Religion and Family Health: A Need for Study

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The review explores efforts to identify a relationship between religion and health, and then examines issues and implications for family health research and practice. First, studies that relate religiosity to individual physiological and psychosocial health are reviewed, highlighting the need for definition of terms and exploration of such issues as pain, healing, the meaning of religion, and the faith-health connection within the family context. Second, theoretical considerations are offered, noting the need for definition of concepts and development of theoretical frameworks that include family science models. Finally, implications for research and practice in family sciences are presented. Emphasis is on the need for study from the family perspective, the need for observation of both healthy and ill populations within naturalistic family environments, the importance of qualitative data in such explorations, and the value of multidisciplinary approaches to research and therapy.

The diagnosis and treatment of health and illness have belonged to faith and spiritual healers of all cultures for most of human history (Numbers & Admunsen, 1986; Reisser, Reisser, & Waldon, 1983), although the relationship of religion to individual and family health has been less recognized in recent times. Levin and Schiller (1987) reviewed several studies from the nineteenth century that proposed correlations between religious affiliation and decreased incidence of cancer and other causes of morbidity and mortality (Billings, 1891; Tavers, 1837). A few modern scientists have further acknowledged an empirical connection between religion and health (Comstock & Partridge, 1972; Croog & Levine, 1972; Frank, 1975; Vanderpool, 1977; Vaux, 1976). However, with these exceptions, study of the impact of religion upon health has been confined mostly to scattered sociological and epidemiological surveys, and largely avoided in professional medical or family literature, reflecting an evident hesitancy among practice sciences to explore the intersection of science, religion, and philosophy (Wiebe, 1988). This article will examine recent efforts to identify the relationship between religion and health, and then explore issues and implications for family health research and practice.

REVIEW OF EMPIRICAL AND CONCEPTUAL DATA

Two significant factors emerge from the following review. The first is the relative preponderance of religious affiliation or attendance as the religion variable, rather than factors of inner belief, faith, hope, or meaning of religion. Michello (1988) noted that

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"most health studies have gone no deeper into religious behavior than to classify subjects by religion 'creed... (or) church attendance'" (p. 63). The second factor in reviewing current professional literature is the conspicuous lack of associations of religion with either physical or psychosocial health at the family level. These issues reflect major underlying needs for definitions of variables and integration of family contexts in the development of a needed theoretical foundation.

Religion and Risk for Disease

Many studies have demonstrated relationships between religion and resistance to illness or death as a result of physiological disease in individuals. Generally, an inverse relationship between degree of religiosity and incidence of myocardial infarction, i.e. heart attack, has been evident (Medalie, Kahn, Neufeld, Riss, & Goldbourt, 1973). Mortality due to cardiac disease is significantly decreased among specific religious groups, such as Mormons, (Lyon, Wetzler, Gardner, Klauber, & Williams, 1978), Seventh-Day Adventists (Phillips, Lemon, Beeson, & Kuzma, 1978), and Amish (Hammon, Barancik, & Lilliendeld, 1981). Low cancer incidence and related mortality also have been reported among Mormons (Enstrom, 1975; Lyon, Gardner, & West, 1980; Gardner & Lyon, 1982) and Seventh-Day Adventists (Jensen, 1983; Phillips, Kuzma, Beeson, & Lotz, 1980; Zollinger, Phillips, & Kuzma, 1984). Greater risk for heart disease has been associated with membership in the Jewish faith (Wardell & Bahnson, 1973).

Church membership and attendance have shown strong epidemiological associations generally with decreased morbidity and mortality to a number of different diseases (Centers for Disease Control, 1984; Comstock & Partridge, 1972; Wingard, 1982; Zuckerman, Kasl, & Ostfeld, 1984). General physical, mental, and social well-being, satisfaction with health, and decreased pain have been associated with a number of variables of religion, including affiliation, attendance, religious beliefs, and strength of religious convictions (Hannay, 1980; Yates, Chalmer, St. James, Follansbee, & McKeegney, 1981).

