HANDBOOK OF THE PSYCHOLOGY OF RELIGION AND SPIRITUALITY

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The Religious Dimension of Coping

Advances in Theory, Research, and Practice

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Each time I knew everything would be all right because I asked God to carry me through—I know that He's got his arms around me.

—KIDNEY DIALYSIS PATIENT following several cardiac arrests and surgeries (in O'Brien, 1982, p. 76)

A year ago this week, Satan drove up 5th Street in a Ryder truck. He blew my babies up. He may have looked like a normal man, but he was Satan.

—GRANDFATHER OF TWO CHILDREN killed in the Oklahoma City bombing (in *Newsweek*, 1996, p. 19)

I am told God lives in me—and yet the reality of darkness and coldness and emptiness is so great that nothing touches my soul.

—MOTHER TERESA (in *Newsweek*, 2001, p. 23)

Major life events touch people spiritually as well as emotionally, socially, and physically. Crises can be viewed through a spiritual lens as threats, challenges, losses, or opportunities for the growth of whatever the individual may hold sacred. In coming to terms with trauma and tragedy, people can draw on a number of resources that have been prescribed by the religions of the world for thousands of years. Yet it is also true that religion can be a burden and a source of struggle for people facing difficult life situations, adding another dimension to the pain and hardship of coping.

Perhaps, then, it should come as no surprise that where we find crisis and tragedy, we often find religion. "In times of crisis," psychologist Paul Johnson (1959, p. 82) wrote, "religion usually comes to the foreground." For example, in a survey of a national

sample of Americans shortly after the 9/11 attacks, Schuster et al. (2001) found that 90% reportedly turned to their religion for solace and support. As singular an event as 9/11 was, it was not unusual in a religious sense. Other groups experiencing traumatic life events also frequently draw upon their religion to cope. Segall and Wykle (1988–1989) asked black primary caregivers of family members with dementia to identify the one special way they dealt with caring for their relative. Prayer or faith in God were, by far, the most common responses. Among hospitalized and long-term care patients, 86% reported using religious activities to cope with their problems (Ayele, Mulligan, Gheorghui, & Reyes-Ortiz, 1999). Bulman and Wortman (1977) asked a group of people paralyzed in severe accidents how they explained their misfortune. The most common response to the question "Why me?" was that God had a reason.

Historically, researchers and theorists have neglected the role of religion in coping or have viewed it from a critical perspective. More recently, however, this picture has begun to change. Over the past two decades, there has been a sharp increase in the number of studies of religion and coping by researchers in the social sciences and health (see Harrison, Koenig, Hays, Eme-Akwari, & Pargament, 2001; Pargament, 1997). Health practitioners have also begun to draw upon religious coping resources in their efforts to ameliorate a variety of problems and conditions. In this chapter, we review the current theoretical and empirical status of the psychology of religion and coping, the practical interventions that have grown out of this body of work, and future directions for research and practice to advance this exciting area of study further.

WHAT WE KNOW ABOUT RELIGION AND COPING

Freud (1927/1961) argued that religion is rooted in the child's sense of helplessness in the face of a world filled with dangerous and uncontrollable forces. By transforming the natural into the supernatural, he maintained, the child is able to defend him- or herself against the threats posed by the external environment. He wrote: "If the elements have passions that rage as they do in our own souls, if death itself is not something spontaneous but the violent act of an evil Will, if everywhere in nature there are Beings around us of a kind that we know in our own society, then we can breathe freely, can feel at home in the uncanny and can deal by psychical means with our senseless anxiety" (p. 20). For Freud, religion was defensive in nature, designed to allay anxiety and avoid the confrontation with reality. This perspective is still widely held within psychology. It is, however, a stereotype, one that oversimplifies religious life and one that is inconsistent with an emerging literature on religion and coping (see Pargament & Park, 1995, for an extensive review).

Religion Is More Than a Defense

Like most stereotypes, there is a grain of truth to the "religion as defense" view. As noted above, many people do, in fact, turn to their faith to reduce their anxiety and to gain solace and support in times of stress. Shrimali and Broota (1987) captured this defensive process at work in their comparative study of Indian patients undergoing major surgery, patients receiving minor surgery, and a control group. Before surgery, the patients facing major surgery reported higher levels of anxiety, superstitious beliefs, and beliefs in God than the other two groups. After surgery, however, the levels of anxiety

and religious beliefs declined significantly among those experiencing the serious procedures, while the levels of anxiety and belief remained constant in the other two groups. It is also the case that religion can help people avoid a direct confrontation with painful situations. The responsibility for problem solving can be deferred passively to God (Pargament, Kennell, Hathaway, Grevengoed, Newan, & Jones, 1988), religious systems of belief can provide justifications for a status quo that perpetuates injustice and inequality, and faith can serve as a cloak for the denial of problems, as we hear in the words of the prison inmate who said: "Since I got Jesus, I don't have no memories of the past" (quoted in Peck, 1988). Nevertheless, while there may be a grain of truth to the notion that religion can serve as a defense, there is little foundation to the idea that religion is *merely* a defense.

