

Definitions

A religion that gives nothing, costs nothing,
and suffers nothing, is worth nothing.

—Martin Luther

DEFINITIONS ARE CONTROVERSIAL when it comes to terms such as *religion* and *spirituality*. Clarity with regard to definitions, however, is crucial if successful communication is to occur, and it is especially important when definitions vary across individuals. Because religion and spirituality are both emotionally and politically charged terms, people hold on to their own definitions with great fervor, often defending them at all costs. Although we do not claim to have any universal authority over determining such definitions, we are obligated to describe how we will use these terms in this text. Oman (2013) provides a nice historical overview within psychological research that describes the origins of the terms “religion” and “spirituality” and reviews selected definitions for each.

The title of this volume is the *Handbook of Religion and Health*, and so the focus is squarely on religion and the effects that religion and religiosity have on health and well-being. However, there are other terms that are often used when

discussing this topic. Among those terms are *secular humanism* and *spirituality*. Each of these terms has their place depending on the situation and circumstances in which they are used. Of particular interest—given the focus of this book on scientific research—are definitions for research purposes. However, *religion*, *spirituality*, and *secular humanism* are used not only to describe results from research studies, but also to address the needs of those with medical or psychiatric illness in clinical settings. Thus, we begin by describing the requirements for each term when (a) conducting quantitative research and (b) addressing needs in clinical practice. Those requirements are quite different because the purpose in each setting is different.

CONSTRUCTS FOR RESEARCH PURPOSES

Because of the importance of replicating results, the definition of a term used in scientific

research should be clearly stated. This is especially true when the definition will be used to develop measures of a construct in order to examine evidence concerning its relationship to other constructs in quantitative studies. When conducting quantitative research, the investigator is charged with developing empirical assessments that provide some form of numerical quantification related to the construct of interest (e.g., religion or spirituality) to determine the extent to which the construct might be said to be present under that assessment. This is needed so that the relationship of such a numerical assessment with other quantifiable variables (e.g., health) can be examined. For example, when examining the relationship between blood pressure and likelihood of stroke, blood pressure is measured in specific units that indicate how high the blood pressure is. Likewise, when examining the impact of depression on likelihood of suicide, depression is quantified in terms of the presence and severity of depressive symptoms to determine whether depression symptom severity increases suicide risk.

In the psychological, social, and behavioral sciences, the extent to which a construct is present is typically quantified by responses to a set of questions on a scale. These responses are then often summed to produce a score that provides an assessment of the construct phenomenon. The scale is typically made up of questions that tap into core aspects of the construct based on its definition. The degree to which a scale reliably and accurately assesses a construct is determined both on conceptual grounds and by its psychometric properties (see Chapter 2).

What is sometimes called the *construct validity* of a scale is especially important in this discussion of definitions. Construct validity is the extent to which a scale adequately captures the underlying construct that is being assessed based on the definition of that construct. There are both theoretical and empirical assessments of construct validity (see Chapter 2). Empirical assessment of construct validity is sometimes called *criterion validity*, which is evaluated by how well a given measure satisfies one or more external criteria. In many classical schemes, criterion validity has

four components: convergent, discriminant, concurrent, and predictive validity. More discussion of these topics is given in the next chapter, but we will briefly comment here on convergent validity and discriminant validity. *Discriminant validity* is what we are after here, and is a very important characteristic that will become more evident below.

As indicated earlier, definitions of constructs are important because they will be used to develop assessments related to the construct, which will then be used to quantify in research surveys the extent to which the construct might be said to be present in some respect. Definitions, like the scales that result from them, should also satisfy various criteria. When conducting research, it is essential to clarify the extent to which definitions of constructs do or do not overlap with definitions of similar constructs, particularly with outcomes in which the researcher may wish to evaluate evidence concerning relationships between phenomena relating the construct of focus to other possible constructs of interest. Overlap across constructs has been a major problem in the field of religion and health, especially as it applies to spirituality, the definition of which sometimes overlaps with aspects of the health outcomes to which spirituality may be associated with, particularly mental health, thus violating the principle of discriminant validity described above. We now apply these principles to research on religion and spirituality in determining the qualities that must characterize such definitions if they are to be useful for empirical research.

(1) The definition of the construct should be operationalized in a way that allows for some aspect of its extent or presence to be measured and quantified, since quantitative research seeks to examine associations between quantitative numerical scores related to various phenomena and constructs.

(2) The definition of the construct should be clear and unambiguous, since measures to quantify the construct when conducting quantitative research will be based on that definition.

(3) The definition of the construct and measures derived from it should be distinct

and unique, not overlapping with similar constructs which researchers may wish to examine for evidence of potential causal relationships (i.e., health outcomes). In other words, the definition and measures derived from it must not violate the principle of discriminant validity.