Faith and Mental Health

Issues of faith, hope, and religious belief have been associated with individual and family health in bereavement (Flatt, 1988), physical illness (Carni, 1988), and psychosocial well-being (Michello, 1988). Anecdotal reports have provoked professional consideration regarding the value of faith, spirituality, and religion in dealing with problems of dysfunctional families (Bradshaw, 1988; Feck, 1978; Whitfield, 1987) and family responses to physical illness (Siegel, 1986; Justice, 1988). To some extent in physical illness and to a greater extent in mental illness, there is a growing recognition that (a) individual illness affects the family unit in a compounding manner, and (b) that the faith, religion, or spiritual beliefs and practices of the family affect the health of individuals as well as the entire family unit. These issues, however, have not been empirically tested.

A significant related area is the therapeutic emphasis on spirituality in the treatment of alcoholism and other dependency illnesses. Though there has been increasing recognition and development of the faith-health paradigm in research and clinical practice in this area, the application of theistic principles to dependency treatment began and has been sustained by lay support groups (Alcoholics Anonymous, 1956). The twelve-step program of Alcoholics Anonymous has been expanded to other self-help groups and to families. Recognition of co-dependency, family responses to individual illness, and the faith-health connection in the well-being of the family unit were pioneered in the Family Group Treatment of Alcoholics (Whitfield, 1987).

There is little evidence that religion and mental health are related. successful psychosocial therapy often results in varying degrees of perceived gains in psychopathology. Such gains (e.g. "healthy" religious, spiritual or "prevailing" religious faith) may be associated with improvements in physical health care. By definition, the "prevailing" faith is that of a "prevailing" religious phenomenon. In the "healthy" faith, there is a growing recognition that (a) individual illness afflicts the family unit in a compounding manner, and (b) that the faith, religion, or spiritual beliefs and practices of the family affect the health of individuals as well as the entire family unit. These issues, however, have not been empirically tested.

Bergin (1975) and others note that the "prevailing" faith is often a religiously-oriented, often divergent or "healthy" religious phenomenon. Such phenomenon have provoked professional consideration regarding the value of faith, spirituality, and religion in dealing with problems of dysfunctional families (Bradshaw, 1988; Feck, 1978; Whitfield, 1987) and family responses to physical illness (Siegel, 1986; Justice, 1988). To some extent in physical illness and to a greater extent in mental illness, there is a growing recognition that (a) individual illness affects the family unit in a compounding manner, and (b) that the faith, religion, or spiritual beliefs and practices of the family affect the health of individuals as well as the entire family unit. These issues, however, have not been empirically tested.

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There is an interesting antithetical philosophy prevalent in the limited study of religion and mental illness, that a person’s religious orientation or beliefs may disrupt successful psychotherapy, or interfere with mental health (Ahlskog, 1985; Schnorr, 1983; Sevensky, 1984). Religious behavior has even been proposed as a risk factor for coronary disease, hypertension, or other stress-related disease where guilt or anxiety are associated with religion (Kaplan, 1976). However, though Schnorr (1983) cited such symptoms as guilt, alienation from God, and punishment as recurrent religious themes in psychopathology, she also proposed the need for inclusion of the spiritual component as essential to holistic psychiatric care. Further, while acknowledging potential psychopathological distortions of religion, Sevensky (1984) validated the concept of "healthy" religion and the need for therapists to address religious beliefs and needs in health care. Beyond such theoretical propositions and anecdotal reports, there exists a paucity of religion-variables in empirical psychiatric research (Grant, 1986) and a "prevailing diagnostic neglect of religion and of the patient's personal agenda" (Pruysor, 1984, p. 5).

Bergin (1980) noted the disparity of values between secular psychotherapists and religiously-oriented clients. Curry (1987) further explored the relationship between the divergent orientations of secular humanism, predominant in the education of psychotherapists, and theism, which dominates values among most populations of clients.

Such contrasts between practices of traditional medicine and religious values and practices are particularly evident in the recent movement among "New Age" religions. New Age philosophies encompass many unconventional approaches to worship and healing that may include spiritism, body energies and auras, use of crystals channeling, experiencing past lives, and other metaphysical practices. Emphasis among such faiths is upon holistic spiritual and physical health by a synchronicity of mind, matter, body, and spirit. Though lay literature offers an abundance of discussion of the New Age movement (Alexander, 1988; Capra, 1989; McGarey, 1988; Peat, 1989; Stabiner, 1988; Weiman, 1988), academic analysis of implications for professional practice is limited (McGuire, 1988).

Social and Cultural Factors in Religion and Health

The social nature of religion has offered implications for research and practice. For example, religion is often a prominent factor in the study of social and cultural environments of particular ethnic groups, such as black families in the United States. Indeed, study of religious influences in family systems is more often found among ethnocultural analyses (Willie, 1988), rather than among the literature of health or family sciences.

