CHAPTER 2
REVIEW OF LITERATURE

A review of literature helps to understand the problem clearly. Therefore, literature from various sources was extensively reviewed and studied in light of the present investigation. In this chapter, various empirical and theoretical studies directly or indirectly related to the objectives of the present study are reviewed under the following main headings:

1. Spiritual Growth and Development
2. Conceptual and Professional Issues
3. Spirituality and Religiosity
4. Life Experience and Spirituality
5. Measurement of Spirituality
6. Spirituality and Psychotherapy
7. Spirituality and Health / Well-Being

**Spiritual Growth and Development** To understand the phenomenon of spiritual growth and development a close scrutiny of studies are required. Under this section studies with this concept have been reviewed.

Chen (1997) pointed out that death is grief because it is an inevitable phase of life. He attempted to pinpoint the enormous potential of grief in advancing our spiritual growth. Jung (1971) states that when encountering a crisis such as loss, the unconscious often break through to help us with new adjustments, whereby a transcendent function takes place. Instead of becoming
an emotional trauma, grief can transcend our everyday experiences and awaken us to our spiritual essence.

Feinstein (1997) discussed personal mythology as it relates to an individual’s psychological and spiritual development. He illustrated a five-stage process for facilitating the evolution of an individual’s personal mythology in a detailed case study, navigate of each stage are discussed. Such tasks include identifying the mythic conflict underlying psychological difficulties, understanding both sides of the conflict, refining the new mythic vision and making a conscious commitment to it, and translating a new mythology into daily life.

Page and Berkow (1998) described group work designed to promote the spiritual development and applied to therapy groups for drug and alcohol abusers. The authors gave definitions of self, spirit, spirituality, and spiritual growth that show spiritual development can be fostered in therapy groups. They discussed research related to the spiritual development of the members of drug and alcohol groups. The authors also made comparisons between the ways that group work and Alcoholic Anonymous promote the spiritual development of drug and alcohol abusers.

James and Samuels (1999) examined the relationships between the experience of common high stress life events and measures of adult spiritual development. 116 male and 216 female (aged 19-79 yrs) completed a 4-part survey, Intrinsic and extrinsic religiousness were measured using the Intrinsic /
Extrinsic-Revised Scale, and universalistic spiritual orientation was assessed using a modified version of the Religious Beliefs Inventory. The Fowler Scale was used to estimate faith style. Experiences of high stress life events were investigated using a life events survey adapted here from several previous studies. Results support the hypothesis that the experience of a high stress life event is associated with a universalistic spiritual orientation, but not the hypothesis that intrinsic religiousness is related to the experience of such events. Males support the hypothesis that faith stage is associated with the experience of a high stress life event only. This study lends support to earlier case-history reports, which indicated that spiritual growth could be a constructive consequence of highly stressful life experiences.

Oyinloye (1999) examined the use of counseling strategies to foster spiritual growth in the church. 160 working adults 7th day Adventist church members, identified as non-complaints to an identified Christian value (tithe), completed a Christian value rating scale and a series of Bible studies. 12 pastoral counseling contacts for the 80-member experimental group were conducted. The results indicate favorable shifts in participants' attitudes to the Church's stand on tithes. The findings also show that the consensual religious person's relationship with the divine wholeness of life can be improved as he/she moves toward a psychological wholeness in therapy.

Cheston (2000) explored the Adlerian practice of encouragement from a spiritual and holistic perspective. Emphasis was given to the physical,
psychological and spiritual impacts on clients. Adler’s view of spiritual
development primarily involves support of the religious activity and commitment
that promoted or expended one’s social interest. The author outlined how
participants in religious behavior meet Adler’s definition of encouragement.

Conceptual and Professional Issues A limited number of researches on the
contceptual and professional issues of spirituality have been conducted. The
studies reported in this section reflect some frontiers such as the inclusion of
spirituality in professional counselor programs, religions and spiritual problems,
spiritual issues with patients, etc.

Everts and Agee (1994) highlighted issues involved in the inclusion of
spirituality in professional counselor education programs. The authors have
discussed the necessity of a careful definition of spirituality, and clarified how it
affects the program’s content. The role of spirituality in client adjustment and an
awareness of counselor educator’s personal spirituality are considered. The
authors have made an illustrative reference to a graduate program in New
Zealand, situated in a multicultural community, with a long-standing
acknowledgement of spirituality; and to the perceptions of its trainees, all with
experience in various areas of community service.

Lukoff, Lu, and Turner (1998) identified that although the acceptance of
the new category ‘Religious and Spiritual Problem’, in 1994 DSM IV, was based
on a proposal documenting the extensive literature on the frequent occurrence of
religious and spiritual issues in clinical practice, the impetus for the proposal
came from transpersonal clinicians whose initial focus was on spiritual emergencies: forms of distress associated with spiritual practices and experiences. The proposal grew out of the spiritual Emergence Network to increase the competence of mental health professionals in sensitivity to such spiritual issues. The authors have described the rationale for this new category, the history of the proposal, transpersonal perspectives on spiritual emergency, types of religious and spiritual problems, differential diagnostic issues, psychotherapeutic approaches, and the likely increase in number of persons seeking therapy for spiritual problems. They also present preliminary findings from a database of religious and spiritual problems.

