Sustained by the Sacred:

Religious and Spiritual Factors for Resilience in Adulthood and Aging[[1]](#footnote-1)

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Abstract

There are many sources of strength when stressful events occur throughout life. Psychologists have identified factors such as social support, positive emotions, and self-compassion that contribute to resilience. Religion and spirituality offer an additional dimension in coping with adversity: *the sacred*. We argue that an integrated connection with the sacred is essential for accessing unique reservoirs of strength in difficult times. Religious resources serve as lifelines that route individuals towards wellbeing. On the other hand, unrelenting spiritual struggles can compound stress or exacerbate difficulties. Thus it is critical to assess the nature of one’s relationship with the sacred. In doing so, targeted interventions to build spiritual resilience and decrease spiritual risk factors can be applied at different points throughout adulthood and aging.

**Introduction**

Human beings endure a multitude of life events, from daily frustrations to the terror of violence. What factors determine our trajectories in the face of adversity? Traditional approaches to this question have investigated biological, sociocultural, and secular psychological variables. Scientists have identified factors such as social support (Moore et al., 2015), positive emotions (Gloria & Steinhardt, 2014), and self-compassion (Neff & Knox, 2017) that contribute to resilience. These discoveries have led to a greater understanding of the framework of resilience. However, another substantive body of research, generated by the field of psychology of religion and spirituality, has further informed our appreciation of resilience pathways.

In this chapter, we focus on the sacred dimension of resilience. It is important to mention here that we argue for attending to people’s psychological experience of the sacred rather than its ontological reality. We offer theory and findings concerning the sacred that support its unique relevance when people suffer. Select contributions relevant to resilience are highlighted. Of note, the terms religion and spirituality are used interchangeably in this review for the sake of simplicity, given their substantial overlap in conceptualizations across researchers, laypeople, and older adults (Oman, 2013; Schlehofer, Omoto, & Adelman, 2008; Zinnbauer et al., 1997). We offer that an integrated connection with the sacred is essential for accessing distinctive reservoirs of strength in difficult times. Religious resources operate as lifelines that route individuals towards wellbeing. On the other hand, unrelenting spiritual struggles can compound stress and exacerbate difficulties. The sections of the chapter are organized by life stage (adulthood and aging), with accompanying overviews of helpful and harmful religious pathways. Subsequently, we offer suggestions for psychospiritual interventions that promote greater resilience in adulthood and later life.

**The Sacred as a Unique Dimension of Resilience**

To begin, it is important to define what is meant by *the sacred*. As conceptualized by Pargament (1997), the sacred refers to one’s core beliefs about God, the divine, or transcendent reality. The sacred also encompasses aspects of one’s life that are viewed as manifestations of this core or imbued with the core’s sacred qualities. Consequently, a drawing of the sacred would comprise a numinous inner core and surrounding ring of sanctified objects, relationships, activities, and experiences (Pargament & Mahoney, 2005). Transcendence, boundlessness, ultimacy, deep interconnectedness, and spiritual emotions are qualities of the sacred (Pargament, 1997; 2007). Transcendence involves perceptions of an object or experience as extraordinary, literally outside of the worldly or mundane. Ultimacy involves the arrival at profound, elemental truths about the universe or existence. Boundlessness refers to the perceived expansion of time and space boundaries. Deep interconnectedness involves the authentic meeting of another living being, as captured in an *I-Thou* encounter (Buber, 1958). Elicited by sacred perceptions, spiritual emotions include uplift, awe, gratitude, and humility. All together, the sacred is at the heart of religious and spiritual life.

Historically, theorists in the field of psychology have viewed religion through a reductionist lens. It has been argued that beliefs in the divine serve more basic purposes, such as a defense mechanism for anxiety (Freud, 1927), an attachment figure (Kirkpatrick, 2005), an object representation (Rizzuto, 1979), a physiological response (D’Aquili & Newberg, 1998), or a source of identity and community (Durkheim, 1915). More recently, Galen (2017) questioned whether religion could provide anything beyond what the secular is able to offer. Religious attendance, for example, ostensibly serves the same psychological functions as social support or civic engagement. One manifestation of the reductionist perspective is the stripping away of spiritual components from healing practices such as yoga and meditation. However, others (e.g., Frankl, 1984; James, 1961; Pargament, 2002; 2013), have argued that there is something unique to one’s relationship with the sacred in religiousness and spirituality, and thus its role in resilience.

We caution against ‘explaining away’ religion for several reasons. Spirituality holds a distinctive and important role for many individuals. National polls reveal that 72% of people in the United States identify with a particular religion, and 77% acknowledge religion as somewhat or very important to them (Pew Research Center, 2015). Moreover, Mercadante (2014) identified themes of the sacred at the forefront of her interviews with the growing faction who identify as spiritual but not religious. One participant describes habitually returning to the ravines behind her home, feeling “just a sense of peace and order and... feeling like I belonged somewhere. There was... [a] fulfilling and rejuvenating kind of silence” (Mercadante, 2014, p. 46-47). As illustrated, individuals have looked within and beyond the structures of organized religion for guidance in their search for the sacred. The search itself seems to be of irreducible and enduring importance.