Those who have recognized the clinical significance of religion as a social force have proposed that professionals work through religious cultures or church community groups to promote social change (Bishop, 1985; Levin, 1984; Remer, Niguel, Anderson, & Terrell, 1984; Ycoob, 1985). Such use of religion as a social vehicle for behavior change certainly highlights, though implicitly, the importance of religion to community well-being, not to mention individual or family health.
Issues of Pain and Healing

One important concept related to religion and health is that of pain. Conwill (1986) affirmed "from a religious perspective, whether pain is considered an illusion or an all-encompassing reality, the fact of suffering is dealt with in one way or another in all living faiths" (p. 46). Emotional and physical pain are issues across all cultures of health care and religion (Jorgensen, 1984; Oates, 1978). Religion can offer interpretations to pain "in such a way that it can become a vehicle for increased holiness" (Glueck, 1988, p. 116), inferring that health, illness, or particularly pain, may reciprocally influence one's experience of religion. Thus, some have reasoned that pain and healing have distinctive meaning in the languages of religion and medicine (Glueck, 1988; Stern, 1985). The individual and family perceptions of physical or emotional pain may be integral parts of religious orientation and conviction. These and other issues regarding the effect of religious faith on family interpretations of the meaning of pain, perceptions of pain intensity, or family growth or dysfunctional exacerbation from suffering, call for professional inquiry.

Along with pain as a key concept in the religion-health connection is the issue of healing. The concept of healing, like religion or health, is poorly defined in scientific study. Although the social factors of religion in the healing process are recognized (Bishop, 1985), the active recognition and integration of spiritual components into healing therapies is not evident. Haggard (1983) attributed this to (a) the increased specialization of medicine, where there is less focus on the whole person (even in the face of increasing lay popularity of holistic medicine), and (b) to the characteristic interest of medicine in pathology rather than in health. Though medicine encompasses "cure", healing has been "treated with embarrassing silence as an archaic remnant of a pre-scientific era" (Kleinman & Sung, 1979, p. 7).

Though traditional practices of care and cure continue predominant in health care, issues of healing are more prominent in the context of the family. For example it is not sure that deals with the impact of disability or terminal illness of a family member, the sense of loss when an imperfect child is born or when a hoped-for child is never born, the daily acceptance of and dealing with chronic illness, or family adjustment to death or divorce. These and so many other issues of illness and health in families, demand not cure, but facilitation of healing from within the body and perspective of the family unit. Such healing often is inextricably related to religious faith.

While such behaviors as prayer, anointing, or unction have been recognized anecdotally as healing practices (McNutt, 1979; Sanford, 1972; Siegel, 1986), and though such reflections of religion are "intrinsically linked" to social and religious aspects of health (Haggard, 1983, p. 234), such issues are not addressed in the body of family health research. Such religious practices are integral parts of family life, healing, and health. Indeed, family religious values and rituals may contribute significantly to variance in perceptions of pain, adjustment to illness or disability, sense of well-being, use of health care services, or even to objective health measures. These need to be studied. Such issues further require definitions of variables, examinations of family contexts, and development of a basic theoretical framework.

THEORETICAL CONSIDERATIONS

The words "health", "wholeness", and "holiness" share common linguistic roots. Further, Hackett (1986) suggested that in the language of psychoanalysis, health means something similar to salvation in the language of theology. Indeed, "the notion that
holiness and health are holistically equivalent implies that one who is not spiritually developed is not fully healthy" (Glueck, 1988, p. 109).

The first major problem in reviewing religion-health phenomena is the obvious lack of established theoretical foundations for study. Conceptual frameworks for the constructs of health and religion, or even generally accepted basic operational definitions of terms, are not developed.

Levin and Schiller (1987) expounded on the problem of definition for the religion variable:

It is rarely clear just what underlying processes are actually being reflected: the effects of early childhood socialization (that is, parental religious affiliation) or a rather passively accepted social convention (for example, "Well, my family went to the such-and-such church and so do I"); or, in terms of frequency of attendance, it is rarely distinguished whether what is being measured is a normative pattern within a religion (for example, weekly communion), a normative social convention (for example, rural people attend church more frequently than do urban people), an indicator of behavioral tendencies (for example, "She attends church religiously"), or a voluntary associational activity...similar to going to an Elk’s Club meeting... or as an innate characteristic of individual person...characterized by cognitive or affective traits, such as "faith" (pp. 10-11).

