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Medicine for the Spirit: Religious Coping in Individuals with Medical Conditions

Jeremy P. Cummings * and Kenneth I. Pargament *

Bowling Green State University, Bowling Green, Ohio 43403, United States;

E-Mails: jpcummi@bgsu.edu (J.P.C.); kpargam@bgsu.edu (K.I.P.); Tel.: +1-419-372-2301 (J.P.C.);

Tel.: +1-419-372-8037 (K.I.P.)

* Authors to whom correspondence should be addressed.

Received: 28 October 2010; in revised form: 11 November 2010 / Accepted: 11 November 2010 /

Published: 12 November 2010

Abstract: Religious coping now represents a key variable of interest in research on health outcomes, not only because many individuals turn to their faith in times of illness, but also because studies have frequently found that religious coping is associated with desirable health outcomes. The purpose of this article is to familiarize readers with recent investigations of religious coping in samples with medical conditions. The present article will begin by describing a conceptual model of religious coping. The article will then provide data on the prevalence of religious coping in a range of samples. After presenting findings that illustrate the general relationship between religious coping and health outcomes, the article will review more specific pathways through which religious coping is thought to impact health. These pathways include shaping individuals' active coping with health problems, influencing patients' emotional responses to illness, fostering social support, and facilitating meaning making. This article will also address the darker side of religious coping, describing forms of coping that are linked to negative outcomes. Examples of religious coping interventions will also be reviewed. Finally, we will close with suggestions for future work in this important field of research.

Keywords: religious coping; health; spiritual struggle

1. Introduction

From its inception, religion has addressed matters of paramount importance to humanity, matters of life, suffering, and death. Major religions portray life as a sacred gift to be enjoyed and used wisely. There are countless religious injunctions for how to live life well, as well as warnings about the failure to do so. Yet, for all its attention to day-to-day issues of living, religion also speaks often and powerfully to the darker aspects of human existence. One of faith's most appealing characteristics is the promise to help humans understand and cope with pain and the prospect of life's end. People want to know how to avoid, ameliorate, and, ultimately, accept suffering and death. Throughout history, humans, individually and collectively, have implored supernatural forces to intervene on their behalf when faced with famine, human aggression, and plague. In the modern Western world, poor health remains a conspicuous threat to human well-being and many people turn to religion when they are ill. The health and social sciences have recognized this dynamic and have devoted considerable time and effort to understanding the causes and effects of religious coping with poor health.

There is already a voluminous literature concerning religious coping, so we will review some of the most recent work in the field, focusing solely on religious coping in samples of patients dealing with medical conditions. Although most of the evidence originates from North American samples, we have taken care to include findings that use European samples; there is unfortunately little recent work in this area outside of North America and Europe. We will first present a conceptual model of religious coping to assist the reader in understanding this phenomenon and associated research. In addition, we will report general findings on the prevalence and outcomes of religious coping. Beyond this preliminary overview, we will explore the functions of religious coping in greater detail, for we assume that religion serves multiple purposes in coping with illness. These purposes include promoting active coping with health problems, fostering emotional well-being, establishing and maintaining social support, and facilitating meaning making. Further, religious coping can help preserve the individual's perceived relationship with the sacred, which is often a valued outcome above and beyond whatever purely secular psychosocial benefits religious coping might have. Despite this list of positive functions, religious coping is not without drawbacks; therefore, we will also describe negative forms of religious coping that have been linked to a range of deleterious outcomes. In order to highlight the applicability of this research to clinical settings, we will then present some studies of psychospiritual interventions designed to improve patients' well-being. Finally, we will conclude with recommendations for future research and practice.

2. A Conceptual Model of Religious Coping

Coping is a universal human activity, for opportunity and adversity are universal human experiences. Psychologists use the term *stressor* to designate an event or situation that has some bearing on the fulfillment or frustration of human desires and that requires people to adapt in order to obtain or preserve valued ends (e.g., relationships, health, employment) [1,2]. Health-related stressors often pose a risk to physical comfort, ability to function in diverse life contexts, and continued existence, among other things. Further, these stressors take many forms including the harmful physical effects of the illness itself, side effects of the treatment, the cost (in terms of both time and money) of seeking treatment, and the obstacles inherent in navigating the healthcare system. It would be easy to

assume that such difficulties have a direct, straightforward effect on the individual, but theory and research stemming from Lazarus and Folkman's [2] account of coping have demonstrated that the individual's perception of, and response to, stressors is integral to understanding and predicting the outcomes of stress.

Lazarus and Folkman [2] contended that humans evaluate their circumstances to determine how they ought to respond to them. The first stage of this process, *primary appraisal*, entails discerning the possible consequences of the event. If it will likely lead to desirable outcomes or poses minimal risk to any of the individual's valued ends, there is no urgent need to respond to the event. If, on the other hand, the event represents a significant menace, additional evaluation is required. Primary appraisals typically classify stressors into one of three categories: challenge, threat, and loss. Challenges represent opportunities to achieve desired outcomes and are commonly considered to be positive stressors. Circumstances believed to reduce one's ability to maintain a valued object are appraised as threats and tend to create anxiety for the individual. Loss appraisals pertain to perceptions that the individual has already been deprived of something he or she values; the common reaction to loss is dysphoria. Upon deciding that an event is a stressor of significance to the individual, *secondary appraisal* occurs. In secondary appraisal, the person evaluates potential options for addressing the stressor and estimates the likelihood of successfully responding to it. Primary and secondary appraisal both contribute to the individual's reaction to stressors; stressors perceived as harmful and beyond the individual's ability to cope are particularly distressing [3].

Following the appraisal of a stressor, humans have two kinds of options for responding to the stressor [4]. *Problem-focused coping* refers to efforts to resolve the stressful situation itself. For individuals with medical conditions, this type of coping is likely to involve seeking treatment to cure the illness or alleviate its symptoms. In contrast, *emotion-focused coping* involves trying to mitigate the negative emotional consequences of the stressor. Patients may engage in emotion-focused coping by participating in mood-lifting activities.

