CHAPTER ONE

RELIGION AND MENTAL HEALTH: THROUGH THE LENS OF THE STRESS PROCESS

CHRISTOPHER G. ELLISON AND ANDREA K. HENDERSON

Over the past two decades a burgeoning research literature has examined the relationships between religious involvement (and its close cousin, spirituality) and mental health outcomes. Although studies in this area have explored many facets of mental health, there has been significant concentration on affective outcomes. To be sure, a long tradition of theory and research in psychology has taken a dim view of the role of religion in shaping mental health. Scholars from Sigmund Freud (1928) to Albert Ellis (1962, 1983), as well as many other prominent figures, have maintained that religious belief is either an expression or a cause of emotional disturbance in many people. In sharp contrast to these critical claims, many more recent studies report that religiousness, measured in various ways, tends to be inversely associated with symptoms of depression, anxiety, or psychological distress (Koenig, Larson and McCullough 2001, Smith et al. 2003, Koenig 2009, 2011). Our chapter has four overarching objectives: (1) to review key findings from this contemporary literature; (2) to set forth the stress process perspective as one potential unifying framework for the vast body of work on religion-mental health, and to identify several conceptual models for research in this area; (3) to review the available evidence linking religious factors with the various components of the stress process model; and (4) to discuss several promising directions for future research on religion and mental health.

We should note several caveats with respect to this chapter. First, we are restricting our focus mainly to the United States, where much of the relevant research has been conducted. Further, because the United States remains primarily Judeo-Christian in culture (if not always in practice), and most studies continue to use concepts and measures that are rooted in the Judeo-Christian tradition, we shall have little to say about religion and mental health in other faith traditions. Second, in keeping with the thrust of the literature in this area, our review will
center on depression, anxiety, and generalized distress. Other mental health outcomes, ranging from substance abuse to schizophrenia to personality disorders, and many more, will necessarily be omitted from the discussion. Third, we note that a wealth of research on religion and mental health is based on clinical samples, i.e., persons selected because of specific health problems or stressful conditions, and the main interest of those studies lies in the treatment and prognosis of subjects. By contrast, we focus primarily on community-dwelling or population-based samples.

Religion and Mental Health: Reviewing the Evidence

In recent years several researchers have attempted to review, synthesize, and take stock of the literature in this broad, multidisciplinary field, with varying degrees of success. These assessments have varied in a number of important ways: (a) they concentrated on very different slices of the literature, from divergent academic disciplines; (b) they employed divergent criteria for inclusion in the review; (c) they embraced different standards for evaluating the strengths and weaknesses of research studies and for assessing religious or spiritual effects on mental health. Thus, despite the best efforts of many talented scholars, consensus on where the field stands and how to proceed remains on the far horizon (Koenig et al. 2001, Hackney and Sanders 2003, Smith, McCullough and Poll 2003, Koenig 2009, 2011). Nevertheless, we offer several broad generalizations about the state of the field, at least with respect to community- or population-based research on religion and mental health.

First, much of the work in this area has been plagued by inadequate conceptualization and measurement of religion and related constructs (Hill and Pargament 2003, Idler et al. 2003). This problem has been exacerbated by the use of large-scale secondary data sources, which, despite their considerable virtues, often lack sophisticated items gauging health-related aspects of religiousness. Thus, many studies have relied mainly on measures of religious behaviors, most prominently the self-reported frequency of attendance at religious services, along with the frequency of prayer or meditation, as well as vague items tapping (a) religious identity, or how religious one considers oneself, and (b) religious salience, or the self-reported importance of religion in one's daily life. Among psychologists, the study of religious
orientations or motivations has been extremely popular. Here researchers typically distinguish between (a) intrinsic orientation, or the tendency to value religion for its own sake and to attempt to carry over the precepts of the faith into other areas of one’s life, and (b) extrinsic orientation, or the inclination to use religion (e.g., congregation, personal spirituality) as a means to an end—social connections, psychic strength in coping, access to services, and so on. For these individuals, religious faith and teachings typically do not occupy a particularly prominent place in their daily thinking or decision-making. With the advent of recent conceptual and measurement advances, investigators increasingly focus on specific causal mechanisms or pathways through which religion may influence mental health. This has led growing numbers of researchers to employ measures of religious support, coping, and other health-relevant religious and spiritual domains (Pargament 1997, Idler et al. 2003, Krause 2008).

Second, many studies in the religion-mental health area are based on clinical samples, or samples of groups experiencing specific types of challenges or problems (e.g., bereaved persons). These samples are typically small convenience samples, not representative of and hence not generalizable to a broader population. Moreover, the patterns detected in such samples may be quite different from those found in community-dwelling, largely healthy samples. The failure to distinguish cleanly between clinical vs. population-based studies is a common source of confusion among researchers, critics and skeptics, and the general public alike.

Third, the vast majority of empirical studies continue to rely on cross-sectional data. Although these works can offer valuable snapshots of associations between religion and mental health outcomes, it is impossible to establish temporal ordering among variables, a key requirement for any assessment of causality. Koenig (2011) has conducted an exhaustive review of studies that probe the links between religion and depression and anxiety. His review includes non-US studies, clinical trials, and other genres that are not the focus of our chapter. He reports that of 342 studies on religion and depression located by online search, only 13% utilized a longitudinal design. Of the 237 studies addressing links between religion and anxiety (which included fear and post-traumatic stress disorder), only 5% employed longitudinal data.

These limitations notwithstanding, a growing body of work suggests that aspects of religiousness have salutary implications for affective
outcomes, particularly depression. In perhaps the most compelling meta-analytic assessment to date, Smith and colleagues (2003) analyzed data from 147 studies with a total of 98,975 subjects. Their pool of studies contains a range of genres, including studies using convenience samples of students and special populations (e.g., homeless, caregivers), but they focus on non-clinical studies. Overall, they concluded that religiousness bears a modest inverse association with depression (weighted $r = -.09$, $p < .0001$). Although this overall effect size seems small, it masks two important further findings: First, religiousness appeared to convey particular benefits for persons experiencing high levels of stress, although the overall effect persisted in direction and significance, and at somewhat lower magnitude, for persons under no stress at all. Second, the association between religiousness and depression also varies by the specific measure of religiousness employed. Some dimensions of religiousness exhibited a notably higher association with depression than the overall weighted correlation would suggest. Examples of salutary associations include those involving intrinsic religiousness ($r = -.175$), religious behaviors ($r = -.124$), positive religious coping ($r = -.167$), religious well-being ($r = -.199$) and God concept ($r = -.199$). Other associations implied undesirable effects of religion, including: extrinsic religiousness ($r = .155$) and negative religious coping ($r = .136$). In sum, then, there appears to be a sound basis to believe that at least certain aspects of religiousness may protect against depression, anxiety, distress, and other negative affective outcomes.

