Understanding the Nature and Role of Spirituality in Relation to Coping and Health: A Conceptual Framework

Terry Lynn Gall, Claire Charbonneau, Neil Henry Clarke, Karen Grant, et al. Canadian Psychology. Ottawa:May 2005. Vol. 46, Iss. 2, p. 88-104 (17 pp.)

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Abstract (Document Summary)

As a leading researcher in this field, Pargament (1997) makes reference to the transactional model of stress and coping (Lazarus & [Folkman], 1984) as a potential point of departure for understanding and organizing research on religiosity and spirituality. Notably, he has focused on the process of religious coping behaviour with some additional emphasis on religious appraisals or attributions in response to various life stressors (e.g., Pargament & Hahn, 1986; [Mahoney, Pargament], Koenig, & Perez, 2000). Pargament continues to expand the application of these religious and spiritual domains in the coping process, most recently addressing the importance of spiritual attachment (connection) to God as a key factor in driving the religious coping process (Belavich & Pargament, 2002). Following Pargament's lead, a handful of researchers have started to apply the transactional model to their investigation of spirituality, coping, and health (e.g., [Stolley] et al., 1999). And yet, these applications remain limited in their focus on one or two aspects of the coping process (e.g., role of person factors).

Sears and Greene (1994) showed that religious coping styles had important implications for the degree of anxiety experienced in a sample of cardiac transplant candidates. In particular, collaborative coping has been related to more positive outcomes for individuals waiting for a loved one in surgery (Belavich & Pargament, 2002). A collaborative relationship with God appears to provide the individual with a sense of empowerment in the face of a difficult life situation (Pargament & Park, 1995) while a deferring style appears to be associated with a reduced sense of personal competence in coping (Pargament, et al., 1988). Research by Wallston and colleagues (Wallston et al., 1999) has indicated that a belief in God's control is a factor in coping with health-related issues. However, it is important that an individual experiences a sense of "shared" control with God that does not negate his or her own sense of responsibility and choice in coping with stress (Jackson & Coursey, 1988). And yet, the deferring style may be more adaptive as a response to an uncontrollable, extreme situation such as the death of a loved one (Pargament et al., 1988). A deferring-collaborative style was related to and may even be more important than social support to the psychosocial adjustment of cancer patients (Nairn & Merluzzi, 2003). Finally, the independent self-directing style has been shown to be a generally effective personal coping style (Pargament et al.), which may only be disadvantageous under uncontrollable circumstances (Pargament, 1997).

Hope. The personal trait of hope can be viewed as an important core factor that can affect various components of the spiritual framework of coping (Snyder, Sigmon, & Feldman, 2002). Hope is a cognitive construct that consists of both the person's sense of motivation or goal-directed purpose (agency) and his or her perception of the ability to initiate and maintain goal-directed behaviour (pathways) (Snyder, Lopez, Shorey, Rand, & Feldman, 2003). As defined, hope has implications for one's emotional well-being as well as the process of cognitive appraisal (Snyder, 2002), and coping behaviour (Nekolaichuk, Jevnc, & Maguire, 1999). Hope theory considers that stress, negative emotions, an inability to cope, and functional difficulties are the result of being unable to successfully envision and pursue strategies to a desired goal (Snyder, Irving, & Anderson, 1991). Research in the area of psychosomatic medicine has long demonstrated that hope has an ameliorative effect on healing (Carson, Soeken, & Grimm, 1988; Mytko & Knight, 1999; Swanston,

Nunn, Oates, Tebbutt, & O'Toole, 1999) and that it is linked to aspects of physical and mental well-being (Chang & DeSimone, 2001; Nekolaichuk et al., 1999; Vandecreek, Nye, & Herth, 1994). Researchers have also found that individuals with high levels of hope tend to find meaning or benefit in the context of difficult and traumatic events (Affleck & Tennen, 1996; [Nolen-Hoeksema] & Davis, 2002).

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[Headnote]

Abstract

The past several years have seen a virtual explosion of research in the area of religion, spirituality, coping, and health. Despite this inundation, most studies have remained at the descriptive level of analysis. It has only been within the past few years that more complex associations, pathways (i.e., mediation), and possible models concerning the influence of religion and/or spirituality on health have been investigated. One psychosocial model of adjustment that holds promise as a potential "scaffold" for the organization and understanding of these vast data on spirituality is the transactional model of stress and coping originally put forth by Lazarus and Folkman (1984). The present paper uses the basic tenets (e.g., dynamic process) and structural components (e.g., coping behaviour) of the transactional model as a framework for the integration of the growing empirical literature on spirituality, coping, and health. The resultant application of the model in a spiritual context was reviewed by four spiritual care workers and/or chaplains from different religious backgrounds. These multifaith chaplains critiqued the "fit" of this model in relation to their understanding of health and coping from their faith perspective and offered suggestions on modifications to the model that would create a better fit.

Over the past 20 years, the study of religion, spirituality, and coping has become an abundant area of research. This surge in interest in religion and spirituality may be due to the fact that many people turn toward their faith under extreme circumstances such as severe illness (Ganzevoort, 1998; Oxman, Freeman, & Manheimer, 1995). Religious coping in particular has demonstrated associations with a variety of social, personal, and situational factors, as well as links to psychological and physical health (Harrison, Koenig, Hays, Eme-Akwari, & Pargament, 2001; Koenig & Futterman, 1996). As a result, attempts have been made to integrate aspects of religiosity and spirituality into psychosocial models of adjustment (e.g., Daaleman, Kuckelman Cobb, & Frey, 2001). While these models are insightful, they often present religiosity as having a cognitive role (Dull & Skokan, 1995), thus ignoring its other possible functions in the overall coping process. As well, such models can be limited in their focus on a Christian view of religion (Nooney & Woodrum, 2002; Stolley, Buckwalter, & Koenig, 1999) rather than on what could be considered the broader concept of spirituality (Stifoss-Hanssen, 1999).