CONSTRUCTS FOR CLINICAL PURPOSES

The criteria for definitions of constructs in clinical settings (at least for the constructs we are discussing here) need not be as rigorous as those required for conducting quantitative research and therefore have more flexibility. Definitions for clinical purposes must address the needs of a wide range of patients in a personal and sensitive manner, particularly when assessing beliefs and practices that are emotionally charged without universal agreement. Below, then, are the characteristics of definitions of constructs such as religion or spirituality that should be present when addressing these issues with patients.

(1) The definition of the construct does not always need to be clear and exact. In fact, ambiguity may be an advantage when dealing with topics that are sensitive and the potential for disagreement or misunderstanding is high.

(2) The definition of the construct may have some overlap with similar constructs, including the psychological states that the construct may affect or influence.

(3) Having a definition of the construct that can be precisely measured and quantified is less important, since addressing the construct in a *qualitative* manner takes priority during clinical encounters.

(4) Definitions of the construct can be broader in order to be relevant to patients with a wide range of experiences and perspectives.

(5) The definition of the construct should promote conversation and focus on similarities, since the use of the construct in clinical settings should stimulate *dialogue* and *engagement* (in contrast to quantitative research, where the definition requires objective assessment and comparison).

MAPPING RELIGION AND SPIRITUALITY ONTO THE PRECEDING CRITERIA

How do the definitions of the constructs in which we are interested (religion, secular humanism, spirituality) map onto the criteria listed above for use in research studies and clinical practice?

Religion

The construct “religion” possesses many of the characteristics necessary for conducting research. Religion involves beliefs, practices, and commitments that are measurable and quantifiable and that often do not conceptually overlap with the outcome of interest here (health). Religion is a specific construct that has multiple dimensions as described below (Koenig, 2011a), each of which is quantifiable and non-overlapping with mental or physical health:

- Religious affiliation (major religious tradition and denomination within the tradition)
- Orthodoxy of belief (based on original teachings of one’s faith tradition)
- Public religious practices (attendance at services or other religious group activities)
- Private religious practices (private prayer, reading religious scriptures, watching religious television, listening to religious programs or music)
- Subjective religiousness (importance or salience of religion, self-rated religiosity)
- Religious motivation (intrinsic vs. extrinsic)
- Religious connection or attachment (quality of relationship to God or the transcendent, love of God, etc.)
- Religious coping (overall religious coping or specific ways of using religion to cope)
- Religious history (exposure to religious beliefs/activities/commitments over a lifetime)
- Religious support (support received, support given, and conflict within faith community setting)
- Religious experience (including mystical experiences)

- Religious giving (proportion of income given to religious causes)
- Religious volunteering (time spent volunteering for religious reasons)
- Religious knowledge (knowledge about religious scriptures of one's faith tradition)
- Religious growth (deepening and maturing of religious faith over time)
- Religious quest (probing and questioning religious beliefs).

These religious beliefs and activities may also be grouped into three major categories: organizational, non-organizational, and subjective/intrinsic religiosity (Koenig & Futterman, 1995b). Organizational religiosity involves religious practices performed in organized social settings, such as attending religious services, involvement in group religious rituals, group prayer, group Scripture study, etc. Non-organizational religiosity involves religious activities performed in private, such as prayer or meditation, reading religious scriptures, viewing religious TV, or listening to religious radio or music. Subjective religiosity has to do with the cognitive dimension of belief that reflects the importance or centrality of religion in a person's life. Regardless of how religiosity is categorized, religious beliefs, practices, and commitments are quantifiable, unique, and independent constructs readily distinguishable from mental or physical health.

Secular Humanism

Secular humanism represents an alternative to transcendent religiosity/spirituality, and includes naturalism, materialism, atheism/agnosticism, and what has been called by Charles Taylor (2007) the "immanent frame" (i.e., a way of being in the world that provides significance, meaning and purpose, but without necessarily involving transcendence). Like religion, this construct has little or no overlap with mental or physical health. As a result, the health of these individuals can be compared to the health of persons who describe themselves as religious. Again, this term fulfills the criteria for use in research: a construct whose definition is largely agreed-upon, distinct, measurable,

and does not overlap with health states that researchers might want to examine.

Spirituality

One of the first mentions of the word "spirit" was perhaps in Genesis 1:2 ("And the *Spirit* of God moved upon the face of the waters") (written approximately 1500 BCE to 1400 BCE; Hayut-Man, 2019). For many centuries since then, the term *spiritual* had been used to describe deeply religious persons, often the clergy—people whose lives revolved around and centered on their religious faith (Sheldrake, 2007). Over the past 20–30 years, however, the meaning of spiritual (and spirituality) has changed. *Spirituality* is now an increasingly popular term used in those settings where religion is in disfavor (often in research or academic settings). *Spiritual* is now used to describe those who are religious and those who are not religious (e.g., those who call themselves "spiritual but not religious"). These individuals may be compared to those who are religious and spiritual, those who are religious but not spiritual, and those who are neither religious nor spiritual. Spirituality, then, has become a nebulous construct that religious and non-religious persons can both fit under, which explains its popularity. Consequently, there is little agreement on exactly what the term *spirituality* means today, or on the components that define and comprise it (other than by self-identification). In an attempt by researchers to further identify the components of spirituality when conducting studies, the definition of spirituality has expanded to also include states of positive mental health (e.g., having meaning and purpose, connectedness to others, sense of peace, feeling deep inner harmony, and experiencing existential well-being) (Koenig, 2008). As a result, this construct has become difficult to use in research, particularly quantitative research that seeks to examine its relationship to health—especially mental health.

