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A DECADE OF RESEARCH ON THE PSYCHOLOGY OF RELIGION AND COPING:
Things we assumed and lessons we learned

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Recently, the field of psychology has begun to display a growing interest in religious coping methods and their implications for health and well-being. Empirical studies have yielded an interesting picture of the relationship between religious coping and physical and mental health. In this paper, we review some of the foundational assumptions on which the theory of religion and coping rests. Then, we summarize recent advances in research in the area of religion and coping. We conclude by highlighting some of the exciting new directions for research in the psychology of religion and coping.

For thousands of years, religious traditions have prescribed religious coping methods for dealing with major life stressors. Despite the close links between religion and coping, this relationship has received relatively little attention from researchers in the mainstream of modern psychological inquiry. More recently, the field of psychology has begun to display a growing interest in religious coping methods and their implications for health and well-being. As we will see shortly, empirical studies have yielded an interesting picture of the relationship between religious coping and physical and mental health.

In this paper, we start by defining our key concepts, namely religion and religious coping and reviewing some of the foundational assumptions on which the theory of religion and coping rests. Then, we summarize recent advances in research in the area of religion and coping. It should be stressed from the onset that our discussion is by no means comprehensive. Instead, we draw attention to several of the advances in the field through illustrations of promising new research and findings. We conclude by highlighting some of the exciting new directions for research in the psychology of religion and coping.

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The Theory of Religion and Coping – Definitions and Foundational Assumption

Elsewhere, Pargament (1997) defined religion as a »search for significance in ways related to the sacred« (p. 32). This definition includes two important elements: *search for significance,* and the *sacred*. The search refers to the process of discovery of the sacred, conservation of the sacred once it has been found, and transformation of the sacred when internal or external pressures require a change (Pargament, 1997; Pargament & Mahoney, 2002). The search can also be understood in terms of the multiple pathways people take to reach their goals and the goals themselves. Religious pathways can be manifested through multiple dimensions in which the sacred is involved, such as ideology, ethical conduct, emotional experience, social intercourse, and study. The goals to be reached are just as diverse. They include achieving personal ends, such as meaning in life and self-development, social ends, such as intimacy with others and justice in the world, and sacred ends, such as closeness to God and living a moral and ethical life (Tarakeshwar, Pargament & Mahoney, 2003). We will define the sacred later in this paper (see the section, »The Centrality of the Sacred to Religious Coping«). Based on this definition of religion, religious coping methods can be defined as ways of understanding and dealing with negative life events that are related to the sacred. With this definition in mind, we now review some of the assumptions in which the theory of religion and coping rests.

Assumption 1: Religion comes in many shapes and sizes
Historically, psychologists and mental health professionals tended to view religion from a narrow, stereotypic perspective. Religion was largely depicted in a negative light; it was referred to as an avoidant method of coping, a form of denial, and a defense mechanism against anxiety. While examples of religious passivity, denial and defensiveness are not in short supply, we can also find examples of active religious coping and willingness to face the hardships of life head-on. In fact, recent empirical studies have demonstrated that religiousness, generally speaking, is more closely and consistently linked to active than passive coping. Stated differently and concisely, religion comes in many shapes and sizes.

Assumption 2: Religious coping does not operate in a vacuum
Religious coping does not operate in a vacuum and does not come from nowhere; it can be fully embodied in the individual's life. People draw on religious solutions to problems from a more general orienting system that is made up of well-established beliefs, practices, attitudes, goals, and values. Religious coping is also triggered by particular situations, especially those situations that push the individual beyond his or her everyday understandings and limited personal and social resources. For example, Ano (2003)

studied religious coping among college students and found that, even after statistically controlling for demographic and other important variables, personality, situational and other religious factors significantly predicted particular types of religious coping strategies. In addition, religious coping depends greatly on cultural factors. For instance, Kula (2001) studied religious coping among 200 people in Turkey one week following the tragic earthquake of 1999. He found that 63% of the participants in the study attributed the earthquake to a punishing God, a figure far greater than we find among people in the United States following major natural disasters. Similarly, working with a sample of 340 Muslims from all over the world, Abu Raiya, Pargament, Mahoney and Stein (under review) found that Punishing God Reappraisal was far more common among Muslims facing life stressors than among Christians in the United States.

Assumption 3: Religious coping has spiritual, psychological, social and physical implications

Religion is a multifunctional phenomenon that can serve multiple purposes. It has been linked to psychological goals, such as anxiety reduction, personal control, peace of mind, self-development and the search for meaning. It has been connected to social ends, such as the desire for social intimacy, solidarity and connectedness. Religion has been tied to physical functions, such as better health practices and physiological relaxation. Above all, religion serves ultimate spiritual ends, such as transcendence and knowing God. Given the variety of functions religion serves, social scientists need to be aware of the multi-dimensional implications of religious coping.

Assumption 4: Religious coping can be both helpful and harmful

Though unique, religious coping is still another way of coping. As such, it may be constructive or destructive, helpful or harmful. The psychology of religion and coping is not the place to look for easy answers when it comes to the value of religious coping. In this field of inquiry, reductionstic and simplistic explanations and interpretations should give way to more sophisticated questions about the extent to which various religious coping methods are well integrated with the individual's needs, goals, situations, and social context.