While some investigators have attempted to isolate specific operational definitions of religion, others have avoided specificity, and simply acknowledged, described, or promoted religion as an inner strength, greater power, relationship with God, or unexplained spiritual dimension of health. This approach is especially evident in recent popular literature (Bradshaw, 1988; Cousins, 1976, 1983; Justice, 1988; Peck, 1978; Siegel, 1986; Tubesing, 1979).

Levin and Schiller (1987) pointed out other serious theoretical and methodological issues, citing distinctions among religious institution attendance (perhaps a variable of social support, according to Michello, 1988), religious practices (such as diet codes of Mormons, Seventh-Day Adventists, or Orthodox Jews), or individual personality characteristics of faith, values, and belief, each with its own implications for confounding research validity. They affirmed, "although many epidemiologists continue to collect some information about subjects' religious preference, background, or practice as part of their inquiries, next to nothing has been accomplished in terms of the refinement of concepts of measures" (Levin & Schiller, 1987, pp. 9-10). Moberg (1979) suggested that religion and spiritual well-being are not synonymous and certainly merit methodological distinction.

Similarly, definitions of health vary along a continuum from absence of symptoms (Folta & Deck, 1979), as seen in numerous epidemiological studies of morbidity and mortality, to constellations of dynamic, positive attributes of biological and psychosocial wellness promoted particularly by modern lay literature (Peck, 1978; Wilson, 1978; Wolinsky, 1980).

Beyond discrepancies in concept definition, theoretical models for health-religion phenomena, particularly in the family context, do not exist. There is a need for the development of a paradigm hypothesizing how and why religion affects health, including the reciprocal impact that health may have on religious experience. A research and theoretical base needs to be established and developed which incorporates these issues.
with family theory. Levin and Schiller (1987) further argued, "Finally, just because religion is a humanistic, imponderable issue does not render it 'soft'. If religious factors are indeed associated--and we have presented overwhelming evidence suggestive of this--perhaps the next question researchers should ask is, 'Why?'" (p. 24). Theoretical foundations need to be developed and tested to explain religion-health phenomena in families.

As family models for religion and health evolve, other models may be tested or modified. For example, the Health Belief Model (Rosenstock, 1974) states that the likelihood of a person's taking a particular action toward health is a function of (a) perceived threat, and (b) perceived benefit. Certainly, such perceptions can be hypothesized to emerge from family-based religion-health phenomena. These have not yet been explored.

**IMPLICATIONS FOR FAMILY RESEARCH AND PRACTICE**

As noted, the past decade has produced some epidemiological and sociological research as well as a number of anecdotal and lay propositional works that highlight a relationship between religion and health, however limited in definition. It must be recognized that most of the empirical inquiry consists of sociological surveys, emphasizing individual health, or observational propositions, with very little biomedical or family research (Levin & Schiller, 1987). The absence of research or application to family theory is most evident.

The Need for Study from the Perspective of the Family

The abundant discussion of holistic health and religion and the need to address the whole person have noticeably deleted important implicating factors for family health. Though family health and family relations would seem to interact with variables of religion and individual health, there has been very little exploration of such interactions.

In a recent search of current works exploring variables of health and religion from a family perspective, only a handful of studies emerged. Schindler (1985) proposed that family tensions and conflicts could be mitigated, and healthy family functioning promoted, among Jewish Orthodox families who followed Halakhic religious guidelines, suggesting further hypotheses related to the impact of formal religious rules or orthodoxy on family relations. Miller (1983) supported research demonstrating positive correlations among religion, emotional health, and father-son relationships. Hanson (1986) assessed characteristics of forty-two healthy single-parent families. Results revealed that religiosity, among other psychosocial variables, correlated with mental and physical health of parents and children, indicating that religion may act as a mediating variable in children's adjustment to divorce. With these few exceptions, study of religion and health variables among families is virtually nonexistent.

