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7

FUTURE DIRECTIONS IN RESEARCH

MICHAEL E. MCCULLOUGH

*National Institute for Healthcare Research
Rockville, Maryland 20852*

DAVID B. LARSON

*Duke University Medical Center
Durham, North Carolina 27705
and*

*National Institute for Healthcare Research
Rockville, Maryland 20852*

In the past 15 years, researchers in religion and mental health have been increasingly generative. Following Bergin's (1980, 1983) early investigations into the relationships between religion and mental health, other comprehensive reviews (Larson, Pattison, Blazer, Omran, & Kaplan, 1986; Worthington, 1986) also helped to usher in a period of intensified scientific interest in the relationship between religion and mental health. Since the 1980s, the publication of several scholarly books (Pargament, 1997; Schumaker, 1992; Shafranske, 1996) and several comprehensive field reviews (Gartner, Larson, & Allen, 1991; Gorsuch, 1995; Larson, et al., 1992; Worthington, Kurusu, McCullough, & Sandage, 1996) in important mental health journals has signaled that religion and mental health have acquired a degree of legitimacy as an area of scientific investigation; to some extent, it is now respectable (or at least permissible) for academic scholars in the mental health professions to study religion. Given this recently acquired degree of legiti-

macy, it might perhaps be time to assess the existing scientific landscape and set new goals for crossing the scientific frontiers in religion and mental health.

MOVING FROM CONSCIOUSNESS-RAISING TO SCIENTIFIC PROGRESS

One of the major effects of the previous years of research on religion and mental health has been to raise scientific awareness about the potentially salutary effects of religion on mental health, despite the vocal minority (e.g., Ellis, 1992; Waters, 1992) who continue to insist that committed religiousness is conducive to mental disorder. Through the accretion of studies in the fields of psychiatry, family medicine, geriatrics, psychology, sociology, counseling, and social work, most informed scholars would probably now agree that religious factors are relevant to a comprehensive understanding of mental health.

Nevertheless, the field of religion and mental health has a long way to go before it yields a hard core of consensually validated scientific findings regarding the relationship between religion and mental health. To date, there are few replicated, well-demonstrated "facts" about the relationship between religion and mental health on which most experts would agree. While the accretion of such replicated, well-demonstrated facts is surely not the only goal of science, our perception is that this field would be helped immensely by the strategic development of a body of generally accepted knowledge about the relationship between religion and mental health. Such facts might help us to develop, for instance, an understanding of which elements of religious experience are relevant to the course of which mental health conditions for which groups of people.

If the field is far from a body of well-accepted, replicated facts, it is even further away from a hard core of research findings that could inform practitioners about how to influence mental health via the appropriate treatment of religion and spirituality. Knowledge is lacking that would allow clinical professions, on the basis of scientific knowledge, to draw clinically useful conclusions, such as "Given that this client is highly committed to religion X and has this set of psychological symptoms, I should be thinking about diagnosis Y", "Given that this client comes from this particular religious or spiritual background, his MMPI scale 2 score is going to be of limited validity in assessing depression. Therefore, I should use another tool for assessing depression as well", or "This patient is expressing spiritual distress that seems to be exacerbating her depressive symptoms. I should refer her to a chaplain for more thorough spiritual assessment."

There does not seem to be any *a priori* reason why the field of religion and mental health could not yield consensually validated and clinically useful findings such as these. However, the development of such a body of knowledge has not been the focal point for the field of research on religion and mental health. We believe that moving from a general recognition that religion is relevant to mental health to the

strategic development of consensually validated and clinically useful knowledge is the next great frontier for this field.

TO BUILD A KNOWLEDGE BASE, RESEARCHERS SHOULD BEGIN TO SPECIALIZE

Currently, most of the researchers who are actively involved in conducting research on religion and mental health are generalists. As such, most have tried to keep up with trends in the measurement of religiousness, religion and depression, religion and anxiety, religion and coping, religion and substance use, and research on using religious approaches to the treatment of psychological disorders. While the generalist approach served the field well through early years of development (e.g., 1980–1997), being a generalist in religion and mental health is becoming increasingly difficult as the scope of the subject grows. Many scientific fields eventually outgrow the abilities of the generalist to monitor the existing literature and, as a result, specialties form.

