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## Commentary

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# Religion and Spirituality in Rehabilitation Psychology

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**ABSTRACT.** This article surveys the current attitudes of rehabilitation specialists regarding spirituality and religiousness. The existing data on the associations of spirituality and religiousness with measures of physical and mental health and well-being in people with disabilities are described. The role of religion–spirituality in the lives of caregivers for people with disabilities is addressed, as are professionals’ attitudes toward considering patients’ religious and spiritual involvement in the course of rehabilitation. Finally, the potential ways to use patients’ spirituality and religiousness in assessment and intervention are discussed, and directions for future research are proposed.

Religion holds considerable importance for many Americans. For example, 92% of the U.S. population is affiliated with a religion (Kosmin & Lachman, 1993). According to a recent survey, 96% of Americans believe in God or a universal spirit, 42% indicate that they attend a religious worship service weekly or almost weekly, 67% indicate that they are members of a church or synagogue, and 60% indicate that religion is “important” or “very important” in their lives (Gallup, 1995). Almost three quarters of Americans say that their approach to life is grounded in their religious faith (Bergin & Jensen, 1990; Princeton Religious Center, 1994a, 1994b). The religiousness of the U.S. population is unmatched by almost any other industrialized nation (Gallup, 1979).

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Spirituality and religion have had a long-standing, if ambivalent, association with people who are ill or disabled (Selway & Ashman, 1998). Historically, care for individuals with severe disease and disability was the primary responsibility of the religious community, particularly churches and synagogues. The first sheltered workshops, hospitals, and cloisters were founded by churches in Europe. Between 1601 and the 1800s, the Queen Elizabeth I Poor Law (1601) put the care of persons with disabilities into the hands of the local parishes. This carried over into the British colonies and protectorates, such as Australia. Services for people with disabilities have also been noted in Eastern religious communities, such as the care institutions of the Buddhist emperor Asoka and Hindu and Muslim efforts in Benares, India (1826), and Lucknow, India (1831), respectively.

Yet, religion has not been universally kind to persons with disability. At various points in the past, disabilities have been considered works of evil spirits. At other times, people with disabilities have been banned from full participation in religious communities. This ambivalent relationship between communities and people with disabilities continues today.

Among the members of this religious nation are approximately 54 million Americans living with disabilities (McNeill, 1997). The impact of disability on society, however, is broader than its effects on people with disabilities. Indeed, in assessing the effects of disability, one must also include the impact on the family members and significant others of those who live with disability. Given the wide prevalence of religiousness and spirituality among persons with disabilities and their families, it is worthwhile to assess the roles of religion and spirituality in the lives of people with disability. In this article, we (a) survey the current attitudes of rehabilitation specialists regarding spirituality and religiousness, (b) describe the existing data on the associations of spirituality and religiousness with measures of physical and mental health and well-being in people with disabilities and their families, (c) discuss rehabilitation professionals' attitudes toward considering patients' religious and spiritual involvement in the course of rehabilitation efforts, (d) discuss the potential ways to use patients' spirituality and religiousness in assessment and intervention, and (e) propose directions for future research.

## **RELIGIOUS BELIEFS OF REHABILITATION PROFESSIONALS**

In contrast to the comfort of many laypersons with religion and spirituality, rehabilitation specialists may be less religiously inclined than the general population (e.g., "Politics of the Professorate," 1991; Shafranske, 1996). Shafranske (1998) examined the religious beliefs and practices of 190 members, fellows, and associates of the Division of Rehabilitation Psychology of the American Psychological Association. In general, Shafranske (1998) found that "—psychologists do not believe in a God who is imminently involved in the events of the world and almost twenty percent believe that notions of God are illusions" (p. 5). This is in direct contrast to the majority of the population who believe in God and pray

regularly. Unlike previous researchers, Shafranske did not find rehabilitation psychologists generally to be apostate (i.e., rejecting of the religious–spiritual heritage in which they were raised); rather, they focused their spiritual belief on personal dimensions of spirituality instead of institutional religion. Although only 43% of the sample reported regular participation in religious activities, 79% considered themselves to be moderately or very spiritual. Rehabilitation psychologists are different from their patients with respect to formal religion, but they may not be so different with respect to personal spirituality.