In fact, several lines of study suggest that religion is more than defensive in nature. First, religion has been linked theoretically and empirically to a variety of functions in coping that go beyond anxiety reduction, including meaning making (Paloutzian, 1981; Park & Folkman, 1997); intimacy (Johnson & Mullins, 1989); personal mastery, growth, and actualization (Park & Cohen, 1993); and the search for the sacred itself (Pargament, Magyar, & Murray-Swank, 2005). These motivations are not necessarily mutually exclusive; in fact, part of the power of religion lies in its ability to serve a wide variety of needs among its adherents.

Second, empirical studies indicate that religion is not generally linked with the blanket denial of the situation. Most religious traditions provide their members with rites of passage that encourage them to acknowledge and mark difficult life transitions (e.g., funerals) rather than deny their reality. For example, Acklin, Brown, and Mauger (1983) found no relationships between measures of religiousness and denial among patients with cancer. Rather than encouraging denial, religion promotes reinterpretations of negative events through the sacred lens. Thus, a major life crisis can be viewed as an opportunity for spiritual growth, a crisis can be attributed to a loving God who is trying to teach the individual a valuable lesson, and a tragedy can be perceived as part of a larger, mysterious, but ultimately benevolent plan. Certainly, these benevolent views may make the pain of the situation more bearable, but people do not necessarily "shut down" emotionally to reach this point. In this vein, McIntosh, Silver, and Wortman (1993) studied parents of infants who died of sudden infant death syndrome (SIDS). Parents who were more religious found greater meaning in their child's death over time and, in turn, experienced less distress. Interestingly, religious parents engaged in *more* rather than less cognitive processing of the event, suggesting that they were actively working through the experience rather than denying it. Similar results have been reported by people coping with war trauma (Ai, Peterson, & Huang, 2003) and breast cancer (Gall & Cornblat, 2002).

Third, although religion has been accused of passivity in response to critical life events, empirical studies suggest otherwise. For example, various studies have shown that measures of religiousness have been linked more consistently to active coping than to passive coping (see Pargament & Park, 1995, for a review). Furthermore, it is possible to identify active as well as passive forms of religious coping. Pargament et al. (1988) distinguished among three ways in which religion can be involved in the search for control in the problem-solving process: a deferring approach in which the individual relinquishes the responsibility for problem solving to God; a self-directing approach in which the individual perceives God giving him or her the skills and resources to solve problems independently; and a collaborative approach in which the individual perceives God to be a partner who shares in the responsibility for problem solving. This and subsequent studies

revealed that the collaborative problem-solving style was more common than the deferring or self-directing styles.

The idea that religion is merely a defense oversimplifies and stereotypes religious life. Empirical studies of people grappling with life crises reveal a much richer, multidimensional picture of religious coping.

Religion Expresses Itself in Many Ways in Coping

When religion has been examined within the general coping literature, it has usually been assessed by only one or two items. For example, in the widely used Ways of Coping Scale by Lazarus and Folkman (1984), religiousness is measured by two items: "found new faith" and "I prayed." This approach can offer only the smallest window into religious life. Religiousness is neither simple nor uniform. It is instead a complex process consisting of cognitive, behavioral, emotional, interpersonal, and physiological dimensions. Empirical investigations have repeatedly revealed multidimensionality in religious life. For example, in their extensive review of the literature, Hill and Hood (1999) identified 125 measures of religiousness representing 17 different categories (e.g., beliefs, congregational involvement, attitudes, religious orientations).

Religious coping represents a rich phenomenon in and of itself. Although religious coping could be defined and measured in terms of the degree to which religion is a part of the process of understanding and dealing with critical life events, it is important to consider not only *how much* religion is involved in coping, but also *how* religion is involved in coping: specifically, the *who*'s (e.g., clergy, congregation members, God), *what*'s (e.g., prayer, Bible reading, ritual), *when*'s (e.g., acute stressors, chronic stressors), *where*'s (e.g., within a congregation, privately), and *why*'s (e.g., to find meaning, to gain control) of coping.

