Religion, Spirituality and Mental Health: Current Trends in Research and Practice

Fr. William Guri, C.Ss.R.

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Introduction.

A young woman of 35 years walks into the Parish Priest's office for consultation. When she leaves, the priest is left mesmerized by the issues that this parishioner brought up. While he has prayed with her, suggested some scripture and spiritual reading, and promised to continue to pray for her, he cannot quite wrap his mind and heart around the complexity of issues that she presented. He detects that she has a mental health issue which remains to him indeterminate. Similarly, after the same woman consults with a medical professional, she receives a prescription and is offered a follow-up visit. Like the priest, the medical doctor remains puzzled. He detects that she has an underlying religious or spiritual issue somehow interacting with her physical and mental health concerns. Many religious practitioners encounter people with mental health issues which require clinical intervention beyond their pastoral ministry. Likewise, many medical professionals encounter individuals with religious and spiritual issues that require pastoral interventions beyond their clinical care. Religious, spiritual and mental health issues coexist in the same individual in a manner that can be confounding to the helping professionals whether they are religious ministers or clinicians. There is always the danger of treating religious or spiritual issues as if they were clinical matters and vise versa. This is a real challenge to those who attend to distressed people in pastoral ministry and to those who attend to the same people in clinical settings. Present methods of assessment, conceptualization, diagnosis and intervention may not

offer clear cut ways for dealing with clinical emergencies in the pastoral setting, and pastoral challenges in the clinical setting. This is an area where we hope that research will enlighten the helping professionals, both clinical and pastoral, with empirically derived or evidence-based conceptualizations that will lead to pastorally sound and clinical effective assessments, diagnoses and interventions. While such research here in Zimbabwe is still emerging, there is an encouraging body of research from other parts of the world from which useful insights may be learnt.

Statement of the Problem

A question that challenges both religious practitioners and medical health practitioners is about the relationships among religion and spirituality on one hand and physical and mental health on the other hand. What is the difference between religion and spirituality? Is the distinction between religion and spirituality real or superficial, necessary or nonconsequential? How do religion and spirituality influence mental health, and how does mental health influence religion and spirituality? Do individuals who are more religious and less spiritual have more or less mental health problems? Do individuals who are more spiritual than religions have more or less mental health struggles? Does having a mental health problem make an individual more or less religious or spiritual? Do religion and spirituality have positive or negative influences on mental health, and under what conditions? These and many others are some of the questions that academics and researchers, as well as practitioners grapple with in the quest to understand better the relationships among these critical human variables: religion, spirituality and mental health.

Current trends in research and practice can enlighten us on how relationships among these variables may be conceptualized, understood, operationalized and utilized. In order to explore these relationships, it is important to clarify what is meant by terms such as

mental health, mental illness, religion, and spirituality in academic research, and in clinical and pastoral practice.

Definitions

Mental Health & Mental Illness

Mental health and illness have been defined in many ways, sometimes being seen as synonymous, interchangeable, or two different sides of the same coin. These two concepts should always be viewed in the ethnocultural context and epistemological assumptions that produce and influence them. In scholarly research and in professional practice definitions of mental health and illness are dominantly influenced by Euro-American or Western philosophical and scientific paradigms. They are further influenced by the religious beliefs that are often salient and unacknowledged. Application of these concepts in non-Western and non-Christian cultural settings need to be cautious and sensitive to local and individual differences. Political power, socio-economic privilege, racial and ethnic superiority, religious exclusivity, gender dominance, and other biases, have often significantly determined the mapping and naming of bodies and spaces as either mentally healthy or ill.

Mental Health

In the Western model, mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (Workplace Mental Health Promotion, 2019). According to the US Surgeon General Report (1999), mental health is defined as: a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and cope with adversity. This definition aligns well with the Euro-American Western cultural values of individualism,

democracy, independence, productivity, efficiency, consumption etc., that undergird first world societies. How appropriate is this definition for non-Western, non-industrialized, non-democratic, third world societies? In our beloved worldview, philosophy and ethics of Ubuntu or Hunhu, how do we conceptualize and operationalize the constructs of mental health and illness?