Ellis, Vinson, and Ewigman (1999) assessed family physicians’ spiritual well-being, identified their perceived barriers to discuss spiritual issues with patients, and determined how often they have these discussions. The authors mailed a questionnaire to 231 Missouri family physicians. The questionnaire included the Ellison Spiritual Well-Being Scale (ESWS), as well as questions about subjects’ attitude towards spirituality and the barriers to and frequency of discussions of spiritual issues with patients. The mean ESWS score indicated that subjects had a high level of spiritual well-being. Nearly all respondents considered spiritual well-being an important health component. Fear of dying was the spiritual issue most commonly discussed, and less than 20% of subjects reported discussing other spiritual topics in more than 10% of patient encounters. Barriers to addressing spiritual issues included lack of time, inadequate training.
for taking spiritual histories, and difficulty in identifying patients who want to discuss spiritual issues. Subjects believed spiritual well-being is an important factor in health and reported infrequent discussions of spiritual issues with patients and infrequent referrals of hospitalized patients to complaints.

**Spirituality and Religiosity** A large number of studies reported here indicate the relative contribution of spirituality and religiosity as human behavior in terms of improving quality of life, health behavior, life threatening illness and solutions to various problems.

Rasmussen and Johnson (1994) assessed the relative contributions of spirituality and religiosity to levels of death anxiety. Results of step-wise multiple analysis reveal that spirituality had a significant negative relationship with death anxiety. As the degree of certainty with respect to life after death, greater levels of satisfaction with life, and greater feelings of purpose in life increased, levels of death anxiety decreased. No significant relationship was found between religiosity and death anxiety, but female subjects reported higher levels of death anxiety than did males.

Suyemoto and MacDonald (1996) utilized a flexible, data-driven research method to derive an inductive theory concerning the content and function of religious beliefs. Data from interviews with 28 undergraduates were content analyzed yielding seven distinct belief domains: higher power, creation, soul, after-death, spiritual connection with others, fate, and supernatural occurrences.
Function domains for each content domain, and for belief systems as a whole, were preliminarily identified.

Helminiak (1997) argued that religion often fosters or, at least, supports violence. The solution to the current impasse between “church and state” is to tease apart religion and spirituality and to elaborate spirituality based on the universal inner make up of the human being. The self-aware and self-transcending dimensions of the human mind that can rightly be called spirit, and the notion of authenticity contribute to the understanding that, apart from religion, God, or theoretical speculation, the human being solidly grounds spirituality. Inherent in humanity as such, spirituality is essential to any society. It is stated that focusing spirituality as the link between theology and psychology can be a major break-through in addressing the problem of our age.

Mytko and Knight (1999) presented overview of the literature relating religiosity and spirituality to physical and emotional health and quality of life. The paper provides a rationale and methodological suggestions for future studies assessing religious and spiritual beliefs of cancer patients in relation to quality of life. The authors conclude that regular inclusion of religiosity and spirituality measures in quality of life studies is needed in order to understand the integration of mind, body and spirit in cancer care.

Harris, Thoresen, McCullough, and Larson (1999) said that studies examining spirituality augmented cognitive-behavioral therapies, forgiveness interventions, different meditation approaches, 12-step fellowships and prayer
have provided some evidence, albeit modest, of efficacy in improving health under specific conditions. They reported that spiritual and religious factors independently influence treatment efficacy. Inclusion of potential moderating variable (e.g. extent of religious commitment, intrinsic religiousness, specific religious coping strategy) in intervention design could help explain relationships and outcomes.

Woods and Ironson (1999) reported results of a study conducted on 60 medically ill people. The authors conducted semi-structured interviews and made an attempt to define what people facing a life-threatening illness mean when they say they are ‘spiritual’ or ‘religious’. Questions were asked about beliefs and affective, behavioral, and somatic realms. Subjects initially self-identified as considering themselves to be spiritual, or both, while some similarities existed between the groups (e.g. amount of time spent in prayer, beliefs set the tone for their life, give them a sense of well-being, guidance, a sense of right and wrong, a connection to God and a sense they will live on in some form). Significant differences were discovered in overall belief system, as well as in interpretation of the mechanism whereby subjects’ belief imparted their health and their recovery. In addition, significant differences existed between the groups in their overall view of God, self, world and others.

Carr (2000) advocated that the distinction between religion and spirituality is important, though not absolute. Two factors emerge from this engagement: (1) critical questioning at the boundary of each discipline; and (2)
both spirituality and mental health are related to life in a specific society. The link between religion and irrational behavior is important, religion being a primary means of acknowledging the irrational facets of everyday life. The author argues that delusion must not be confused with illusion: between these two imagination, art and religion flourish. Each of these is dangerous, since they connect the “normal” with the “riskily marginal”. In a multi-cultural society, behavior that may be acceptable in one context may in another be regarded as a sign of illness. This is particularly true of religious behavior.

Cook, Borman, Moore, and Kunkel (2000) made an attempt to clarify the concepts of religion and spirituality in a general population. Sixteen college students were drawn for a task of concept mapping to elicit their perceptions of what the designations spiritual person and religious person mean. Many positive character traits were used to describe both religious and spiritual people. However, participants described spiritual people with an emphasis on intellectual activities and inner peace, placing less emphasis on external, physical characteristics than their descriptions of religious people.

George, Larson, Koenig, and McCullough (2000) focused on (1) defining spirituality and religion both conceptually and operationally; (2) the relationships between spirituality / religion and health; and (3) priorities for future research. Although the effect sizes are moderate, there typically are links between religious practices and reduced onset of physical and mental illness, reduced mortality and likelihood of recovery from or adjustment to physical and mental illness. The
three mechanisms underlying these relationships involve religion increasing healthy behavior, social support and a sense of coherence or meaning.

Herrera (2000) assessed the qualities of Ignatian spirituality as a holistic approach to spirituality, in the study of the psychology of religion. Ignatian spirituality is analyzed from the point of view of its holistic worldview and understanding of the human person. This spirituality is placed within a tradition that recognizes humility as self-knowledge. The specific contribution of Ignatian spirituality is one in which personal discernment is given priority. It is recognized as further supported by a prayer style that is intensely holistic. The experiential aspects of Ignatian spirituality are presented as a response to the condition of post-modernism.