The Stress Process: A Brief Overview

As outlined by Pearlin (1999), Wheaton (1999), and others, the stress process involves the interplay of stressors, resources, and mental health outcomes. Briefly, stressors are circumstances that require changes in the relationship of the individual to his or her environment and significant adjustments of lifestyle, behavior, or outlook, thereby taxing the capacity of the individual to respond (Lazarus and Launier 1978). Stressors consist of three types: (a) acute stressors, or major traumas or life events (e.g., job loss, bereavement); (b) chronic strains (e.g., poverty, disablement, marital conflict, neighborhood deterioration); and (c) daily hassles (e.g., traffic congestion, long lines for services). The idea behind this approach dates at least to the animal experimental
studies of Selye (1956); a wealth of evidence links each of these types of
stressors with poorer mental health outcomes over time (e.g., Turner,
Wheaton and Lloyd 1995).
However, research has also demonstrated that the noxious effects of
stressors on mental health may depend upon the kinds of resources
available to individuals for dealing with these various problems
(Wheaton 1985, Lin and Ensel 1989). Two crucial types of resources in
the stress process literature are social resources and psychological
resources. Social resources typically refer to: (a) social integration
(e.g., social network size, frequency of interaction); (b) enacted social
support (e.g., receipt or provision of instrumental assistance, such as
goods and services, informational aid, and such emotional support as
companionship and morale support); and (c) anticipated support
(e.g., the expectation that members of one’s support network can be
relied upon to provide help if one needs and requests it, whether or not
one has actually drawn upon this network in the past) (Cohen 2004,
Krause 2008). In the stress process tradition, the key psychological
resources include: (a) self-esteem, or the global sense of one’s intrinsic
moral self-worth; and (b) personal efficacy (or the sense of control), or
the perceived ability to influence one’s life circumstances and engage
one’s environment to achieve one’s daily objectives (Turner and Roszell
1994). Some researchers working within this tradition have also
invoked other resources, including: (a) positive psychological traits
and character virtues, such as optimism, meaning, gratitude, and
forgiveness (Krause 2003a, 2006a); and (b) coping styles, or recurrent
patterns by which individuals mobilize personal resources to deal with
stressful events and conditions (Folkman and Lazarus 1986, Carver,
Scheier and Wemtraub 1989).
The core ideas of the stress process are highly flexible and can be
integrated with other social and behavioral science approaches to
address a range of specific problems and topics. For example, Pearlin
(1989), Turner and others (Turner, Wheaton and Lloyd 1995, Turner
and Lloyd 1999), have sought to explain social structural variations in
mental health outcomes — e.g., by socioeconomic status, race and
ethnicity, age, gender, etc. — in terms of (a) differential exposure to
stressors, or variations in the number or intensity of negative events
and conditions; and (b) differential vulnerability to stressors, or vari-
ations in levels or effectiveness of personal resources in promoting to
resilience in the face of these stressors (McLeod and Nonnemaker
1999, Mirowsky and Ross 2003). With respect to religious variations in
mental health, investigators have examined the role of religious and spiritual factors in (a) reducing levels of social stress, (b) facilitating the accumulation of social and psychological resources, and (c) promoting specific coping approaches and enhancing the efficacy of personal resources in dealing with stress (Ellison 1994, Ellison and Levin 1998, Ellison et al. 2001).

Religion and Exposure to Stressors

How and why might religious involvement influence risk and number of stressful life events and conditions? Most religious communities and traditions attempt to shape the behaviors and lifestyle choices of their adherents in ways that conform to group norms that stem from doctrinal and theological tenets. Although these attempts at influence vary widely in the degree of their success, they may deter members from conduct that is unhealthy, immoral or unethical, or problematic for family solidarity and social order. Religious influences may operate in a number of different ways: (1) formal statements and "moral messages" from religious leaders, e.g., denominational pronouncements, sermons; (2) informal sanctions against members who deviate from group norms, e.g., expressions of disapproval, gossip, social ostracism; (3) emulation of role models or reference groups within the congregation, i.e., persons or groups who are recognized and respected as exemplary members; (4) the threat of divine punishment for violation of religious standards, i.e., the so-called "hellfire effect"; (5) limitations on the opportunities to engage in counter-normative activities due to lack of time or the dominance of coreligionist networks; and (6) cultivation of practices, routines, and habits that make deviant activities unlikely and unappealing (Hoffmann and Bahr 2005). In addition, McCullough and Willoughby (2009) have recently argued that religion shapes behavior by influencing self-control, selection and pursuit of personal goals, self-monitoring, and self-regulatory strength and behavior.

There is significant evidence linking aspects of religious involvement with a number of specific stress-related lifestyle factors. One important set of these factors involves health behaviors. For example, the frequency of attendance at religious services, in particular, is associated with avoidance of negative behaviors, such as heavy drinking, binge drinking, and carousing; smoking and other forms of tobacco
use; use of illicit drugs; promiscuity, infidelity, and other risky sexual practices; and others as well (Baier and Wright 2001, Hill et al. 2006, Burdette and Hill 2009, Gillum and Holt 2010). In addition, aspects of religious engagement are positively associated with positive behaviors, such as the use of preventive health care services (e.g., regular checkups, various types of screening tests); dental care; seat belt use; and regular diet, exercise, and sleep (Wallace and Forman 1998, Benjamins and Brown 2004, Hill et al. 2006). These health behaviors influence the risk of various chronic health problems, which in turn bear a strong influence on psychological distress and other mental health outcomes.