The purpose of this paper is to organize and integrate the diverse findings and concepts found within this literature into a conceptual model of the role of spirituality in coping. In its vastness, the existing literature on spirituality, coping, and health can be overwhelming to the established, as well as to the "new," researcher in this area. Although rich in possibility, this literature is plagued by a lack of consistency in the definitions given to spirituality, the domains of spirituality investigated, and in the diverse measures used to assess spirituality. As a whole, the empirical work also tends to remain at the descriptive level with little reference to an overarching conceptual model that could guide hypotheses and set the groundwork for the investigation of specific pathways of effect among the various spiritual constructs.

As a leading researcher in this field, Pargament (1997) makes reference to the transactional model of stress and coping (Lazarus & Folkman, 1984) as a potential point of departure for understanding and organizing research on religiosity and spirituality. Notably, he has focused on the process of religious coping behaviour with some additional emphasis on religious appraisals or attributions in response to various life stressors (e.g., Pargament & Hahn, 1986; Pargament, Koenig, & Perez, 2000). Pargament continues to expand the application of these religious and spiritual domains in the coping process, most recently addressing the importance of spiritual attachment (connection) to God as a key factor in driving the religious coping process (Belavich & Pargament, 2002). Following Pargament's lead, a handful of researchers have started to apply the transactional model

to their investigation of spirituality, coping, and health (e.g., Stolley et al., 1999). And yet, these applications remain limited in their focus on one or two aspects of the coping process (e.g., role of person factors).

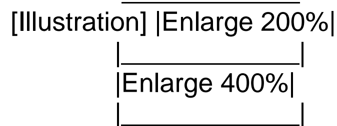

Figure 1. The Spiritual Framework of Coping (an adaptation/application of the transactional model)

We are proposing to use the transactional model of stress and coping in its most recent form (Folkman, 1997; Folkman & Greer, 2000) as a framework from which to approach, organize, and understand the diverse literature on spirituality, coping, and health. Specifically, the basic tenets (e.g., dynamic process) and structural components (e.g., coping behaviour) of the transactional model are used as a "scaffold" for the integration of the growing empirical research on spirituality. The goal of this paper is to provide a conceptual framework of spirituality and coping that illuminates key spiritual constructs that can have a role in coping as well as provide a schema of how these constructs might function in the process of coping with stress. It is acknowledged that our approach represents a rational-theoretical framework that requires empirical validation. Although individual studies suggest that some of the components of our proposed framework (e.g., meaning making, spiritual connections) are relatively distinct or nonoverlapping in nature (e.g., Gall, 2003a; Pargament, et al., 1990), future empirical work is needed to validate the overall proposed structure of this spiritual framework of coping.

Overview of a Spiritual Framework of Coping

Like the concept of personality, spirituality is considered to be a complex, multifaceted, construct that manifests in the process of an individual's behaviour, beliefs, and experience (Miller & Thoresen, 1999). Given its subjective and dynamic nature, the construct of spirituality is congruent with the basic tenets of the transactional model of coping. Specifically, this framework is seen to be dynamic and relational, phenomenological, transactional, and process-oriented. As well, as a multi-dimensional construct, spirituality can operate at several levels of the stress and coping process at any one point in time (Park & Folkman, 1997). It can function at the level of person factors (e.g., beliefs), primary and secondary appraisals (e.g., God attributions), coping behaviour (e.g., prayer), coping resources (e.g., connection to nature), and meaningmaking (e.g., spiritual reappraisal) (seeFigure 1).

In this framework, spiritual person factors (e.g., beliefs) operate as a contextual framework that orients an individual in his or her interpretation, comprehension, and reaction to life experiences (Acklin, Brown, & Mauger, 1983; Dull & Skokan, 1995). Such beliefs help the individual construct meaning out of his or her suffering and provide for a more hopeful and optimistic attitude (Schwab & Petersen, 1990). Beliefs also facilitate an active attitude toward coping and a strengthening of social support (Koenig, 1995; Levin & Chatters, 1998) in response to stress.

Spiritual appraisals and coping behaviours operate as mediating factors in the process of coping with stress. Spiritual appraisals involve initial attempts at making sense of the stressor based on one's spiritual beliefs. An individual can attempt to explain the situation through an attribution of causal origins (e.g., God's will). Such attempts at making meaning may help the individual to reduce initial levels of distress (Davis, Nolen-Hoeksema, & Larson, 1998) enough to engage in coping behaviour. Spiritual coping involves the specific behaviours that an individual uses to respond to either the stressor (problem-focused) or related emotional reactions (emotion-focused).

Finally, spirituality and religion can function at the level of situational meaning, or the meaning that evolves within the circumstances of a specific personenvironment transaction (Park & Folkman,

1997). In fact, the process of meaning-making, itself, is often viewed as synonymous with "spirituality" (Ameling & Povilonis, 2001). Within a transactional model of coping, meaning-making is conceptualized as a process of cognitive reappraisal that is particularly important to a successful adaptation under circumstances that are chronic or not easily ameliorated by coping efforts (Park & Folkman). The ability to make meaning when faced with a stressful event often promotes successful coping, adaptation, and well-being (Emmons, 1999). In contrast, the inability to find meaning is related to psychological distress, doubt, and uncertainty, which in turn can lead to inactivity and the inhibition of effective coping behaviours (Emmons, 1999; Krause, 1998). Spirituality can play a significant role in meaning-making in relation to attitudes and beliefs about the world, self, and others (Park & Folkman). A spiritual process of meaning-making (or seeking significance in an event) can touch on all aspects of life, including work, interpersonal relationships, general philosophy of living, attitudes, and/or whatever that person's "God" may be (Pargament, 1997).

Being based on well-established constructs (e.g., appraisal) from coping research, this spiritual framework is considered to be relatively parsimonious. As well, clear distinctions have been made theoretically and empirically between the various spiritual constructs. For example, Pargament (1997) has made a distinction between the person (or dispositional) factor of a religious coping style, religious appraisals, and specific religious coping behaviours with each construct contributing unique variance to the prediction of well-being (Pargament et al., 1990). Gall (2003a) has shown that even factors that tap into a similar domain (e.g., the transcendent), such as relationship with God (spiritual connection) and God attribution (appraisal), are only moderately interrelated and demonstrate different associations with well-being. Finally, although this spiritual model has some hierarchical elements (i.e., certain constructs affect each other in an apparent linear progression), it should be noted that as with the transactional model, it is ultimately recursive in nature. For example, as presented in Figure 1, spiritual coping "leads to" meaning-making. However, the effects of this process of meaningmaking feeds back to the earlier processes of primary appraisal and indirectly to spiritual coping in an individual's attempts to readjust his or her response to a situation.