The training of rehabilitation psychologists in regard to religion and spirituality is quite minimal. Eighty-two percent of the rehabilitation psychologists surveyed by Shafranske (1998) indicated that religious or spiritual issues were never presented or discussed in training and that they felt uncomfortable addressing religious or spiritual concerns in counseling. However, 78% of the sample indicated that it was important to know a patient's religious background, whereas only 10% either recommended prayer or prayed with a patient. Although 53% of the rehabilitation psychologists endorsed religious journal writing, only 6% actually used that intervention. The more religious a psychologist reported being, the more likely he or she was to use religious interventions in practice.

Dein and Stygall (1997) suggested three reasons why clinicians have not addressed their patients' religious concerns well: (a) the personal nature of religion, which makes religious discussion awkward; (b) the association of religion with superstition, intolerance, and persecution of others; and (c) the idea that patients who view religion only as a last resort when all else fails to sustain life or health may be hesitant to address these concerns. Another reason why rehabilitation professionals so infrequently address clients' religious and spiritual concerns may be their lack of knowledge regarding the role that spirituality plays in the lives of people who have (or are at risk for developing) disabilities.

## **SPIRITUALITY AND DISABILITY: THE RESEARCH**

To help remediate this relative dearth of knowledge, we review five domains of research: (a) the role that religious involvement and spirituality might play in preventing disability among at-risk samples, (b) the associations of spirituality and religion with physical health among people who have disabilities, (c) the associations of spirituality and religion with mental health and coping among people who have disabilities, (d) the associations of spirituality and religion with well-being and quality of life among people who have disabilities, and (e) the associations of spirituality and religion with the mental health and well-being of caregivers for persons with disability.

### **Religion and Disability in Community-Dwelling Adults**

Religious involvement might deter disability among community-dwelling adults. Idler and Kasl (1997a) reported the results of an epidemiological study of

2,812 older adults in the New Haven, Connecticut, area. They found that, in cross-sectional analyses, functional disability had a strong negative relationship to attendance at religious services. Furthermore, attendance at religious services was associated with better health practices, including higher levels of exercise, lower rates of alcohol consumption, and never having smoked. Higher levels of subjective religiousness were associated with never having smoked and, unfortunately, a higher weight-to-height ratio (but not lower disability). Older people who attended religious services benefited from large and involved family lives, large and involved friendship networks, more holiday parties to attend, and a larger number of other leisure activities. One of the most surprising findings was that "religious attendance is linked to many other forms of social integration, not only in spite of disability, but especially where disability is present" (Idler & Kasl, 1997a, p. S301). In regression models controlling for disability, regression coefficients demonstrating the links among religious attendance and social integration were as follows: leisure activities,  $r = .25$ ; number of close friends,  $r = .36$ ; number of kin contacts,  $r = .25$ , and number of friend contacts, were as follows: leisure activities,  $r = .41$  ( $ps < .05$ ). In fact, participants with greater levels of disability who also attended religious services displayed more positive affect and more optimism than those with less physical disability. Attending religious services was associated with fewer depressive symptoms, fewer complaints of physical illness, and fewer interpersonal conflicts.

In a 6-year longitudinal study of religion and disability involving the same sample of older adults, Idler and Kasl (1997b) investigated both the effect of religious involvement on functioning and the effect of disability on religious practices. Idler and Kasl measured functional ability, public and private religious involvement, health status, health practices, social activities, well-being, and demographics. Religious involvement in 1982 appeared to have a negative association with functional disability in each of the following 6 years (betas ranged from  $-0.91$  to  $-1.61$ ,  $ps < .05$ ). However, disability did have a short-term effect on attendance. After a decrease in functioning resulting from illness or injury, there was also a decrease in attendance at religious services at the next measurement period. This decrease in functioning was undetectable 3 years after the illness or injury for those individuals who attended religious services at the beginning of the study. The benefit of religious attendance on subsequent functioning was greatest for those who had some disability at the beginning of the study. In attempting to identify some of the mechanisms through which religious attendance might have affected functioning, the authors found that higher levels of physical activity, higher levels of leisure activity, more close kin, and higher levels of optimism were characteristic of religious attendees but did not completely account for the effect of religious attendance on subsequent disability.