A few authors have offered propositional efforts related to a family approach to religion-health phenomena. Most noteworthy among these is the work of Edwin Friedman (1985). Friedman proposed a holistic approach to pastoral counseling that recognized the interrelationships among religion, health, and family functioning. He noted that individual symptoms of illness seemed related to the person's position in "stress fields" within a family, and that individual symptomatology eventually manifests as family symptoms. Friedman further proposed provocative theories about individual acquisition of disease based on position in family relationships, unique family characteristics, and observations of religious groups and health, but such

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Yura and Mauger (1985) reported that religious beliefs and perceptions are not exclusively from the individual, but are related to the spiritual nature of the group as a whole, but as illness or changes in religious beliefs, they are related to each other. Thus, religion and the nature of family relationships can be studied in research and family therapy.

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The Need for a Family Perspective

An emphasis on religious beliefs and meanings can be addressed by the study of church attendance, religious beliefs, and social science.

Meaning and Church Attendance

Michello, & Mauger, 1976; Allport & Ross, 1967; Allport & Mauger, 1976) have reported increasing efforts at understanding religious meaning, even though the majority of religious studies have focused on religious beliefs and meaning with respect to social and psychological levels of description.

In a study of church attendance, a good predictor of religious beliefs was found to be significant predictors in predicting religious meaning of church attendance from a family perspective.
characteristics, and confluence of stressful forces related to family functioning. His observations offer an intriguing, well-developed family systems view of religion and health, but such a view needs to be verified through empirical support.

It has been noted that family styles and religious convictions may influence acceptable ways of being ill, or decisions of when to seek health care, based on perceptions of symptom severity. For example, Herz and Rosen (1982) reported that families of the Jewish faith tended to notice symptoms earlier than those of other ethno-religious groups.

It has long been recognized in family therapy that individual symptoms are not solely intrapsychic, but that they most frequently represent symptoms in a family system. Thus, illness of an individual symptom-bearer may represent complex phenomena within the religious orientation of a family constellation (Leahey & Wright, 1987).

Yura and Walsh (1982) asserted that at times of illness, families are most likely to act from what appear to be religious motives. For example, Fox and Swazey (1978) reported that in cases of organ transplants, family donor decisions were made almost exclusively from religious influences. Yura and Walsh (1982) further suggested that the spiritual nature and values of families are faced most directly during times of crisis, such as illness or death. Since it is during health and illness events that families often come together to explore and re-evaluate essential intrinsic spiritual values, the transcending nature of family relationships, or relationships with a supreme being, it is critical that research and practice in family and health sciences become fluent in issues of religion and family health.

It also must be recognized that health-illness issues may act reciprocally to influence a family's religious convictions. Religion may become more important as a family seeks spiritual strength to deal with the illness or disability of a family member (Yura & Walsh, 1982). These, and many other issues, cry for scientific inquiry.

The Need for Discovery of Meaning

An emerging theme among recent health research is the significance of perception and meaning of religion as opposed to traditional objective measures of affiliation or church attendance. Surely, this issue offers particular clinical significance to family science.

Meaning and perception of religion have been studied as spiritual well-being (Michello, 1988), hope and faith (Carni, 1988), intrinsic religious values (Acklin, Brown, & Mauger, 1983), and the classical intrinsic and extrinsic religiosity (Allport, 1963; Allport & Ross, 1967). The issue of meaning in religion-health connections enjoys increasing emphasis. Ellens (1984) proposed the "humans possess a deep need to find meaning, even if negative, in all things, particularly in illness and pain" (p. 61). A few studies have validated these premises. In cancer patients, higher levels of attributed life meaning were positively associated with intrinsic religious orientation, and with lower levels of despair, anger-hostility, and social isolation (Acklin, Brown, & Mauger, 1983). In a study of youth substance abuse and religion, although religious affiliation was not a good predictor of substance abuse, perceived importance of religion was the most significant predicting variable of alcohol and drug abuse (Lorch & Hughes, 1985). Meaning of religion as it relates to health must be studied further from a family perspective.
The Need for Methodological Refinement

With increasing interest in family theory development (Burr, Herrin, Day, Beutler, & Leigh, 1987; Holman & Burr, 1980; Sprey, 1988), concurrent conceptualizing of religion-health phenomena as they relate specifically to family function is timely and crucial. Four major methodological tenets for future inquiry into family data are proposed here.