The expansion over time of the territory that the term *spirituality* covers is illustrated in Figures 1.1–1.4. As noted earlier, the traditional meaning of *spiritual* was to describe the deeply religious person (Figure 1.1). In the modern understanding, however, spirituality

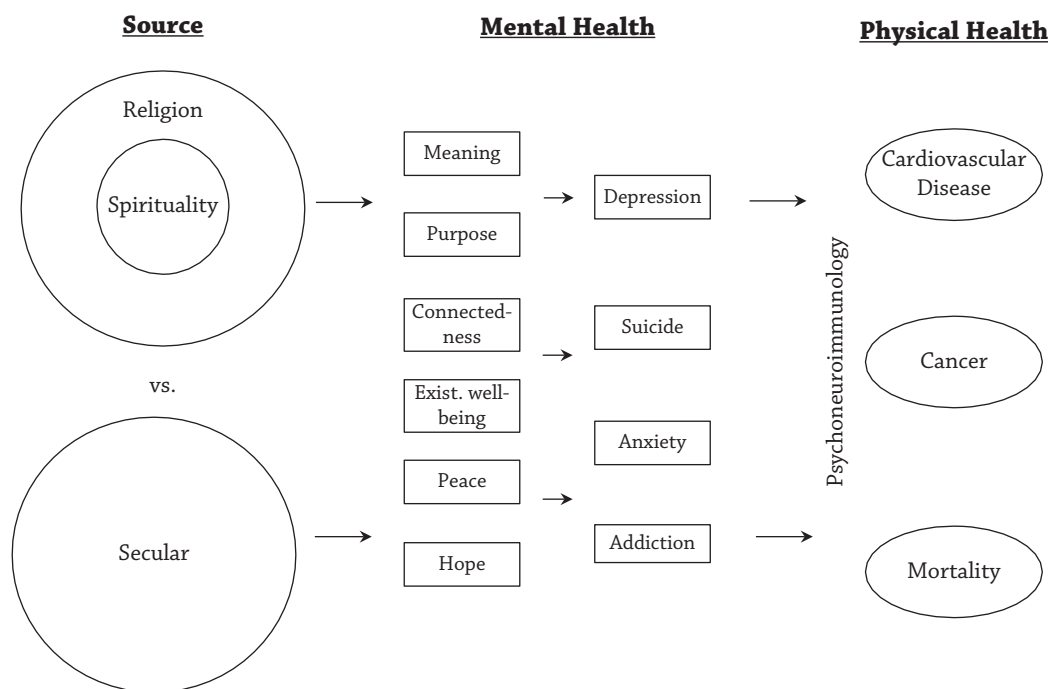


FIGURE 1.1. Traditional understanding of spirituality (Koenig, 2008).

has expanded to include (a) those who are religious and (b) those who are not religious but describe themselves as spiritual (Figure 1.2). This latter understanding of spirituality has created a dilemma for researchers trying to study the construct. The challenge has been to measure spirituality in a way that goes beyond simple self-description as a member in one of these four categories (spiritual but not religious; religious but not spiritual; spiritual and religious; neither spiritual nor religious). The category “spiritual but not religious” has become the most challenging to define. This is also how many individuals in the United States now describe themselves (more than 25% of US adults; Lipka & Gecewicz, 2017).

However, this category has defied characterization, apart from simple acknowledgment that one is spiritual but not religious. Such self-description has not been enough for researchers who wish to further refine this category in order to measure it. What types of questions can be asked to identify those who are using a religious word (“spiritual”) to describe themselves, yet insist that they are

not religious? The challenge of determining a richer description of those in this self-defined category has resulted in a further expansion of spirituality by researchers to now include positive emotions and character traits (Figure 1.3). In our view, the positive emotions and character traits indicative of good mental health (i.e., having meaning and purpose in life, deep inner peace and harmony, feeling connected to others, being moral and altruistic, etc.) may be *the result or outcome of a deep spiritual life*, but they are not a way to define and measure spirituality itself, which is something quite different. A major goal of researchers in the social, psychological, and behavioral sciences is to identify the “sources” of good mental health that may be targets for intervention. Defining and measuring spirituality as good mental health to start with does not contribute to this goal.