Mansager (2000) explored religion and spirituality by means of the presidential address of two prominent scholars – one in the presidential address of the psychology of religion, the other in the field of spirituality. Reviewing the history provides differentiation between spirituality and religion, religion as a personal transformative experience and spirituality as an academic discipline studying that experience. The author presents Adler’s psychological theory as a key component for understanding religion and spirituality in a holistic and dimensional manner. It demonstrates how religion and spirituality, as constituent aspects of humanity, can be understood without appeal to a dualistic supernatural reality.
Mattis (2000) explored the meaning of spirituality in the African-American women and distinctions that women made between spirituality and religiosity. In experiment I, content analysis of 128 women’s written narratives revealed 13 categories of meaning that were assigned to spirituality, in experiment II, in depth interviews with a sub sample of 21 women revealed 3 key differences between religiosity and spirituality. First, whereas religiosity was associated with organized worship, spirituality was defined as the internalization of positive values. Second, religion was conceptualized as a path and spirituality as an outcome. Finally, whereas religion was tied to worship, spirituality was associated with relationships.

Pederson, Williams, and Kristensen (2000) examined the relationship of spiritual self-identity related to religious orientations and religious attitudes with the help of Who Am I? Scale, the Religious Life Inventory and the Religious Attitude Questionnaire, respectively. 315 undergraduates from four universities participated in the study. Those with higher scores on spiritual self-identity scored significantly lower on the means and quest orientations. They also manifested higher scores on the affect and conation scales regarding religious matters. Participants manifesting low spiritual self-identity exhibited an opposite pattern of scores. These findings suggest that spiritual self-identity is a salient feature of self-identification and contributes to the research literature on religiosity.
Life Experiences and Spirituality

The evidence to date does not suggest that current scientifically based health care methods should be replaced by spiritual approaches. Rather, the evidence emphasizes the importance of incorporating spirituality into negative life experiences for the purpose of health care.

Christo and Franey (1995) examined the relationship among spiritual beliefs, locus of control, and disease concept beliefs and determined their direct effect on outcome and their indirect effect by facilitating engagement with Narcotics Anonymous (NA). 90% of 101 drug users in treatment were followed up after 6-month of treatment. A modified version of the Opiate Treatment Index and a Spirituality Beliefs questionnaire was used at both baseline and follow-up. NA attendance was inversely related to drug use for subjects who had left residential care. Spiritual beliefs and disease concept beliefs were not prerequisites for attendance for NA, and spiritual beliefs were not found to cause external attributions for previous drug use or possible future lapse events. The most powerful predictors of non-attendance were positive attitudes to the use of alcohol.

Nathanson (1995) explored how the divorce experience affected spirituality for 12 women divorced 3 yrs or less recruited from support groups. Individual interviews revealed how the divorce experience was affected by spirituality through common patterns and recurring themes. For the majority, spirituality facilitated healing. This finding, along with the fact that over 80%
sought counseling, implies that tapping spiritual strength for post divorce may have profound influence for social work intervention.

Dosajh (1999) showed that repression of the spiritual urge (s-factor) could lead to psychoneurosis, which can be treated successfully with meditation. In the context of spiritualism the author discussed the states of consciousness and various techniques of meditation. He discussed a case of repression of spiritual urge of “Holy Neurosis”.

Young, Cashwell, and Shcherbakova (2000) used the Human Spirituality Scale, Beck Depression Inventory, State-Trait Anxiety Inventory and the Life Experiences Survey to examine how spirituality moderates relationships between negative life experiences and psychological adjustment, operationalized for this study as levels of depression and anxiety. Subjects were 303 male and female enrolled in psychology courses aged 18-29 yrs. Results suggest that spirituality provides a significant moderating effect for both depression and anxiety. The moderating effect was stronger for depression than for anxiety.

**Measurement of Spirituality** Few attempts have been made to measure the phenomena of spirituality through psychological testing. Most of them questioned the psychometric issues and clinical utility for the well-being of the population under study. Studies based on development of the spiritual assessment scale are reviewed under this section.

Hatch, Burg, Naberhaus, and Hellmich (1998) designed a new instrument, called the Spiritual Involvement and Beliefs Scale to assess actions as well as
beliefs, to address key components not assessed in other variable measures, and can be easily administered and scored. The instrument is a questionnaire containing 26 items in a modified Likert-type format. Following careful pretesting, the instrument was then evaluated. By several measures, instrument reliability and validity are very good, with high internal consistency, strong test-retest reliability, a clear four-factor structure, and a high correlation with another established measure of spirituality, the Spiritual Well-Being Scale.

Scott, Agresti, and Fitchett (1998) investigated the clinical utility of the Spiritual Well-Being Scale (SWBS) with psychiatric inpatients. Specific questions addressed were possible ceiling effects in the SWBS 's factor structure. Statistical analysis on archival data from 141 female and 61 male patients suggested a lack of significant ceiling effects in the SWBS with this population. Factor analysis, using Direct Obliman rotation, evidenced a three-factor solution for this sample. Psychometric issues and clinical utility of the SWBS with this population was discussed.

Brady et al. (1999) addressed 3 questions relevant to spirituality in quality of life (QOL) measurement using a sample of 1610 ethnically diverse patients with HIV/AIDS and/or cancer (aged 18-90 yrs) through the application of a packet of questionnaires. The authors had 3 hypothesis: (1) Spiritual well-being is positively associated with QOL; (2) The association between spiritual well-being and QOL is unique; and (3) Subjects with high level of spiritual well-being will report high life employment even in the presence of high levels of
symptoms. Spirituality was found to be associated with QOL to the same degree as physical well-being. The significant association between spirituality and QOL was unique, and spiritual well-being was found related to the ability to enjoy life even in the midst of symptoms. The authors conclude that the results support the move to the bio-psycho-social-spiritual model for QOL measurement in oncology.