Idler and Kasl's (1997a) cross-sectional findings were not replicated in a recent study of low-income older adults. In a nationwide longitudinal study, Krause (1998) examined the role of religious coping in relation to self-rated health and functional disability among older adults in deteriorated neighborhoods. Eight items measured religious coping (i.e., "When dealing with difficult times in my

life, I get much personal strength and support from God”), organizational religiousness (i.e., “How often do you attend religious services?”), and nonorganizational religiousness (i.e., “How often do you read the Bible or other religious literature at home?”). Results indicated that older adults who use religious coping strategies effectively defend against the negative effects of a seriously harmful environment on self-ratings of physical health status. In contrast, analyses in which functional disability was the dependent variable showed that religious coping was *not* a buffer for the deleterious effects of deteriorating neighborhoods. Thus, whereas perception of health may have been better in the religious participants, functional ability was unrelated to religious involvement or religious coping.

In summary, both cross-sectional and longitudinal studies have produced evidence suggesting that religious attendance might have some relationship to functional disability. Religious coping strategies may be related to self-ratings of physical health, yet religiousness has been associated with objective measures of functional disability inconsistently. There is also some indication that social factors (i.e., more social interaction, more leisure activity, and larger social networks) and psychological factors (i.e., optimism and perception of physical health) may be mediators or moderators of the relationship between religious involvement and health. Clearly, more longitudinal research, such as that of Idler and Kasl (1997b), is needed.

### **Impact of Religion–Spirituality on Physical Health**

Researchers have also examined the association of spirituality and religion in patients at particular risk for disability.

***Religion and disability in heart transplant recipients.*** Harris and colleagues (1995) examined the role of religion in the long-term well-being of heart transplant recipients through the 1st year posttransplant. They interviewed transplant recipients 2, 7, and 12 months postsurgery. Over the year of the study, the percentage of patients frequently attending church increased from 18% at 2 months to 44% at 12 months. However, during the same period, the percentage of patients reporting that religion was a significant influence in their lives declined from 46% to 37%. Patients who reported their religious beliefs to be highly influential in their life had better physical functioning, fewer health worries, and less difficulty following the regimen at 1 year than other patients. Patients who reported regularly consulting God to make important decisions and who prayed frequently in private had less difficulty following the medical regimen than other patients. Patients who were frequent attendees at religious services reported less anxiety than those who were not frequent attendees, and those who were active within their own congregation had higher self-esteem than those who were not active in their congregation.

***Religion and disability in hip fracture patients.*** In a study of elderly women with broken hips, the relationships among religious belief, depression, and

ambulation status were examined (Pressman, Lyons, Larson, & Strain, 1990). The measure of religiousness was a three-item scale including attendance at religious services, perceived religiousness, and rating of degree that religion (and/or God) is a source of strength and comfort. Ambulation status was measured by assistance required and linear distance walked at discharge. Religiousness was significantly, negatively related to depression even when severity of illness was controlled. Although religiousness was positively correlated with distance walked at discharge, the association was nonsignificant when depression was controlled. This implies that the effect of religiousness on ambulation status at discharge might have been mediated by the effect of religiousness on depression.

Another study showed that the influence of religious and spiritual variables disappeared after controlling for other psychosocial factors. In a sample of 156 adults in rehabilitation for both chronic and sudden onset of illness or injury, Kim and Heinemann (1998) measured the relationships of spiritual well-being, spiritual support, and spiritual dogmatism with emotional health, life satisfaction, and functional recovery. Concerning outcomes for physical health, there was no reliable relationship between spirituality and functional status after controlling for initial levels of motor and cognitive function, life satisfaction, and emotional health.

