Journal of Spirituality in Mental Health, 15:107–122, 2013

ISSN: 1934-9637 print/1934-9645 online
DOI: 10.1080/19349637.2013.776442

Routledge
Taylor & Francis Group

Assessing Spirituality: The Relationship Between Spirituality and Mental Health

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This research study investigated the possible relationship between two spirituality variables (religious coping styles and spiritual well-being) and two psychological variables (anxiety and depression). Also studied were differences between those who self-disclosed a spiritual/religious identify and those who did not. Although a relationship was not noted between religious coping styles and the psychological variables, significance was reported in the relationship between spiritual well-being and both psychological variables. Overall, this study finds that individuals reporting higher levels of religiosity and spiritual well-being may also experience a reduction in mental and emotional illness.

KEYWORDS spirituality, religiosity, anxiety, depression

Over the past few decades, spirituality has become an increasingly important consideration in the mental health profession (Richards & Bergin, 2005; Young, Wiggins-Frame, & Cashwell, 2007). This has included an emphasis

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and awareness of the importance of integrating spirituality and religion within the counseling process (Parker, 2011; Seybold & Hill, 2001). The integration of spirituality into the counseling process is reflective of recognition that spirituality can be beneficial to client welfare (Koenig, 2010; Miller & Thoresen, 2003; Seybold & Hill, 2001). Moreover, there is significant evidence that spirituality may be related to or positively impact overall mental health or well-being (Hodges, 2002; Townsend, Kladder, Ayele, & Mulligan, 2002). This point is reflected in the growing body of research examining the physical, emotional, and psychological effects of spirituality and religiosity (Hayman et al., 2007). For many individuals, spirituality and religion are central and foundational aspects of their lives and their well-being, and thus critical elements of the counseling process and interpersonal dynamic (Miller & Thoresen, 2003; Parker, 2011; Seybold & Hill, 2001).

As previously noted, evidence suggests that spirituality may be linked to physical health and well-being (Hodges, 2002; Townsend et al., 2002), and that spirituality is a significant component of holistic wellness (Myers & Williard, 2003). From a mental health perspective, religion and spirituality may be involved in how individuals and groups make decisions, solve problems, and cope with life experiences; all of these activities incorporate spiritual themes and subsequently can correspond to overall improved mental health (Thurston, 1999; Pargament et al., 1988). In addition, spirituality may be an asset or a coping strategy for dealing with negative life events, as well as with psychological concerns (Koenig, 2010; Pargament et al., 1988); for example, Hayman et al. (2007) reported that spirituality helped buffer the negative effect of stress on self-esteem. There are also indicators that spirituality may relate to how an individual deals with or is affected by depression (Srinivasan, Cohen, & Parikh, 2003; Westgate, 1996) and anxiety (Graham, Furr, Flowers, & Burke, 2001).

LIMITATIONS OF CURRENT RESEARCH IN SPIRITUALITY AND RELIGIOSITY

Although research has supported that spirituality is linked to both positive physical health (Miller & Thoresen, 2003; Townsend et al., 2002) and positive mental health (Koenig, 2010; Hayman et al., 2007), the same research also notes a number of complicating factors in studying spirituality and religiosity. A review of literature reveals that similar limitations are noted in many research studies, the most common problem being the definition of spirituality. When questioning if spirituality can be measured, Oakes and Raphel (2008) noted that a common concern is defining the constructs: "these definitional problems make it difficult to know what a measure of spirituality actually assesses" (p. 243). This problem in defining spirituality echoes Speck's (2005) concerns regarding the inherent difficulty in determining a

consensual definition of spirituality because of its epistemological nature. Further, Seybold and Hill (2003) suggested that the inconsistencies in defining spirituality and religiosity have resulted in an ambiguous nature of research findings, which then leads to conflicted reporting when linking research outcomes to the mental and physical health issues being treated.