In perhaps the most comprehensive effort to identify various religious coping methods, Pargament, Koenig, and Perez (2000) developed a measure of 21 types of religious coping activities through interviews and a literature review. The coping methods encompass active, passive, and interactive strategies; emotion-focused and problem-focused approaches; and cognitive, behavioral, interpersonal, and spiritual domains. As can be seen in Table 26.1, the religious coping activities represent five key religious functions: the search for meaning, the search for mastery and control, the search for comfort and closeness to God, the search for intimacy and closeness to God, and the search for a life transformation. As comprehensive as this measure is, though, it still does not capture many of the religious coping methods specific to various religious traditions among Western and non-Western cultures (e.g., karma, spiritual healing, pilgrimage). Clearly, religion can express itself in a variety of ways in the coping process.

To digress for a moment, the transformational role of religion in coping is particularly noteworthy (see Pargament, 1997, for discussion; also see Park, Chapter 16, this volume). Generally, religion has been viewed as a conservational force in coping: an attempt to hold on to or sustain the sense of meaning, control, comfort, intimacy, or spiritual connection in the midst of life crisis. At times, however, conservation is no longer possible. Internal changes, developmental transitions, or external life events may result in the loss of those goals and strivings that have given direction to the individual's life. During these times religious coping methods (e.g., religious conversion, seeking religious direction, religious forgiving) are also available to assist the individual in the process of acknowledgment of the loss, letting go of old goals and values, and moving toward new purpose and meaning (see Park & Folkman, 1997).

TABLE 26.1. The Many Methods of Religious Coping

Religious methods of coping to find meaning

Benevolent religious reappraisal—redefining the stressor through religion as potentially beneficial
Punishing God reappraisal—redefining the stressor as a punishment from God for the individual's sins
Demonic reappraisal—redefining the stressor as an act of the devil
Reappraisal of God's powers—redefining God's power to influence the stressful situation

Religious methods of coping to gain mastery and control

Collaborative religious coping—seeking control through a partnership with God in problem solving
Passive religious deferral—passive waiting for God to control the situation
Active religious surrender—active giving up of control to God in coping
Pleading for direct intercession—seeking control indirectly by pleading to God for a miracle or divine intervention
Self-directing religious coping—seeking control through individual initiative rather than help from God

Religious methods of coping to gain comfort and closeness to God

Seeking spiritual support—searching for comfort and reassurance through God's love and care
Religious focus—engaging in religious activities to shift focus from the stressor
Religious purification—searching for spiritual cleansing through religious actions
Spiritual connection—seeking a sense of connectedness with forces that transcend the self
Spiritual discontent—expressing confusion and dissatisfaction with God' relationship to the individual in the stressful situation
Marking religious boundaries—clearly demarcating acceptable from unacceptable religious behavior and remaining within religious boundaries

Religious methods of coping to gain intimacy with others and closeness to God

Seeking support from clergy or members—searching for intimacy and reassurance through the life and care of congregation members and clergy
Religious helping—attempting to provide spiritual support and comfort to others
Interpersonal religious discontent—expressing confusion and dissatisfaction with the relationship of clergy or members to the individual in the stressful situation

Religious methods of coping to achieve a life transformation

Seeking religious direction—looking to religion for assistance in finding a new direction for living
Religious conversion—looking to religion for a radical change in life
Religious forgiving—looking to religion for help in shifting from anger, hurt, and fear associated with an offense to peace

Religious Coping Methods Can Be Helpful or Harmful

In the past, macroanalytic studies that investigated religiousness as a global, dispositional variable yielded mixed results. Consequently, the efficacy of religious coping for people undergoing stressful life events remained unclear. However, advances in the measurement of religious coping have led to microanalytic studies that clarify the efficacy of religious coping by focusing on the relationships of specific religious coping strategies to the outcomes of stressful situations. The results of these studies show that religious coping can be helpful or harmful, depending upon the particular type of religious coping strategy employed.