Thus, the relation of religiousness to physical health is mixed and inconsistent across studies. It may be that the relationship of spirituality–religion with health is mediated (partially or completely) through psychosocial factors. Potential mediating variables may include better health behaviors (e.g., more exercise and lower tobacco and alcohol consumption), higher levels of leisure activity, better social support, higher levels of optimism, and higher socioeconomic status. Whereas many of these variables were mentioned or accounted for in the previously reported studies, they cannot be entirely dismissed as possible causal or mediating factors in the relationship between spirituality and health.

### **Impact of Spirituality–Religion on Well-Being and Psychological Symptoms**

In addition to studies mentioned earlier (Harris et al., 1995; Idler & Kasl, 1997a; Kim & Heinemann, 1998; Pressman et al., 1990), several other studies have examined the association of spirituality and religiousness with measures of well-being and psychological symptoms (Meier, 1981). In the context of a larger quantitative investigation, Heinemann and Kim (1998) conducted a qualitative study to examine faith beliefs, the impact of illness on beliefs and on life in general, and the role of spirituality in illness behaviors, coping, and recovery. The sample was composed of 29 patients with a wide variety of presenting problems, 3 months after their release from rehabilitation. Patients were selected to fall in three distinct categories: particularly high religious or spiritual maturity and well-being, particularly low religious or spiritual maturity and well-being, and marked fluctuation in religious or spiritual maturity and well-being over time.

There was little variation in the themes that patients expressed concerning religion or spirituality. "Almost all respondents indicated that religious faith was important to them in some way. Even among those few respondents who initially stated that faith was not important to them, all independently identified at least one way in which religious faith could be considered significant or influential in their lives" (Heinemann & Kim, 1998, p. 9).

Patients differed in their views of how spirituality or religion was related to their disability, and these differences were, in part, a function of their overall view of their disability. Preliminary analyses suggested that patients who viewed their disability as negative, producing loss or threat of loss in their lives, had prayed more since their injuries but also felt angry with God and questioned God. This group of patients apparently had not found any meaning or purpose in their illness or disability. Patients who viewed their disability as a benign or neutral influence on their lives reported no change in prayer or other religious practices. They saw faith as a way of coping with illness, facilitating positive thinking and helping to put things in perspective. Overall, they saw no special meaning or purpose in their illness or disability. It was simply a part of the natural aging process to them. Finally, patients who viewed their disability as a benefit or positive influence on their lives reported an increase in prayer and an increase in the significance of religion in their lives. They reported that faith was a means of coping with the illness, providing hope, positive thinking, and a way of preventing depression. For these individuals, faith was viewed as an essential element of recovery. It provided meaning and purpose for the patients in that they believed the experience was a message from God. Spiritual variables accounted for between 7.4% (dogmatism decreased cognitive function) and 30.9% (spiritual well-being increased life satisfaction) of the variance in the general well-being dependent variables (Heinemann, 1999; Kim & Heinemann, 1998).

Ai, Dunkle, Peterson, and Bolling (1997) studied the role of religiousness in psychosocial recovery after cardiac surgery. One year after surgery, 151 patients reported on religiousness and religious practices within the preceding 12 months, postsurgical depression, and current psychological distress. Using structural equation modeling, the authors demonstrated that those patients who reported praying after cardiac artery bypass surgery reported less psychological distress than those patients who did not pray,  $\beta = -.11$ ,  $t = 2.54$ , after controlling for levels of postsurgical depression.

The effects of religious belief on disability and psychological assessment of that disability are not limited to the United States. In a study of temporarily and permanently disabled patients hospitalized in India, both patient reports and doctor reports pointed to the influence of religion on recovery (Dalal & Pande, 1988). When those with permanent and temporary disabilities were asked about the cause of their disability, they often mentioned karma and God's will. Attributing cause to karma or God's will was significantly, positively associated with psychological recovery ( $r_s = .37$  and  $.24$ , respectively). Personal control was not associated with psychological recovery, and number of doctor-reported complaints and depressive symptoms were significantly, negatively correlated

with psychological recovery. All patients experienced decreases in psychological distress over time.