Further, a wealth of evidence links religious factors to the quality and stability of marital and family relationships. Specific research in this arena has focused on marital and relationship satisfaction (Ellison, Burdette and Wilcox 2010); risk of divorce (Call and Heaton 1997); frequency and types of marital disputes (Curtis and Ellison 2002); marital conflict resolution patterns, including forgiveness; domestic violence (Ellison, Bartkowski and Anderson 1999); and others (for review, see Mahoney 2010). Other studies have linked religion with the quality of relationships between parents and their adult children, and between grandparents and grandchildren (Pearce and Axinn 1998, King 2010). Some studies also find that more religious persons report greater affective family closeness overall, as well as more frequent contact with extended kin group members (Ellison 1997). In sum, then, religious involvement may influence mental health partly by decreasing the risk or frequency of family-related acute and chronic stressors.

Finally, most religious groups attempt to define and encourage moral, ethical behavior in other realms of life. Examples include economic affairs, where employees may be enjoined to be diligent workers and to avoid idleness and laziness. Most religious traditions promote honesty and integrity (e.g., Perrin 2000), as well as thrift and prudent stewardship – including charitable giving – in the management of personal and household financial resources (Wuthnow 1994). Religious persons are also encouraged to honor duly-constituted civil authorities, to obey law enforcement and other officials, to pay their taxes, and to fulfill their obligations as citizens (Grasmick, Bursik and Cochran 1991). To be sure, there is wide latitude in these directives, and some religious groups may offer very different counsel on these issues. Overall, however, it is reasonable to speculate that adherence to these
norms may reduce the risk of serious economic difficulties and legal hassles, which can take a significant toll on mental well-being.

Religion and Social Resources

A large body of research indicates that persons with larger and more supportive social networks tend to fare better on a range of mental health outcomes than their counterparts with fewer of these social resources (Cohen 2004, Krause 2008). How might religion affect access to and the effectiveness of social resources? First, with respect to social integration, or the quantitative aspect of social resources, religious congregations are network-driven institutions (e.g., Cornwall 1987). Individuals and families are often recruited into congregations through preexisting social ties. At the same time, religious groups are fertile ground for the cultivation of friendships because they bring together persons who share common beliefs, values, and interests on a regular basis, for worship, ritual, and other activities to which members ascribe particular significance (Ellison and George 1994). Indeed, several studies show that regular churchgoers enjoy larger networks and interact more frequently with their network members through in-person contact, by phone, etc., than other persons (Ellison and George 1994, Bradley 1995). Further, these patterns do not appear to result from dispositional factors; that is, they do not necessarily result from any tendency of churchgoers to be "joiners" in general or to exhibit greater extroversion or lower neuroticism than other persons (Bradley 1995).

Second, religious congregations offer valuable contexts for the exchange of tangible assistance such as goods (including financial aid), services, and information, as well as such emotional support as companionship and morale support (Taylor and Chatters 1988, Krause 2008). Some of this support occurs in formal church programs, which may be aimed at assisting persons with such particular needs as poor members, at-risk families, elders, persons with illness or disablement, and so on (Chaves and Tsitsos 2001). Indeed, some congregations go further, sponsoring programs to educate members about health behaviors and other physical health matters (Trinitapoli, Ellison and Boardman 2009). Religious groups often provide pastoral counseling or other forms of advising for members facing emotional difficulties, marital or family issues, or other types of problems (Neighbors, Musick and Williams 1998, Taylor et al. 2000).
However, a great deal of church-based social support is channeled through informal networks, exchanged among friends within the congregation. Everyday helping practices and acts of love and kindness are encouraged by the teachings of most religious traditions and by the ethos and rhetoric of many local congregations, which may emphasize fellowship and view themselves as an extended family (Pargament et al. 1983). Informal exchanges of support are also facilitated by the density of many church-based networks, which are characterized by long-term relationships among members (i.e., support convoys). This is particularly important because studies point to anticipated support – i.e., the perception that network members will deliver assistance when and if needed and requested – is a stronger predictor of mental health outcomes than either social integration or enacted social support, i.e., that which has been delivered or exchanged (Krause 2008). Regular churchgoers may enjoy higher levels of anticipated support than others due to (1) norms of reciprocity within most religious groups, which allow them to draw upon "credits" for investments and assistance they have provided in the past; (2) confidence that fellow members will help them due to their own moral and religious convictions; and in some groups, (3) the possibility that members who decline or fail to deliver assistance when needed may lose status or respect within the congregation (Ellison 1994, Ellison and George 1994, Krause 2002, 2008).

Third, the support, particularly socio-emotional aid, provided by fellow church members may also be more beneficial than the support obtained from other sources (e.g., neighbors, coworkers, etc.). Although few studies have tested this hypothesis empirically, there are several reasons to believe that it may be accurate (e.g., Krause 2003b, 2006b). Research has revealed that individuals derive greater benefits from support when it is provided by persons who share common status characteristics, and especially by individuals who share common cultural values and life experiences (Suitor, Pillemer and Keeton 1995). This may be the case because support providers are likely to have greater empathy for the difficulties confronted by the recipient and may understand particular reasons why specific conditions are experienced as challenging or problematic, in part because these reasons may be shaped by culture and community norms. Such insight may help them to calibrate their support to the needs of the intended beneficiaries, thus reducing the potential for a failed support attempt (Jacobson 1987, Ellison 1994). In addition, the members of religious
communities often have a shared set of meanings and discourses concerning human suffering and the significance of helping others. It is possible that the use of such religious language and symbols may also hold particular psychosocial benefits for support recipients. Although we have emphasized the benefits of church-based social support for the recipients, it is important to note the value of such exchange networks for support providers, who may profit from opportunities to deliver assistance, thereby (1) not becoming overly dependent on their fellows (Maton and Rappaport 1984, Maton 1987), and (2) gaining a sense of self-worth and empowerment, as well as meaning and purpose, through helping others (Krause 2009).