Mental Illness

Mental illness is a recognized, medically diagnosable illness that results in the significant impairment of an individual's cognitive, affective or relational abilities. Mental disorders result from biological, developmental, and or psychosocial factors, and can be managed using approaches comparable to those applied to physical disease, namely prevention, diagnosis, treatment, and rehabilitation. According to the Diagnostical Statistical Manual for Mental Disorders (DSM-5) a mental disorder or illness is:

> characterized by significant dysfunction in an individual's cognitions, emotions, or behaviors that reflects a disturbance in the psychological, biological, or developmental processes underlying mental functioning. A mental disorder is not merely an expectable or culturally sanctioned response to a specific event, such as the death of a loved one. The deviation from the norm is not political, religious, or sexual, but results from dysfunction in the individual (APA 2013).

This definition privileges a Euro-American or Western conceptualization. Research waits to be done to explore and develop alternative constructs that adequately capture and represent the lived experiences of people in other world contexts. An interesting conceptualization is that of the therapy management and therapy management group developed by Janzen (1987). Janzen pointed out that the control of therapeutic knowledge and resources is often perceived in terms of lay versus professional realms of discourse and understanding, or in terms of doctor-patient relationship. But the reality of medical decision-making shows that information and critical

symbols are embedded in the totality of social relationships in which neither professionals nor the laity dominate. A therapy management perspective helps to understand the dynamic qualities of lay and professional interactions, rather than imposing a lay-professional binary.

Mental Health or Illness?

Mental health and mental illness are often used interchangeably but they are not the same thing, and they are not mutually exclusive. Fundamentally, mental health and mental illness differ in that everyone has some level of mental health all the time, just like physical health, whereas it is possible to be without mental illness. Figure 1., below illustrates how mental health and mental illness are found on two separate continua. Optimal mental health, or mental wellbeing or mental wellness, is at one end of the continuum, and poor mental health, or languishing, at the other end of the same vertical axis. Serious mental illness it at one end of the horizontal continuum, while no symptoms of a mental illness is at the opposite end of the same axis. This means that one can be mentally healthy with a mental illness, while another can have poor mental health without a mental illness. Even though poor mental health is not defined as an illness, it is associated with emotional distress and psychosocial impairment comparable to that or a major depressive episode. The effects of poor mental health are both severe and prevalent, with poor mental health being more common than depression. When exploring the relationships between mental health and religion and spirituality, it is important to be clear whether we are measuring mental health or mental illness, and whether we are comparing that with religion or with spirituality, however we construct, conceptualize and operationalize these variables. When we talk of religion and spirituality, you will notice that these are also very complex and multidimensional constructs whose aspects or certain features can be engaged at one time in research and practice. This intentional selection of certain aspects of a phenomenon for practical research and practice

purposes can be justifiable, but at the same time can lead to a reductionism that fails to account for the totality of a reality.

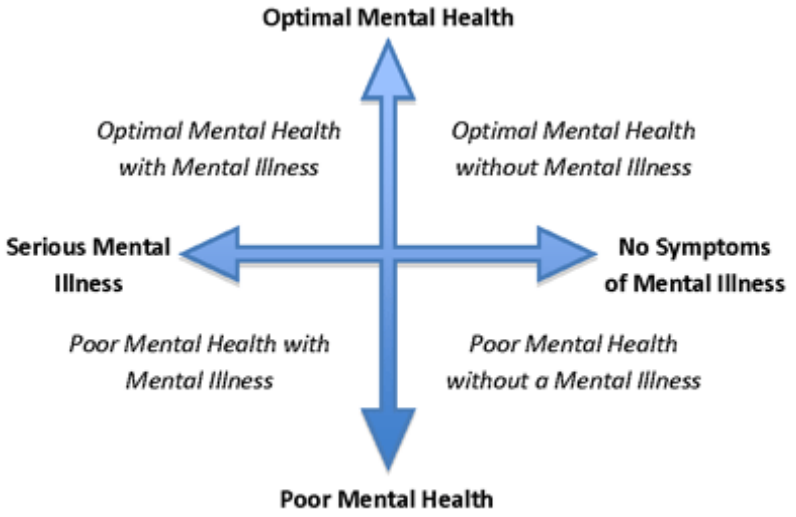

Figure 1: The Mental Health/Illness Continuum

There are three most significant determinants of mental health, namely: social inclusion, freedom from discrimination and violence; and access to economic resources. These factors are intricately intertwined with other factors such as employment, culture, politics, religion, age, sex, gender, race, ethnicity, geography, and socio-economic status. These and other pertinent determinants of mental health need to be factored in research, practice and programing.