While some studies have examined specific types of religious coping in fine detail, higher order factor analyses have revealed that particular religious coping methods can also be grouped into two broad overarching categories: positive and negative religious

coping (Pargament, Smith, Koenig, & Perez, 1998). In general, positive religious coping strategies, those that reflect a secure relationship with God and a sense of spiritual connectedness with others, tend to be more beneficial for people undergoing stressful life events. For example, in a recent meta-analytic review of research on religious coping and psychological adjustment to stress, positive religious coping strategies, such as spiritual connectedness, benevolent religious reappraisals, collaborative religious coping, seeking spiritual support, and seeking support from clergy or members, were positively associated with positive outcomes, such as stress-related growth, spiritual growth, and greater life satisfaction, and negatively associated with negative outcomes, such as depression, anxiety, distress, hopelessness, and guilt, among various samples dealing with a variety of life stressors (Ano & Vasconcelles, 2005). Positive religious coping methods have also been associated with indices of better physical health in a few studies (see Koenig, McCullough, & Larson, 2001, for a review)

In contrast, negative religious coping methods, those that reflect an insecure relationship with God and tension between congregation members, are generally more maladaptive (see Exline & Rose, Chapter 17, this volume). For example, in their meta-analysis of the literature on religious coping and psychological adjustment to stress, Ano and Vasconcelles (2005) found that negative religious coping strategies, such as spiritual discontent, punishing God reappraisals, reappraisals of God's powers, demonic reappraisals, and interpersonal religious discontent, were positively associated with negative psychological outcomes, such as depression, anxiety, callousness, posttraumatic stress disorder (PTSD) symptoms, and spiritual injury, among different samples coping with a variety of negative life events. Such negative religious coping strategies also have harmful implications for physical functioning, as evidenced by findings from longitudinal studies with medical samples. For example, in a longitudinal study of religious coping among medically ill, elderly patients, Cox's regression analysis revealed that spiritual discontent and demonic reappraisals at baseline were associated with a 19–28% increased risk of mortality 2 years later, even after controlling for other important demographic and predictor variables, such as baseline illness severity and mental health status (Pargament, Koenig, Tarakeshwar, & Hahn, 2001). Additional analyses suggested that it was the group of patients who displayed consistently high levels of spiritual struggle over 2 years that was at greatest risk for declines in physical and mental health. In a sample of medical rehabilitation patients, Fitchett, Rybarczyk, DeMarco, and Nicholas (1999) found that spiritual struggles during hospital admission were significantly related to poorer recovery of somatic autonomy at follow-up 4 months postadmission, even after controlling for activities of daily living at admission, depression, social support, and relevant demographic variables. Thus, religious coping is not automatically beneficial; some types are more harmful than others.

Three additional points are important here. First, although much of the existing literature has demonstrated relationships between measures of religious coping and psychological indicators of adjustment, several studies have also linked religious coping to measures of social, spiritual, and physical well-being (e.g., Koenig, Pargament, & Nielsen, 1998; Pargament, Koenig, Tarakeshwar, & Hahn, 2004). Second, the relationships between religious coping and adjustment have remained significant after adjusting for the effects of demographic variables and nonreligious coping measures. For example, in their study of patients undergoing kidney transplants, Tix and Frazier (1998) found that religious coping predicted life satisfaction 12 months after transplantation, after controlling for measures of cognitive restructuring, internal control, and social support. Findings

such as these suggest that religious coping represents a distinctive resource, one that cannot be "explained away" in terms of presumably more basic phenomena (Pargament, 2002). Finally, some studies of religious coping have reported nonsignificant or contradictory findings (e.g., Culver, Arena, Antoni, & Carver, 2002; VanNess & Larson, 2002). Differences in samples, stressors, and measures may partly account for these discrepancies. It is also possible that some forms of religious coping have mixed rather than exclusively positive or negative implications for health and well-being. For example, religious groups that respond to threats by marking boundaries (i.e., sharply distinguishing between insiders and outsiders) may preserve the integrity of the group and the psychological well-being of its members (e.g., Seth & Seligman, 1993), but at the cost of prejudice toward outsiders (Altemeyer & Hunsberger, 1992).

People Draw on a General Orienting System in Religious Coping

Research examining the nature of religious coping has shown that people do not come to coping empty-handed. They enter the coping process with a general orienting system of resources and burdens that influences the particular ways they interpret and handle stressful situations. The *orienting system* is a general disposition to the world that involves beliefs, feelings, practices, and relationships from religious, personality, and social domains (Pargament, 1997). In specific situations, people draw on religious coping methods that are a part of their general orienting system. For example, in studies employing hierarchical multiple regression analyses, dispositional variables (e.g., neuroticism, attachment to God, religious orientation), significantly predicted different types of religious coping strategies above and beyond the effects of other potentially relevant demographic and predictor variables (Ano, 2003; Pargament et al., 1992).

