Selected Annotated Bibliography on Spirituality and Mental Health

John Peteet, MD

Kirov G, Kemp R, Kirov K, et al. Religious faith after psychotic illness. Psychopathology 1998;31:234–245.

Relatively little data is available about what role religion plays in the lives of psychotic individuals. The authors of this paper used a semistructured format to interview 52 consecutive patients hospitalized for psychosis about their religious beliefs. Over 66% were religious, and over 20% said that religion was the most important part of their lives; 30.4% reported that there had been an increase in their religiousness since the onset of their illness, and 61.2% were using their religion for coping with the illness.

Contrary to common assumptions that religion reflects denial, religious patients had more insight into their illness and were more compliant with medication.

Although limited by its small sample size, completely Christian population and reliance on subjective measures, this study's use of follow-up interviews provides a window into the use by religious patients of integrative versus "sealing over" coping, as well as into the possible impact of a devastating illness on faith. The findings call attention to the significance of religion in the lives of many patients with psychosis, to the need for researchers to better understand its dynamic importance, and to the need for clinicians to find ways of working with their psychotic patients' religious resources for healing.

Mohr S, Brandt P, Borras L, et al. Toward an integration of spirituality and religiousness into the psychosocial dimension of schizophrenia. Am J Psychiatry 2006;163:1952–1959.

A growing literature shows religion to be prevalent among psychotic individuals. In contrast to earlier descriptions emphasizing religious delusions and hallucinations, recent studies have more often found associations with indices of mental health. The authors of this study go further to explore how religiousness functions in the coping of patients with psychotic illness.

Semistructured interviews of 103 outpatients with nonaffective psychosis in a Geneva hospital revealed that, for some patients, religion encouraged hope, purpose, and meaning (71%), while for others, it engendered spiritual despair (14%). Religion also showed both positive and negative effects on symptoms, social integration, suicide attempts, substance use, and compliance with treatment.

The study's cross sectional design did limit the extent to which the dynamic role of faith in each individual could be understood. Interestingly, no patients whose religious beliefs were involved with their delusions or hallucinations were in contact with individuals from religious communities, suggesting that collaboration with religious persons could be a unique resource for patients for whom religion has primary importance. This paper brings helpful attention to the unique clinical importance of religion in each individual.

Sulmasy DP. Spiritual issues in the care of dying patients: ". . . it's okay between me and God". JAMA 2006:296:1385–1392.

The author reviews the spiritual issues arising frequently in the care of dying patients and describes the role that physicians should play in ascertaining and responding to these needs. He begins with the case of a man who expected a miracle from God at the end of his life.

Boxes summarize practical ways for clinicians to explore questions of meaning, value, and relationship; suggest ways of taking a religious history; outline selected religion-specific needs of dying patients; and distinguish negative from positive religious coping.

He explains why expecting a miracle does not disqualify patients from hospice care. This classic paper effectively shows how attending to the spiritual needs of patients is integral to the job of being a good physician.

The author is professor of medicine at NYU, a Franciscan friar, a trained ethicist, and an uncommon writer.

Sulmasy DP. The Rebirth of the Clinic: An Introduction to Spirituality in Health Care. Washington, DC, Georgetown University Press, 2006.

The author describes medicine as intrinsically spiritual. The clinic in the title refers to the scientific and rational approach to medicine that came to dominance in the 20th century, but which has become increasingly symptomatic and unstable for lack of a soul.

Part I offers a historical and philosophical perspective on the physician's role. Part II considers the meaning of the growing empirical research on spirituality and healing. Part III asks whether the physician has an obligation to address the spiritual needs of patients, eg, at the end of life.

The book is practical, evocative and integrative. Among its pearls include the distinction between intrinsic and attributed dignity; the dying patient's need for value, meaning and reconciliation; and the spiritual questions raised by the recent play "Wit."

Corrigan P, McCorkle B, Schell B, et al. Religion and spirituality in the lives of people with serious mental illness. Community Mental Health J. 2003;39:487–499.

Over 90% of individuals in this study described themselves as religious or spiritual, and nearly half considered themselves "very" or "extremely" religious or spiritual. Clinicians need to attend to the importance of this domain as a resource in the lives of their patients with serious mental illness.