Adams et al. (2000) administered a series of survey instruments to 112 undergraduate students (aged 16-58 yrs) under quiet classroom conditions to explore the relationship between measures of spirituality and psychological wellness and perceived wellness in a college student population. They used the Life Attitude Profile to measure spiritual wellness, the Life Orientation Test and the Sense of Coherence Scale to measure psychological wellness, and the Perceived Wellness Survey to measure overall wellness. Path analysis performed with a proposed theoretical model revealed that the effect of life purpose was mediated by optimism and sense of coherence, which had independent effects on perceived wellness beyond that life purpose. The findings suggest that an optimistic outlook and sense of coherence must be present for life purpose to enhance a sense of overall well-being.

Hays, Meador, Patricia, and George (2001) developed a valid and reliable measure of lifetime religious and spiritual experience and assessed its value in explaining late-life health. They used semi-structured interview followed by structured interviews of a stratified random sample. Principal component analysis
suggested 4 factors with favourable psychometrics. Health-impaired subjects reported a history of seeking / receiving divine aid (God Helped). At every level of impairment, lifetime Religious Social Support and current religious attendance were positively correlated. Regardless of current attendance, subjects who reported higher lifetime Religious Social Support received more instrumental social support. Healthy behaviors were associated with both God Helped and Lifetime Religious Social Support. Cost of Religiousness predicted depressive symptoms and impaired social support. Family history of religiousness was unrelated to late-life health. The evaluation of Spiritual History Scale (SHS-4) was warranted in 4 dimensions namely, geographical settings, cultural subgroups, age cohorts, and clinical samples.

Spirituality and Psychotherapy A number of studies examining the relationship between spirituality and psychotherapy have been reviewed in the following section. This includes considering therapists’ spirituality as a component of health as well as drawing on spiritual resources in the process of healing.

Grimm (1994) examined the nature of therapists’ spiritual and religious values and the impact of these values on the practice of psychotherapy. Counselor spiritual and religious values can contribute to therapy, even when the therapist is engaged in a dialectic involving personal and epistemic values; cross-cultural training and sensitivity regarding spirituality may enhance the probability of positive therapeutic outcome. The author suggested that it is critical for the therapist to be aware of their own related values, their attitudinal
and affective responses to particular spiritual and religious values, and any
unresolved conflicts pertaining to these values. Reconciliation through religious
approaches requires religious counselors to have sensitivity and preparation in
counseling; integration through secular approaches requires that therapists
receive training in dealing with spiritual and religious issues.

Holmes (1994) discussed how Schwartz’s Internal Family System (IFS)
model serves as a bridge between spirituality and psychotherapy. In IFS model
there is a multiplicity of super personalities led by the self within the person. The
Self is the center of the person, the place from which one observes. The main aim
of the therapist is to help the clients to differentiate the self from the parts so their
self can take a leadership role, much as the parents get back in charge of a
family. The therapeutic work focuses on bringing balance back into the system.
The ability of IFS to transform the internal system of clients is examined and
three case studies involving inner dialogue with significant spiritual content are
presented.

Hutton (1994) examined the attitudes, beliefs, assumptions, and practices
that transpersonal therapists share and those that distinguish them from other
therapists. Findings point to the likelihood that transpersonal psychotherapy
practitioners can be distinguished from practitioners from other schools of
psychology. The transpersonal group demonstrated itself to differ from the other
two groups in spiritual practice, spiritual experience, and use of specific
technique and in terms of spiritual beliefs relative to the practice of
psychotherapy. Findings suggest that transpersonal psychology may be better suited to the study of psycho-religious and psycho-spiritual concerns than other psychological and psychiatric discipline.

Mark (1994) reviewed selective understandings of spirituality among early, contemporary, and current theorists to suggest the multiple implications for practicing clinicians in counseling psychology. Professionals may need to increase objective and subjective interpretations of spirituality in the therapeutic realm. With this awareness, it is assumed that clinical sensitivity to multiculturalism, recovery movements, and dysfunctional religious systems may be achieved and therapeutic competence may be increased.

Adams (1995) explored the shift from dichotomies of therapy/spirituality to the convergence of science and religion. Various therapists suggest that some form of religious/spiritual input during the training of psychiatrists and therapists will produce useful information during patient assessments. However, barriers to integration between therapy and spirituality include the quest for scientific status and authenticity in new disciplines, confusion of spirituality and religion, therapist bias against organized religion. Science and spirituality are no longer seen as diametrically opposed or mutually exclusive. The links between spirituality and psychological healing are apparent in psychoanalytic therapy. There is a need for a closer integration between family therapy and spirituality, which may apply to family adaptation following trauma.
Bristow-Braitman (1995) provided the helping professional with an overview of treatment issues referred to as spiritual by those recovering from alcohol and drug addictions through 12-step programs like that of Alcoholic Anonymous. He has reviewed conflicts between academic between academically trained helping professionals and researches and those advocating spiritually oriented programs. Spiritual aspects of recovery are found to related to the academically trained helping professional. The author discusses these spiritual constructs in terms of cognitive-behavioral psychology, a knowledge base common to professionally trained helpers.

Elkins (1995) emphasized the importance of the spiritual dimension and focuses on the soul as the central, organizing construct for psychotherapy. The author has presented a theory of the soul and psychotherapy from the perspective of the soul. It is argued that psychotherapy from the perspective of soul proceeds from two basic assumptions: (1) psychopathology really is the suffering of the soul, and (2) psychotherapy is the process by which therapists touch, nurture, and heal the clients’ soul.