There are many different types of mental illness. The Diagnostic and Statistical Manual for mental disorders (DSM 5) and the World Health Organization's (WHO) International Classification of Mental Disorders (ICD-10; WHO, 1992), are the leading classifications of mental illness in use. Some of the important defining characteristics of mental illness are that:

- It is a recognized and medically diagnosable illness
- It causes significant cognitive, affective, behavioral, and or, relational impairment
- It results from biological, developmental, and or, psychosocial factors
- That it can be managed using disease approaches i.e., prevention, diagnosis, treatment and rehabilitation.

As research on mental illness continues to evolve, more mental illnesses are being discovered and diagnosed. Some of the more common and well researched mental illness categories include:

- Mood disorders (affective disorders) such as depression, mania and bipolar
- Anxiety disorders such as generalized anxiety disorder, post-traumatic stress disorder, obsessive compulsive disorder, panic disorder
- Psychotic disorders such as schizophrenia
- Concurrent disorders such as addictions and substance abuse
- Personality disorders such as antisocial personality disorder, obsessive compulsive personality disorder.

Mental illness, like physical illness, is something that one can live with, and, or recover from. Recovery does not mean the individual no longer has the illness, but that one has stabilized and regained their functionality.

The DSM-5 includes a glossary of terms for culturally specific mental health conditions. This goes to show the awareness among scholars that the categories of the dominant Euro-American culture may not be arbitrarily applied to non-Western contexts. An interesting item on that glossary is the condition called *kufungisisa*:

> The experience of thinking too much (Shona: *kufungisisa*) is associated with general psychological distress and common mental disorders in Zimbabwe. Thinking too much is considered both a symptom of distress and a cause of other physical and psychological health problems: thinking too much can cause pain and feelings of physical pressure on the heart (APA, 2013, p.834).

The inclusion of *kufungisisa* in the DSM-5 is the result of the work of researchers and practitioners in Zimbabwe who seek to develop concepts and constructs that adequately capture the reality of mental health and illness informed by the lived experiences of people in this context. Much remains to be done in research and practice to develop culturally sensitive and contextually relevant ways of describing the lived experiences of people with mental health problems in their localities. Kohrt and colleagues (2014), in a meta-analysis of research on cultural concepts of distress and psychiatric disorders found that these concepts are difficult to study. They cited poor study quality as impeding conceptual advancement and service application. By improving study design research can enhance the detection of mental health problems, reduce cultural bias, and increase cultural salience of interventions. Patel (1995), and others, have pioneered in the research on alternative explanatory models of mental distress in Zimbabwe and in other non-Western environments. Still, much remains to be done to incorporate indigenous, Afro-centric epistemologies into the conceptualization and operationalization of the constructs of mental health and illness.

Defining Religion and Spirituality

There is no consensus of the definition of any of these terms. Each definition proffered must be understood in the context and positionality of the author. We owe much to Western and Christian scholarship for the developments in the scientific study of religion and spirituality. Non-Western and non-Christian religions and spiritualities may not be captured adequately by the dominant epistemologies and methodologies in currency. Scholars of religion from other parts of world have the double burden to develop indigenous methodologies and enunciate indigenous experiences in alternative ways to the received Western Christian tradition. The epistemological and methodological positions of a scholar, as well as their assumptive worldview influence how they define religion and spirituality. Working definitions are functional and useful in starting a

conversation, are at best descriptive rather than prescriptive, open ended rather than closed. The most useful definition remains open-ended and amenable to change, abandonment, or improvement, in the face of new evidence and evolving understanding.