The definition and measurement of spirituality in research studies with indicators of positive mental health has caused concern about the interpretability of findings from studies that have examined the relationship between

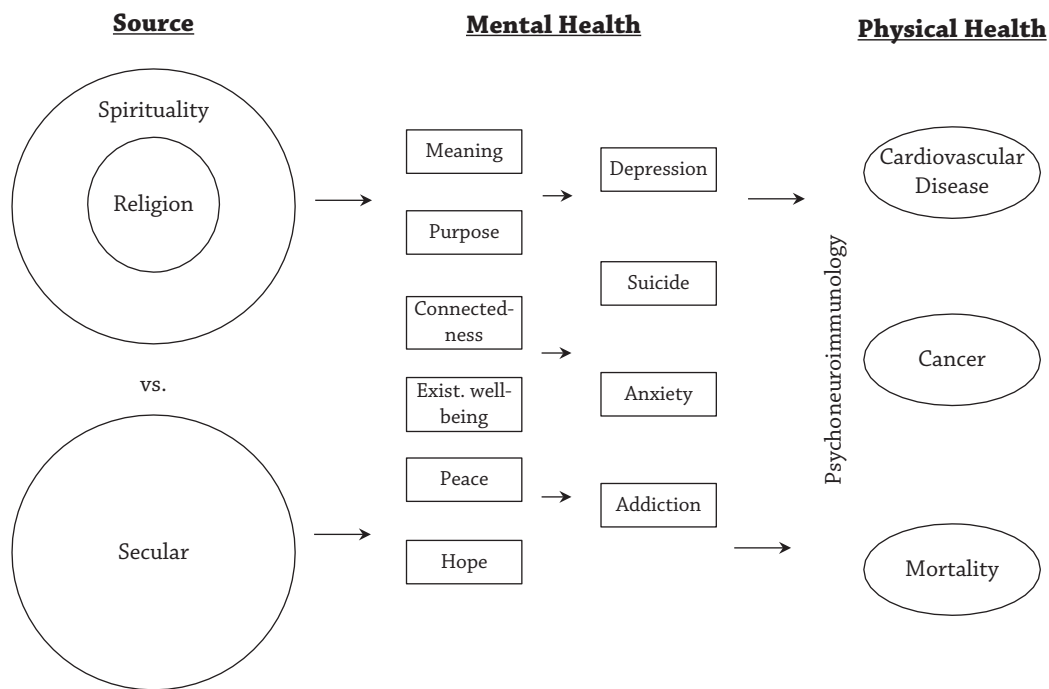


FIGURE 1.2. Modern understanding of spirituality (Koenig, 2008).

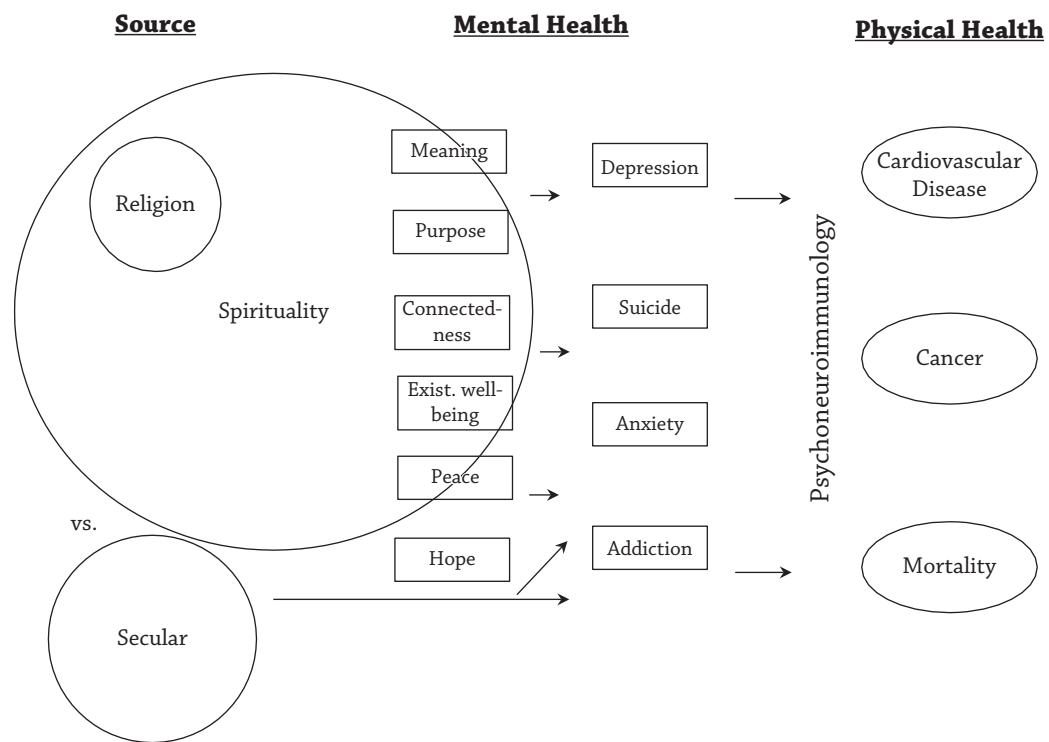


FIGURE 1.3. Modern understanding of spirituality—tautological version (Koenig, 2008).