Components of Spiritual Coping

Spiritual Appraisal

As an initial stage in the appraisal process, causal attributions can play an important part in coping with stress (Park & Cohen, 1993). Individuals can make sense of events in relation to the causal representation of self, chance (fate or luck), others, and God (Pargament £ Hahn, 1986; Spilka, Shaver, £ Kirkpatrick, 1985) and the devil (Mahoney, Pargament, et al., 2002). Spiritual causal attributions are a common means for understanding life events such as illness or injury (Spilka & Schmidt, 1983). For example, Gall (2003a) found that religious and spiritual causal attributions were endorsed frequently by older adults coping with illness. In another study, accident victims with severe injuries viewed their situation as being part of God's purpose or as an indication of God's will (Bulman £ Wortman, 1977).

In turn, spiritual causal attributions have been linked to the use of religious coping activities (Shortz £ Worthington, 1994), general coping such as positive refraining (Gall, 2003a; Miner £ McKnight, 1999), and adjustment to negative life events (Pargament et al., 1990). For example, older adults' causal attributions of illness to a spiritual force other than God and to various aspects of God (e.g., His will) were negatively related to aspects of daily functioning (Gall, 2003b). Attributions to God may help individuals preserve their belief in a just world (Pargament £ Hahn, 1986), which in turn helps them hold onto a sense of personal control when confronted with an uncontrollable situation (Spilka et al., 1985). In contrast, the attribution of demonization (i.e., influence of the devil) may play a role in situations of extreme stress and trauma. Those individuals who attributed the 9/11 terrorist attack to the devil, experienced higher levels of PTSD symptoms, more extremist reactions (e.g., desire for revenge), greater national solidarity, as well as a greater sense of personal growth (Mahoney, Pargament, et al., 2002).

In terms of primary appraisal, the concept of desecration can be seen as a spiritual evaluation of harm/loss. Desecration refers to what extent people view an event as having violated a part of their lives that they viewed as sacred or connected to God. As with demonization, the appraisal of desecration in relation to the 9/11 attack is related to negative and positive adjustment factors (Mahoney, Pargament, et al., 2002).

Finally, the process of secondary appraisal represents an individual's evaluation of the availability and the potential effectiveness of specific spiritual coping methods that could be used in response to a stressor. secondary spiritual coping appraisals have implications for specific coping behaviour (Pargament & Hahn, 1986). Gall (2003a) reported that older adults' plans to turn to and utilize spiritual resources (e.g., reliance on God) are related to more positive general appraisals of their illness and a greater use of problem- and emotion-focused coping.

Person Factors

Religious denomination and doctrine. Many individuals conduct their lives through the understanding of the doctrine of a particular religious group or denomination. Personal beliefs become intertwined with those of the religious community that provides both the social support as well as the social norms that identify roles for the believer to assume (Blaine, Trivedi, & Eshleman, 1998; Dull & Skokan, 1995). In this way, religious doctrine can direct how an individual will cope with life stress.

Lifestyles that are religiously oriented have been shown to be healthier and may be associated with a reduced occurrence of disease (Martin & Carlson, 1988). This could be due in part to the prescriptions adopted by a particular religion such as abstinence from harmful substances. Religion is associated with lowered rates of cigarette smoking, and alcohol and drug abuse, as well as certain mental illnesses such as depression (Koenig, et al., 1999). Religious beliefs that adhere to a "Protestant work ethic" may encourage active coping as an individual will understand that "God helps those who help themselves" (Levin & Chatters, 1998). Holland, and colleagues (Holland et al., 1998) noted that hospital patients who held specific spiritual/religious beliefs reported experiencing less anxiety and stress, lower depression, and a greater ability to co-operate and collaborate with hospital staff. Despite a general positive effect, there are times when religious doctrine runs counter to the well-being of an individual. Some religious groups (e.g., Jehovah Witness) may forbid certain types of medical treatments due to their prescription on how life is to be lived. As well, it should be kept in mind that there is significant individual variability among members of a particular religious denomination in relation to held beliefs (Jenkins & Pargament, 1995), including the embracing of a spirituality that is more philosophical than religious in origin.

Religious orientation. The concepts of intrinsic and extrinsic religious orientation play a role in most research involving personality and religion. Allport (1961) described extrinsic religion as serving the individual for his or her own sake. This form of religious belief is utilitarian in that its main aim is to provide comfort and safety (Hergenhahn & Olson, 1999). Extrinsic religious practices are not guided by an individual's faith but are prompted by the experience of guilt, anxiety, and/or external sources of pressure (Pargament, 1997). As a result, the effect of an extrinsic religious orientation on the process of coping and appraisal is believed to be less effective than an intrinsic orientation (Park & Cohen, 1993). Pargament and colleagues (Pargament et al., 1992) found that an extrinsic orientation was related to a greater perceived threat and sense of an inability to handle a situation in addition to a lesser feeling that there is an opportunity to grow from the stressful experience.

Intrinsic religiosity is described as an internalized understanding of who the Transcendent is through faith, hope, and love for others, God, and self. It involves an altruistic motivation that is linked closely to a search for meaning and purpose as an end in itself (Allport, 1961; Hergenhahn & Olson, 1999). Individuals with high intrinsic scores generally rely on their religious resources in times of crisis especially if the event is perceived to be out of their personal control (Park & Cohen, 1993). An intrinsic religious orientation appears to be linked to an individual's appraisal of a

potential for personal growth and his or her reliance on problem-solving coping in the context of severe life stress (Pargament et al., 1992). Park, Cohen, and Herb (1990) found that an intrinsic religious orientation provided individuals under severe stress with a sense of meaning. In this way, intrinsic religiosity demonstrated a positive role in the healing process for individuals as it was predictive of a decline in depression over time.