Religion and Psychological Resources

A long tradition of psychological theory and research has maintained that religious faith and practice – primarily the Christian tradition – can undermine psychological resources by teaching that: (a) individuals are innately sinful and depraved, thereby lowering self-esteem and feelings of personal control; (b) God is omnipotent and omniscient, thereby promoting passivity and fatalism among the faithful; (c) believers should rely on God for assistance in times of trouble, thus diverting attention and energy from more realistic and productive coping strategies; and (d) God is judgmental and punitive, thereby instilling fear, guilt, and hopelessness (Ellis 1962, 1983, Watters 1992, Branden 1994). Albert Ellis (1962: 146), founder of Rational Emotive Therapy, went so far as to claim that “the concept of sin is the direct and indirect cause of virtually all neurotic disturbance.” However, much of this critical work is based on theoretical analyses and case-based studies. Recent research based on both population and clinical samples yields a rather different picture of the links between religious engagement and psychological resources such as self-esteem and the sense of control (Ellison 1993, Krause 1995, Schieman, Nguyen and Elliott 2003, Krause 2005, Schieman, Pudrovskia and Milkie 2005).

How and why might religion foster self-esteem and personal control? Investigators have offered several theoretical explanations for such patterns. First, although self-esteem is shaped by a number of factors, two social-psychological processes are particularly important: reflected self-appraisals and social comparisons (Rosenberg 1981). Briefly, based on notions of the “looking-glass self” dating from the
classical work of Cooley (1902), individuals can develop positive feelings of self-esteem, or the intrinsic sense of moral self-worth, if they perceive that others whose opinions they value hold them in high regard. Religion may contribute to positive reflected appraisals in at least two ways. As discussed above, religious congregations are settings in which friendships and supportive social ties often flourish. In contrast to secular contexts, in which persons are often evaluated in terms of their material wealth or possessions, education, physical attractiveness, or other external attributes, religious congregations may allow for evaluations of individuals based on quite different criteria, such as one’s personal spirituality, kindness to others, service to the church, morality and wisdom (Ellison 1993). In these settings, individuals, even those with modest secular resources or social standing, may gain a sense of belonging and mattering to others (Bierman, Schieman and Ellison 2010). Such positive reflected appraisals, in turn, can build feelings of self-esteem.

Further, many persons of faith construct ongoing relationships with divine others (i.e., God, Jesus) much as they would build connections with friends and associates (Pollner 1989). In lieu of face-to-face verbal exchanges or contacts via phone, e-mail, or letter, religious persons typically cultivate an intimate relationship with divine figures through various types of prayer, including conversational, meditative, ritual, and petitionary prayer (Poloma and Gallup 1991). Understandings of who or what God is and what God may expect from each person in the way of faith and conduct may emerge from scriptural study, as well as accounts of the faith journeys of historical figures and testimonials from religious leaders and popular celebrities, and others (Wikstrom 1987, Pollner 1989). Recent developments integrating insights from attachment theory with the psychology of religion suggest that God may be an ideal secure attachment figure who can be counted on to provide valuable assurance, an emotional “safe haven” for believers (Kirkpatrick 2004, Bradshaw, Ellison and Marcum 2010), because God is always available for guidance and solace for the faithful.

With regard to orthodox religious doctrine, a number of religious authors have countered the criticisms of Ellis (1962, 1983) and his ideological compatriots by noting the following tenets of Christian teaching: (a) God is believed to be the creator of all, and the most powerful entity in the universe; (b) all humans were made in God’s image; (c) God demonstrated love by allowing the sacrifice of Jesus on the cross to cleanse the sins of humanity; (d) God wishes to have a close,
loving relationship with each person; and (e) believers receive the gift of eternal life. For believers, these core doctrinal tenets convey a clear sense of the dignity, significance and purpose for the existence of each individual, and thus may offer a basis for elevated feelings of self-worth (Narramore 1984, Schuller 1989).

Recent studies have also reported positive links between aspects of religious involvement and the sense of control, a pattern of findings that runs counter to the longstanding claims of critics (Krause and Tran 1989, Schieman, Pudrovská and Milkie 2005, Ellison and Burdette 2010). Why might this be the case? First, this facet of the self is influenced partly by processes of self-attribution; individuals come to attribute to themselves the ability to influence their environments and control their daily affairs when they have gained some experience in successfully doing so (Bandura 1997). Although this varies somewhat by tradition and denomination (e.g., Verba, Scholzman and Brady 1995), many religious congregations offer extensive opportunities for lay participation, including involvement in leadership activities. Specific examples include, among many others, church committees, charitable events, athletic teams, and other social activities, and youth and adult religious education classes. Through such endeavors, individuals may build self-confidence and gain valuable experiences. Further, they may develop skills that they can also utilize in other settings (e.g., secular groups, political activism), such as public speaking, organizing groups, writing letters, raising funds, and others (e.g., Schwadel 2002). Taken together, these activities may enhance feelings of personal control or mastery.

In addition, individuals' sense of control may also be influenced by religious beliefs and non-organizational practices, but not always in the deleterious ways that critics have often assumed. Strong beliefs that one is solely in control of one's affairs are not always conducive to positive mental health outcomes, and beliefs in divine control do not always involve relinquishing control of one's own affairs. Some researchers have begun to explore the prevalence and role of beliefs about divine control more carefully, and findings suggest that beliefs that God is actively involved in shaping one's life may have salutary implications for mental health (Schieman, Pudrovská and Milkie 2005, Schieman et al. 2006, Schieman 2008, 2010). Further, data from a representative sample of adults in the United States link religious attendance and belief in an afterlife with greater sense of control, suggesting that many believers gain a sense that the world, and their own affairs in
particular, are under control, though ultimate control may rest with a Higher Power (Ellison and Burdette 2010). Clearly existing understandings of the links between religious beliefs and the sense of control are currently in flux, and longstanding criticisms of the effects of religion are facing new questions.

Although much of the work within the stress-process tradition emphasizes the importance of self-esteem and personal control as key psychosocial resources (e.g., Turner and Roszell 1994, Wheaton 1999), there is growing interest in other psychological resources as well. Especially relevant here are key constructs from positive psychology, often termed virtues or character strengths (Peterson and Seligman 2004). Prominent examples of such strengths include forgiveness, gratitude, and the sense of meaning and purpose. Briefly, most religious traditions encourage forgiveness of others for misdeeds (McCullough and Worthington 1999, Rye et al. 2000). Consistent with this logic, it appears that there is a positive association between religiousness and the extent to which individuals are, or claim that they are, forgiving. Several studies have linked forgiveness, especially unconditional forgiveness, with desirable mental health outcomes (Krause and Ellison 2003). Although few studies have examined the links between stressors, forgiveness, and mental health, it is reasonable to expect that persons who can let go of feelings of anger, betrayal, shame, and other negative emotions that can stem from certain stressors (e.g., marital discord, interpersonal conflicts) are likely to experience lower levels of distress, depression, and other unpleasant affective states (Thoresen, Harris and Luskin 2000, Krause and Ellison 2003). Religion can also be an important source of meaning and purpose, as well as gratitude (Pargament 1997, Emmons 2005). Once again, the available evidence links these psychological resources with better mental health, and an emerging literature suggests that they may be particularly useful for persons grappling with stressful events or conditions (Krause 2003a, 2006a).