It is probable that the sacred is not the *only* answer to coping with challenges, but it is a good one. The sacred has accounted for variance in outcomes above and beyond secular analogues in several studies (see Pargament, Magyar-Russell, & Murray-Swank, 2005). One such study compared the roles of religious engagement and secular civic engagement in buffering stress (Acevedo, Ellison, & Xu, 2014). In a cross-sectional random sample of adults, religious engagement significantly moderated the association between financial hardship and psychological distress in a model controlling for demographic factors and physical health. Furthermore, the researchers observed that religious engagement played a greater part in buffering stress relative to secular volunteering. In addition, religious resources seem to steer individuals towards wellbeing. In one study on medically ill patients with HIV, those who drew from the sacred to cope were two to four times more likely to survive over 17 years (Ironson, Kremer, & Lucette, 2016). Strategies that increased resilience included prayer, meditation, attending services, expressing gratitude to a higher presence, and re-interpreting situations through a benevolent spiritual lens. These findings suggest that the sacred holds a distinct and compelling role in resilience.

More recently, findings across cultures have supported the ubiquitous nature of sacred perceptions. In a sample of Brazilian outpatients with bipolar disorder, higher levels of engagement with religious resources predicted better quality of life two years later (Stroppa, Colugnati, Koenig, & Moreira-Almeida, 2018). This effect was consistent across physical, mental, social, and environmental domains of life. In a sample of Asian American older adults, Lee (2007) observed associations between religious resources and life satisfaction. A survey of Swiss churchgoers revealed significant links between stress-related growth and the use of religious resources (Winter, Hauri, Huber, Jenewein, Schnyder, & Kraemer, 2009). In their cross-cultural review of religious coping research, Abu-Raiya and Pargament (2015) concluded that patterns of prevalence and correlates were strikingly similar across major religious traditions, with wellbeing linked positively to religious resources and negatively to spiritual struggles. These diverse studies affirm the central role of the sacred in the lives of people worldwide.

Why does the sacred draw so many to its shores, especially when under duress? This is perhaps due to its very nature. In his theory of religious coping, Pargament (1997) posited that the sacred offers a direct response to human frailty and finitude. People turn to the sacred for solace or unique solutions to life problems when pushed beyond their worldly resources. When one’s connection is healthy, the sacred delivers a deep wellspring of sustenance. Furthermore, Pargament, Wong, and Exline (2016) have postulated that the sacred is an essential ingredient of eudaimonic wellbeing and wholeness, functioning as a higher order organizing force that lends cohesion, purpose, depth, breadth, and flexibility to one’s search for significance.

However, when one’s connection to the sacred is broken or unhealthy, people can encounter unique distress that leads to negative outcomes throughout the lifespan. Spiritual struggles, previously termed as negative religious coping, refer to tensions, conflict, or strain in relating to the sacred (Pargament, 1997; 2007; Exline, 2013). Given the salience of the sacred in the lives of many people, threats, challenges, and struggles in this realm may be particularly problematic. For example, in a nationally representative cross-sectional study on American adults, spiritual struggles predicted unique variance across indicators of wellbeing and psychological distress, even after controlling for potentially confounding secular variables such as neuroticism and social isolation (Abu-Raiya, Pargament, Krause, & Ironson, 2015). Struggles with the sacred contributed to higher levels of depression and anxiety, as well as lower levels of happiness and life satisfaction. Those who wrestle with sacred matters may experience a distinctive form of distress due to the profound nature and core relevance of these questions, doubts, and tensions.

Powerful as spiritual struggles may be, more often than not people benefit from sacred perceptions. Across studies on religious coping, Pargament (1997) observed that the prevalence of religious resources is reliably higher than spiritual struggles, although neither struggles nor resources are uncommon. Thus it is critical to assess the natureof one’s relationship with the sacred in order to predict one’s trajectory following adversity. In doing so, targeted interventions to build spiritual resilience and decrease spiritual risk factors can be applied at different points throughout adulthood and aging. To better frame these methods of coping and relating to the sacred, we provide some background on religious resources and spiritual struggles.

**Religious Resources**

In 1997, Pargament introduced a framework for organizing the concept of positive and negative religious coping with major life stressors. Positive religious coping methods or religious resources encompass ways of responding to life events that reflect a healthy connection with the sacred. Such responses may involve benevolent religious appraisals, a collaborative approach with the divine to solve problems, and searching for spiritual connectedness with others. Others may summon the sacred to engender feelings of forgiveness, purification, gratitude, or purpose. Joining forces with the sacred to cope with life’s problems can help people conserve their beliefs in a higher power, surrender control over the uncontrollable, and draw meaning from stressful circumstances (Pargament, 2007). This profound trust in the divine is exemplified by a community-dwelling octogenarian woman (Manning, 2013, p. 6):

It’s like this: You’re more confident in whatever happens. I know I’ll get through it. I always have. I don’t know what it will be, and I’ll be okay. I have confidence in what I call God. So, whatever happens, there is a plan. ...I trust in the process and I trust in God to help me overcome whatever I need to. ...I’ve had many chances to practice overcoming hardship, and I get better at it each time.

This quote demonstrates a secure, enduring connection with the sacred, which proves to be a protective factor when dealing with accumulated hardships over time. Research has demonstrated that an integrated religion and spirituality are associated with decreased levels of depression (Ronneberg, Miller, Dugan, & Porell, 2016), anxiety (MacKinlay & Burns, 2017), and chronic pain (Wachholtz, Pearce, & Koenig, 2007). In addition, engaging with the sacred predicts greater posttraumatic growth (Prati & Pietrantoni, 2009), happiness (Martinez & Scott, 2014), wellbeing (Yonker, Schnabelrauch, & Dehaan, 2012), life satisfaction (Doolittle, Courtney, & Jasien, 2015), and mental and physical health (Koenig, 2015). Furthermore, in a meta-analysis of 49 studies, Ano and Vasconcelles (2005) concluded that religious resources were linked to better psychological adjustment to stress. Thus, a healthy relationship with the sacred appears to be a protective feature for life’s turbulence. There are times, however, when this relationship can be threatened.