McDowell, Galanter, Goldfarb, and Lifshutz (1996) investigated the importance of the spirituality among 101 severely mentally ill and chemical dependent in-patients on a dual diagnosis unit and 31 members of the nursing staff who treated them. Patients and staff members were questioned about their spiritual beliefs and the role of spirituality in the patients’ recovery from addiction. In addition, staff members were equally spiritually oriented. The
patients viewed spirituality as essential to their recovery and valued spirituality programming in their treatment more than some concrete items. The nursing staff under-estimated both the patients’ level of spirituality and the importance patients’ placed on spiritual issues.

Cassell, Dubey, and Roth (1997) discussed the medical, psychological, and spiritual applications of the Somatic Inkblot Series (SIS) technique. Health professionals have emphasized the role of interaction between psychological and physiological processes in health and disease. Pastoral counsellors have recognized the healing power of spirituality. Six approaches can effectively bridge physical-psychological-spiritual dimensions and, if appropriately integrated with modern medical therapies, can enhance the healing powers of spirituality. Case histories have been discussed to demonstrate how what is projected on the SIS inkblots relates to the stream of consciousness associated with the highly personal imagery of dreams, hallucinations, and religious experiences.

Galanter (1997) examined the nature of contemporary movements that offer treatment procedures and their impact on medical care. A typology of spirituality-oriented recovery movements is presented, including those associated with established religious, holistic medicine or programs for self-liberation. These psychological and physiological impacts on health status are discussed. The psychological appeal of this treatment is analyzed in the light of the way sick people may attribute meaning to illness and may then become engaged into a
spiritual recovery movement, achieve a sense of self-efficacy through affiliation and finally comply with healing practices. Although some spiritual recovery movements provide hope in the face of illness and even offer therapeutic benefits, they may also discourage patients from getting appropriate medical treatment and promote harmful regimens.

Angell, Brent, and Dumain (1998) examined the therapeutic use of reminiscence and storytelling in the bereavement process of an adult-child adjusting to the death of a parent. The goal of spirituality and resiliency is discovery rather than recovery concerning to the clients' journey of adjustment and coping with trauma of loss.

Green, Fullilove, and Fullilove (1998) pointed out that as substance use and abuse continues to ravage communities, researches remain in the dark about what works to ensure successful recovery from addiction. In searching for the answers, researches have often overlooked the role of religious and spiritual practices and beliefs in presenting use and relapse. The authors have described the process of spiritual awakenings experienced by some persons in recovery during their quest for sobriety. The data suggests that persons in recovery often undergo life-altering transformations as a result of embracing a power higher than one's self that is, a Higher Power. The result is often an intense spiritual journey that leads to sustained abstinence. Given how widespread substance abuse is, research on the nature, implications, and limitations of a spiritual approach to addiction might offer new options for treatment.
Haug (1998) defined spirituality as attributions of a personal nature which give meaning to life events, help transcend difficult experience, maintain hopefulness, and lead to behavior which honour connectedness and proposes a rationale for including the spiritual dimensions in therapy and therapy training. He also suggested steps for graduate training programs and supervisors may take the role raise therapists' spiritual understanding.

Jacques (1998) identified the analytic therapy group as a spiritual community that can deepen the implications of group transference. From this perspective, group as-a-whole dynamics include a spiritual dimension in addition to the recapitulation of the family of origin. Clinical vignettes are introduced from a mid phase group to illustrate a means of working with spiritual and religious themes psychodynamically through managing them like dreams. Amplifications and interpretations of the symbolic themes guide members through the transference to the family of origin. Then, members gain access to childhood memories and to the childhood transitional space of religious experience where they created their God reorientations as a means of solving their self and object dilemmas. The working-through process facilitates the integration of transformation of new self and God images.

Robinson (1998) advocated that the quest for heart of psychodynamic work involve some people a need to be true to their professional training and to the tradition of spirituality. Ontology is explored as a way of holding the two areas together in a state of creative tension albeit one involving great difficulties.
Six themes are offered that provided the author with focus for this tension: a sense of mystery; the danger of ontological collapse; the history of desire; the mystery of origins and ends; paradigm shifts; hermeneutics.

Samuels (1998) noted that the therapists who focus on the spiritual dimension as part of their ordinary work still tend to be marginalized. Similarly the political dimensions of the client’s experience often receive insufficient attention. He offers an initial sketch of a new “anatomy of spirituality”: into social spirituality, democratic spirituality, craft spirituality, profane spirituality and spirituality sociality. He criticizes the practice of safe therapy meaning therapy based on an object relations paradigm that repress the incestuous sexuality that lies at the heart of spiritual values.

West (1998) interviewed nineteen Quackers who were also counselors or psychotherapists to study the impact of their spiritual beliefs on their work. The spiritual faith of the therapists impacted on their work in several ways: their clients’ spiritual journey; their spiritual faith underpinned their work; it gave them something extra which included inspiration, spiritual preparation before and between therapy sessions, and prayers; and for a minority of respondents there were conflicts which were sometimes expressed in supervision.

Cole and Pargament (1999) described a pilot group psychotherapy program for people who have experienced cancer that integrates spirituality issues and resources, and presents rationales for the interventions that are included in the therapy process. The program addresses four existential concerns
in ways that integrate spiritual issues and assist participants in drawing on spiritual resources. The authors asserted that results are promising.

Daaleman and Frey (1999) identified the personal religious and spiritual beliefs and practices of family physicians and to test a valid and reliable measure of religiosity that would be useful in physician populations. Physicians reported that their religious and spiritual beliefs and practices, including frequency of religious service attendance and private prayer or spiritual practice, and self reported intrinsic or subjective religiosity. 74% of the surveyed physicians reported at least weekly or monthly service attendance, and 79% reported a strong religious or spiritual orientation. A small percentage of physicians (4.5%) stated that they do not believe in God. A dimensional religiosity scale that assessed organized religious activity, non-organized religious activity and intrinsic religiosity was determined to be a valid and reliable measure of physician religious and spiritual beliefs and practices.