Pargament [3] applied Lazarus and Folkman's [2] model to the sphere of religion. He defined religion as "the search for significance in ways related to the sacred" [3]. This definition of religion assumes that humans are agents who actively pursue personally significant or valued ends. Religious pursuits are those that incorporate *the sacred*, either as the goal toward which one strives or the means by which one hopes to reach a goal. Pargament's [3] definition of *the sacred* is not limited to deities, but includes anything the individual perceives to be divine or to have qualities of the divine—that which transcends mundane reality, possesses no natural boundaries or limitations, or is of ultimate significance. Sacred goals can take many forms, including communion with God or enlightenment about the nature of ultimate reality. Prayer is one possible sacred method to achieve the former, whereas meditation may be employed in service of the latter. It is also important to note that Pargament [3] does not assume that all forms of religious coping lead to positive outcomes. In concert with colleagues, he has identified harmful religious coping strategies that will be discussed further below [5,6].

Religious coping occurs when a stressor related to a sacred goal arises or when people call upon a coping method they view as sacred in response to a stressor [3]. If life and health are sacred gifts for the individual, or if illness disrupts one's relationship with God, religious coping may be activated. Even if a sacred goal is not at stake, people may turn to religious coping methods to help them

withstand and overcome stress in times of poor health. For example, they may pray for healing, guidance in health decisions, or emotional strength. They may look to faith communities for comfort and aid. Reflecting on core religious beliefs and concepts may help them gain perspective on their situation.

Central to Pargament's [3] theory of religious coping is the notion that it is critical to understand the functions of religious resources people call upon in stressful times; in fact, understanding the functions of religious coping is more valuable in predicting outcomes than understanding the forms of religious coping. In other words, it is not enough to know that someone prays multiple times a day or attends religious services every week or considers him or herself to be highly religious. The content of prayers, the types of support sought from faith communities, and the perspectives about what the stressor means in light of one's faith may vary dramatically across people performing the same religious behaviors or even within the same person across different stressors. For this reason, he argues that researchers should assess how patients use religious coping to deal with a particular stressor. In contrast, most researchers simply ask study participants about how much they engage in religious behaviors or consider themselves to be religious in general, assuming that these global variables capture the coping dynamic. Because these variables are more distal from the function of religious coping strategies in a particular situation, they may exhibit weaker, though similar, relationships to measures that assess the mechanisms involved in religious coping.

For the purpose of measuring religious coping in greater detail, Pargament *et al.* [5] developed the RCOPE. They generated 105 items intended to represent five theoretical functions of religious coping, including finding meaning, gaining control, gaining comfort and closeness to God, gaining intimacy with others, and achieving a life transformation. Factor analysis yielded 17 factors. For instance, the benevolent religious reappraisal factor contained items asking about the extent to which individuals viewed the stressor as having a positive, divinely ordained purpose. Other factors assessed the extent to which the individual believed he or she needed to work with God to resolve the problem or to wait passively for God to resolve it. These measures provide a more fine-tuned picture of religious coping than is afforded by more general measures. In addition, a 14-item version, the Brief RCOPE, was derived to give researchers a broader view of the extent to which individuals engage in positive and negative forms of religious coping [6]. The Positive Religious Coping subscale assesses efforts to maintain a positive connection with God, collaborate with God, find positive meaning in the stressor, and let go of negative emotions. The Negative Religious Coping subscale assesses perceptions of a disrupted or conflictual relationship with God and one's faith community, as well as loss of faith in God's power and belief that the devil caused the stressor.

In recent years, researchers have become more aware of the complex, multivalent nature of religious coping and have consequently included more specific measures of religious coping. Nevertheless, many continue to rely on global markers of religiousness, as will be seen in the following review.

3. Prevalence of Religious Coping

The majority of studies of religious coping in samples with medical conditions have taken place in the United States, which is well known for its citizens' reportedly high levels of religiousness. As one

might expect, these studies tend to find that substantial proportions of patients engage in religious activities that may be construed as religious coping methods. In spite of the challenges people with health problems face in participating in public religious activities, sizable proportions of American samples make efforts to do so. For example, with respect to attendance at religious services, between 39% and 51% of HIV/AIDS and cancer patients reported attending services at least once per month [7-9]. Religious practices that may take place in private, such as prayer, meditation, or reading sacred texts, offer an option that is perhaps more accessible for those with health problems. Over a quarter of a sample of male and female patients with HIV/AIDS reported engaging in private religious activities between a few times a month and two or more times a week, while another third reported daily private religious activities [9]. In a study of cancer patients, 75% said they spent time in private religious activities at least once a month [8]. Although most studies using the Brief RCOPE do not provide prevalence rates of positive and negative religious coping, they generally suggest that patient samples make use of positive religious coping strategies more frequently than negative religious coping [8,10-13]. Tarakeshwar *et al.* [8] noted percentages of cancer patients who endorsed any use of negative religious coping strategies, breaking the results down by ethnicity and gender. Slightly over half of whites and a little over a quarter of non-whites reported engaging in any negative religious coping; 32% of males and 42% of females endorsed one or more negative religious coping items.

Other studies suggest that religious coping is not uncommon among European patients. Büssing, Fischer, Ostermann, and Matthiessen [14] presented nearly 1,700 patients in German hospitals with five items related to religion and religious coping, assessing the extent to which their faith was a stronghold even in hard times, their trust in a higher power, their belief that God would help them, their effort to live in accordance with religious convictions, and their use of prayer to become healthy. Approximately half of the patients endorsed each of the items. In a study of Swedish chronic pain patients, Andersson [15] noted that 37% of patients completely denied praying for an end to their pain or relying on faith in God or a higher power; he did not provide details about the degree to which the other 73%, engaged in these forms of coping, but it seems that they must have indicated at least minimal use of religious coping. Although Soothill *et al.* [16] did not measure actual use of religious coping resources, their study provides useful information on patients' perceived importance of religious coping. Of 189 cancer patients in England, 35%, 31%, and 18% described opportunities for personal prayer, support from people of their faith, and support from a spiritual adviser as important needs, respectively. Finally, over three fifths of hospitalized children between the ages of eight and 16 in Switzerland said they asked God for help or prayed to God for comfort [17].

Pargament [3] has argued that stress can trigger increases in religious coping. This process, termed the *stress mobilization effect*, may be responsible for contradictory findings across cross-sectional religious coping studies. That is, some studies find positive relationships between religious coping and distress, whereas others find negative relationships. Among studies of the former type, it may be that the tendency of people to turn to their faith in times of stress yields positive correlations between coping and distress; in contrast, the ability of religious coping efforts to ameliorate distress may produce the negative correlations seen in the former type of study.