**Spiritual Struggles**

As mentioned previously, spiritual struggles refer to tensions, conflict, and strain related to the sacred. It is meaningful to speak of spiritual struggles in both the singular and plural. After a decade of research, six types of spiritual struggles have been clarified, each possessing discriminant validity: divine, supernatural evil, moral, ultimate meaning, doubt, and interpersonal (Exline, 2013). Furthermore, in 2014, Exline, Pargament, Grubbs, and Yali developed the Religious and Spiritual Struggles Scale, confirming a six-factor model that is being increasingly used to examine the phenomenon. Divine struggles are characterized by negative feelings towards the sacred, such as expressions of anger or disappointment towards God as well as feelings of abandonment, alienation, and punishment by the divine. Another type of struggle with the supernatural involves feelings of being tormented, attacked, or tempted by evil spirits or demonic forces. Moving into the intrapersonal domain, moral struggles involve wrestling with one’s perceived wrongdoings, desires, and moral or religious standards. Feelings of guilt and worry are commonly encountered in the moral struggle domain. Struggles of ultimate meaning relate to existential concerns and the challenge of finding a deeper purpose in life. Doubt is the experience of questioning, confusion, and instability in one’s beliefs about the sacred or larger religious institutions. Lastly, interpersonal struggles refer to negative encounters with individuals when sacred matters are raised. Practically speaking, people can and do experience various configurations of spiritual struggles concurrently (Exline, 2013). Yet Stauner et al. (2016) also demonstrated the viability of examining struggles as a unidimensional factor.

Broadly, spiritual struggles predict myriad indicators of maladjustment and poor health. In longitudinal and cross-sectional studies, higher levels of spiritual struggles have been tied to greater depressive symptoms (Abu-Raiya et al., 2015; Exline et al., 2014; Henslee et al., 2015; Park, Holt, Le, Christie, & Williams, 2017), anxiety (Abu-Raiya et al., 2015; Exline et al., 2014), stress (Henslee et al., 2015), negative affect (Park et al., 2017), less happiness (Abu-Raiya et al., 2015), lower satisfaction with life (Abu-Raiya et al., 2015) lower quality of life (Henslee et al., 2015), mortality (Pargament, Koenig, & Tarakeshwar, 2001), and poorer physical health (Krause, Pargament, & Ironson, 2017). In the same meta-analysis reviewing 49 studies by Ano and Vasconcelles (2005), spiritual struggles in coping were significantly related to poorer psychological adjustment to stress.

Despite these unwanted outcomes, spiritual struggles should not be confused with signs of weak faith or pathology. Consider the divine struggles of Mother Teresa featured in her letters (Teresa & Kolodiejchuk, 2007, p. 210): “I just long and long for God—and then it is that I feel—He does not want me—He is not there. …The torture and pain I can’t explain.” Quite the contrary, they can represent a turning point or transitory state. When successfully worked through, spiritual struggles can result in positive outcomes, such as spiritual- and stress-related growth (Cole, Hopkins, Tisak, Steel, & Carr, 2007; Desai & Pargament, 2015; Exline, Hall, Pargament, & Harriott, 2017; Pargament, Desai & McConnell, 2006). On the other hand, when people “get stuck” in their struggles, they may be at greater risk for problems (Pargament, Koenig, Tarakeshwar, & Hahn, 2004).

**Resiliency And Religion**

Most people experience the sacred as a source of strength and struggle during their lives and, at times, these processes occur simultaneously. The following review explores some of these religious resilience factors and their outcomes in adulthood (ages 18-65 years) an in older adulthood (65 years and older).

**Resiliency in Adulthood**

Adulthood is a tenuous time filled with a multitude of transitions and personal discoveries, and the exploration and deepening of beliefs and behaviors. This phase of life can be filled with monumental growth while also presenting great risk. A large fund of data regarding the role of religious coping highlights both ends of this spectrum.

***Religious Resources in Adulthood***

Few people survive adulthood untouched by distressing or traumatic events, whether in the form of community violence, car accidents, natural disasters, unexpected losses, or life-threatening illness. Sometimes, stressors are more enduring, as in the case of chronic illness, partner abuse, and discrimination. Fortunately, many individuals are able to recover and flourish in spite of such experiences (Bonanno, 2004). In pain and brokenness, people often stumble upon sacred pathways to wholeness. This notion is reflected in a line of poetry by the Sufi mystic Rumi, “The wound is the place where the Light enters you.” Sacred pathways take the form of various religious resources used in coping with hardship.

One major finding recapitulated in the literature is the link between religious attendance and lower mortality. Hummer, Ellison, Rogers, Moulton, and Romero (2004) verified this association in their review of several high quality, population-based studies emerging from disciplines such as medicine, public health, and the social sciences. Such studies also controlled for demographic variables. Across the board, religious attendance has been reliably correlated with lower mortality risk in the U.S. (Hummer et al., 2004). Further substantiation of this finding is seen in the association between religious attendance and leukocyte telomere length, a biological marker of cellular aging (Hill, Ellison, Burdette, Taylor, & Friedman, 2016). That is, longer telomeres indicate longer life. Engaging with institutions that center upon the sacred seems to have a dose effect, extending the lives of people who participate more often at religious services.

