

A BRIEF MEASURE OF CORE RELIGIOUS BELIEFS FOR USE IN PSYCHIATRIC SETTINGS

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ABSTRACT

Results from several national studies in the United States suggests that: (1) religious beliefs and practices are highly prevalent; (2) spirituality and religion are statistically and clinically relevant to mental health and symptoms; and (3) many patients have a preference for spiritually integrated care. However, many existing protocols that assess for salient religious themes in psychiatric settings are time-consuming to administer, relevant only to specific populations (e.g., Christians), and have poor psychometric properties. Further, evidence suggests that religious beliefs can take on a positive and negative valence, and both of these dimensions are worthy of assessment. We, therefore, developed a brief (six-item) self-report measure of positive and negative core beliefs about God which is uniquely suited for use with a broad range of religious patients. Across three studies, we evaluated its psychometric properties and ability to predict symptoms of anxiety and depression. Results provide support for the validity and reliability of our measure and further highlight the salience of both positive and negative religious beliefs to psychiatric symptoms. It is hoped that this measure will help to decrease the burden of spiritual assessment in psychiatric and medical settings, and further have research utility for this area of study.

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INTRODUCTION

Numerous surveys conducted with nationally representative samples in the United States have reported that religion and spirituality are highly prevalent [1, 2]. Further, and more importantly, a substantial body of research now ties these factors to mental health and illness. Specifically, indicators of religious beliefs and practices are associated with lower levels of depression [3], anxiety [4], and other psychiatric symptoms [5]. It is, therefore, not surprising that in some studies nearly half of medical and psychotherapy patients would like to discuss spiritual issues with their healthcare providers [6, 7].

In the last decade, interest in meditation, mindfulness, and positive psychology has grown from within mental health disciplines and there is increasing openness among professionals to spirituality. However, basic core competencies in addressing this area of life are lacking. In particular, religious beliefs are often ignored in the context of treatment as mental health professionals are often ill-trained in the assessment of these factors in clinical settings [8]. This deficit creates a reticence to broach this topic in psychiatric research and practice, which in turn perpetuates assumptions throughout the field that these facets are tangential to human functioning and a side issue in treatment [9]. It is, therefore, important to help facilitate the measurement of religious beliefs within the field.

Currently, assessing religious beliefs in a psychiatric context is complicated by the fact that religion and spirituality tend to be closely tied to specific cultures and affiliations, and diversely relevant assessment tools are lacking. Pragmatic challenges present as well; many existing measures are exceedingly comprehensive and laborious to administer. Further, a recent critique has highlighted the importance of moving beyond cursory indicators of global religiousness (e.g., religious affiliation, frequency of church attendance, belief in God) toward facets of religion that are proximally and functionally connected to mental health and illness [10]. For example, recent research has demonstrated that spirituality and religion can take on negative as well as positive themes, which differentially predict higher and lower symptoms respectively; assessments should thus measure both of these dimensions [11].

Previously, our research has established the relevance of trust and mistrust in God to affective symptoms [12-14]. Trust in God involves the conviction that God takes care of one's best interests, whereas mistrust in God involves the belief that God is intentionally ignorant or malevolent. These constructs originate from traditional Jewish thought [15] but are central to all Abrahamic traditions and monotheistic faiths [16]. In addition to their empirical linkages, these core religious beliefs are theoretically tied to anxiety and depression in a functional manner. A trust in God worldview may mitigate negative appraisals of adversity. Trust in God may further contribute to positive religious coping and serve as a spiritual resource in the face of stressful life events. By contrast, mistrust in God may exacerbate perceptions of threat and danger, and further indicate spiritual struggle and conflict [17].

In sum, most existing assessments of spiritual/religious factors appear to be best suited for social psychology research as they are overly comprehensive, not functionally tied to mental health/illness, fail to assess for negative as well as positive facets, and are not usable in a diverse context. We, therefore, developed a brief self-report measure of trust and mistrust in God for use in psychiatric settings, and we determined its psychometric properties and predictive capabilities in three studies. In Studies 1 and 2, we conducted exploratory factor analyses and examined correlates of our measure with indices of symptoms in community samples of Christians and Jews. In Study 3, we conducted a confirmatory factor analysis in a sample of Jewish individuals seeking treatment for anxiety symptoms.

STUDY 1

Method

Procedure and Participants

One hundred and twenty Christian participants were recruited to participate in an Internet-based survey via advertising on Christian religious community websites and e-mails sent to distribution lists of Christian organizations. Further, participants were asked to aid in recruitment by informing their Christian friends and associates about the study. No monetary or other compensation was given for participation. The majority of participants were female (74.2%), Protestant (80.8%), and residing in the United States (85.0%). Mean age was 33.9 ($SD = 15.3$) years and about half (53.3%) of respondents were college graduates.