Assumption 5: Religious coping is a better predictor of outcomes than more general religious orientation

In studies of how people express their faith in the midst of difficult life situations, widely used global religious measures (e.g., average frequency of church attendance, frequency of prayer, self-rated religiousness or spirituality) fall short in providing satisfactory answers to key questions: what features of participation in religious services, if any, are helpful; how a person is praying; what kind of Higher Power the individual is seeking or praying

to. Religious coping methods are concrete manifestations of religion in difficult times and stressful situations. Working collaboratively with God to solve a problem, seeking God's love and care, seeking spiritual support from others, reappraising a situation in a benevolent way, questioning God's power, reappraising the situation as a punishment from God – religious coping methods such as these are directly and functionally related to the situation at hand. As a result, it is not surprising that these coping methods are intimately linked to the outcome of that situation. Actually, several studies have shown that religious coping methods predict outcomes more strongly than global religious measures (e.g., Roech & Ano, 2003; Loewenthal, MacLeod, Goldblatt, Lubitsh & Valentine, 2000; Nooney & Woodrum, 2002). For example, working with data from the 1998 General Social Survey, Nooney and Woodrum (2002) found that the relationship between church attendance and depression was mediated through church-based social support and the effects of prayer on depression were mediated through religious coping.

Assumption 6: To study religion, multiple research methods and tools are needed

Religious coping is a complex, multi-faceted phenomenon that has no single character. As such, no single research method can sufficiently capture its full essence. To develop a clearer picture of the various manifestations of religious expression, many research methods and tools (e.g., experiments, surveys, correlational analyses, naturalistic observations, case studies, qualitative methods) are needed. Further, it is problematic to assume that we can study the religious lives of people while adapting an arrogant, elitistic and distant stance. Surveys from a distance are not adequate. If we are genuinely interested in the essence of spiritual experiences and religious coping, we need to talk to people, get to know them, learn about their lives and faiths, and follow their concerns and difficulties over time.

Assumption 7: Religion can be more fully interwoven into efforts to help people

Religious beliefs, attitudes and practices are essential ingredients of the daily functioning of many individuals. When seeking professional help, it is natural to assume that these individuals carry with them their religious coping resources. For different reasons, clinicians are typically hesitant to address religious topics in the context of their professional relationships. Perhaps due to their discomfort in dealing with these topics, when religious issues are raised, many clinicians may quickly change the subject to a more familiar ground or reduce religion to presumably more fundamental processes. If a client does not raise the issue of religion, clinicians may assume, sometimes wrongly, that religion is irrelevant to the life of that client. Nevertheless, it is known that clients search for spiritually-sensitive treatment, and

as mentioned previously, religion is linked to mental and physical health. Hence, instead of ignoring religious issues or reducing them to presumably more basic processes, psychologists and other mental health professionals should learn to address religious issues in their helping relationships.

Researchers are Getting Closer to Religious Life

Survey data have revealed clear links between religion and mental and physical health. Though important, these findings are based on the briefest, most global indices of religion, such as frequency of prayer, self-rated religiousness and frequency of church attendance. Unfortunately, using global indices to assess such a multi-dimensional complex phenomenon can lead to an incomplete and perhaps distorted understanding of religion. Even when significant findings are obtained, we are left with a key question: What it is about religion that can account for these findings? This question cannot be answered unless we get closer to the heart of the religious experience. Towards this end, we find the metaphor of coping especially helpful.

We think that the metaphor of coping is a fitting one because it forces us to look more carefully and closely at religious experience. Coping is an active and dynamic process; it is an attempt to make sense of, deal with and manage stressful life circumstances in a specific time and place. Approaching religion from a coping perspective helps us to move from the abstract to the concrete; it allows us to see how particular individuals use specific religious elements in specific life contexts and circumstances. It forces us to leave our comfortable academic environment and clinical offices and get to know real people facing real life problems. Psychologists who adapt the coping framework are getting closer to religious experience. The following examples explicate this point.

First, when assessing religious coping, we pay special attention to the details. As mentioned earlier, global single items of religiousness are insufficient. For example, a question such as »To what degree have you involved your religious beliefs and practices in the way you have coped with your illness« assesses merely *how much* religion is accessed. It does not yield knowledge about the *who* (benevolent God, punishing God), *what* (spiritual, interpersonal), *when* (during acute major stressors, for how long), *where* (in public, privately) and *why* (to find meaning, to gain control, to achieve life transformation) of religious coping. Working with a sample of college students and medically ill elderly patients, and using a factor analysis, Pargament et al. (2000) identified 17 religious coping methods that shed light on the complexity and diversity of religious coping. These factors include seeking spiritual support, religious problem solving, religious forgiveness, punishing God reappraisal and spiritual discontent, and were grouped into two higher order factors: positive religious coping and negative religious

coping methods. Positive religious coping activities reflect a secure relationship with God, a belief that there is a greater meaning to be found, and a sense of spiritual connectedness with others. Negative religious coping activities reflect an ominous view of the world, and a religious struggle to find and conserve significance in life (Pargament, Smith, Koenig & Perez, 1998).

Second, rather than studying people in a retrospective manner, an approach that has been shown to possess serious limitations (Stone et al., 1991), researchers are starting to work with people in the midst of their problems and have begun to assess religious coping longitudinally across various points in life. These longitudinal attempts make clearer the workings of religion and its diverse impacts on people struggling through extreme moments. For example, Keefe et al. (2001) evaluated the role of daily spiritual experiences and daily religious/spiritual coping in the experience of individuals with pain due to rheumatoid arthritis (RA). They worked with thirty-five individuals with RA who were asked to keep a structured daily diary for 30 consecutive days. The diary included standardized measures designed to assess spiritual experiences, religious and spiritual pain coping, salience of religion in coping, religious/spiritual coping efficacy, pain, mood, and perceived social support. The participants in this study reported having spiritual experiences, such as feeling touched by the beauty of creation or feeling a desire to be closer or in union with God, on a relatively frequent basis. These participants also reported using positive religious and spiritual coping strategies much more frequently than negative religious and spiritual coping strategies. Individuals who reported frequent daily spiritual experiences had higher levels of positive mood, lower levels of daily negative mood, and higher levels of each of the social support domains.