We have selected two studies that demonstrate the stress mobilization effect. Balboni *et al.* [18] asked advanced cancer patients to report their religiousness (retrospectively) prior to and after being diagnosed with cancer. Reported church attendance significantly decreased, but private religious

practices increased. Further, religiousness was positively associated with distress. Another illustrative case is a prospective longitudinal study of women being tested for breast cancer that assessed the women prior to diagnosis, one week prior to surgery to remove the cancer, and at multiple follow-up assessments up to two years after the surgery [19]. Women diagnosed with breast cancer showed an increase in seeking spiritual support (reassurance and comfort from God's love) from pre-diagnosis to around the time of their surgery, after which this form of religious coping declined. The strategies of providing spiritual support to others, focusing on religion to distract oneself from the cancer, and seeking spiritual transformation and new meaning in life increased in use following diagnosis and remained at elevated levels 14 months post-diagnosis. All in all, health-related stressors appear to predict increases in religious coping.

4. Religious Coping and Health-Related Outcomes

Having established that religious coping is a common response to health problems, researchers seek to determine whether religious coping is associated with any outcomes of interest. There is a sizable body of work intended to answer this question, and the general picture appears to be that religious coping is often related to important outcomes. We will present a brief survey of the correlates of religious coping in samples of patients.

Quality of life and general measures of perceived health are common outcomes assessed in research on health and religious coping. Quality of life is a multifaceted construct that includes an assortment of physical symptoms, pain, one's ability to perform daily activities, satisfaction with one's relationships, emotional well-being, cognitive functioning, financial stability, and other variables; different measures of quality of life assess different combinations of these domains. Composite measures of religion and spirituality [20,21] and positive religious coping [8] have been linked to higher levels of overall quality of life in samples diagnosed with cancer. In a heterogeneous medical sample, patients who attended public religious services and activities and who perceived having interactions with the divine generally viewed themselves as being healthier than those who engaged in these religious coping strategies less frequently [22]. A longitudinal study of cancer patients noted an interaction effect for positive and negative religious coping; those who reported both high levels of positive religious coping and low levels of negative religious coping indicated greater physical well-being [23].

Religious coping has also been associated with more specific health outcomes. Cardiac patients who reported praying prior to bypass surgery were less likely to experience post-operative complications [24]. Endorsing strong, traditional religious beliefs was associated with reduced likelihood of complications following heart surgery and with shorter length of stay in the hospital in another sample [25]. Five-year survival rates were higher among HIV patients who had experienced a spiritual transformation, compared to those who had not [26]. Additional studies of HIV/AIDS patients have found beneficial relationships between measures of religion and spirituality and physiological indicators of health, such as CD4 cell count and percentage, viral load, and urinary cortisol [26-29].

It is important to note that religious coping is not always found to be positively related to health outcomes. Many studies find partial or no support for religious coping as a predictor. For example, various measures of religious coping were unrelated to quality of life and physical outcomes in studies of patients with congestive heart failure [30], life-threatening illnesses [31], and HIV/AIDS [32]. Other

studies find that religious coping is related to negative outcomes, such as poor glycemic control in diabetic patients [33], greater length of stay in the hospital [25], impairment in activities of daily living [34], increased likelihood of complications following surgery [24]. The stress mobilization effect can account for some of these findings. Nevertheless, it is also likely that factors such as the type of coping strategy, the outcome measured, the sample from which data were collected, and other variables may reduce the strength of relationships between religious coping and positive outcomes or even produce undesirable relationships.

Although the studies discussed above offer much evidence supporting the existence of correlations between religious coping and beneficial outcomes, they do little to further our understanding of the mechanisms through which religious coping is related to well being in people with medical conditions. Fortunately, there are many other studies that have attempted to elucidate this matter by testing associations between religious coping and variables that may promote health (e.g., active coping, emotional well-being, social support, meaning making). We review research that illustrates these relationships below.

5. Religious Coping and Active Coping

A common charge against religion has been that it prevents individuals from actively coping with their stressors because they wait for supernatural intervention that may never materialize [35]. Some of the most striking examples of this phenomenon are seriously ill people who refuse medical care due to their religious beliefs [36]. On the other hand, religious teachings that the body is a temple and that life is a divine gift may instill a sense of responsibility to care for one's body and maintain good health status. A study of college students found that those who viewed their bodies as linked to God or possessing divine qualities reported higher levels of health protective behaviors and general exercise and lower levels of unhealthy dieting practices and substance use [37]. The following studies suggest that the contribution of faith to attitudes and behaviors that foster health extends to people with medical conditions.

Religious coping has been linked to a variety of attitudes that might promote medical care. For instance, chronic cardiac patients in Crete who reported higher levels of intrinsic religiousness (*i.e.*, valuing religion for its own sake rather than for the secular benefits it may provide) also indicated lower levels of helplessness [38]. In a sample of cancer patients, those who endorsed having more daily spiritual experiences indicated greater self-assurance [39]. Because perceived helplessness and lack of self-assurance may inhibit seeking medical care, religious coping may indirectly encourage actual help-seeking behavior by obviating these obstacles to treatment. In a sample of Latina breast cancer patients, a composite measure of spiritual beliefs, practices, and support was linked to greater perceived positivity of one's relationship with one's physician [40]. It seems reasonable to presume that people with positive relationships with their physicians would be more likely to seek medical care and cooperate with the medical advice they receive.

Beyond health-related attitudes, studies have demonstrated a range of ways in which religious coping may be related to actual health behaviors and active coping. Composite measures of religious beliefs and practices, as well as self-reported spiritual transformation, were related to more reports of making plans and taking action to resolve health problems in studies of cancer and HIV

patients [21,26,41]. Other studies identify more specific health behaviors related to religious coping. Religious well-being has shown a positive association with knowledge about AIDS among African American men with HIV [42]. According to Friedman *et al.* [43], self-rated spirituality was related to less delay in reporting cancer symptoms to a medical professional after noticing the symptoms. Büssing *et al.* [14] reported that German patients who reported relying on God for help also reported higher levels of searching for health-related information, adhering to medical advice, and engaging in preventative health behaviors (e.g., exercise, healthy diet). Similar results were found in samples of cancer patients and individuals with congestive heart failure [39,44]. A few studies have addressed medication adherence in HIV-positive samples. Two of them found better medication adherence among patients who had experienced a spiritual transformation or who believed that spirituality helped them cope with the side effects of medication [26,45]; a third found no relationship between religious coping and adherence, but patients who said they used religious coping reported fewer reasons for failing to take their medication [46].