Spiritual problem-solving or coping styles. Dispositional styles of religious/spiritual problem-solving assume that the individual is predisposed to respond to stressors in a certain way, and that these responses are relatively consistent across situations. A self-directing style is indicated when an individual functions in an active manner independent of God; a deferring style is apparent when an individual takes on a passive role and waits for God to resolve a situation; and a collaborative style involves engaging God in a mutual problem-solving process (Pargament, 1997; Schaefer & Gorsuch, 1993).

Sears and Greene (1994) showed that religious coping styles had important implications for the degree of anxiety experienced in a sample of cardiac transplant candidates. In particular, collaborative coping has been related to more positive outcomes for individuals waiting for a loved one in surgery (Belavich & Pargament, 2002). A collaborative relationship with God appears to provide the individual with a sense of empowerment in the face of a difficult life situation (Pargament & Park, 1995) while a deferring style appears to be associated with a reduced sense of personal competence in coping (Pargament, et al., 1988). Research by Wallston and colleagues (Wallston et al., 1999) has indicated that a belief in God's control is a factor in coping with health-related issues. However, it is important that an individual experiences a sense of "shared" control with God that does not negate his or her own sense of responsibility and choice in coping with stress (Jackson & Coursey, 1988). And yet, the deferring style may be more adaptive as a response to an uncontrollable, extreme situation such as the death of a loved one (Pargament et al., 1988). A deferring-collaborative style was related to and may even be more important than social support to the psychosocial adjustment of cancer patients (Nairn & Merluzzi, 2003). Finally, the independent self-directing style has been shown to be a generally effective personal coping style (Pargament et al.), which may only be disadvantageous under uncontrollable circumstances (Pargament, 1997).

A fourth dispositional style, surrender, has been recently proposed (Wong-McDonald & Gorsuch, 2000). A surrendering style involves an active decision to release personal control to God over those aspects of a situation that fall outside of one's control. The act of surrendering control provides an emotionally overwhelmed individual some relief, comfort, and sense of security in that God is now in charge of the situation (Cole & Pargament, 1999). Breast cancer survivors, for example, have reported feeling a sense of relief in the process of sharing their burden with God (Gall & Comblat, 2002). Rather than entail a sense of fear over a perceived "loss of control," a surrendering style paradoxically enhances spiritual well-being and engenders a deepened sense of faith for individuals under extreme stress (Wong-McDonald & Gorsuch). Such results have led researchers to conclude that a just and benevolent God provides the individual with a framework of control that is experienced as more benign than that of fate (Pargament, Sullivan, Tyler, & Steele, 1982).

Hope. The personal trait of hope can be viewed as an important core factor that can affect various components of the spiritual framework of coping (Snyder, Sigmon, & Feldman, 2002). Hope is a cognitive construct that consists of both the person's sense of motivation or goal-directed purpose (agency) and his or her perception of the ability to initiate and maintain goal-directed behaviour (pathways) (Snyder, Lopez, Shorey, Rand, & Feldman, 2003). As defined, hope has implications for one's emotional well-being as well as the process of cognitive appraisal (Snyder, 2002), and coping behaviour (Nekolaichuk, Jevnc, & Maguire, 1999). Hope theory considers that stress, negative emotions, an inability to cope, and functional difficulties are the result of being unable to successfully envision and pursue strategies to a desired goal (Snyder, Irving, & Anderson, 1991). Research in the area of psychosomatic medicine has long demonstrated that hope has an ameliorative effect on healing (Carson, Soeken, & Grimm, 1988; Mytko & Knight, 1999; Swanston,

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Spintual Coping Behaviour

Spiritual coping behaviour is a multidimensional construct that covers a range of negative and positive, problem- and emotion-focused strategies (Harrison et al. 2001; Pargament, 1997). It can be categorized as organizational religious behaviour, private religious or spiritual practices, and nontraditional spiritual practices (Maltby, Lewis, & Day, 1999). Organizational religious behaviour refers to the involvement of an individual with a formal, public religious institution and includes such practices as service attendance and worship as well as volunteer activity (Idler, 1999). Strawbridge, Shema, Cohen, and Kaplan (2001) have shown that weekly service attendance is associated with improving and maintaining health towards long-term survival. Harris and colleagues (Harris et al., 1995) reported that following the post-surgery period, 25% of heart transplant recipients continued to pray regularly, attend services, and make financial contributions to faith communities.

Private religious or spiritual practices are characterized as nonorganizational, noninstitutional, and informal and include behaviours such as prayer, sacred scripture study, saying grace, and watching religious television (Levin, 1999). Prayer and song have been relied upon by seniors living in institutions (Koenig et al., 1997) and patients suffering from various forms of mental distress in conjunction with serious medical illness (Koenig, Pargament, & Nielsen, 1998). Tepper, Rogers, Coleman, and Malony (2001) found that a majority of persons suffering from a persistent mental illness devoted up to half their coping time to religious/spiritual practices with the most frequent being prayer followed by sacred scripture reading. However, in the case of mental illness, the strength of this relationship may be more tenuous than with physical illness (Baetz, Larson, Marcoux, Bowen, & Griffin, 2002).

Finally, nontraditional practices are those that express one's spirituality in ways that are conceptually separate from the traditional expressions of religiosity (Dyson, Cobb, & Forman, 1997). Richards and Bergin (1997) present the acts of contemplation, meditation, and spiritual imagery as forms of spiritually based mental exercises. There is a large body of research that demonstrates the effects of these spiritual strategies on health and well-being (Benson, 1996; Borysenko & Borysenko, 1994). Benson concluded that those relaxation techniques that incorporate spiritual beliefs tend to be more powerful. For example, individuals who used devotional meditation experienced less anger, anxiety, and tension than those who used progressive relaxation (Carlson, Bacaseta, & Simanton, 1988). Brown-Saltzman (1997) also found that a spiritually based guided imagery in the context of narrative therapy aided individuals in coping with stress. Carter (1998) in examining spiritual practices of substance abuse clients pointed to the 12-step program's success with an overall recovery rate of 34%. Nontraditional spiritual practices, including introspection, helping others, and meditation, as well as the more traditional prayer correlated with a lower incidence of relapse than routine therapy and Alcoholics Anonymous follow-up.