Third, we are now seeing efforts to integrate religious coping into the larger framework of people's lives (Hays, Meador, Branch & George, 2001; Tepper, Rogers, Coleman & Malony, 2001). For example, Tepper et al. (2001) studied 406 patients from diverse backgrounds who were diagnosed with persistent mental illness. Participants in this study completed questionnaires assessing various demographic, religious coping, and mental health indicators. The researchers found that a greater number of years that religious coping had been used as well as greater proportion of overall coping time devoted to religion were predictive of less severe psychopathology and better mental health. Though limited in their cross-sectional design, these studies represent an attempt to examine the prevalence and impact of religious coping over the course of people's life.

Fourth, researchers have begun to examine religious coping using different methods such as life stories and narratives (Ganzevoort, 1998, 2001; Pendlton, Cavalli, Pargament & Nasr, 2002). For example, Pendlton et al. (2002) conducted interviews with 23 children diagnosed with cystic fibrosis and examined their drawings. They found that many children expressed a

persistent, unalterable belief that God would do whatever they want. This study is unique in its methodology and its focus of concern-children. Despite the fact that the findings of studies like these are limited in generalizability, they illustrate promising alternative methods for studying religious coping.

We believe that getting closer to religious experience makes our job as researchers both challenging and rewarding. It is challenging because it forces us to leave our comfortable academic setting and work »harder« in unfamiliar environments. It is rewarding because it provides us with a more accurate picture of religious experience.

Helpful and Harmful Effects of Religious Coping

Since the publication of *The Psychology of Religion and Coping: Theory, Research, Practice* in 1997 (Pargament, 1997), a large body of empirical research has examined the relationship between religious coping and mental health. These studies have demonstrated robust links between both positive religious coping and negative religious coping and different indices of physical and mental health. Below we draw attention to some of the recent relevant studies. As noted above, positive religious coping activities reflect a secure relationship with God, a belief that there is a greater meaning to be found, and a sense of spiritual connectedness with others, while negative religious coping activities reflect an ominous view of the world, and a religious struggle to find and conserve significance in life (Pargament, Smith, Koenig & Perez, 1998).

A clear picture has emerged from studies of the relationship between positive religious coping and mental health: positive religious coping is positively and persistently associated with desirable mental health indicators (Smith, Pargament, Brant & Oliver, 2000; Tarakeshwar & Pargament, 2001; 2002; Narin & Merluzzi, 2003; Smith, McCullough & Poll 2003; Ai, Peterson & Huang, 2003; Meisenhelder & Marcum, 2004; Pieper, 2004; Ano & Vasconcelles; 2005; Abu Raiya, Pargament, Mahoney & Stein, under review). For example, Smith, Pargament, Brant and Oliver (2000) examined the relationship between religious coping by church members and psychological and religious outcomes following the 1993 Midwest flood. They found that positive religious attributions and coping activities predicted better psychological and religious outcomes both 6 weeks and 6 months post-flood, after controlling for exposure and demographics. Tarakeshwar and Pargament (2001) assessed the role of religion in the coping of families of children with autism. They found that positive religious coping was associated with better religious outcomes (e.g., changes in closeness to God/church and spiritual growth). Mattis, Dwight, Fonteb and Hatcher-Kay (2002) explored the relationship between social support, everyday racism,

religiousness, spirituality, and dispositional optimism among 149 African American individuals. They found that subjective spirituality and relationship with God were positively related to optimism. Further analyses revealed that the perception that one has a supportive and loving relationship with God was the sole religiousness variable that emerged as the predictor of optimism. Ai, Peterson and Huang (2003) collected information about religiousness, war-related trauma, religious-spiritual coping, optimism, and hope from a sample of 138 Muslims who escaped from Kosovo and Bosnia and settled in the United States. Applying Pargament's (1997) concept of religious-spiritual coping and using a path model, they found that higher religiousness was positively associated with positive religious coping, which in turn was related to higher optimism and education. Working with 841 ministers in the Presbyterian Church, Meisenhelder and Marcum (2004) examined posttraumatic stress, religious and nonreligious coping in relation to positive religious outcomes following the tragedies of 9/11. They found that looking to God for strength, support, and guidance was the most frequently used strategy; the second was increased prayer. They also found that more frequent positive religious coping was related to less severe stress symptoms and numbness and avoidance, and higher positive religious outcomes. Ano and Vasconcelles (2005) conducted a meta-analysis of 49 studies testing the efficacy of religious coping for people dealing with stressful situations with a total of 105 effect sizes. The results of the study generally supported the hypothesis that positive religious coping was related to positive psychological adjustment to stress. Using a factor analysis with an international Muslim sample, Abu Raiya, Pargament, Mahoney & Stein (under review) identified Islamic Positive Religious Coping & Identification as one of 7 factors of Islamic religiousness. They found also that greater levels of Islamic Positive Religious Coping & Identification were consistently and strongly linked to greater levels of desirable outcomes (general Islamic well-being, purpose in life, satisfaction with life) and lower levels of undesirable outcomes (symptoms of physical health, alcohol use). Because of the persistent links between this factor and positive indices of well-being, they labeled this factor the »positive predictor« of Islamic religiousness.