Religion and Coping

Another way in which religion may influence mental health outcomes is by providing specific coping tools and methods by which individuals can deal successfully with stressful events and conditions. According to Lazarus and Launier (1978: 288) coping refers to "efforts, both
action-oriented and intrapsychic, to manage (that is, master, tolerate, reduce, minimize) environmental and internal demands ... which tax or exceed a person's resources." Early work on coping often assumed that religion plays a detrimental role, mainly offering a unidimensional passive, escapist, and counterproductive approach that diverts attention from more proactive coping techniques. Empirical studies subsequently revealed some beneficial effects of religious coping, but these desirable consequences surfaced mainly for persons dealing with a narrow range of problems for which (a) emotion-regulation was the primary coping task, (b) problem-solving approaches were ineffective, or (c) worldly explanations were unavailable. Examples of such stressors included bereavement, natural disasters, and unexpected tragedies that challenged everyday assumptions about the fairness of life (Bulman and Wortman 1977, Mattlin, Wethington and Kessler 1990).

More recent work has cast fresh light on the rich and variegated domain of religious coping. An important touchstone for much of this literature has been the classic theoretical approach of Lazarus, Folkman and their associates (Lazarus and Folkman 1984, Folkman et al. 1986). This line of analysis distinguishes between two key facets of the coping process: (a) primary appraisal, in which individuals assess the meaning of the given event or condition and attempt to gauge its challenges to the self and the future; and (b) secondary appraisal, in which individuals take stock of the resources available to address and overcome these challenges. Theorists and researchers have argued that religion can influence both of these elements of the coping process.

For example, a long tradition of work has noted the key role of religion in the search for meaning in the face of suffering (e.g., Frankl [1946] 2006), and a number of studies have identified a range of religious responses to adversity that correspond closely to the ideas of Lazarus and Folkman (1984) regarding primary appraisals. Religious cognitions may lead persons of faith to reframe the stressor as part of God's plan, as a "blessing in disguise," as an opportunity for personal or spiritual growth, and so on (e.g., Foley 1988). In a notable study of religious responses to physical disability, Idler (1995) observed that persons who adapted successfully were those who cultivated "non-physical" senses of self. Since these individuals could no longer count on being able to pursue activities that required mobility or regular physical activity, they came to emphasize (to others and in their own thinking) different sets of personal attributes, skills and components of their identity. In some instances, such reframing made the onset of
disability less threatening to their core sense of self and their vision of the future.

Many major contributions to our understanding of religious coping have emerged from the research program of Pargament (1997) and his many students and colleagues. Briefly, Pargament has identified many methods through which individuals may draw upon religion and spirituality in dealing with personal problems. He argues that these methods are portable; i.e., individuals tend to use similar religious coping methods across episodes and types of stressor. In one important early foray into the diversity of religious coping approaches, Pargament and associates (1988) squarely engaged the perception of many in the psychological community that religious coping is mainly passive, as individuals turn to God as a crutch to avoid taking responsibility for and dealing with their problems. To be sure, Pargament and his colleagues found that some persons did cope in this way, with undesirable consequences. However, this was not the modal style of religious coping; rather, many more individuals formed dynamic partnerships with God and perceived that they were working together to resolve problems. These collaborative copers drew strength from their relationship with God and fared much better on emotional, physical, and spiritual outcome measures. The results of that study cast fresh light on the phenomenon of religious coping, demonstrating that certain coping styles yield psychosocial dividends while others conform to negative stereotypes.

Pargament and his associates have continued to examine various methods of religious coping over the past two decades. His efforts have yielded a rich, theoretically-grounded understanding of the multidimensional phenomenon of religious coping (Pargament 1997), as well as a sophisticated scheme for measuring the many methods of religious coping, known as the RCOPE (and its short-form cousin, the Brief RCOPE) (Pargament et al. 1998, Pargament, Koenig and Perez 2000). These instruments have been employed in numerous studies of coping within diverse samples in a wide array of contexts. Although most of these works are based on cross-sectional data, the results of these studies highlight what appear to be salutary effects of several specific coping practices. Among the most productive religious coping methods are (a) collaborative coping, or engaging in problem-solving efforts with God, as in the popular epigram “God is my copilot”; (b) benevolent religious reappraisal, or reframing potentially negative conditions in religious terms, e.g., as part of God’s plan; (c) seeking spiritual support and comfort from God; and (d) active
religious surrender, or attempting to solve those problems that can be
tackled successfully, and then turning over more difficult aspects to
God, as in the popular epigram “let go and let God.” In one meta-
analysis of 49 studies, with 105 effect sizes, Ano and Vasconcelles
(2005) report substantial associations between these “positive” reli-
gious coping approaches and positive mental, physical, and spiritual
adjustment outcomes (weighted $r = .33$, $p<.01$), and more modest but
robust associations between such coping practices and negative adjust-
ment (weighted $r = -.12$, $p<.01$). These patterns are highly consistent
with the patterns reported by Smith et al. (2003), described above.

Is There a Dark Side of Religion?