Furthermore, path analytic studies have shown that elements of the general orienting system, such as religious orientation (Roesch & Ano, 2003), church attendance and prayer (Nooney & Woodrum, 2002), and attachment to God (Belavich & Pargament, 2002) differentially shape the specific religious coping strategies that are employed in stressful life events. In these studies, religious coping mediated the relationship between dispositional variables (e.g., religious orientation and attachment to God) and the outcomes to stressful events. Thus, as a general disposition, the orienting system appears to influence the types of religious coping strategies that are employed in specific situations, with general resources (e.g., intrinsic religious orientation, secure attachment to God, church attendance) leading to more positive religious coping strategies and general burdens (e.g., insecure attachment to God, neuroticism) leading to more negative religious coping methods. However, it is the specific religious coping methods that are related more directly to the resolution of critical situations.

Effects of Religious Coping Are Moderated by Different Factors

Religious coping does not occur in a vacuum. It is employed by particular people, in particular contexts, in response to particular stressful situations. As such, different factors have been identified that moderate the links between religious coping and outcomes to stressful events. First, religious coping appears to be more helpful for those who are more religious. In two studies of religious coping among a national sample of Presbyterian members, elders, and clergy in the United States, religious coping was more strongly associated with psychological adjustment for those who were more religious (i.e., for clergy

than for elders, and for elders than for members) (Krause, Ellison, & Wulff, 1998; Pargament, Tarakeshwar, Ellison, & Wulff, 2001). More specifically, among those who were more religious, positive religious coping and church-based emotional support were more strongly related to positive affect and less depression, whereas negative religious coping and interpersonal conflicts in the church were associated with less positive affect and greater depression.

Second, religious coping appears to be more helpful during more taxing situations that push people to the bounds of their human limitations, when immediate personal and social resources are depleted. For example, in a study of religious coping among parents dealing with the loss of a child, spiritual support was more strongly associated with lower levels of depression among those who were more distressed (i.e., recently bereaved parents) than for those who were less distressed (i.e., parents who lost a child more than 2 years ago) (Maton, 1989).

Third, religious coping has differential effects for people from different religious affiliations. In two different studies, religious coping was more helpful for Protestants than for Catholics. For example, in a sample of hospital patients and their loved ones dealing with the stress of a kidney transplant surgery, Tix and Frazier (1998) found that religious coping was associated with greater life satisfaction and less distress for Protestants, but not for Catholics. In another study involving a sample of Hispanic women coping with breast cancer, higher levels of religious coping were associated with less distress among Evangelicals, but greater distress among Catholics (Alferi, Culver, Carver, Arena, & Antoni, 1999). However, these findings do not necessarily mean that Protestants are "better off" than Catholics. In a study of religious doubting among parochial school adolescents, religious doubts were more strongly associated with distress among Dutch Reformed Protestants than Catholics (Kooistra & Pargament, 2002). Thus, religious affiliation clearly moderates the effects of religious coping, but it does so in complex ways (see Park, Cohen, & Herb, 1990).

FROM RESEARCH TO PRACTICE

Building on the growing body of research that has demonstrated empirical links between religious coping and adjustment, researchers and practitioners have begun to develop and evaluate therapeutic methods that draw upon religious coping resources or address religious struggles in the counseling process. Spiritually integrated psychotherapeutic approaches are still in their infancy. However, promising models of treatment that build on religious coping methods are in the process of development (e.g., Avants & Margolin, 2004). Although empirical evidence of efficacy is only just beginning to emerge (see Harris, Thoresen, McCullough, & Larson, 1999; McCullough, 1999; Worthington, Kurusu, McCullough, & Sandage, 1996), the results are encouraging.

A number of studies have demonstrated the positive effects of meditation on various aspects of health and well-being (e.g., Shapiro, Schwartz, & Bonner, 1998). Wachholtz and Pargament (in press) conducted a study that underscores the potential value of a more explicitly spiritual form of meditation. They compared the effects of spiritual meditation with secular meditation. Participants in the two groups meditated either to a sacred mantra (e.g., God loves me) or a secular mantra (e.g., I am loved) over a 2-week period. Spiritual meditation was associated with significantly greater anxiety reduction, greater spiritual well-being, and greater ability to withstand pain than the secular medita-

tion or a relaxation group. These findings suggest that spiritual meditation may be a distinctive therapeutic resource, one that could potentially improve patients' quality of life and activity level without some of the financial expense and negative side effects of pain medications.