Another well-studied topic is the role of religious coping in post-traumatic growth. In 2009, Prati and Pietrantoni conducted a meta-analysis of 103 studies to identify factors predicting posttraumatic growth in adults. Religious resources yielded one of the largest effect sizes in comparison to secular strategies that included acceptance, optimism, social support, and positive reappraisal. Of note, favorable effects of the sacred were stronger for women and those who were older (Prati & Pietrantoni, 2009). Findings from this meta-analysis bolster the role of the sacred in resilience and underscore the heightened importance of the sacred for disadvantaged and vulnerable populations.

Indeed there is variance in the use of religious coping by demographic variables. Generally, religious coping is more frequent among females, older, black, and married people (Ferraro and Koch, 1994). Additionally, prayer is more frequent in African-Americans than Caucasians, as well as in those who are less educated (Bearon & Koenig, 1990) and have lower incomes (Poloma & Gallup, 1991). Even by country, the poorest nations tend to be most religious (Crabtree, 2010). The countries with the largest proportion of adults endorsing the importance of religion were Bangladesh, Niger, and Yemen, and each had an average per-capita income of less than $2000 (Gallup, 2010). It seems reasonable that those who face greater odds would draw upon the sacred when other options are limited or appear bleak.

In recent years, the protective potential of the sacred has been explored in minorities. For example, the benefits of religious resources were investigated in a large sample of African American adults (Park et al., 2017). Those utilizing more religious resources reported greater wellbeing two and a half years later. Specifically, participants endorsed fewer depressive symptoms and more positive affect, self-esteem, and meaning in life. In another study, Brewster et al. (2016) examined the role of religious resources in sexual minority individuals. The majority of their sample identified as lesbian, gay, or bisexual. Notably, the link between internalized heterosexism and psychological wellbeing was moderated by the use of religious resources, such that those who engaged more with the sacred were less likely to be affected by the homophobic beliefs that they had internalized (Brewster et al., 2016). Stated otherwise, the sacred acted as a buffer against self-stigma for being a sexual minority. In both studies discussed (i.e., Brewster et al, 2016; Park et al., 2017), the authors used the Brief Measure of Religious Coping Styles (Pargament, Feuille, & Burdzy, 2011) to assess participants’ level of engagement with the sacred. Items for religious resources included seeking divine support (e.g., “I sought God’s love and care”) and collaborative problem solving with God (e.g., “I tried to put my plans into action together with God”). It appears the sacred is a vital ingredient for wellbeing, particularly for individuals who identify with marginalized identities.

Immigrants represent another kind of vulnerable population that may face issues related to discrimination and acculturation to their country of reception. One cross-sectional study examined the role of the sacred in Latino immigrants in coping with acculturative stress related to settling in the U.S. (Sanchez, Dillon, Concha, & De La Rosa, 2015). All of the participants had emigrated within the past two years. They responded to questions about religious coping, acculturative stress, and problematic alcohol use. Contrary to the researchers’ hypothesis, religious resources failed to moderate the association between acculturative stress and harmful drinking behavior. That is, Latino immigrants who frequently drew upon the sacred while enduring acculturative stress were no more likely to refrain from problematic drinking than those who did not. In addition, the use of religious resources was positively correlated with acculturative stress and spiritual struggles. How do we make sense of these seemingly incongruous findings?

The stress mobilization hypothesis is relevant when interpreting results from cross-sectional studies on religious coping (Pargament, 1997). Religious resources have occasionally been found to predict undesirable outcomes or null effects. Known as the *stress-mobilization hypothesis*, Pargament (1997) posited that distress itself mobilizes the use of religious resources and other means of coping. Consequently, a positive or non-significant association between negative outcomes and religious resources can be explained by the mobilizing effects of the stressor, which offsets the benefits of religious resources when examined cross-sectionally. Support for this hypothesis is found in longitudinal studies on the healthful effects of religious resources (Pargament, 1997). In the sample of Latino immigrants surveyed by Sanchez et al. (2015), acculturative stress triggered both adaptive and maladaptive ways of spiritual coping, resulting in a null finding regarding the role of religious resources.  
 Nonetheless, at a phenomenological level, people report finding comfort, strength, and inspiration in the sacred. The value of religious resources in coping with chronic disease is supported in several qualitative studies (e.g., Alcorn et al., 2010; Rafferty, Billig, & Mosack, 2014; Ridgeway et al., 2014; Unantenne, Warren, Canaway, & Manderson, 2013). Consider the power of active spiritual surrender in an Australian interviewee with type 2 diabetes (Unantenne et al., 2013, p. 1154):

You’ve got your toes rotting away...then finally comes the day and [doctor] says “oh, we do [the amputation] tomorrow.” And then you sit in bed [and think]: “well that’s the last day that I walk to the toilet...It’s the last time I scratch my leg” ...then you go into a sort of prayer or meditation... and you hand it over. ...You can call it Allah. You can call it Buddha. You just hand it over. And you have that relief... All these voices in your head stop. It’s a real relief! ... You don’t have the fear anymore.

Overall, these studies support the notion that an integrated connection with the sacred provides people with powerful resources that can facilitate positive emotions, relief, meaning making, post-traumatic growth, and longevity. The sacred dimension is wholly relevant to resilience. However, it is important to explore how other religious coping methods can hinder one’s growth and grounding during stressful life experiences.