As part of a multisite survey funded by SAMHA of the impact of services on individuals with serious mental illness (an Axis I diagnosis of schizophrenia, bipolar disorder or major depression, and significant functional disability), the authors asked 1,824 indi-

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viduals whether they were religious and/or spiritual, and correlated their responses with measures of three health outcome domains: self-perceived wellbeing, psychiatric symptoms, and life goal achievement.

Religion and spirituality were both associated with wellbeing and symptoms, but not with goal achievement. Effects were significant in relation to recovery, social inclusion, hope and personal empowerment. Contrary to expectations, spirituality did not show a greater effect than religiousness, raising the question of the importance of social support provided by religious communities.

Hathaway WL. Clinically significant religious impairment. Mental Health, Religion and Culture. 2003;6:113–129.

The author suggests that clinicians systematically consider the potential impairment in religious functioning caused by mental disorders.

Although increasing recognition of the importance of religion and spirituality in mental health has recently extended to the DSM-V revision process in the form of a monograph in preparation by APIRE, the author does not consider this move to be enough. Rather than viewing religion as a secondary ("exogenous") variable influencing mental health via its effects on mental functioning, the author proposes that clinicians consider religion as a significant domain of adaptive functioning in its own right. Examples of factors to take into consideration include a reduced ability to perform religious activities, achieve religious goals, or experience religious states, due to a psychological disorder.

Perhaps the paper's greatest strength is in its philosophical perspective on the research literature. Whether its call for the development and use by the mental health community of a nosology of clinically significant religious impairments is realistic remains to be seen, particularly given the challenge (not directly addressed here) of distinguishing religion from spirituality.

Although it lacks clinical examples, this paper does offer a conceptual and ethical foundation for addressing patients' religious problems in treatment.

Phillips RE, Lakin R, Pargament KI. Development and implementation of a spiritual issues psychoeducational group for those with serious mental illness. Community Ment Health J 2002:38: 487–495.

The authors briefly review the positive effects of incorporating unstructured and psychoeducational group interventions for individuals with serious mental illness before proceeding to describe one such group.

The group had a 7-week, semistructured format with ten outpatients with a primary diagnosis of schizophrenia, depression or personality disorder (individuals with substance use disorders were excluded). After an introductory session in which participants shared their spiritual histories, sessions focused on spiritual resources, strivings, struggles, forgiveness and hope. Some sessions were intense, but group members appeared to appreciate the opportunity to address together both encouraging and distressing aspects of this relatively neglected area. Most felt that topics chosen could have been explored in greater depth and wanted the groups to continue.

A potential limitation to generalizability of the report's findings is that all participants were either Protestant or Catholic.

Borg J, Andree B, Soderstrom H, et al. The serotonin system and spiritual experiences. Am J Psychiatry 2003:160:1965–1969.

In this intriguing report, investigators ascertained the brain serotonin 5-HT 1A receptor binding potential of 15 healthy male subjects using MRI and PET scans, and correlated these findings with personality measures using the Temperament and Character Inventory, covering Cloninger's four temperament dimensions of self-directedness, cooperativeness, and self-transcendence. The values for serotonin binding potential correlated significantly with the self-transcendence, but not with any of the other six Temperament and Character Inventory dimensions, in all three brain regions studied. The three subscales of the self-transcendence dimension include religious behavior, subjective experience and individual worldview. Further analysis showed that the spiritual acceptance subscale, measuring a person's apprehension of phenomena that cannot be explained by objective demonstration, accounted for this correlation with self-transcendence.

While the study is limited by its size and the male gender used, it offers interesting possibilities for exploring drug-induced experiences, religious hallucinations, and the genetics of religiosity. It is a start toward understanding the interface between spirituality and psychiatry by looking at the biology of spiritual experience.

Koenig HG. Faith and Mental Health: Religious Resources for Healing. Philadelphia, Templeton Foundation Press, 2005.

This book explores the role that faith-based organizations play in delivering mental health and substance abuse services.