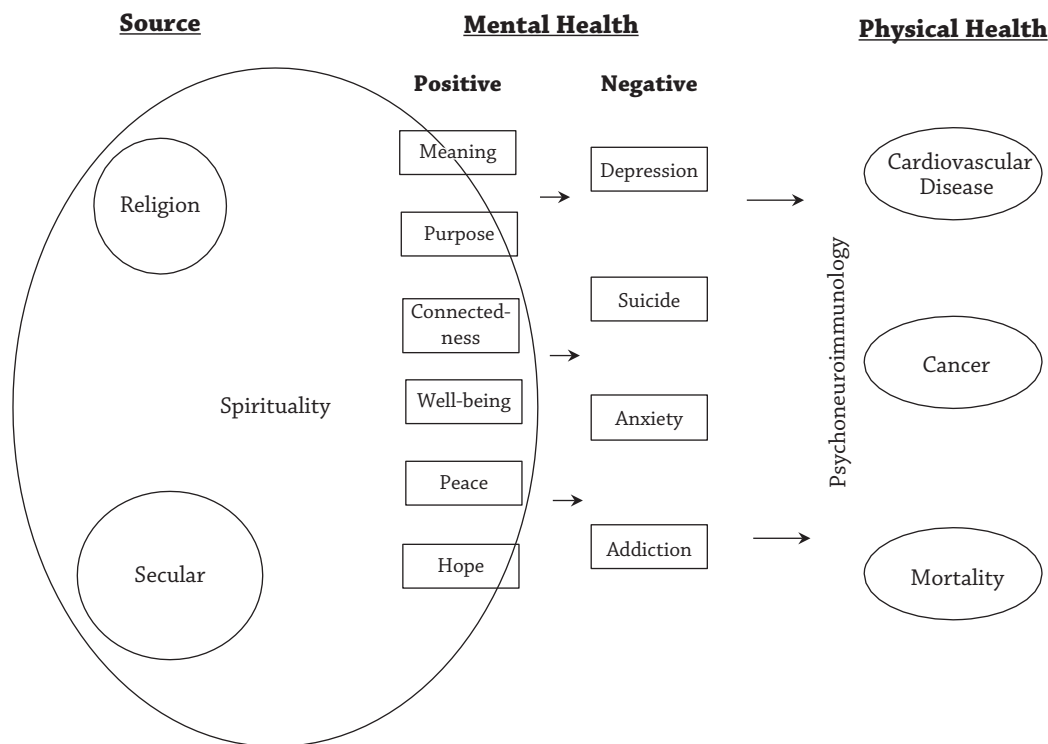


FIGURE 1.4. Modern understanding—clinical version (not for research) (Koenig, 2008).

spirituality (measured in this way) and health, particularly mental health (Koenig, 2008). Some of these concerns are listed below.

(1) Atheists and agnostics who deny any connection with spirituality may rightly claim that their lives have meaning and purpose, that they have strong social connections with others, that they practice forgiveness and altruism, and that they have times of great inner peacefulness, and hold high moral values and ethical standards. As a result, they may object to defining spirituality using the terms above.

(2) Because of the importance of having clear, distinct constructs with boundaries when conducting research, the use of religious language (spiritual or that having to do with the spirit) to characterize non-religious persons adds confusion to an already complex area of study.

(3) *Investigators can now no longer examine the relationship between spirituality and mental health because many measures of spirituality are*

now conceptually confounded by indicators of mental health.

(4) Such confounding also influences findings on the relationship between spirituality and physical health because mental health is intimately connected to physical health, as reflected in the now widely accepted biopsychosocial model of health.

(5) Those burdened with psychiatric disorders such as major depression, anxiety disorders, or schizophrenia often struggle with meaning and purpose in life, feel socially disconnected, and rarely feel deep inner peace, harmony, and well-being. Does this mean that these unfortunate individuals are not spiritual, as low scores on recent spirituality measures would suggest?

(6) Finally, if spirituality is defined a priori as good mental health, researchers can no longer study the negative effects of spirituality on health because spirituality has already become synonymous with good mental health, excluding the possibility that spirituality may

have negative effects on mental health. Thus, spirituality has become a construct whose relationship with mental health has already been determined before a single study is done.

When spirituality is defined and measured in this way, positive associations reported by researchers between spirituality and mental health could be considered tautological (correlating a construct with itself) and meaningless. Thus, the modern understanding of spirituality is a construct that does not map well onto the requirements necessary for conducting research on its relationship to mental or physical health, though as discussed below, may still be useful in clinical practice.

How common is research using measures of spirituality contaminated by mental health indicators? A systematic review of research examining the relationship between spirituality and mental health found that 26 of 58 published studies (45%) used spirituality scales where psychological well-being items made up 25% or more of the scale items, thus resulting in tautological findings (Garssen et al., 2016a; see also Salander, 2006, 2012; Garssen & Visser, 2016b).

Given the considerations above, we now provide definitions of religion, secular humanism, and spirituality as they will be used in this text, and will relate these to research and clinical practice.