Other noted limitations in studying spirituality and religiosity are that quantitative measures may not fully assess the subjective nature of spirituality (Moberg, 2002) and that a majority of spiritually related assessment instruments are developed from a Judeo-Christian perspective (Stanard, Sandhu, & Painter, 2000). Moberg (2002) suggested that qualitative assessments may provide more useful and specific information about an individual's spirituality than a quantitative measure, as individual responses may better express spiritual needs and experiences. As noted by Stanard et al. (2000), many measures of spirituality and religiosity also lack normative information, thus limiting their usefulness in clinical settings. Because a lack of normative information inhibits the ability to generalize assessed results, Moberg's (2002) suggestion for a qualitative assessment of spirituality reflects an understanding of the individualistic nature of spiritual experience and expressions, as well as articulating the difficulty in even developing a normative understanding of spirituality. Miller and Thoresen (2003) stated that spirituality and religiosity are best described as *latent constructs,* which are complex and multidimensional variables. Therefore, such complexity in a construct implies that no single assessment instrument can adequately capture its meaning.

Research in spirituality and religiosity has attempted to address this complexity through the development of a multitude of assessment instruments. Hill and Hood (1999) published a review of 125 spirituality/religiosity assessment instruments, which were placed into 17 categories; each designed to assess a different construct of spirituality and religiosity. These 17 categories were defined as (a) religious beliefs and practices, (b) religious attitudes, (c) religious orientation, (d) religious development, (e) religious commitment and involvement, (f) religious experience, (g) religious/moral values or personal characteristics, (h) multidimensional religiousness, (i) religious coping and problem solving, (j) spirituality and mysticism, (k) God concept, (l) religious fundamentalism, (m) death/afterlife, (n) divine intervention/religious attribution, (o) forgiveness, (p) institutional religion, and (q) related constructs. Unfortunately, as noted by Stanard et al. (2000), most of the assessment instruments reviewed by Hill and Hood (1999) suffered from a lack of normalizing data, questionable design, and most were developed from a Judeo-Christian perspective. Some instruments, although initially developed from a Judeo-Christian view, have shown promise through the development of normalized information, validation through repeated use within numerous research studies, and refinement of nonspecific religious vocabulary. Assessment instruments, such as the Spiritual Well-Being Scale (Ellison, 1983; Paloutzian & Ellison, 1982) and the Religious Problem-Solving

Scale (Pargament et al., 1988), have demonstrated high levels of validity and reliability, thus suggesting greater utility in research and practice.

The increase of interest in the study of spirituality and religiosity has resulted in the development and improvement of assessment instruments designed to evaluate various constructs of spirituality and religiosity. Research studies, such as Hayman et al. (2007) and Davis, Kerr, and Robinson-Kurpius (2003), used assessment instruments designed to measure faith maturity and levels of spiritual well-being and religious orientation, respectively, related to various mental health concerns. Davis et al.'s (2003) study reported that "greater spiritual well-being predicted lower trait anxiety among at-risk adolescents" (p. 361), although they did caution against over-generalization of these results. Similarly, Hayman et al.'s (2007) study reported that higher levels faith maturity correlated with higher levels of self-esteem and lower levels of stress and body-image concerns. Although further study in the areas of spirituality and religiosity is recommended, sufficient evidence has already been collected to demonstrate correlations among spirituality and religiosity with both mental and physical health. It appears that further research should focus in refining an understanding of various spiritual constructs with physical and mental health, as well as determining how to resolve the deficiencies in the qualitative assessment of spirituality and religiosity, as noted previously.

THE CURRENT STUDY

The current study was designed to evaluate the relationship of spiritual well-being and religious problem-solving with anxiety and depression. The selected spiritual constructs were partially determined through the selection of well-validated instruments designed to evaluate spirituality. Because of noted limitations with spirituality assessment instruments, the authors resolved to carefully select assessment instruments that have demonstrated fewer such limitations; a discussion of these instruments is provided below. Furthermore, because anxiety and depression are currently understood as two of the most common psychological concerns throughout the world (Seligman & Reichenberg, 2007), they presented as common, personal characteristics that could be present in a nonclinical sample population.

