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RESEARCH ON FAITH AND HEALTH

New Approaches to Old Questions

THOMAS G. PLANTE
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In recent years there has been a surge of interest in relationships between religious faith and health. Domains that traditionally have been viewed as separate are coming together in new ways. This heightened interest is evident not only in academic conferences and journals but also in the popular press. Social and biomedical scientists have focused on religion for more than 100 years and have forged a rich research tradition within psychology, as well as in sociology, gerontology, epidemiology, and nursing (e.g., Durkheim, 1897/1951; James, 1902/1985; Osler, 1910; for reviews see Johnstone, 1997; Levin & Vanderpool, 1991; Wulff, 1991). Typically, however, this work was regarded with a measure of indifference or derision within mainstream psychology and medicine (Levin & Schiller, 1987; Wulff, 1991). Science and faith were viewed as separate worlds with little common ground. Thus the breadth and intensity of current interest, particularly with respect to health, represents a significant change. The landscape has shifted.

Does religious faith influence health? Are religious practices associated with altered risks for morbidity or mortality? Do religious or spiritual individuals tend to enjoy better well-being or mental health across the lifespan? Does spiritual or religious involvement change the way individuals adapt to the demands of chronic illness? This volume brings together some of the

leading investigators who have explored these intriguing questions. Though research is in its early phases, the chapters that follow review some of what we have learned and begin to trace the outlines of the many mysteries that remain.

FAITH AND HEALTH: IRRECONCILABLE DIFFERENCES?

Historically, religion and healing have been closely tied. In Western culture, according to Kuhn (1988), the first known medical license was issued by the church in the 12th century; the license was forfeited in the event of excommunication. These links were largely eroded as medicine became increasingly grounded in Enlightenment rationalist sensibilities and Cartesian philosophy of science, which viewed mind and body as fundamentally separate. The body and corporeal world were seen as the appropriate focus for science, whereas the mind and soul were the purview of the church. Over the past several decades, the dualistic, biomedical model that evolved from this perspective has been increasingly supplanted by a broader, biopsychosocial paradigm (Engel, 1977). Health and illness are viewed as a reflection of reciprocal interactions among biological, psychological, and social influences. This change has been driven in part by massive evidence that psychological and cultural factors have an important impact on health. Is it possible that religious faith is among the tapestry of psychosocial factors that influence health and morbidity?

Some individuals are uncomfortable with inquiry in this area. Methodological and ethical objections have been raised both by scientists (Sloan, Bagiella, & Powell, 1999) and by clergy (*Christian Century*, 1999). Interestingly, some of these reservations would sound familiar to social scientists who embarked on the study of religion a century ago. Some researchers have been hesitant to endorse this line of investigation because the methodological and conceptual challenges seem too daunting. How can one approach scientifically something so ineffable, intangible, and mysterious as religious experience? The arena seems inherently too "fuzzy" and obscure to be conducive to empirical investigation. As noted, however, there is a long history of research on religion in the social and health sciences; although the scientific rigor of these studies varies widely, a broad foundation is in place to support investigations concerning the health correlates and consequences of faith. Moreover, as in any complex field of study, one can expect the methodology to become more rigorous and the questions more refined as the field progresses.

Conversely, another objection is that scientific inquiry will obscure the vitality and richness of religious expression. Attempts to approach religion

from a scientific vantage point are destined to be grossly reductionistic and oversimplified. Clearly, spirituality is, at its core, intensely personal and experiential, and cannot be distilled in a test tube or captured on a questionnaire. The question is whether there are modest traces of the experience that are conducive to scientific investigation, and that can be approached in a meaningful way. We believe the answer to that question is yes, that the question can be approached in much the same manner in which investigators have sought to explore other complex, dynamic experiences (e.g., emotions, family dynamics) without confusing the map with the territory.