Part I explores the historical relationship between faith communities and care. Part II systematically reviews the evidence for the importance of spirituality in fostering positive emotions, coping and recovery from the range of psychiatric disorders. Part III, the core of the book, distinguishes and provides examples of several categories of faith-based mental healthcare that include local religious congregations, networking and advocacy organizations, mission-driven faith-based services, and faith-integrated counseling services. Part IV discusses both barriers to implementation of faith-based care, and possible solutions. Non-Christian examples, and unhelpful uses of religion receive some attention.

The book is a clearly written, practical resource for understanding how healthcare professionals and religious professionals can more effectively collaborate.

Kendler KS, Liu X, Gardner CO, et al. Dimensions of religiosity and their relationship to lifetime psychiatric and substance use disorders. Am J Psychiatry 2003;160:496–503.

The relationship between religiousness and mental health entails a series of complex associations.

Reported are the responses to 78 items assessing various aspects of broadly defined religiosity obtained from 2616 male and female twins in a general population registry and their relationship to the lifetime risk of 9 psychiatric disorders assessed at interview.

Consistent with previous research, high levels of religious involvement predicted low levels of substance misuse. Social religiosity was also inversely related to illness. Potentially important factors more associated with "intrinsic" religiosity involved thankfulness and lack of vengefulness. Somewhat different patterns of association were found between "internalizing" (major depression, phobias, generalized anxiety disorder, panic disorder, and bulimia nervosa) and "externalizing" (nicotine dependence, alcohol dependence, drug abuse or dependence, and adult antisocial behavior) disorders.

While some findings reported here are suggestive, disentangling the many factors involved with religiosity and their relationship to emotional disorders will require further and deeper work.

Wagner LC, King M. Existential needs of people with psychotic disorders in Porto Alegre, Brazil. Br J Psychiatry 2005;186:141–145.

In this study three focus groups were conducted to assess the perspective of patients and their caregivers in a major Brazilian city: one with 24 individuals with illness (of 3–15 year duration); one with 16 informal caregivers; and one of 17 formal (professional) caregivers. The psychiatrist who facilitated each group asked members to identify the needs of schizophrenic individuals in all domains of life, how the illness had provoked changes in these needs, and whether they needed more or different kinds of care.

Existential needs were the most important and pressing needs for patients in a Brazilian city. Needs included personal development, integrity of the self, winning respect and avoiding shame, autonomy, love, acceptance and understanding of the psychosis, and spirituality.

Although this study is limited by small sample size in a single developing country, it is provocative in its implications for the comprehensive care of psychotic patients. At the very least, it suggests that caregivers should listen to the existential suffering of patients with these illnesses. The next step might be to help them use spiritual resources, broadly defined, in their search for answers.

Mueller PS, Plevak DJ, Rummans TA. Religious involvement, spirituality, and medicine: implications for clinical practice. Mayo Clin Proc 2001;76:1225–1235.

Reviewed are published studies, meta-analyses, systematic reviews, and subject reviews (citing 146 references) that discuss the importance of spirituality to patients and the relative importance for them to physical health in times of illness.

Findings are summarized under the following headings: use of religious and spiritual variables in medical research; religious involvement, spirituality, and physical health (including mortality, cardiovascular disease, and hypertension); religious involvement and spirituality in terminally ill patients; religious involvement, spirituality and mental health (including depression, anxiety, substance abuse and suicide); religious involvement, spirituality and coping with illness; religious involvement, spirituality and HRQOL; possible beneficial mediators associated with religious involvement and spirituality; and negative effects of religious involvement and spirituality.

The association between religious involvement and spirituality is valid, though the causal relationships remain unclear.

Further summarized are implications for clinical practice in the areas of support for patients' spirituality, ethical issues, taking a spiritual history and sources of spiritual care.

Although six years old, this paper is a comprehensive, clear, thoughtful, evidence-based resource.

Flannelly KJ, Koenig HG, Ellison CG, et al. Belief in life after death and mental health: findings from a national survey. J Nerv Ment Dis 2006;194:524–529.

Attempted was a systematic examination of the association between beliefs about the afterlife and measures of psychiatric symptoms.