Decker and Schulz (1985) studied the relations among life satisfaction, health, disability perception, social support, and perceived control among middle-aged and older persons with spinal cord injury. Self-reported religiousness was among several small, positive correlates of higher levels of well-being in patients with spinal cord injuries ( $r < .3$ ). However, religious involvement does not appear to be uniformly positive for all persons with disabilities. For example, Brooks and Matson (1982) conducted a longitudinal study examining sociodemographic, disease-related, medical, and social psychological factors among 103 people in the middle and later stages of multiple sclerosis. Self-concept was also assessed at two time periods 7 years apart. Persons who relied primarily on religion or family to cope with the disease experienced reductions in self-concept over time (mean decrease in self-concept scores =  $-.13$  and  $-.16$ , respectively). On the other hand, patients who coped by accepting the disease and who had an internal locus of control experienced improved self-concept over time.

In summary, people generally find spirituality and religiousness to be helpful resources for coping with their physical disabilities. For the most part, religious involvement and spirituality appear to be associated with better well-being and fewer psychological symptoms among people at risk for experiencing disability. However, a great deal more research is needed to replicate and extend findings gleaned from these initial studies.

### Caregivers, Religion, and Rehabilitation

Rehabilitation psychologists often work with the families and caregivers of persons with disability. It is important to understand the influence of religion and spirituality on caregivers, because caregivers' views may have an indirect impact on the physical and mental health of persons with disability. In a study of the emotional impact of caring for patients with Alzheimer's disease and cancer, Rabins, Fitting, Eastham, and Fetting (1990) found that caregiver positive emotional states were associated with number of social contacts ( $r = .40$ ), degree of family cohesiveness ( $r = .27$ ), and feeling that one is supported by religious faith ( $\rho = .40$ ), as well as caregiver neuroticism ( $r = -.24$ ) and extraversion ( $r = .39$ ). Caregiver emotional distress was predicted by low support from religious faith ( $\rho = -.24$ ), low openness to experience ( $r = -.24$ ), and neuroticism ( $r = .24$ ). However, attendance at religious services was unrelated to a positive emotional state.

In a unique study of kidney transplant recipients' coping strategies, psychological adjustment and marital adjustment were measured for both patients and spouses (Vinyon, 1995). A coping instrument included subscales for cognitive restructuring, emotional expression, problem avoidance, social withdrawal, and God-religion. The God-religion coping technique and the cognitive restructuring coping technique were the most commonly used among male patients, female



patients, and male spouses. The God–religion coping technique was the one most commonly used among female spouses. Results also revealed that male and female spouses used God–religion in coping with transplant-related stress more than did the transplant recipients. Although relying on God–religion in coping with the transplant was correlated among married couples ( $r = .49$  for female patients and  $r = .54$  for male patients,  $ps < .01$ ), only the use of God–religion by male patients and their female spouses was related to higher marital satisfaction among male patients,  $F = 3.87$ ,  $p < .05$ . All other relationships between the use of God–religion and patient or spouse distress were nonsignificant. Although both patients and spouses regularly used religious coping strategies, it seemed to have only a small positive influence on the relationship between the partners and no influence on the psychological distress of either partner.

In a study of the coping strategies of families of children with sickle cell disease, Royal (1997) found that acceptance of the condition was used more often by siblings in highly religious families, whereas denial was used more frequently by siblings in less religious families. In this highly religious sample, both positive and negative outcomes were observed. For example, the use of acceptance versus denial by siblings of these patients seemed strongly influenced by their religious home environment. However, mothers who were not prepared for having a child with sickle cell disease appeared to fall back on religious coping as a last resort.

Selway and Ashman (1998) reported on two studies indicating that parents of children with disabilities (Bennett, Deluca, & Allen, 1995) or developmental delays (Weisner, Beizer, & Stolze, 1991) were influenced by religion or spirituality in the care of their children. Bennett et al. (1995) interviewed 12 parents who had children with disabilities and found religion, church attendance, prayer, and specific religious beliefs to be sources of support that led to increased strength and more hope. Weisner et al. (1991) studied parents in 102 families with developmentally delayed young children. “Religious commitment was found to be an inherently important and meaningful factor for many of those families and one that needed consideration by professionals when working with families” (as reported in Selway & Ashman, 1998, p. 433).