LACK OF SPECIALIZATION LEADS TO BLAND GENERALIZATIONS

As early as 1983, the published research on religion and mental health portended the eventual need for greater specialization. In his meta-analysis of 24 published studies on religion and mental health, Bergin (1983) found that the overall relationship between measures of religiousness and measures of mental health was very small (mean $r = .09$) providing, in Bergin's words, "little positive information or incentive for further inquiry" (p. 176). Based on other relevant research in the social sciences, Bergin suggested that his bland meta-analytic results were probably the result of synthesizing many diverse measures of mental health that were likely to be influenced by religious involvement in different (and perhaps opposite) directions. Adding to the blandness, Bergin's meta-analytic effect size combined the results of studies that had used many diverse measures of religiousness. Finally, Bergin acknowledged that the studies included in his review included both clinical and nonclinical (e.g., captive undergraduate) samples. Given this aggregation across clinical measures, measures of religiousness, and samples, it is not surprising the Bergin found such meager evidence for a relationship between religion and mental health.

Building on Bergin's (1983) review, Gartner et al. (1991) used a different approach to reviewing the research on religion and mental health. By dividing the research according to clinical outcomes (e.g., depression and anxiety), Gartner et al. concluded that religious involvement appears to have a beneficial role on some indexes of mental health but an ambiguous or negative relationship on oth-

ers. Gartner et al.'s review shows that monolithic statements about the relationship between religion and mental health are clearly unwarranted; religious commitment can influence various aspects of mental health in very different ways. In the following sections, we delineate several of the dimensions along which the research on religion and mental health might become more specialized in order to develop a broader base of consensually validated and clinically useful knowledge about the relationship between religion and mental health that avoids the bland generalizations that necessarily result from aggregating findings too broadly.

THE DIMENSIONS OF SPECIALIZATION

DIMENSION 1: RELIGIOUS INVOLVEMENT

The measurement of religion in the social sciences presents a perpetual challenge for researchers interested in religion and health (Gorsuch, 1984; Levin & Vanderpool, 1987; MacDonald, LeClair, Holland, Alter, & Friedman, 1995; Williams, 1994). Much of the measurement of religion in mental health has consisted of single-item measures of religious affiliation, religious attendance, or self-rated religiousness. While such single-item measures of religiousness are generally presumed to be indicators of a single underlying construct—"religiousness" or "religious commitment"—Levin and Vanderpool observed that the amalgamation of such variables into single measures of religiousness tends to obfuscate the effects of religion on health since it is not clear what such a "metavariable" of religiousness might mean.

The Pitfalls of Taking the Measurement of Religion for Granted

Similarly, generalizations about the relationship between religion and mental health without respect for how religion is conceptualized or measured in these various studies also confuses the effects of religion on mental health; measures of religiousness are not necessarily interchangeable. For example, in Smith's (1996) investigation of 131 citizens of Missouri and Illinois who were affected by the 1993 Midwest flood, frequency of church attendance was inversely proportional to subjects' positive affect 5 months after the initial assessment. On the other hand, self-rated religiousness was directly proportional to positive affect 5 months after the initial assessment. Thus, these are two important findings for an at-risk population. The difference between these two results is important, but no adequate explanation for such discrepancies currently exists (although researchers commonly offer post hoc methodological explanations such as sampling error or restriction of range or measurement error in one or both variables). Should we conclude, then, that church attendance is risky and that "self-rated religiousness" is salutary in coping with natural disasters or should we conclude from Smith's study that, on balance, religiousness has no reliable longitudinal effect on positive affect fol-

lowing a natural disaster? Other studies (e.g., Ellison, 1995; Pressman, Lyons, Larson, & Strain, 1990) also find that the direction of the religion-mental health relationship is very much dependent on how religiousness is assessed. As a result of the field's inability to adequately predict which aspects of religion might be conducive (or deleterious) to mental health in a given circumstance, such studies are less helpful than they could be in helping to build a base of consensually validated knowledge. Moreover, no research-minded clinician could have felt comfortable in making a recommendation to a flood victim about how religion might assist or hinder him or her in efforts to cope (based on Smith's inconsistent findings). The lack of specificity in teasing out the effects of various measures of religion leads to an unfortunate bottleneck: If these practices are maintained our hard-won scientific data might never be translated into scientifically defensible clinical practices.