Because literature has suggested that the relationship between mental health and spirituality is complex (Miller & Thoresen, 2003; Seybold & Hill, 2001), it is important to note that understanding this relationship is made even more complex when one considers the overlapping and differing constructs and definitions of religiosity and spirituality, as noted by Moberg (2002) and Richards, Bartz, and O'Grady (2009). For the purposes of this study, *spirituality* will be defined as a sense of connectedness to a higher power and openness to the infinite beyond human existence and

experience (Burke et al., 1999). *Religion* (or *religiosity*) will be defined as "an institutionalized set of beliefs and practices by which groups and individuals relate to the ultimate" (Burke et al., 1999, p. 252). Inherent in these definitions is an understanding that both religion and spirituality are complex constructs, to address this issue the current study focused on two specific aspects of spiritual and religious identity: religious problem-solving (specifically religious coping styles as they correspond to one's relationship with God in a passive, collaborative, or self-initiating approach, as developed by Pargament et al., 1988) and spiritual well-being. The latter (spiritual well-being) consists of a global concept relating to one's own perception of spirituality and well-being, including one's sense of quality of life (Ellison, 1983; Paloutzian & Ellison, 1982). Furthermore, it was the intent of this research study to compare across the spirituality measures to determine which demonstrated a more significant relationship with the measures of mental health used in this study (Beck Anxiety Inventory and Beck Depression Inventory-II). In addition, this study will address any differences noted within the sample population, as some participants were recruited from a private, religiously affiliated university, and other participants were recruited from a public university. The findings of this study could provide critical information for counseling professionals about this relationship, as well as how it relates to psychological and mental health concerns.

METHOD

Participants and Sampling

Both undergraduate and graduate students from two universities were recruited as a convenience sample to participate in this study: one university is a large, public institution in the Southeast (Southeastern), and the second university is a small, private, religiously affiliated university located in the Midwest (Midwestern). All participants were recruited from both undergraduate and graduate courses and were offered extra credit to complete an assessment packet. A total of 150 surveys were distributed at the end of a class session and collected the following class session; in all, 121 survey packets were returned (response rate of 81.3%; there was no follow-up). All responses were anonymous. There were 30 male and 91 female participants. Participant ages ranged from 19 to 56 years ($M = 24.50$ years). Ethnic diversity among participants was slight as 82% self-reported as Caucasian, 13.1% self-reported as African-American, and 4% self-reported with other distinct ethnicities. Furthermore, religious diversity was low; 96.2% ($n = 25$) of the Midwestern participants reported to be Christian (3.8% [$n = 1$] reported to be Messianic Jew) or of a Christian denomination, and 90.6% ($n = 87$) Southeastern participants reported to be Christian or of a Christian denomination. Other Southeastern participants reported as Agnostic (4.2%, $n = 4$), Gnostic (1.0%, $n = 1$), Jewish (2.1%, $n = 2$), and Seventh-Day Adventist (1.0%, $n = 1$).

Participants completed a packet consisting of a demographic questionnaire and four assessment instruments. The demographic questionnaire requested grouping data such as age, ethnicity, gender, religious/spiritual affiliation, and the use of the word "God" in their spiritual/religious affiliation. To counterbalance the presentation of measures and not affect the participant responses, the order of documents placed in half of the survey envelope packets contained documents in a different order.

Measures

The Religious Problem-Solving Scale (RPSS) was used to measure religious coping and problem-solving styles. This scale was designed by Pargament et al. (1988). Consisting of three subscales (Self-Directing, Collaborative, and Deferring), the RPSS contains 36 items on a 5-point Likert scale (1 = *never,* 2 = *occasionally,* 3 = *fairly often,* 4 = *very often,* and 5 = *always*) in which item responses indicate how often the individual engages in an activity. According to Thurston (1999), reliability and validity are reportedly strong: Collaborative ($r = .94$, $\alpha = .93$), .94 Self-Directing ($r = .94$, $\alpha = .91$), and Deferring ($r = .91$, $\alpha = .89$). Test-retest reliability returned promising reliability estimates: $\alpha = .93$ (Collaborative), $\alpha = .94$ (Self-Directing), and $\alpha = .87$ (Deferring). According to Pargament et al. (1988), in respect to measures of religiousness, the Self-Directing subscale correlated to a significantly negative relationship with a Higher Power, whereas the Collaborative and Deferring exhibited a positive relationship.