In research conducted to explore the spiritual aspects of the grief process for caregivers of persons living with HIV–AIDS, T.A. Richards and Folkman (1997) found both helpful and harmful effects of spirituality on the experience of the caregivers. On the basis of a content analysis of caregivers’ reports of the end of life experience for their partners, participants were classified as spiritual or nonspiritual because of explicit mention of spiritual beliefs, spiritual experiences, religious rituals, or self-created rituals. The two groups were compared, via  $t$  tests, on coping, mood, and physical health measures (both HIV-related symptoms and general health symptoms). Caregivers who mentioned spiritual beliefs engaged in more positive reappraisal, planful problem solving, and confrontive coping than caregivers who did not express spiritual belief. However, caregivers who expressed spiritual beliefs had higher levels of depression and anxiety than did those who did not express spiritual beliefs. Furthermore, caregivers expressing spiritual

beliefs reported more HIV-related and general health symptoms than did caregivers not expressing spiritual beliefs.

In summary, one of the clearest findings in the review of studies concerning caregivers and family members of persons with chronic illness and disability is that a significant number use religious and spiritual coping resources. The outcomes for the caregivers of using coping strategies are mixed. On the positive side, religious faith, religious support, and spirituality seem to be associated in some samples with decreased emotional distress, positive emotional state (cf. T.A. Richards & Folkman, 1997), acceptance by siblings, increased marital satisfaction for men, increase in strength and hope of parents, positive reappraisal, planful problem solving, and confrontive coping. However, on the negative side, there is no evidence linking attendance at religious services with positive emotions (e.g., Rabins et al., 1990) or evidence linking marital satisfaction of women with religious coping. Furthermore, there exists some evidence that unprepared mothers in caregiving roles may rely more on spiritual beliefs and that caregivers of people with HIV–AIDS have more health problems.

## DISCUSSION

Although rehabilitation professionals are somewhat less traditionally religious than the general population, they appear to be generally open to considering the potential spiritual needs of the clients they serve. Perhaps the field of rehabilitation psychology will eventually succeed in fulfilling its mandate to address the spiritual needs of rehabilitation patients (Commission on the Accreditation of Rehabilitation Facilities, 1993; Joint Commission on Accreditation of Healthcare Associations, 1993). At present, the research provides a rather mixed picture regarding the potential role of spiritual and religious factors in people's risk for developing disability, likelihood of remaining disabled after medical illness, subjective well-being, and mental health, as well as the well-being of caregivers for persons with disability. Several high-quality studies have been conducted to date, but their findings have been inconsistent (and, in some cases, contradictory). It is likely that these inconsistencies are due, in part, to the substantial heterogeneity of study samples, designs, and measures. Until a more substantial body of research accumulates in this embryonic field, it will be difficult to draw definitive and more fine-grained conclusions regarding the role that spiritual and religious factors play in the health, adjustment, and recovery of people at risk for and recovering from disability and their caregivers. One consistency in this area of research seems to be that a good number of persons with disability and their caregivers have religion or spirituality as a part of their lives, and some of them use religious or spiritual resources to help them cope with disability and illness.

There are relatively straightforward steps that rehabilitation professionals might consider taking to fulfill their mandate to address the spiritual needs of persons with disability. These steps are related to assessment, collaboration with clergy and other spiritual health professionals, and training.