Unique case of prayer. According to Richards and Bergin (1997), prayer is an expression of relatedness to the divine rooted in most religions. Praver is a personal type of ritual that can function in multiple ways (Cook & Bade, 1998) and be effective at many levels in dealing with crises (Hood, Spilka, Hunsberger, & Gorsuch, 1996; McCullough & Larson, 1999). Ai, Dunkle, Peterson, and Boiling's (1998) study of coronary bypass surgery found that 67.5% of patients chose private prayer as the most frequent technique out of a list of 21 nonmedical help-seeking or coping behaviours and that it was associated with lower distress postsurgery. Koenig and colleagues (Koenig et al., 1998) noted that when frequency of prayer was taken into account, older adults were 40% less likely to have diastolic hypertension compared to the 8% when just religious attendance was used as the predictor. In a study of caregivers, Stolley et al. (1999) concluded that prayer may

be the most profound religious coping behaviour used and can support the use of other positive coping methods (Dunn & Horgas, 2000).

The findings on prayer have been inconsistent, however. Poloma and Pendleton (1991) found in a random sample of community adults that frequency of prayer was negatively, while prayer experience was positively, related to life satisfaction. Prayer has also been associated with greater levels of chronic pain and greater functional impairment (Fry, 1990; Keefe, Crisson, Urban, & Williams, 1990; Tuttle, Shutty, & DeGood, 1991). Results from such cross-sectional studies need to be interpreted with care as it could be that individuals pray more when they are in a bad situation (Koenig, McCullough, & Larson, 2001). In fact, a longitudinal study by Turner and Clancy (1986) revealed that an increase in the use of prayer or hoping strategy was predictive of a decrease in pain intensity. As well, the effects may differ depending on the type of prayer being used. Poloma and Pendleton found that conversational and meditative prayers had stronger relationships with happiness and existential well-being, respectively. In contrast, ritual and petitionary prayers are associated with lower levels of well-being (Pargament, Smith, Koenig, & Ferez, 1998) and greater negative affect (Poloma & Pendleton). In particular, pleading for direct intercession from God may be an indicator of psychosocial distress and poorer daily functioning following a negative life event such as illness (Gall, 2003b).

In general, spiritual coping behaviour is a frequent response to severe stress (King, Speck, & Thomas, 1999; Koenig, 1998) and has significant associations with a wide variety of adjustment factors, including lower depression (Kennedy, 1998), greater happiness and life satisfaction (Bergan & MConatha, 2000; Kehn, 1995), use and availability of social support (Koenig et al., 1997; Simoni, Martone, & Kerwin, 2002), optimism (Gall, Miguez de Renart, & Boonstra, 2000), better self-rated health (Krause, 1998), lower alcohol consumption (Musick, Blazer, & Hays, 2000), fewer somatic complaints, more social activity, and fewer interpersonal problems (Idler & Kasl, 1997), general coping behaviour (Gall, 2003b), finding meaning in events (Hall & Carpenter, 1990), and lower mortality (Oman & Reed, 1998). Notably, spiritual coping has predicted well-being beyond the contribution of general coping (Gall, 2000; Pargament et al.,1990) both cross-sectionally and longitudinally (Pargament et al., 1994).

Although most studies report positive results, there is evidence that spiritual coping can be negative (e.g., discontent) or positive (e.g., support) in nature (Pargament & Brant, 1998). For example, the use of religious discontent and pleading coping were related to greater psychological distress and lower life satisfaction for long-term breast cancer survivors while religious avoidance (i.e., prayer, readings), good deeds, and spiritually based coping were related to optimism (Gall et al, 2000). It is important to take into consideration the timing of spiritual coping as a "negative" form such as pleading may have different effects depending on when in the process it is used (Pargament et al., 1994). As well, spiritual coping demonstrates different patterns of association with positive and negative aspects of adjustment. Although religious coping predicted improvement in life satisfaction one year after kidney transplant, it was not related to reductions in depression (Tix & Frazier, 1998).

Spiritual Connections

Nature. In contrast to religiousness, spirituality is more often linked to a sense of sacred connection to nature and all living things (Zinnbauer, Pargament, & Scott, 1999). Unfortunately, very little empirical research has been conducted on the role of connection to nature and stress and coping; yet, the potential for such an association is evident in anecdotal evidence. In interviews of Appalachian women, Burkhardt (1994) found that the concept of spirituality was frequently linked to their connection to the natural world. Appalachian women derived strength and a sense of "groundedness" from their interaction with nature (e.g., gardening). Suzuki (2002) also suggests that a connection with nature may exist as a potent resource for individuals coping with stress. He recalls incidences when terminal cancer patients talked about the soothing effects of nature. These patients described how "being in nature" engendered a sense of hope in their day-to-day living. Thus, a connection with nature may afford a sense of emotional comfort to the stressed individual.

Others. Early on researchers noted that religion represents a common source of support (Koenig, Moberg, & Kvale, 1988). Girisburg, Quirt, Ginsburg, and MacKillop (1995) found that family (79%) and religion (44%) were the two most frequently used support systems by patients diagnosed with cancer. In fact, religious/spiritual communities can be important sources of care (Koenig et al., 2001). Holland et al. (1998) noted that patients who received support from their clergy tended to cope more easily with a lifethreatening illness. Koenig (1997) also found that clergy visits were related to positive outcomes for individuals with mental health problems. Heilman and Witzum (2000) reported that Orthodox Jews relied on overall faith community membership in addition to religious dogma and practices in dealing with mental health issues. Social support related to religion appears to be associated with various health factors such as lower morbidity for hypertension (Ferraro & Koch, 1994); while, the lack of religious involvement has been related to an increased risk of mortality even after controlling for the effects of various demographic, physical health factors, and other social support indicators (Oman & Reed, 1998; Strawbridge et al., 1997).