***Spiritual Struggles in Adulthood***

Spiritual struggles in adulthood are natural. In a large national sample, the prevalence of spiritual struggles was highest in younger adulthood compared with older and middle adulthood (Krause, Pargament, Hill, Wong, & Ironson, 2017). Specifically, those between the ages of 18 and 40 were more likely to report having difficulties with the sacred (Krause et al., 2017). The widespread experience of spiritual struggles is also found in college students. Nearly half of the 5472 students surveyed across higher education institutions in the U.S. endorsed some degree of distress related to spiritual concerns (Johnson & Hayes, 2003). Perhaps surprisingly, non-believers are not immune to spiritual struggles. Exline, Park, Smyth, and Carey (2011) found that some atheist and agnostic individuals reported feelings of anger toward God when recalling past adverse events. Such individuals were also able to summon anger at a hypothetical God (Exline et al., 2011). As such, the occurrence of spiritual struggles has been supported across the spectrum of belief and non-belief.

Many studies have underscored the prevalence and potency of longstanding spiritual struggles in adulthood. Left unaddressed, spiritual struggles are predictive of poorer psychological adjustment. Severe levels of pathological indicators have been found in those experiencing spiritual struggles. In a cross-sectional national study of people with and without a personal illness, spiritual struggles predicted greater levels of phobic anxiety, depression, paranoid ideation, hostility, obsessive-compulsiveness, and somatization even after controlling for demographic and religious variables (McConnell, Pargament, Ellison & Flannelly, 2006). These findings are corroborated by longitudinal research. For example, spiritual struggles predicted poorer mental health and quality of life in a sample of Brazilian adult outpatients with bipolar disorder, who were tracked over two years (Stroppa et al., 2018). Those who had spiritual struggles were also more likely to experience manic symptoms two years later, which may be interpreted as difficulties with mood stabilization (Stroppa et al., 2018). Similarly, Park et al. (2017) observed the negative impact of spiritual struggles in a non-clinical sample of African American adults surveyed via telephone. Those reporting greater spiritual struggles had more depressive symptoms, negative affect, lower self-esteem, and less meaning in life at follow up, which occurred two and a half years later (Park et al., 2017). The detrimental effects of spiritual struggles on psychological health are clear.

Moreover, spiritual struggles play an influential role in coping with traumatic experiences. Gerber, Boals, and Schuettler (2011) examined the link between spiritual struggles in coping with trauma in a large cross-sectional sample of college students. After controlling for secular coping methods and demographic variables, spiritual struggles in coping predicted greater post-traumatic stress symptoms. In other words, struggling with the sacred was associated with more trauma-related intrusions, avoidance, and hyper-arousal. Furthermore, Wortmann, Park, and Edmonson (2011) observed that divine struggles partially mediated the association between trauma and post-traumatic stress symptoms at follow-up months later. Those who were dissatisfied with God, reappraised God’s powers, and believed God to be punishing them as a result of the trauma were more likely to suffer psychologically (Wortmann et al., 2011). A third study explored the role of spiritual struggles in a sample of outpatient veterans (Raines et al., 2017). Two types of spiritual struggles, divine and ultimate meaning, predicted greater suicidality in veterans with posttraumatic stress disorder and/or substance use problems (Raines et al., 2017). Thus the unique and harmful role of spiritual struggles in coping with adverse life events is supported.

Given the distress brought by spiritual struggles, it may be tempting for individuals to suppress, compartmentalize, or otherwise avoid them. The term *spiritual bypass* is used to describe a person’s maladaptive efforts to use the sacred for the purposes of evading psychological discomfort (Whitfield, 2003). Such attempts are costly over the long run. Oemig-Dworsky, Pargament, Wong, and Exline (2016) investigated avoidance in a cross-sectional online sample of adults who were experiencing spiritual struggles. Avoiding spiritual struggles exacerbated the link between spiritual struggles and poorer mental health. That is, struggle-specific avoidance predicted higher levels of anxiety, depression, somatic symptoms, functional difficulty, goal difficulties, impulse difficulties, and difficulties with emotion regulation (Oemig-Dworsky et al., 2016). As such, spiritual strugglers would benefit from heeding the words of Cashwell, Bentley, and Yarborough (2007, p. 139) who stated in their discussion of spiritual bypass, “The only way out is through.”

**Resiliency in Later Years**

As the “Baby Boomer” generation enters older adulthood, there are important insights to be gained about their experiences and sources of resiliency. This sizeable cohort persevered through the Cold War (1947-1991), the Civil Rights movement (1954-1968), the Vietnam War (1955-1975), the Watergate scandal (1972), the Iranian hostage crisis (1979-1981), the height of the 1980’s HIV/AIDS crisis, the Persian Gulf War (1990-1991), the 9/11 terrorist attacks (2001), the Iraq War (2003-2011), and the ongoing War in Afghanistan. They also navigated their families through the economic recession from 2007-2009. Today, they are witnessing increasing political polarization, their children’s generation reeling from terrorist attacks, and their grandchildren contending with issues of climate change and gun violence.