### **Assessment**

A variety of approaches might be used to develop effective assessments of rehabilitation clients' religious and spiritual functioning. The most straightforward of these approaches would be simply to ask clients to articulate whether (and, if so, how) their religious or spiritual beliefs and practices might be relevant for how they cope with their physical problems (Matthews et al., 1998). Such informal assessments can reveal a variety of important data, including whether clients (a) believe their health problems to be a punishment or test from God, (b) feel estranged from God or a higher power because of their disability, (c) find comfort or feel alienated from other people in their religious or spiritual traditions, (d) blame God or a higher power for their physical problems, or (e) actively petition God for relief from their difficulties. All of these spiritual coping strategies have been related to impairment in samples of medically ill patients (e.g., Koenig, Pargament, & Nielsen, 1998) and could be important aspects of religious and spiritual coping for rehabilitation psychology. Moreover, these particular forms of religious and spiritual coping appear to be more relevant to health and well-being than static measures of public and private religious involvement.

More structured tools have been developed for assessing the many dimensions of religious and spiritual coping (e.g., Koenig et al., 1998; see Pargament, 1997, for a review). Although such instruments do not yet have meaningful clinical norms that facilitate interpretation of scores in absolute terms, they can be used ipsatively to isolate both potential sources of spiritual-religious distress and aspects of patients' religious and spiritual functioning that might be unique resources for coping. A variety of other measures of religious involvement and spirituality (mostly research instruments) are also widely available (for a review, see Hill & Hood, 1999).

### **Collaboration**

In most rehabilitation settings, it is likely that there is little communication between religiously based groups devoted to helping persons with disabilities and rehabilitation specialists. McCarthy (1995) suggested that this lack of collaboration might be due to the insecurity of the clergy in the realm of mental health and the failure of counselors to recognize the contributions clergy can make to the rehabilitation process. However, the professional psychology literature in general contains very little guidance for the psychologist interested in collaborating with clergy and other religious-spiritual professionals (Weaver, 1997). Thus, it is probably safe to assume that many rehabilitation professionals do not collaborate with clergy simply because they have not been trained to do so. However, clergy trained in clinical pastoral education programs and hospital-based pastoral care are too often neglected as a potential resource for patients and clients. Rehabilitation professionals would do well to begin to explore ways that they can consult,

collaborate with, and refer rehabilitation patients to clergy and other religious–spiritual professionals.

### **Training**

McCarthy (1995) also noted that the rehabilitation education literature does not contain much information on the role of religion–spirituality in rehabilitation. This includes citations of work in both professional journals and introductory-level textbooks. It seems that neither professionals nor the students of rehabilitation psychology are exposed to literature addressing the religious–spiritual aspects of the person or of his or her care. Two notable exceptions to this are the *Journal of Religion in Disability and Rehabilitation* and Vash's (1994) book titled *Personality and Adversity: Psychospiritual Aspects of Rehabilitation*. Relevant works in clinical and counseling psychology include *A Spiritual Strategy for Counseling and Psychotherapy* (P.S. Richards & Bergin, 1997) and *Religion and the Clinical Practice of Psychology* (Shafranske, 1996). Other works useful for education and training might include books by Pargament (1997) and Koenig, McCullough, and Larson (in press).

Of course, rehabilitation professionals also need experience in wrestling with the spiritual dimensions of disability and rehabilitation in their practical training. We hope that as interest in the spiritual aspects of rehabilitation psychology becomes more mainstream, professional programs will give more emphasis to training concerning spiritual and religious issues of patients than they have historically done.

### **CONCLUSION**

Clearly, much work remains to be done in understanding the religious and spiritual dimensions of disability and rehabilitation. Specifically, more research is needed that examines not only the association of religious and spiritual involvement (as measured in static terms such as public religious involvement or frequency of prayer or meditation) but also the ways that people deploy their religion or spirituality to cope with the challenges of disability and rehabilitation. Longitudinal research would be particularly valuable at this stage.

Informal and formal assessments of patients' spiritual issues could enrich clinical practice. Interventions may be augmented with regular consultation and collaboration with clergy and spiritual professionals. More specific techniques from the religious counseling literature may prove useful to those unfamiliar with these techniques (for a review, see Worthington, Kuru, McCullough, & Sandage, 1996). Finally, developing comfort and skill in discussing patients' religious and spiritual issues in professional training would help considerably to ensure that rehabilitation psychology adequately deals with the spiritual side of disability and rehabilitation.

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