In addition to its positive relationships with beneficial behaviors, there is evidence that religious coping is negatively related to risk behaviors. Many of the studies that report these relationships have been conducted in HIV-positive samples. Religious well-being is positively related to self-efficacy to use condoms [42], and religious coping is associated with reduced likelihood of recent unprotected sex among men but not women [47]. Religious coping and attendance at religious services in particular have been negatively related to substance use, including use of alcohol, crack cocaine, and other non-marijuana substances [7,48]. In a similar vein, a study of congestive heart failure patients found that spiritual support and positive religious coping were related to less substance use [44].

Religious coping is not always associated with an active approach to dealing with health problems, however. Multiple studies have not found relationships between religious coping and active coping [49-51]. Further, some studies indicate that religious coping may be negatively related to desirable responses to ill health. Among cancer patients in England, claiming to have a faith was linked to less perceived importance of health information [16]; if patients do not value health information, they may not obtain it and may therefore be less able to engage in health-protective behaviors. Over a quarter of a sample of African American women with breast cancer said they had only told God about their symptoms; these women reported greater delays in seeking medical care [52]. Samuel-Hodge *et al.* [50] likewise noted that in African Americans with diabetes, church attendance was related to taking less action to address the illness. HIV patients who said they believed God or a Higher Power controls their health were more likely to refuse antiretroviral medication [45]. These results are disconcerting and suggest religious coping may have a negative impact on cooperation with medical care.

To sum up, the evidence often suggests religious coping is a catalyst for active coping with health problems. However, there are also quite a few studies with contrary findings. It may be that there are moderator variables (e.g., the type of religious coping measure used, the demographic characteristics of the sample, the type of active coping assessed) that vary across studies and give rise to the differences in observed relationships between religious coping and active coping. More specifically, the main theme that emerges from the studies that find negative effects of religious coping on active coping is that some individuals believe they have no need of medical care if they have faith; they may passively defer any responsibility for protecting their own health, waiting for divine intervention.

Pargament, Koenig, and Perez [5] included a subscale assessing this deferring style of religious coping in their RCOPE measure. Future studies of the deferring coping style may provide valuable insight into why this style develops and how to overcome it as an obstacle to medical care.

Our discussion of religious coping and health-related choices would be incomplete without a comment on end-of-life care. End-of-life care presents especially complex and significant issues for the medical field involving the financial cost of intensive measures, the ethical implications of choosing not to prolong life, and the designation of the appropriate person or group to make end-of-life decisions. Balboni *et al.* [18] reported that religiousness was associated with a desire to preserve life by any means necessary in a sample of advanced cancer patients. More recently, Phelps *et al.* [53] conducted a prospective, longitudinal study of advanced cancer patients to investigate the relationship of religious coping to end-of-life preferences, advance care planning, and the actual care received in the last week of life. Positive religious coping was related to active coping and acknowledgement of having terminal illness. Patients higher in positive religious coping were more likely to prefer heroic measures (doing anything necessary to prolong life, even if the patient will die within a few days) and less likely to engage in advance care planning (establishing Do Not Resuscitate Order, living will, or healthcare proxy). They were also more likely to receive mechanical ventilation and intensive life-prolonging care. One way of interpreting these results would be that patients who use religious coping maintain an active approach to handling their illness, or a “fighting spirit,” all the way to the end of life. Alternatively, one could argue that these individuals are in denial of the inevitability of their demise. Considering the conflicting motivations to preserve life and contain healthcare costs, the influence of religious coping on end-of-life care will likely receive more attention in future research and public policy debates.

6. Religious Coping, Emotion, and Health

Religion has long been believed to have an effect on individuals’ emotional well-being, and theories abound concerning the origins and mechanisms underlying this effect. Terror Management Theory asserts that one function of religion is to help individuals cope with the recognition of their mortality [54]. According to the theory, such recognition threatens to overwhelm the individual with terror, but religion offers people a chance to escape mortality by offering them some form of eternal existence. If mortality is more salient to people suffering from a medical condition, it stands to reason that religious coping could be a valuable asset in staving off noxious emotions for these individuals. Others have suggested that, in addition to reducing negative emotion, religious coping creates positive emotion by helping individuals believe they are connected to and valued by a divine presence [55].

The ability of religion to regulate emotion may be valuable in and of itself, but it takes on a special significance with respect to health. Psychoneuroimmunological research, the study of how psychological factors are interconnected with the nervous and immune systems, has indicated that emotions are linked to physical health. In fact, there is evidence that high levels of negative emotions create deleterious physical effects, whereas high levels of positive emotions cause beneficial physiological changes. Kiecolt-Glaser, McGuire, Robles, and Glaser [56] cited studies demonstrating that negative mood was related to lower levels of salivary antibodies and reduced activity of natural killer cells that may attack tumors and virus-infected cells. They also noted studies in which

psychological interventions were associated with both lower levels of distress and better immune function. In their review of research on positive emotions and health, Cohen and Pressman [57] stated that there was some evidence (though not conclusive) that positive affect was related to lower morbidity and patient reports of fewer symptoms and less pain. If religious coping indeed impacts emotional states, emotion may therefore serve as a pathway for additional effects on health outcomes.

One common finding in research on religious coping is a negative relationship with depression. Studies that test the link between depression and measures of well-being, comfort, and strength derived from religion and spirituality and report that patients with greater levels of spiritual well-being indicate less severe symptoms of depression [28,58]. Similarly, a longitudinal study tested the association between measures of spiritual striving, which included items about feeling alive and joyful, and depression among individuals with HIV/AIDS [32]. Participants who stated that they were striving to grow spiritually indicated being less depressed at a six month follow-up. However, studies such as these contain a significant limitation. Because they use measures of spiritual well-being that represent inherently positive emotional states, it is possible that they actually function as measures of the absence of depression and therefore have a built-in negative correlation with explicit measures of depression.

It is important to note that there are other studies of religious coping and depression in which positive emotional states are less likely to contaminate the coping measures. Kilbourne, Cummings, and Levine [59] found that endorsing religious beliefs, praying, reading religious texts, and attending religious services were all concurrently related to less depression among diabetic patients, even when controlling for demographic variables. A study of patients preparing to undergo heart surgery supported the negative relationship between strong, traditional religious beliefs and depression [25]. A review of research on prayer also confirmed that prayer is negatively related to depression [60]. Spiritual transformation and faith in God have been identified as additional possible predictors of lower depression [26,61], and German breast cancer patients who said they used positive religious coping indicated being less depressed [51]. Koenig [62] conducted a longitudinal study of 1000 medical inpatients with either congestive heart failure or chronic pulmonary disease who were also diagnosed with depression. Patients who scored higher on a composite measure of prayer, Bible study, watching or listening to religious programs and intrinsic religiousness, manifested a shorter time to remission from depression. The effect was weak for moderately religious patients, but the most highly religious patients improved substantially more quickly than their peers.