Measures

Trust/Mistrust in God

Three items assessing trust in God (e.g., God loves me immensely) and three items reflecting mistrust in God (e.g., God hates me) were exacted from previous research (see Appendix for copy of measure). Participants rated these items for degree of belief using a 5-point anchor Likert-type scale (anchors ranging from *Not at All* to *Very Much*).

Depression

Depressive symptoms were measured with the Center for Epidemiologic Studies Depression Scale (CES-D), a 20-item self-report scale that has been validated extensively in clinical and community settings [18]. A cut-off score of 16 was used to indicate clinical levels of depression [19].

Worry

The Penn State Worry Questionnaire (PSWQ) was used to assess for worry [20].

Anxiety

The State-Trait Anxiety Inventory was also used as a general measure of anxiety. A previously established cut-off score of 53 was used as an indicator of clinical levels of symptoms [21].

Results

The psychometric properties of the six trust and mistrust in God items were examined in an exploratory factor analysis. Participants' responses were subjected to a principal components analysis with direct oblimin (oblique) rotation. Two factors emerged with Eigenvalues of 3.1 and 1.9 (52.45% of variance explained), representing trust and mistrust in God respectively. Factor loadings were very high (.93–.98 for trust, and .79–.94 for mistrust) and there were no cross-loaded items (i.e., no items on one factor with loading values $> .25$ on the other factor). Reliability for all six items was high when separating the factors (trust $\alpha = .94$; mistrust $\alpha = .84$) and moderate when combining them ($\alpha = .60$). These results support two separately summed subscales measuring trust ($M = 13.93$, $SD = 2.27$, Skewness = -2.61) and mistrust in God ($M = 3.42$, $SD = 1.45$, Skewness = 4.92).

Regression was then utilized to examine the relationship of these subscales to symptom measures. Trust in God was significantly tied to lower levels of depression ($r = -.39$, $p < .01$), worry ($r = -.27$, $p < .01$) and anxiety ($r = -.32$, $p < .01$) but mistrust was not associated with symptoms. Trust remained a significant predictor of symptoms after controlling for age and gender, accounting for an additional 12.5% of the variance in depression, 3.3% of the variance in worry, and 8.5% of the variance in anxiety. Further, the trust in God subscale discriminated between clinical and subclinical levels of depression (P^2 ($n = 108$) 21.26 , $p < .02$), and both the trust (P^2 ($n = 108$) 53.42 , $p < .001$) and mistrust (P^2 ($n = 107$) 36.67 , $p < .001$) subscales discriminated clinical levels of anxiety.

STUDY 2

Method

Procedures, measures, and statistical analyses in this study were identical to Study 1, except that Jewish participants were solicited. A total of 234 Jewish individuals participated, of which 54.7% were female, 60.3% were Orthodox, and 82.8% from North America (40.6% from the United States and 42.2% from Canada). The sample had a mean age of 37.3 ($SD = 13.5$) and 72.2% reported having a college degree.

Results

Principal components analysis again revealed that trust and mistrust in God items were split between two factors. Eigenvalues were 3.3 and 1.2 respectively

(accounting for 55.8% of scale variance). Factor loadings were again very high for both trust (.90–.96) and mistrust (.69–.82) and again no cross-loaded items were identified ($> .25$). Reliability was very high for the trust subscale ($\alpha = .94$) and moderate for the mistrust subscale ($\alpha = .69$). Scale means were comparable to Study 1 ($M = 10.51$, $SD = 4.09$ for trust; $M = 4.08$, $SD = 1.88$ for mistrust); however, mistrust was more normally distributed in this sample (Skewness = 2.39). Trust in God was tied to lower levels of depression ($r = -.25$, $p < .01$) and anxiety ($r = -.18$, $p < .01$). After controlling for age and gender, trust in God was tied to all three symptom measures, accounting for an additional 8.1% of the variance in depression ($p < .001$), 9.1% of the variance in anxiety ($p < .005$), and 2% of the variance in worry ($p = .06$). However, the trust in God subscale did not discriminate clinical levels of symptoms. Mistrust in God was linearly correlated with higher depression ($r = .31$, $p < .01$), anxiety ($r = .22$, $p < .01$), and worry ($r = .15$, $p < .05$). These relationships were significant after controlling for age and gender; mistrust accounted for 10.9% of the variance in depression ($p < .001$), 6.1% of the variance in anxiety ($p < .001$), and 3% of the variance in worry ($p < .05$). Further, the mistrust subscale was able to discriminate between clinical and subclinical levels of depressive (P^2 ($n = 204$) 24.61, $p < .01$), but not anxiety symptoms.