Contrary to expectations, results provided no support for the hypothesis that organized religious activity would be positively related to mental health. Frequency of prayer varied directly with symptom severity, consistent with the findings of others suggesting that prayer may be used as a source of comfort in times of distress. Belief in life-after-death was consistently related to better mental health.

Hypothesizing that both religious attendance and belief in life-after-death, but not necessarily prayer, would be inversely related to psychiatric measures, the authors e-mailed a random sample of Americans inviting them to participate in a Web-based survey. 1895 individuals responded to the questionnaire that included the following aspects of religion: six subscales of the Symptom Assessment-45 Questionnaire measuring anxiety, depression, obsession-compulsion, paranoid ideation, phobia anxiety, and somatization; demographics; and measures of stress and social support.

The authors consider ways that belief in life after death may help put one's identity, adverse experiences, and interpersonal struggles into a broader context.

While this study's cross-sectional survey design did not permit exploration of the dynamic role of belief in the lives of symptomatic individuals, it raises intriguing possibilities for further study.

Taylor RJ, Ellison CG, Chatters LM, et al. Mental health services in faith communities: the role of clergy in black churches. Soc Work 2000;45;73–87.

Ministers are often the first professionals contacted by individuals with emotional problems, and the most accepting of them. They function as gatekeepers for individuals with a variety of problems and are a heterogeneous group themselves. Many black churches provide both counseling and community outreach and show a range of referral practices.

Critically reviewed is the research describing the role of ministers in providing mental healthcare, the factors important in understanding this role, and barriers to effective collaboration among churches and other resources for mental health.

Fruitful collaboration with formal sources of mental health treatment can be impeded by conflicts over basic beliefs and values, as well as by concerns over confidentiality and privileged communication.

Although short on practical solutions, this broad overview of the literature provides a basis for considering what form they might usefully take.

Young JL, Griffith EE, Williams DR. The integral role of pastoral counseling by African-American clergy in community mental health. Psychiatr Serv 2003;54:688–692.

Black churches address individuals' emotional concerns through both communal and counseling activities. One hundred twenty-one black pastors in the New Haven Clergy Association were interviewed about their backgrounds, attitudes, concerns and work, including how they identify and help individuals amenable to pastoral counseling, as well as how they think about and make referrals. Participants averaged more than six hours a week in counseling.

Although 2 of 5 congregations contained individuals with major mental illness, problems that were encountered very often were difficulties of a religious/spiritual nature, alcoholism and drug addiction, adolescent problems, unemployment or work-related problems, marital or family problems, and grief. When asked what they did to help, pastors gave responses ranging from psychotherapeutic to religious, 33 respondents giving answers that combined psychological and spiritual themes. 68 pastors said that they knew of a mental health agency or professional to whom they would be comfortable making a referral; for 46 of these, this agency was a public mental health center.

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This unusually detailed view of the Black clergy's pastoral counseling work should be helpful to mental health professionals in knowing what to expect in building bridges with churches, both at an individual and organizational level.

Baetz M, Bowen R, Jones G, et al. How spiritual values and worship attendance relate to psychiatric disorders in the Canadian population. Can J Psychiatry 2006;51:654–661.

Some 37,000 Canadians, ages 15 and older, were surveyed about lifetime, 1-year and past psychiatric disorders; frequency of attendance at worship; and "spiritual values." Those who responded that spiritual values played an important role in their lives (62.5%) were asked whether they made use of spiritual values to find meaning in life or for strength or understanding in coping with life's difficulties. Responses to these questions contributed to a "spiritual values" score.

Controlling for demographic variables, researchers found that higher attendance at worship was associated with lower odds of mood, anxiety and substance use disorders. This result contrasts with higher scores for spiritual values were correlated with higher odds of having mood and anxiety disorders.

Discussed are possible explanations for this finding. It is speculated that individuals with mood and anxiety disorders may use spirituality to a greater extent to deal with these difficulties, and that spiritual values are associated with higher odds of past but not lifetime or current personality disorders. This may mean that spirituality may be helpful in dealing with these disorders.

Although these findings are limited by the cross-sectional design of the study and the use of limited measure, they are generally consistent with those of other studies and call for further dynamic study and explanation.