Researchers have also evaluated the effects of prayer as a form of intervention. However, prayer is a global resource that can encompass many types of religious coping. For example, Rajagopal, Mackenzie, Bailey, and Lavizzo-Mourey (2002) studied the effects of using a prayer wheel on anxiety and depression among an elderly population. The prayer wheel actually embodied several types of prayer and coping, such as requests for spiritual protection and guidance, forgiveness of oneself and others, and offering spiritual support to others. Participants who made use of the prayer wheel reported significant decreases in anxiety and, to a lesser degree, depression.

Confession represents another potentially important, yet understudied, religious coping resource that could be integrated into treatment. Working with a sample of college students, Murray-Swank (2003) compared the effects of spiritual confession to secular confession and a control condition. Participants in the spiritual confession condition wrote a letter to God asking for forgiveness for something they had done wrong. Participants in the nonspiritual confession condition simply wrote a letter about something they had done wrong. The results were interesting and complex. In comparison to the other two conditions, spiritual confession was associated with greater reports of spiritual growth immediately after writing the letter to God and 2 weeks later. However, spiritual confession was also linked with higher levels of guilt in comparison to the nonspiritual confession condition. Finally, the participants' images of God moderated the impact of spiritual confession on positive affect, such that those who perceived God in loving terms experienced increases in positive affect from baseline to the 2-week follow-up, and those with less loving images of God showed a decrease in positive affect. In another study with implications for confession, Exline, Smith, Gregory, Hockemeyer, and Tulloch (2005) found that people with PTSD who wrote about their trauma in positive religious terms experienced more positive mood by the third session of writing.

Several researchers have developed and tested psychospiritual interventions that use mixed religious and spiritual resources to facilitate the health and well-being of women with cancer (Cole, 1999; Targ & Levine, 2002). For example, Targ and Levine (2002) compared the effects of a mind–body–spirit group intervention for women with breast cancer with a support group. The spiritual group was taught to use meditation, imagery, ritual, and affirmation. Participants in both groups demonstrated positive changes in quality of life, depression, anxiety, and spiritual well-being. In comparison to the support group, the spiritual group also showed greater increases in spiritual integration and less avoidance. However, the support group showed more declines in confusion and helplessness/hopelessness.

A number of studies have been conducted that evaluate the effects of religious coping resources that are specific to particular religious traditions. For instance, religious support, encouragement, and guidance have been shown to be helpful to Muslim religious patients from Malaysia coping with bereavement (Azhar & Varma, 1995) and with generalized anxiety disorder (Azhar, Varma, & Dharap, 1994). In these studies, patients who were encouraged to pray, discuss religious issues, and read verses from the Qur'an reported more significant and more rapid improvement than patients in support groups. Similarly, McCullough (1999) conducted a meta-analysis of five studies that compared the effectiveness of a Christian-accommodative form of cognitive-behavioral therapy

with standard cognitive-behavioral therapy. The Christian treatments emphasized the use of religious imagery, prayer, and biblical perspectives. While both forms of treatment produced positive results, the Christian-accommodative and standard treatments did not differ from each other in their efficacy.

One program examined the impact of an intervention that encouraged religious transformation. Gruner (1984) evaluated a residential drug rehabilitation program for adolescents administered through the Assemblies of God church. The program was designed to help participants challenge feelings of meaninglessness, hopelessness, and alienation, and overcome their addiction through a reprioritization of their values and new dedication of their lives to God. The retention and rehabilitation rates in this program were higher than those reported by other comparable, secular programs.

Finally, a few researchers have begun to examine the impact of spiritually oriented interventions on people encountering spiritual struggles. Murray-Swank and Pargament (2003) developed and evaluated an 8-week manualized individual intervention that drew on spiritual resources to help women who had experienced childhood sexual abuse. The treatment draws on a variety of spiritual coping resources and modalities (e.g., visualizations of a loving God, letter writing to God, benevolent spiritual appraisals, prayer/meditation, rituals) to address spiritual struggles (e.g., feelings of abandonment by God, anger at God, and feelings of shame). Following the intervention and at 1 month follow-up, 80% of the women reported reductions in psychological and spiritual distress. Similarly, Phillips, Lakin, and Pargament (2002) implemented a psychospiritual intervention specifically designed for individuals experiencing serious mental illness. This 7-week intervention provided group members with an opportunity to share their religious journeys and discuss topics such as spiritual resources, spiritual strivings, spiritual struggles, forgiveness of others, and hope. In contrast to concerns that have been raised about raising spiritual matters among people with serious mental illness, the intervention did not trigger any serious psychological disturbances in group members. In fact, the participants asked the leaders to continue the group over the next year.