The Spiritual Well-Being Scale (SWBS; Ellison, 1983; Paloutzian & Ellison, 1982) was designed to provide a global measure of a respondent's quality of life and one's perception of spiritual well-being (Boivin, Kirby, Underwood, & Silva, 1999). The instrument is constructed of two subscales: religious well-being (Religious) and existential well-being (Existential), as well as an overall score of spiritual well-being (SWB). The SWBS is a 20-item assessment answered on a 6-point Likert-type scale (1 = *strongly agree* to 6 = *strongly disagree*), where reliability and validity appear to be high (Stanard et al., 2000): Religious ($r = .96$, $\alpha = .96$), Existential ($r = .86$, $\alpha = .78$), and SWB ($r = .93$, $\alpha = .89$), with a slight correlation between the two subscales ($r = .32$), a high correlation between SWB and the Religious subscale ($r = .90$), and a moderate correlation between SWB and the Existential subscale ($r = .59$). However, the test-retest reliability coefficients with four samples on a 1-, 4-, 6-, and 10-week interval resulted in high reliability; the SWB global scale ranged from .82 to .99, the Religious subscale ranged from .88 to .99, and the Existential subscale ranged from .73 to .98 (Paloutzian & Ellison, 1991). Internal consistency reliability coefficients for the two subscales and the global scale reported results for SWB ranging from .89 to .94, results for the Religious subscale ranging from .82 to .94, and results for the Existential subscale ranging from .78 to .86.

The Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1988) was used in this study to measure symptom levels of anxiety. The BAI was created from three existing anxiety assessments to more accurately discriminate anxiety-related diagnoses from non-anxiety-related diagnoses. Consisting of 21 items, the BAI is answered on a 4-point Likert scale (0 = *not at all* to 3 = *severely; I could barely stand it*) to indicate severity of anxiety symptoms. Beck et al. (1988) reported that the BAI displayed high levels of internal consistency ($\alpha = .92$). Furthermore, Dowd and Waller (1998) reported that internal consistency reliability coefficients ranged between .85 and .94 and test-retest reliability over one week resulted in a coefficient of .75.

The Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996) was utilized in this study to evaluate levels of depression in participants. The BDI-II consists of 21 items, each scored on a 4-point Likert scale (0 = *not present* to 3 = *severe*). Beck et al. (1996) reported that the BDI-II exhibits high Cronbach's alphas: outpatients ($\alpha = .92$) and college students ($\alpha = .93$). Internal consistency reliability was measured using corrected item-total correlations for both the clinical (range = .39 to .70) and convenience (range = .27 to .74) samples. The test-retest reliability resulted in a reliability coefficient of $\alpha = .93$. The BDI-II also correlated well with the BAI with a small subject sample (n = 297; $r = .60$).

RESULTS

Because the spirituality assessments were developed from a Judeo-Christian perspective, participants were asked to respond to the following on the demographics questionnaire: "Does your spiritual/religious identity use the word 'God'?" One hundred percent of participants indicated that the word "God" is used in their spiritual/religious identity. Familiarity with the word "God" clearly did not invalidate the results. Analysis of assessment results reported that Midwestern participants reported higher scores on the Collaborative ($M = 43.88$; $SD = 7.039$; $\alpha = .88$) and Deferring ($M = 30.15$; $SD = 7.358$; $\alpha = .83$) subscale than Southeastern participants ($M = 37.31$; $SD = 12.531$; $\alpha = .96$ and $M = 29.25$; $SD = 10.595$; $\alpha = .93$, respectively). Conversely, the Southeastern participants reported higher scores on the Self-Directing subscale ($M = 25.32$; $SD = 12.015$; $\alpha = .96$) than the Midwestern participant ($M = 21.96$; $SD = 6.109$; $\alpha = .87$). Overall, the mean responses on the Collaborative ($M = 38.72$, $SD = 11.861$, $\alpha = .96$), Deferring ($M = 29.45$, $SD = 9.967$, $\alpha = .92$), and Self-Directing ($M = 24.60$, $SD = 11.080$, $\alpha = .96$) subscales suggested that participants were more likely to use a collaborative relationship with God to address problems and cope with negative life experiences, as well as demonstrating strong reliability factors. Overall mean results for the Religious ($M = 52.59$, $SD = 10.061$, $\alpha = .95$) and Existential