Richards PS, Hardman RK, Berrett ME. Spiritual Approaches in the Treatment of Women with Eating Disorders. Washington, DC, American Psychological Association, 2007.

In the tradition of Richards and Bergin's previous work on a theistic spiritual approach to treatment, this book lays out the clinical and research implications of the authors' experience in the residential eating disorders program Center for Change. The result is an ecumenical, conceptually clear, well-referenced, and practical resource that reviews existing scholarship, presents a theistic view of therapeutic change, and describes a multidimensional model of theistic treatment. Clinical examples illustrate specific assessment and individual, group and family intervention guidelines.

The book concludes with suggestions for future research and three extended case descriptions. The authors write about therapeutic change: "At the core, healing and change are spiritual processes. Psychological, relational and even physical healing are facilitated and are more profound and lasting when people heal and grow spiritually." By this they mean in their relation to God and in the view of themselves that this relationship engenders.

Despite the book's thoroughness, readers may have a few remaining questions: How can one implement the approach that the book advocates outside of a comprehensive, residential program that reinforces the importance of spirituality? How are believing therapists and patients to think about the actual activity of God (versus God as an important object) in patients' lives?

Dell ML. Religious professionals and institutions: untapped resources for clinical care. Child Adolesc Psychiatric Clin N Am 2004;13:85–110.

Many individuals turn first to clergy for help with their own or their children's emotional problems and difficulties in living. Dell, who is both a child and adolescent psychiatrist and an Episcopal priest, provides here a guide for clinicians in understanding religious professionals and institutions as potential resources. She reviews the backgrounds, education, training, and roles of religious professionals; discusses types and characteristics of churches; notes distinguishing characteristics of major faith traditions; discusses hospital and psychiatric chaplaincy, including various possible models of pastoral counseling; and describes services available through other, and para-church, organizations. She both encourages collaboration between mental health professionals and religious individuals and groups, and offers practical clinical caveats for child and adolescent psychiatrists less familiar with the issues that such cooperation raises.

Murray-Swank AB, Lucksted A, Medoff DR et al. "Religiosity, psychosocial adjustment, and subjective burden of persons who care for those with mental illness." Psychiatric Services 2006; 57:361–365.

In a moderately religious and spiritual sample of people caring for those with mental illness, 37% reported that they had received religious or spiritual support in coping with a relative's illness in the previous three months.

The most frequently reported types of spiritual support were praying or meditating, reading the Bible or other religious literature, and watching or listening to religious programs on the TV or radio. 23% reported that they contacted clergy or other religious leaders to talk about these problems, and 8% said they did so "very often or fairly often." In this report on data obtained from 83 participants in Family to Family courses offered by the National Alliance on Mental Illness (NAMI), the following measures were used: religiosity, spiritual support, depression, mastery and self-esteem, subjective caregiver burden (worry and displeasure), and self-care.

Religiosity was correlated with greater self-esteem and self-care and with less depression but not with subjective burden or mastery.

The small sample size and limited measures used constrain the generalizability of the findings, but they support the potential value of collaboration between mental health professionals and religious and spiritual resources in meeting the needs of family members of patients with major mental illness.

Cloninger CR. Fostering spirituality and well-being in clinical practice. Psychiatr Ann 2006;36:157–162.

Reviewed is the literature showing the relevance of spiritually-augmented therapy in enhancing well-being and reducing vulnerability to illness. The 3 stages of self-awareness that underlie the development of well-being are outlined, which are as follows:

0—unaware: immature, seeking immediate gratification ("child-like");
1—average adult: purposeful but egocentric cognition, with frequent negative emotions ("adult");
2—meta-cognition: mature and allocentric, aware of one's own subconscious thinking, calm and patient, able to supervise conflicts and relationships ("parental");
3—contemplative: effortless calm, impartial awareness, wise, creative and loving, able to access what was unconscious without effort or distress, "state of well-being."

Practical methods for fostering character development and well-being are suggested. Further detail is available on DVD and book: *The Happy Life-Voyage to Well-Being* and *Feeling Good: the Science of Well-Being* (Oxford University Press, 2004), respectively.