***Religious Resources of Older Adults***

Older adults are the likeliest group to cultivate an integrated spirituality. According to the Pew Research Center’s (2015) national religious landscape survey, 70% of older adults reported believing in God with absolute certainty. Those who were 65 years and older also endorsed greater importance of religion, attendance at religious services, frequency of prayer and meditation, and feelings of spiritual peace and wellbeing compared with other age groups. In a multi-generational longitudinal study spanning 35 years, greater age was related to more self-reported religiosity and stronger religious beliefs across cohorts from the World War I era, the Depression, Baby Boomers, and Generation Xers and Millennials (Bengtson et al., 2015). Next, the religious trajectories of Baby Boomers were observed using mixed-methods as they aged from their 50’s to 60’s (Silverstein & Bengtson, 2018). The majority of participants maintained their level of religiosity and over one in five grew more religious over that decade. When asked what influenced their trajectories, typical responses from Baby Boomers included a loss of interest in worldly matters and the experience of a significant loss or adverse life event. Economic decline was also a chief contributor to increases in religiosity. Of note, the most cited reason for religiosity was the desire to connect with the sacred or a Higher Power (Silverstein and Bengtson, 2018). These findings align with those of Hayward and Krause (2016), who found that older adults drew upon religious resources at relatively high levels over the span of eleven years. Taken together, the sacred is likely a formidable resource as people transition into older adulthood.

Cognitive decline is an inevitable part of aging, but empirical evidence suggests that older adults may draw upon the sacred to slow such processes. Broadly speaking, cognitive decline impedes people’s capacity to think, function independently, and adapt to the environment (Plassman, Williams, Burke, Holsinger, & Benjamin, 2010). Yet many older adults engage with religion to their cognitive and spiritual benefit. In one study, Kaufman, Anaki, Binns, and Freedman (2007) tracked 70 patients with signs of Alzheimer’s disease over the course of three years. Remarkably, self-reported spirituality and engagement in religious practices predicted a slower rate of cognitive decline, accounting for approximately 17% of the variance after controlling for demographic variables (Kaufman et al., 2007). The authors concluded that engaging with the sacred appears to delay the progression of Alzheimer’s disease. Addressing the role of religious coping with dementia in older adulthood, Agli, Bailly, and Ferrand (2014) systematically reviewed 11 quantitative articles. Their findings recapitulated that individuals who actively integrate their spirituality benefited from less cognitive decline. In addition, it was noted that religion facilitated the use of healthy coping strategies in eight studies (Agli et al., 2014). The authors summarized the benefits of the sacred in late life, mentioning outcomes such as higher levels of meaning making, self-transcendence, positive attitudes, and interconnectedness.

The central role of the sacred is further elucidated in studies on HIV-positive older adults, a historically marginalized population. Those with HIV often bear psychological wounds from the stigma of the illness (Porter, Brennan-Ing, Burr, Dugan, & Karpiak, 2017). However, spirituality significantly mediated the negative association between HIV stigma and mental health in a cross-sectional sample of 914 older adults diagnosed with the illness (Porter et al., 2017). Using structural equation modeling, the authors demonstrated how aspects of a patient’s spirituality facilitated a greater sense of mastery, autonomy, purpose in life, positive relations, self-acceptance, and personal growth in spite of HIV stigma (Porter et al., 2017). Moreover, Emlet and colleagues (2018, p. 264) uncovered the theme of “HIV as a spiritual journey” in their interviews with older adults who self-identified as successfully aging with HIV. These participants commonly marked points of spiritual struggle, resolution, and transformation in relating to the sacred. For example, many interviewees recounted the pain of being rejected by organized religion for their sexual identity (Emlet et al., 2018). Yet they also described revitalizing their sacred connection through various processes, including cultivating a personal relationship with the divine, engaging in choir and music, sanctifying nature, and finding a more accepting religious community.

More evidence for the utility of religious resources comes from studies on older adults with cancer, which is another common, protracted source of stress in late life. Research has demonstrated lower levels of depressive symptoms and suicidal ideation in more religious older Muslim patients with colorectal cancer in Saudi Arabia (Shaheen et al., 2016), in addition to greater satisfaction, less conflict, and less difficulty related to treatment decision-making in more spiritual older men with prostate cancer in the U.S. (Mollica, Underwood, Homish, Homish, & Orom, 2016). The former study utilized the Muslim Religiosity Scale (Koenig et al., 2014) to assess people’s level of engagement in worship, prayer, almsgiving, reading the Qur’an, experiencing Allah’s presence, and the centrality of Islam to their life. The latter study measured spirituality with the Functional Assessment of Chronic Illness Therapy—Spiritual Wellbeing Scale (FACIT-Sp; Peterman, Fitchett, Brady, Hernandez, & Cella, 2002), which evaluates the degree to which people draw strength, comfort, meaning, and transcendence from spirituality during sickness. In a meta-analysis on cancer patients that included 101 independent samples, spirituality was positively tied to better physical health and functional wellbeing (Jim et al., 2015). The authors adopted a broad conceptualization of spirituality, including the subdimensions of spiritual wellbeing and use of religious resources in coping. Thus the prominence of the sacred dimension and its benefits for wellbeing are supported in studies of those successfully coping with chronic diseases in later life.

Women in later life are another group for whom the sacred plays a valuable role. For example, Manning (2014) interviewed six women who were 80 years or older and noted the ways in which the sacred has sustained them through extreme adversity. Consider the following experience of one older woman (Manning, 2014, p. 357-358):

I’ve watched loved ones die and nursed them in their sickness. That is hard and it takes strength. I am able to do that because of God. He helps me handle what at times I think I cannot deal with...I’m on my knees every Sunday morning. ...The reminder that there is something greater than myself, something that I can be a part of that’s greater and better than myself. This gives me strength.

