THE RELATIONSHIP BETWEEN SPIRITUALITY AND DEPRESSION, CHURCH ATTENDANCE, AND PRAYER AMONG ELDERLY PEOPLE

by

MONIQUE ELISE JIMERSON

A Dissertation Submitted to the Faculty in the Counselor Education and Supervision Program, Department of Counseling Studies, Penfield College, Mercer University in Partial Fulfillment of the Requirements for the Degree

DOCTOR OF PHILOSOPHY

Atlanta, GA

2019
THE RELATIONSHIP BETWEEN SPIRITUALITY AND DEPRESSION, CHURCH ATTENDANCE, AND PRAYER AMONG ELDERLY PEOPLE

by

MONIQUE ELISE JIMERSON

Approved:

W. David Lane, Ph. D.         Date
Dissertation Committee Chair

Suneetha Manyam, Ph. D.       Date
Dissertation Committee Member

Morgan E. K. Riechel, Ph. D. Date
Dissertation Committee Member

W. David Lane, Ph. D.         Date
Doctoral Program Coordinator, Counselor Education and Supervision

Karen D. Rowland, Ph.D.       Date
Chair, Department of Counseling

Priscilla R. Danheiser, Ph. D. Date
Dean, Penfield College
DEDICATION

For always teaching me to give God all the glory for the things He has done,
this dissertation is dedicated to

Mom
(Mary Ella Echols “Peggy” Jimerson),

Dad
(Clarence “Jimbo” Jimerson),

Grandmother
(Mary “Lizze” Graham, March 13, 1927- June 17, 2012),

and

Beloved Family and Friends
ACKNOWLEDGEMENTS

“I thank my God upon every remembrance of you” (Philippians 1:1, New King James Version). This dissertation process has been a journey, and I would like to acknowledge the people who have walked alongside me in Christian love and support.

First, I would like to thank my Mother, Mary Echols “Peggy” Jimerson, for her unwavering support and fervent prayers as I journeyed through this process. Her words of encouragement and comfort have been the wind that guided my sail to the harbor of fulfilling my destiny in Jesus Christ. Mom is the “wind beneath my wings.”

Second, I would like to thank my Dad, Clarence Jimerson, who always stands by my side with quiet support, always reminding me to be a “soldier for Christ.” I honor his Army service during the Vietnam War. I thank him for the life lessons of survival that he has taught me. As he taught me to meditate, “I can do all things through Christ who strengthens me” (Philippians 4:13, New King James Version).

Third, I would like to thank the chair of my dissertation committee, W. David Lane, Ph. D., for his servant-leader leadership. He has “eagle vision” and continuously encouraged me to pursue my passion for studying spirituality and depression among the older adult population. His words of life encouraged me to think “outside” the box, embracing my call to study the elderly population of the local church.
Fourth, I am ever grateful for the support of Arthur J. Williams, Ph.D., dissertation committee member. Seeing potential in me that I could not see, he stepped out in faith and accepted me into both the Masters (Spring, 2005) and Doctoral Counseling Programs at Mercer University (Fall, 2014). His excitement about seeing me grow and thrive as a new counseling student, ultimately blossoming into a mature, graduate student with a Masters in Community Counseling (Fall, 2009) and a Doctor of Philosophy in Counselor Education and Supervision, ensures me that God still places angles in our paths. I thank the Holy One of Israel for allowing Dr. Williams to witness my personal realization of my hidden, educational potential. Dr. Williams is my angel!

Fifth, I am appreciative of the support of dissertation committee member Morgan E. K. Riechel, Ph.D., while on this pilgrimage. Her willingness to ask her students about their personal passions for research speaks volumes to my heart. I thank her for having the courage to let me pursue my research interests, empowering me to grow like the tiny caterpillar into the clouded yellow butterfly. I fly high like the colias croceus in my destiny in Christ because of her inspiration.

Sixth, I am deeply thankful for the support of dissertation committee member Suneetha Manyam, Ph. D., as I continue to walk out my destiny in Jesus Christ. Dr. Manyam’s statistical acumen combined with her academic scholarship has encouraged me to soar on eagle’s wings.

In addition, I am ever grateful to the Penfield College Counseling Department Chair, Mercer University, Atlanta, Georgia, Karen D. Rowland, Ph.D. Her persistence for keeping me motivated to continue writing my dissertation over the years resembles the
logs one adds to the fire as it slowly starts to burn down. Thanks to Dr. Rowland for keeping the embers of my proverbial “dissertation fire” ignited. May God bless her!

Also, I am eternally grateful for Kenyon C. Knapp, Ph.D., Penfield College Counseling Department of Mercer University, Atlanta, Georgia. His words of wisdom about self-care and professional counseling career advice have been greatly appreciated! In addition, Denise Massey, Ph.D., McAfee School of Theology of Mercer University, Atlanta, Georgia, is immensely appreciated for her guidance and mentorship as I pursue my vocational call of teaching pastoral care classes. Thank you also to Penfield College Dean, Priscilla R. Danheiser, Ph. D., for her support during my dissertation process.

Last, but not least at all, I want to acknowledge Theresa Catherine Reese, Ph.D. It was a clear day in August of 2014 when I walked into her office pondering in the back of my mind this thought, “What am I going to do my research study on?” She shared her dissertation topic, and my breath was immediately taken away. God spoke to me at that moment in a “still small voice” about the title of this research project. Dr. Reese placed me on a strategic research plan for my dissertation on that humid, hot summer day in 2014 and, as they say, “The rest is history!” Thank you, Dr. Reese, for your foresight and embracing my dissertation vision. To God be the glory!

In closing, my benediction prayer for you all is: “The Lord bless you and keep you; The Lord make His face shine on you, and be gracious to you; The Lord lift up His countenance upon you, and give you peace” (Numbers 6:24-26, New King James Version). In Jesus’s name, we pray. Amen.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEDICATION</td>
<td>iii</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>iv</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>x</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td>xi</td>
</tr>
<tr>
<td>LIST OF APPENDICES</td>
<td>xii</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>xiii</td>
</tr>
<tr>
<td>CHAPTER</td>
<td></td>
</tr>
<tr>
<td>1. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Background of the Study</td>
<td>2</td>
</tr>
<tr>
<td>Increased Life Expectancy</td>
<td>2</td>
</tr>
<tr>
<td>Depression and the Elderly</td>
<td>3</td>
</tr>
<tr>
<td>Spirituality and Health</td>
<td>4</td>
</tr>
<tr>
<td>Purpose of the Study</td>
<td>5</td>
</tr>
<tr>
<td>Problem Statement</td>
<td>5</td>
</tr>
<tr>
<td>Theoretical Framework</td>
<td>6</td>
</tr>
<tr>
<td>Significance of Study</td>
<td>11</td>
</tr>
<tr>
<td>Research Questions</td>
<td>12</td>
</tr>
<tr>
<td>Nature of the Study</td>
<td>13</td>
</tr>
<tr>
<td>Definition of Terms</td>
<td>13</td>
</tr>
<tr>
<td>Assumptions</td>
<td>14</td>
</tr>
<tr>
<td>Limitations</td>
<td>15</td>
</tr>
<tr>
<td>Delimitations</td>
<td>18</td>
</tr>
<tr>
<td>Summary</td>
<td>19</td>
</tr>
<tr>
<td>CHAPTER</td>
<td>Page</td>
</tr>
<tr>
<td>---------</td>
<td>------</td>
</tr>
<tr>
<td>2. LITERATURE REVIEW</td>
<td>20</td>
</tr>
<tr>
<td>Theoretical Framework</td>
<td>22</td>
</tr>
<tr>
<td>Effects of Daily Spiritual Experiences on Depression</td>
<td>25</td>
</tr>
<tr>
<td>Spirituality and Depression among Institutionalized Elderly</td>
<td>28</td>
</tr>
<tr>
<td>Perception of Spirituality on Physical and Mental Health</td>
<td>31</td>
</tr>
<tr>
<td>The Role of Spirituality among Depressed Elderly</td>
<td>35</td>
</tr>
<tr>
<td>Assessment of Instruments for the Study</td>
<td>42</td>
</tr>
<tr>
<td>Daily Spiritual Experience Scale</td>
<td>43</td>
</tr>
<tr>
<td>Clinical Assessment of Depression</td>
<td>47</td>
</tr>
<tr>
<td>Summary</td>
<td>52</td>
</tr>
<tr>
<td>3. RESEARCH METHOD</td>
<td>53</td>
</tr>
<tr>
<td>Research Design and Rationale</td>
<td>53</td>
</tr>
<tr>
<td>Research Questions and Hypotheses</td>
<td>54</td>
</tr>
<tr>
<td>Methodology</td>
<td>55</td>
</tr>
<tr>
<td>Population</td>
<td>55</td>
</tr>
<tr>
<td>Sample Description</td>
<td>55</td>
</tr>
<tr>
<td>Sampling Techniques</td>
<td>57</td>
</tr>
<tr>
<td>Setting</td>
<td>57</td>
</tr>
<tr>
<td>Procedures</td>
<td>58</td>
</tr>
<tr>
<td>Data Analysis</td>
<td>59</td>
</tr>
<tr>
<td>Ethical Procedures</td>
<td>63</td>
</tr>
<tr>
<td>Summary</td>
<td>64</td>
</tr>
<tr>
<td>4. RESULTS</td>
<td>66</td>
</tr>
<tr>
<td>Data Collection</td>
<td>67</td>
</tr>
<tr>
<td>Results</td>
<td>68</td>
</tr>
<tr>
<td>Summary</td>
<td>71</td>
</tr>
</tbody>
</table>
TABLE OF CONTENTS (Continued)

<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. DISCUSSION</td>
<td>73</td>
</tr>
<tr>
<td>Summary of Findings</td>
<td>74</td>
</tr>
<tr>
<td>Discussion of the Findings</td>
<td>76</td>
</tr>
<tr>
<td>Limitations</td>
<td>81</td>
</tr>
<tr>
<td>Implications</td>
<td>84</td>
</tr>
<tr>
<td>Recommendations for Future Research</td>
<td>86</td>
</tr>
<tr>
<td>Conclusion</td>
<td>87</td>
</tr>
</tbody>
</table>

| REFERENCES                     | 89   |
| APPENDICES                     | 99   |
LIST OF TABLES

Table 1 Demographic Characteristics of Participants ..................................................68

Table 2 Results of Descriptive Statistics Analysis – Measures of Central Tendency ....69

Table 3 Results of Pearson’s Correlational Analysis ...................................................71
LIST OF FIGURES

Figure 1. Regression line testing linearity of the data set................................................. 133

Figure 2. Regression line testing homoscedasticity of the data set ..................................... 136
LIST OF APPENDICES

APPENDIX A HUMAN SUBJECTS APPROVAL .................................................................100


APPENDIX C DAILY SPIRITUAL EXPERIENCE SCALE PUBLISHER CONSENT ..........................................................108

APPENDIX D CLINICAL ASSESSMENT OF DEPRESSION PUBLISHER CONSENT ..........................................................114

APPENDIX E GRADUATE RESEARCH PERMISSION AT GREATER PLEASANT HILL MISSIONARY BAPTIST CHURCH ..........................................................117

APPENDIX F DEMOGRAPHIC QUESTIONNAIRE .................................................121

APPENDIX G DAILY SPIRITUAL EXPERIENCE SCALE ........................................126

APPENDIX H CLINICAL ASSESSMENT OF DEPRESSION .......................................128

APPENDIX I REGRESSION LINE TESTING LINEARITY OF THE DATA SET .....131

APPENDIX J REGRESSION LINE TESTING HOMOSCEDASTICITY OF THE DATA SET .........................................................................................................................134
The purpose of this quantitative study was to determine if there was a relationship between levels of spirituality and levels of depressive symptoms, church attendance, and prayer experiences in elderly people. Researchers have projected that all baby boomers (those born between 1945 and 1964) will be 65 years of age or older by 2030 (Cleary, Sayers, Bramble, Jackson, & Lopez, 2017). Although the future seems optimistic, many elderly people are vulnerable to depression. This research reviewed the literature on aspects of spirituality and depression and proposes to study: (a) the use of daily spiritual experiences (DSE) as a treatment to lower depression for the elderly, (b) the role of spirituality in increasing or decreasing depression among the institutionalized elderly, (c) how older adult’s perception of spirituality and religion impacts physical and/or mental health, (d) the role of spirituality among depressed individuals, (e) assessment instruments for the study, and (f) Pargament’s (2009) theoretical model for understanding and evaluating spirituality. The literature review revealed a gap concerning the relationship of spiritual practices and the occurrence of depression. A sample of elderly
people were obtained using the convenience sampling method by contacting members of a local church. Relationships between the variables were analyzed using Pearson’s product-moment correlation for three research questions. The results indicated no statistically significant relationships between levels of spirituality and depression and between levels of spirituality and prayer. Last, the results indicated a large-positive statistically significant correlation between levels of spirituality and church attendance.

*Keywords:* elderly, depression, spirituality, religion, Pargament’s (2009) theoretical model for understanding and evaluating spirituality
CHAPTER 1

INTRODUCTION

Mother Teresa (2007) said the following:

The greatest disease in the world in the West today is not tuberculosis (TB) or leprosy; it is being unwanted, unloved, and uncared for. We can cure physical disease with medicine, but the only cure for loneliness, despair, and hopelessness is love. There are many in the world who are dying for a piece of bread but there are many more dying for a little love. The poverty in the West is a different kind of poverty—it is not only a poverty of loneliness but also of spirituality. There’s a hunger for love, as there is a hunger for God. (p. 79)

At any age, anyone can embark on a spiritual journey or a quest to make meaning of one’s life in connection to their ideological beliefs and values (Temple & Gall, 2016). Older adults can begin or continue their spiritual journeys, as they progress through life (Fowler, 1981). Saroglou and Munoz-Garcia (2008) defined spirituality as an expression of a person’s affiliation with the supremacy, minus religious affiliation. As lifespans are increasing across the globe, researchers have become aware of the intersection between the physical health of the elderly and their spirituality at this stage in their lives. Within the research community, there is a growing body of literature concerning the correlation between high levels of spirituality with high levels of depression (McCoubrie & Davies, 2006; Nelson, Rosenfeld, Breitbart, & Galietta, 2002; Nelson et al., 2009). Depression
and depressive symptoms make up the most frequently reported mental disorders and health grievances, and these symptoms are the most frequently reported psychiatric disorders among elderly people (Kim, Kang, & Kim, 2015; Smith, McCullough, & Poll, 2003). In contrast, other researchers have reported that older adults who frequently engaged in spiritual activities reaped health benefits (Koenig, King, & Carson, 2012; Rushing, Corsentino, Hames, Sachs-Ericsson, & Steffenes, 2013).

After a review of the literature, the researcher has determined there is not a consensus about the relationship of spiritual practice and the prevalence of depression among the elderly due to a lack of research in this area. This lack of research is the gap that this dissertation will attempt to address. This study seeks to evaluate the relationship between levels of spirituality and manifestation of depressive symptoms, church attendance, and prayer. The remainder of this chapter will include a background of the study, the research problem that the proposed study addresses, the purpose of the research, the research questions that will guide the study, and the significance and nature of the study. The chapter will conclude with a brief summary and a preview of the following chapter.

Background of the Study

Increased Life Expectancy

Over the past few decades, the life expectancy for older adults has dramatically increased (Eberhardt, Ingram, & Makuc, 2001). Older adults who retire at age 65 may live 30% of their lives after retirement (Davis, Worthington, Hook, & Wade, 2014). In
the Global Burden of Disease Study 2013, Murray et al. (2015) found that the life expectancy for healthy individuals, as well as for those with disabilities and illness, increased around the world. From 1990 to 2013, life expectancy at birth rose by 6.2 years to 71.5 years. For the United States specifically, male life expectancy rose from 71.9 years in 1990 to 76.3 years in 2013. For females, life expectancy rose from 78.8 years in 1990 to 81.4 years in 2013 (Murray et al., 2015). However, the prevalence of mental health disorders rises with age, as well as physical ailments, such as musculoskeletal and neurological disorders, diabetes, hearing loss, and vision loss. Adults over 80 have an increased chance of living with a combination of more than one of those disorders (Murray et al., 2015).

Depression and the Elderly

Even though depression is a common mental illness among persons of a variety of ages and races, it is the most prevalent mental health condition among older adults (Blegen, 2016). In contrast to younger persons, older adults who experience depression are at a greater risk of mortality, use of long-term health services, and suicide (Blegen, 2016). Collard, Comijs, Naarding, and Voshaar (2014) found that depressed older adults were more likely considered physically frail or in a state of increased risk of negative health outcomes, such as reduced mobility and independence, falling, hospitalization, disability, and death. Many researchers have investigated the relationships between depression in older adults and other health factors, as well as a variety of preventative measures against depression in older adults (Aparicio, Robles, Lopez-Sobaler, & Ortega,
Greater longevity in life has led to expanded research on the relationship between religion and spirituality among depressed older adults. Researchers have indicated that older adults who have participated in religious events experienced benefits regarding mortality (Comstock & Partridge, 1972; Koenig et al., 2012; Mueller, Plevak, & Rummans, 2001; Strawbridge, Cohen, Shema, & Kaplan, 1997). Other researchers have reported that older adults who have frequently participated in religious activities have lower blood pressure; protection against suicide; and have an increased sense of self-worth and self-esteem, lower anxiety, and lower rates of depression (Koeing, 1995; Koenig et al., 1998; Krause, 1995; Levin, 1994; Rushing et al., 2013). In addition, researchers have shown participation by older adults in spiritual experiences, such as meditation, reading spiritual literature, or prayer, are predictors of well-being (Bush et al., 2012).