Richards PS, Bergin AE (eds). Casebook for a Spiritual Strategy in Counseling and Psychotherapy. Washington, DC, American Psychological Association, 2004.

A series of central concepts from an earlier volume* are reviewed, followed by a series of case reports which illustrate in greater depth several applications of this approach. Groupings are as follows (1) programmatic, group and marital therapies; (2) individual denominational therapies (within faiths); and (3) individual ecumenical therapies (across faiths).

Authors come from Christian, Jewish, Muslim and other broadly theistic traditions, each describing their own orientation, the particulars of a case, their use of spiritual interventions, and how they expect that an atheistic therapist might have approached the same patient. Also discussed are the challenges of dealing with harmful religion, and of working across differences in beliefs.

There are certain weaknesses: The book does not include Eastern, transpersonal, or humanistic spiritual perspectives. All but one of the contributors is a psychologist. It is questionable whether the comparisons drawn between naturalistic-atheistic and spiritual-theistic therapies are completely justified and/or helpful to therapists with contrasting worldviews in finding common clinical ground.

Griffith JL, Griffith ME. Encountering the Sacred in Psychotherapy: How to Talk with People about their Spiritual Lives. New York, Guilford Press, 2002.

Offered are suggestions for listening to patients' spiritual lives, and then for following the threads that emerge toward therapeutic ends. Chapters include conversations between a person and God; spiritual and religious beliefs; rituals, ceremonies and religious practices; and community in spirituality. These explore the rich opportunities presented by the ways of being connected to sources of meaning, solace and wisdom beyond the self. Additional chapters thoughtfully consider the problem of destructive spirituality and the role of spirituality in living with medical and psychiatric illness. Clinical examples, including dialogue, are plentiful.

While some scientifically-oriented clinicians may find the book's discursive, evocative style difficult to embrace, those who make the effort will appreciate how working with spirituality in psychotherapy is a matter of both the head and the heart, for both patient and clinician.

Sperry L, Shafranske EP (eds). Spiritually Oriented Psychotherapy. Washington, DC, American Psychological Association, 2005.

The editors of this volume have asked experts in several forms of psychotherapy to address the incorporation of spirituality in the clinic. Ana-Maria Rizzuto offers a psychoanalytic perspective on the spiritual dimension of the engagement of two persons in therapy. Lionel Corbett and Murray Stein delineate Jungian approaches to the use of the revelatory unconscious, and their limitations. Siang-Yang Tan and W. Brad Johnson review the rapidly growing field of religiously-based cognitive behavioral therapy (CBT). Similarly, other chapter authors discuss spiritually oriented psychotherapy within humanistic, interpersonal, transpersonal-integrative, forgiveness-promoting, theistic integrative, and integrative approaches. These chapters are clearly written, well-referenced, and frequently make use of case examples. A summary chapter compares these 10 approaches across categories that include their theoretical and historical base, relationship between spirituality and psychotherapy (primary, secondary or parallel), the therapist's role and attributes, therapeutic indications and contraindications, and their strengths and weaknesses. The final chapter discusses opportunities and challenges for acquiring knowledge, improving practice, and enhancing education and training in this recent but growing area. This book makes both theoretical and practical contributions that will be valuable to clinicians of many types.

Wasner M, Longaker C, Fegg MJ, et al. Effects of spiritual care training for palliative care professionals. Palliat Med 2005;19: 99–104.

Effective spiritual care requires an awareness of one's own beliefs and resources that sustain compassion in the face of suffering and death.

The aim of this study was to assess the impact of a spiritual care training program for palliative care professionals, consisting of a three-and-a-half day training course: Wisdom and Compassion in Care for the Dying designed by Christine Longaker. Key elements included reflection on one's own fear of death, active listening exercises, practical exercises in meeting the needs of disturbed patients, and nondenominational spiritual exercises such as contemplation and meditation.