In the example above, we see the sacred resources of divine support, acceptance of human limitations, transcendence, and ultimacy utilized to build resiliency during and after each loss in the woman’s life. Furthermore, Vahia et al. (2011) found that spirituality was linked to greater resilience in a large cross-sectional sample of community-dwelling older women. Other correlates of spirituality included lower income, lower education, and unmarried status. These findings echo the theme of the sacred being especially important for those who have the least. In another qualitative study on rural women living in poverty or near poverty, it was found that an integrated spirituality predicted wellness throughout adulthood, extending well into later adulthood (Gill, Barrio Minton, & Myers, 2015). Again the sacred is seen to be of relevance for older women, especially those with fewer social and financial resources.

Finally, when disaster strikes, older adults can rely on their sacred connection for grounding and guidance. In 2005, Hurricane Katrina wreaked havoc in the lives of those in New Orleans and surrounding areas. For older adults who survived the event, many described constantly engaging with the divine during the crisis (Lawson & Thomas, 2007). A substantial proportion of older adults also drew inspiration from the sacred to help others in the midst of their own uncertain fate, shifting their priorities to providing aid. One interviewee cited his spiritual philosophy as the motivating force behind his distributing food and clothing to other survivors, stating, “Giving to others and helping those is in need is how God blesses you” (Lawson & Thomas, p. 348).

It seems that many older adults who find themselves in unstable or dangerous situations are able to draw from religious resources, bolster their wellbeing, and direct their behaviors towards the welfare of others. Whether facing acute stressors or bearing chronic strife, the relevance of the sacred in the lives of older adults has been reinforced by scientific literature.

***Spiritual Struggles in Older Adults***

Spiritual struggles are less prevalent in old age. Krause et al. (2017) noted that individuals age 65 and over reported fewer spiritual struggles compared to younger adults (i.e., those under the age of 40). On the other hand, older adults who do experience spiritual struggles are at greatest risk for poor health, physical illness, chronic conditions, and functional disability (Krause et al., 2017). It is not surprising that the role of spiritual struggles is augmented in the elderly, given increased global health vulnerabilities related to old age.

One cross-sectional study explored spiritual struggles in a sample of 603 older adults with late-stage cancer (Trevino, Balboni, Zollfrank, Balboni, & Prigerson, 2014). All participants had fewer than six months to live as determined by their healthcare team. Spiritual struggles predicted suicidality after controlling for demographic factors, cancer characteristics (e.g., number of physical symptoms, pain management, physical quality of life), and other risk and protective factors related to suicidal ideation (e.g., social support, support by one’s religious community, secular coping methods). Thus spiritual struggles appear to function as a unique risk factor, signaling poorer mental health in older adults during their final days.

The real danger of a fractured relationship with the sacred is captured in a study by Pargament, Koenig, Tarakeshwar, and Hahn (2004). The researchers measured spiritual struggles in a sample of medically ill elderly patients at a hospital over two years. Spiritual struggles predicted greater mortality risk longitudinally, after controlling for demographic and health variables at baseline (Pargament et al., 2004). Those who endorsed feelings of being unloved by and alienated from God (“Questioned God’s love for me,” “Wondered whether God had abandoned me”), or felt that the devil was involved in their illness (“Decided the devil made this happen”) were 20-30% more likely to die over the 2-year period. As such, the experience of strain with the sacred may prove fatal in sick older adults.

Overall, spiritual struggles have predicted mortality, poorer quality of life, functional decline, and depressive symptoms longitudinally in older adults (Pargament et al., 2004), as well as suicidality (Trevino et al., 2014) and poorer physical health (Krause et al., 2017) in cross-sectional studies. Thus the importance of addressing spiritual struggles in healthcare cannot be understated.

**Practical Applications**

As outlined above, research has supported that religion and spirituality serve distinct functions in strengthening people. However, as we have noted, spiritual struggles can impede resiliency. We, therefore, argue that it is critical to understand the *nature* of one’s spirituality so that interventions can specifically target spiritual mechanisms for growth and attend to hidden risk factors.

**Adulthood**

To implement spiritually integrated healthcare, we first encourage providers to utilize spiritual assessments. Spiritual assessments involve both implicit and explicit questions about the relevance of the sacred in people’s lives, particularly during times of hardship. Consider the sets of questions provided by Pargament (2007) that may help illuminate areas of struggle and resources for coping. One could ask (Pargament, 2007, p. 226), “To what degree has your spirituality been a source of pain?” Alternatively, practitioners can apply instruments such as the Multidimensional Measure of Religiousness and Spirituality (Fetzer Institute, 1999), a compilation by multiple experts for use in health research. Moreover, Hodge (2005) introduced various pictorial methods of assessment such as the spiritual lifemap, spiritual genogram, and spiritual ecomap (Hodge, 2005). Diverse types of spiritual assessments are available for eliciting the client’s whole story, identifying problematic spiritual pathways and destinations.