Religion.

Traditionally the term religion was used to refer to all aspects of human relationship to the Divine or Transcendent – that which is great than us, the source and goal of all human life and value. More recently scholars have started to understand religion as activities and a way of life along with a distinctive way of living together, and a language for expressing this reality. This conceptualization of religion is on one hand about the transcendent and on the other hand the immanent. Some religions stress the transcendent, e.g., Islam, while others stress the immanent, e.g., Eastern religions. Christianity stresses both. Religion is therefore multidimensional, a complexity which must be understood if religion is to be properly grasped and evaluated (Nelson, 2009). In research and practice when we talk about religion, we want to be specific about the aspect or dimension or facet of religion that we are engaging. A researcher can study the relationship between daily mass attendance, as an aspect of religion, and compliance with antidepressant medication, rather than the relationship between being a catholic in its totality and have a major depressive diagnosis. In research religion needs to be parceled out in order to be studied meaningfully. Similarly, in clinical practice treatment goals and objectives can be established on the basis of the targeted parts of a religion that might seem to be associated with a psychopathological or a disordered personality presentation.

Spirituality

In recent times the term spirituality has begun to be used as an alternate way of describing the search for the transcendent. Originally, "spiritual" contrasted church life with "worldly" or materialistic ways

of being. In the 19th century spirituality was not a common term and "spiritualism" referred to contact with spirits and other psychic phenomena. Today spirituality has a number of common meanings and scholarly definitions vary. These differences show that spirituality is a broad term encompassing multiple domains of meaning that may differ among various cultural, national, and religious groups (Nelson, 2009).

A popular usage of the term spirituality denotes the experiential and personal side of our relationship to the transcendent or sacred" (Hill et al., 2000; Emmons and Crumpler, 1999). This usage typically contrasts spirituality with religion and defines the later narrowly as the organizational structures, practices, and beliefs of a religious group. Theologians and religious practitioners tend to prefer definitions that draw less of a strict division between religion and spirituality. Thus, they see spirituality as the living reality of religion as experienced by an adherent of the tradition. According to Roof (1999, p.35), spirituality encompasses 4 themes, namely:

1. A sense of values and ultimate meaning or purpose beyond the self, including a sense of mystery and self-transcendence;
2. A way of understanding;
3. Inner awareness, and;
4. Personal integration

The integrative aspect of spirituality is very important because it is the harmonizing function that involves (a) our inner unity, and (b) our relationship and connectedness with others and to a broader reality that powers our ability to be transcendent. Spirituality is therefore not a separate nature or characteristic but an inseparable part of all that we are and do.

Most conceptions of spirituality involve contact with the sacred, whose dominance over humanity seems to increase in proportion to human efforts to master the sacred. Thus, spirituality has a powerful, mysterious quality that cannot be reduced to a simple object of study.

Spirituality takes us beyond ordinary daily experiences and transforms our lives and relationships. It is about being, experience and doing. Contemporary practices of spirituality involve a search for higher values, inner freedom, and things that give life meaning. While this search typically involves a search for God, a nontheistic can also be involved in the quest for meaning.

Conceptions of spirituality can be divided between those that involve thick definitions and those that involve thin or generic ones. Religious conceptions of spirituality generally involve thick definitions that are rich in allusions to specific beliefs and practices. On the other hand, thin or generic definitions focus more on natural experiences, personal values, or human and environmental connectedness. An example of a thin definition is offered by Jernigan (2001, p. 418), "spirituality is the organization (centering) of individual and collective life around dynamic patterns of meanings, values, and relationships that are trusted to make life worthwhile, or at least livable, and death meaningful." Jernigan offers a thick definition of Christian spirituality: "the organization (centering) of individual and collective life around loving relationships with God, neighbor, self, and all creation – responding to the love of God revealed in Jesus Christ and at work through the Holy Spirit" (2001, p. 419).