A DEFINITION OF RELIGION

We define religion as the phenomenon wherein a system of beliefs and practices unites adherents into a community with a shared vision for attaining union with, or the experience of, the divine or transcendent.¹ The definition here has both a horizontal dimension—constituted by a community of adherents to religion's beliefs and practices—and also a vertical dimension, wherein the individuals in that community are seeking an experience of or union with the divine or transcendent. The transcendent here may be called God, Allah, or HaShem in Western

religious traditions. In Eastern religious traditions, the transcendent is often referred to as Brahman (the Supreme God), Buddha, Dharma, Ultimate Truth, or Ultimate Reality. Some faith traditions, as in Christianity, believe that the transcendent exists both outside of the ego-self (God or Jesus) and within the self (Holy Spirit); largely outside of the self, as in Judaism and Islam (with perhaps the exception of the mystical branches in these traditions); or merges with the self and universe, as in some Eastern faith traditions.

Religious beliefs may also include aspects of the supernatural, including beliefs about spirits, angels, or demons. Religions usually have specific beliefs about the afterlife and rules to guide behaviors and interactions with others during the present life. Religion is typically organized and practiced with others in community, a community which itself arises from the religion's system of beliefs and practices. The practices typically include various rituals carried out either individually or within a community. For a particular individual, religion can also in principle be practiced alone and in private, outside of a group. The latter might involve personal beliefs about the transcendent and private activities such as prayer, meditation, scripture study, private religious rituals, watching religious television, online access to religious programming, listening to religious programs on the radio, or listening to religious music (as described earlier). However, even in this private context, the practices themselves, when they are referred to as “religious,” are still typically shaped by or pertain to the beliefs, practices, and rituals of a broader community. The term *religiosity* refers to how involved and committed a person is to their religious beliefs, rituals, and practices. Thus religion, as we define it, not only involves attending religious services or other institutional forms of religious involvement, but also includes many other aspects that are personal and private. However, religions are usually rooted in an established tradition shared by a group of people with common beliefs about the

1. Although phrased differently and updated, there is strong overlap between the definitions of religion, secular humanism, and spirituality provided here and those provided in Koenig, 2011a; Koenig et al., 2012; and Koenig, 2018a.

transcendent, accompanied by devotional practices that involve reverence for and worship of the transcendent.

The definition given here bears similarities to many other definitions given elsewhere (Oman, 2013) including that given by Durkheim. In *Elementary Forms of Religious Life*, Durkheim in 1912 defined religion as follows: “A religion is a unified system of beliefs and practices relative to sacred things, that is to say, things set apart and forbidden . . . which unite into one single moral community . . . all those who adhere to them” (Durkheim & Swain, 2008, p. 47). Durkheim’s definition makes reference to the “sacred” or “things set apart,” and the community that is described in his formulation is a “moral community.” Our proposed definition borrows heavily from Durkheim’s but makes reference to the “transcendent” rather than the “sacred”; moreover, the community we refer to is constituted by a “shared vision for attaining union with, or experience of, the . . . transcendent,” rather than a “single moral community.” While it is certainly the case that religions do produce communities with moral systems and shared values, the ultimate aim of these religions, and of the systems of morality which they produce, is arguably the experience of or communion with the divine or transcendent itself, that which extends beyond ordinary experience. It is the shared vision of this union or experience, we would argue, that draws adherents and brings them to participate in the religion’s beliefs and practices and moral conduct.

A DEFINITION OF SECULAR HUMANISM

Secular humanism we define as an understanding of human existence that is not grounded in religion. It often does not involve the transcendent at all. The focus is on the rational self, science, and the human community as the ultimate sources of power and meaning. What counts is the observable and measurable. Secular humanism includes various humanistic philosophies such as naturalism, materialism, atheism/agnosticism, and other manifestations of the secular immanent frame, as noted above (in contrast to the transcendent frame).

A DEFINITION OF SPIRITUALITY

We define *spirituality* as a set of individual beliefs, practices, and ways of being that are intended to assist in attaining union with, or experience of, the divine or transcendent. This definition is largely but not entirely equivalent to the traditional, historical definition of spirituality, which views the spiritual person as one who is deeply religious and whose life centers on and revolves around their religious faith (Figure 1.1) insofar as the *individual* beliefs, practices, and ways of being in the world are often derived from the beliefs, practices, and rituals of a religious *community*. According to our definition, spirituality is, like religion, distinguished from everything else, by its link to the transcendent (God, Allah, HaShem, Higher Power, Brahman, the Supreme God, Ultimate Truth, Ultimate Reality, the Dharma, or the Buddha). We do not define spirituality by its consequences (i.e., high ethical standards, morality, meaning and purpose, peace, feeling connected to others, or feelings of wonder or awe), though it may be the ultimate *source* of these positive moral and emotional states.