Transcendent Other. Research indicates that a relationship with the Transcendent (God) plays an important role in the coping process (Levin, 2001; Maynard, Gorsuch, & Bjorck, 2001) especially if God is perceived to be nurturing, loving, comforting, protective and available (Heller, 1986; Johnson £ Spilka, 1991). Perceived support from God has been related to lower depression and greater self-esteem for individuals experiencing high stress (Maton, 1989). Kirkpatrick and Shaver (1990) discovered that individuals who described their relationship to God as secure scored significantly lower on measures of loneliness/depression, anxiety, and physical illness, and higher on general life satisfaction. Attachment to God in turn lias implications for the type of spiritual coping engaged in, with a secure attachment being more consistently related to positive forms of coping and outcomes (Belavich & Pargament, 2002).

Relationship with God can fulfill various functions, including the provision of comfort, social support, and a sense of belonging, the encouragement of inner strength and acceptance, empowerment, and control, the relief of emotional distress and specific fears (e.g., of death), and the creation of meaning (Gall & Cornblat, 2002; Siegel & Schrinshaw, 2002). Relationship with God has been related to optimism, hope, and inner strength in coping with illness (Gall et al., 2000; Gaskins & Forte, 1995; Highfield, 1992). Individuals who attribute illness to a loving God are more likely to report positive reinterpretations of their illness, including a focus on personal growth (Park & Cohen, 1993). Many women with breast cancer make reference to their need for a closeness to God and how it helps [hem to feel less alone and gives them courage in dealing with their illness (Johnson & Spilka, 1991). It thus appears that a positive and accepting attachment with God can exist as an important source of emotional comfort for individuals confronting significant life stress (Siegel £ Schrinshaw).

In contrast, a negative relationship with God (e.g., punishing, withholding) may be related to an individual's experience of greater distress under stressful circumstances (Flores, Hansdottir, Malcarne, Clements, & Weisman, 1998; Gall & Comblat, 2002). For example, Berg, Fonss, Reed, and VandeCreek (1995) found that individuals, diagnosed with an affective disorder, who suffered spiritual injuries (e.g., feeling God has been unfair), experienced a longer hospital stay. As well. Bclavich and Pargament (2002) found that avoidant and anxious styles of attachment to God were related to religious discontent coping (i.e., anger with God), which in turn was related to poorer adjustment. However, more research needs to be conducted in this area as the results regarding a negative relationship with God have been inconsistent (Belavich & Pargament). For example, Gall (2004) found that for prostate cancer survivors, a negative relationship with God did not appear to be a factor in relation to their well-being.

Relationship with God appears to embody a complex process in that it does not preclude the experience of negative emotional states of disappointment, questioning, and doubt. Pargament (2003) discussed how spiritual struggles (i.e., with the Divine) can be triggered by a painful event. Such struggles are typically manifested as anger, complaints, and pleading for a miracle in relationship to God (Gall & Comblat, 2002). Left unresolved these spiritual struggles may-have a negative impact on well-being over the long-term.

For example, in a sample of medically ill elderly, indicators of religious struggle were predictive of increased risk of mortality after controlling for other factors such as significant demographics (Pargament, Koenig, Tarakeshwar, & Hahn, 2001). These researchers concluded that, without longitudinal studies, it is difficult to know if a spiritual struggle arises from the impact of a stressful event as well as to know the duration of such a negative reaction and its ultimate effect on the coping process.

Meaning-Making

Several studies have found that religion and/or spirituality play an important role in finding meaning in a stressful event (Cohen, 2002; Gordon et al., 2002; Yickberg et al., 2001). Situational meaning can involve making more benign attributions to an event, seeing opportunities for growth or benefits resulting from the event, or determining that an event is less central to one's life than originally perceived (Park & Folkman, 1997; Park, Folkman, & Bostrom, 2001). The stressful event can be reframed as a spiritual opportunity that offers benefits (Pargament, 1997), and a chance to gain insights about life (Pryds, Back-Pettersson, & Segesten, 2000). Ersek and Ferrell (1994) suggested that spiritual interpretations of illness can help the individual with cancer reframe his or her experience as having some positive consequences such as being brought closer to others. If a higher power is perceived to be at work in a stressful event, then the event may be viewed as an opportunity to learn something that this higher power is trying to teach. The event may also serve as a "wake-up call" to take stock of life and rearrange priorities (Angen, 2000; Emmons, 1999). In turn, such "benefit-finding" has been related to long-term bereavement adjustment (Davis et al., 1998).

A stressful event can also be interpreted as a punishment for something bad, a test, a form of purification, or something one can do best as one believes that a higher power would not give more than one can handle (Barkwell, 1991; Gall & Comblat, 2002). Another interesting aspect of reframing and the influence of spirituality on meaning-making is the possibility of seeing oneself as having a limited ability to understand the entirety of events. In this way, one feels less of a need to find a "reason" for one's suffering, and can be more content with accepting that some things are just beyond one's comprehension (Pargament, 1997).

Spirituality can help locate an event within the context of a "bigger picture" or an overall plan or purpose. Once this reinterpretation acknowledges a deeper purpose than was first recognized, the event takes on new meaning and can be seen as less random. For example, Gall and Comblat (2002) found that women reported that their breast cancer served some divine purpose. Black (2000) and Block (2001) each studied a different terminally ill man as he journeyed toward his death. Both case studies found that, through illness, the minutiae of everyday events become the locus of the sacred, and one's place in the world took on a diminished perspective. Through this process these dying men were able to maintain an integrated and meaningful sense of their lives.

Even with extensive reappraisal of the situational meaning, some events (e.g., severe victimization) are too aversive or extreme to fit into existing beliefs. In order to find meaning in such events, one may have to change fundamental belief systems or goals, and/or make major shifts in one's spirituality (Park & Folkman, 1997). For example, Wong and McDonald (2001) found that trauma survivors can develop a "tragic optimism" to the extent that their new positive views of life have been tempered by a tragic past and the expectation of possible misfortunes in the future. Tragic optimism has links to spirituality in being defined as "the capacity to hope in spite of and because of tagic experiences" (Wong & McDonald, p. 240).