As a whole, this body of research suggests that religious coping resources may offer valuable adjuncts to the treatment process. As yet, however, we do not know which religious coping methods may be particularly helpful in the therapeutic process. Additional studies are needed to pinpoint and evaluate the efficacy of specific religious coping methods in treatment.

FUTURE DIRECTIONS FOR RESEARCH AND PRACTICE

In the past quarter century, the psychology of religion has reemerged as a significant area of scientific inquiry (see Emmons & Paloutzian, 2003). Within this context, there has also been a dramatic rise in studies of religion and coping. Nevertheless, the study of religion and coping remains in its infancy. We conclude this chapter by pointing to several important directions for future research and practice.

First, studies of religion and coping remain somewhat parochial, designed, implemented, and interpreted by researchers within the scientific study of religion. Given its significance for the physical, psychological, social, and spiritual well-being of people, research in the domain of religion and coping should be more fully integrated into mainstream research and practice within the applied health professions and the social and health sciences. Toward this end, researchers in the area of religion and coping should

draw more fully upon theory and research from other disciplines and, in turn, make more concerted efforts to disseminate their findings to the wider applied and scientific community.

Second, although empirical advances in the psychology of religion and coping have yielded a reasonable base of established findings, the majority of research has been conducted with Caucasian/European-American samples. Future research should investigate religious coping in ethnically and religiously diverse samples. A few studies have examined religious coping among particular ethnic groups, such as African Americans (Woods, Antoni, Ironson, & Kling, 1999), Hispanics (Alferi et al., 1999), and Koreans (Kim & Seidlitz, 2002), but very few studies have compared religious coping across ethnicities, with the exception of one study that examined appraisals, coping, and distress among Korean American, Filipino American, and Caucasian American Protestants (Bjorck, Cuthbertson, Thurman, & Lee, 2001). Drawing from research on multicultural psychology, it would be interesting to examine the nature and prevalence of specific religious coping strategies, such as interpersonal religious discontent and seeking support from clergy and members in such ethnic groups as Asian Americans, given the greater value such groups place upon collectivism compared to Caucasian/European Americans. In terms of religious diversity, the majority of research on religious coping has been conducted with Christian samples, with the exception of a few studies that have examined religious coping among Hindus (Tarakeshwar, Pargament, & Mahoney, 2003), Jews (Dubow, Pargament, Boxer, & Tarakeshwar, 2000), and Muslims (Ai et al., 2003). Future studies should examine religious coping in Eastern and nontheocentric religious traditions to identify other forms of religious coping and to understand how other religious beliefs and practices might contribute to the coping process

Third, there is a need for more longitudinal studies of religious coping. Cross-sectional findings could either reflect the impact of religious coping on adjustment, or the stress mobilization effects of distress on religious coping. Fortunately, a few longitudinal studies of religious coping have begun to clarify the temporal relationships between stressors, religious coping, and adjustment as well as the longer-term impact of religious coping (e.g., Fitchett et al., 1999; Pargament, Koenig, Tarakeshwar, & Hahn, 2001; Pargament et al., 1994; Tix & Frazier, 1998). Longitudinal studies are also needed to examine fluctuations in religious coping over time and their implications for adjustment. In this vein, Keefe et al. (2001) conducted a diary study of religious coping with rheumatoid arthritis patients and found significant variation in religious coping scores from day to day over the course of 30 consecutive days, indicating that religious coping was a dynamic phenomenon sensitive to changing times and circumstances. Diary studies represent one promising and creative way to study religious coping "up close," as it unfolds over time.

Fourth, future studies should investigate religious coping among relatively neglected groups, such as people with serious mental illness. Tepper, Rogers, Coleman, and Malony (2001) examined religious coping among a sample of 406 participants with persistent mental illness and found that more than 80% of the sample used religion to cope with daily frustrations. Given the prevalence of religious coping among this sample, future research should examine the unique implications that religious coping might have for those with serious mental illness. Another neglected group in the literature on religious coping is children (Mahoney, Pendleton, & Ihrke, 2005; Pendleton, Cavalli, Pargament, & Nasr, 2002). Researchers should examine religious coping from a developmental perspective and investigate how religious coping evolves throughout the lifespan or between

developmental stages. For example, it would be interesting to explore how cognitive development influences religious coping. Are children in the concrete operational stage of cognitive development capable of more meaning-based religious coping strategies? How does religious coping evolve from childhood and adolescence, when cognitions might be more fantasy-laden and egocentric, to adulthood, when cognitions may be more rational and reality-based? Such research would draw upon cognitive-developmental theory and could, in turn, inform cognitive-developmental psychology. For example, could spending more time in contemplative prayer (a particular type of religious coping strategy) improve abstract cognitive reasoning? Ideas such as these illustrate how the psychology of religion might be influenced by and simultaneously impact mainstream general psychology.