In contrast, one must also consider that researchers have associated the negative aspects of religious coping with increases in depression among the chronically ill older adult population (Pargament, Koenig, Tarakeshwar, & Hahn, 2004). An example of two negative aspects of religious coping includes one feeling disappointed by God or an individual feeling spiritually malcontent (Pargament et al., 2004). Researchers have shown that negative beliefs, misunderstanding, miscommunication, and negative religious coping can damage mental health (Weber & Pargament, 2014). Therefore, it is
not conclusive whether older adults may experience health benefits from higher levels of spirituality or if higher levels of spirituality have a negative influence on their health, especially in the area of depression.

Purpose of the Study

The purpose of this quantitative study was to determine if there was a relationship between the level of spirituality and levels of depressive symptoms, church attendance, or prayer experiences in elderly people. A sample of 29 elderly people were asked to respond to the Daily Spiritual Experience Scale (DSES) and the Clinical Assessment of Depression (CAD), with the purpose of gathering information about levels of spirituality and depression symptomology (Appendices G and H). These data were analyzed using Pearson product-moment correlation analysis. The theory guiding this research was Pargament’s (2009) theoretical model for understanding and evaluating spirituality, as it provided a framework for understanding how individuals of any age embark upon spiritual journeys comprised of diverse pathways to the sacred, as well as a multifaceted description of their possible sacred terminus. The goal of this research project was to produce research that will make clergy, chaplains, and pastoral care providers and pastoral counselors aware of the findings to increase awareness of the efficacy of practical, evidenced-based pastoral care and counseling interventions for a specific population.

Problem Statement

Life expectancy is increasing, resulting in a larger population of older adults (Mathers, Stevens, Boerma, White, & Tobias, 2015; Murray et al., 2015). Older adults,
those 65 years of age and older, are prone to health-related issues that can affect their quality of life and their mortality, such as depression and depressive symptoms (Churpek, Yuen, Winslow, Hall, & Edelson, 2015; Kim et al., 2015; Singh & Bajorek, 2014). Researchers have shown that older adults who frequently participate in religious activities may enjoy health benefits and greater longevity (Koeing, 1995; Koenig et al., 1998; Krause, 1995; Levin, 1994; Rushing et al., 2013).

The problem to be studied was how spirituality and depression in the elderly were related (Bush et al., 2012). The specific problem studied was whether there was a correlation between levels of spirituality and symptoms of depression, church attendance, or prayer experiences among elderly people (Nelson et al., 2009; Pargament et al., 2004). The impact of the problem is that, if spirituality was positively related to depression, elderly people may be at greater risk of experiencing depression or depressive symptoms. However, if spirituality was negatively related to depression, spirituality may serve as a preventative measure against experiencing depression among the elderly (Bush et al., 2012; Pargament et al., 2004). If the problem is not addressed, older adults may experience a poorer quality of life due to the lack of knowledge regarding factors influencing rates of depression (Smith et al., 2003).

Theoretical Framework

The theory used to support this research was Pargament’s (2009) theoretical model for understanding and evaluating spirituality. Pargament (1999) defined the meaning of spirituality as “a search for the sacred” (p. 12). From this definition of spirituality, Pargament (1999) distinguished two words: sacred and search.
First, the concept of sacred includes two perceptions. One concept of the sacred is a perception of God or higher spiritual powers (Pargament, 1999). Second, the concept of sacred includes other facets of an individual’s life that are considered as “having divine character and significance” (Pargament & Mahoney, 2005, p. 183). Last, the concept of search is the path one takes to learn about the scared to initiate and cultivate their connection with the sacred, and when deemed essential, transform his/her connection with the sacred (Pargament, 2014).

Pargament (2009) described a theoretical model for understanding and evaluating spirituality (Appendix B). Pargament (2009) stated that the pursuit for the sacred could transpire over an individual’s lifespan. When the search for the sacred starts, the individual begins the “process of discovery” (Pargament, 2009, p. 213). The process of discovery of the sacred can occur in numerous ways. Some individuals may believe they are being called on by the sacred, or some may initiate contact with the sacred (Pargament, 2009).

Next, the individual identifies the sacred realm as desirous and creates a number of pathways to cultivate and “conserve” his or her connection with whatever he or she deems sacred (Pargament, 2009, p. 215). For example, individuals may attempt to uphold and develop their connections to the sacred by following traditional pathways, such as praying, attending studies of sacred text, or meditating (Pargament, 2009). Individuals may also follow a nontraditional path in pursuit of conserving their connections to the sacred by attending yoga classes or doing cross stich.
After the conservation phase, an individual on the search for the sacred may experience distress through trauma or crisis due to major life events during the phase of “threat, violation, or loss” (Pargament, 2009, p. 215). Conversely, an individual may first enter the “conservation” phase, next enter the “conservational spiritual coping” stage, and then experience the “threat, violation, or loss” phase (Pargament, 2009, p. 215). Nevertheless, during the “threat, violation, or loss” phase, the individual becomes spiritually unsettled and believes it is difficult to continue on familiar spiritual routes (Pargament, 2009, p. 215).

Although the “threat, violation, or loss” phase is distressing, an individual can pick from several “conservational spiritual coping” methods to keep their spirituality (Pargament, 2009, p. 215). Pargament (2009) identified seven “conservational spiritual coping” methods (p. 215). The first one is “benevolent spiritual reappraisals,” which means the individual reconsiders a stressor as valuable through the lens of spirituality (Pargament, 2009, p. 219). The second “conservational spiritual coping” method is “seeking spiritual support,” which indicates the person pursues affection and attention from the sacred (Pargament, 2009, p. 219). The third “conservational spiritual coping” method is “seeking support from clergy/congregation members,” meaning the individual searches for affection and attention from the members of clergy and the congregation (Pargament, 2009, p. 219). Fourth, the individual may seek a divine connection by reaching out for a relationship with a higher spiritual power (Pargament, 2009, p. 219). Fifth, the individual may become a spiritual helper by endeavoring to offer spiritual care to others (Pargament, 2009, p. 219). Sixth, “collaborative spiritual coping may occur,”
meaning the individual seeks to unite with the Higher Power in problem solving (Pargament, 2009, p. 219). Last, “spiritual purification” may occur as one embarks on a quest for spiritual cleansing though ritual (Pargament, 2009, p. 219).

After the “threat, violation, or loss” phase or the “conservational spiritual coping” phase, the individual’s spiritual perception is in crisis (Pargament, 2009, p. 219). Pargament (2009) reported that when an individual experienced a period of spiritual doubt, stress, or war, the spiritual perception of the individual entered a phase of “spiritual struggle” (p. 215).

There are three types of spiritual struggle. One type is an “interpersonal spiritual struggle,” which includes clashes with the “family, friends, tribes, and nations” (Pargament, 2009, p. 220). Another type is the intrapsychic spiritual struggle, which involves an individual’s inquires and disbeliefs about issues of faith (Pargament, 2009, p. 220). The last type is a struggle with the high power. During this struggle, the individual may express feelings of being disciplined by God, that God’s presence abandoned them, or rage and dread projected toward God. At this point on one’s spiritual pursuit of the sacred, they may face an intersection of growing or declining spirituality. After the spiritual struggles phase, the pathways of growth or decline can lead to “transformational spiritual coping” or “spiritual disengagement” (Pargament, 2009, p. 215).

“Transformational spiritual coping” involves an individual’s vital change in knowledge and understanding of the sacred (Pargament, 2009, p. 215). After major life crisis occurs and one endures the spiritual struggles phase, some individuals may embrace change by highlighting the confines of their knowledge of or method of
accessing the sacred. One may shift by reimaging the sacred or making the sacred the focus of one’s identity, instead of on the margins of one’s life.

In contrast, all spiritual transformations are not positive. The individual’s spiritual struggles can lead to “spiritual disengagement” (Pargament, 2009, p. 215). Spiritual disengagement is described as an individual who briefly or eternally disengages from pursuit of the sacred (Pargament, 2009, p. 215). Some individuals may engage in negative transformations by trying to replace the lost relationship of the sacred with other objects they know are flawed and negative. In contrast, some individuals may decide to forever disengage from the purist of the sacred and enter a permanent decline away from spirituality.

Pargament (2009) asserted that the quest for the sacred was not time constrained; however, it occurred over an individual’s lifespan. Pargament (2009) suggested that the evaluation of spirituality should consist of “process-based criteria” (p. 216). The worth of a person’s spirituality should not be determined in a “single belief, practice, affiliation, trait or experience” (Pargament, 2009, p. 216). In comparison, the individual should possess a “well-integrated spirituality” that

is defined by pathways that are broad and deep, responsive to life’s situations, and oriented toward a sacred destination that is large enough to encompass the full range of human potential and luminous enough to provide the individual with a powerful guiding vision (Pargament, 2009, p. 216).

Pargament’s (2009) theoretical model for understanding and evaluating spirituality was appropriate for this research study because it provided an understanding of an
individual’s spiritual journey, while confronting major life crisis or events that may cause depression. These events may overall influence his/her spiritual destination regarding growth or decline away from the sacred.

Many researchers have studied the influence of the “threat, violation, or loss” and “spiritual struggles” phases of Pargament’s (2009) theoretical model for understanding and evaluating spirituality (Pargament et al., 2005; Murray-Swank & Pargament, 2005). This theory provided an adequate framework for conceptualizing spirituality and the effect of major life stressors on an individual’s grow or decline to his or her spiritual destination to address the extent to which spirituality was related to depressive symptoms.

Significance of Study

Life expectancy has increased globally due to progress in sanitation, technological advances in medical care, improved living conditions, and a decrease in mortality among children (Jin, Simpkins, Ji, Leis, & Stambler, 2015). When incorporating world population demographics, there will be a doubling of people over 60 years between 2000 and 2050 (Jin et al., 2015). Depression in the elderly has grown and contributed to a common social and economic problem for the world as the life expectancy has increased (Pradhan, 2014).

Depression among the elderly is a common problem. Depression causes emotional despair, increased death, increased risk of physical activity decline, and disability (Blazer & Hybels, 2005). Researchers have reported that older adults who engaged in spirituality experienced decreases in depression. For example, McCauley,
Tarpley, Haaz, and Bartlett (2008) found that frequent daily spiritual experiences were correlated with increased energy and decreased depression among adults age 50 and over who were diagnosed with chronic health conditions.

This study contributed to the data on the relationship between spirituality and depression, church attendance, and prayer among elderly people in America with the purpose of increasing awareness among clergy, chaplains, pastoral care providers, and pastoral counselors on the effectiveness of evidenced-based pastoral care and counseling interventions for depressed elderly people. Additionally, this study added to the body of research that identifies an association between spiritual beliefs and the healthcare field. Finally, this study was significant because it provided additional research supporting the validity of Pargament’s (2009) theoretical model for understanding and evaluating spirituality.

Research Questions

In this study, a quantitative correlational analysis was conducted. The following research questions and hypotheses were proposed:

RQ1: What is the relationship between “spirituality,” as defined by Pargament (1999), and depression among elderly people?

$H_0$: There is a significant relationship between “spirituality,” as defined by Pargament (1999), and depression among elderly people.

RQ2: What is the relationship between “spirituality,” as defined by Pargament (1999), and church attendance among elderly people?
H₀: There is a significant relationship between “spirituality,” as defined by Pargament (1999), and church attendance among elderly people.

RQ3: What is the relationship between “spirituality,” as defined by Pargament (1999), and prayer experiences among elderly people?

H₀: There is a significant relationship between “spirituality,” as defined by Pargament (1999), and prayer experiences among elderly people.

Nature of the Study

A quantitative study was used to examine whether a relationship exists between levels of spirituality and manifestation of depressive symptoms, church attendance, and prayer among elderly people. The data from the CAD was used to determine levels of depressive symptomology. The DSES was used to determine levels of spirituality among elderly subjects. The data obtained from the CAD and the Daily Spiritual Experiences Scale were analyzed using Pearson product-moment correlation to identify any significant associations between the two variables (Puth, Neuhäuser, & Ruxton, 2014).

Definition of Terms

The definitions of terms used throughout are provided for clarity:

Church attendance. Church attendance is one component of the multifaceted definition of religiosity (Azzi & Ehrenberg, 1975).

Diagnosed depression. According to the American Psychiatric Association (2013), diagnosable depressive disorders include major depressive disorder, persistent depressive disorder, pre-menstrual dysphoric disorder, disruptive mood dysregulation disorder, substance/medication induced depressive disorder, depressive disorder due to
another medical condition, other specified depressive disorder, and unspecified depressive disorder.

Elderly Person. Elderly person refers to individuals 65 years and older (Churpek et al., 2015).

Major Depressive Disorder. Major depressive disorder criteria includes nine symptoms. Five or more of these symptoms must be present during the same 2-week period, including either one or two: depressed mood; loss of interest or pleasure; significant weight loss or gain; insomnia or hypersomnia; psychomotor agitation or retardation; fatigue or loss of energy; feelings of worthlessness or excessive feelings of inappropriate guilt; and a diminished ability to think, concentrate, or make decisions; recurrent thoughts of death; recurrent suicidal ideation, and suicide attempt or plan (Andrews et al., 2007).

Prayer. Prayer is an effort to establish a significant relationship with a supreme being (Whittington & Scher, 2010).

Religiosity. Religiosity is the pursuit of the sacred via the public realm of membership in religious institutions, participation in formal rituals, and adherence to official denominational doctrines (Burris, Sauer, & Carlson, 2011).

Spirituality. Spirituality is “a search for the sacred” (Pargament, 1999, p. 12).

Assumptions

The researcher made several assumptions to conduct this study. The first of these assumptions was that the age of 65 is an adequate age by which to define elderly people (Churpek et al., 2015; Davis et al., 2014). There are variations within the literature
regarding the definition of the term elderly as it relates to chronology; however, for the purposes of this study, elderly people will include persons aged 65 and older.

Another assumption was that the sample obtained for this study would reflect the unique population being studied. Recruitment occurred through a church; therefore, the levels of spirituality of the persons included in the sample may be different compared to those who do not attend or belong to a church because spirituality and religiousness are different constructs, though these concepts are often discussed together (Fallot, 2008).

Finally, it was assumed that the identification of depressive symptoms in elderly people would provide adequate data to draw conclusions about the relationship between spirituality and depression. The researcher was not a medical doctor or a licensed professional counselor and was not trained or authorized to diagnose depression; therefore, the study only included variables relating to the manifestation of depressive symptoms.

Limitations

Several limitations may have influenced this study. The participants of this study consisted of a convenience sample from Greater Pleasant Hill Missionary Baptist Church in Atlanta, Georgia. Therefore, due to selection bias, generalizations were limited to this geographical region, type of church, and the congregants, which were used in this study.

The second limitation was the small sample size of 29. The researcher ran a bivariate correlation with three variables using the small sample size of 29. The minimum sample size to run a bivariate correlation should be 56 for the results to be generalizable,
therefore, the results of this study may not be generalizable to the population due to small sample size.

Another was the measure of church attendance. Church attendance was a limitation because it did not differentiate between the possible impacts of or participation in religious activities, religious belief systems, or the religious body (Van Wagoner et al., 2014).

The fourth limitation was that the CAD was not normed for individuals beyond the age of 79 years. Several participants in this study were over 79 years of age. Dr. Bracken, the author of the CAD, explained via email that the CAD was not normed for individuals above 79 years of age for two reasons. First, there are not many people over 79 years of age who seek mental health services “for depression for the first time.” Last, it would have been challenging “to get a normative sample beyond” age 79.

A fifth limitation was conducting the study on the telephone. When speaking with some participants on the telephone, there were several interruptions. Some participants were caretakers of their grandchildren or children. During two to three telephone calls with some participants, the participants would ask the researcher to hold on while he/she cared for a family member. The wait time would interrupt the research study.

A sixth limitation was the use Pargament’s (1999) definition of spirituality. Pargament (1999) defined spirituality as “a search for the sacred” (Pargament, 1999, p. 12). The researcher chose this definition because it was broad and did not narrow an individual into one specific way of “searching for the sacred” (Pargament, 1999, p. 12).
In addition, self-report surveys were utilized to obtain data analysis in the study. Construct validity was a major issue when researchers utilize self-reports (Kormos & Gifford, 2014). Construct validity is defined as the extent to which a test precisely assesses an underlying construct (Kormos & Gifford, 2014). Participants of the study may have exaggerated or answered survey questions in a subjective manner, compromising construct validity (Kormos & Gifford, 2014). Therefore, the use of the self-report surveys contributed to the limitations of the study.

Lastly, there were several natural limitations of the study to be considered. One limitation was the small population of 98 Greater Pleasant Hill Missionary Baptist Church members, thus limiting the number of participants in the study aged 65 and over to 29. Another natural limitation was access of transportation to attend church services.

The third natural limitation was possibly fatigue from taking the DSES, CAD, and the demographic questionnaire over the telephone or face-to-face. In addition, the participant’s own mental health status in terms of taking these studies may have been a natural limitation.

The last natural limitation may have been the spiritual thought process of the participants. When the researcher originally asked the pastor of Greater Pleasant Hill Missionary Baptist Church for permission to conduct the study at the church, the pastor foretold that the results would indicate there was no significant relationship between spirituality and depression for church members 65 years of age or older. The pastor’s prediction opposes research literature which indicates high correlations between spirituality and levels of depression among elderly people.
The pastor further explained that church members age 65 and older were people who highly valued the Word of God by living and speaking the Word of God daily. These congregants did not consider themselves as “victims.” In contrast, they considered themselves a victorious people who desired to attend church, who willingly shared their testimonies, who had their hope in Heaven, and who were looking toward the rapture of Jesus Christ.

Delimitations

Many delimitations may have influenced this research study. First, the researcher had chosen to focus only on elderly people age 65 and older. This population has been chosen because the focus of the research project was to determine if there was a relationship between levels of spirituality and depressive symptoms or a relationship between spirituality and church attendance and prayer experiences.