STUDY 3

Method

Two hundred and sixty-two Jewish individuals with elevated levels of anxiety symptoms were recruited to participate in a randomized controlled trial of a spiritually-integrated intervention [22]. Participants were not compensated monetarily; however, all treatment was provided without cost. Mean age in the sample was 41.0 years ($SD = 13.2$) and the majority of participants were female (57.3%), from the United States (51.5%) and college educated (78.2%). Approximately half the sample (49.2%) reported Orthodox affiliation. Participants completed the six-item measure and its psychometric properties were evaluated by confirmatory factor analytic methods.

Results

Analyses were conducted with the statistical software R [23]. Multiple indices of fit were evaluated, including the root mean square error of approximation (RMSEA), the Comparative Fit Index (CFI), and the Non-Normed Fit Index (NNFI). Based on previously established criteria, values greater than .90 for the CFI and NNFI, and less than .08 for the RMSEA were seen to indicate an acceptable fit [24]. The two-factor model described in Studies 1 and 2 fit the data well (CFI = .99; NNFI = .98; RMSEA = .07; 90% CI = .66–.78), and provided a

significantly better fit than a single factor model. The Chi-square value for the overall model was within an acceptable range $\chi^2 (n = 262) 18.03, p < .05$, and standardized coefficients were high for both trust (.75–.96) and mistrust (.68–.90) items. These results indicate good psychometric properties, and provide further support for the measure's two-factor structure. As in Study 1, internal consistency was high ($\alpha = .90$ for trust and $\alpha = .85$ for mistrust in God).

DISCUSSION

In this article, we report findings from three studies evaluating the psychometric properties of a brief (six-item) measure of core religious beliefs. Results provide strong initial support for our measure's construct validity and item-total reliability. All three studies found evidence for a robust, two-factor solution measuring positive and negative beliefs about God (trust and mistrust in God), and subscale alphas were consistently high. We further examined our measure's ability to predict affective symptoms in community samples of both Christians and Jews. Trust in God was tied to lower levels of symptoms among both Christians and Jews. Mistrust in God was associated linearly with greater symptoms among Jews, but not Christians. This discrepancy may be due to Christians reporting low levels of mistrust with very low variance in the obtained sample. Further, subscales were able to differentiate clinical from non-clinical levels of symptoms in these populations, though not on all measures.

While additional research is needed to substantiate the test-retest, convergent, and incremental validity of our measure, these encouraging results highlight the clinical as well as research utility of our measure. As noted above, there is a pressing need to offer spiritually integrated services in psychiatric settings. The existing lack of clinically-relevant, psychometrically valid, cross-culturally applicable and easily administered spiritual assessment tools is, therefore, a formidable barrier to patient care. Furthermore, many existing measures of spirituality and religion fail to assess for both positive and negative dimensions. The brief measure reported in this study can be utilized as a simple clinical index of core religious beliefs when treating Christian and Jewish patients, and it may further apply to individuals from other monotheistic religious backgrounds (e.g., Islam). It should be noted, however, that the measure is appropriate for use with individuals who have a personal God concept, which may vary considerably both across and within traditions. It can further be easily included in self-report batteries in the context of psychiatric research.

This study further suggests an important link between religion and mental health. In Studies 1 and 2, core religious beliefs accounted for up to 12.5% of the variance in symptom measures after controlling for demographic covariates. This suggests that, for some individuals, the spiritual domain is highly relevant to symptoms. It, therefore, behooves clinicians and researchers to pay closer attention to the spiritual and religious, as well as the cognitive, affective, intra-

and interpersonal domains, in the course of psychiatric assessment, treatment, and research.

Limitations of this study include reliance on Internet-based administration, and a cross-sectional design which precludes determining the direction of influence between study variables. As well, in Studies 1 and 2, convenience sampling methods were utilized. Furthermore, although beliefs about the nature of God are central to almost all monotheistic traditions, our measure nevertheless provides a highly specific focus on only one aspect of religious life. It would be advantageous to create similar brief measures to examine additional facets of human spirituality and religion. It would further be advantageous to examine the psychometric properties and predictive capabilities of our measure in other religious groups. It is also unclear whether the mistrust subscale taps into a stable religious disposition, or is an indicator of a more dynamic process of religious struggle that may be less stable over time. Despite these limitations, it is hoped that the Brief Trust/Mistrust in God Scale will help to increase the availability of spiritual assessment in psychiatric and medical settings, and spawn further research in this area of study.

APPENDIX: Brief Trust/Mistrust in God Scale

The following statements are concerned with your beliefs about God (Higher Power, Divine, Creator). Please indicate how strongly you generally believe in each statement.

Anchors: Not at all; A Little; Somewhat; A Lot; Very Much

1. God loves me immensely
2. God ignores me
3. God cares about my deepest concerns
4. God hates me
5. No matter how bad things may seem, God's kindness to me never ceases
6. God doesn't care about me

Note: Trust in God items: 1, 3, 5; Mistrust in God items: 2, 4, 6; Subscale should be scored/summed separately.

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