However, religious coping can be also a source of strain. A significant body of empirical work is making it increasingly clear that certain forms of religious coping can be harmful. In a study of medically ill, elderly patients, Pargament, Tarakeshwar and Hahn (2001) found unexpected results. Over the two-year period of their study, 176 of the patients they studied died. Consequently, they were able to test whether religious coping measures predicted mortality. After controlling for other variables (illness severity at baseline, mental health status, demographic variable), they found that negative religious coping was associated with a significantly greater risk of dying over two years. Specifically, people who felt that God had abandoned them, who questioned God's love and care, and who felt that the devil was

at work in their illness had a 19 to 28% increased risk of dying. This was perhaps the first study that has established a link between certain forms of religious expression and risk of mortality.

Other studies have linked signs of religious struggle to poorer mental health and even psychopathology (Fitchett, Rybarczyk, DeMarco & Nicholas, 1999; Exline, Yali & Lobel, 1999; Pargament, Zinnbauer et al., 1998; Smith, Pargament, Brant & Oliver, 2000; Sherman et al., 2005; Cole, 2005; McConnell & Pargament et al., 2006; Abu Raiya, Pargament, Mahoney & Stein, under review). For example, Sherman et al. (2005) examined general religiousness and two modes of cancer-specific religious coping, drawing closer to faith (positive) and struggling with faith (negative), among 213 multiple myeloma patients evaluated at the same point in treatment, during their initial work-up for autologous stem cell transplantation. The outcomes assessed included standardized measures and clinician ratings of depression, general distress, physical functioning, mental health functioning, pain, and fatigue. After adjusting for relevant control variables, negative religious coping was associated with significantly poorer functioning in the areas of depression, distress, mental health, pain, and fatigue. Cole (2005) compared the efficacy of spiritually-focused therapy for people diagnosed with cancer to a no-treatment control condition. One of the major findings of her study was that negative religious coping was correlated with greater depression, anxiety, pain frequency and severity, and poorer overall physical well-being. McConnell and Pargament et al. (2006) investigated the relationship between spiritual struggles and various types of psychopathology symptoms in individuals who had and had not suffered from a recent illness. Participants completed self-report measures of religious variables and symptoms of psychopathology. Spiritual struggles were assessed by a measure of negative religious coping. As they predicted, negative religious coping was significantly linked to various forms of psychopathology, including anxiety, phobic anxiety, depression, paranoid ideation, obsessive-compulsiveness, and somatization, after controlling for demographic and religious variables. In addition, the relationship between negative religious coping and anxiety and phobic anxiety was stronger for individuals who had experienced a recent illness. Abu Raiya, Pargament, Mahoney and Stein (under review) identified religious struggle as one of two negative types of religiousness among Muslims. Greater levels of Islamic Religious Struggle were linked consistently and strongly with greater levels of negative outcomes (angry feeling, alcohol use, depressed mood) and lower levels of positive outcomes (positive relations with others, purpose in life). Hence, they coined the Islamic Religious Struggle factor the »negative predictor« of Islamic religiousness.

It seems that religious struggles are the symbol of the »dark night of the soul« (Flower, 1987). Their negative impacts are found across different religious groups and cultures. Initially, these findings surprised us. After

all, from Abraham to Moses to Buddha to Jesus to Muhammad to Mother Teresa, illustrious religious figures have experienced their own religious struggles only to come out the other side steeled and strengthened. How can these findings be explained? One key may be whether the individual is able to resolve his or her struggles. Some recent analyses suggest that this may be the case; it appears that those who are unable to resolve their struggles over time are at greater risk of poorer mental and physical health, while people who experience these struggles temporarily do not face the same risk (Pargament, Koenig, Tarakeshwar & Hahn, 2004). Another key may be the degree to which religious struggles are socially acceptable. In this vein, Abu Raiya, Pargament, Mahoney and Stein (under review) hypothesized that expressions of religious struggles, especially doubts about the existence of God or the afterlife, are not socially acceptable in the Islamic culture. As a result, Muslims who have religious doubts may experience alienation and loneliness, which may lead to depression or angry feelings. To cope with these negative feelings, some individuals may use destructive methods of coping such as alcohol use. Promising as these explanations might be, it is important to recognize that they are still speculative. Future studies are needed to explicate the mechanisms that mediate between religious struggles and negative outcomes.

Findings with regard to spiritual struggles suggest that mental health professionals need to be aware of »religious red flags« or signs of religious struggle when working with clients. Interventions to help people deal with their »dark nights of the soul« seem called for. As we will see shortly, steps in this direction have been already taken. Referral to a pastor or religiously-trained psychologist would seem appropriate to help these individuals work their struggles through before they become chronic.

The Centrality of the Sacred to Religious Coping

Stressful events have the potential to influence the lives of people on multiple levels: the psychological, the social, the physical. Traditionally, psychologists tended to ignore another important life domain that can be strongly affected by these events, namely the spiritual domain. Examples of the negative impact of stressful events on the spiritual realm of life are not in short supply. For example, many women who have been sexually abused as children suffer damage not only to their sense of themselves and their relations with other people, but also to their feeling of being loved and accepted by God and the conviction that they have a greater purpose in life. As one survivor put it: »Our God seems to have abandoned us, and the sacred seems untouchable« (Flaherty, 1992; p. 28).

The sacred lies at the heart of any attempt of religious coping. But what does the sacred mean? According to the Oxford Dictionary, the sacred refers

to the holy, those things that are »set apart« from the ordinary and deserve veneration and respect. Pargament and Mahoney (2002) define the sacred as divine beings, higher powers, God, or transcendent reality, and other aspects of life that take on spiritual character by virtue of their association with the divine. According to this definition, any aspect of life can take on extraordinary character through its association with, or representation of, divinity. Little and Twiss (1973) summarize this point well:

> It may be a quality (e.g., wisdom, love), a relation (e.g., harmony, unity), a particular natural entity (e.g., sun, earth, sky, river, animal), a particular individual or group (e.g., king, the dead), nature as a whole, a pure form or realm of pure forms (e.g., good, truth, all Ideas), pure being (e.g., One, Being Itself, Ground of Being), a transcendent active Being (e.g., Allah, Yahweh, God (pp. 64-65).