Current work on meaning-making and spirituality is focusing on how seemingly secular aspects of life can be perceived as having spiritual character and significance, a process termed "sanctification" (Pargament & Mahoney, 2002). With theistic sanctification, an event can be eperienced as a manifestation of one's images, beliefs, or experience of God. In nontheistic sanctification, an individual can attribute sacred qualities (e.g., ultimate value, purpose) to an event even if one does not espouse beliefs in God or a higher power (Pargament & Mahoney). For

example, a study of college students showed that greater levels of theistic or nontheistic sanctification of the body were related to greater health protective behaviours, higher levels of exercise, greater subjective satisfaction with one's body, less unhealthy eating habits, and more disapproval of alcohol and illicit drug use (Mahoney et al., 2002).

Multi-Faith Perspectives on the Spiritual Framework of Coping

Four individuals from different faith backgrounds and who are currently involved in spiritual care in hospital settings were asked to examine and comment on this spiritual framework. Only the spiritual care worker from the Muslim faith perspective is a woman. These individuals were provided with a brief written summary and the figure of the spiritual framework of coping about 1-2 weeks prior to the scheduled interview. At the beginning of the interview, each care worker signed a consent form giving the researchers permission to use the interview content in any publications. Each interview was conducted in person and lasted 1-1.5 hours. The interviews were semi-structured, addressing the spiritual care workers' views on: overall impressions of the framework, elements of the framework that fit or do not fit with their experience of dealing with people from their faith group, missing elements from their faith perspective, and an example of how they might apply the framework to their work. Written summaries were prepared from transcriptions of the audiotapes of these interviews. Each spiritual care worker read and approved his or her summary. It is recognized that the views of these spiritual representatives are subjective and other representatives of these faiths may have somewhat differing opinions.

Muslim Faith Perspective

The representative of the Muslim faith is a pastoral care worker who provides services to various hospitals in a large Canadian city. Although she is open to providing services to other faith groups, she is usually regarded as the religious authority on the Muslim faith within the hospital network.

This individual found the framework presented in this paper to be "acceptable in every way." In particular, she emphasized the importance of prayer to the Muslim community. She described prayer as ritualized, formal, and occurring five times a day. Two types of prayer are used most often: petitionary prayer and prayers that act as a form of supplication and expression of worship. The weekly sermon and congregation prayers are central to the Muslim faith and nclude readings from the Qu'ran. Another aspect of the model consistent with her experience was the concept of connection. Connection to the Transcendent, Allah, is paramount and involves asking Him to protect and to help His people fulfill their needs and wishes. Mohammed's message could be included under the person factor of beliefs as it is used to guide the people in right and wrong action in their daily lives. Connection to others is also important, as the purpose of the Muslim faith is to serve and respect others. The concept of life purpose is conceptualized as praying, worshipping, and having hope in Allah and serving others, tenets central to the Muslim faith.

In order to make this spiritual framework more specific to the Muslim faith it would be necessary to omit certain examples subsumed under each dimension (e.g., meditation) while emphasizing other aspects (e.g., prayer). Instead, the framework presented in this paper would be more consistent with the Muslim faith if fasting (Ramadan), propriety, patience, and fortitude, and trust in Allah, as well as "spiritual cleanliness" were emphasized and included as specific examples of spiritual behaviours, beliefs, and relationship with God. The concept of "spiritual cleanliness" is a constant goal within the Muslim tradition ("Cleanliness is next to Godliness"). Connection to nature is also seen in a different way in the Muslim experience. Rather than experiencing a "connection," Muslims recognize God's creation of all nature and thank Him for this in their prayers. They express their wonder at the beauty of nature with words of praise to God ("Subhan Allah: Glory be to God").

Jewish Faith Perspective

The representative of the Jewish faith provides spiritual care services to a major general hospital as well as serves as the Jewish community chaplain (commissioned by a senior Rabbi) in nursing

homes and chronic care hospitals in a large Canadian city. He has served as a Torah-scroll reader at one Orthodox and two Conservative congregations in the same region.

This spiritual care worker found the framework presented in this paper to be comprehensive in its ability to capture the basic human experience of the total person and thus to fit with a secular/humanistic approach to life that many Jewish individuals adopt. Although he did not find any main elements to be missing from the framework, he did emphasize the importance of the two dimensions of personality and community for the individual coping with stress. As well, he offered that the specific examples under a dimension could be expanded to be more clearly applicable to a Jewish population. For example, he mentioned that study/learning (e.g., of the Torah) would be an important manifestation of spirituality under the domain of spiritual coping while prayer tends to be more communal.

This individual focused on the key component of the role of community in a Jewish individual's sense of identity and coping. He noted that a Jewish individual will make meaning of an event, for example, by situating it within the historical context of the Jewish community - "Is this something that has happened to others?" and "How do I respond to this?" He noted that Jewish individuals may appear "fatalistic" in that they can accept that "bad things happen" or that "this is the way things are" based on their knowledge of this shared cultural history. This sense of connectedness to the greater community provides a measure of comfort, belonging, and continuity. An individual need not even believe in Judaism (the religious faith) but can define his or her identity in terms of his or her participation in the Jewish community. In this way, being Jewish is related more to issues of practice rather than the expression of explicit beliefs or faith. Within this context, he commented that an individual's relationship with God is defined in more personal terms.

Christian Faith Perspective

The representative of the Christian faith is the chaplain and director of Spiritual Care for a tertiarylevel mental health hospital in a large Canadian city. For over 15 years, he has been responsible for coordinating the spiritual care of staff and clients. Although his own faith background is of the mainstream Protestant tradition, he offers spiritual care to persons of all faiths in his setting.

First, this chaplain found the framework presented in this paper to be helpful in identifying and integrating spiritual factors of human experience into other dimensions of life (e.g., the psychological). second, the inter-relatedness of the parts of the working framework allows it to be inclusive of persons from a range of faith traditions. Third, what he describes as the dialectic between one's personal response and the continuing engagement with reality is healthy and reflects a person's lived experience. This individual was particularly drawn to the person factors as a critical aspect involved in the understanding of a client's "attitude" or "stance" in the process of coping. A starting point in the framework is whether one's disposition is dynamic or fixed and is critical in evaluating his or her flexibility within the healing process. As well, he emphasized the role of connection (others or God) and then making "meaning" as one's ultimate aim in coping.