Prest, Russel, and D'Souza (1999) explored the attitudes of 52 marriage and family therapy graduate students toward the interface among the spirituality, religion, professional training and clinical practice. Students were surveyed regarding their spiritual and religious attitudes and practices in their personal and professional lives. In most areas, graduate students were found to be similar to the precisely published reports of practicing professionals. In other areas, students report even more investment in spirituality and religion. The results of
the survey suggest a need to include systematic attention to these areas in graduate training curricula and in the supervision individual process.

Ellis (2000) contends that spiritual goals in psychotherapy can but do not necessarily include religious beliefs and values or beliefs in a supernatural being. He states that dogmatic religious beliefs are potentially some rational self-helping beliefs as well. A number of spiritual beliefs are considered in terms of their advantages and their potential harm to adherents. The author concludes that spiritual values, if framed rationally, can be definite help to believers and non-believers alike.

Hickson, Housley, and Wages (2000) assessed the attitudes of 147 male and female licensed professional counselors (aged 40-75 years) concerning spirituality in the therapeutic process by responding to a mail out survey. Results indicate that counselors recognize the importance of being aware of their own spiritual beliefs. Spirituality was viewed as a universal phenomenon that can act as a powerful psychological change agent. Respondents believed that women and men experience spirituality differently, although spirituality is expressed differently as a function of gender. Age of the client emerged as a salient variable. One’s place in the aging process and perception of the aging process were perceived to affect the client’s spiritual search.

Josephson, Larson, and Juthani (2000) have discussed the current status of spirituality and religion in psychiatry, reviewed several historical antecedents related to psychiatry rediscovering the forgotten factor, and offered a brief
review of research findings relevant to clinical practice. It is concluded that religion and spirituality have entered in the mainstream of psychiatric practice.

Koepfer (2000) addressed religious and spiritual issues in therapeutic settings that have become increasingly common in many areas of health care. There is a prevalent myth that children are not capable of cognitively grasping spiritual or religious ideas and concepts. Furthermore, spirituality has often been disregarded as an active variable in treatment and therapeutic relationships. The author has explored the role of children’s religious and spiritual beliefs and pediatric medicine and healing, cultural variables, methods for addressing religious and spiritual concerns in treatment, and the importance of the therapists own religious and spiritual sensitivity.

Meador and Koenig (2000) discussed the principles of psychiatric practice with regards to spirituality and religion. Topics of discussion include: (1) performing a spiritual assessment, (2) incorporating spirituality into treatment plan, (3) assessing the clinicians beliefs, (4) examining the clinical implications of the patients’ spirituality, (5) using religion to cope with stress, (6) employing cognitive therapeutic models, and (7) avoiding clinician bias. The referring of patients with religious or spiritual issues to a colleague is also addressed.

Northcut (2000) opined that spirituality has become in vogue for the media as well as for professional conferences, journals, and schools of social work likewise, our clients are struggling with how to integrate religion and / or spirituality into their therapy. He examined how to make room for religion and
spirituality in psychodynamic theories and postmodernism. He also discussed the following areas: definition of terms, self-awareness, deconstruction of clients’ narrative, assessment of strength, and vulnerabilities and reconstruction of a useful narrative.

Puchalski, Larsen, and Lu (2000) stressed on the introduction of spirituality courses in psychiatric residency programs. Survey data demonstrate that spiritual issues are significant to many patients. Psychiatrists are becoming more skilled at recognizing this dimension in their patients’ lives and, accordingly, have made changes in their clinical practice several significant changes in the field of psychiatry in its training of residents are highlighted.

Shafranske (2000) conducted a self-administered survey among 111 psychiatrists. Results showed that 49% of the respondents reported that religious or spiritual issues were involved in psychiatric treatment often or a great deal of the time. The personal religious orientation of the clinician was not found to contribute to the perception of the frequency of religious or spiritual issues in treatment. The religious dimension was addressed through implicit integration in which spiritual resources were not directly and systematically addressed and spiritual resources were included.

Sperry (2000) discussed whether it is appropriate and professionally sanctioned to incorporate spirituality in psychiatric practice and whether psychiatrists would need specialised training in their application. Four interrelated dimensions characterize the context of incorporation of the spiritual
dimension into clinical practice: (1) patients, (2) psychiatrists, (3) professional and scientific development, and (4) treatment setting. Research suggests that religion and spirituality correlate with health. The field of psychiatry mandated training in religious and spirituality for residents.

Taylor, Mitchell, Kenan, and Tacker (2000) developed an attitude questionnaire to examine the (1) occupational therapists’ attitudes about spirituality in practice on the basis of whether they identified themselves as religious, (2) whether their personal definition of spirituality related to their religiousness, (3) whether their definition related to their attitude about spirituality in practice, and (4) the methods they used to address the spiritual needs of clients. Out of 396 attitude questionnaire mailed to occupational therapist only 206 were analyzed. Overall, subjects indicated a slightly positive attitude towards spirituality in occupational therapy practice than those who did not consider themselves to be religious. Religiousness accounted for only 28% of the variance in choice of spirituality definition, indicating that additional variables account for what determines therapists’ definitions of attitude regarding spirituality into practice. The three methods that was commonly used to address the spiritual need of their clients were to: (1) pray for a client and (2) use spiritual language or concepts with a client and (3) discuss with clients ways that their religious beliefs were helpful.