The definition given above is very similar to our definition of religion since both definitions concern beliefs, practices, and rituals or ways of being related to the transcendent. The difference is the emphasis on whether these beliefs, practices, and rituals pertain to the individual or to the community. In many cases, beliefs, practices, and rituals will be both spiritual and religious—they not only pertain to the individual’s relation to the transcendent, but also are grounded in a broader community context. The definition for spirituality given here, however, does extend beyond the purely traditional understanding of spirituality in Figure 1.1 in that certain practices might be “spiritual” but not “religious” if they concern the individual’s relation to the transcendent but are not connected to the practices, beliefs, or rituals of a community. A walk within nature that gives rise to a sense of the oneness of all reality, but that is unconnected to beliefs or rituals of a broader community, might be one such example. Likewise, it is, in principle, possible for an

activity to be religious but not spiritual. An atheist who feels no relation to the transcendent and yet participates in a community's rituals (perhaps on account of a spouse) might be said to participate in religion without having spirituality. We recognize that this definition in some instances departs from the way spirituality is usually defined today.

In the clinical arena, spirituality has been defined by Puchalski and colleagues (2014a) as: “. . . [an] individuals' search for meaning and purpose; it includes connectedness to others, self, nature, and the significant or sacred; and it embraces secular and philosophical, as well as religious and cultural, beliefs and practices” (p. 10). Elsewhere, spirituality is defined as “a search for the sacred” (Pargament, 2013, p. 257). While a search for the sacred comes closest to our definition, what is “sacred” in a person's life may not be in any way related to the transcendent. Instead, what is treated as sacred in a person's life may be material possessions, public recognition and power, success in one's occupation, or even a personal relationship (girlfriend, boyfriend, spouse, child, etc.). In our opinion, neither of the definitions above are specific enough for research purposes, particularly research where “the transcendent” is front and center in the construct being examined.

Nevertheless, these broader notions of spirituality may still be useful in understanding what is most important in a person's life. Zahl (2019), relatedly, makes the case that we all pursue what he calls “seculosity” as “what we lean on to tell us we're okay, that our lives matter.” Seculosity is “another name for all the ladders we spend our days climbing toward a dream of wholeness. . . . Our small-r religion is the *justifying* story of our life” (Zahl, 2020). This could refer to career, romance, technology, politics, even food. His approach seems consistent with Ken Pargament's way of thinking about spirituality as a search for the sacred, and one that presumably even a secular person could recognize in himself as potentially universal. Although this would not easily lend itself to a researchable definition, to the extent that it has explanatory power (going beyond the cognitive implications of the notion of worldview, or the private and interior implications that the

modern notion of spirituality often has), it is one way of thinking more broadly about these issues.

Non-Contaminated Spirituality

Although many approaches to spirituality today utilize contaminated definitions and measures, this is not universally true. One could assess “spiritual practices” such as meditation, taking walks in nature, walking around a labyrinth (Artress, 1996), or contemplating oneness with the cosmos, all the while contemplating the transcendent (however the person understands the transcendent). Again, the primary focus is on the transcendent. Measures of this type could then be examined in their relationship with health and well-being without concern for contamination or tautology. Approaches to spirituality in this way we consider to be methodologically sound.

Spirituality in the Clinic

The same characteristics (nebulous, vague, universal in nature, overlapping with mental health) that make spirituality difficult to assess when conducting research make it an ideal term for use in healthcare settings where a construct with a crisp and distinct definition is not required. Instead, as noted earlier, a broadly inclusive term that fosters dialogue, conversation, and engagement is ideal (Figure 1.4). Spirituality, as it is understood and defined today, maps perfectly onto the requirements for use when providing clinical care. A “spiritual” history is taken, and then “spiritual” needs are identified and addressed in a broad and open fashion, where spirituality is defined by patients themselves. This will not work, however, when conducting research that seeks to identify the determinants of health and well-being.

RECOMMENDATIONS

Based on the preceding discussion, we recommend the following—all depending on whether the intention is to conduct quantitative research or to assess and address spiritual needs in clinical settings.

Research

Construct definitions are crucial for developing measures to quantitatively examine relationships with health. There must be clarity on these definitions for communication between researchers and for replicability of results across studies. The definitions must be operationalizable in such a way that each construct can allow for some form of assessment in a reliable and valid manner, accurately quantifying what it intends to measure. The constructs of interest here are religion/spirituality (as predictors) and mental/physical health (as outcomes).

Religion as we have defined it above is a specific, generally agreed-upon construct that can be measured and quantified in various ways and whose definition does not overlap with health outcomes. Thus, when conducting research that examines relationships with and effects on health outcomes, we recommend measures of religiosity or, as described above, very specific “non-contaminated” constructs of spirituality (Figure 1.5). These measures should be based on a relatively broad but specific definition of religion that grounds it in the transcendent.

Spirituality, as understood based on the historical definition above, may often be synonymous with a deeply committed version of religion. Defined in this manner, spirituality is also a specific and clear construct that does not overlap with mental or physical health and that can be assessed using measures of religiosity.