The second delimitation that may influence this study was the researcher’s decision to choose Pargament’s (2009) theoretical model for understanding and evaluating spirituality to make assumptions about the results of the data. The last delimitation was the researcher’s decision to use the convenience sampling method to recruit participants in the study from Greater Pleasant Hill Missionary Baptist Church in Atlanta, Georgia. This decision was made by the researcher to ensure that the goal of the research study was accomplished. The goal of this research project was to produce research which would make clergy, chaplains, pastoral care providers, and pastoral counselors aware of my findings to increase awareness of the efficacy of practical, evidenced-based pastoral care and counseling interventions for a specific population.
Summary

Researchers have shown that people were living longer (Murray et al., 2015); however, older adults were experiencing depression at a growing rate. Older adults who have higher levels of spirituality have experienced health-related benefits. The purpose of this study was to determine if a relationship existed between levels of spirituality and depressive symptoms, church attendance, and prayer experiences in elderly people and, if so, to what extent. To accomplish this purpose, a correlational analysis using Pearson’s product-moment correlation was conducted.

Chapter 1 contained information outlining the background of the study, the study problem, the theoretical framework used to support the research, the significance, nature of the study, assumptions, limitations, and delimitations of the study. The research questions were introduced and the definitions were discussed. Chapter 2 consists of a discussion of contemporary and seminal literature relating to spirituality and depression among elderly people. Additionally, the theoretical framework will be described in detail. In Chapter 2, the research gap will be identified and the need for conducting this study.
CHAPTER 2
LITERATURE REVIEW

In 2020, baby boomers are predicted to become 16% of the United States population (Karel, Gatz, & Smyer, 2012). Baby boomers were born between 1946 and 1964 are defined as individuals who are between ages “52-70 years old” (Cleary, Sayes, Bramble, Jackson, & Lopez, 2017, p. 61). By 2030, researchers projected that all of the Baby boomer cohort would be 65 years or older (Cleary et al., 2017). Researchers also projected that by the year 2030, the total population that identified as age 65 and older in the United States, would double the size of the amount of people who became age 65 during the year of 2000 (Cleary et al., 2017). Despite these projected numbers and the positive futuristic outlook, many older adults are vulnerable to depression (Ganatra, Zafar, Qidwai, & Rozi, 2008).

Many researchers have investigated the role that various spiritual practices have played in decreasing depression among the elderly population (Bekelman, Dy, Becker, Wittstein, Hendricks, Yamashita, & Gottlieb, 2007; Dein, 2006; McClain, Rosenfeld, & Breitbart, 2003). With spiritual practices playing such a key role in reducing depression among the elderly, one must review the literature for insights about this topic. Other researchers have found that negative aspects of spirituality and religion may have negative health consequences (Bekelman et al., 2007; Dein, 2006; McClain et al., 2003). It is not conclusive as to whether older adults may experience health benefits from higher
levels of spirituality or if higher levels of spirituality has a negative influence on their health, especially in the area of depression. After a review of the literature, it has been determined that there is not a consensus as to the relationship of spiritual practices and the prevalence of depression among the elderly due to a lack of research in this area. This lack of consensus is the gap that will be addressed by this research.

The purpose of this quantitative study was to determine if there was a relationship between level of spirituality and depressive symptoms, church attendance, and prayer in elderly people. If spirituality was positively related to depression, older adults may be at a greater risk of experiencing depression or depressive symptoms; however, if spirituality was negatively related to depression, spirituality may serve as a preventative measure against experiencing depression among the elderly (Bush et al., 2012; Pargament et al., 2004). The review of the literature on depression and spirituality is an attempt to reflect the present state of the body of knowledge in this area and to identify the gap in the literature that this study will address.

For this literature review, Google Scholar, Educational Resource Information Center (ERIC), JSTOR: Journal Storage, and EBSCOhost Online Research Databases were utilized. Search terms included elderly, depression, spirituality, religion, and Pargament’s (2009) theoretical model for understanding and evaluating spirituality. Using these keywords, both individually and in combinations, relevant studies were generated from database searchers. Those that were deemed relevant to the study were included in the literature review. Most of the literature included in the review was
published between 2013 and 2017 to ensure that the most current research and reports were included. However, older literature relating to the theoretical framework of the study and other related seminal studies were included.

The literature review is divided into the theoretical framework and additional sections: (a) the use of daily spiritual experiences (DSE) as a treatment to lower depression for the elderly, (b) the role of spirituality in increasing or decreasing depression among the institutionalized elderly, (c) how older adult’s perception of spirituality and religion impacts physical and/or mental health, (d) the role of spirituality among depressed individuals, and (e) the assessment of instruments for the study. The chapter ends with a summary of the literature review.

Theoretical Framework

The theoretical framework that will be used to support this research is Pargament’s (2009) theoretical model for understanding and evaluating spirituality. Pargament (1999) described spirituality as “a search for the sacred” (p. 12). Although the quest for the sacred can occur over an individual’s lifespan, the initial search for the sacred starts during the “process of discovery” (Pargament, 2009, p. 213). Next, the individual expresses a desire to linger in the sacred space and finds ways to “conserve” his or her partnership with whatever he or she believes sacred (Pargament, 2009, p. 215). The next phase, “conservational spiritual coping,” is categorized as consisting of spiritual coping methods that individuals can draw strength from to help them keep their spirituality (Pargament, 2009, p. 214).
The individual may experience “threat, violation, and loss” before or after the conservational spiritual coping phase (Pargament, 2009, p. 214). The individual enters this phase when catastrophic life events occur that the individual believes are spiritual hazards, abuses, or damages.

Research has indicated that if an individual perceives the major life event as a spiritual “threat, violation, or loss,” then there are significant warnings for the individual’s healthiness and welfare (Pargament et al., 2005, p. 59). For example, Pargament et al. (2005) explored the hypothesis that major life events, which were viewed as losses of the sacred or violations of the sacred, have momentous consequences on the health and welfare on the person. The research study consisted of 117 adults randomly selected from a community (Pargament et al., 2005). The participants were asked to identify the most negatively influential event over the past two years. Next, they completed measures in which they rated the major life event as a sacred loss, a desecration, religious coping, and the influence of the major life event under four sets of criteria that included: “traumatic impact, physical health, emotional distress, and growth” (Pargament et al., 2005, p. 59). One significant finding of the Pargament et al. (2005) study indicated that the individual’s perceptions of sacred loss was also correlated with depression. The next phase of the spiritual journey consisted of a struggle.

After experiencing a major life crisis and the individual’s spiritual perception is in peril, the individual enters the “spiritual struggle” phase (Pargament, 2009, p. 214). The individual may have a brief period of spiritual wrestling, and then return to their previous
traditional spiritual journey, or the individual may experience “spiritual disengagement” or “spiritual transformation” (Pargament, 2009, p. 215). The disengagement of spirituality may be temporal or eternal. In contrast, the transformation of spirituality may lead to an expansion of the individual’s knowledge and relationship with the sacred.

Practitioners have created programs to help individuals who are in the spiritual struggle phase. For example, the Solace for the Soul: A Journey Towards Wholeness (Murray-Swank, 2003) was created to meet the spiritual struggles that women sexual abuse survivors had experienced. The study was designed to increase using spirituality as a viable coping method.

Through eight innovative sessions, a spiritually-integrated program for women sexual abuse survivors that identified as spiritually struggling, Murray-Swank and Pargament (2005) conducted a study that analyzed the effectiveness of the Solace for the Soul: A Journey Towards Wholeness (Murray-Swank, 2003) program. The study included two female participants who received the spiritually-integrated interventions via manualized sessions with an individual therapist. Murray-Swank and Pargament (2005) utilized an “interrupted time-series design” that included everyday measurements of religious coping both negative and positive, spiritual anguish, and spiritual self-value (p. 20). The comprehensive measurements of religious coping, both positive and negative; spiritual health; and spiritual images were also completed both during the pre-intervention and post-intervention and one to two months after the study. Murray-Swank and Pargament (2005) found significant changes in the participant’s spiritual health,
positive ways of religious coping, and the views of images of God as positive. Murray-Swank and Pargament (2005) found significant implications for innovative programs that assisted individuals who faced significant spiritual struggles.

Given that this study focuses on the influence that major life crisis has during one’s spiritual journey, utilizing Pargament’s (2009) theoretical model for understanding and evaluating spirituality as a framework is appropriate. Researchers have used phases of this theory in research to explore how the “threat, violation, or loss” phase and the “spiritual struggles” phase affects one’s spiritual destination (Murray-Swank & Pargament, 2005; Pargament et al., 2005). Even though a person can experience the spiritual phases at any time during his/her life span, specific life crisis can dramatically alter his or her spiritual destination of growth or decline, which may be the case for some depressed older adults. Consequently, using this theory for this study can explain the spiritual destination that older adults exhibit, which can be related to the manifestation of depressive symptoms.

Effects of Daily Spiritual Experiences on Depression

The elderly depressed population practices several types of spiritual practices in an effort to decrease depression (Allen, Phillips, Roff, Cavanaugh, & Day, 2008; Koenig, 1995, 2007). Bush et al. (2012) conducted a quantitative study in which older adults were asked to complete the Brief Multidimensional Measure of Religiousness and Spirituality (BMMRS). Of the eight domains of the BMMRS, the Daily Spiritual Experiences (DSE) domain survey results became the only “predictor of spiritual well-being, satisfaction
with life, and depressive symptoms” (Bush et al., 2012, p. 200). The DSE domain had six items that measured the frequency “with which one finds strength and comfort in religion, is spirituality touched by the beauty of creation, and/or feels God’s presence” (Bush et al., 2012, p. 194). This study was significant because the reported Cronbach’s Alpha of several domains for the BMMRS was 0.62 to 0.90, and each older adult’s frequent participation in daily spiritual experiences clearly decreased their symptoms of depression.

Park and Roh (2013) purported that both DSE and social support alleviated depression among the elderly Korean immigrant population. Their research utilized the DSE scale of the BMMRS to measure how elderly Korean participants sensed the existence of a connection to a higher being while performing DSE (Park & Roh, 2013). After analyzing the data using the hierarchical regression model, these researchers provided two significant data conclusions. Using the bivariate analysis, Park and Roh (2013) concluded that social support and DSE have an inverse relationship with depression ($p < 0.01$). Using the Sobel test, Park and Roh (2013) also concluded that social support mediated the relationship between depression and DSE ($z = 1.87, p = 0.030$). These findings were significant because Korean elderly could decrease depression by practicing DSE and engaging in social support.

Ronneburg, Miller, Dugan, and Porell (2014) examined the relationship between organized religious service attendance and non-organized forms of religiosity. They included private prayer for depressed and non-depressed elderly individuals. Participation
in religious public and non-public religious activities were revealed to defend against and aid persons in their recovery from depression (Ronneburg et al., 2014).

Yoon and Lee (2006) described a significant, inverse relationship between spirituality/religiousness and depression and social support. Yoon and Lee (2006) utilized the BMMRS, surveying a rural community of older adults. In addition to using the hierarchical regression analysis to discover the inverse relationship between spirituality/religiousness and depression and social support, the researchers claimed a positive relationship existed between spirituality/religiousness and life satisfaction. These findings were significant because the DSE of spirituality/religiousness practiced, coupled with social support by rural older adults, seemed to affect depression negatively.

Weber and Pargament (2014) acknowledged that there were negative aspects of religion and spirituality, as these aspects related to psychology and well-being. For example, negative religious coping, such as being angry with God, having negative encounters with other believers, or experiencing internal guilt and doubt, can result in poorer mental health outcomes. Additionally, religious and spiritual beliefs may cause conflict between patients and doctors regarding medical advice. For example, Weber and Pargament (2014) related religious affiliation with delays in seeking treatment for mental health issues. In addition, persons who hold a negative or punitive image of God are more likely to have more symptoms of depression, anxiety, obsession and compulsion, and paranoia.
Weber and Pargament (2014) showed that spirituality was related to mental health. However, there is not a consensus that spirituality only has positive effects on mental health. While some researchers have concluded that spirituality and religious activity have been associated with lower rates of depression (Park & Roh, 2013), other researchers have reported that negative aspects of religion are positively correlated with depression and other mental health issues (Weber & Pargament, 2014).

**Spirituality and Depression among Institutionalized Elderly**

The institutionalized elderly is an often-overlooked population. Many researchers examined the interconnection between the decrease of depression and the spiritual needs of the community dwelling elderly (Commerford & Reznikoff, 1996; Erichsen & Bussing, 2013; Pargament et al., 2004; Ronneburg et al., 2014; Vitorino & Vianna, 2012). Commerford and Reznikoff (1996), in their survey of 83 nursing home residents, utilized the Mental Status Questionnaire (MSQ), Hoge’s Intrinsic Religious Motivation Scale (HIRS), the Beck Depression Inventory and the Rosenberg Self-Esteem Scale. Commerford and Reznikoff (1996) concluded that there was a relationship between depression and self-esteem to “perceived social support from family, public religious activity, and length of stay in the (nursing) home residents” (p. 35). They further suggested that there was a negative relationship between depression and health status and personal selection of the desired nursing home. The researchers reported that there was no association between depression or self-esteem, and the resident’s intrinsic religious practices and their perceived support from their friends. This study was significant
because nursing home residents indicated that depression and self-esteem were related to perceived family support, affiliation with public religious activities, and how long they had been residents in the facility.

Erichsen and Büssing (2013) found that of the 100 elderly nursing home residents surveyed, the results of the Spiritual Needs Questionnaire (SpNQ) indicated a strong correlation between the existential needs of inner peace needs and the need to give. Erichsen and Büssing (2013) also utilized the Spiritual and Religious Attitudes in Dealing with Illness (SpREUK) to measure religious trust. They found that religious trust was positively, strongly associated with religious needs ($r = 0.75, p < .01$).

Erichsen and Büssing (2013) performed regression analyses to highlight predictors of spiritual needs. According to the research results, religious need was predicted by religious trust ($R^2 = .67$). These claims were significant because the mood states of older adults, when correlated to life satisfaction, seemed to contribute to the prediction of specific spiritual needs. The researchers reported that grief ($r = -.53$) and tiredness ($r = -.30$) were moods that contributed most to the prediction of spiritual needs. However, if grief and tiredness of mood persist, the diagnosis of depression may be inevitable. In summary, if depression was diagnosed, then there was an expected increase of spiritual needs among the institutionalized elderly.

Vitorino and Vianna (2012) evaluated the spiritual/religious coping (SRC) of 77 institutionalized older adults. The Spiritual/Religious Coping (SRC) instrument was utilized in the study. The instrument consisted of a scale with two dimensions: the SRC
negative and the SRC positive. The significance of this study, in relationship to the depressed elderly, derived from the negative religious/spiritual coping (NRSC) factors. Some examples of NRSC include questioning God or taking a negative posture in front of the Divine. In conclusion, the results showed that if older adults were being perpetually faced with religious/spiritual issues, then their health was at risk due to the use of NRSC (Vitorino & Vianna, 2012). The Spearman correlation between NRSC and variables of age the time of residence in the two living facilities was $r = 0.008$ and $p < 0.05$. The health risks are interconnected to the beginning stages of depression and other fatal sicknesses.

Vitorino and Vianna (2012) reported that the least contributable factor to the NRSC was the pessimistic reassessment of the Divine. This factor was accompanied by “questions of the existence, power, love, protection, responsibility, desire, acts, and/or punishment of God” (Vitorino & Vianna, 2012, p. 141). According to Panzini and Bandeira (2005), this NRSC was partnered with the release of undesirable feelings, such as shame about one’s past, unwanted dependency, and sadness. In summary, elderly depressed people may be susceptible to depression if they engaged in the frequent use of NRSC.

Pargament et al. (2004) conducted a study of older adults who were diagnosed as medically ill and hospitalized. The researchers surveyed the participants at baseline using the RCOPE and during a 2-year follow-up using the Brief RCOPE. Pargament et al. (2004) concluded that positive ways of religious coping were correlated to positive health
enhancements at baseline. For example, religious conversion was correlated to depressed mood \((r = .21, p \leq .001)\), activities of daily living \((r = .20, p \leq .001)\), and spiritual outcome \((r = .38, p \leq .001)\). In contrast, negative ways of religious coping were correlated to the prediction of diminishing health. For example, spiritual discontentment was correlated to quality of life \((r = .22, p \leq .001)\), depressed mood \((r = .17, p \leq .05)\), and activities of daily living \((r = .13, p \leq .05)\). This study was significant because it illustrated that older adults might develop depression because of participating in negative religious coping methods.

Institutionalized older adults represent a subgroup of the elderly that is not frequently researched. However, the studies that have been conducted regarding this population support the conclusion that the elderly experience spirituality and religiosity in ways similar to that of their non-institutionalized counterparts (Vitorino & Vianna, 2012). Consequently, data yielded from non-institutionalized older adults may also inform practice relating to the elderly who are being served in nursing homes, hospitals, or other facilities.

Perception of Spirituality on Physical and Mental Health

There is a growing awareness within the older adult community of the potential health benefits attached to spirituality and religion (Mackenzie, Rajagopal, Meilbohm, & Lavizzo-Mourey, 2000; Meisenhelder & Chandler, 2002; Schwarz & Cottrell, 2007). Many quantitative and qualitative researchers reported that perceived spirituality and religion might have a distinct role in the healing from disease and overall maintenance of
physical and mental health within the elderly population. Researchers showed that older adult’s perception of spirituality and religion might influence physical and mental health, thereby possibly lowering depression (Mackenzie et al., 2000; Meisenhelder & Chandler, 2002; Schwarz & Cottrell, 2007).

Mackenzie et al. (2000) conducted a qualitative study utilizing focus groups and interviews with older adults living in continuing care retirement communities (CCRC). Mckenzie et al. (2000) concluded, “Religious beliefs may have a significant influence on the psychological well-being of older adults and that the subjective experience of spiritual support may form the core of the spirituality-health connection” (p. 37). For example, some elderly participants believed that prayer would cure both physical and mental maladies if it were the will of the Holy One. This study was significant because it demonstrated how the association between the older adult’s perception of spirituality and religion might influence his or her mental and physical health, thereby possibly lowering depression (Mackenzie et al., 2000).