($M = 50.40$, $SD = 6.361$, $\alpha = .82$) subscales indicated that participants endorsed strong religious well-being, as well as a high degree of existential well-being. Specifically, the Midwestern participants reported higher levels of spiritual well-being on both the Existential subscale ($M = 51.15$; $SD = 5.767$; $\alpha = .78$) and the Religious subscale ($M = 56.73$; $SD = 6.625$; $\alpha = .85$) than the Southeastern participants ($M = 50.20$; $SD = 6.528$; $\alpha = .83$ [Existential]; $M = 51.45$; $SD = 10.824$; $\alpha = .96$ [Religious]). These findings imply that the participants perceive a robust sense of satisfaction in one's relationship with God and a solid identity with spiritual/religious practices, as well as a high level of satisfaction with one's life. Additionally, overall mean responses from the BDI-II ($M = 7.21$, $SD = 6.275$, $\alpha = .88$) and the BAI ($M = 6.93$, $SD = 6.263$, $\alpha = .87$) reveal that the participants in this study did not positively endorse many symptoms of depression or anxiety, respectively. Table 1 provides information regarding the overall Pearson correlation coefficients.

To determine the relationship between spirituality and mental health, a multiple regression was used. Table 2 provides a summary of the multiple regression analysis, demonstrating the independent variables (spirituality subscales) used within the full and restricted models. The coefficients of determination ($R^2 = .236$) indicated that in the full model, all five spirituality subscales significantly accounted for approximately 23.6% of the relationship with the BDI-II, $F(5,115) = 7.113$, and approximately 15.4% ($R^2 = .154$) of the relationship with the BAI, $F(5,115) = 4.171$. Additionally, the effect sizes

TABLE 1 Pearson Correlations between the Spirituality Subscales and Mental Health Inventories

	Deferring	Self-Directing	Existential	Religious	BAI	BDI-II
Collaborative	.748***	−.698***	.358***	.760***	−.092	−.077
Deferring	—	−.586***	.283**	.605***	−.001	−.012
Self-Directing		—	−.348***	−.809***	.117*	.196
Existential			—	.489***	−.299***	−.448***
Religious				—	−.041	−.212*

*$p < .05$. **$p < .01$. ***$p < .001$.

TABLE 2 Multiple Regression Model Summary

Regression model	IV	R	R^2	F	$F\Delta$
Full models					
BDI-II	5	.486	.236	7.113***	—
BAI	5	.392	.154	4.171*	—
Restricted models					
BDI-II	1	.448	.201	29.848***	2.136
BAI	3	.369	.136	6.155*	.625

*$p < .05$. **$p < .01$. ***$p < .001$.

were relatively small at $f^2 = .309$ (BDI-II) and $f^2 = .182$ (BAI). These models, however, were further restricted to the spirituality subscales that made a significant contribution toward the relationship with mental health.

For the BDI-II, the model was restricted to a single spirituality subscale (Existential) and accounted for 20.1%, $R^2 = .201$; $f^2 = .252$; $F(1,120) = 29.848$, of the relationship. For the BAI, the restricted model retained three subscales (Existential, Self-Directing, and Religious) and accounted for 13.6%, $R^2 = .136$; $f^2 = .157$, $F(1,118) = 6.155$. The R^2 values from the full and restricted models were not statistically significant for the BDI-II ($p = .146$) or the BAI ($p = .431$), indicating that the restricted models did not significantly decrease the effect size by removing variables. In summary, the restricted regression model contains the spirituality subscales that significantly contributed to the relationship with the mental health measures. The primary findings from the results suggests that existential well-being is a significant factor in lower levels of anxiety and depression, and that religious coping styles do not appear to factor into lowered levels of anxiety and depression.