Most recent studies of religion and mental health have emphasized
salutary religious effects. But this does not necessarily mean that critics
(e.g., Ellis 1962, 1983) were entirely incorrect in some of their claims.
Indeed, a growing literature demonstrates that certain facets of reli-
gious belief and experience can indeed have deleterious consequences
for health and well-being, thus documenting a “dark side” of religion
(Exline 2002, Pargament 2002). Although researchers in this area have
identified a number of possible elements of this “dark side,” often
termed “spiritual struggles,” three elements have been the focus of
most of the theoretical and empirical work on this topic: (a) interac-
tional (or divine) struggle, or troubled or problematic relationships
with God that are especially likely to surface during the coping proc-
есс; (b) intrapsychic struggle, or difficulties with sustaining religious
faith or practice; and (c) interpersonal struggle, or negative interac-
tions with clergy or church members in religious settings (Exline and

Interational, or divine, struggle refers to difficult relationships
between individuals and God (Pargament 1997, McConnell et al.
2006). Although for most persons of faith, practices such as prayer,
scriptural study, and other devotional pursuits lead to the perception
of a close bond with a loving, caring deity, this is not the case for eve-
Some persons come to experience God as a judgmental figure, and
they may interpret negative life events and chronic stressors as punish-
ment for their sins or lack of spirituality. Others come to feel angry
toward God, wonder whether God has abandoned them in their time
of trouble, or question whether God cares about them or has the ability to help them with their problems. Such feelings of estrangement from God constitute the core of divine struggle, and this can impair mental health by (a) depriving individuals of a close personal bond with God and (b) eliciting feelings of worthlessness, helplessness and hopelessness, which are important precursors to depression and other negative affective conditions. Several researchers have documented potent associations between divine struggle and depression, suicide ideation and other undesirable emotional outcomes in diverse samples (Exline, Yali and Lobel 1999, Exline, Yali and Sanderson 2000, Pargament et al. 2004, McConnell et al. 2006, Ellison and Lee 2010).

Closely related, but conceptually and empirically distinct, is the phenomenon of intrapsychic struggle, often gauged in terms of religious doubts. The status of doubt within the Christian tradition is somewhat ambiguous (Hech 2003). On the one hand, some liberal theologians, e.g., Paul Tillich, have argued that the maturation of one’s faith requires questioning and doubting. However, Pauline writings admonish the faithful to believe without doubting, and conservative theologians such as Karl Barth have asserted that religious doubt should be a source of shame for all Christians (Krause et al. 1999). Doubt may foster feelings of emotional distress, depression, anxiety, and related outcomes for several reasons. First, individuals who experience doubt are deprived of a valuable source of existential meaning, coherence, and coping assistance. Second, those who are (or have been) persons of faith are likely to feel guilt due to their non-normative status as doubters. Third, these feelings may make them reluctant to share their doubts with fellow church members or clergy, which in turn may eliminate a potentially valuable source of spiritual nurturance and social support in addressing these issues (Krause and Ellison 2009). Several studies have investigated the links between religious doubt and various mental health outcomes, and their results generally confirm that doubting has undesirable emotional sequelae (Ellison 1991, Krause et al. 1999, Krause 2006c, Ellison and Lee 2010). In addition, the harmful effects of doubt vary by age, with younger people experiencing higher levels and greater deleterious effects, as compared with older adults. Doubts may also be more problematic for persons with lower levels of education and those who have recently experienced major stressful events (Krause et al. 1999, Galek et al. 2007).

Religious groups can also be sites of interpersonal strife and conflict, as well supportive bonds and acts of kindness. Negative interactions
within religious settings can arise from a number of causes (Krause et al. 2000). For example, some congregations may make excessive demands on their members, requiring high levels of time, energy, and financial resources. Such demands may overload members, affecting family roles, work life, and exhaustion (Krause, Ellison and Wulff 1998). Many religious groups also attempt to shape members’ behaviors in such areas as lifestyle choices and political orientations, among others. Individuals who deviate from normative behaviors may face unpleasant interactions with fellow members or even church leaders. Congregations, like other social groups, can fall prey to interpersonal jealousies, bickering and backbiting as well. Finally, congregations can experience more serious, large-scale conflicts (e.g., Becker 1999); these rifts can occur over matters of administration (e.g., management of facilities and finances); theological or doctrinal views of the clergy; or political matters, such as homosexuality, war, or other controversial topics.

Studies have repeatedly shown that the harmful effects of negative interactions may be proportionally greater than the salutary influence of positive encounters (Schuster, Kessler and Aseltine 1990, Okun and Keith 1998). This may be true for several reasons. Broad social norms create the expectation that most interactions will be neutral or positive, therefore, overtly unpleasant or hostile exchanges are unexpected and counter-normative, hence they can be especially damaging when they occur (Rook 1984). This may be especially true within religious groups, where such negativity is highly discouraged and therefore unanticipated. In addition, stressors can be particularly problematic when they challenge roles that are highly valued (Krause, Ellison and Wulff 1998). Because religious roles and moral standing may be especially important to members of faith communities, negative interactions with coreligionists could be expected to take a particularly heavy toll on emotional well-being. This impact could be even more deleterious for clergy members or lay leaders. Indeed, several cross-sectional and longitudinal studies of church-based negative interaction and mental health report findings that are consistent with these arguments (Krause et al.1998, Krause 2003b, Ellison, Zhang et al. 2009).

Conceptual Models

The secular literature on the stress process provides several conceptual models of the relationships between stressors, resources and health
outcomes (Wheaton 1985, Lin and Ensel 1989). Several researchers have adopted these models readily for use in the study of links between multiple dimensions of religious involvement and mental health (Tix and Frazier 1998, Ellison et al. 2001, Fabricatore et al. 2004). Three models, which we will term the stress-deterrent, offsetting effects, and additive models, posit that stressors and resources have deleterious main effects on mental health outcomes. In the stress-deterrent model, represented in Figure 1.1a, religious involvement is simply regarded as exogenous, and aspects of religious participation (e.g., frequency of attendance, embeddedness in congregational networks) are expected to influence mental health partly by reducing levels of exposure to traumatic events and chronic conditions. Thus, according to this model, controlling for the presence, number, or severity of stressors would be expected to diminish the link between religious involvement and mental health. In the offsetting effects model, religious resources
(e.g., congregational social support, psychological or coping resources) are expected to have salutary effects on mental health, thus partly or entirely countering the impact of stressors well-being. This model is depicted in Figure 1.1b. By contrast, in the additive effects version, those aspects of religiousness (e.g., maladaptive coping, religious doubt, negative interpersonal encounters), which we have termed the "dark side" of religiousness, have an independent role in undermining mental health, thereby adding to the problems caused by stressful events or conditions, as depicted in Figure 1.1c.