Pargament and Mahoney (2002) have hypothesized that people are particularly motivated to preserve the sacred and protect those aspects of life they hold sacred from various threats and violations. Several studies support this hypothesis. For example, Mahoney et al. (1999) found that couples who view their marriages as sacred engage more in constructive problem solving activities when they face conflict. Individuals who view their environment as sacred are also more likely to act in ecologically friendly ways (Tarakeshwar et al., 2001). Mahoney et al. (2005) applied the construct of *sanctification* to college students' perceptions of their bodies. Students completed measures of the extent to which they viewed their bodies as being a manifestation of God (e.g., »My body is a temple of God«) and as characterized by sacred qualities (e.g., holy, blessed, sacred). Greater levels of both forms of *sanctification* were related to higher levels of health-protective behaviors, strenuous exercise, satisfaction with one's body, and disapproval of alcohol consumption as well as to lower levels of illicit drug use, unhealthy eating practices, and alcohol consumption. Viewing the body as having sacred qualities was also related to lower rates of binge eating and illicit drug use. Working with a community sample of 150 adults, Mahoney et al. (2005) found that most participants perceived their top 10 strivings in life as being connected to God and having sacred, transcendent qualities, with highest ratings given to religious goals, family relationships, altruistic endeavors, and existential concerns. They also found that greater sanctification of strivings correlated positively with the importance, commitment to, longevity, social support for, and internal locus of control of strivings.

However, sacred objects cannot always be protected. When a sacred aspect of life is harmed or violated, people may be particularly vulnerable to distress, for we are talking about events that are more than traumas or major life stressors; words like these cannot do justice to the spiritual character of these experiences. Elkins (1995) puts it nicely: »some violations and betray-

als…wound so deeply that they can only be called abuses to the soul« (p. 91).

Several studies have examined the ties between perceptions of spiritual loss and desecration and subsequent physical and mental health. The results of these studies have been consistent. Appraisals of sacred threat, loss, and violation have powerful ties to mental health (Magyar, Pargament & Mahoney, 2000; Mahoney et al., 2002; Pargament et al., 2005; Pargament et al., 2007). For example, in a study of college students in Ohio and New York City after the 9/11 attacks, students who perceived the attacks as desecrating sacred values were more likely to experience depression, anxiety, and symptoms of post-traumatic stress disorder (Mahoney et al., 2002). Working with 117 adults selected randomly from the community, Pargament et al. (2005) found that people who experienced life events that were perceived to be sacred losses or violations of the sacred (i.e., *desecrations*) reported higher levels of emotional distress. More specifically, sacred loss was predictive of intrusive thoughts and depression, and *desecration* was tied to more intrusive thoughts and greater anger. Furthermore, sacred loss was linked to greater posttraumatic growth and positive spiritual change; in contrast, *desecration* was associated with less posttraumatic growth. Pargament et al. (2007) examined whether the appraisal that Jews desecrate Christian values is linked to anti-Semitic attitudes. Furthermore, they considered whether religious coping methods mitigate or exacerbate the ties between religious appraisals of Jews and anti-Semitic responses. Working with 139 college students in a midsize university in the Midwest, they found that greater perceptions of Jews as desecrators were associated with greater anti-Semitism, after controlling for demographic variables and personological measures (e.g., particularism, pluralism, church attendance, Christian orthodoxy, fundamentalism, authoritarianism). They also found that religious coping in ways that emphasized expressions of Christian love were associated with lower anti-Semitism; ways of coping that emphasized views of Jews as being punished by God and demonic were tied to greater anti-Semitism.

The Direction of Causality: What Causes What?

Cross-sectional methods are the predominant methods applied when studying the relationship between religious coping and mental health. Although studies utilizing these methods have discovered important relationships between religious coping and mental health, these studies have a major shortcoming: they do not allow for causal inferences. Consequently, we cannot determine whether positive/negative religious coping lead to better/worse outcomes or people who experience better/worse adjustment are more likely to report greater/lesser use of particular religious coping strategies.

To assess the causal connections between religious coping and well-being, longitudinal studies are called for. Steps in this direction have already been taken. Within the past few years, several investigators have studied religious coping longitudinally. These studies have demonstrated that religious coping significantly predicts changes in mental health over time (Ai, Dunke, Peterson & Bolling, 1998; Alferi, Culver, Carver, Arena & Antoni, 1999; Krause, 1998; Tix & Frazier, 1998; Pearce et al., 2002; Loewenthal, MacLeod, Goldblatt, Lubitsh & Valentine, 2000). For example, working with a sample of 51 coronary bypass surgery, Ai et al. (1998) examined religious coping and its effect over a one-year period. Participants completed questionnaires measuring demographic variables, health conditions, spiritual support, social support, and psychological adjustment immediately after surgery and at one-year follow-up. They found that religious coping with the surgery (e.g., private prayer) was tied to decreased depression and general distress one year post-surgery. Pearce et al. (2002) examined associations between religious coping, health, and health service use among a sample of 265 recently bereaved adults. Participants were interviewed an average of 6.3 months after their loss and again 4 months later. They found that at baseline, those high on religious coping had significantly more functional disabilities than did those low in religious coping. In addition, participants with higher religious coping scores were significantly less likely to visit their doctor during the 60 days prior to the baseline interview. Despite poorer health and less health services use at baseline, those high on religious coping had equivalent health status to those low on religious coping at follow-up. Loewenthal, MacLeod, Goldblatt, Lubitsh & Valentine (2000) examined the long-term effects of religious coping beliefs. They followed up on 84 Jewish and Protestant participants to see whether religious coping beliefs were predictive of outcomes nine months later. They found that the most robust effects of the religious coping beliefs were on positive mood, indicating that religious coping has a long-lasting effect on mood.