Numerous effective treatments have populated the literature. For instance, spiritually integrated interventions have resulted in decreased depressive symptoms, greater use of religious resources, fewer spiritual struggles, and lowered cortisol levels in adults with HIV (Tarakeshwar, Pearce, & Sikkema, 2005; Bormann, Aschbacher, Wetherell, Roesch, & Redwine, 2009). An intervention for people with moral spiritual struggles resulted in greater spiritual development, more engagement in virtues, lowered stress, and decreased engagement in vices (Ano, Pargament, Wong, & Pomerleau, 2017). In *Solace for the Soul*, an intervention for survivors of sexual abuse, participants reported improved spiritual wellbeing and use of religious resources (Murray-Swank & Pargament, 2005). Furthermore, meta-analyses and systematic reviews of spiritually integrated interventions have consistently supported their efficacy and ability to outperform, or at least perform equally as well as secular interventions on treatment outcomes (Anderson et al., 2015; Candy et al., 2012; Holloway, Adamson, McSherry, Swinton, 2009; Gonçalves, Lucchetti, Menezes, & Vallada 2015; Hulett & Armer, 2016; Oh & Kim, 2014). However, larger scale randomized controlled trials of spiritually integrated interventions remain necessary to unequivocally establish the benefits of addressing the sacred. Nonetheless, the data widely suggest that spiritual interventions can have far-reaching and potent implications for adults.

Accordingly, it is essential for providers to develop spiritual competence. One aspect of spiritual competence involves gaining basic knowledge about the beliefs, practices, and sources of authority for major world religions (Oxhandler & Pargament, 2017; Vieten et al., 2016). Another component of competence involves building spiritual self-awareness. We encourage practitioners to reflect upon natural biases related to certain types of spiritual expression. Awareness of one’s ‘blind spots’ allows for clinicians to continuously revisit these areas and actively shape their orientation into one that is effective rather than exclusive, over-inclusive, or rejectionist (Pargament, 2007). Training in the area of spiritual competence is highly encouraged.

**Older Years**

The role of the sacred is amplified in later life. When presented with concerns about the afterlife, existence, and meaning, it is especially important for health providers to normalize spiritual struggles and refrain from proselytizing. Instead, older adults would benefit from review and exploration of religious resources. They can also be encouraged to develop new ways of relating to the sacred when past methods are no longer viable. There are several promising spiritually integrated interventions for older adults in this regard.

In the *Hear My Voice* program, Piderman et al. (2017) examined the feasibility and impact of a spiritual legacy intervention in older adults with brain cancers and other neurologic illnesses. Trained chaplains conducted a review of each participant’s spiritual life. The older adults answered questions about their spiritual beliefs, community, activities, changes, and challenges throughout the years. They were also given the opportunity to communicate with their loved ones through their spiritual legacy and to provide spiritual guidance or wisdom in light of their experiences. Next, the chaplains organized each person’s responses into themes and helped create a spiritual legacy document. The majority of patients and their support persons reported greater feelings of peacefulness and use of religious resources at one- and three-month follow up. Moreover, nearly 90% of older adults persisted in developing and reviewing their spiritual legacy (Piderman et al., 2017). Such interventions appear to be feasible and beneficial, particularly in collaboration with allied health professionals and pastoral care.

In a brief spiritual intervention involving engaging with the sacred through different forms of prayer, older adult with depressive symptoms reported lowered anxiety following participation (Rajagopal, MacKenzie, Bailey, & Lavizzo-Mourey, 2002). Similarly, Berning and colleagues (2016) explored a chaplain-guided spiritually integrated intervention for adults and older adults who were mechanically ventilated in the intensive care unit. The researchers utilized spiritual picture cards for patients to communicate their religious affiliation, emotion, and spiritual pain. Patients were also offered a selection of spiritual care options. Examples included a blessing, reading from a sacred text, chanting, meditation, sitting with them, and speaking to them. Overall, participants’ anxiety and stress decreased following the intervention (Berning et al., 2016). Whether older adults are critically ill or feeling low, the validation of spiritual pain and connecting with the sacred seems to bring comfort.

Our collective vision of spiritually integrated healthcare across the lifespan is bound only by creativity and resources. One potential avenue for interventions with older adults is pairing music with the sacred. Given increasing age-related difficulties with reading and memory, connecting with the sacred through music seems favorable. In fact, at three-year follow up, listening to gospel music modestly predicted decreases in death anxiety and increases in a sense of control in a sample of community-dwelling older adults (Bradshaw, Ellison, Fang, & Mueller, 2015). Sacred recollections and spiritual emotions may be readily facilitated through music. Empirical research on *sacred moments* suggeststhat many people can vividly recall important periods of time in which they experienced the qualities of transcendence, boundlessness, ultimacy, and deep interconnectedness (Pargament, Lomax, McGee, & Fang, 2014). Findings on sacred moments have supported their relevance to therapeutic gains, motivation, and meaning in samples of mental health providers, mental health patients, nurses in psychiatric units, and family caregivers of older adults with dementia (Alvarado, 2016; Pargament et al., 2014; Wong & Pargament, 2018).

**Conclusion**

Although theory and research on resilience has risen dramatically over the last 25 years, the sacred dimension of resilience has been relatively overlooked. In this chapter, we have surveyed a growing body of literature that supports the unique and critical resources offered by religion and spirituality to people coping with the challenges and crises of life. Conversely, religion and spirituality can also contribute to distress when people encounter struggles in their relationship with the sacred. The findings from this literature underscore the importance of a more spiritually integrated approach to health care. To date, numerous empirical studies and systematic reviews of spiritually integrated interventions have shown promising results. However, this work is in its early stages of development and additional studies are needed. Treatments that focus on promoting the use of religious resources and helping individuals work through their spiritual struggles are an important future direction. Addressing spiritual competence in the training of healthcare providers is another significant priority. By helping people draw upon the sacred for resilience, practitioners and researchers can contribute to a more holistic approach to building resources amidst adversity in adulthood and aging.

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