Specialized Measurement of Religion

Greater specialization with respect to the measurement of religion might lead to greater understanding of how aspects of religious involvement, such as religious attendance (Levin & Vanderpool, 1987), prayer (e.g., McCullough, 1995), or use of religious resources for coping with stress (Pargament, 1997), might influence mental health status (see Levin, 1996, for a helpful taxonomy of eight dimensions of religious involvement). Social scientists interested in religion from clinical and social science perspectives have invested tremendous energy in developing measures of religious beliefs, motivations, behaviors, and knowledge (Hall, Tisdale, & Brokaw, 1994; Hill & Hood, in press; Miller, 1997) as well as a wide variety of measures of spiritual experience and spiritual well-being (MacDonald et al., 1995). Use of such well-accepted measures of religious involvement and spirituality would add considerable depth to the broad range of studies on religion and mental health that currently involve a single-item measures of religiousness. They would also help us gain a greater understanding of which aspects of religiousness are particularly conducive or deleterious to mental health in specific clinical contexts and disorders.

Development of Clinical Measures

Another bottleneck related to the measurement of religion is that research-based tools for assessing mental health-relevant aspects of religion in the clinical setting are virtually nonexistent ((Strayhorn, Wiedman, & Larson, 1990). For example Kehoe and Gutheil (1994) reviewed many scale-based measures of suicide assessment to determine how many assessment tools assessed aspects of clients' religious beliefs. They found not a single tool that included religious beliefs or religious involvement as an aspect of the assessment of suicide risk, even though the existing data suggest that some aspects of religious involvement could deter suicide (Bagley & Ramsay, 1989; Gartner et al., 1991; Stack, 1992).

Similarly, very little work has been done to develop clinically useful tools for assessing patients' religious lives and how various elements of their religious lives

might be related to greater resiliency or greater risk for psychological difficulties. Pargament and Koenig (1998) are validating of a tool for assessing various dimensions of religious coping in a sample of medical patients. Other researchers in religion and mental health should examine the prospects for developing measures of religiousness that would enable clinicians to assess the religious components of clients' mental health difficulties or their risk for developing mental health difficulties in the face of stressful life circumstances. These assessment tools could be based on religious beliefs that have been linked to particular mental health outcomes (e.g., Bagley & Ramsay, 1989; Kroll & Sheehan, 1989). The development of such assessment tools would be a natural way to begin building a clinically useful science of religion and mental health.

In addition, research on the differential validity of psychological assessment tools for various religious groups, especially culturally distinct groups that might respond differently to the content of standardized measures of well-being and psychopathology, is needed to ensure that such tests are providing valid assessments for members of such groups (Hall et al., 1994; Larson, Lu, & Swyers, 1996). The work of Richards and Davison (1992) illustrates the need for such psychometric research. They found that Rest's (1979) Defining Issues Test, an instrument for assessing Kohlbergian moral development, had a built-in bias against subjects from conservative religious groups (e.g., Latter-day Saints), who responded to some of the items differently than did subjects from nonconservative religious groups.

Given Richards and Davidson's (1992) results, it is not unreasonable to expect that other psychometric instruments are also plagued with differential validity problems for conservative religious groups (Gartner et al., 1991). Since a scientifically based approach to mental health treatment requires the accurate assessment of patients' well-being and symptomology, the need for systematic examination of the differential validity of psychological tests for religious groups could be a productive area of inquiry for research on religion and mental health.

DIMENSION 2: DIAGNOSTIC GROUPS

A second dimension on which researchers should concentrate is the dimension of diagnostic groups. Researchers rarely find that all measures of mental health and mental illness are related to measures of religiousness in the same way. For example, Kendler, Gardner, and Prescott (1997) conducted interviews with nearly 1000 pairs of female twins from the Virginia Twin Registry. They assessed the women on measures of personal religious devotion, religious conservatism, and the conservatism of the religious group with which the women were affiliated. Also, they assessed depression, panic disorder, phobia, bulimia, alcoholism, and generalized anxiety disorder according to *DSM-IV* (American Psychiatric Association [APA], 1994) criteria. While one or more of the measures of religion were inversely related to lifetime risk of major depression, alcoholism, and nicotine dependence, none of the religious measures were related to lifetime risk of generalized anxiety disorder, panic disorder, phobia, or bulimia. Such inconsistencies are

not uncommon. Other researchers have found religious measures to predict some measures of well-being, psychopathology, and psychiatric symptoms but not others (e.g., Benson, Masters, & Larson, 1997; Strayhorn et al., 1990).