Religious coping may also be associated with lower levels of other undesirable emotional states. HIV-positive African American women who were more engaged in public and private religious activities tended to have more stressors in their life but nevertheless said they experienced less psychological distress [41]. Spiritual transformation and positive religious coping have also shown negative relationships with distress and anxiety [26,51]. Hollywell and Walker's [60] review of research on prayer suggested that studies typically find negative relationships between prayer and anxiety. Swiss children who asked God for help or prayed to God for comfort reported fewer posttraumatic stress symptoms during a follow-up assessment 11 months later [17]. In a longitudinal study of cardiac patients, positive religious coping was concurrently related to lower levels of anger coping; both positive religious coping and a composite measure of religious activities and self-rated religiousness were negatively related to hostility [10]. Finally, British cancer patients who reported

having a faith perceived help with feelings of guilt as a less pressing need, implying that they may experience less guilt than patients without a faith [16].

Much of the research on religious coping and emotional outcomes has been concentrated on the negative side of the equation, devoting comparatively little space to positive emotions and attitudes. Recent studies that do assess positive affect tend to support the existence of a positive relationship with religious coping. For example, a measure combining religious beliefs and practices was positively related to emotional well-being among cancer patients [21]. In a similar vein, Simoni, Martone, and Kerwin [7] found that a measure assessing prayer and spiritual activities, meditation and visualization, and finding new faith was associated with greater levels of psychological adaptation (*i.e.*, high mastery, high self-esteem, low depression, and low distress). Belgian chronic pain patients who possessed a positive God image reported being happier [63], and a sample of German patients mainly suffering from chronic pain were more likely to be satisfied with themselves, their future prospects, and their overall life if they indicated trusting in God to help them [64].

Optimism, the expectation of positive outcomes rather than negative outcomes, is often tied to religious coping. Cardiac patients reporting strong, traditional religious beliefs tend to be more optimistic [25]. In a study by Cotton *et al.* [12] involving persons with HIV/AIDS, optimism was related to public, organized religious behaviors; private, nonorganized religious behaviors; and intrinsic religiousness. Other predictors of optimism and positive attitudes include self-reported increase in religiousness/spirituality [29], positive image of God [65], as well as private prayer and self-rated importance and degree of religious faith [66]. Religious coping may also have indirect effects on other outcomes by way of its relationship with optimism. In a sample of HIV/AIDS patients, optimism partially mediated the positive relationship between a composite measure of religiousness/spirituality and the belief that one's life had improved since being diagnosed with HIV/AIDS [67].

Despite the considerable amount of research supporting the contribution of religious coping to emotional well-being, a substantial subset of studies fails to find such relationships. Attendance at religious services, prayer, spiritual experiences, and self-rated importance of religion were unrelated to depression in coronary artery bypass patients [24]. Likewise, positive God image and a composite measure of religiousness were unrelated to distress among cancer patients [65], and general religious coping was unrelated to mental health outcomes in congestive heart failure patients [30]. Some studies of positive religious coping reported no relationship with depression or distress [13,31], while other studies found positive relationships with depression, anxiety, and worry [23,68]. Moreover, negative emotional and mental health outcomes have been associated with prayer [15,69] and intrinsic religiousness [49]. As noted earlier, the stress mobilization effect is one possible explanation for these findings. If emotional distress triggers religious coping, a positive relationship between these two variables would be observed. In other samples, the opposing tendencies of distress to activate religious coping and of religious coping to reduce distress may cancel each other out, producing no observable relationship.

7. Religious Coping, Social Support, and Health

Social interaction is a ubiquitous facet of human life, and people typically place high value on and seek out positive interactions with others. More to the point, humans rely on each other for the fulfillment of basic needs; this exchange of assistance is called *social support*. Social support has been divided into four subtypes: instrumental, informational, appraisal, and emotional [70]. Instrumental support is intended to facilitate the achievement of a tangible goal and might consist of providing someone with necessary resources or actively working with the individual [71]. Informational and appraisal support are less direct means of assistance; the former involves sharing knowledge, whereas the latter entails guidance in decision making [71]. Emotional support refers to the positive interpersonal emotions of love, sympathy, understanding, and esteem [72]. Berkman *et al.* [71] detailed a comprehensive conceptual model of the ways in which social networks produce social support, which then impacts health through behavioral, psychological, and physiological pathways.

Religion has long been recognized as a social phenomenon, and religious organizations have the potential to be a major source of social support. Yet, a study by Balboni *et al.* [18] suggests there may be a discrepancy between the extent to which patients value social support from religious sources and their satisfaction with the amount of support they receive. The majority of advanced cancer patients in their sample said that receiving visits from chaplains or clergy was comforting, but 47% noted that their religious communities had not provided adequate support. Below, we review more studies to shed light on the relationship between religious coping and social support, as well as the effects of social support from religious sources.

Research often finds that religious coping is related to higher levels of social support. Composite measures of public and private religious activities, traditional religious beliefs, and positive religious coping have been positively related to social support in samples with cancer, HIV/AIDS, and heart conditions [7,8,25,40]. In a study of Turkish women with breast cancer, seeking assistance from supernatural forces was related to better social functioning [73]. Striving for spiritual growth predicted greater social support six months after the initial assessment [32]. Cancer patients in England who endorsed having a faith perceived less need for help with loneliness and housework, which might imply that they receive more emotional and instrumental support than those without a faith [16]. On the whole, the evidence suggests religious coping and social support go hand in hand, though there are some studies that contradict this conclusion [20,65].

There are several possible explanations for the link between religious coping and social support. One explanation might be that attending religious services may expand and strengthen the individual's social network such that there are more people who are willing and able to provide the individual with support in times of need. Further, groups that hold altruistic religious beliefs and values might be more willing to help ill members. For their part, patients who adhere to religious ideals might be more socially appealing and hence garner more favor from their acquaintances. An alternative explanation is that illness interferes with religious coping, especially public religious activities, thereby weakening the individual's social network. Participants in a qualitative study of Alzheimer's disease stated that their symptoms did make it more difficult to go to church [74]. On the other hand, patients may receive social support to help them maintain their religious lifestyles.