Fifth, there is a need for studies of specific religious coping methods. For example, while a number of studies have examined forgiveness (for reviews, see McCullough, Pargament, & Thoresen, 2000; McCullough, Bono, & Root, Chapter 22, this volume), particularly from the perspective of the victim, few studies have examined its flip side, confession, which may have unique and important implications for social psychology, since most transgressions are interpersonal in nature. Religious rites of passage (e.g., confirmations, bar/bat mitzvahs, and funerals) are another type of specific religious coping activity that involve ceremonial rituals to signify the passing from one stage of spiritual identity to the next (see Pargament, Poloma, & Tarakeshwar, 2001). These rites of passage are often imbued with deep emotions and significance, and thus represent rich targets for studies of the affective basis of spirituality. These studies, in turn, may hold important implications for more general psychological theories of emotion. Finally, researchers should pay closer attention to situations that could be perceived as a threat or violation to whatever people may hold sacred. This type of primary appraisal may be particularly powerful. Magyar, Pargament, and Mahoney (2000) examined the degree to which college students perceived an offense in a romantic relationship as a sacred violation (i.e., desecration) and its impact on health and well-being. People who perceived the romantic offense as a desecration were more likely to report negative affect, more physical health symptoms, and more intrusive and avoidant thoughts and behaviors related to the event, even after controlling for the negativity of the offense. These results were largely replicated in a community sample faced with a wider range of stressful life events (Pargament, Magyar, Benore, & Mahoney, 2005).

Sixth, future research should incorporate both quantitative and qualitative methods of studying religious coping. In this vein, Ganzevoort (1998) conducted a qualitative study of religious coping by examining people's life narratives and weaving the storylines of religion together with other prominent life themes. Ganzevoort (2001) then integrated quantitative methods with this qualitative narrative reformulation of religious coping by conducting cluster analyses of story themes and examining their intercorrelations. This innovative methodology allows for an even more fine-grained analysis of this complex construct, providing a richer picture of religious coping that could lead to unique insights.

Seventh, because religious coping has implications for people across a variety of domains, there is a need for studies that include multiple criteria of well-being. Most of the research on religious coping has been conducted by psychologists who are predominantly interested in mental health. However, there is a need for studies that consider the implications of religious coping for other social, spiritual, and physical dimensions to expand knowledge on religious coping and make the psychology of religion more relevant to other academic and applied disciplines. For example, with respect to the social dimen-

sion, Mahoney et al. (2002) found that college students who perceived the 9/11 terrorist attacks as desecrations of something sacred adopted more severe retaliatory attitudes toward the terrorists responsible for these acts. From a sociological perspective, these findings could explain the perpetuation and exacerbation of tensions between societies, cultures, and nations that simultaneously perceive the other as desecrating their own sacred objects, lands, values, and ideals.

Finally, although researchers and practitioners have begun to develop and evaluate religiously oriented treatments, additional studies are needed to compare the efficacy of these treatments with other traditional secular interventions through experimental designs. For example, Rye and Pargament (2002) developed a group-based, religiously oriented forgiveness intervention for college women who were hurt in a romantic relationship and compared its efficacy with a secular forgiveness treatment group and a no-treatment control condition. Results of the study showed that, although both treatment groups were more effective than the control group, as evidenced by improvements on measures of forgiveness and existential well-being, there was no difference between the religious and secular interventions. However, post hoc content analyses revealed that participants in the secular treatment group reported that they drew upon religious resources, even though psychospiritual techniques were not explicitly integrated in the intervention. Thus, more controlled experimental studies that successfully distinguish between religious and secular interventions are needed to examine the unique contributions that particular psychospiritual techniques might make toward well-being. Furthermore, most psychospiritual interventions augment traditional approaches to the treatment of psychological problems. Additional studies are needed to develop and evaluate spiritually based interventions that specifically address religious problems, such as spiritual struggles.

There is no shortage of basic or applied questions about the roles of religion in coping. A rapidly growing body of research, however, suggests that this is a promising area of study, one that holds significant implications for our efforts to understand and help people come to terms with the most significant problems of their lives.

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