Table 3 summarizes the effects of each spirituality subscale in the full and restricted regression models. As expected by the researchers, the Existential subscale provided the greatest predictor variable in both the BDI-II ($\beta = -.448$) and the BAI ($\beta = -.299$), indicating a strong inverse relationship between experiencing meaning and purpose in one's life and experiencing symptoms of anxiety and depression. Although not found with the BDI-II, the Religious and Self-Directing subscales loaded with smaller effect sizes with the BAI. More specifically, a moderate positive predictor value ($\beta = .120$) was found for the Self-Directing subscale and a smaller negative predictor value ($\beta = -.041$) was found for the Religious subscale. These results appear to indicate having a meaningful, purposeful relationship

TABLE 3 Multiple Regressions with the Spirituality Measures and the Mental Health Inventories

	BDI-II		BAI	
Regression model	β	*r*	β	*r*
Full model				
Collaborative	.125	−.077	−.219	−.094
Deferring	.148	−.012	.171	−.001
Self-Directing	.205	.196	.301	.120*
Existential	−.460	−.448***	−.387	−.299***
Religious	−.006	−.212	.456	−.041**
Restricted model				
Existential	−.448	−.448***	−.387	−.299***
Self-Directing	—	—	.306	.120*
Religious	—	—	.396	−.041*

*$p < .05$. **$p < .01$. ***$p < .001$.

with God or a Higher Power is the most significant factor in reduced levels of anxiety and depression.

A multivariate test of significance found a Wilks' lambda of .843 ($p = .030$) with the BAI. This value indicated a significant difference between the BAI and spirituality subscales; the observed power (.883) denoted these values were likely a true effect and did not result from chance. Additionally, a Wilks' Lambda of .700 ($p < .001$) with the BDI-II indicating a significant difference between the BDI-II and the spirituality subscales. Also reporting a high observed power (.992), the effect between the BDI-II and the spirituality subscales was likely a true effect. Therefore, for the participants in this study, these results appear to be an accurate representation of the inverse relationship between spiritual well-being and mental health concerns.

A final consideration for this study concerned the response differences between the two sample populations. As previously noted, the Midwestern participant group was recruited from a small, private, religiously-affiliated university, whereas the Southeastern participants were recruited from a large, public university. As a primary critique of the spirituality assessment instruments is that past research participants were recruited from religiously affiliated universities or church groups (Boivin et al., 1999; Thurston, 1999), it was of interest to determine if differences exist between the two participant groups in this study. A t-test analysis was conducted and two subscales indicated group differences: Collaborative ($t = 3.49$, $p < .001$) and Religious ($t = 3.64$, $p < .001$). Table 4 provides results for all spirituality subscales. Because the t-test analysis reported significant differences on only two of the five spirituality subscales, the data was evaluated as a single participant group.

DISCUSSION

Although a generalization of these research results is limited due to the homogeneity of ethnicity and religiosity, the findings of this study do suggest

TABLE 4 *T*-Test Analysis with the Spirituality Subscales and Mental Health Instruments

	Midwestern participants			Southeastern participants				
Subscale	*n*	*M*	*SD*	*n*	*M*	*SD*	*t*	*p*
Collaborative	26	43.88	7.039	95	37.31	12.531	3.488	.001[a]
Deferring	26	30.15	7.358	95	29.25	10.595	.499	.620
Self-Directing	26	21.96	6.109	95	25.32	12.015	−1.951	.054
Existential	26	51.15	5.767	95	50.20	6.528	.676	.500
Religious	26	56.73	4.754	95	51.45	10.824	3.640	.001[a]
BAI	26	5.62	4.900	96	7.29	6.558	−1.213	.227
BDI-II	26	7.96	8.388	96	7.01	5.607	.546	.589

[a]Using a Bonferroni-adjusted alpha level of .05/7 = .007.