Several recent studies have tested social support as a mediator of the relationship between religious coping and outcomes. Cardiac patients were assessed shortly before surgery and again approximately a month later [75]. In this sample, positive religious coping longitudinally predicted lower levels of distress; perceived social support was also related to greater positive religious coping and less distress. When controlling for perceived social support the relationship between religious coping and distress was reduced, suggesting that social support mediated this relationship. Likewise, social support accounted for the positive relationship between religious beliefs and adjustment in cancer patients [76]. In contrast, other studies have found that the effect of religious coping on outcomes cannot be entirely attributed to its relationship with social support. Combined measures of religion and spirituality had a direct, positive relationship with perceived life improvement among HIV/AIDS patients that was not mediated by social support [67]. Social support also did not mediate the negative relationship between spiritual striving and depression in another sample with HIV/AIDS [32].

Whereas the studies discussed above utilized general measures of social support, others assess support specifically provided by religious communities. When religious communities as well as medical professionals assist patients with their spiritual needs, these patients report greater quality of life [18]. Congregational support has also shown positive relationships with general mental health and maintaining a healthy diet, as well as a negative relationship with substance use [44,77]. Sometimes, religious social support can even be a life-saving resource. Military veterans with traumatic brain injury stated that the support they received from their religious communities helped them resist their desire to commit suicide [78]. Social support is not always related to positive outcomes, however. Johnstone and Yoon [79] found that congregational support was unrelated to health status in patients with stroke or traumatic brain injury. For Greek cancer patients, there was no relationship between social support received from one's faith community and any quality of life outcomes [20].

8. Religious Coping, Meaning, and Health

Meaning making has emerged as a prominent construct in the field of psychology. Park and Folkman's [80] seminal article explained the significance of meaning making and its relevance to coping. According to Park and Folkman, humans orchestrate their lives based on systems of *global meaning*, overarching theories about the way the world works and the individual's place in it. One typical feature of global meaning is the assumption that events generally unfold in the world in an orderly, predictable manner. Moreover, people usually expect positive outcomes to occur more than negative ones and that the nature of a person's circumstances corresponds to his or her quality of character – that is, bad things happen to bad, incompetent people, and good things happen to good, competent people; of course, most people believe themselves to be in the latter camp. Another component of global meaning is the sense that one is purposefully pursuing worthwhile ends. Park and Folkman asserted that religion is a prime example of a belief system that affords the individual with global meaning.

Park and Folkman [80] further explained that, occasionally, stressors threaten to undermine the global meaning system by contradicting core assumptions. Something unexpected or beyond human control happens, like an injury or an illness, and people's certainty about the "just world" in which they live, the loving God in whom they believe, or their own personal morality and competence on

which they depend is shaken. Changing one's global meaning system may entail the significant costs of emotional upheaval, investment of personal resources in the search for plausible and functional new beliefs, and lifestyle adaptation. Hence, Park and Folkman contended, individuals prefer seeking *situational meaning* that resolves apparent incongruities between their experiences and their existing global meaning systems. They may try to identify the cause of the stressor so that they can retain belief in an orderly world and their own ability to control what happens to them. Another option is to reappraise the stressor as a source of positive changes or perceived benefits (e.g., spiritual growth, improved relationships). Just as religion contributes to global meaning, it also specifies strategies for finding situational meaning; religion's role in meaning making will be described in greater detail below.

Empirical evidence supports the theoretical relationship between religious coping and global meaning in patient samples. Tarakeshwar *et al.* [8] found that engaging in positive religious coping was related to believing that one is living a meaningful life, even after controlling for self-efficacy, depression, and demographic variables. Prostate cancer patients who reported that they valued religion for its own sake scored higher on the meaning/peace subscale of the FACIT Spiritual Well-Being scale; in contrast, valuing religion for the psychosocial benefits it confers (e.g., social recognition, comfort) was not related to greater reports of meaning/peace [58]. This may mean that in order to derive meaning from one's faith, one must be truly devoted to the substantive content of that faith. Experiencing spiritual transformation may also promote higher levels of perceived meaning and purpose in life, goal seeking, and acceptance of responsibility for one's choices [26]. In a longitudinal study of congestive heart failure patients, those who indicated using religious coping at baseline showed an increase in meaning in life six months later [30].

There is also support for the contribution of meaning to well-being among individuals in poor health. Military veterans with traumatic brain injury stated that their religious faith gave them a sense of meaning that made it feel worthwhile for them to keep on living instead of committing suicide [78]. Studies that utilize the FACIT meaning/peace subscale as a predictor variable often find positive relationships with beneficial outcomes, including cancer-related quality of life in men with prostate cancer [81] and self-esteem, life satisfaction, social support, and optimism in a sample with HIV/AIDS [12]. The meaning/peace subscale has also been found to mediate the negative relationship between intrinsic religiousness and depression [58]. Using the World Health Organization Spirituality, Religious and Personal Beliefs inventory (WHOSRPB), researchers in Italy identified a factor through factor analysis that they termed "Personal Meaning;" this factor included measures of meaning and purpose in life, spiritual connection, wholeness and integration, spiritual strength, faith, and love [82]. Personal Meaning was positively correlated with general quality of life in their sample of patients with chronic neurological conditions. We should note that the studies described here may be subject to a particular criticism we have outlined above: namely, the measures of meaning may not be conceptually pure. They include positive emotions and variables in addition to assessing perceived meaning, so it may be that these other variables account for the observed positive relationships between the measures of meaning and the outcome measures.

Beyond providing a sense of global meaning in life, religious coping may help patients reframe their illness in a larger spiritual context, which is a form of situational meaning making. For example, Pakistani and Iranian Muslim patients stated that they believed their medical conditions were gifts

from God intended to strengthen their faith, absolve them of their sin, and foreshadow divine blessings in this life or the next [83,84]. HIV patients who had reportedly experienced a spiritual transformation also endorsed higher levels of benefit finding and said they believed they had a meaningful reason for contracting their disease [26].

Multiple studies of European samples support the hypothesis that religious coping is a resource for situational meaning making. More intrinsically religious cardiac patients in Crete were better able to identify beneficial consequences of their illness [38]. Reliance on help from God was related to viewing one's illness as an opportunity for personal growth or a challenge in two studies of German patients [14,85]. Among Belgian patients with chronic pain, those who reported experiencing closeness and security with God interpreted their condition as an opportunity to change their life or reflect upon what is essential in life [63].