Others have objected that focusing on the health correlates of religiousness conveys an implicit message that religion should be evaluated based on whether it is functional according to some arbitrary criterion: "Does it work?" Challenging a utilitarian approach to religion, VandeCreek (1999) argues that "such attempts are degrading to religious faith and practice whose driving force can never be intentional self-enhancement. . . . We need to remind ourselves regularly that true religiousness is a positive end in itself even if it contributes to poorer health" (pp. 200–201). Obviously, irrespective of whether some aspects of religious observance are associated with favorable or unfavorable health outcomes for some individuals, the value of a religious life rests on much broader concerns and commitments. Health researchers do not study religion *per se*; they do not "test" the veracity of doctrinal beliefs or pass judgment on the merits of different theological positions (Hood, Spilka, Hunsberger, & Gorsuch, 1996). Happily, their task is much more modest and prosaic—to study the psychosocial functioning and medical status of human beings engaged in religious pursuits.

TRACING THE CONNECTIONS BETWEEN FAITH AND HEALTH

In their attempts to understand the relationships between psychosocial factors and health, health psychologists have focused on several broad areas of inquiry. One area concerns health behaviors and beliefs, which influence risk of morbidity and mortality (e.g., diet, smoking, alcohol consumption, hygiene, contraceptive use, seeking medical care). A second area concerns adjustment to illness (e.g., coping, quality of life). Life may change in dramatic ways in response to a particular disease—how do patients and their families manage these burdens? A third area concerns physiological functioning and disease end points. How do psychosocial factors influence neuroendocrine activity, immune function, or disease onset and progression?

Religious or spiritual involvement may have relevance for each of these broad areas. It is widely recognized that some health behaviors, such as alcohol consumption or premarital sex, are strongly influenced by religious pro-

scriptions among certain religious communities (Levin & Vanderpool, 1991; Vaux, 1976). As Van Ness (1999) wryly observes, "violent deaths among pacifist Quakers and automobile fatalities among the mostly pedestrian Amish are relatively infrequent" (p. 17). The health implications of religious guidelines are usually positive (e.g., lower rates of smoking-related cancer among Mormons; Troyer, 1988), but they may be negative as well. For example, teenagers from denominations with strict prohibitions against drinking are more likely than other adolescents to abstain from alcohol, but they may be at elevated risk for binge drinking when they decide to indulge (Kutter & McDermott, 1997). Aside from their impact on risky health behaviors, religious beliefs may also shape attitudes toward preventative health practices, such as contraceptive use, cancer screening, and vaccinations (Conyn-van Spaendonck, Oostvogel, van Loon, van Wijngaarden, & Kromhout, 1996; Erwin, Spatz, Stotts, & Hollenberg, 1999; Studer & Thornton, 1987).

Once an illness is diagnosed, religiousness or spirituality may also be important in understanding how individuals adapt. A growing number of studies have focused on faith as a resource for coping with illness and its impact on adjustment and quality of life (Baider et al., 1999; Hughes, McCollum, Sheftel, & Sanchez, 1994; Keefe et al., 2000; Koenig, Pargament, & Nielsen, 1998; Saudia, Kinney, Brown, & Young-Ward, 1991; Tix & Frazier, 1998). In the wake of a debilitating disease, religion may offer a reassuring sense of comfort, a source of social support from other church members, a framework for deriving meaning in adversity, or guidelines for how to cope. Alternately, for a Christian Scientist who has recently discovered a breast lump, religious convictions may contribute to dangerous avoidance of conventional medical care. For a lesbian woman raised in a Fundamentalist Church, with HIV, religion may evoke depleting feelings of shame and guilt. How patients interpret symptoms, define the type of assistance that is needed, and communicate about their problems may all be colored by religion (Walsh, 1999).