Think definitions are often theistic, have strong communal content, are multidimensional with experiential, relational, and behavioral components. Thin definitions are attractive to scientists because they are thought to tap universal human qualities related to relevant natural laws that can be scientifically discovered through research. However, some scholars contend that thin definitions may distort the fundamental nature of spirituality (Slife, Hope, & Nebecker, 1999). Thicker definitions may contain important content and contextual information necessary for understanding a particular type of spirituality. Different groups and individuals have diverse ideas about it, making thin or global interpretations difficult. Because religion and spirituality are complex concepts that have different meaning for

different groups it is difficult to articulate a single definition for either of them. However, multidimensionality suggests that definitions that focus on only one aspect of religion or spirituality should be avoided.

There is a scholarly view that sees religion and spirituality as conceptually different. The advantage of separating these two is the recognition that a broadly defined spirituality is possible for those outside of religious traditions and communities. This fits very well within the Western framework that focusses on the individual and their experiences rather than the needs and experiences of the larger community. Scholars who associate the decline in traditional values and religion with a turn towards spirituality see this distinction as attractive.

Research with Western samples has indicated that it is possible to:

1. Develop definitions and measurement tools that reliably measure religion and spirituality separately.
2. Find that religion and spirituality have different qualities and effects, and
3. Identify people who are either spiritual or religious, but not both, although in many people religion and spirituality are highly related.

Dowling and colleagues (2004), found that religion and spirituality have independent effects on thriving, although spirituality also has an effect on religiosity. They found that spirituality involved an orientation to help others and to do good works, as well as to participate in activities of self-interest. This finding contrasts with religiosity, which involves things related to beliefs and institutional influences. Further research with adults has shown that religion and spirituality can be separated and that they change differently during the aging process, with group averages of religiosity staying fairly the same across the lifespan, while spirituality tends to increase, especially after the age 60 (Dillon, Wink, & Fay, 2003). Individuals who are spiritual but not religious have been found to differ in beliefs, for

example, they have higher levels of nihilism – the belief that life has no purpose (Shahabi, et al., 2002).

The separation of the constructs of religion and spirituality in research and practice is not without its objectors. Theologians and religious scholars generally reject the idea that religion and spirituality are separate entities (Merton, 2005, p.46). Zinnbauer and colleagues (1999) pointed out that drawing a distinction between religion and spirituality often polarizes these concepts in value-laden way, with organized, communal religion defined in negative terms and individualistic spirituality portrayed in positive terms. These types of definitions can tell us more about the values and prejudices of the researchers than the phenomenon that they are purporting to study. Zinnbauer and colleagues noted that the people who are studied often do not make the distinction that scholars make between religion and spirituality. There is evidence that in some cultural settings a distinction between religion and spirituality may not be meaningful and that even when the two are distinguished, they tend to support each other in positive ways.

A pertinent question in the empirical research on religion and spiritualty is this: Is it possible to be spiritual without being religious? Can an individual engage in a spiritual quest without formal membership in a religious group? Elkins (1998) argued that it is possible, and he presented a program of spiritual life outside religion. However, this program makes extensive use of practices and beliefs taken from major religious traditions, and frequently quotes religious figures to support his arguments. Wittingly or unwittingly, Elkins work illustrates the fact that it is impossible to divorce religion and spirituality (Hill & Pargament 2003; Eliassen, Taylor, & Lloyd, 2005), and that the practice of spirituality without the support of religion is difficult in many ways. Even though there is evidence of the separation of spirituality and religion in some historic periods, in Christianity, religious practitioners and theologians have traditionally resisted the move to split religion and theology from spirituality as inaccurate and

harmful. Christian scholars argue that ultimately the Christian religion and spirituality require each other, and the same is probably true in other religions (Tillich, 1963; Rahner, 1975; Sheldrake, 1995). Furthermore, the study of spirituality among those who are outside of religious groups is particularly difficult, so that research on spirituality to date preponderately involves those affiliated with churches and other religious groups (Emmons, 1999).