For the field to develop certainty about the disorders and conditions that are most heavily influenced by religion, individual researchers should commit themselves to programs of research on, for example, the effects of religion on anxiety disorders, on depressive disorders, or on drug use. While several scholars have clearly identified themselves with the study of religion on small clusters of clinical problems such as drug use (e.g., Gorsuch, 1995; Miller, 1997), few researchers have managed to specialize successfully in single disorders or sets of disorders.

A Natural History Approach to Studying Specific Disorders

Researchers might focus their programmatic research by using a "natural history" approach to studying religion and specific indexes of mental health. A natural history approach—a concept that Levin (1996) adapted from epidemiology—assumes that understanding how religion influences mental health or mental illness requires conceptualizing how the effects of religion on physical health might change across the various phases or stages through which a person (a) becomes vulnerable to a disease, (b) experiences a "full-blown illness," and (c) eventually recovers or is disabled by the illness. Levin argued that we must begin to investigate how religion influences health and illness by promoting (or interfering with) processes that move an organism toward vulnerability, dysfunction, illness, and disability or toward equilibrium and, eventually, recovery.

Were many researchers to adopt a natural history approach to the study of religion and mental health, we might one day have an integrated body of research on religion and depression, for instance, that elucidates the mechanisms by which religious involvement is associated with (a) genetic and biologic factors that affect one's vulnerability to major depression, (b) psychological and perceptual factors that influence the appraisal of stressful circumstances, (c) perceived social support during and effective coping with environmental stressors that often precede the onset of depression, (d) social support and coping during a full-blown major depressive episode, (e) effective treatment of depression, and (f) eventual recovery from depression. Currently, we know of no theoretical framework that incorporates all six of these points at which religious involvement might influence the natural history of major depressive illness.

The lack of specialization in conceptualizing the effects of religion using the natural history concept is unfortunate because data are available as building blocks for several of the stages. While little is known about how religion might influence biological vulnerabilities to major depression, research has revealed that religious commitment might endow some benefits through influencing how people appraise, seek social support during and cope with stressful events (e.g., Pargament et al., 1988, 1990; Pargament & Koenig, 1998; Pargament, Smith, & Koenig, 1996; Pressman et al., 1990).

In addition, at least seven studies have used experimental designs to explore the

efficacy of religious approaches to treating depression in Christian and Muslim patients. These studies suggest that religious approaches to treatment might play a very small role in enhancing treatment outcomes (McCullough, 1998; Worthington et al., 1996).

Obviously, many gaps must be filled. However, a natural history approach to conceptualizing the effects of religion on depression holds much promise for helping to specify the relationship between religion and mental health.

DIMENSION 3: AGE GROUP

Just as it has been shown in the fields of medicine, psychiatry, and psychology that there is a need to develop specialties (e.g., pediatrics and geriatrics) to understand and treat the physical and mental health issues that accompany particular phases of life, the field of research on religion and mental health also needs specialists who concentrate their efforts on the relationship between religion and mental health for specific age groups (e.g., children, adolescents, adults, older adults, and the very old). While many researchers have conducted studies examining specific age groups (e.g., Shortz & Worthington, 1994), it does not appear that many researchers have focused programmatic efforts on specific age groups, though there are notable exceptions in the area of geriatrics (Sherrill, Larson, & Greenwald, 1993). Virtually no researchers, for instance, have focused on religion and mental health in children or adolescents (Benson et al., 1997).

There are two reasons why we must begin to develop specialists in certain age groups. First, as people age, changes occur in manifestations of religious involvement (Levin & Taylor, 1997). For example, the religious faith of children is obviously quite closely related to the religious faith of their parents and other adult figures in their lives (Benson et al., 1997; Shafranske, 1992). Also, since children often lack higher-order cognitive processes and abstract reasoning, approaches for assessing children's religious faith might need to be different from those that assess adults' religious faith (Bassett et al., 1990; Goldman, 1964). Second, as people age, their manifestations of mental health and mental illness change (e.g., Kohn, Westlake, Rasmussen, Marsland, & Norman, 1997; Rummans, Smith, Lin Waring, & Kokmen, 1997).