Although these studies did not use comprehensive measures of religious coping (i.e., positive and negative forms), they shed important light on the temporal relationships between religious coping and well-being. What these studies suggest basically is that religious coping *leads* to some relatively long-lasting alterations in mental health. Stated differently, the concrete actions people undertake with their religion when facing stressful events and situations have significant long-term ramifications. More studies are needed to verify this conclusion.

Links between Religious Coping and Outcomes – Potential Moderators

The links between religious coping and outcomes are neither simple nor straightforward. Researchers have tried to identify some of the variables that moderate the relationships between religious coping and outcomes. In this process, several conclusions appear to be warranted. First, it is clear that religious coping takes different forms across different religious groups and cultures. For instance, when administering the RCOPE to Christian populations, Pargament et al. (2000), using factor analysis, identified two higher order factors – positive and negative religious coping. Within other religious groups, however, the picture was somehow different. Within a Jewish sample, three factors were identified; in addition to the positive and negative factors, a third factor was identified that speaks to the importance of Jewish communal and ethical involvement in dealing with difficulties (Dubow, Pargament, Boxer & Tarakeshwar, 2000). Working with a Hindu sample, Tarakeshwar, Pargament and Mahoney (2003) identified three factors of a different kind. The first was a negative religious coping that included bad karma; the second was positive religious coping – God-focused (looking to God for love, guidance and strength), and the third was positive religious coping-spirituality-focused (a search for spiritual connection, spiritual reawakening, yoga and meditation).

Second, it is likely that religious coping is more helpful to people who are more religious. Some empirical studies lend support to this hypothesis. For example, working with a sample of Presbyterian members, elders, and clergy in the United States, Pargament, Tarakeshwar, Ellison and Wulff (2001) found that religious coping and religious support were more strongly related to positive affect and depressed affect for clergy than for elders, and for elders than for members. Similar results were found in another study (Krause, Ellison & Wulff, 1998). It should be added that in both studies, negative religious coping and negative church interactions were also more strongly associated with depression and less positive affect for the more religious groups. It seems that religious coping can be a »double-edge sword;« people who center their lives on religion experience more of the costs as well as the benefits of religious involvement.

Third, there is evidence to suggest that religious coping may be more beneficial to some religious groups than others. For example, Alferi et al. (1999) studied the relationship between religious coping and emotional distress among a sample of Roman Catholic and Evangelical Hispanic women who were recently diagnosed with breast cancer. Participants completed questionnaires assessing demographic variables, religious coping, and emotional distress before surgery, after surgery, and at three, six, and twelve months follow-up. The researchers found that religious coping was more helpful for Evangelical women, but was related to greater distress

among Roman Catholic women. Tentatively, the authors suggested that the Evangelical women's focus on faith and acceptance during the crisis might have been more helpful for them than the emphasis on confession, judgment, and absolution from guilt among the Catholic women. However, we should not rush to the simple conclusion that Evangelical Protestants are »better off« than Roman Catholics. In another study, Kooistra and Pargament (1999) found that religious doubts were more strongly associated with distress among Protestant Dutch Reformed adolescents than Roman Catholic adolescents. Involvement in any religious domination is probably linked to distinctive advantages and disadvantages.

Finally, religious coping appears to be particularly beneficial to individuals experiencing more stressful situations that push them beyond the capacity of their immediate resources (e.g., death, terminal illness). In these situations, people seem to recognize their limitations and call for more ultimate solutions (Krause, 1998; Wink & Dillon, 2001; Pargament 2002). In such circumstances, religious coping may be more compelling. For example, Krause (1998) studied about 500 older adults living in dilapidated neighborhoods over a four-year interval. He found that people who made more use of religious coping methods were better protected over the four-year period from the ill-health effects of the more deteriorated neighborhoods.

Religious Coping is a Unique Process

»How unique is religion?« This question has concerned psychologists and other social scientists for a number of years. This question is far from an intellectual exercise; the answer to it has important implications for the ways that psychologists study, understand, and approach religion (Pargament et al., 2005).

In an attempt to clarify the workings of religion, many researchers are examining questions about potential mediators of the relationship between religion and well-being. For example, can the relationship between church attendance and lower rates of mortality be explained by the social support members receive from the church or the sense of meaning received from religious doctrine? Can the relationship between religious struggles and negative outcomes be explained by the degree to which the individual is able to work struggles through or the extent to which the individual's community accepts these struggles? Explaining how religion works at the psychological and social levels is part of our job as researchers and practitioners. Nonetheless, there is an important difference between explaining religion and explaining religion away.

Many renowned social scientists have argued that there is nothing unique about religion. For them, religion is merely an expression of more basic psychological, social or physiological processes. For example, Leuba (1933)

maintained that mystical experiences could be ultimately explained by physiological processes. Freud (1927/1961) asserted that religion is a set of illusions designed to reduce anxiety and satisfy childish wishes. Durkheim (1915) viewed religion as an expression of basic social needs. More recently, Funder (2002) expressed a similar point of view: »The psychological processes by which religion affects subjective well-being and psychological and physical health are interesting and important, and research on them is easily justified – but they have very little to do with religion per se, and there is nothing that necessarily leads from an interest in these processes to a focus on religion« (p. 214). Each of these theorists tried to integrate and explicate religious phenomena within his specific theoretical framework. None saw the need for special concepts, theories, or methods tailored to religious life.

