AUBURN UNIVERSITY INSTITUTIONAL REVIEW BOARD

APPROVAL TO CONDUCT STUDY

AUBURN

UNIVERSITY

Office of Human Subjects Research
307 Samford Hall
Auburn University, AL 36849

Telephone: 334-844-5966
Fax: 334-844-4391
hsubjec@auburn.edu

December 6, 2007

MEMORANDUM TO: David Brown
Counselor Education Counseling Psychology

PROTOCOL TITLE: "Assessment of Spirituality: The Relationship between Spirituality and Mental Health"

IRB AUTHORIZATION NO: 07-255 EP 0712

APPROVAL DATE: December 6, 2007
EXPIRATION DATE: December 5, 2008

The above referenced protocol was approved by IRB Expedited procedure under 45 CFR 46.110 (Category #7):

> " Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

You should report to the IRB any proposed changes in the protocol or procedures and any unanticipated problems involving risk to subjects or others. Please reference the above authorization number in any future correspondence regarding this project.

If you will be unable to file a Final Report on your project before December 5, 2008, you must submit a request for an extension of approval to the IRB no later than November 22, 2008. If your IRB authorization expires and/or you have not received written notice that a request for an extension has been approved prior to December 5, 2008, you must suspend the project immediately and contact the Office of Human Subjects Research for assistance.

A Final Report will be required to close your IRB project file. You are reminded that you must use the stamped, IRB-approved information sheet when you consent your participants.

If you have any questions concerning this Board action, please contact the Office of Human Subjects Research at 844-5966.

Sincerely,

Niki L. Johnson, JD, MBA, Director
Office of Human Subjects Research
Research Compliance Auburn University

Enclosure

cc: Dr. Holly Stadler
Dr. Jamie Carney

APPENDIX G

CINCINNATI CHRISTIAN UNIVERSITY REVIEW BOARD FOR RESEARCH

APPROVAL TO CONDUCT STUDY

CINCINNATI
CHRISTIAN UNIVERSITY

October 16, 2007

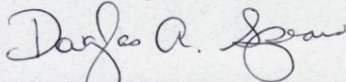
Counselor Education, Counseling Psychology
and School Psychology (COUN)
2084 Haley Center
Auburn University, AL 36849

To Whom It May Concern:

We have received David R. Brown request to conduct research on the Cincinnati Christian University (CCU) campus. His investigation in "Assessment in Spirituality: The Relationship between Spirituality and Mental Health has been reviewed. The Cincinnati Christian University Review Board for Research has granted him permission to conduct his investigation on our campus. He may contact Tina Thompson, Office Manager for the Counseling and Family Studies Department and the CCU Counseling Center (1-513-244-8193) or me to make arrangements for his collection of data.

Please feel free to contact us if you have any questions.

Douglas A. Spears Ph.D., PCC/s



Cincinnati Christian University
Professor/Chair - Counseling and Family Studies
Center Director – CCU Counseling Center
513-244-8428 – Office
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2700 Glenway Avenue Cincinnati OH 45204 www.CCUniversity.edu
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APPENDIX H:

AUBURN UNIVERSITY DEPARTMENT OF COUNSELOR EDUCATION, COUNSELING PSYCHOLOGY, AND SCHOOL PSYCHOLOGY APPROVAL TO CONDUCT STUDY

COLLEGE OF EDUCATION

DEPARTMENT OF COUNSELOR EDUCATION,

COUNSELING PSYCHOLOGY, AND SCHOOL PSYCHOLOGY

December 4, 2007

Dr. Kathy Jo Ellison
Office of Human Subjects Research
307 Samford Hall
Auburn University, AL 36849

Dear Dr. Ellison:

We have received David R. Brown's request to conduct research in Department of Counselor Education, Counseling Psychology, and School Psychology (COUN) courses. His investigation in "Assessment of Spirituality: The Relationship between Spirituality and Mental Health" has been reviewed. David has been granted permission to conduct his investigation in the COUN 1000, COUN 3100, and COUN 7350 courses. He may contact the course instructors to make arrangements for the collection of his data.

Please feel free to contact me if you have any questions.

Sincerely,

Holly A. Stadler, Ph.D.
Auburn University
Head of Department – Counselor Education,
Counseling Psychology, and School Psychology
334-844-5160 – Office
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