The historical definition of spirituality above has evolved over time, resulting in a broad, nebulous, nonspecific construct on which there is little consensus. Attempts to quantify spirituality defined in this manner have resulted in measures that are heavily contaminated with indicators of good mental health, resulting in research findings that are tautological, uninterpretable, and meaningless. Thus, we do not recommend defining or measuring spirituality in this way for research purposes.

Clinical Practice

Clinical practice is different from research. Because spirituality is a sensitive topic and because all patients need to be given a seat at the table, whether they are religious or not, spirituality as currently defined (the expanded

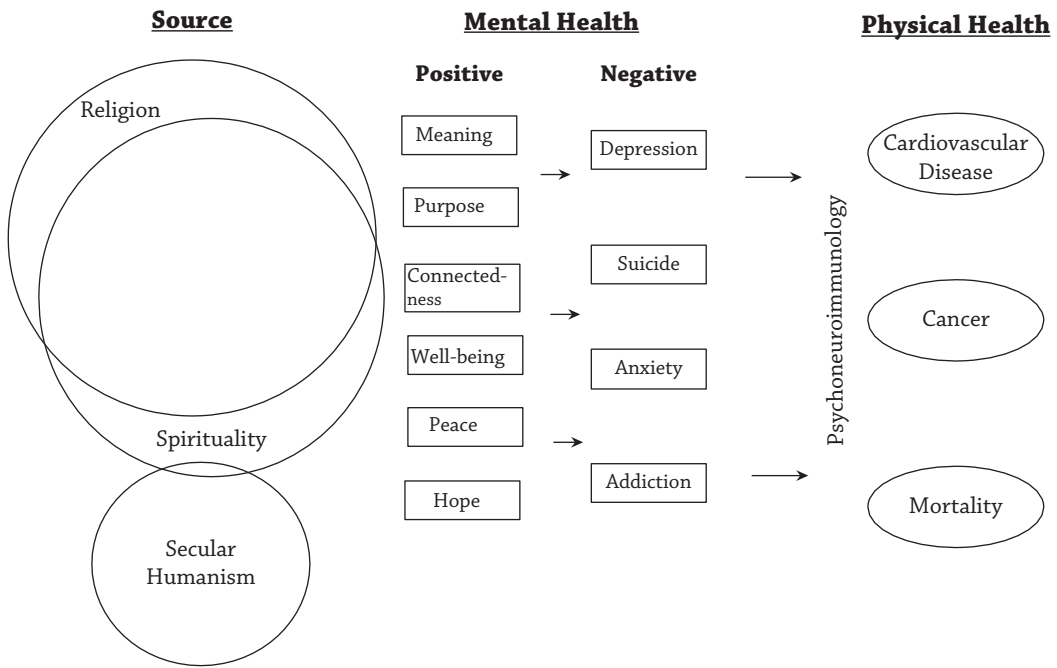


FIGURE 1.5. Model recommended for conducting research.

modern version that applies to everyone) is recommended for use in clinical interactions with patients (Figure 1.4). Because of its nebulous and vague nature, a broad conceptualization of spirituality (defined by patients themselves) is ideal for use in clinical practice because it allows for engagement and conversation. In contrast to what is required for research, there is no need to quantify spirituality. Instead, qualitative descriptions of interactions with patients on this subject are sufficient for communication among providers. Sometimes this will involve religious beliefs and practices; sometimes mental health topics such as meaning and purpose in life, well-being and peace, or social connections with others; and sometimes moral, ethical, or a variety of other issues. These interactions will be guided by how patients define spirituality (determined by the spiritual history). Spiritual needs will be identified in this way and addressed as patients direct.

SUMMARY AND CONCLUSIONS

Definitions of constructs in quantitative research are crucial because they determine the content of measures that will be used to assess those constructs. In this chapter we have focused on definitions of religion, secular humanism, and spirituality.

First, guidelines for constructs to be used in research were presented, followed by guidelines for constructs in clinical practice. The construct of religion was first examined to determine

the extent to which it maps onto the requirements for conducting research, finding that religion fulfills many of these criteria. Second, the construct of secular humanism was examined and likewise was found to have potential for definitions that are specific and distinct enough for use in research. Third, spirituality was examined as it has evolved over time from its historical/traditional definition to a much broader construct that has expanded to include those who are religious, not religious, and even those who do not acknowledge they are spiritual (i.e., everyone). Attempts by researchers to quantify spirituality in this broad manner have led to an encroachment on mental health by including indicators of good mental health in its definition and measurement. This has made it difficult if not impossible to examine relationships with health outcomes without producing meaningless, tautological findings. Fourth, we presented definitions for religion and spirituality that will be used in this text, and have recommended these definitions for future research that seeks to examine how these constructs relate to and influence health outcomes.

The recommendations for research provided here, however, contrast with those for use in clinical practice, where it is argued that the modern definition for spirituality fits perfectly. This is because of its nonspecific, nebulous nature that allows for patients to define spirituality themselves and for healthcare providers to address it in that manner, keeping such interactions patient-centered and patient-directed.