Watts (2000) discussed the common ground between basic tenets of biblically based Christian spirituality and individual psychology. He concludes
that Adlerian approach to psychotherapy is amenable to work with clients who hold a biblically based view of Christian spirituality when the therapist provides thoughtful attention to and respect for clients' spiritual beliefs.

Bollentino (2001) discussed about the spiritual revolution that has permeated our culture challenges psychotherapists and other health practitioners to address the spiritual concerns of their clients and themselves. Given the non-spiritual tradition of professional psychology and medicine as a whole, practitioners as a group have no clear and cogent concept or standards with which to acknowledge and address these concerns. The article aims to formulate a concept of spirituality that allows practitioners to include spirituality in their work in a clear, sound, and meaningful way.

Helminiak (2001) discussed spirituality as a human phenomenon that is independent of matters of personal religion and belief in God. The author viewed spirituality as a universal mental phenomenon with an inherent "normality", therefore, it can be legitimately addressed as a prescriptive aspect of psychology apart from theology and religion. An elaborated psychology of spirituality helps therapists focus the psychotherapeutically relevant and spiritual issues in the client's presentation; build on the client's healthy commitments; and reinterpret or deflect the unhealthy and, thus, foster the client's personal integration and, ipso facto, the client's spiritual growth.

White, Wampler, and Fischer (2001) operationalized and measured spirituality and examined whether higher levels of spirituality are associated with
indicators of successful recovery. 252 participants (aged 17-69 yrs) from a variety of treatment settings completed the Spiritual Health Inventory, the Surrender Scale, and the Life Orientation Test. Although all three measures were significant predictors of perceived quality of recovery and the total number of 12 steps completed, surrender, optimism, and internal spiritual well-being differed significantly by (1) length of recovery (<1yr vs. 1yr or more), (2) level of recovery behaviors (high vs. low), and (3) whether steps 1-3 had been completed. The results indicate that spirituality is an important element in recovery and support the concept of including the practice of spirituality as part of recovery programs.

**Spirituality and Health/Well-Being** Few evidences indicate that the spirituality and the related phenomena had a moderating effect on the health/well-being of the people. The literature indicates the main predictors of spirituality were spiritual health, spiritual well-being, personal and integrated spirituality. In general, studies have reported fairly consistent positive relationship with physical health, mental health and substance-abuse outcomes. Some spiritual factors have failed in some studies to demonstrate the relationship between spirituality and health. Although the overall evidence is promising enough to warrant careful and expanded study, empirical studies have been commonly based on only a few questionnaire items.

Seaward (1995) illustrated and highlighted several aspects of human spirituality in the context of health promotion and explains how this cornerstone
of the wellness paradigm can be more fully integrated into the work-site setting. The concept of holism, in which the health of the human entity is comprised of the integration, balance and harmony of mental, physical, and spiritual components, is discussed. Human spirituality at the work-site, job-stress and suggestions for wellness for programs are discussed.

Fehring, Brennan, and Keller (1997) conducted two separate correlational studies to investigate the relationship between spirituality and psychological mood states in response to life change. In the first study a spiritual well-being index, a spiritual-maturity scale, a life-change index, and a depression scale were administered to 95 freshman-nursing students. The spiritual well-being index was composed of two sub-scales; a religious well-being and an existential well-being scale. In the second study a spiritual-outlook scale and the Profile of Mood State Index was added to the above tests and administered to 75 randomly selected college students. The results demonstrated a weak positive relationship between life change and depression. Unlike a previous study, spiritual well-being, existential well-being, and spiritual outlook showed strong inverse relationships with negative moods suggesting that spiritual variables may influence psychological well-being.

Verma (1998) described the concept of well-being and healthy mind from the Indian point of view by drawing upon the Bhagwat Gita and the observations of J. Krishnamurti as the framework. Krishnamurti’s talk on “seeking and the state of search” which explicates the quality of the silence of the mind.
According to him, by virtue of having a motive that generates seeking behavior, the experience is trapped in the network of cause and effect. By being aware of the truth and falseness of seeking, the mind is no longer caught in the machinery of seeking and becomes quite on its own. The author then describes the theory of Karma or action and notes that a mind, which is perfectly comfortable with its swadharma or natural duty, enjoys well-being. It is argued that the spirit of sacrifice (yagnya), the spirit of detachment (anasakti), and the mood of surrender or the spirit of devotional offering (samarpan) lead to psychological well-being. Finally, the author suggests that the steady state of mind (sthita pragya), self-control, and the dissolution of the self (self-expansion) are some of the psychological qualities of a healthy individual.

Cotton et al. (1999) examined the relationships among spiritual well-being, quality of life, and psychological adjustment in 142 women (aged 26-78 yrs) diagnosed with breast cancer. Participants were given a set of questionnaires that measured spiritual well-being, quality of life, and adjustment to cancer. Results indicate a positive correlation between spiritual well-being and specific adjustment styles. There was also a negative correlation between quality of life and use of a helpless / hopeless adjustment style, and a positive correlation quality of life and fatalism. After controlling for demographic variables and adjustment styles, spiritual well-being contributed very little additional variance in quality of life. Findings suggests that while spiritual well-being is correlated with both quality of life and psychological adjustment, the relationships among
these variables are more complex and perhaps and indirect than previously considered.

Krause, Ingersoll-Dayton, Ellison, and Wuff (1999) examined age differences in religious doubts and psychological well-being. The differences of this study were twofold: (1) to see whether religious doubt was related to psychological well-being and (2) to test for age differences in relationship between these constructs. The data came from a national sample of 1,815 Presbyterians (mean age 55.58 yrs). Results suggest that doubt is associated with greater psychological distress and diminished feelings of well-being. Moreover, the results reveal that the deleterious effects of doubt are greater for younger than for older people.