DIMENSION 4: GENDER (AND OTHER SUBJECT VARIABLES)

Certainly, researchers could specialize in other subject variables. For example, it would be quite appropriate for researchers to focus exclusively on the role that gender might play in the relationship between religion and mental health, especially since expressions of religious faith (Levin & Taylor, 1997; Strawbridge, Coen, Shema, & Kaplan, in press) and the prevalence and manifestations of many mental disorders (APA, 1994) differ between men and women. While several researchers have begun to examine the "gendered" aspects of the relationship between religion and mental health (e.g., McCullough, Worthington, Maxey, & Rachal, 1997), greater specialization could and should occur.

Another subject variable that might be an important dimension of specialization is ethnicity (Benson et al., 1997). It is quite clear that both religious faith and mental health manifest themselves in specific ways for particular ethnic groups. Again, some researchers have focused on the relationship between religion and mental health for specific ethnic groups (e.g., Herd & Grube, 1996; Stack & Wasserman, 1995) and on the differences between ethnic groups in the religion-mental health relationship (e.g., Ellison, 1995). However, in the next decade, it will be important to find ways to convert these findings into clinically useful knowledge about how the religion-mental health relationship manifests itself for specific age, gender, and ethnic groups.

THE ROLE OF QUANTITATIVE REVIEWS IN THE FORMATION OF SPECIALTIES

Two types of quantitative literature reviews could be immensely helpful in delineating the most productive areas in which specialization could begin to occur. First, systematic reviews (e.g., Larson et al., 1992; Sherrill et al., 1993) could be used to quantify how frequently (and with what methods) religious variables are addressed in the best journals within specific mental health specialties. For example, it would be enlightening to assess how frequently religious variables have occurred in the leading journals that address (a) child and adolescent psychology and psychotherapy, (b) psychology and psychotherapy with ethnic minorities, and (c) psychology and psychotherapy with women. These findings could help to estimate the extent to which researchers in the mental health specialties have begun to build specialized knowledge about religion and mental health.

Second, meta-analytic reviews could be useful in actually producing consensually validated and clinically useful knowledge about the relationship between religion and mental health for which we have been advocating in this chapter. While several meta-analytic reviews of research on religion and mental health have appeared in the literature (e.g., Bergin, 1983; Donahue, 1985; Witter, Stock, Okun, & Haring, 1985), we are unaware of any published meta-analytic review on religion and mental health in the past 10 years. This is most unfortunate since ample studies now exist for conducting meta-analytic reviews that would specify the nature of the relationship between religion and mental health along some of the dimensions that we have described.

In preparing this chapter, for example, we searched through PsycLIT and MEDLINE to survey the existing literature on religion and depression. We found dozens of published empirical studies that investigated the relationship between religion and depressive symptoms. We suspect that many others may have been conducted as masters theses or doctoral dissertations. Since the data are available for conducting a meta-analytic review of research on religion and depression, it is puzzling that more researchers have not used this methodology. Whereas earlier meta-analyses of research on religion and mental health might have only attempted to estimate the mean effect size for the relationship between religion and de-

pression (Bergin, 1983; Donahue, 1985; Witter et al., 1985), many more interesting questions can be addressed as well, such as whether the relationship between religion and depression changes (a) according to which measures are used to assess religious involvement, (b) according to which measures are used to assess depression, (c) across the natural history of depression, and (d) as a function of subjects' characteristics, such as age, gender, and ethnicity.

Clearly, these are the very questions that need to be addressed in order to develop the kind of knowledge base we have been advocating for in this chapter. While many researchers in this area might recall that meta-analytic technology received criticism earlier in its development for conceptual and methodological shortcomings (e.g., Shapiro, 1994), many of these shortcomings have been remedied. Indeed, the meta-analytic technology available to researchers in the 1990s is quite robust (Cooper & Hedges, 1994; Hunter & Schmidt, 1990; Johnson, 1989). We hope meta-analyses will be performed on the relationship between religiousness and mental illnesses, such as depression, substance use, suicide, and anxiety disorder, in the years to come.

SUMMARY

The research on religion and mental health has been a source of sustained scientific interest for many researchers since the early 1980s. This vigorous activity has, almost through brute force, raised a general awareness among many scholars that a curious and perhaps important relationship exists between religious faith and mental health. However, for religion and mental health to become a scientific discipline, it is necessary to develop a strategic approach to conducting research so that we can accumulate a database of well-established, clinically useful knowledge. The approach that we have recommended here will probably require that researchers specialize. However, if the field of research on religion and mental health can meet the challenges of specialization, the field might not only continue to grow but also begin to mature and yield valid, clinically useful knowledge about the relationships between religion and mental health.

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