In terms of a lack of fit with the Christian perspective, he found that religiously mainstream clients in his mental health setting rarely used the spiritual coping of prayer and rituals although they may indeed wish to tap into these potential resources. During mental health crises, many are cut off from their faith communities and are at a loss regarding how to independently make prayer and rituals work for them. He reflected that clients of other faith traditions (Islam, Christian Science, Judaism) used prayer and rituals more often and that prayer in particular can be a bridge between the different faith traditions of chaplain and client.

Hindu Faith Perspective

The representative of the Hindu faith is a pastoral care worker who provides services to patients within a general hospital setting in a large Canadian city. This individual has been involved in the development of the local Hindu community for over 20 years.

This individual reported using all the elements of the framework (presented in this paper) in his daily work as a pastoral care worker. Specifically, he emphasized the inclusion of connection as an area of significance for Hindus coping with stress. In times of coping, the community elders and family are usually the people who provide support, presence, and advice on how to lead a better life. As coping with stress is often regarded as an inevitable part of life, the presence of others is of significance. He also described a significant relationship that people of Hindu faith have to nature, and particularly to the solar system. Within his faith tradition, there is a belief in the influence of planet rotation on well-being. Meaning-making in coping with stressful circumstances was dependent upon the connection one develops with self as well. If one is not connected to self then one will repeatedly encounter the same problem. Expressions of faith are also significant to the Hindu perspective. For example, some cancer patients go to the Temple and sit quietly, an activity that seems to help them cope. Worship of the "givens" (aspects of one's life such as family) strengthens the connection and understanding of how God works in the world.

The Hindu also embrace the concept of Karma, which is described as "the actions you are born with; some are accumulated over previous lives, and some we generated in this life." Stress related to one's past lives is inevitable, and the amount of stress varies from person to person. The belief of Karma helps Hindus cope through acceptance and the understanding that some stressors are beyond personal control. Once this acknowledgement is made, they try to resolve their situation by leading a good life under the direction and consultation of others. Finally, the Hindu belief of reincarnation helps individuals who are facing death recognize that it is merely a transition in the larger scheme of life. Thus, there is a temporal dimension to the Hindu belief system as it takes into consideration the past, present, and future in the process of meaning-making.

Implications for Future Research

Despite the plethora of research on the issue of spirituality, religion, and health, surprisingly few studies have proposed and/or tested pathways of effects for the various spiritual factors that can be implicated in the process of coping with stress. Notably, some of this research has referenced the transactional model of Lazarus and Folkman (1984) as a guiding rubric for the testing of specific pathways of coping. For example, Stolley et al., (1999) proposed a model of religious coping for caregivers but did not test the pathways in their subsequent analyses. Of the models that have been tested, across studies, preliminary evidence exists for various pathways among religious beliefs, coping styles, prayer, coping, support, and meaning as well as among these factors and aspects of psychological adjustment and well-being (Fitchett, Rybarczk, DeMarco, & Nicholas, 1999; Hathaway & Pargament, 1990; McIntosh, Silver, & Wortman, 1993; Nairn & Merluzzi, 2003; Nooney & Woodrum, 2002; Pargament et al, 1992). And yet, more research needs to be done on how spirituality functions in the enhancement of coping and well-being (Simoni et al., 2002). Studies have to focus on the identification of potential mediators and moderators in the process of spiritual coping.

This spiritual framework of coping is an attempt to capture the complexity of this field of research and to set out a comprehensive roadmap for the testing of various pathways of effect between specific spiritual coping and resources and well-being. This framework may be particularly applicable to understanding responses to stressors that are severe and out of an individual's control (Pargament, 1997). Being a process framework, it ideally should be researched within the context of longitudinal studies that will allow for the testing of the potential for the "mobilization" of a spiritual process of coping (Pargament & Brant, 1998) as well as for the adaptiveness of a particular spiritual factor (e.g., anger with God) across time. The spiritual framework of coping can also be easily integrated and studied within the context of the original transactional model, allowing for the

exploration of relationships between the spiritual and the general psychosocial aspects of life. Finally, this framework holds much promise for cross-cultural applications as it has the potential to be applied to various types of stressors encountered by individuals from different faith backgrounds or from no faith background. This model allows for specific changes in content under a spiritual dimension to better accommodate a particular tradition such as the Muslim faith. The area of multicultural aspects of spiritual coping has been largely ignored to date and represents a particularly rich area for future research.

[Sidebar]

Résumé

Depuis plusieurs années, nous assistons à une prolifération de travaux de recherche dans le domaine de la religion, de la spiritualité, de l'adaptation et de la santé. Malgré ce déferlement, la plupart des études s'en tiennent à un niveau d'analyse descriptif. Ce n'est que ces dernières années qu'on examine des associations plus complexes, des voies (c.-à-d., la médiation) et les nouveaux modèles possibles en ce qui a trait à l'influence de la religion et/ou de la spiritualité sur la santé. Le modèle transactionnel du stress et de l'adaptation élaboré à l'origine par Lazarus et Folkman (1984) est un modèle d'ajustement psychosocial qui semble prometteur en tant que « plateforme » de l'organisation et de la compréhension des vastes données sur la spiritualité. Le présent article utilise les principes élémentaires (p. ex., le processus dynamique) et les composantes structurelles (p. ex., les comportements d'adaptation) du modèle transactionnel comme cadre d'intégration des ouvrages empiriques de pins en plus nombreux qui portent sur la spiritualité, l'adaptation et la santé. Le résultat de l'application du modèle a été examine dans une perspective spirituelle par quatre travailleurs dispensant des soins spirituels et/ou aumôniers d'appartenance religieuse diverse. Les aumôniers multuonfessionnels ont critiqué l'« insuffisance » de ce modèle à appuyer leur compréhension de la santé et de l'adaptation du point de vue de leurs Croyances religieuses et ont proposé des modifications qui permettraient de rendre plus adéquat le modèle.

[Reference]

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