Research and Practice

How then must we understand the two concepts of religion and spirituality in research and practice? If these two concepts are distinct yet related, they are two ways of understanding their connection. Firstly, we can suppose that one of these constructs is actually a subset of the other – so that religion can be seen as a response to spirituality, or spirituality is seen as a response to religion. Pargament (1999) defines religion broadly as a "search for significance in ways related to the sacred" (p.32) and sees religion as a broader concept than spirituality (Pargament, 1999; Zinnbauer et al., 1999). Stifoss-Hansen (1999) offered an opposite perspective. He argued that spirituality is a broader concept than religion because the quality of sacredness emphasized in religion is not experienced by atheists and agnostics. Demerath (2000) proposes a third perspective that sees religion as related to the sacred, but that sacredness can be approached from other ways. Hill and colleagues (2000), suggest that a sensible way to resolve this issue is to treat religion and spirituality as distinct but overlapping constructs.

Psychological Approaches to Religion and Spirituality

The conceptualization of religion and spirituality as distinct but overlapping and interdependent constructs is of particular importance in psychological research and practice that engages religion and spirituality as variables. Psychology itself is not a homogenous field and its definitions need to be put into consideration. Originally the

term psychology comes from the Greek words *psyche* or soul and *logos* or study. The association of psychology with the human soul implies attention to the interior life of a person, and most definitions have construed it as the study of mental life or the mind. Early works of psychology, before 1850, were written by philosophers. In the latter half of the 19th century the study of psychology moved from the theoretical to the experimental methodology. Researchers began to apply natural science methods to the study of the mind. This led to psychology becoming the scientific study of behavior and this is the definition prevalent in contemporary works of psychology. In North America this emphasis on natural science led to a loss of contact between psychologists and scholars in fields like philosophy and theology that did not have an exclusively scientific outlook (Gorsuch, 2002; Fuchs & Viney, 2002). This split is not as pronounced in Europe, especially on the continent, where interdisciplinary study and cooperation has a much stronger tradition.

Psychology and Religion

Many early psychologists were interested in and sympathetic to religion. Freud, the father of modern psychology, spent much time studying religious texts and behavior. Subsequent developments in psychology namely behaviorism, psychodynamic or psychoanalytic schools, neuroscience and cognitive psychology have not been particularly friendly to religion. In the US psychologists tend to be less religious than the general population. This reality, as well as the disciplinary isolation that begun in the early 20th century, kept psychologists and theologians or religious scholars relatively unacquainted with current trends in each other's work. As a result, theologians and other religious scholars tend to respond to older psychological theories that are no longer of wider interest. Similarly, psychologists are often unaware of the important aspects of the religious traditions that they study. However, recently, an appreciation of alternative perspectives and an openness to more theoretical perspectives by psychologists, and an openness to empirical

perspectives by religionists is helping to bridge the chasm. Multidisciplinary and international research and practice is evolving and is helping to bridge the gap between religion and psychology.

Religion, Spirituality and Mental Health

In recent times, religion and spirituality have become variables of great interest in psychological research and practice especially how they relate to mental health. Research across many countries of the world has found that religious coping is widespread. Researchers found overwhelming evidence of religious coping among people with mental health problems and concluded that religion "serves as a pervasive and potentially effective method of coping for persons with mental illness, thus warranting its integration into psychiatric and psychological practice." (Koenig, 2009, p. 285). Koenig (2009) reviewed studies examining the relation between religion and mental health focusing on five areas: depression, suicide, anxiety, psychotic disorders and substance abuse. While some of the studies reported no association between religion and mental health, and a few reported negative associations, the majority (476 of 724) reported statistically significant positive associations (p. 285). Koenig concluded that people suffering from the pain of mental illness, emotional problems, or situational difficulties seek refuge in religion for comfort, hope, and meaning. While some are helped, not all such people are completely relieved of their mental distress or destructive behavioral tendencies. Thus, patients displaying unhealthy forms of religion and practice are often encountered in psychological practice. Another finding was that, among the emotionally vulnerable, religious beliefs and doctrines were seen to reinforce neurotic tendencies, enhance fears or guilt, and restrict life rather than enhance it. In such cases religious beliefs were seen to be used in primitive and defensive ways to avoid making necessary life changes.