These types of reductionstic explanations of religion have not received empirical support. Numerous studies have testified to religion's distinctiveness with respect to several dimensions: motivation and personality (Allport, 1961; Emmons, 1999; Piedmont, 1999; Pargament & Mahoney, 2002; Mahoney, 2005; Tarakeshwar, Swank, Pargament & Mahoney, 2001), mortality and health (McCullough, Hoyt, Larson, Koenig & Thoresen, 2000; Hummer, Rogers, Nam & Ellison, 1999), coping (Mickley, Pargament, Brant & Hipp, 1998; Pargament et al., 1999; Tix & Frazier, 1998), and distress (Richards & Bergin, 1997; Trenholm, Trent & Compton, 1998; Murray-Swank et al., 2005). For example, Piedmont (1999) examined spirituality as a »motivational trait,« one he described as an intrinsic, stable dimension of personality. Working with a college sample, he constructed the Spiritual Transcendence Scale (STS) that assessed prayer fulfillment, universality and connectedness. Piedmont showed that STS predicted outcomes (e.g., social support, interpersonal style, stress experience) above and beyond the effects of personality (the five-factor model of personality). McCullough, Hoyt, Larson, Koenig and Thoresen (2000) conducted a meta-analysis of data from 42 independent samples examining the association of a measure of religious involvement and all causes of mortality. They found that religious involvement was significantly associated with lower mortality, indicating that people with higher religious involvement were more likely to be alive at follow-up than people lower in religious involvement. Moreover, McCullough et al. (2000) examined whether potential mediating and confounding variables (demographics, health behaviors, social support) could explain the relationship between religiousness and mortality. Smaller, but still substantial, associations between religious involvement and mortality remained even after controlling for these variables. Trenholm, Trent and Compton (1998) investigated the role of religious conflict in individuals with panic disorder. Working with a sample of 60 adult women divided into three groups (panic disorder without therapy, panic disorder in therapy, and therapy patients without panic disorder), they found that religious conflict

was a unique predictor of panic disorder, even after controlling for anxiety state, hypochondriacal beliefs, and abnormal illness behaviors and irrational thoughts.

In a study of religious coping, Tix and Frazier (1998) studied kidney transplant patients and their loved ones. They found that religious coping predicted life satisfaction even after controlling for general coping dimensions, such as cognitive restructuring, internal control, and social support. Similarly, working with a sample of 150 family members of loved ones undergoing coronary artery bypass surgery, Pargament et al. (1999) found that religious problem-solving strategies for gaining control (e.g., collaborative, deferring, self-directing coping) were uniquely associated with coping efficacy, anxiety and depression, and spiritual well-being after partialling out the effects of demographics and nonreligious methods of coping.

Thus, empirical studies suggest that religion in general, and religious coping in particular, may not be fully reducible to presumably more basic processes. The most parsimonious explanation of these findings may be that religion has direct and unique effects on well-being. To put it another way, religion represents a significant dimension of life that stands on its own ground. Though additional research is needed that examines potential mediators between religion and health more comprehensively, it is highly unlikely that religion will be »explained away.« Religion certainly interacts with other basic human processes. Yet, extensive theoretical and empirical evidence suggest that religion is a distinctive dimension.

Psychospiritual Interventions

After a decade of intensive research on the intersection between religion and coping, it is safe to assert that we have gained some important insights about this fascinating topic. However, our goals as psychologists of religion do not end with describing, explaining and understanding the religious phenomenon. Our ultimate goal, perhaps, is converting abstract knowledge to practical applications that can be beneficial to people in their communities.

Increasingly, psychotherapists are incorporating a variety of spiritual and religious elements into their work with clients, with promising results (Richards & Bergin, 1997; al-Issa, 2000; Pargament, 2007; Pargament, Murray-Swank & Tarakeshwar, 2005; Freedman & Enright, 1996; McCullough & Worthington, 1994). For example, Murray-Swank and Pargament (2005) evaluated the effectiveness of an 8-session, spiritually-integrated intervention for female survivors of sexual abuse with spiritual struggles. Two clients (ages 39 and 49) participated in manualized sessions from the intervention, Solace for the Soul: A Journey Towards Wholeness, with an individual therapist. An interrupted time-series design included daily measurements of positive and negative religious coping, spiritual distress, and

spiritual self-worth, as well as comprehensive measures of spiritual well-being, religious coping, and images of God before the intervention, immediately after the intervention, and 1-2 months later. Both clients increased in positive religious coping, spiritual well-being, and positive images of God. In addition, ARIMA analyses revealed significant changes during the course of the intervention (e.g., increased daily use of positive religious coping). Several studies have found that different forms of religious psychotherapy were effective with Muslim clients who suffered from anxiety, depression, and bereavement (Razali, Hasanah, Aminah & Subramaniam, 1998; Azhar, Varma & Dharap, 1994; Azhar & Varma, 1995). In these studies, clients in the groups receiving psychotherapy that included Islamic components (i.e., prayer, expressing repentance and forgiveness, relying on Allah and supplicating to Him in times of needs) responded significantly faster to therapy and manifested better adjustment than those receiving standard treatment.