Meisenhelder and Chandler (2002) researched the correlation between “attitudinal and behavioral measures of spirituality, physical, and mental health outcomes in a sample of elderly community residents” (p. 1). The participants in the study were over age 65 and resided in residential communities located in Massachusetts. There were 271 participants in the study, ages ranging from 65 to 94. Of the sample, half was Protestant, one-third was Catholic, 4% identified themselves as Jewish, and 6% identified as atheist.
The instrument used was a mailed questionnaire called the Medical Outcomes Study Short Form-36 Health Survey, which measured functional health with eight subscales. The subscales include Physical Functioning, Role Functioning-Physical, Bodily Pain, General Health, Vitality, Social Functioning, and Role Functioning-Emotional and Mental Health (Meisenhelder & Chandler, 2002). The eight categories of physical and mental health were investigated for their relationship with regularity of prayer, significance of faith, and dependence on religion for coping mechanisms. This study was significant because it emphasized that attitudes are indicators of strong spiritual variables associated with mental health outcomes among the elderly (Meisenhelder & Chandler, 2002). Using the Pearson Product-moment Correlation, the researchers’ found that the variables for frequency of prayer and importance of faith were highly correlated to mental health ($r = .146, p < .018$). The results also indicated that multiple regression analyses predicated that the value of a person’s faith had the strongest association with positive mental health (Meisenhelder & Chandler, 2002). The researchers explained the importance of highlighting an older adult’s faith instead of religion. In addition, frequency of prayer was negatively related to physical functioning ($r = -.127$).

Meisenhelder and Chandler (2002) emphasized that when addressing the participant’s belief system, the goal was to highlight the affirming, personal components of the individual’s faith. The researchers chose this method because highlighting external teachings could invoke positive or negative connotations. The researchers also focused on
personal beliefs and behaviors in an effort to separate personal faith from the influence of social support gained from participation in public religious events. Meisenhelder and Chandler’s (2002) findings reinforced the power of personal faith choice for the older adult in relation to having positive or negative implications for the person.

Schwarz and Cottrell (2007) conducted a qualitative study utilizing the phenomenological approach. The participants were residents of a long-term care facility undergoing occupational therapy with the integration of spirituality. The researchers concluded that the participant’s discerned spirituality was critical during rehabilitation (Schwarz & Cottrell, 2007). They identified six key themes of the interviewees: “meaning and purpose, coping and positive outlook, reliance and dependence, comfort and consolation, hope for recovery and therapeutic rapport” (p. 43). Schwarz and Cottrell’s (2007) study was significant because the perceived spirituality of the participants positively influenced their rehabilitation.

There is evidence in research to support the conclusion that spirituality may have positive physical and mental health benefits. Researchers have evaluated various aspects of faith, as demonstrated by older adults, and have identified relationships between these faith factors and increased physical and mental health and rehabilitation (Meisenhelder & Chandler, 2002; Schwarz & Cottrell, 2007). Therefore, this research provides a foundation for understanding the potential role that spirituality may have in the rates of depression among the elderly.
The Role of Spirituality among Depressed Elderly

Although a gap existed in the literature for evidence-based research on interfaith spirituality groups for the elderly depressed population, several researchers highlighted positive outcomes for the pivotal role that religion and spirituality played in decreasing the symptoms of depression (Cheston et al., 2003; Rushing et al., 2013). Rushing et al. (2013) supported the conclusion that religious participation was correlated with a plethora of positive health outcomes, including reduced chances of suicide. The researchers conducted the study with 248 depressed patients who were 59 years old or older and who were participants in the Neurocognitive Outcomes of Depression in the Elderly study. Suicidal ideation was assessed using items indicating suicide on the Montgomery-Asberg Depression Rating Scale (Rushing et al., 2013). Rushing et al. (2013) conducted a Sobel test, which highlighted that “perceived social support partially mediated the relationship between church attendance and current suicidal ideation ($z = 2.068, SE = .015, p = .039$)” (p. 6). In addition, Rushing et al. (2013) suggested that their findings were connected to the network theory, which purported that participation in religious events and the interaction with network contacts decreased suicide risk due to the promotion of social engagement. Church attendance by the depressed elderly provides social support that accounts for the link between religiosity and decrease in suicide risk. The findings of Rushing et al. (2013) supported the concept of interfaith spirituality group for the elderly depressed population. Similar to ways in which church attendance provides a spiritual network that decreases suicide risks, an interfaith spirituality group
also provides a strong support network, thereby lowering depression and suicide risk.

Other research studies support the importance of spirituality among depressed individuals and support the importance of spirituality among depressed individuals.

In comparison, Cheston, Piedmont, Eanes, and Lavin (2003) conducted a study involving 98 participants ranging from 20 to 80 years old. The researchers examined the effectiveness of outpatient counseling on the client’s mental health symptoms and his or her picture of the Divine. The participants in the treatment and non-treatment group were given the Brief Symptom Inventory (BSI) and the Adjective Checklist on two different occasions. Cheston et al. (2003) found that “personal development of the experience of self is related to the personal experience of God and that these experiences mutually influence each other” because those in the treatment group experienced a significant decrease in psychological symptoms and those in the control group showed no changes (pp. 104-105). Cheston et al. (2003) used a mixed-model multivariate analysis of variance with the nine BSI scales as independent variables. The results indicated significant interactions on all nine BSI scales (Wilks’s lambda = .67, multivariate $F(9, 88) = 4.93, p < .001$). In sum, there was a direct correlation between an individual’s personal relationship with the Lord and their personal development. If the individual’s relationship with God was positive, then their personal development of self was positive. If the individual’s relationship with God was negative, then their personal development of self was negative (Cheston et al., 2003).
To explain the study further, the participants in both the control and treatment group rated their image of God based on these factors twice during the study: neuroticism, extraversion, openness, agreeableness, and conscientiousness (Cheston et al., 2003). The therapist had the role of evaluating each client, citing how much expressive and spiritual transformation was achieved during treatment. This research promoted the idea that counselors should become more cognizant of the contact with the spiritual element in their client’s lives and should reflect on using the client’s picture of the Holy One within the discussion about their communion with the All Knowing.

Further, if an older adult felt depressed, Cheston et al. (2003) suggested that they might also feel vulnerable in their relationship with God. Exploring their image of God and asking the client to meditate and share revelations on Psalm 42 would be an influential technique that could be utilized during interfaith spirituality counseling for the elderly depressed population.

Psalm 42 is a lament (Mills & Wilson, 1995). The beginning of the Psalm describes a parched deer who is desperately seeking to drink water in the “dried up wadis of an arid region” (Mills & Wilson, 1995, p. 465). The speaker in the Psalm is also parched, for he is thirsting for God (Mills & Wilson, 1995). While pouring over his lament, he begins thinking about his participation in the Temple of God and remembers God (Mills & Wilson, 1995). Next, the speaker expresses about the inner depression of his soul is “like a groaning and grieving mourner” (Mills & Wilson, 1995, p. 465). The resolve of the lamenting worshiper is to speak words of encouragement to himself, which
are “Hope in God” (Mills & Wilson, 1995, p. 465). If elderly depressed individuals share their laments and the words they speak to themselves that encourages them to decrease depression by hoping in the Holy One of Israel during interfaith spirituality group counseling, then others in the group may benefit with a reduction of depressive symptoms and increased levels of spirituality. Tarakeshwar, Pearce, and Sikkema (2005) supported this theme of speaking words of hope aloud in an effort to locate one’s spiritual destiny and increase positive outlook.

Tarakeshwar et al. (2005) claimed that an 8-week spirituality coping group for 13 HIV positive adults produced positive, significant results as post-intervention. The average age of the participants was 45.77 years. The spiritual coping group used the cognitive theory of stress and coping, used the outline for spiritual coping, and identified stressors synonymous to HIV (Tarakeshwar et al., 2005). After receiving the intervention, the HIV affected adults reported increases in self-assessed religiosity (pre = 2.92, post = 3.38, $p < 0.05$) and optimistic coping (pre = 7.54, post = 8.09, $p < 0.10$). The clients also reported decreases in pessimistic spiritual coping (pre = 2.31, post = 1.61, $p < 0.02$) and in depressive feelings (pre = 18.00, post = 12.73, $p < 0.05$) during post intervention (Tarakeshwar et al., 2005). Psychological distress was measured using the Center for Epidemiological Studies Depression Scale and the Beck Anxiety Inventory. Similar to the outcomes of this study that greatly affected the adult participants, one might assume that depressed elderly populations could benefit by decreasing their depression as participants of spirituality group that would motivate them to locate their spiritual destiny.
Other research directly contrasts, yet indirectly supports this conclusion. Post, Cornish, Wade, and Tucker (2013) found that the majority of 54 counselors, employed at nine university counseling centers who participated in religion and spirituality group counseling, responded positively by agreeing that religious and spirituality groups were appropriate for use. Post et al. (2013) and Hill et al. (2000) defined spirituality as “the feelings, thoughts, experience, and behaviors that arise from a search for the sacred that receives validation and support from an identifiable group of people,” and religion as “the feelings, thoughts, experiences, and behaviors that arise from a search for the sacred that receives validation and support form an identifiable group of people” (Hill et al., 2000, p. 66). The researchers concluded that counselors identified religion and spirituality differently and that counselors in this study “endorsed higher ratings for spiritual interventions compared to their religious counterparts” (Post et al., 2013, p. 264).

The distinction between spirituality and religion is important for this study in the literature review. Not only did Post et al.’s (2013) research conclude that counselors favored the use of religious concerns during group counseling, they also concluded that the intervention, most often approved as suitable for group counseling, was the exploration of spiritual conflicts. The counselors in Post et al.’s (2013) study also indicated that the most typical and frequently used religious/spiritual intervention in-group counseling was identifying spirituality as a foundation of strength. Although the results did not specifically explore the effect that religious or spiritual interventions used by group counselors had on depressed clients, it explored possible interventions that
could be used by group counselors to help lift an older adult’s depression. The interventions listed in this study are engaging, interactive, and innovative. If group counselors used these interventions, intertwined with the exploration of Psalm 42, speaking hope to the elderly who are depressed, the burden of depression might dissipate for the elderly population.

Cornish, Wade, and Post (2012) conducted a similar study by utilizing an on-line questionnaire that asked how 242 experienced group counselors integrated religion and spirituality into group counseling. In sum, the average experienced group counselor had worked as a mental health professional for 25 years, and over 90% reported that they had at least ten years of counseling experience. Cornish et al. (2012) defined group therapy as “a therapeutic group (themed or open-ended) comprised of a potentially heterogeneous clientele led/facilitated by at least one professional therapist/counselor, without a specifically religious or spiritual theme” (p. 126). As in Post et al.’s (2013) study, Cornish et al. (2012) asked questions about the appropriateness and use of specific religious interventions. The participants of Cornish et al.’s (2012) study deemed that interventions that were less engaging and less overtly connected to spiritual or religious rituals were preferred. In addition, the participants reported a high level of agreement with a spiritual themed group (Cornish et al., 2012). Lastly, the participants revealed that they believed in the therapeutic value of discussing religion and spirituality in group counseling.
The results from Cornish et al.’s (2012) study affirmed the value and needed intervention of interfaith spirituality for elderly depressed populations. Because the participants viewed spiritual interventions as appropriate, the effectiveness of an interfaith spirituality group for the elderly depressed should be further explored and researched (Cornish et al., 2012).

Another investigation that indirectly supported the importance of spirituality among depressed individuals was written by a psychologist who was also a nun. Kehoe (1999) conducted an interfaith therapy group that focused on spiritual beliefs and values for chronically ill psychiatric patients in a day treatment program for 18 years. She described the interfaith group, as attended by both males and females ages 22 to 60. The group facilitator introduced the group to a safe place when patients could contemplate personal religious systems and rituals, as well as explore issues, problems, or inner thoughts about personal faiths.

Over the years of conducting the group, Kehoe (1999) found that this group fostered “tolerance, self-awareness, and nonpathogenic therapeutic exploration of value systems” (p. 1081). Because Kehoe (1999) described an interfaith spirituality group and was intricately related to the theme of this literature review, one must describe the group rules contributing to the group’s success. The rules include embracing diversity and reverence for other’s personal faith, while prohibiting evangelizing with an open invitation for anyone to participate. Kehoe’s (1999) research findings served as a model on how pastoral care providers or professional counselors should conduct interfaith
spirituality group. She asserted that there was a distinctive gap in the literature concerning the study of religious beliefs and spiritual practices of chronic psychiatric patients.

The author of this chapter concurs that there is a gap in the literature concerning the effectiveness of religious beliefs and spiritual practices for the depressed elderly. In this study, the use of the DSES and the CAD will attempt to explore the gap in the literature. The assessments of the DSES and the CAD will be further explained.

Assessment of Instruments for the Study

The DSES and the CAD will be administered to each older adult in the sample to collect data relating to level of spirituality and depression. Information on the demographic survey will be selected based on a review of similar studies addressing spirituality and depression levels among elderly people (Bush et al., 2012; Ronneburg et al., 2014; Vitorino & Vianna, 2012; Yoon & Lee, 2006). The purpose of the demographic survey is to gain knowledge about the characteristics of the elderly sample. Knowledge gained from the demographic survey will include specific information, such as ethnicity/racial group, age, gender, marital status, current religious affiliation, how often one attends church services, living arrangements, how often one prays, and an opportunity for one to write in a single word or a few words about his or her definition of spirituality (Appendix F).
Daily Spiritual Experience Scale

Underwood (2011) developed the DSES (Appendix G) to measure a person’s mundane spiritual experience with the divine. This instrument measures an individual’s discernment of the transcendent in every day, ordinary life, and his or her perceived interactions or experiences with the Holy One in his or her life. The DSES includes 16 items. A modified Likert scale is used to score the first 15 questions. The categories for the Likert scale for the first 15 questions are *many times a day, every day, most days, some days, once in a while, and never or almost never.*

An example of one question is, “I feel God’s presence.” Examples of other items include “I find strength in my religion or spirituality”; “I feel deep inner peace or harmony”; “I ask for God’s help in the midst of daily activities;” and “I experience a connection to all of life.” Question 15 states, “I desire to be closer to God or in the union with the divine” (Underwood & Teresi, 2002, p. 25). Question 16 is scored using a different Likert scale, which consists of *not at all, somewhat close, very close, or as close as possible.* The last question asks, “In general, how close do you feel to God?” (Underwood & Teresi, 2002, p. 25). All items are “cast in positive terms” (Underwood & Teresi, 2002, p. 25). Item 16 will not be included in the study because the final item was initially included for “calibrating” Question 15 (Underwood & Teresi, 2002, p. 25). Underwood and Teresi (2002) suggested that lower scores indicated a heightened amount of daily spiritual experiences. For example, a low DSES score signified an individual
who encountered spiritual experiences many times a day. A high score on the DSES indicated that a person never or almost never had daily spiritual experiences.

Underwood and Teresi (2002) conducted an analysis of the DSES 16 item scale, and the data demonstrated reliability with high internal consistency: Cronbach’s alpha equated to 0.94 and 0.95. Underwood and Teresi (2002) tested 47 substance abusers who sought treatment over two days for their stability in responses to the 16 item DSES. The test-retest method reported a high Pearson product moment correlation of 0.85 (Underwood & Teresi, 2002). The Cronbach’s alpha was 0.88 for the test and 0.92 for the retest (Underwood & Teresi, 2002). Underwood (2011) based the DSES instrument on a review of a plethora of sources. The sources included “theology, comparative religion, the social sciences, a review of available scales, and many in depth interviews with a large variety of people over time” (Underwood, 2011, p. 31). During the refining process of the DSES, Underwood (2011) developed a method of grouping words that would capture the meaning of the construct of the instrument.

DSES factor analysis confirmed the single factor of spirituality for the scale (Ellison & Fan, 2008; Underwood & Teresi, 2002). The instrument includes the following constructs: “awe, gratitude, mercy, sense of connection with the transcendent, and compassionate love” (Underwood, 2011, p. 29). The operational definition of spirituality within the DSES context refers to the components of an individual’s life that are inclusive of the supernatural or holy, beyond what one’s normal senses experience. Predictive validity, construct validity, and concurrent validity have been demonstrated
through studies that have used American participants (Loustalot, Wyatt, Boss, May, & McDyess, 2006; Underwood & Teresi, 2002), as well as international populations for samples (Amr, El-Mogy, & El-Masry, 2013; Bennett & Shepherd, 2013).

In a sample and subgroup comparison, Underwood and Teresi (2002) examined summary statistics for the 16-item DSES to test preliminary construct validity. The first group was from the Rush Presbyterian-St. Luke’s Medical Center, Chicago and consisted of the Study of Women Across the Nation (SWAN). The second group included 45 patients of the Ohio Medical Center. The third group consisted of 122 participants from the University of Chicago area, of which Loyola University administered the 16-item DSES. The reported means for the groups were close to 47 for the SWAN ($SD = 18.69$) and the Loyola groups ($SD = 7.91$). In addition, the results indicated that African-American women in the SWAN group reported a significantly higher relation to DSES than whites. The mean score for African-American women of the SWAN study (37.78, $SD = 14.87$) were lower in comparison to Whites (52.79, $SD = 18.58$; $t = 6.82$, $p < 0.01$).

Underwood and Teresi (2002) reported that a 6-item version of the DSES was created for utilization in the Brief Multidimensional Measure of Religiosity and Spirituality. Ellison and Fan (2008) purported that the 6-item DSES demonstrated high internal consistency: Cronbach’s alpha = 0.95. Loustalot et al. (2006) examined the reliability and validity of both the 6-item and 16-item DSES versions with a 34 to 85-year-old African-American sample. The stability of the 16-item DSES was measured using the Pearson’s correlation ($r = 0.776$, $p > 0.05$) and deemed as acceptable. The Cronbach’s
Alpha level for the 16-item DSES for Test 1 was 0.86; at Test 2, it was 0.90. Lastly, the concurrent validity of the 16-item DSES was analyzed using ANOVA \( F = 2.892, p < 0.05 \).