The first tenet is the need to study healthy as well as ill populations. While observation of the role of religion in illness is important, particularly from the perspective of perceptions of pain, suffering, and the meaning of healing, study of the role of religion among healthy families is equally significant. Few investigations have been directed toward those elements of populations that remain healthy or seem able to avoid or overcome maladaptive effects of life stress. Peck (1978) proposed that though science has been able to identify determinants of illness and healing, it has not been able to determine the origins of resistance and health:

We know very well why people become...ill. What we don't understand is why people survive the traumas of their lives as well as they do...All we can say is that there is a force, the mechanics of which we do not fully understand, that seems to operate routinely in most people to protect and to foster their...health even under the most adverse conditions...We know a great deal more about the causes of physical disease than we do about the causes of physical health. (pp. 237-239).

Surely the hypothesis that religion or faith may play a role with variables of family functioning in such natural health promotion is appropriate for investigation.

The second basic tenet for requisite theory building is the need for a naturalistic emphasis: well-designed field studies that provide "ecological validity" (Lazarus, 1981, p. 183). Observation in natural settings of families can provide descriptive data, a full range of religion-health processes beyond epidemiological correlations, can provide data over time, and can allow study of meaning and individual differences. This implies a need for methods that elicit authentic subjective report.

Referring to stress-coping research, Folkman and Lazarus (1984, p. 321) affirmed self-report to be the "primary source" of data to "identify meaningful relationships" among variables. They reasoned that in theory-building, subjective data are prerequisite to traditional quantitative physiological and behavioral observations. Such arguments also apply to religion-health phenomena.

Thirdly, there is a need for multidisciplinary approaches to research and clinical practice. Religion and health in families are issues relevant to family sciences, theology, psychology, medicine, nursing, and other health and social sciences. Shriver (1980) described an interdisciplinary group project that included representatives from medicine, public health, nursing, biomedical research, theology, pastoral care, and sociology of religion, who (a) explored contributions of religious study to the study of medicine, and (b) described practical modes of teaching and collaboration among scholars and practitioners in religion and medicine. Such interdisciplinary study and practice are rare, but valuable in all aspects of family health sciences.

Finally, as such theory-building is in its infancy, qualitative, inductive data are most important. This calls for an expansion of research methodologies beyond traditional quantitative techniques that produce correlations of demographic variables. Accordingly,
individual differences may need to be observed as primary rather than confounding variables. Qualitative methods emphasize meaningfulness rather than control. Lazarus (1981) asserted that measurement control presumed in past correlation research may be illusion and that confounding variables of individual differences may actually be the most valuable sources of data.

Qualitative, theory-generating methods such as grounded theory (Glaser & Strauss, 1975), ethnography (Boas, 1948; Wallace, 1972), hermeneutics (Cairns & Hunter, 1984; Ihde, 1971), or phenomenology (Heidegger, 1988; Roche, 1973) allow researchers to elicit meaning of experiences "rather than to discover causal connections or patterns of correlation" (Dukes, 1984, p. 197). Such discovery of meaning regarding religion and family health is critical to appropriate theory generation and to effective clinical practice.

CONCLUSIONS

The theologian-scholar Paul Tillich (1948) proclaimed that humanity lives in two orders: the human and the divine. Jourard (1971) further noted that the need to study man's spiritual dimension has been the plague of psychologists for years. While the filiation of religion, healing, and health have been known to human families throughout history, scientific investigation into such factors has been limited. Effective intervention into family health and functioning, both physiologically and psychosocially, must include recognition and understanding of the role of intrinsic family influences, particularly one as potentially intense and pervasive as religion.

Though some correlations of religion and health are evident, there is a need to define operationally and theoretically the spiritual elements of the family unit. Such enlightenment must come from sciences, religion, and from the families themselves. It is reasonable to hypothesize that perceptions and expressions of illness and pain, effective treatment modalities, as well as means of maintaining health may be embedded in family characteristics intrinsically related to religious influences. An obvious current example is the situation of the person with acquired immunodeficiency syndrome (AIDS). Conceivably, religious convictions affect family responses and functioning in such conditions.

Empirical evidences and proposed research questions abound related to family-based relationships between religion and health. Spiritual components of family conditions need to be explored in such situations as family care-givers to elderly family members. Does religion affect decisions of home care or of which family member offers the care? In cases of terminal illness among children, how does religion affect adjustment of child siblings or other family members? How does religion affect the re-ordering of the family unit following the crisis of death, divorce, or chronic illness? What is the religious orientation of families who remain healthy and find strength through life crises? Further efforts are needed to define variables, develop theoretical explanations, and refine methodological techniques to discover meaning related to religion and family health.

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