The second set of models described here involves more complex relationships between stressors, resources, and mental health outcomes. According to the suppressor model, persons facing stressful events and conditions tend to mobilize resources in order to deal with the consequences of these problems, e.g., by drawing on religious support networks or positive religious coping strategies. These resources, in turn, assist individuals by countering the noxious effects of stressors. Thus, the magnitude of harmful consequences of stressful events and circumstances may be "suppressed" (or masked) by the salutary role of religious resources; only when the salutary effects of these resources are controlled can the "true" scope of the deleterious effects of stressors be detected. This suppressor model is displayed in Figure 1.2a. The mediator model also assumes that stressors impair mental health, but this model suggests that one way in which traumas and chronic problems take their toll is by promoting religious or spiritual problems, e.g., increasing levels of religious doubt, feelings of estrangement from God, and so on. Thus, negative facets of religion mediate the link between stressors and mental health; by adjusting for these unwholesome aspects of religiousness, it is possible to observe
one of the pathways linking stressors with poorer mental health. This 
mediator model is represented in Figure 1.2b.

Finally, the third set of conceptual models involves contingent or 
interactive effects. Once again, stressors are assumed to impact mental 
health adversely. In the stress-buffering model, the deleterious effects of 
stress are conditioned by the levels of positive religious resources, e.g., 
congregational support, psychological resources. The salutary effects 
of religiousness are most evident among persons facing elevated levels 
of stressful events and conditions, and the harmful sequelae of stress-
sors are substantially blunted among persons with higher levels of reli-
gious resources. By contrast, the undesirable impact of stressors is 
strongest among those persons with the lowest levels of such resources. 
This stress-buffering model, displayed in Figure 1.3a, is commonly 
evaluated by adding cross-product interaction term(s) to multivariate 
models predicting individual-level variations in mental health out-
comes. Another interactive model is the stress-exacerbating model, 
depicted in Figure 1.3b. According to this conceptual model, negative 
aspects of religiousness or spirituality, such as those discussed earlier, 
may augment or compound the already-negative consequences of 
( secular) stressful events or conditions, thus having a harmful multi-
plier effect on mental health problems. Where this is the case, the nox-
ious effects of stressors should be greatest among persons with the 
highest levels of these negative facets of religiousness, such as doubt, 
estrangement from God, and negative interpersonal encounters in the 
church. The magnitude of stressor effects should be weakest among 
persons who do not suffer from this “dark side” of religion or spiritual-
ity. This final model, the stress-exacerbating model, is presented in 
Figure 1.3b.
Subgroup Variations

In addition to exploring the issues outlined above, investigators are increasingly attentive to possible subgroup differences in the links between religious involvement and mental health outcomes. Much of the existing literature has centered on the potential moderating effects of race-ethnicity, social class and gender. Why might associations between religious factors and mental health outcomes be contingent on race-ethnicity? Many observers have called attention to distinctive aspects of African American theology, congregational life, worship practices, and other features of religious life that may hold implications for mental health (for a review, see Ellison et al. 2010). In particular, due to the legacy of racism, segregation, and economic exclusion, African American theology developed as a practical response aimed at healing, hope, and the individual and collective liberation of African Americans.

Despite commitment to Evangelical Protestant theology, which sometimes envisions God in highly judgmental terms, African American theology has tended to emphasize a benevolent, loving, forgiving God, a God of redemption and second chances. In addition, African American religion often embodies a communal orientation, with congregations serving as extended families and as focal points of members’ social support systems. Moreover, many (but certainly not all) African American religious services involve ecstatic worship styles – including call-and-response preaching, dancing and other physical expressiveness, dynamic music, etc. – that may facilitate the management and release of negative emotions (e.g., grief, anger) and increase feelings of euphoria. Finally, there is a growing body of evidence confirming the distinctive role and high importance of religious faith and practice among African Americans, especially elders. A number of studies report that religious effects on health and well-being are stronger among African Americans as compared with whites, and also that religion buffers the noxious effects of experiences with discrimination and racist encounters on mental health (Bierman 2006, Ellison, Musick and Henderson 2008).

To date, few studies have examined the relationships between religion and mental health among Latino Americans, and we are aware of virtually no studies comparing the effects of religious factors among Latinos and non-Hispanic whites or other groups. Emerging work among older Mexican Americans discusses several distinctive
facets of Latino religion, particularly the valorization of suffering in silence, emulating the journey of Christ (Krause and Bastida 2009). Another recent study among working-age Mexican Americans in California reports what appear to be salutary effects of religious salience on depressive symptoms. This relationship is present for both women and men, although it is notably stronger for women, a pattern that may reflect the empowering image of the Virgin of Guadalupe, patron saint of Mexico and Mexican Americans (Ellison, Finch et al. 2009).

Another potentially important source of subgroup variation in links between religion and mental health is socioeconomic status. Relevant research extends longstanding interest in the role of religion in the lives of less fortunate groups. Schieman, Nguyen and Elliott (2003) have examined a productive debate about whether religious involvement compensates for social and economic deficits, or amplifies the advantages associated with higher levels of education and income. Several studies report that the salutary effects of religious faith and practice for mental health are moderated by education, with stronger associations generally emerging among persons with lower levels of education (Pollner 1989, Ellison 1991, Krause 1995). Taken together, such findings suggest that religious faith may substitute for education in providing a plausibility structure, or coherent interpretive framework, with which individuals can make sense of mundane events, world affairs, and personal challenges (Berger 1967). Recent work by Schieman and colleagues (2006) reveals that the sense of divine control predicts lower levels of psychological distress for lower-SES elders, but predicts higher levels of distress among their upper-SES counterparts. Further, there is new evidence that religious belief (particularly belief in an afterlife) mitigates or buffers the deleterious effects of financial hardship and decline, as well as feelings of relative deprivation, on psychological distress (Ellison, Burdette and Hill 2009, Bradshaw and Ellison 2010).