Amr et al. (2013) confirmed the predictive validity of the DSES with Egyptian, Muslim patients with schizophrenia. Amr et al. (2013) conducted a cross-sectional descriptive study aiming to investigate whether “insight, spirituality, and patient beliefs” about the need and interest in medication were correlated with “adherence” among the sample (p. 60). After visiting their psychiatrist, participants were asked to complete the Schedule for the Assessment of Insight, Morisky Medication Adherence Scale, Arabic DSES, and Beliefs about Medicines Questionnaire. The results of the logistic regression analysis showed that the DSES scores and the SAI scores were positive predictors of adherence to treatment \((OR = 1.6, 95\% CI = 1.3-2.1, p = 0.000)\).

Bennett and Shepherd (2013) noted the predictive validity of the DSES with 278 Western Australian women ages 18 to 78. The participants completed the DSES, Depression Anxiety Stress Scale, and the Social Provisions Scale online. These scales assessed factors relating to depression, anxiety, social support, and daily spiritual experiences. Bennett and Shepherd (2013) used Pearson correlation coefficients to assess correlation between scores on the mental health scales and the DSES. The first significant correlation was found between daily spiritual experience and the depression subscale \((r = -0.21, p < 0.01)\). The second significant correlation was found between daily spiritual experience and anxiety \((r = -0.13, p < 0.05)\). The third significant correlation was found
between daily spiritual experience and social support ($r = 0.21, p < 0.01$). In summary, participants who indicated higher levels of daily spiritual experience also reported high levels of social support and lower depression levels (Bennett & Shepherd, 2013).

Clinical Assessment of Depression

Bracken and Howell (2004) developed the CAD (Appendix H) to assist with the measure of depressive symptoms among “children, adolescents, adults, and older adults from eight to 79 years of age” (Aghakhani & Chan, 2007, p. 416). The CAD is a 50-item self-report assessment that is sensitive enough to measure “depressive symptomatology across the lifespan” (Aghakhani & Chan, 2007, p. 416). The CAD utilizes the 4-point, Likert-type scale, self-report format that includes strongly agree, agree, disagree, and strongly disagree and is written on a third-grade level (Bracken & Reintjes, 2010). The CAD is time limited and allows 10 minutes to complete (Bracken & Howell, 2004). Although the authors of the CAD did not require the person administering or scoring the CAD to have formal graduate training, they strongly recommended that those administering the assessment have supervision by a professional with graduate training (Aghakhani & Chan, 2007). The appropriate professional training for engagement of interpretation of scores includes clinical, counseling, or school psychology; behavioral/developmental pediatrics; or a closely related field. Researchers also recommended that the professional trainers of the CAD be well trained in “diagnostic nomenclature and schemas; the limitations of using self-report scales; and theories of

The CAD test stems were written to mirror the diagnostic measure for depression according to the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders Text Revision (DSM-IV-TR; American Psychiatric Association, 2000) and reflect the current literature regarding depression among children, adolescents, and adults (Aghakhani & Chan, 2007). The CAD utilizes the two hallmarks of depression across the life span, which include depressed mood (i.e. feeling sorrowful) and anhedonia (i.e. lessened interest in all or most activities; Bracken & Reintjes, 2010). In addition to these two hallmarks of depression, the CAD assesses the defined symptomatic criteria and agreed on affective characteristics commonly associated or found among individuals with major or minor depressive episodes and subclinical depression (Bracken & Reintjes, 2010). The inclusion of the items associated with symptoms of depression within the DSM-IV-TR and the literature ensures the content validity of the CAD (Bracken & Howell, 2004).

The CAD has four Symptom Scales, which include Depressed Mood (DM), Anxiety/Worry (AW), Diminished Interest (DI), and Cognitive and Physical Fatigue (CPF). The first scale, the DM scale, has 23 items associated with diminished personal significance, sorrowfulness, feeling alone, or poor self-concept (Bracken & Reintjes, 2010). Those who score in the “mild to very significant clinical risk” range on the DM scale present with a sad appearance and a pessimistic affect (Bracken & Reintjes, 2010).
The second scale is the AW. This scale has 11 items that mirror symptoms of worry, anxiety, fear, and related symptoms (Bracken & Reintjes, 2010). The items on this scale reflect behaviors that include disorientation, problems relaxing, or inability to make decisions (Bracken & Reintjes, 2010).

The third scale is DI. This scale consists of six items that mirror the decline in interest in activities that were once enjoyable (Bracken & Reintjes, 2010). The DI items are associated with issues, such as diminished interest or lack of enjoyment and declining to participate in day-to-day routines (Bracken & Reintjes, 2010). If an individual is depressed, he/she declined in the life they once had previously and described that there was little in life to be excited about or interested in (Bracken & Reintjes, 2010).

The last and fourth scale is the CPF. This scale includes 10 items that reflect somatic issues associated with inability to sleep, fatigue, lack of sufficient energy, absence of physical or mental clarity, and inability to complete duties (Bracken & Reintjes, 2010). This lack of energy can also become a physical and mental slowness that makes a depressed individual unable to complete simple duties (Bracken & Reintjes, 2010). The total score of the CAD includes all four scales. Only scores from the four symptom scales and the CAD total score will be analyzed for this study.

The CAD also consists of six sets of items that are combined to form clinical clusters, which include Hopelessness, Self-Devaluation, Sleep/Fatigue, Failure, and Worry and Nervous (Bracken & Reintjes, 2010). The three validity scales of the CAD include Inconsistency, Infrequency, and Negative Impression (Bracken & Reintjes, 2010).
Scoring for the CAD may be done by hand or the hand entering of scores for computer analysis. Hand scoring is completed by one separating the answer sheet from the scoring sheet, and then relaying the circled items to the related scale boxes (Bracken & Howell, 2004). The scale scores are then calculated and placed on the “Score Summary sheet where they are then converted to T-scores, percentiles, and 90% confidence intervals based on tables within the manual” (Bracken & Howell, 2004, p. 20). Next, the Inconsistency Score must be calculated on the Score Summary Sheet (Bracken & Howell, 2004). The Negative Impression and the Infrequency Scores must be transferred from the scoring sheet to the Score Summary sheet (Bracken & Howell, 2004). Last, T-scores are placed on the Profile Form and plotted (Bracken & Howell, 2004).

The CAD total score T-Score (CAD TS T-score) will be analyzed for this dissertation. All scores except validity scales are reported as T-scores, and the scores indicating 60 or higher indicate clinical relevance (Bracken & Howell, 2004). T-scores ranging between 60 and 69 indicate Mild Clinical Risk (MCR; Bracken & Howell, 2004). T-scores ranging between 70 and 79 indicate Significant Clinical Risk (SCR; Bracken & Howell, 2004). T-scores that reflect 80 and above indicate Very Significant Clinical Risk (VSCR; Bracken & Howell, 2004). In summary, the Total Scores (TS) higher than 60 indicate many levels of depression (Bracken & Howell, 2004). Although the TS scores below 60 indicate No Risk (NR), the interpreter may analyze the scale scores and critical item clusters for specific problem areas needing intervention.
The CAD was normed and validated for use with 950 females and 950 males, ages 8 to 79 years of age (Bracken & Reintjes, 2010). A total of 1,900 participants included children ages 8 to 11, adolescents ages 12 to 17, young adults ages 18 to 25, and older adults ages 26 to 79 (Bracken & Reintjes, 2010). This standardization sample largely reflects the U.S. population; however, the CAD normative sample is skewed due to the sample consisting of those who are more educated and from the Midwest Region of the United States (Bracken & Reintjes, 2010). The total standardization sample was divided by age, race/ethnicity, and gender for the calculation of internal consistencies or coefficient alpha and standard errors of measurement for the CAD TS and symptoms scale (Bracken & Reintjes, 2010).

Per age group, the coefficient alphas for CAD TS were 0.96 for ages 8 to 11, 0.97 for ages 12 to 17, 0.96 for ages 18 to 25, and 0.97 for ages 26 to 79 (Bracken & Reintjes, 2010). The coefficient alphas for the age ranges 26 to 79 expressed some variability for each scale, which included 0.95 for the DM, 0.86 for the AW, 0.86 for the DI, and 0.87 for the CPF.

In addition, corrected test-retest reliabilities were established for the CAD TS and symptom scales utilizing a sample size of 99, including 40 children and adolescents and 59 adults (Bracken & Howell, 2004). The average time interval for the children and adolescents was 7 to 36 days (Bracken & Howell, 2004). The average time interval for the adults was over a range of 1 to 51 days (Bracken & Howell, 2004). Coefficient alphas
for the CAD TS ranged from 0.81 for the children and adolescent group and 0.87 for the adult group (Bracken & Howell, 2004).

**Summary**

Researchers revealed that spirituality has a relationship with mental health (Ronneburg et al., 2014; Weber & Pargament, 2014). Researchers made connections between the spirituality of the elderly people and depression, mental health, and stress and coping (Cheston et al., 2003; Rushing et al., 2013; Tarakeshwar et al., 2005). Benefits of spirituality for the elderly may include decreased suicide risks, a support network, and lower rates of depression (Rushing et al., 2013). When applied in a positive manner, elements of spirituality have proven beneficial. However, there has also been an indication in research that spirituality can negatively influence mental health (Commerford & Reznikoff, 1996). There is not a consensus in the literature regarding the nature of the relationship between levels of spirituality and depressive symptoms in older adults. This lack of consensus will be a gap addressed in this study, as reflected in the purpose and research questions. Chapter 3 will provide details of the method on how to achieve the study purpose and to address the gap established in this chapter.
CHAPTER 3
RESEARCH METHOD

The purpose of this quantitative, non-experimental, correlational research study was to determine if there was a relationship between levels of spirituality and depressive symptoms, church attendance, and prayer experiences in elderly people. A sample of older adults were obtained using the convenience sampling method by hand delivering invitations to participate or calling to ask members of a local church if they would like to participate. Also, informed consent, demographic questionnaires, and surveys were hand delivered or read over the telephone to all participants. Relationships between the variables were analyzed using Pearson’s product-moment correlation to quantify the nature and significance of relationships.

This chapter will focus on the methodology and procedures of the study. Chapter three is organized into five main components including a chapter summary. The components consist of the Research Design, Research Questions and Hypotheses, Research Methodology, Ethical Procedures, and the Summary.

Research Design and Rationale

The researcher utilized a non-experimental correlational research design to identify any relationships between levels of spirituality and manifestation of depressive symptoms in elderly people and among levels of spirituality, church attendance, and prayer experiences (Gelo, Braakmann, & Benetka, 2008). According to Puth et al. (2014),
Pearson’s product-moment correlation assumes that there are two continuous variables, X and Y, which can be measured for each of the participants in the sample. The X variable is the level of spirituality, and the Y variable includes depressive symptoms, church attendance, and prayer experiences. A quantitative methodology was selected because it was the methodology that will answer the research questions. Consequently, because the research questions required a quantitative measure to answer, this methodology was justified. (Vogt, Gardner, & Haeffele, 2012).

Correlational researchers determine the existence of relationships between variables and analyze the nature and strength of those relationships (Curtis, Comiskey, & Dempsey, 2016). Therefore, the purpose of this study and the objective of correlational research were aligned. Additionally, this research was non-experimental because the researcher did not manipulate any of the study variables or provide any treatment in a controlled experimental setting (Mahoney & Goertz, 2006). Based on the study purpose and research questions, as well as the characteristics of quantitative, correlational research, the researcher concluded that the research methodology and design were appropriate for this study.

**Research Questions and Hypotheses**

In this study, a quantitative correlational analysis was conducted. The following research questions and hypotheses were proposed:

RQ1: What is the relationship between “spirituality,” as defined by Pargament (1999), and depression among elderly people?
$H_0$: There is a significant relationship between “spirituality,” as defined by Pargament (1999), and depression among elderly people.

RQ2: What is the relationship between “spirituality,” as defined by Pargament (1999), and church attendance among elderly people?

$H_0$: There is a significant relationship between “spirituality,” as defined by Pargament (1999), and church attendance among elderly people.

RQ3: What is the relationship between “spirituality,” as defined by Pargament (1999), and prayer experiences among elderly people?

$H_0$: There is a significant relationship between “spirituality,” as defined by Pargament (1999), and prayer experiences among elderly people.

Methodology

Population

The population studied through this analysis was elderly people living in the United States. The elderly make-up 14.5% of the total U.S. population (Administration for Community Living, 2016). For the purposes of this study, an elder person was considered a person aged 65 or older (Churpek et al., 2015).

Sample Description

The sample consisted of elderly people age 65 and over who were members of Greater Pleasant Hill Missionary Baptist Church. The church culture was based on the intergenerational family model, which meant that each church member’s family member was considered church family. The church does not consider each church member’s
family as strangers, but they welcome each family member as “coming home.” This philosophy allows each church member the privilege of having funerals and weddings for his/her relative at the church without paying fees for using the church facility. Because of the use of the intergenerational family model, congregants reported feeling a sense of security and connectedness to their church.

Additionally, Greater Pleasant Hill Missionary Baptist Church stands on a firm church covenant proclaiming Jesus as Lord and is a member of the National Baptist Convention, USA, Inc. Last, Greater Pleasant Hill Missionary Baptist Church prides itself on conducting traditional, worship services, inclusive of old hymns, alter calls, deacon prayer meetings, revivals, Sunday School, and serving the community, while walking by faith in Jesus Christ.

Greater Pleasant Hill Missionary Baptist Church members are comprised of 97% African-American and 2% Caucasian. Second, they believe strongly in supporting the vision of the pastor, tithing, participating in outreach ministries, showing hospitality to visitors, and corporate prayer. Lastly, church members reported a sense of contentment because the church embraces the traditional African-American, Baptist worship experience.

The target sample size was 29 participants who were adults age 65 and over who were members of Greater Pleasant Hill Missionary Baptist Church. A power analysis for Pearson’s product-moment correlation was conducted a priori using G*Power to determine sample size. To conduct a two-tailed analysis with an effect size of $\rho = .5$, alpha
error probability of .05, and a power of .80, the minimum sample size needed was 29. A target sample size of 29 participants was selected to account for incomplete or invalid surveys that may be discovered during data analysis. The effect size of $\varphi = .5$ was chosen for this study because the results of the quantitative study conducted by Bush et al. (2012) revealed that elderly people’s persistent participation in daily spiritual experiences distinctly decreased their symptoms of depression.

Sampling Techniques

This research study used the non-probability sampling technique of convenience sampling. Convenience sampling was used in the recruitment of older adult members of the local church. First, permission from Greater Pleasant Hill Missionary Baptist Church was obtained to solicit participants from a list of age 65 and over older adults’ addresses, so they could be invited to participate in the study (Appendix E). Packets were hand delivered to participants or participants were called for all who are age eligible based on the list. The packets that were hand delivered or read via telephone included the informed consent letter, the demographic questionnaire, the paper version of the DSES, and the paper version of the CAD. This process continued until the target sample size of 29 participants was obtained and for a time of four weeks.

Setting

Greater Pleasant Hill Missionary Baptist Church is a small, urban church located in the English Avenue Community of Atlanta, Georgia. The English Avenue Community is a neighborhood with a rich history of serving the needs of the people of this
community. The church’s vision statement is “the transformation of the church to assist in revitalizing the community through the love of Jesus Christ, Our Savior.” The church has 98 members as indicated by the church membership address list. The church engages its older adults throughout the organizations of the Senior Choir, Senior Usher Board, Mother’s Board, Senior Deacon’s Board, and Senior Deaconess Board. Both the Senior Choir and Senior Usher Board regularly provide Christian hospitality at Greater Pleasant Hill Missionary Baptist Church, other church locations, or funeral homes for wakes and funerals of deceased church members or per the request of church member’s relatives of deceased persons who were not members of Greater Pleasant Hill Missionary Baptist Church.

Procedures

First, permission to utilize the DSES was requested from the author of the instrument (see Appendix C). Next, permission to utilize the CAD was requested from the author of the instrument (see Appendix D). After the permission was obtained from the senior experts, Dr. Underwood (2016) and Dr. Bracken, the study was submitted to the Mercer University Institutional Review Board (IRB), Human Subject Committee for permission to collect data (Appendix A). Once IRB approval was granted, the informed consent letter, demographic questionnaire, and paper copies of the surveys were hand delivered to the residence of those 65 and older from Greater Pleasant Hill Missionary Baptist Church or read to participants via telephone. The principal researcher purchased the CAD introductory kit, which included the professional manual, 25 rating forms, and
25 score summary/profile forms, and an additional 25 rating forms and score summary/profile forms from Psychological Assessment Resources (PARinc.com).

Data Analysis

The data, which was obtained from the demographic survey and the scores from the DSES and the CAD TS T-score, were analyzed using descriptive and inferential statistics. An alpha level of 0.05 was used to define the level of significance for the study. Data was analyzed using Pearson’s product-moment correlation.

Pearson’s product-moment correlation is a commonly used measure for association or relationship and is denoted as $r$ (Puth et al., 2014). Further explained, Pearson’s product-moment correlation describes the strength of the relationship and the linear trend within two continuous variables (Puth et al., 2014). The strength of the correlation refers to the direction of the relationship. Cohen (1988) advised these following guiding principles: “small $r = 0.10$ to $0.29$, medium $r = 0.30$ to $0.49$ and large $r = 0.50$ to $1.0$” (pp. 79-81). These principles are to be followed, regardless if there is a negative sign in front of the $r$ or not.