Oishi, Diener, Suh, and Lucas (1999) investigated individual differences in the processes of subjective well-being (SWB) among 2 samples of undergraduates (sample 1; n=121, sample 2; n=151). There are considerable individual differences in the domain that was most strongly associated with global life satisfaction. Individuals also differed significantly in the types of activities that they found satisfying. Moreover, these individual differences in the patterns of SWB were systematically related to value orientations. A 23-day daily diary study (with subjects from sample 2) revealed that intra-individual changes in satisfaction were strongly influenced by the degree of success in the domains that individuals' value. Findings highlight the meaningful individual differences in the qualitative aspects of subjective well-being.
Waite, Hawks, and Gast (1999) evaluated the strength of the relationship between the psychosocial variable, spiritual health, and health-promoting behavior among 200 employees of a home fitness equipment company. The product moment correlation coefficients indicate that a moderate to small positive linear relationship existed. Results show that the relationships were strongest when the spiritual health sub-scales were combined into a composite measure and correlated to the composite measure of spiritual health is more predictive of health promoting behaviors, in general, than are related psychological variables (e.g. self-esteem, locus of control, connectedness, sense of coherence) which may be components of spiritual health.

Clan and Joseph (2000) examined the association between personality, self-relevant intrinsic and extrinsic values and expectations and psychological well-being. 40 male and 67 female college students (aged 18-37 yrs) completed the Eysenck Personality Questionnaire, the Aspiration Index, as well as measures of happiness, self-actualization, and self-esteem. Scores on the personality and aspiration scales were entered together in a regression equation to predict scores on happiness, self-actualization, and self-esteem. In accord with previous research it was found that greater extraversion and lower rated importance of financial success were associated with higher scores on happiness, self-actualization, and self-esteem. The authors also found that likelihood of financial success was associated with higher scores on self-esteem, likelihood of self-
acceptance was associated with higher scores on self-actualization, and likelihood of community feeling was associated with higher scores on happiness.

Daaleman and VandeCreek (2000) discussed religion and spirituality in end-of-life care, as serving two primary functions: the provision of set scores of beliefs about life events and the establishment of an ethical foundation for clinical decision making. Religious doctrine and belief systems provide a framework for understanding the human experience of death and dying for patients, family members, and health care professionals. Terminally ill patients acknowledged a greater spiritual perspective and orientation than both non-terminally ill hospital patients and healthy patients. Religion and spirituality potentially can mediate quality of life by enhancing patients’ subjective well-being through social support and stress coping strategies. The authors concluded that by offering a health care delivery model that incorporates a community-based approach while emphasizing the uniqueness of the individuals’ life, hospice and palliative care facilitate the process that are involved in this most basic human experience, of dying.

Fabricatore, Handal, and Fenzel (2000) examined the impact that a personal, integrated spirituality has on well-being and its role in moderating the effects of stressors (both significant life events and hassles) on well-being among a sample of 120 undergraduates (aged 18-22 yrs) at a private religiously affiliated college. The hypotheses were as follows: (1) stressors would have a negative impact on subjective well-being (SWB) which consists of satisfaction with life
SWL), and affective well-being (AWB); (2) personal spirituality would positively predict SWB independently of stressors; (3) personal spirituality would moderate the relationship between stressors and SWB. The results showed that stressors predicted both dimensions of SWB and that personal spirituality significantly added to the prediction of SWL. Personal spirituality was also found to moderate the relationship between stressors and life satisfaction, accounting for a small yet significant portion of the variance. Personal spirituality is conceptualized as a useful resource among undergraduates for maintaining life satisfaction in the face of stressors.

Kim et al. (2000) examined: (a) how spiritual well-being (WB), emotional WB, life satisfaction, and functional status change during and after rehabilitation; (b) the relationships among these variables over time; and (c) associations with demographic and clinical characteristics. The authors used longitudinal assessment across three points among 155 adults admitted to a freestanding rehabilitation hospital. The results revealed that Emotional WB increased during rehabilitation, whereas life satisfaction and spiritual WB did not change; however, substantial subgroups of individuals experienced changes in life satisfaction and spiritual WB over time. Measures of spiritual WB, and life satisfaction were moderately correlated within and across time points. Persons making smaller functional gains during inpatient rehabilitation were least likely to experience increased emotional WB.
Lauver (2000) discussed commonalities between contemporary women’s spirituality and women’s health. The meanings of religion and spirituality are clarified. Assumptions, themes, and characteristics in women’s spirituality health are delineated and processes are proposed that are common to the development of individual women’s spirituality and health.

Thomson (2000) examined the role of spiritual well-being in hospice patients’ overall quality of life. Patients (mean age 72.1 yrs) admitted over a four-month period were surveyed, using the Functional Assessment of Cancer Therapy Scale, at admission, one month later, three months later, and six months later. Data showed spiritual well-being to be an important contributor to overall quality of life.

Brewer (2001) invited counselors to consider integrating spiritual, philosophical, and psychological ideas regarding work and life to encourage clients’ well-being. He used the Vocational Souljourn Paradigm model with adult clients who were exploring their work and life choices in a holistic and spiritual context; and defined the variables: meaning, being and doing. The model explains how dynamic interactions of meaning, being and doing can propel an individual into a particular work / life path.

**Conclusion**

A comprehensive review of literature reported in this chapter reflects different areas of spirituality. Yet, a great deal remains to be done. With regard to assessment, the new measures those are most pertinent for the assessment of spiritual behavior of the solace seekers is yet to be developed. Although there
appears to be a general perspective effect of holy shrines, little is known about why the people pay visit to holy shrines and how it affects their subjective well-being. Spirituality is a significant dimension in health and well-being. As that understanding expands, it will become clearer how to study spiritual factors in relation to well-being.