In general, systematic research published in mental health literature to date does not support the argument that religious involvement usually

has negative effects on mental health. Instead, studies of people in medical, psychiatric, and the general population, from different ethnic backgrounds, in different age groups, and in different locations have found that religious involvement is related to better coping with stress, and less depression, suicide, anxiety, and substance abuse. While religious delusions are common in people with psychotic disorders, healthy normative religious beliefs and practices seem to be stabilizing and may reduce the tremendous isolation, fear and loss of control that is experienced by those with psychosis. Researchers and practitioners, therefore need to be aware of the religious beliefs and spiritual activities of their subjects and patients, appreciate their value and recognize when those beliefs and practices are distorted, limiting and contribute to pathology or mental health suffering, rather than alleviating it. Two constructs developed by researchers that are useful in the clinical treatment, as well as pastoral ministry, with people with mental health problems are that of the spiritual bypass and moral injury.

Spiritual Bypass

Cashwell and colleagues define the spiritual bypass as: the unhealthy misuse of the spiritual life to avoid dealing with psychological difficulties." (2011, p.2). Essentially, spiritual bypass has an avoidance function. It enables an individual to avoid the often painful and difficult psychological work of healing old wounds. For example, a client may report that she/he uses most of her/his spare time participating in church projects and has strong spiritual convictions, transpersonal experiences, and a disciplined spiritual practice. What is not readily apparent, however, is that this client uses these practices as an unconscious way to avoid dealing with her early experiences of verbal abuse or the shame that she/he associates with her well-hidden sex or alcohol addiction. As such, the person in spiritual bypass actually might be best conceptualized as in a state of developmental arrest, which may result in increased psychological symptoms. Such a

person would be likely to score high on a measure of spirituality or would respond to an initial assessment of spirituality in a way that could easily lead a clinician to believe that she/he has a strong and healthy spiritual life. Although researchers have found significant relationships between spirituality and such mental health issues as depression and anxiety, it is possible that the true relationships between spirituality and psychological symptoms are truncated by respondents who are in spiritual bypass.

Moral Injury

According to Matthews (2018) the concept of moral injury has emerged in research and practice to describe a cluster of symptoms, similar to those associated with post-traumatic stress disorder (PTSD), that result from personal experiences, which violate a person's deepest and most closely held values and principles. Matthew argued that moral injury is more associated with an existential crisis, stemming from the violation of values relating to the sanctity of life, than with trauma. From this perspective, moral injury involves a more abstract cause than PTSD, which is thought to occur after direct contact with a traumatic event. Nash and colleagues (2013) presented moral injury as an emerging model to explain how events may be traumatic even though they do not involve direct threats to life and safety. They defined moral injury as, "as the enduring consequences of perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations." (p. 373) To the extent they participate morally in military operations and their after- math, while subscribing to military values and ideals, military spouses and children may be as vulnerable to moral injury as military service members. Research on the phenomenology, natural history, and treatment of moral injury has only just begun, and focuses on military combatants and veterans. So far, no research has targeted moral injury in military family members. Nevertheless, the conceptual model of moral injury suggests specific techniques for promoting

recovery and healing from moral injury that may be as useful in military spouses and older children.

Conclusion.

I began this presentation by highlighting the challenges that the relationships among religion, spirituality and mental health pose to pastoral ministry and clinical practice. I looked at the contributions of research to the conceptualization and operationalization of these constructs and how that impacts pastoral and clinical practice. I presented the concepts of spiritual bypass and moral injury as examples, among many, of the products of current research in the area of religion, spirituality and mental health that is promising new and better ways of attending pastorally and intervening clinically. Most of the research that I reviewed has been carried out in the West, by Western scholars, among Western populations. These findings are valuable in the generation of empirically verified knowledge and evidence-based practices. However, the application of such research and practices to other world contexts needs to be carefully adjusted and adapted to local realities. The challenge remains for scholars in their non-Western parts of the world, to engage in robust and rigorous research that produces contextually relevant and culturally sensitive funds of knowledge that will drive effective and timeous intervention with the most pressing issues of human wellbeing and thriving.

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