The value of $r$ always occurs within the range of a -1 and a +1 (Puth et al., 2014). If $r$ is 0, this indicates no relationship between the variables (Puth et al., 2014). If $r$ is 1, there is a “perfect positive linear relationship” among both variables (Puth et al., 2014, p. 184). If $r$ is between 0 and 1, there is a positive linear trend, and the increase in the value of one variable lends to the assumption that the value of the other variable may increase as well (Puth et al., 2014). If $r$ is -1, this indicates a “perfect negative relationship”
between both variables (Puth et al., 2014). If values are between -1 and 0, then the linear trend will have a negative slope, and the assumption is made that as one variable increases, the other variable decreases (George & Mallery, 2014).

For this study, preliminary analyses were performed to ensure that no violations of the assumptions of normality, homoscedasticity, and linearity occurred. The purpose of the Normal P-Plots of Regression Standardized Residual (Appendix I) and scatterplots (Appendix J) were to determine if the assumptions required for the correlational analysis procedure were met.

The X variable, identified in the research question, was spirituality. Spirituality referred to an individual’s connection with the divine, without necessarily referring to affiliation with a particular religious institution or group (Saroglou & Munoz-Garcia, 2008). As noted in Pargament’s (2009) theoretical model for understanding and evaluating spirituality different phases of spirituality among one’s life span can influence a person’s life in different ways. Consequently, one must understand how spirituality may influence one’s health.

For this study, participants responded to the DSES to ascertain their levels of spirituality. Scores from the DSES ranged from 15 to 90, due to the exclusion of Item 16 (Underwood, 2016). The variable of spirituality was measured as an interval level or continuous variable because the values of the DSES can “fall anywhere between adjacent scale units” (Steinberg, 2010, p. 17).
The Y variables, identified in the research questions, include depression, church attendance, and prayer experiences. For this study, depression referred to the manifestation of depressive symptoms. Symptoms may include depressed mood; loss of interest or pleasure; significant weight loss or gain; insomnia or hypersomnia; psychomotor agitation or retardation; fatigue or loss of energy; feelings of worthlessness or excessive of inappropriate guilt; and a diminished ability to think, concentrate, or make decisions, with recurrent thoughts of death, suicidal ideation, or suicide attempt or plan (Andrews et al., 2007).

For this study, participants responded to the CAD to ascertain their levels of depression and responded to the demographic questionnaire to ascertain their levels of prayer experiences and church attendance (Appendices F and H). CAD TS T-scores ranged from 60 or above to indicate clinical relevance. The depression levels variable was measured as an interval variable because the scores among the scale are equally distant between the CAD (Steinberg, 2010). The church attendance and prayer experiences variables are ratio variables because these variables have a point that is absolute zero, and the distance between the variables is the same among the distribution (Steinberg, 2010). For example, participants indicated that they never pray or pray one, two, three, or four times a day or beyond.

Last, participants indicated they never attend church or attend church one time per month, two times per month, three times per month, or four times per month. Asking about the amount of church attendance in the demographic survey realistically reflected
the typical amount of church services offered among the Protestant community. Older adult Protestants normally attend church once a week. Protestant churches normally offer a single worship service per week. This demographic survey question provided participant’s church attendance habits for an entire month.

Information obtained from the demographic survey was reported and illustrated in the descriptive statistics as mean, standard deviation, and frequency tables. All data analysis was completed using IBM SPSS Version 23.0. Data collected via paper survey was manually inputted into the .csv file. These data was then uploaded into SPSS to be analyzed for “missingness.” Participants who did not respond to all questions in the survey were removed from the sample. Final scores for each of the variables were calculated, as per the literature for each survey instrument.

From the data, the researcher obtained the descriptive statistics, including measures of central tendency, which are reported in the results. To address the research questions, Pearson’s product-moment correlation was conducted. Data was verified to determine that all assumptions had been met, including normality, linearity, and homoscedasticity. The two-tailed test of significance was used because the researcher had no idea of the direction of the correlation results, as suggested by researchers (George & Mallery, 2014).

Once the researcher determined all assumptions had been met, data was analyzed based on the results of the SPSS analysis. Results included Pearson’s product-moment correlation and the number of participants in the study for each hypothesis. Pearson’s
product-moment correlation results were analyzed, and the strength and direction of the relationship was determined. If there was a determination of strength and direction among the Pearson’s product-moment correlation, then the hypothesis was accepted. If there was not a determination of strength and direction among the Pearson’s product-moment correlation, then the hypothesis was rejected. Last, the researcher calculated the coefficient of determination to determine the amount of variance that two variables shared for each hypothesis (Pallant, 2016).

Ethical Procedures

The researcher employed safeguards to ensure that the proposed study was conducted in an ethical manner. First, the researcher obtained appropriate permission to conduct the study through the university’s IRB before commencing the study (Appendix A). The researcher also obtained approval to use the instruments included in this study from the authors of the instruments (Appendices C and D). Next, the researcher obtained informed consent via hand delivery to their residence or via telephone from all participants before they were permitted to participate in the study (Appendix A). There were no expected adverse effects to participants because of participating in this study; however, if a participant experienced any adverse consequences because of participating, then they had the option of immediately ceasing the survey, as described on the informed consent form.

As described on the informed consent form, each participant received a code upon return of each survey following a two-part process. If the participant’s CAD TS T-score
indicated depressive symptomatology, the principle researcher provided a formal letter with the resource address of Jenny Heuer, MS, Licensed Professional Counselor, NCC, 2751 Buford Highway, NE, Ste 700, Atlanta, Georgia, 30324, a counselor who specialized in therapy with the elderly, via hand delivery or mail.

The confidentiality of participants and their data remained ensured because any identifying information was coded as part of this study in a two-step process. If the participant did not indicate that he/she needed follow up resources, then the survey was coded immediately. However, if CAD TS T-score results indicated the participant needed follow-up resources, once the participant had received the follow-up resources via hand delivery to their place of residence or mail, the survey was coded, and no identifying information was available on the participant. Surveys, collected using paper copies, were coded and transferred manually into an electronic file. Data, collected for this study, will be maintained on a password-protected hard drive for 5 years or longer, as required by the IRB. Paper copies of surveys will be stored in a file cabinet locked with a key for 5 years or more. After this time, all paper and electronic data will be permanently destroyed.

Summary

The purpose of this quantitative study was to determine if there was a relationship between level of spirituality and levels of depressive symptoms, prayer experiences, and church attendance in elderly people. The sample, selected for the study, consisted of 29 elderly people in the local area who were recruited through church by means of
convenience sampling. Levels of spirituality were measured using the DSES; levels of depression symptomology were measured using the CAD TS T-score; and levels of church attendance and prayer experiences were ascertained from the demographic questionnaire. Relationships between variables were evaluated using Pearson’s product-moment correlation analysis.
CHAPTER 4

RESULTS

The purpose of this quantitative, non-experimental, correlational research study was to determine if there was a relationship between levels of spirituality and depressive symptoms, church attendance, and prayer experiences in elderly people. To address this purpose, the following research questions and hypotheses were formulated:

RQ1: What is the relationship between “spirituality,” as defined by Pargament (1999), and depression among elderly people?

\( H_0: \) There is a significant relationship between “spirituality,” as defined by Pargament (1999), and depression among elderly people.

RQ2: What is the relationship between “spirituality,” as defined by Pargament (1999), and church attendance among elderly people?

\( H_0: \) There is a significant relationship between “spirituality,” as defined by Pargament (1999), and church attendance among elderly people.

RQ3: What is the relationship between “spirituality,” as defined by Pargament (1999), and prayer experiences among elderly people?

\( H_0: \) There is a significant relationship between “spirituality,” as defined by Pargament (1999), and prayer experiences among elderly people.
A set of correlational analysis procedures were performed to address these research questions. This chapter contains the results of the analysis procedures performed.

Data Collection

Data for this study was collected from a sample of 29 members of the Greater Pleasant Hill Missionary Baptist Church. These participants were all African-American adults aged 65 and above. The participants completed a demographic questionnaire, the DSES, and the CAD.

Data was collected using two methods. The first was by soliciting responses from the participants on a face-to-face basis and the second was by soliciting responses through the telephone. A total of 18 respondents provided data through telephone interviews, while 11 respondents provided information through face-to-face interviews. Based on this information, 62.07% of the responses were obtained through the telephone (18 out of 29), while 37.93% of the responses were obtained through face-to-face interaction (11 out of 29).

Data on the participants’ gender and age were also collected. Out of the 29 participants, 25 were female (86.21%), while only 4 out of 29 (13.79%) were male. With regard to age, the largest number of participants were those aged between 73 and 76 years of age (12 out of 29, 41.38%), followed by those aged between 81 and 84 years of age (7 out of 29, 24.13%). This information is shown below in Table 1.
Table 1

Demographic Characteristics of Participants

<table>
<thead>
<tr>
<th></th>
<th>N (29)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>4</td>
<td>13.79</td>
</tr>
<tr>
<td>Female</td>
<td>25</td>
<td>86.21</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>65 - 68</td>
<td>2</td>
<td>6.89</td>
</tr>
<tr>
<td>69 – 72</td>
<td>1</td>
<td>3.45</td>
</tr>
<tr>
<td>73 – 76</td>
<td>12</td>
<td>41.38</td>
</tr>
<tr>
<td>77 – 80</td>
<td>2</td>
<td>6.90</td>
</tr>
<tr>
<td>81 – 84</td>
<td>7</td>
<td>24.13</td>
</tr>
<tr>
<td>85 – 88</td>
<td>2</td>
<td>6.90</td>
</tr>
<tr>
<td>89 – 92</td>
<td>1</td>
<td>3.45</td>
</tr>
<tr>
<td>93 – 96</td>
<td>1</td>
<td>3.45</td>
</tr>
<tr>
<td>97 – 99</td>
<td>1</td>
<td>3.45</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not married</td>
<td>3</td>
<td>10.34</td>
</tr>
<tr>
<td>Married</td>
<td>11</td>
<td>37.93</td>
</tr>
<tr>
<td>Divorced</td>
<td>6</td>
<td>20.70</td>
</tr>
<tr>
<td>Widowed</td>
<td>9</td>
<td>31.03</td>
</tr>
</tbody>
</table>

Only one participant’s CAD TS T-score indicated depressive symptomatology. This participant was mailed a formal letter with the resource address of Jenny Heuer, MS, Licensed Professional Counselor, NCC, 2751 Buford Highway, NE, Ste 700, Atlanta, Georgia, 30324, a counselor who specializes in therapy with the elderly.

Results

The data was first processed for descriptive statistics by calculating the measures of central tendency. As shown below in Table 2, the scores of the 29 participants for the DSES measuring spirituality had a mean of $M = 29.83$ (SD = 7.04). Scores within the
sample ranged from a minimum of 15 and a maximum of 43. For the scores for depression, as measured by the CAD, the sample resulted in a mean of $M = 50.79$ (SD = 7.93), with the scores ranging from 33 to 63. Scores for church attendance ranged from 1 to 4, with a mean of $M = 3.41$ (SD = 1.09), while scores for prayer experiences ranged from 1 to 12, with a mean of $M = 4.93$ (SD = 3.55).

Table 2

*Results of Descriptive Statistics Analysis – Measures of Central Tendency*

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Min</th>
<th>Max</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spirituality</td>
<td>29</td>
<td>15.00</td>
<td>43.00</td>
<td>29.83</td>
<td>7.04</td>
</tr>
<tr>
<td>Depression</td>
<td>29</td>
<td>33.00</td>
<td>63.00</td>
<td>50.79</td>
<td>7.93</td>
</tr>
<tr>
<td>Church Attendance</td>
<td>29</td>
<td>1.00</td>
<td>4.00</td>
<td>3.41</td>
<td>1.09</td>
</tr>
<tr>
<td>Prayer Experiences</td>
<td>29</td>
<td>1.00</td>
<td>12.00</td>
<td>4.93</td>
<td>3.55</td>
</tr>
<tr>
<td>Valid N (listwise)</td>
<td>29</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Research Question 1.** The first research question of the study was focused on determining the relationship between spirituality and depression among elderly people. The hypothesis formulated for this research question was:

$H_0$: There is a significant relationship between “spirituality,” as defined by Pargament (1999), and depression among elderly people.

This research question was addressed by conducting a Pearson’s correlation analysis procedure. As shown below in Table 3, there was no statistically significant relationship between spirituality and depression, therefore the hypothesis was rejected.
**Research Question 2.** The second research question of the study was focused on determining the relationship between spirituality and church attendance among elderly people. The hypothesis formulated for this research question was:

\[ H_0: \text{There is a significant relationship between “spirituality,” as defined by Pargament (1999), and church attendance among elderly people.} \]

This research question was addressed by conducting a Pearson’s correlation analysis procedure. As shown below in Table 3, there was a statistically significant large-positive correlation between the two variables \( r = .551, p = .002 \). The \( r \)-value or correlation coefficient is positive, which indicates a direct relationship between the two variables. This means that as the scores for spirituality increase, there is a correspondent increase in church attendance, and vice versa. Hence, based on the results of the correlation analysis, the hypothesis for this research question was accepted.

In addition, for research hypothesis two, the Pearson correlation was \( r = .551 \), which when squared indicated 30 per cent shared variance or the coefficient of determination \( R^2 = 0.30 \). Hence, spirituality helps to explain nearly 30 per cent of the variance in church attendance responses.

**Research Question 3.** The third research question of the study was focused on determining the relationship between spirituality and prayer experiences among elderly people. The hypothesis formulated for this research question was:

\[ H_0: \text{There is a significant relationship between “spirituality,” as defined by Pargament (1999), and prayer experiences among elderly people.} \]
This research question was addressed by conducting a Pearson’s correlation analysis procedure. As shown below in Table 3, there was no statistically significant relationship between spirituality and prayer experiences. Hence, based on the results of the correlation analysis, the hypothesis for this research question was rejected.

Table 3

Results of Pearson’s Correlation Analysis

<table>
<thead>
<tr>
<th></th>
<th>Church Attendance</th>
<th>Prayer Experiences</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Depression</strong></td>
<td>.173</td>
<td>.551*</td>
</tr>
<tr>
<td><strong>Spirituality</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pearson Correlation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.369</td>
<td>.002</td>
</tr>
<tr>
<td><strong>N</strong></td>
<td>29</td>
<td>29</td>
</tr>
</tbody>
</table>

*. Correlation is significant at the 0.05 level (2-tailed).

Summary

The purpose of this quantitative, non-experimental, correlational research study was to determine if there was a relationship between levels of spirituality and depressive symptoms, church attendance, and prayer experiences in elderly people. To address this purpose, three research questions were formulated and data was collected from a sample of 29 members of the Greater Pleasant Hill Missionary Baptist Church. The data
collected was analyzed using Pearson’s correlation analysis procedures to determine the nature and existence of statistically significant relationships between the variables. Based on the results of the correlation analysis, there was a large-positive statistically significant relationship between spirituality and church attendance, but not between spirituality and depression, and spirituality and prayer experiences. These results will be discussed in line with existing literature in the next chapter of this study, along with the conclusions of the study, and the recommendations based on these results.
CHAPTER 5
DISCUSSION

Anyone, no matter their age, can begin their spiritual journey (Temple & Gall, 2016). Older adults can embark, or continue their spiritual journeys, as they progress through their lives (Fowler, 1981). Depression is the most predominant mental health condition among older adults (Blegen, 2016). Researchers have indicated that older adults who have frequently participated in religious activities have lower blood pressure; protection against suicide; and have an increased sense of self-worth and self-esteem, lower anxiety, and lower rates of depression (Koeing, 1995; Koenig et al., 1998; Krause, 1995; Levin, 1994; Rushing et al., 2013). The theory guiding this research is Pargament’s (2009) theoretical model for understanding and evaluating spirituality, as it provides a background for understanding how persons of any age begin their spiritual journeys comprised of diverse pathways to the sacred, as well as a multifaceted description of their possible sacred ending. The purpose of this quantitative study was to determine if there was a relationship between the level of spirituality and levels of depressive symptoms, church attendance, or prayer experiences in elderly people.

Focusing on the importance of the relationship between the level of spirituality and levels of depressive symptoms, church attendance, or prayer experiences in elderly people and results of the current research, this chapter will include a summary of the
findings, a discussion of the findings, study limitations, implications and recommendations for future research.

Summary of Findings

To review, based on Pargament’s (2009) theoretical model for understanding and evaluating spirituality and previous research, the following three research questions and hypotheses were proposed:

RQ1: What is the relationship between “spirituality,” as defined by Pargament (1999), and depression among elderly people?

H_a: There is a significant relationship between “spirituality,” as defined by Pargament (1999), and depression among elderly people.

RQ2: What is the relationship between “spirituality,” as defined by Pargament (1999), and church attendance among elderly people?

H_a: There is a significant relationship between “spirituality,” as defined by Pargament (1999), and church attendance among elderly people.

RQ3: What is the relationship between “spirituality,” as defined by Pargament (1999), and prayer experiences among elderly people?

H_a: There is a significant relationship between “spirituality,” as defined by Pargament (1999), and prayer experiences among elderly people.

Results of the analysis of the first and third research questions and hypotheses indicated there were no statistically significant relationships between spirituality and depression and prayer; therefore, both hypotheses were rejected.
In contrast, the results of the analysis of the second research question and hypothesis indicated there was a large-positive correlation between spirituality and church attendance \((r = .551, p = .002)\). Therefore, the hypothesis was accepted.

The coefficient of determination \((R^2 = 0.30)\) indicated 30 per cent shared variance, hence, spirituality helps to explain nearly 30 per cent of the variance in participant’s responses to church attendance.

These findings sought to fill the gap in the literature demonstrating a lack of consensus as to the relationship of spiritual practices and the prevalence of depression among the elderly due to a lack of research in this area.

These findings also provide several contributions. First, they contribute to the data on the relationship between spirituality and depression, church attendance, and prayer among elderly adults in America with the purpose of increasing awareness among clergy, chaplains, pastoral care providers, and pastoral counselors on the effectiveness of evidenced-based pastoral care and counseling interventions for depressed elderly people. Secondly, this study adds to the body of research that identifies an association between spiritual beliefs and the healthcare field. Finally, this study is significant because it can provide additional research supporting the validity of Pargament’s (2009) theoretical model for understanding and evaluating spirituality. These contributions will be addressed in the discussion of the findings section for each research question.
Discussion of the Findings

The purpose of RQ1 was to determine a relationship between spirituality and levels of depression among elderly people. The hypothesis was formulated from this research question. The hypothesis was rejected for this study indicating there is no statistically significant relationship between spirituality and levels of depression.