Further, there is evidence that the situational meaning that religious coping facilitates may in turn lead to additional positive outcomes. In a sample of people with HIV, a mixed measure of religious/spiritual variables was positively related to the tendency to reappraise HIV in a positive light and benefit finding [27]. Positive reappraisal and benefit finding mediated the negative relationship between religion/spirituality and depression; benefit finding also mediated the negative relationship between religion/spirituality and urinary cortisol, which has been linked to depressive symptoms and HIV disease progression.

9. Spiritual Struggle: The Dark Side of Religious Coping

Religious coping, especially among religious populations, is often assumed to be a powerful and valuable resource for well-being. Images of people calling upon a benevolent higher power for strength and comfort, finding solace in their faith communities, and serenely reminding themselves of a transcendent purpose for their experience of illness may readily come to mind. Indeed, we have presented research on the religious coping response to health problems that may be adduced as evidence for the power of religious coping to ameliorate suffering. To stop here, however, would be to overlook the reality of spiritual struggle, or negative religious coping. Instead of patiently turning to God, people with medical conditions may view their illness as an indication that God has abandoned or is punishing them; they might even experience distressing doubts about their faith. People who contract an illness through a behavior their religion classifies as sinful, such as drug use or sexual activity, may find themselves in conflict with or shunned by their religious community. These are just a few examples of the kinds of spiritual struggles that illness can occasion.

While it is true that general religious variables and positive religious coping receive the most publicity, researchers have conducted a sizable number of studies on spiritual struggle [86]. One common measure of spiritual struggle is the negative religious coping subscale from the Brief RCOPE [6]. As noted above, patients report using negative religious coping strategies to a lesser extent than positive religious coping [10]. Contrary to what one might expect, both non-religious and religious cardiac patients indicated engaging in negative religious coping [10]. Moreover, negative religious coping has consistently shown significant relationships with undesirable outcomes, with the exception of some studies suggesting links to stress-related growth [87].

In terms of physical well-being, negative religious coping appears to be a liability. Scores on general measures of physical well-being and health were negatively related to spiritual struggle in a sample of patients with a life-threatening illness [31], as well as another sample of patients with traumatic brain injury, spinal cord injury, or stroke [79]. Cancer patients who were struggling spiritually reported greater pain and less energy [13]. Viral load and HIV symptoms were positively related to negative religious coping, whereas CD4 levels and quality of life were negatively related to it among HIV/AIDS patients [9]. Even more striking, negative religious coping predicted greater mortality risk over a two-year, prospective longitudinal study of medically ill older adults [88]. Although the mechanisms underlying the relationships described above have not been firmly established, one possibility is that negative religious coping may impair physical well-being by reducing patients' efforts to preserve their health and serving as a trigger for risk behaviors intended to distract them from their illness. In support of this hypothesis, Park *et al.* [39] noted that negative religious coping was associated with reduced adherence to medical advice and medication adherence, as well as higher levels of alcohol use among cancer patients.

Negative religious coping is associated with a variety of negative emotional outcomes and psychopathology. Zwingmann *et al.* [51] found that it was related to higher levels of depression and anxiety in German breast cancer patients. Studies of patients with HIV/AIDS [9] and other life-threatening illnesses [31] also reported positive relationships between negative religious coping and depression, and spiritually struggling cardiac patients indicated greater anxiety [10]. In the same sample of cardiac patients, negative religious coping was a risk factor for hostility and anger coping [10]. In addition, negative religious coping has been linked to posttraumatic stress symptoms in burn patients [11].

Patients experiencing spiritual struggles may also lack social support, according to a few studies. Negative religious coping has been linked to lower levels of social support in samples of cancer patients [8] and HIV/AIDS patients [9]. Women being tested for breast cancer who endorsed a negative image of God reported less social well-being [65]. Further, lower levels of social support partially mediated the positive relationship between negative religious coping prior to cardiac surgery and distress approximately one month after the operation [75].

This brief review indicates that negative religious coping may have a variety of negative effects on outcomes in medical patients. Indeed, negative religious coping appears to be at least as potent of a predictor of undesirable outcomes as its positive counterpart is of beneficial outcomes. In light of these findings, this phenomenon likely warrants continued attention in future research.

10. Psychospiritual Interventions

Researchers have sought to capitalize on the evidence that religious coping has implications for people with medical conditions by designing interventions that incorporate religious or spiritual elements for the purpose of improving outcomes for patients. This area of work is still in the early stages of development, but it has significant potential for health care. We present findings from three different kinds of interventions to illustrate possible means of translating basic research on religious coping into practice.

Psychospiritual intervention has long been a part of medical practice, at least in the hospital setting, in the form of chaplaincy services. Chaplains are representatives of various faith traditions charged

with providing spiritually oriented counseling to patients and their families concerning issues of grief and death, praying with patients, and performing religious rituals or services, in addition to providing other services [89]. Two studies in the past decade have compared inpatients who received visits from chaplains with those who did not. In the more recent study, researchers assigned 166 coronary artery bypass patients to a treatment group and a no-treatment control group [90]. The treatment consisted of a chaplain visiting once with the patient prior to the surgery, once with the family during the surgery, and three times with the patient during the week following the surgery; the visits lasted an average of 44 minutes. For each visit, the chaplain initiated conversation with the patient or the patient's family and attempted to create an atmosphere in which emotional and spiritual concerns could be discussed by using reflective listening. The chaplain also posed one question intended to facilitate discussion during each visit. An example of one of the questions is, "How do you make sense out of what you are going through?" [90]. The outcome measures were administered before the surgery, one month after the surgery, and again six months after the surgery. Statistical analyses revealed a marginally significant group-time interaction effect for positive religious coping and negative religious coping, suggesting that the treatment group and the control group showed different trends across time for these two variables. Further examination of the results showed that, whereas the two groups scored similarly on positive and negative religious coping before their surgery, the treatment group was significantly higher on positive religious coping and lower on negative religious coping at the six-month follow-up. However, there was no effect for anxiety, depression, or hope. The other study compared 25 chronic obstructive pulmonary disease inpatients who received daily chaplain visits to 24 who received no visits [91]. The average number of visits for the treatment group was 4.2, with each visit lasting about 20 minutes. The treatment group stayed an average of 3.3 fewer days than the control group and reported greater satisfaction with their stay. Also, controlling for their levels of anxiety upon admission to the hospital, patients who received chaplain visits indicated experiencing less anxiety at the time of discharge than did those who did not receive visits. Considered together, these studies support the notion that chaplaincy services may promote beneficial (rather than harmful) forms of religious coping, physical recovery, and emotional well-being, all of which should be important to health professionals.