that a relationship exists between the symptoms of anxiety and depression and level of spiritual well-being. Not surprisingly, the findings also suggest that the spirituality constructs measured in this study were related, as indicated in Table 3; the spiritual well-being subscales and religious coping subscales were significantly correlated. Specifically, the results of this study indicates that individuals who reported a high use of religious coping styles also reported high levels of spiritual well-being. Because the mean values of all spirituality subscales are relatively high and are highly correlated, these results may indicate multicollinearity among the independent variables (spirituality subscales), or even a mediating variable. This idea has been supported in literature: it has been suggested that spirituality assessment instruments may measure similar constructs (Miller & Thoresen, 2003; Phillips, Pargament, Lynn, & Crossley, 2004); the findings in this study suggest that the spirituality subscales do not adequately discriminate among the constructs they measure. It should be noted that two characteristics of the study participants may have influenced these overall findings: a large majority of the participants reported a relatively high level of spiritual well-being, as well as a high level of use of religious coping styles. This homogenous demographic characteristic of the sample may limit the generalized application of these findings. However, group differences need to be viewed in relation to differences between levels of religious affiliation within the sample. This suggests the need for further assessment in this area.

Surprisingly, the results reported that participants who indicated a greater desire to work together with God to resolve a problem (Collaborative) also strongly endorsed a belief that they address problems without any intervention from God (Self-Directing). While this result may initially appear contradictory, it may also suggest that the study participants are articulating a strong sense of spiritual well-being, as well as maintaining a strong sense of self-confidence in their ability to address negative life events; however, this does not diminish their emphasis on relying upon themselves. Spiritual well-being can clearly incorporate God into ones' life while also incorporating self-reliance. Because many participants were traditional undergraduate students, it is important to note that Ma (2003) proposes that during the stresses and uncertainty found during the college years, students might feel supported by, but not totally rely upon, spiritual guidance. Students may not feel the need to turn to God with all problems, just the concerns that are significant or overwhelming. Ma's (2003) assertion could explain this apparent contradiction of indicating both a collaborative and self-directing relationship with God or a Higher Power.

Among the Religious Problem-Solving Scale subscales, only the Self-Directing subscale demonstrated a significant positive correlation to the depression, as measured by the BDI-II (see Table 1); this finding suggests that the participants who reported higher levels of depressive symptoms also reported using a self-initiating, self-reliant approach to coping with negative

life events. Two possible explanations may be that less reliance upon a higher power may increase the possibility of feeling alone and unsupported, thus leading to increased symptoms of depression (Phillips et al., 2004) or that higher levels of depression may also indicate a loss of hope, thus preventing the individual from utilizing spiritual and/or religious resources (Hodges, 2002).

The findings also demonstrated that participants who reported higher levels of existential well-being also reported fewer or less intense symptoms of depression. This result parallels the previously discussed findings and those reported in previous research; specifically, individuals reporting a higher level of involvement in spiritual and/or religious activities also report decreased symptoms of depression, especially as it relates to life satisfaction and finding meaning in life (Wachholtz & Pargament, 2005; Young, Cashwell, & Shcherbakova, 2000). Additionally, the results suggested that individuals reporting lower levels of depressive symptoms endorsed a higher level of religious well-being. Much like the Existential subscale, these results may indicate that persons experiencing fewer symptoms of depression may perceive a closer relationship with God as expressed through religious activity. These results also support research reporting that religious activity may alleviate symptoms of depression (Hodges, 2002; Wachholtz & Pargament, 2005). These findings, however, should be viewed cautiously as the majority of participants reported relatively low levels of depressive symptoms and high levels of religiosity. Even so, the results of this study appear to support previous research in mental health: engaging in spiritual and/or religious activities may reduce or alleviate symptoms of depression.

These results should be considered relative to the results that indicated participants who reported high levels of existential well-being also reported lower levels of anxiety symptoms. This suggests that persons reporting higher levels of existential well-being may be better equipped to handle stressful and anxiety-producing situations. Furthermore, this correlation may be bi-directional, meaning that a lack of anxiety could also encourage an increase in existential well-being and vice-versa. Similarly, other studies have demonstrated an inverse relationship between spirituality and mental health concerns (Berry & York, 2011; Graham et al., 2001). Specifically, previous research has suggested that persons with a high level of spiritual well-being also report lower levels of mental health concerns. Although not statistically significant, the slight negative trend between the Beck Anxiety Inventory and the Religious subscale is consistent with other research which has suggested that persons engaging in spiritual and/or religious activities are more likely to report fewer mental health concerns (Miller & Thoresen, 2003; Seybold & Hill, 2001). Furthermore, Townsend et al. (2002) and McCorkle, Bohn, Hughes, and Kim (2005) suggested that religious activity has demonstrated positive results in the treatment of anxiety and other mental health issues. Finally, these results indicated that the constructs measured by the spirituality