The results related to the first research question have a triple purpose. The first purpose is to contribute to the data on the relationship between spirituality and depression among elderly adults in America with the purpose of increasing awareness among clergy, chaplains, pastoral care providers, and pastoral counselors on the effectiveness of evidenced-based pastoral care and counseling interventions for depressed elderly people.

For example, Rajagopal, Mackenzie, Bailey, and Lavizzo-Mourey (2002) conducted a study to determine the efficiency of the use of the Prayer Wheel as a spiritually-based intervention that decreased “subs syndromal anxiety and depression” among 26 elderly persons diagnosed with the mental illness of minor depression (p. 153). The elderly participants lived in “continuing care retirement communities” (p. 156). Rajagopal et al. (2002) reported that the participants had a significant reduction in anxiety and a result of decreased depression. Rajagopal et al. (2002) also reported that after a six-week follow up, the participants with a decrease in depression scores had continued to use the Prayer Wheel and that those participants who had not continued to use the Prayer wheel experienced an increase in depression scores. The findings of this study suggested that clergy, chaplains, pastoral care providers, and pastoral counselors could become
aware of how to use the Prayer Wheel during pastoral counseling sessions or in group settings as a spiritual intervention for depression.

Secondly, the results related to RQ1 add to the body of research that identifies an association between spiritual beliefs and their relation to the healthcare field. For example, Baker’s (2001) earlier study identified the importance of chaplains in healthcare.

Baker (2001) conducted a study in which the effectiveness of pastoral care was explored as both a buffer for depression and as a “prophylactic to deter” the possible undesirable influence of life situations and changes in life (p. 63). The elderly sample was recruited from “independent-living, assisted-living” and skilled-care nursing homes (Baker, 2001, p. 67). The sample consisted of elderly people, of which 40 were actively on anti-depression medication, 40 were diagnosed as being at risk to develop depression, and 40 were recruited using the convince method. The treatment group received 30-minute weekly visitations from the chaplain for the duration of six months.

The control group received the minimal amount of pastoral care from the chaplain. Baker (2001) concluded that the depression post-test scores for the treatment group decreased. The depression scores for the follow-up treatment group increased when the pastoral care intervention stopped. Baker (2001) also found the following pastoral counseling interventions as significantly correlated with the decrease of depression scores: counseling for issues raised during the pastoral intervention, prayer, grief counseling, utilizing the life review technique, actively listening, and the providing of
blessings. Pastoral care providers may utilize these pastoral care techniques during visitations in a health care setting.

Finally, the results of RQ1 were significant because they provide additional research supporting the validity of Pargament’s (2009) theoretical model for understanding and evaluating spirituality. For this research study question, the hypothesis was rejected. This indicates that there is no relationship between spirituality and depression among the elderly sample. These findings support Pargament’s (2009) theoretical model for understanding and evaluating spirituality because an elderly individual may exit the “spiritual struggle” phase and embrace “spiritual disengagement” or “spiritual transformation” (Pargament, 2009, p. 214, 215). There is no defined or permanent pattern in Pargament’s (2009) theoretical model for understanding and evaluating spirituality, just as there is no relationship between spirituality and depression as shown in this study.

The second research question sought to determine a relationship between levels of spirituality and church attendance among elderly people. The results indicated there was a large-positive correlation between spirituality and church attendance ($r = .551$, $p = .002$).

The results related to RQ2 provide a dual purpose. First, the results contribute to the data on the relationship between spirituality and church attendance among elderly people in America with the purpose of increasing awareness among clergy, chaplains, pastoral care providers, and pastoral counselors regarding the effectiveness of evidenced-
based pastoral care and counseling interventions for elderly people. For example, participation in non-public religious activities and public religious activities defend against and help assist persons in their healing from depression (RonneBurg et al., 2014).

Secondly, the results of RQ2 indicate a large-positive statistical significance in the relationship between levels of spirituality and church attendance. This also provides additional research supporting the validity of Pargament’s (2009) theoretical model for understanding and evaluating spirituality.

For example, during the “threat, violation, or loss” phase, an individual can pick from seven “conservational spiritual coping” methods to maintain their spirituality (Pargament, 2009, p. 215). Of the seven, the results of RQ2 validated the third “conservational spiritual coping” method (Pargament, 2009, p. 215), “seeking support from clergy/congregation members,” meaning the individual searches for affection and attention from the members of clergy and the congregation (Pargament, 2009, p. 219).

The third research question sought to determine a relationship between spirituality and prayer experiences among elderly people. The hypothesis was rejected for this study and indicated there was no statistically significant relationship between levels of spirituality and prayer experiences.

The results related to RQ3 serve a triple purpose. First, the results add to the data on the relationship between spirituality and church attendance among elderly people in America by increasing awareness among clergy, chaplains, pastoral care providers, and
pastoral counselors on the effectiveness of evidenced-based pastoral care and counseling interventions for elderly people.

For example, White (2004) reported on pastoral and spiritual care techniques from the Challenge Depression Manual. The Challenge Depression Manual refers to the management of mild depression in aged care institutions using pastoral and spiritual care approaches. The Challenge Depression Manual includes the function of pastoral care as offering the mildly depressed resident the “gift of time and listening” as he/she transitions from independent living into residential care (White, 2004, p. 96). The ministry of religious presence provides the resident with the power to decide if they prefer the ministry of sacred readings, prayer, religious sacraments, or the “rite of passage” (White, 2004, p. 96).

White’s (2004) suggestions do not limit the pastoral caregiver to prayer as the only technique to decrease mild depression; therefore, the findings of RQ3 serve as a precaution for all pastoral care providers to not rely on requested prayer experiences or expression of non-prayer experiences as an indication of spirituality or connection with God in mildly depressed elderly people. If a mildly depressed elderly person asks the pastoral care provider to read sacred text, their request is not a direct indication of their spirituality or prayer experiences. These conclusions support the results of this study that indicate there was no statistically significant relationship between spirituality and prayer experiences.
Last, the results of RQ3 are significant because they provide additional research supporting the validity of Pargament’s (2009) theoretical model for understanding and evaluating spirituality during the “spiritual struggle” phase (p. 215). One type of struggle is with the high power. During this struggle, the individual may express that the higher power’s presence abandoned them, display feelings of being disciplined by the higher power, or show rage and dread projected toward the higher power.

If an individual believes the higher power’s presence has abandoned them, the person may be attempting to talk or pray to God, but not feeling the higher power’s manifested presence, contributing to a low level of spirituality. For example, the individual may project rage to the higher power during prayer experiences but may not feel connected to the Divine while experiencing low levels of spirituality. In contrast, the individual may experience a high level of spirituality because the Divine is disciplining she/he, resulting in low or non-existent prayer experiences. The results of this study validate Pargament’s (2009) theoretical model for understanding and evaluating spirituality by supporting the lack of a relationship between spirituality and prayer experiences.

Limitations

There are several limitations to consider during this study. The participants of this study were a convenience sample of 29 African-American congregants from Greater Pleasant Hill Missionary Baptist Church in metro Atlanta, Georgia who are physically able to attend church services. Therefore, due to selection bias, generalizations are
limited to this geographical region, type of church, and the congregants, used in this study.

The second limitation was the small sample size of 29. The researcher conducted a bivariate correlation with three variables using the small sample size of 29. The minimum sample size of 56 should be used to conduct a bivariate correlation for the results to be generalizable, therefore, the results of this study may not be generalizable to the population due to the small sample size of 29 participants.

Another limitation was the measure of church attendance at Greater Pleasant Hill Missionary Baptist Church in metro Atlanta, Georgia. Church attendance was a limitation because it did not differentiate between the possible impacts of or participation in religious activities, religious belief systems, or the religious body (Van Wagoner et al., 2014).

The fourth limitation was the CAD was not normed for persons above the age of 79 years. Several participants in the study were 79 years of age or older. Dr. Bracken, the author of the CAD, explained via email that the CAD was not normed for individuals above 79 years of age for two reasons. First, there are not many people over 79 years of age who seek mental health services “for depression for the first time.” Last, it would have been challenging “to get a normative sample beyond” age 79.

A fifth limitation was conducting the study on the telephone. When speaking with some participants on the telephone, there were several interruptions. Some participants were caretakers of their grandchildren or children. During two to three telephone calls
with some participants, the participants would ask the researcher to hold on while he/she cared for a family member. The wait time would interrupt the research study.

Another limitation was this research study’s utilization of Pargament’s (1999) definition of spirituality. Pargament (1999) defined spirituality as “a search for the sacred” (Pargament, 1999, p. 12). The researcher chose this operational definition because it was nebulous and did not restrict the person into one particular path of “searching for the sacred” (Pargament, 1999, p. 12). For example, in a 24-hour time period, an individual may choose to seek God during private prayer time in the morning, choose to seek God by attending mid-day Bible study, and choose to seek God by attending evening leisure activities with family. One’s search for the Divine can manifest in a myriad of different paths.

Seventh, self-report surveys were utilized to obtain data for this study. Construct validity is a major issue when researchers utilize self-reports (Kormos & Gifford, 2014). Construct validity is defined as the extent to which a test precisely assesses an underlying construct (Kormos & Gifford, 2014). Participants of the study may have exaggerated or answered survey questions in a subjective manner, compromising construct validity (Kormos & Gifford, 2014). Therefore, the use of self-report surveys contributed to the limitations of the study.

Lastly, there were five natural limitations of the study to be considered. One limitation was the small population of 98 church members, thus, limiting the sample size. Another natural limitation was availability of transportation to attend church services.
The third natural limitation was possibly fatigue from answering the DSES, CAD, and the demographic questionnaire over the telephone or face-to-face. In addition, the participant’s own mental health status in terms of taking these studies may have been a natural limitation.

The last natural limitation may have been the spiritual mindset of the participants. When the researcher initially asked the pastor of Greater Pleasant Hill Missionary Baptist Church for permission to conduct the study, the pastor predicted that the results would indicate there was no significant relationship between spirituality and depression for church members 65 years of age or older. The pastor’s prediction contradicts research literature which indicates high correlations between spirituality and levels of depression among elderly people.

The pastor further explained that church members age 65 and older were people who highly valued the Bible by living and speaking scripture daily. These congregants did not consider themselves as “victims.” In contrast, they considered themselves a triumphant congregation who wanted to attend church services, who eagerly shared their testimonies, who had their confidence in Heaven, and who were expecting the rapture of Jesus Christ.

Implications

The findings of this study present several implications for spirituality and levels of depression, church attendance, and prayer which require discussion. First, existing instrumentation to measure levels of depression. Although the CAD is a well-known
instrument to measure depression, it does not measure depression beyond the age of 79 years. Therefore, a new measurement should be required for adults over age 79.

Second, RQ1 investigated the relationship between spirituality and levels of depression. The study did not find the relationship statistically significant regarding levels of depression; however, both the DSES and CAD TS T-scores were low. For example, the DSES highest score of 90 would indicate low spirituality. The lowest DSES score indicated by this research study was 15 and the highest score was 43, indicating nobody in the sample ranked high in spirituality. Next, a CAD TS T-Score of 60 or higher indicated mild clinical risk and a score of 59 or lower indicated normal range. The lowest CAD TS T-Score indicated by this research was 33 and the one highest was 63. This has several implications.

One implication is that pastoral caregivers should not associate self-reported levels of spirituality with levels of depression. Another implication is that an individual may report low levels of spirituality as indicated by the DSES yet may report high levels of depression. Pastoral care providers should seek training in recognizing the signs of depression among the elderly and provide referral resources for the individual to obtain counseling from a licensed professional.

Third, RQ2 investigated the relationship between spirituality and church attendance. The study found the relationship statistically significant. This implies that pastoral caregivers should not minimize the church experience for elderly people. Pastoral care providers should not ignore but rather embrace the traditions of the elderly
population during church services. For example, pastoral care providers should listen to
the elderly congregant’s suggestions about song selection, order of service, alter call
methods, or other church decisions. Listening and implementing elderly congregant’s
ideas would best serve this population.

Fourth, RQ3 investigated the relationship between spirituality and prayer
experiences. The study did not find the relationship statistically significant regarding
prayer experiences. These findings imply that pastoral care providers should not judge an
individual’s level of self-reported spirituality or prayer experiences. For example, one
may express a negative spiritual experience in which he/she believes God is manifesting
wrath or anger, therefore, rendering them unable to have a prayer experience.

Recommendations for Future Research

To further this study, it is recommended that qualitative methods be used to gather
more information about the relationship between spirituality and levels of depression,
church attendance, and prayer among elderly person. With the use of this qualitative
method, participants would be given the opportunity to explain their feelings and belief
systems about spirituality, levels of depression, church attendance, and prayer. Also,
future researchers may utilize a different definition of spirituality.

In addition, repeating this study with a different religious denomination of elderly
adults may change the significance of the statistical results. Third, repeating this study
with a different gerontological depression scale to measure depression among elderly
persons could result in statistically significant findings. Fourth, when repeating this study, the researcher could use a different definition of spirituality.

Fifth, the researcher discussed having a sample size of 29 from the 98-member congregants listed on the Greater Pleasant Hill Missionary Baptist Church address list, which is approximately 30% of the entire church congregation. When repeating this study, the researcher may move toward publication of this research with the goal of having 50% of the congregation in the sample size.

Lastly, repeating this study using the same scales, with a population of elderly people who live in nursing homes or with a larger population who attend church, may also change the results.

Conclusion

The purpose of this quantitative study was to determine if there was a relationship between the level of spirituality and levels of depressive symptoms, church attendance, or prayer experiences in elderly people. A sample of 29 elderly people from Greater Pleasant Hill Missionary Baptist Church were asked to respond to the demographic questionnaire, the DSES, and the CAD, with the purpose of gathering information about levels of spirituality and depression symptomology, church attendance, and prayer experiences. Three research questions were formed and the data was analyzed using Pearson product-moment correlation analysis.

Based on the results for RQ1 using correlational analysis, the hypothesis was rejected, indicating no statistically significant relationship between spirituality and levels
of depression. Next, based on the results of correlational analysis for RQ2, the hypothesis was accepted; therefore, indicating a statistically significant, large-positive correlational relationship between spirituality and church attendance. Lastly, based on the results RQ3 using correlational analysis, the hypothesis was rejected, indicating no statistically significant relationship between spirituality and prayer experiences.

This study sought to fill a gap in the literature concerning the relationship between spirituality and levels of depression, church attendance, and prayer experiences. The findings and conclusions of this study are grounded in the community of the sample. Future studies should consider quantitative and qualitative research methods to continue to fill this research gap.

The researcher initially chose Pargament’s (1999) definition of spirituality because it was nebulous; however, the researcher’s operational definition of spirituality has evolved and is twofold. After reflecting on what was learned through this study, the researcher might now define spirituality as “the Holy One’s revelation to an individual or the individualistic pathway one pursues in expectation to receive revelation from the Holy One.”
REFERENCES


89


APPENDIX A

HUMAN SUBJECTS APPROVAL
Dear Participant,

I am Monique Jimerson, M.Div., M.S., and a doctoral candidate under the direction of Professor David Lane, Ph.D. in the Penfield College Counseling Department at Mercer University. You are invited to participate in a research study titled “The Relationship Between Spirituality and Depression, Church Attendance, and Prayer Among Elder Adults.” The purpose of this research study is to determine if there is a relationship between spirituality and depression, church attendance, and prayer among aging elder adults.

Your participation in this study is voluntary at all times. If you choose not to participate or to withdraw from the study at any time, there will be no penalty to you in any way. If you decide not to participate, or to leave the study, there will be no penalty or any effect on your relationship with the researcher, or any other negative consequences.

You are being asked to participate in the study because you are age 65 years and older.

I am requesting your participation, which will involve completing a demographic questionnaire and two paper and pencil questionnaires about spirituality and depression. The total time commitment would be about 20 minutes to complete the surveys.

The surveys will be collected via being hand received or via telephone.

All of the responses to both questionnaires will remain anonymous and cannot be linked to you in any way. No identifying information about you will be collected at any point during the study and both surveys will only be identified with a random number. The results of the study may be published but your name will not be known. You may withdraw from the study at any time.

Mercer University IRB
Approval Date: 02/07/2019
Protocol Expiration Date: 11/11/2019
However, once both completed surveys are received back into the hands of the principal investigator or if surveys are completed via the telephone, there will be no way of withdrawing your responses from the study because the survey contains no identifying information. Study data will be kept in the paper format and manually uploaded to a .csv file. Access to paper data will be protected by storage in a locked, safe space. Only myself and Dr. David Lane will have access to the data.

Any risks to you associated with this study are not expected to be greater than anything you encounter in daily living. While you may not experience any direct benefits from participation, information collected in this study may benefit during future life encounters by helping to make you more aware of daily spiritual encounters or aware of the manifestation of depressive symptoms. If the Clinical Assessment of Depression results indicate depressive symptoms, I will provide a counseling resource to you in a formal letter via hand delivery or mail.

If you have any questions concerning the research study or need for psychological services, please contact the principal investigator, Monique Jimerson, at 404.254.8906, or faculty mentor, Dr. W. David Lane at 678.547.6301 or you may send an email to: lane_wd@mercer.edu.

If you have any questions about your rights as a research participant, please contact the Mercer University Institutional Review Board at 478.301.4101 or orc_research@mercer.edu.

Thank you,
Monique Jimerson, M.Div., M.S.
THE RELATIONSHIP BETWEEN SPIRITUALITY AND DEPRESSION,
CHURCH ATTENDANCE, AND PRAYER AMONG ELDER ADULTS

Informed Consent

You are being asked to participate in a research study. Before you give your consent to volunteer, it is important that you read the following information and ask as many questions as necessary to be sure you understand what you will be asked to do.