However, empirical research thus far has not provided conclusive evidence that interventions which integrate religious components are more effective than traditional psychological interventions. Some studies have found that there are no significant differences between interventions which integrate religious components and traditional psychological interventions. For example, Rye, Pargament et al. (2005) evaluated the effectiveness of 2 versions of an 8-session forgiveness group intervention for divorced individuals. 149 participants were randomly assigned to a secular forgiveness condition, a religious forgiveness condition, or a no-intervention comparison condition. The researchers hypothesized that a religiously-integrated forgiveness intervention would be more effective than a forgiveness intervention that was not explicitly linked to religion. Measures of forgiveness and mental health were obtained at pretest, posttest, and 6-week follow-up. Participants in both intervention conditions increased significantly more than comparison participants on self-reported forgiveness of an ex-spouse and understanding of forgiveness. However, the religious and secular conditions did not differ from each other for the most part.

Other studies have suggested that whether the spiritually focused interventions are more effective than traditional interventions depend on the controllability of the stressor. For instance, Cole and Pargament (1999) compared the effectiveness of a spiritually focused group therapy with a cognitive behavioral group therapy for adults coping with cancer. The intervention centered on four existential themes believed to be relevant to this population: control, meaning, identity and relationships. In the spiritually focused group, spiritual issues were discussed and participants were encouraged to draw on their relationship with whatever they defined as transcendent to achieve their goals in therapy. While participants in the CBT group deteriorated in their mental health over the course of the study, those in the spiritually focused group maintained their level of mental health before and after treatment. Thus, the spiritually focused group appeared to be more effective

than the secular treatment in sustaining the well-being of these participants over time. However, when the researchers replicated the study in a sample of adults with cardiac syncope, the findings were different; the cognitive behavioral treatment proved to be more effective in lowering anxiety than the spiritually focused treatment (Cole, Pargament & Brownstein, 2000).

Still, some studies have found that spiritually focused interventions are more effective than secular interventions. For example, Wachholitz and Pargament (2005) compared secular and spiritual forms of meditation. Participants in this study were taught a meditation or relaxation technique to practice for 20 min a day for two weeks. After two weeks, participants returned to the lab, practiced their technique for 20 min, and placed their hand in a cold-water bath of 2°C for as long as they could endure it. The length of time that individuals kept their hand in the water bath was measured. Pain, anxiety, mood, and spiritual health were assessed following the two-week intervention. They found that individuals in the spiritual meditation group had greater decreases in anxiety and more positive mood, spiritual health, and spiritual experiences than individuals in the other two groups. Participants in the spiritual meditation group also tolerated pain almost twice as long as those in the other two groups.

These studies suggest that, like other psychological interventions, spiritually oriented interventions may need to be tailored to particular groups dealing with particular problems in particular contexts.

Concluding Remarks

Based on a decade of intensive research, we have learned many lessons and gained many insights regarding the fascinating intersection of religion and coping. We have begun to move beyond stereotyped and pathological views of religion to a more accurate and comprehensive understanding of religion as a complex phenomenon. However, questions still outnumber answers. Let us conclude our discussion by pointing to some of the exciting new directions for research in the psychology of religion and coping.

First, we should investigate religious coping among different cultures and religious traditions. Researchers are beginning to examine religious coping methods that are specific to particular religious traditions such as Lutherans in the United States (Hummel, 1999), Jews (Dubow, Pargament, Boxer & Tarakeshwar, 2000), Hindus (Tarakeshwar, Pargament & Mahoney, 2003) and Muslims (Abu Raiya, Pargament, Mahoney & Stein, under review). However, though this accumulating body of research supports the potential for some comparative results, it is still in its »infancy.« Further empirical studies are needed to clarify the picture of the relationship between religion and coping among different religious groups, especially non-Western religious traditions.

Second, the vast majority of studies on the intersection of religion and coping have used psychological and physical outcome measures. One type of outcome, the spiritual, has been particularly neglected. Because religion is designed primarily to serve spiritual functions, the effects of religious coping strategies on spiritual outcomes (e.g., spiritual maturity, commitment to faith, religious stewardship, and spiritual security) seem crucial to consider.

Third, much of the research in the psychology of religion and coping has focused on the conservational functions of religion (i.e., the role religion plays in helping people preserve, protect, and sustain their sacred objects). The role religion plays in personal transformation, what has been called »quantum change« (Miller & C'de Baca, 2001), has been largely neglected. Given that religion, at times, serves as a catalyst for profound changes in underlying goals, values and lifestyles, researchers should take a serious look at religion's capacity for promoting life transformations.

Fourth, we should investigate religious coping among some relatively neglected groups. Though religious coping has its roots in childhood and extends throughout the lifespan, most of the research on religious coping has been conducted with adult populations. It is time to learn more about the developmental aspects of religious coping and how religious coping evolves over the course of the individual's lifetime. Interesting questions to consider are, do religious coping methods change at different phases of life? Are certain forms of religious coping especially helpful to certain groups, such as the elderly?

Finally, many individuals rely on religious resources to cope with difficulties and crises. Thus, it is important to study the impact of such resources in psychotherapy. Moreover, because studies have linked signs of religious struggle to poorer mental health and even psychopathology, it seems natural to assume that interventions targeting religious struggles may help improve the mental health status of the individual and prevent distress and psychopathology (Pargament et al., 2006). This assumption has received some empirical support (Pargament, 1999; Murray-Swank & Pargament, 2005), but further evidence is needed to verify the effectiveness of efforts to address religious struggles in psychotherapy.

We hope that researchers will find these new directions for research in the psychology of religion and coping as fascinating as we do. We believe that answers to the questions we outlined will help us better understand how people utilize religion in coping with difficulties and crises. Because religion is perhaps the most distinctively human dimension of life, any psychological approach that neglects the religious dimension is necessarily incomplete. But by expanding our understanding of religious life, we can enhance our more general understanding of what it means to be human and, in turn, apply this knowledge to our efforts to enhance the lives of people in their communities.

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