More provocatively, religious or spiritual engagement may influence physiological functioning and host vulnerability to disease. A growing number of epidemiological studies point to connections between attendance at services and all-cause mortality among community residents (e.g., Hummer, Rogers, Nam, & Ellison, 1999; Oman & Reed, 1998; Strawbridge, Cohen, Shema, & Kaplan, 1997; McCullough, Hoyt, Larson, Koenig, & Thoresen, 2000; see McCullough, Chapter 3, this volume). Other studies have examined associations between religiousness and survival among individuals who are seriously ill (e.g., Kune, Kune, & Watson, 1992; Oxman, Freeman, & Manheimer, 1995; Ringdal, 1996). These findings are intriguing, though their interpretation is not without controversy (see Sloan, Bagiella, & Powell, 1999; Sloan, Bagiella, & Powell, Chapter 14, this vol-

ume). Relative to the large number of population-based studies on religion and health, there are fewer clinical studies that examine medical outcomes among patients with established disease (e.g., myocardial infarction among patients with coronary heart disease), and still fewer physiological investigations that focus on putative mechanisms of action (e.g., ischemic episodes). Moreover, most studies have examined only very narrow aspects of religion and spirituality, such as church attendance. Nevertheless, research in these areas is expanding rapidly, and our knowledge base is apt to become appreciably more sophisticated in the next few years.

Aside from the potential impact of religious faith on health, interesting questions are also being raised about the potential impact of health on faith (Andrykowski et al., 1996; Collins, Taylor, & Skokan, 1990; Feher & Maly, 1999; Moschella, Pressman, Pressman, & Weissman, 1997). How does a brush with serious illness or disability influence one's spiritual concerns? Under what circumstances does illness usher in stronger faith or painful doubts? How do these responses change over time, and how do they color other areas of life?

Thus there are compelling reasons for both health professionals and students of religion to focus on the interface between religion and health. For those interested in health, religious orientation carries with it a broad array of potential health influences, risk moderators, and coping responses, both positive and negative. For those interested in religion, major health changes are among the nodal transitions in life that may call forth the deepest spiritual needs and responses. There is ample room for collaboration.

DEFINING RELIGIOUSNESS AND SPIRITUALITY: BEYOND THE QUAGMIRE

Among the innumerable challenges of studying religion and health, one of the most fundamental problems concerns definitions. Religiousness and spirituality are both complex, multidimensional constructs—how are they best defined and distinguished? Like love, most of us “know it when we see it,” but operationalizing these terms proves elusive. Unfortunately, research, theory building, and clinical coordination all require some reasonable consensus about how these terms are to be delineated.

Despite more than a century of research and theoretical work devoted to religion, there is no widely accepted definition. Research on spirituality is of a more recent vintage, and attempts to define it are even more challenging. Some writers have steadfastly refused to address issues of definition, whereas others have devoted endless pages to it (Hood et al., 1996). Most would probably agree with the conclusion reached by sociologist J. Milton Yinger more than 30 years ago: “any definition of religion is likely to be

acceptable only to its author" (1967, cited by Hood et al., 1996, p. 4). For most health researchers, "religion" involves a social or institutional dimension. It includes the theological beliefs, practices, commitments, and congregational activities of an organized institution. "Spirituality" has increasingly come to mean a more personal experience, a focus on the transcendent that may or may not be rooted in an organized church or a formal creed (Burkhardt, 1989; Fetzer Institute/National Institute on Aging, 1999; King, Speck, & Thomas, 1994). Not everyone accepts these distinctions, however. Investigators in the field of psychology of religion often use the terms "personal religion" or "faith" to encompass some of what health researchers usually mean by "spirituality"—internalized beliefs and experiences, as opposed to the social and institutional aspects of organized religion (Hood et al., 1996; Wulff, 1991). "Religion" is seen as reflecting *both* personal and institutional qualities (Hill et al., 1998; Pargament, 1997). And, of course, the personal and social domains of religion are not always readily separated.

Just as definitions of religion differ in their emphasis on personal versus institutional dimensions, they also differ in their emphasis on substantive versus functional perspectives. Substantive approaches try to illuminate the central characteristics of religion, such as beliefs about God or the sacred, whereas functional approaches are concerned with how individuals make use of religion (e.g., as a means of managing the ultimate, existential challenges in life; Pargament, 1997; Zinnbauer et al., 1997). Pargament (1997) offers a useful definition that attempts to combine substantive and functional approaches. In his view, religion is a process, "*a search for significance in ways related to the sacred. . . . Religion has to do with building, changing, and holding on to the things that people care about in ways that are related to the sacred*" (1997, p. 32, emphasis in original). He challenges the increasingly popular view that "spirituality" involves personal experience, whereas "religion" is primarily an institutional entity. Instead, spirituality is seen as the major function of religion—the search for the sacred.