Meditation has gained recognition as a potential intervention to foster physical and mental health. Despite the tendency of researchers and clinicians to portray meditation as a secular practice, it has roots in major religious traditions and may produce powerful spiritual experiences. Bormann *et al.* [92] preserved the spiritual aspect of meditation in a study of its effects on health outcomes. Ninety-three HIV-positive adults were randomly assigned either to a 10-week meditation group or to an attention control group [92]. The meditation group was received a collection of mantras (spiritual words or phrases) from a variety of religious traditions (*i.e.*, Buddhism, Hinduism, Judaism, Islam, Christianity, and Native American traditions). They were then taught how repeat their mantra and focus on it during weekly sessions with group facilitators. Compared to the control group, the meditation group showed significantly greater reductions in non-HIV intrusive thoughts and trait anger over time, in addition to a marginally significant reduction in depression. Frequency of mantra repetition was positively correlated with quality of life.

A third approach to psychospiritual treatment is spiritually integrated psychotherapy [93]. In this approach, a mental health professional uses established psychological interventions while addressing

religious/spiritual concerns and helping clients make use of religious/spiritual resources. Cole [94] developed a group therapy program consisting of eight weekly two-hour sessions for people diagnosed with cancer. The intervention deals with the themes of control, identity, meaning, and relationships. The therapist works with clients to identify and resolve spiritual struggle with each of these themes and promotes spiritual coping. In the pilot study of this program, nine cancer patients chose to participate in the therapy group and seven patients volunteered to receive no treatment [94]. Both groups were assessed before the treatment was initiated, shortly after the end of treatment, and two months post-treatment. The control group showed a marginally significant increase in pain severity from pre-treatment to post-treatment and a significant increase in depression from pre-treatment to the two-month follow-up. The levels of pain severity and depression remained stable in the treatment group. Therefore, the spiritually integrated psychotherapy intervention appeared to prevent cancer patients' physical and emotional well-being from deteriorating.

Conclusion

Based on our review of recent studies of religious coping, we believe there is ample evidence to conclude that religious coping is an important predictor of health-related outcomes among patients with medical conditions. It is a complex collection of beliefs, attitudes, and behaviors that may operate through an array of mechanisms, promoting active coping behaviors, emotional well-being, social support, and meaning making. Nevertheless, it may be a double-edged sword with the power to harm as well as to heal. Having surveyed the landscape of this field of inquiry, we hope that researchers will use this overview as a guide for their own exploration of the numerous questions that remain and that clinicians will find it helpful in their efforts to assist patients on the road to wellness.

We have several recommendations for optimizing future research. Identifying and using more refined measures of religious coping should be a major priority for investigators. They should take care to include measures of one or more of the myriad functions of religious coping (e.g., seeking supernatural healing, understanding and accepting illness, demonstrating good stewardship of one's body) in their studies instead of relying on global markers (e.g., private and public religious activities, self-rated religiousness) that may perform different functions in different contexts. It will also be important for researchers to include measures of both positive and negative religious coping strategies to account for the fact that religious coping is not always salutary and to document the unique ways in which positive and negative religious coping may be related to outcomes. When conducting research on mental health or other emotion-related variables as outcomes, religious coping measures that closely overlap with emotional well-being measures should not be used as predictor variables because the constructs may not be distinct enough from each other to be treated as separate variables. Finally, in spite of the proliferation of religious coping measures, there is a need for measures that assess religious coping in a culturally valid manner. Promising initial efforts have already been made to develop scales that are appropriate for people who self-identify as Jewish [95], Muslim [96], Hindu [97], or Buddhist [98].

Other aspects of research design deserve notice, as well. For instance, the field would benefit from more empirical studies of complex theoretical models specifying mediators and moderators of the relationships between particular religious coping strategies and outcomes. In order to make a stronger

case for causal effects of religious coping on health, we need additional prospective longitudinal studies and, to the extent possible, randomized controlled trials of religious coping interventions. Studies of all kinds should statistically control for potential confounding variables, such as demographic variables and the severity of the participant's health condition. Last, greater attention should be devoted to the impact of religious and cultural differences on the religious coping-health relationship. Most studies have been conducted with Christian samples in the United States, whose inhabitants report moderate to high levels of religiousness. Investigations of Muslim, Jewish, Hindu, and Buddhist groups may reveal new forms and effects of religious coping. Similarly, studies conducted in the more secularized culture of European countries may yield results that differ from those obtained in the United States. For instance, a team of Dutch researchers [99] created a measure assessing individuals' trust that they will find meaning in and solutions to life's problems; in contrast to similar American measures that assume belief in an active, personal God, this measure does not specify the agent that will provide the individual with meaning and solutions. This measure was negatively related to anxiety in Dutch and Belgian samples, whereas a more theistic measure did not demonstrate such a relationship. Ideally, researchers will carry out comparative studies of representative samples from different religious groups and cultures so as to shed light on these important questions.

As for the practical implications of the findings reviewed above, the main point is that health professionals must not dismiss religious coping as irrelevant to their work. Like it or not, patients bring their own religious resources and struggles with them into the medical center. Religious coping may work in conjunction with medical treatment to promote health, or it may interfere with treatment goals, so it behooves practitioners to address these issues. We recommend handling religious coping with sensitivity, initiating conversation with each patient to determine whether the patient engages in religious coping or perceives personal spiritual needs. Health professionals should review published guidelines for assessing patients' spirituality [100]. In cases where religious coping is clearly relevant for the patient, one may encourage the patient's use of positive religious coping techniques, such as interacting with a faith community or participating in private religious activities. Lo *et al.* [101] suggested that a physician may choose to comply with a patient's request for prayer or for an accommodation for a religious ritual if the request is consistent with the physician's ethical, religious, and professional values. However, they added that health professionals should not feel obligated to do so, especially if the request disrupts medical care or conflicts with other patients' rights. Declining patients' requests must be done politely and in such a way that the patient feels his or her beliefs are respected [101]. Finally, it is important to gauge the patient's interest in services designed to promote positive religious coping and resolve spiritual struggle, referring interested clients to a chaplain, minister, or mental health professional who has developed competency in addressing spiritual issues [100]. We recommend reading Koenig's [102] book, *Spirituality in Patient Care*, for more in-depth guidelines about how health professionals might work with spirituality in their clinical practice. To achieve the best physical, psychological, and spiritual outcomes for patients, professionals from various disciplines will have to address religious coping cooperatively and with a solid understanding of the research on this topic.

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