Investigators
Monique Elise Jimerson, M. Div., M. S. Penfield College of Mercer University, Counseling Department
3001 Mercer University Drive, Atlanta, GA 30341, 404.254.8906
Dr. W. David Lane, Ph.D. Penfield College of Mercer University, Counseling Department
3001 Mercer Drive, Atlanta, GA 30314, 678.547.6301

Purpose of the Research
This research study is designed to find out if there are any links between spirituality, church attendance and the prayer life of older persons (65 years and older) and feelings of depression.

The data from this research will be used to as part of the requirements for a doctoral degree.

The data will be used to complete my doctoral degree.

Procedures
If you volunteer to participate in this study, you will be asked to read through this form and sign it if you agree to take part in the study. You will be asked to complete the survey questions included in the pack and hand everything to the researcher by using the envelope provided.

If you volunteer to participate in this study via telephone, I will read through this form and ask for your verbal consent to participate in this study. You will be asked to answer the survey questions via telephone.

Your participation will take approximately 20-30 minutes only.

Potential Risks or Discomforts

Mercer University IRB
Approval Date: 02/07/2019
Protocol Expiration Date: 11/11/2019
There are no foreseeable risks to this research. You might get tired while completing the survey forms.

Potential Benefits of the Research

There are no benefits to you for taking part in this study.
The results of this study may help counselors to better assist older church-going persons with depression.

Confidentiality and Data Storage

All obtained information will be held in strict confidentiality and will only be released with your permission. The results of this study may be published but your information such as your name and other personal information will not be revealed. All electronic data will be kept on a password protected hard drive which will be stored in a specially bought lock box and stored in a different drawer in the locked file cabinet in the researcher’s home office which is locked when not in use. All documentation will be maintained for a minimum of 5 years before destroying it either by shredding or permanent deletion.

Participation and Withdrawal

Your participation in this research study is voluntary. As a participant, you may refuse to participate at any time. To withdraw from the study please voice your unwillingness to participate while I am at your residence or while I am on the telephone.

Referral for Counseling

If the survey results show that you would benefit from visiting a counselor, I will hand deliver or mail a formal letter to your residence with a referral to a counselor who specializes in working with older persons.

Questions about the Research

If you have any questions about the research, please speak with the Mercer University Institutional Review Board at 478.301.4101 or orc_research@mercer.edu. Alternatively, you may contact the principal investigator, Monique Jimerson, at 404.254.8906, or faculty mentor, Dr. W. David Lane at 678.547.6301 or you may send an email to: lane_wd@mercer.edu.

Reasons for Exclusion from this Study

Persons younger than 65 years or who are not members of the Greater Pleasant Hill Missionary Baptist Church may not participate in this study.

This project has been reviewed and approved by Mercer University’s IRB. If you believe there is any infringement upon your rights as a research subject, you may contact the IRB Chair, at (478) 301-4101. You have been given the opportunity to ask questions and these have been answered to your satisfaction.

Mercer University IRB
Approval Date: 02/07/2019
Protocol Expiration Date: 11/11/2019
<table>
<thead>
<tr>
<th>Signature of Investigator</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monique E. Jimerson</td>
<td></td>
</tr>
<tr>
<td>Name of Investigator (Print)</td>
<td></td>
</tr>
<tr>
<td>Signature of the Participant</td>
<td></td>
</tr>
</tbody>
</table>

Mercer University IRB
Approval Date: 02/07/2019
Protocol Expiration Date: 11/11/2019
Fig. 11.1 The spiritual process
APPENDIX C
DAILY SPIRITUAL EXPERIENCE SCALE PUBLISHER CONSENT
Re: Seeking Permission to use the Daily Spiritual Experience Scale from M. Jimerson

Monique Elise Jimerson
Sat 6/9/2018 11:05 AM
Sent Items

To: Lynn Underwood <lynnunderwood@researchintegration.org>

Daily Spiritual Experience Scale Registration Form

In affixing your name to this form you agree to include:

"© Lynn Underwood www.dsescale.org permission required to copy or publish"

Daily Spiritual Experience Scale > Home
www.dsescale.org

Homepage for information about the Daily Spiritual Experience Scale (DSES), a scale used to measure one aspect of spirituality, created by Lynn G. Underwood.

on any copies of the scale you distribute, print or publish, and appropriately cite one of the papers below in your publication of results:

If you are using the open-ended form or checklist form of the scale, contact me for a copy with the appropriate acknowledgments.

www.dsescale.org contains an accurate form of the scale and additional information. It is the best source for updated information about the scale. Scoring information can be found in Underwood (2006) and Underwood (2011).

Daily Spiritual Experience Scale > Home
www.dsescale.org
Homepage for information about the Daily Spiritual Experience Scale (DSES), a scale used to measure one aspect of spirituality, created by Lynn G. Underwood.

In affixing your name to this form you agree to keep Lynn Underwood informed of uses of the scale, results from your work, and publications and presentations that come from use of the scale.  
lynn@lynnunderwood.com  

And you are giving permission for Lynn Underwood to send you occasional updates related to this work.

Your full name and title:  
Monique E. Jimerson, M. Div., M.S., Principal Investigator

Your email address(es):  
monique.elise.jimerson@live.mercer.edu

College/University/Other Organization:  
Penfield College, Counseling Department, Mercer University, Atlanta, Georgia

Full Address, including city and country:  
Penfield College  
Counseling Department  
Mercer University  
3001 Mercer University Drive, Atlanta, Georgia, 30341

Date:  
June 9, 2018

Reason for use of the scale and/or study description. Give details.  
I am conducting research as part of the requirements for the Doctor of Philosophy in Counselor Education, and Supervision degree under the supervision of Dr. W. David Lane at Penfield College, Counseling Department at Mercer University, Atlanta, Georgia. The title of my dissertation is “The Relationship Between Spirituality and Depression, Church Attendance, and Prayer Among Elder Adults.” A sample of elderly persons age 65 and over will be asked to respond to the Daily Spiritual Experience Scale (DSES) with the purpose of gathering information about levels of spirituality.
Work supported by a Research Grant or other support?

- No

Is your work for profit?

- No

How did you find the scale and my contact information?

- I found the scale and contact information on the Daily Spiritual Experience Scale website.

Which language version of the scale are you using?

- English

How many individuals do you expect to administer the scale to?

- Up to 100 elderly persons age 65 and older

Why have you picked this particular scale (give details)?

I have picked the DSES for several reasons. First, an analysis of the DSES scale was performed by Underwood and Teresi (2002) and the results indicated reliability with high internal consistency: Cronbach’s alpha = 0.94 and 0.95. Second, the DSES factor analysis established a single factor of spirituality (Ellison & Fan, 2008; Underwood & Teresi, 2002). Last, predictive, construct, and concurrent validity have been confirmed by studies that have used populations for samples from the United States (Loustalot et al., 2006; Underwood & Teresi, 2002), as well as international populations for samples (Amr, El-Mogy, & El-Masry, 2013; Bennett & Shepherd, 2013).

References


---

**From:** Lynn Underwood <lynnunderwood@researchintegration.org>
**Sent:** Saturday, June 9, 2018 10:57:35 AM
**To:** Monique Elise Jimerson
**Subject:** Re: Seeking Permission to use the Daily Spiritual Experience Scale from M. Jimerson

Dear Monique

You have my permission to use the Daily Spiritual Experience Scale for non-profit use if you return the attached registration form to me and agree to the terms of use.

I have written a book on the scale designed for personal and professional use, *Spiritual Connection in Daily Life: 16 Little Questions That Can Make a Big Difference*, and it has been published in paperback. Information on it can be found at [www.lynnunderwood.com/book](http://www.lynnunderwood.com/book)

I think it would be helpful in your work with the scale. It is not expensive, and is on Amazon and in bookstores. In 2016 an international ebook is now available on Amazon international sites.

There was a recent public radio interview on the scale
[http://www.abc.net.au/radionational/programs/spiritofthings/are-you-spiritually-connected/8376242](http://www.abc.net.au/radionational/programs/spiritofthings/are-you-spiritually-connected/8376242)

You might find it of interest.

Best wishes to you in your life and in your work,

Lynn Underwood PhD
Senior Research Associate
Inamori International Center for Ethics,  
Case Western Reserve University

www.dsescale.org

On Jun 9, 2018, at 10:34 AM, Monique Elise Jimerson <Monique.Elise.Jimerson@live.mercer.edu> wrote:

Lynn Underwood, Ph. D.  
Senior Research Associate  
Inamori International Center for Ethics, Case Western Reserve University  
Honorary Fellow, University of Liverpool, UK

June 9, 2018

Dear Dr. Underwood,

Currently I am a doctoral candidate in the Penfield College Counseling Department at Mercer University, Atlanta, Georgia. I am conducting research as part of the requirements for the Doctor of Philosophy in Counselor, Education, and Supervision degree under the supervision of Dr. W. David Lane. The title of my dissertation is “The Relationship Between Spirituality and Depression, Church Attendance, and Prayer Among Elder Adults.”

The purpose of this letter is to obtain written permission to use and print the Daily Spiritual Experience Scale (DSES). I will provide the data collected from the DSES to you for the purpose of further validation of this instrument.

Thank you for your time.

Sincerely,

Monique Jimerson, M. Div., M.S.
APPENDIX D

CLINICAL ASSESSMENT OF DEPRESSION PUBLISHER CONSENT
Re: Seeking Permission to use the Clinical Assessment of Depression Scale from M. Jimerson

From: Bracken, Bruce A <babrac@wm.edu>
Sent: Saturday, June 9, 2018 11:03:56 AM
To: Monique Elise Jimerson
Subject: Re: Seeking Permission to use the Clinical Assessment of Depression Scale from M. Jimerson

Hi Monique,

No permission is needed to use the CA. You can obtain the scale from Psychological Assessment Resources (PARinc.com).

Good luck with your study!

Best, Bruce Bracken

Sent from my Verizon, Samsung Galaxy smartphone

-------- Original message --------
From: Monique Elise Jimerson <Monique.Elise.Jimerson@live.mercer.edu>
Date: 6/9/18 10:48 AM (GMT-05:00)
To: "Bracken, Bruce A" <babrac@wm.edu>
Subject: Seeking Permission to use the Clinical Assessment of Depression Scale from M. Jimerson

Bruce A. Bracken, Ph. D.
School of Education
The College of William & Mary
310 Monticello Avenue
Williamsburg, VA 23187

June 9, 2018

Dear Dr. Bracken,
Currently I am a doctoral candidate in the Penfield College Counseling Department at Mercer University, Atlanta, Georgia. I am conducting research as part of the requirements for the Doctor of Philosophy in Counselor, Education, and Supervision degree under the supervision of Dr. W. David Lane. The title of my dissertation is “The Relationship Between Spirituality and Depression, Church Attendance, and Prayer Among Elder Adults.”

The purpose of this letter is to obtain written permission to purchase and use the Clinical Assessment of Depression (CAD). My dissertation committee member, Morgan E. K. Riechel, Ph. D., will provide supervision for scoring and interpretation of results.

Thank you for your time.

Sincerely,

Monique Jimerson, M. Div., M.S.
APPENDIX E

GRADUATE RESEARCH PERMISSION AT

GREATER PLEASANT HILL MISSIONARY BAPTIST CHURCH
Reverend Griffin
Head Pastor
Greater Pleasant Hill Missionary Baptist Church
1029 Joseph E. Boone Blvd.
Atlanta, Georgia 30314

Re: Graduate Research Permission

Dear Reverend Griffin,

I am a doctoral candidate in Penfield College Counseling Department at Mercer University, Atlanta, Georgia. I am conducting research as part of the requirements for the Doctor of Philosophy in Counselor, Education, and Supervision degree. The title of my research project is “The Relationship Between Spirituality and Depression, Church Attendance, and Prayer Among Elderly People.” The purpose of my research is to evaluate the relationship between levels of spirituality and manifestation of depressive symptoms, church attendance and prayer among elderly people.

First, I am writing to request your permission to utilize your name, telephone, and address membership list of elders age 65 and over to recruit participants for my research. Participants of the study will be asked to complete two surveys, the Clinical Assessment
of Depression (CAD) and the Daily Spiritual Experience Scale, and to return the completed surveys via mail to the principal investigator. Participants will be presented with informed consent prior to participating. Taking part in this study is completely voluntary, and participants are welcome to discontinue participation at any time. If results of the CAD indicate depressive symptoms, I will provide resources for the participant.

Thank you for considering my request. If you choose to grant permission, please provide a signed statement on formal letterhead indicating your approval.

Sincerely,

Monique Jimerson, M. Div., M.S., Principal Investigator
Greater Pleasant Hill Missionary Baptist Church  
1029 Joseph E. Boone Blvd.  
Atlanta, Georgia 30314  
June 10, 2018

To Monique Jimerson:

Thank you for asking to conduct research for your doctoral study at Greater Pleasant Hill Missionary Baptist Church. Yes, I am granting permission for you to utilize the church’s address and telephone membership list of elders age 65 and over to recruit participants for the research study.

Please call me at 404.525.8004 if there are any further questions.

In His service,

Demetrius Griffin, Pastor
APPENDIX F

DEMOGRAPHIC QUESTIONNAIRE
DEMOGRAPHIC QUESTIONNAIRE

Please provide the following demographic information for data analysis purposes. Your responses will be used only for research and will remain completely confidential. Please answer all of the questions.

Thank you.

1. Gender
   - Female
   - Male

2. Age ________

3. Heritage
   - Caucasian
   - African-American
   - Hispanic
   - Asian
   - Native American
   - Other _____________ (specify)
4. Marital Status
   - Not Married
   - Married
   - Divorced
   - Widowed
   - Other _____________(specify)

5. Your current religious affiliation:
   - Christian- Catholic
   - Christian- Other (i.e., Protestant, Baptist, Methodist, etc.)
   - Jewish
   - Agnostic
   - Atheist
   - Other ______________ (specify)

6. How often do you attend church services?
   - Never
   - 1 time per month
   - 2 times per month
   - 3 times per month
   - 4 times per month
7. Please indicate your living arrangement:
   - by myself
   - with spouse/partner
   - with family (biological and non-biological)
   - in an Assisted Living facility
   - in a nursing home
   - homeless

8. How often do you pray?
   - Never
   - 1 time a day
   - 2 times a day
   - 3 times a day
   - 4 times a day
   - 5 times a day
   - 6 times a day
   - 7 times a day
   - 8 times a day
   - 9 times a day
   - 10 times a day
   - 11 times a day
9. In a single word or a few words, “What is spirituality?”

_____________________________________________________________________

________________________

Thank you.
APPENDIX G

DAILY SPIRITUAL EXPERIENCE SCALE
The list that follows includes items you may or may not experience. Please consider how often you directly have this experience, and try to disregard whether you feel you should or should not have these experiences. A number of items use the word ‘God.’ If this word is not a comfortable one for you, please substitute another word that calls to mind the divine or holy for you.

<table>
<thead>
<tr>
<th>Item</th>
<th>Many times a day</th>
<th>Every day</th>
<th>Most days</th>
<th>Some days</th>
<th>Once in a while</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel God's presence.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I experience a connection to all of life.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>During worship, or at other times when connecting with God, I feel joy which lifts me out of my daily concerns.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I find strength in my religion or spirituality.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I find comfort in my religion or spirituality.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel deep inner peace or harmony.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I ask for God’s help in the midst of daily activities.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel guided by God in the midst of daily activities.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel God's love for me, directly.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel God’s love for me, through others.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am spiritually touched by the beauty of creation.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel thankful for my blessings.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel a selfless caring for others.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I accept others even when they do things I think are wrong.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I desire to be closer to God or in union with the divine.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>General question</th>
<th>Not at all</th>
<th>Somewhat close</th>
<th>Very close</th>
<th>As close as possible</th>
</tr>
</thead>
<tbody>
<tr>
<td>In general, how close do you feel to God?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Daily Spiritual Experience Scale © Lynn G. Underwood [www.d sescale.org](http://www.dsescale.org)
Do not copy without permission of the author.

Size was adjusted due to the population who will be studied.
APPENDIX H

CLINICAL ASSESSMENT OF DEPRESSION
### CAD Answer Sheet

<table>
<thead>
<tr>
<th>Instructions: Read each statement carefully and circle the response that describes how you have been feeling lately.</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I am generally a happy person.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Sometimes I am so nervous I can’t think.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. I am usually relaxed.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. Lately, I haven’t been able to express my thoughts very well.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. I often cannot decide what to do.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. Even after a night’s sleep, I still don’t feel rested.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. I don’t like myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. Even unimportant things bother me too much.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. No one seems to care about me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. I’m afraid my life will never get better.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11. I cannot stop worrying.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12. I am so unhappy that I can’t stand it much longer.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13. Life is good to me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14. It feels like no one loves me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15. My days are mostly pleasant.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16. I am always tired.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17. I feel depressed.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18. I feel very alone.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19. I have lost interest in almost everything.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20. I feel like I am not good at anything.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>21. I am excited about the future.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>22. I feel like I am being punished.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>23. I haven’t been able to concentrate.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>24. I worry about bad things happening to me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>25. I am afraid things will never change.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Size was adjusted due to the population who will be studied.
APPENDIX I

REGRESSION LINE TESTING LINEARITY OF THE DATA SET
The purpose of the Normal P-Plots of Regression Standardized Residual (Appendix I) was to determine if the assumptions required for the correlational analysis procedure were met.

*Figure 1.* Regression line testing linearity of the data set
APPENDIX J

REGRESSION LINE TESTING HOMOSCEDASTICITY OF THE DATA SET
Figure 2. Regression line testing homoscedasticity of the data set

The purpose of the scatterplots (Appendix J) was to determine if the assumptions required for the correlational analysis procedure were met.