Despite these divergent perspectives, most health researchers agree that investigations should encompass several broad dimensions of religious involvement. Which particular dimensions are included and how they are clustered together varies somewhat from one model to the next, but these generally include: religious values and beliefs, personal commitment, spiritual experiences, public or organizational religious practices, private or nonorganizational religious practices, fellowship, and religious or spiritual coping (Davidson, 1975; Fetzer Institute/National Institute on Aging, 1999; Glock, 1962; Hill et al., 1998; Hood et al., 1996). Thus there is some consensus about what elements should be studied even if particular definitions of religion remain a subject of debate.

Defining spirituality is more problematic. Traditionally, spirituality was viewed as part and parcel of religion, and it has been distinguished from reli-

giousness only within the past few decades, as some segments of society became more secular and disenchanting with traditional religious institutions (Turner, Lukoff, Barnhouse, & Lu, 1995; Zinnbauer et al., 1997). Unfortunately, in the effort to separate highly personal experience from formalized theology and rituals, the literature sometimes implies that spirituality is "good," a mature developmental achievement, whereas religion is "bad," stymied by external trappings and social convention (Hill et al., 1998; Zinnbauer et al., 1997).

The nursing literature has been a particularly active forum for discussions about spirituality and health. A commitment to providing holistic care has been part of the impetus for work in this area and is reflected in attempts to avoid mechanistic or reductionistic explanations. Descriptions have focused on concepts such as life principle or unifying force, unfolding mystery, inner strength (e.g., joy, peace), and harmonious interconnectedness with self, others, a higher power, and the environment (Burkhardt, 1989; Dombeck & Karl, 1987; Emblen, 1992; Granstrom, 1985). From a research vantage point, some of these constructs are problematic because their referents are so broad and vague, and because they include some of the health outcomes that they purport to predict (e.g., hope, peacefulness, self-esteem, social affiliation). However, most writers seem to agree that spirituality involves a personal concern with meaning and transcendence—a belief that "what is 'seen' is not all there is" (Elkins, Hedstrom, Hughes, Leaf, & Saunders, 1988). These concerns may or may not be grounded in institutional beliefs and practices. Whether this concern for the transcendent, for something outside of oneself, necessarily involves the sacred is a matter of some debate (Hill et al., 1998). We would suggest that the sacred is an important element. Being captivated by a sunset, a sports team, or a political campaign is not intrinsically a spiritual experience simply because one feels connected to something larger than oneself. However, if these experiences are imbued with a sense of connection with the sacred, or ultimate reality, or things as they really are, then that would represent a spiritually significant experience. The ordinary activities of everyday life can thus become invested with spiritual meaning, as is the case for a Buddhist focusing mindfully on sweeping the steps or eating a raisin, a Jew reciting a prayer while washing her hands, or a Catholic who views preparing a meal as a sacrament (Emmons & Crumpler, 1999).

In sum, religion and spirituality are multifaceted, overlapping constructs whose specific definitions remain a subject of debate; however, there is some agreement about the general outlines and boundaries of these terms. The recent consensus report issued by the National Institute for Healthcare Research (Hill et al., 1998) is a good example of collaborative efforts to identify the basic characteristics of these constructs; both religiousness and spirituality were seen as reflecting "the feelings, thoughts, experiences, and

behaviors that arise from a search for the sacred" (p. 21). In this volume, we use "spirituality" to refer to personal concerns with the transcendent—with something sacred, ultimate, or beyond superficial appearance. Spirituality may or may not be embedded in a formal, established religious tradition. We use the general terms "religiousness," "religious involvement," and "religious orientation" synonymously to refer to both the personal and social/institutional aspects of engagement with an established faith tradition. Relative to these broad terms, we use "religious or spiritual coping" more specifically, to designate particular efforts to manage the demands of a specific, challenging situation (e.g., diagnosis of heart disease, coronary artery bypass surgery). However, given the lack of consensus about specific definitions, in the following chapters the contributors have been invited to delineate what they mean by religiousness or spirituality in the context of their work.