Participants ($n = 63$) completed questionnaires before and after the training, as well as three and six months afterwards. Additional measures used were the Self-Transcendence Scale (STS), the spiritual subscale of the Functional Assessment of Chronic Illness Therapy (FACIT-Sp), and the Idler Index of Religiosity (IIR). Training had a positive and sustained impact on several measures of spiritual well-being, including perceived compassion for the dying and for oneself, attitude toward one's family, satisfaction with work and attitudes toward colleagues, as well as in the results of the FACIT-Sp.

Although the study has acknowledged limitations such as its small size and use of subjective measures, it suggests that training in spiritual care that includes the spirituality of the professional caregiver can be helpful. It also indicates the potential for prospective studies to evaluate how various spiritual care trainings can influence the quality of life and the quality of work of clinicians in stressful settings.

Mabe PA, Josephson AM. Child and adolescent psychopathology: spiritual and religious perspectives. Child Adolesc Psychiatric Clin N Am 2004;13:111–125.

There are significant links between spirituality/religion, child psychopathology, and parental/family functioning, a relationship which is usually (but not always) supportive of greater mental health; this relationship can sometimes be complex, even reciprocal.

A compelling case is made for clinicians to explore the details of the interaction, positive and/or negative, within the family and to consult with clergy and other religious sources of information when attempting to understand or address distorted or dysfunctional religious beliefs and practices.

*Richards PS and Bergin AE (eds) *A Spiritual Strategy for Counseling and Psychotherapy*. Washington, DC, American Psychological Association, 2004.

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Considered are the obstacles to research in the impact of spiritual beliefs and practices on children's mental health area, such as the difficulty of agreeing on definitions and instruments, contending with religious diversity and separating religious from cultural effects. Also examined is the available evidence regarding means by which spiritual and religious beliefs and practices would be expected to influence childhood mental health: core beliefs about life, religious coping skills, prescription for healthy lifestyles, social support, skill development opportunities, and spiritual experiences. Turning to clinical problems, data for the following areas is summarized: depression and suicide, adolescent sexuality, substance abuse, antisocial behavior and delinquency. Finally, literature regarding parental behaviors and coping and marital/family relationships is reviewed.

Reviewed by Mary Lynn Dell, MD

Dowling EM, Scarlett WG (eds). Encyclopedia of Religious and Spiritual Development. Thousand Oaks, Sage Publications, 2006.

This single volume work is a current compendium of 268 terms and topics of interest or relevance to youth and the adults who work with them in religious settings or who are attuned to people and events influential in the spiritual lives of children and adolescents. Representative entries in some of the 13 categories include: John Donne and African-American Spirituals (The Arts); Eschatology and Adolescent as Theologian (Religious and Spiritual Concepts); Dorothy Day and Archbishop Desmond Tutu (Leading Religious and Spiritual Figures); and Cults, Faith-Based Service Organizations, and Quaker Education (Supports/Contexts). At least 50 references address religious diversity and various world faith traditions.

Strengths are the relative detail and depth the editors achieved in such a comprehensive overview, and the focus on aspects of broad topics especially relevant and of interest to youth. References are included at the end of each entry. This is a helpful, all-purpose reference, guaranteed regular use by those interested in religion, spirituality, and young people.

Roehlkepartain EC, King PE, Wagener LM, et al (eds). The Handbook of Spiritual Development in Childhood and Adolescence. Thousand Oaks, Sage Publications, 2006.

This work is a single volume synthesis and review of the multitude of research studies and publications in the area of spiritual development in childhood and adolescence. Though generally multidisciplinary in scope, there is a heavy emphasis on summaries of the various subspecialties of research psychology as they pertain to faith development. The emphasis is heavily Judeo-Christian, although most of the research in this area has been conducted in that tradition. Contributors are experts, leading scholars, and researchers in developmental and clinical psychology and, quite often, pioneers in the scientific study of the psychology of religion and spiritual development.

Areas surveyed include various faith development theories: measurement and research design; spiritual and religious pathology; neuropsychological perspectives; family, peer, and nonparent influences on spiritual development; and practice, policy and research implications for the future. This is a most desirable reference for serious students and teachers in this field, though its highly technical, and the scholarly approach may limit its usefulness to those with only a casual interest in this area.

We need men who can dream of things that never were.

—John F. Kennedy