assessments could explain a significant portion of the relationship between anxiety and depression as measured by the BAI and the BDI-II, respectively. These results parallel previous research (Graham et al., 2001; Wachholtz & Pargament, 2005), which has also demonstrated a relationship between mental health and spirituality. Overall, the findings of the current study and this previous research help support the importance of addressing and integrating spirituality and/or religiosity into the treatment of persons suffering from physical, emotional, or mental illness. As discussed by others (Moberg, 2002; Oakes & Raphel, 2008; Van Asselt & Senstock, 2009), this should be done with respect to, and with appreciation of the individual's personal religious and spiritual identity.

In summary, this study suggests that individuals with higher levels of existential well-being are also more likely to report lower levels of anxiety and depression; a finding that is supported by a variety of research studies (Baetz, Bowen, Jones, & Koru-Sengul, 2006; Graham et al., 2001; Wachholtz & Pargament, 2005). Moreover, existential well-being may correspond to spirituality and mental health and individuals with a higher degree of religious well-being may be more likely to report depression. This study also suggests that individuals who participate in religious activities and/or are seeking a closer relationship with God or a Higher Power may have fewer or less intense depressive symptoms. Overall, the findings of the study suggest that individuals with greater levels of religiosity and spiritual well-being may also experience an increased sense of well-being and a decrease in mental, emotional, and physical illness.

Implications for Counselors and Counselor Education

Throughout the past few decades, many research studies have examined the relationship between spirituality and mental health, joining with the sizable research base that has focused upon the relationship between spirituality and physical health (Miller & Thoresen, 2003; Powell, Shahabi, & Thoresen, 2003; Seybold & Hill, 2001). The results of the current study further extend this research base to consider how spiritual well-being, specifically existential well-being and religious well-being, may correspond to mental health. In particular, the findings supported the idea that spirituality and religious well-being can contribute to mental health. This helps add to the ever-growing call to train counselors to be prepared to integrate spirituality into the counseling process. Furthermore, the results add to increasing support for counselor training programs to consider how religion and spirituality relate to the counseling process and to clients' well-being. Based upon this growing support, counselor education training programs should consider how to incorporate training on these issues in counseling practice and in counseling supervision. There is also evidence that a component of this is helping counselors explore personal perceptions and beliefs about the

role of spirituality and religious well-being, and how they can be explored during counseling process. This is a critical element, for it has been suggested that this process should rely on counselors being able to appreciate an individual's spiritual and religious identity versus attempting to "force" their religious beliefs on a client (Oakes & Raphel, 2008; Van Asselt & Senstock, 2009). An appropriate integration of counseling and spirituality can only occur if the counselor has adequate training on the role of spirituality in counseling and the opportunity to examine his/her own attitudes and beliefs.

Finally, many have asserted that there is clearly sufficient evidence to support the need for counselors to understand the role of religion and spirituality in the lives of their clients (Koenig, 2010; Miller & Thoresen, 2003; Seybold & Hill, 2001). A potential starting point in this process may be extending research on the role of spirituality and religion in the counseling process. Richmond (2004) has claimed that research concerning spirituality has been a part of the counseling profession for well over a century; however, there remains a real need for additional research and study focused on addressing the negative perceptions of spirituality and religiosity as they relate to the counseling process (Miller & Thoresen, 2003; Seybold & Hill, 2001). Moreover, this study highlights that spirituality and religious well-being may have a significant influence on overall mental health. The challenge of future research will be defining the specifics of this relationship: is it preventative or simply a coping process? In addition, and even more importantly, how can counselors integrate it, assess it, or use spirituality in a manner that will empower the counseling process?

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