OVERVIEW OF THE BOOK

The chapters that follow review recent findings concerning the intriguing connections between faith and health. They offer a broad survey of current scientific activity that examines physical and mental health outcomes among populations ranging from healthy adults to those with specific clinical disorders, spanning adolescence to old age. We explore emerging trends and highlight areas of controversy. Though most research has focused on white Christian participants, we include discussion of other ethnic and cultural groups. It is difficult for a single volume to do justice to such an expansive field. Of necessity, we have neglected relevant areas of inquiry, such as altruism; important disease entities, such as heart disease; and influential perspectives, such as pastoral care. Nevertheless, we hope this volume provides an engaging overview of a rapidly expanding field.

The first part of the book examines ties between faith and health in the general population. Thoresen, Harris, and Oman (Chapter 2) offer a broad review of the epidemiological and clinical literature. They summarize findings concerning medical and mental health outcomes and highlight important methodological and conceptual issues that need to be considered as the field moves forward. McCullough (Chapter 3) examines links between religious involvement and mortality—a topic that has sparked intense interest and debate. He sifts the evidence from large population-based studies, focusing on insights from a recent meta-analytic review. Wink and Dillon (Chapter 4) share results from a longitudinal study of older adults, currently in their late 60s to mid-70s, who have been followed with repeated assessments since adolescence. Their investigation offers unusually rich data about prospective relationships between religiousness and a broad range of physical and mental health outcomes. The chapter by Worthington, Berry, and Parrott (Chapter 5) shifts from research to theory. They offer an intriguing

conceptual model of forgiveness, which is an area that has commanded growing attention in the past few years. Finally, Sherman and Simonton (Chapter 6) discuss assessment of religiousness and spirituality in health research. They review some of the measures that seem practical for use in health settings and that have established or promising psychometric properties.

The second part of the book moves the focus from the general population to groups of special interest. The first two chapters consider how religious and spiritual involvement shape responses to life-threatening illness. Sherman and Simonton (Chapter 7) examine connections between religious or spiritual variables and adjustment to cancer. Remle and Koenig (Chapter 8) explore faith and health among individuals with HIV. Willis, Wallston, and Johnson (Chapter 9) examine the impact of religious involvement on health behaviors among adolescents and young adults. They explore whether smoking and alcohol use are associated with religious faith, God locus of control, and religious coping. Plante and Sharma (Chapter 10) review ties between religiousness and mental health outcomes. In particular, they discuss depression, anxiety disorders, schizophrenia, substance abuse, and general psychological well-being.

The third part shifts the discussion from descriptive research to clinical practice. Chirban (Chapter 11) discusses clinical assessment of spiritual and religious concerns in the psychotherapy setting. He offers specific guidelines for conducting a clinical assessment that offer rich, qualitative information unavailable in brief research measures. In addition, he considers how assessment of religious concerns might be influenced by the clinician, as well as the client. Tan and Dong (Chapter 12) discuss the use of spiritual interventions in treatment. They examine a number of religiously based treatment strategies, some of which might be offered by an individual clinician and others by the broader religious community. Shafranske (Chapter 13) surveys personal and professional attitudes toward religion among rehabilitation psychologists and physicians. He examines the role of religion in their personal lives, the religious issues they encounter in treatment, and their use of religious interventions.

The final part of the book offers commentaries about the current status of the field. Sloan, Bagiella, and Powell (Chapter 14) provide a critical appraisal. They highlight methodological weaknesses in research concerning faith and health. They also discuss ethical reservations about clinical applications, questioning the appropriateness of physicians offering spiritual interventions. Smith (Chapter 15) reviews the field from the vantage point of health psychology. As a leading investigator in health research rather than in religious studies, he offers the perspective of an informed "outsider." In the conclusion (Chapter 16), we weave together some of the themes expressed in prior chapters and offer reflections and recommendations about future directions for the field.

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