The associations between religion and mental health may also be conditioned by gender. It is well established that, on average, women are more religious than men, by virtually all conventional indicators. But in addition to these gender differences in levels of religiousness, there are indications that the benefits from religious belief and practice may vary by gender as well, although the specific patterns may depend upon which aspects of religiousness are considered. For example, on average women attend religious services more often than men, and
they enjoy higher levels of church-based emotional support than men. However, men may derive proportionally greater benefits from religious attendance and support (Krause, Ellison and Marcum 2002, McFarland 2010). On the other hand, several recent studies suggest that spiritual perceptions (e.g., feelings of union with God and deep connection to nature) may be more strongly linked with mental health outcomes for women than for men (Maselko and Kubzansky 2006, Ellison and Fan 2008, Greenfield, Vaillant and Marks 2009). Further, as noted earlier, at least one study of Mexican Americans reports that the inverse association between religious salience and depression is stronger among women (Ellison, Finch et al. 2009).

Although race-ethnicity, socioeconomic status, and gender are obvious starting points for sociologists interested in subgroup variations and moderator effects in this area, there are other promising directions as well. For example, it would be useful to determine whether religious involvement, particularly congregational social support and attachment to God, may substitute or compensate for a dearth of close interpersonal ties, or whether religion enriches existing relationships and ameliorates the mental health advantages that are already enjoyed by individuals with close and supportive relationships. In addition, a recent study by Brashears (2010) reveals that associations between religiousness and anomia are moderated by the degree of religious homogeneity that characterizes personal social networks. Specifically, religious protective effects are stronger among persons whose social networks are composed primarily of coreligionists. Thus, closer attention to the broader contexts within which individual religious faith and practice are embedded can enhance our understanding of the links between individual religious involvement and mental health outcomes.

**Concluding Thoughts**

In this chapter we have sought to (a) provide a brief review of literature on religion and mental health, focusing on studies of affective disorders conducted using community- or population-based samples drawn in the United States; (b) identify the most promising mechanisms or explanatory pathways that may underlie associations between religious factors and mental health outcomes from the perspective of the stress process; (c) outline the most plausible conceptual models linking
religion with components of the stress process; and (d) briefly review evidence regarding subgroup variations in the relationships between religion and mental health.

Although considerable progress has been made over the past two decades, a number of important research questions in this area remain unaddressed, and several issues deserve the urgent attention of investigators. One key concern is the dearth of relevant high-quality, longitudinal data on representative community or population samples. Such data are vitally important if we are to move beyond simply observing tantalizing cross-sectional associations, toward establishing causal relationships. Moreover, given that individuals select into (or out of) religious belonging or belief, it is important to consider the role of selectivity in shaping observed relationships between religion and mental health. Longitudinal data will be essential for this purpose.

Another key issue involves the availability of appropriate measures of religiousness and related constructs. In particular, although conceptualization and measurement of health-relevant religious and spiritual domains has moved forward rapidly (e.g., Hill and Pargament 2003, Idler et al. 2003), the small number of valuable data sources in this area often lack sophisticated measures of such central constructs as congregational support processes, religious coping methods, character strengths (e.g., forgiveness, gratitude) and other constructs from positive psychology (e.g., meaning and purpose). It would also be productive to incorporate elements of religious belief, which are now receiving fresh attention from researchers (e.g., Schieman 2010), as well as spiritual experiences (e.g., Ellison and Fan 2008), although observers rightly worry that some constructs in this domain – especially “spiritual well-being” – may be confounded with mental health outcomes (Koenig 2008).

Given the religious makeup of the United States, which remains primarily Christian, it is understandable that the religious measurement approaches used in many survey data collection projects emphasize Christian practices and beliefs. However, it is also important for researchers to develop culturally appropriate strategies for gauging facets of other non-Judeo-Christian faith traditions, due to their prevalence around the world and their expanded numbers within the U.S. In recent years researchers have begun this task, developing and validating measures of core facets of religiousness for Hinduism (Tarakeshwar et al. 2003), Islam (Abu Raiya et al. 2008), and other faiths. Further work is needed to link these and other dimensions of
religion and spirituality with mental health outcomes among adherents of these faith traditions.

Finally, much more information is needed on the interface of religion with genetics, gene-environment interactions, and neuro-physiological processes. Briefly, it is becoming clear from studies of monozygotic and dizygotic twins that religiousness has some genetic basis, although it appears that the extent of this inherited component varies widely depending upon the specific facet of religiousness under consideration. For example, according to one study of midlife adults in the United States, approximately 30% of individual-level variation in the frequency of religious attendance may be attributable to genetic factors; this figure rises sharply, to nearly 70% for the propensity for a “born again” or life-changing religious experience (Bradshaw and Ellison 2008). It is also well established that depression, anxiety, and other negative affective outcomes are significantly influenced by genetic factors. However, relatively few studies have attempted to assess whether the observed link between religiousness and mental health can be explained – at least in part – by genetic factors (for an exception, see Kendler, Gardner and Prescott 1997). Moreover, there is considerable interest in studying the interplay of genes and environments, i.e., the extent to which genetic influences on outcomes such as depression or other mental health conditions may be contingent on (delayed, hastened, or forestalled altogether by) factors such as aspects of religiousness (religiously-based psychosocial resources, coping methods, etc.). Further work along these lines could make a valuable contribution to our understanding of the overall connection between religion and mental health.

In addition, a small but growing body of research documents the association between religious belief and experience, on the one hand, and brain functioning on the other hand. Moreover, recent work indicates that those persons who believe fervently are less reactive to errors, as measured by the changes in the function of the anterior cingulate cortex (ACC), which may offer a neurological mechanism for the observed link between religious beliefs (in God, an afterlife, etc.) and reduced anxiety (Inzlicht et al. 2009, Inzlicht and Tullett 2010). In addition, ongoing work relates specific facets of religious involvement, including particular religious coping styles and methods, with depression among older adults through changes in the size of the hippocampus (Hayward et al. 2011). Such research is vitally important, because it has the potential to connect social processes, such as those identified
by our discussion of religion and the stress process, with neuro-physiological pathways that ultimately give rise to affective states such as depression and anxiety.

Clearly research on religion and mental health has come a long way in a relatively short time. As investigators continue to pursue balanced, multi-disciplinary research programs, such advances are likely to continue, and indeed, to accelerate. By building upon the core constructs and models of the "stress process" tradition and integrating them with findings from other relevant fields, social scientists can make vital contributions to our understanding of the complex relationships between religion and mental health outcomes.

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