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Religion and Health

The Role of Religious Communities

Abstract
Religion and health have been intertwined since the dawn of humanity. In recent centuries, this connection has tended to be separated at various levels, ranging from the provision of healthcare to an exclusively biological/empirical view of health, illness, and healing. The 19th and early 20th century were characterized by a widespread emphasis on the negative influence of religion on mental health, particularly in the field of psychotherapy. This shift strongly marked the beginning of the 20th century, and it took several decades for medical research to return to the question of the influence of faith and religion on health. In the first part of this paper, attention will be given to the impact of religion on health. This will be followed by a discussion of religion's place in global public health and the role of local church communities.

Zusammenfassung
Religion und Gesundheit sind seit den Anfängen der Menschheit miteinander verwoben. In den letzten Jahrhunderten wurde diese Verbindung tendenziell auf verschiedenen Ebenen getrennt, angefangen bei der Gesundheitsvorsorge bis hin zur ausschließlich biologisch-empirischen Sichtweise auf Gesundheit, Krankheit und Heilung. Das 19. und frühe 20. Jahrhundert waren geprägt von der weit verbreiteten Annahme des negativen Einflusses von Religion auf die psychische Gesundheit, insbesondere im Bereich der Psychotherapie. Es dauerte mehrere Jahrzehnte bis sich die medizinische Forschung sich wieder mit der Frage nach dem Einfluss von Glauben und Religion auf die Gesundheit befasste. Diesem Thema widmet sich der erste Teil dieses Beitrags. Anschließend wird die Bedeutung von Religion für die globale Gesundheit und die Rolle lokaler Kirchengemeinden diskutiert.

1 Introduction

Religion and health have been intertwined since the dawn of humanity. Religious prayers and rituals in a variety of contexts have often focused on healing and well-being. From its beginning, Christianity placed strong emphases on helping the sick and healing. This interconnection of faith and health has shaped the history of the development of medical care in Europe. The care for the sick, the opening of hospices, pharmacies, and later the first hospitals, was largely provided by religious orders and institutions. The Age of Enlightenment and later the nationalization of

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social welfare in European countries brought about a separation between religion and healthcare. The modern divide between science and religion tended to further separate these two aspects. In the 19th and early 20th century, scholars working in psychotherapy began to emphasize the negative influence of religion on mental health explicitly. This paradigm shift strongly marked the beginning of the 20th century, and it took several decades for science to return with renewed interest to the question of the influence of faith and religion on health. The first part of the paper examines the impact of religion on health. This is followed by a consideration of the place of religion in the context of global public health and the role of the Catholic communities in this regard.

2 Religion and Health

In the 19th century, Jean Charcot and Sigmund Freud associated religion with hysteria and neurosis. Freud convincingly argued the neurotic influence of religion on mental health. Later, some other authors, such as Albert Ellis and Wendel Watters, continued to emphasize the negative impact of religion on mental health (cf. Koenig 1997). Ellis sustained that "devout, orthodox or dogmatic religion (or what might be called religiosity) is significantly correlated with emotional disturbance" (Ellis 1980, 637). Watters' critique was even more specific, emphasizing how religious teachings, and Christian doctrine in particular, are incompatible with the primary components of good mental health, especially self-esteem, self-actualization, mastery, the establishment of supportive social networks, etc. (cf. Watters 1992, 140). It appears that many 20th-century mental health scholars sustained that religion had either negative effects on mental health or none at all (cf. Koenig 2000).

Sociologist Émile Durkheim was the first to study statistical links between mortality by suicide and a range of social influences, including religion (cf. Durkheim 1951). He saw that alienation was causing the increased rate of suicide, while on the other side, social groups, including those associated with religion, were the ones that provided support and played a social role. Larson and colleagues (cf. 1992) challenged the classical negative view on the religious impact by conducting systematic reviews of quantitative research on religion in psychiatry. They found that 72 % of studies reported a positive relationship between religious involvement and better mental health, 16 % worse mental health, and

12 % no correlation. A broader systematic review report from 2013 also found that 72 % of studies reported significant positive associations between religious involvement and better mental health (cf. Bonelli/Koenig 2013). Harold Koenig's extensive research in this area has provided abundant empirical evidences supporting the relevance of religion for health outcomes.

Beyond the high positive correlation between religion and good mental health, what about the data in which religion was associated with poorer mental health? This correlation does not necessarily imply causation and the study design of each of the studies reviewed must be considered and examined. Religious persons may have high expectations, condemn themselves or others for struggles they deem improper in the context of their religion, or judge themselves more harshly, etc. However, the complexity of mental health issues and their relationship to religious experience and involvement requires more in-depth research.

In discussing the negative effects of religion, Harold Koenig (1997, 105) acknowledges in his extensive research that religious teachings are rarely pathological in themselves, "rather, it is the neurotic tendencies of those who use religion that make it pathological for them". The problem often lies in the individual's neurotic or manipulative use of religion. Another critical aspect is the different types of abuse that are also being reported in religious settings. Koenig (1997, 157) argues that "mature employments of religion that emphasize love, forgiveness, acceptance, mercy, and compassion are difficult to neuroticize". However, in the absence of such maturity and for other reasons, physical, sexual, and psychological violence can occur. Recently, research and psychological practice have also focused on so-called spiritual abuse, which happens in a religious context and involves various aspects of violence in the person's intimate spiritual sphere (using control, deception, oppression, and manipulation).[1] All types of abuse can have negative health effects, especially in terms of psychological well-being. In addition, spiritual abuse can have deep effects on spiritual levels, distorting the image of God, undermining systems of meaning, leading to loss of freedom, in ability to trust oneself and others, as well as the onset of depression (cf. Fernandez 2022, 3). The authors emphasize that "however defined, trauma occurring in

1 There are still different working definitions of the phenomenon that have not yet been described in the most relevant *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). For more detailed approach to the topic cf. Kießling 2021.

a religious/spiritual setting has the effect of reducing a victim's ability to use religion/spirituality as a coping strategy, at least for those who exercise their religion/spirituality in organized contexts" (Koch/Edstrom 2022, 478). An abusive experience is then seen as an obstacle to experiencing the benefits of an active religious life. This seems particularly relevant in light of recent large prospective studies suggesting that religious engagement positively affects health and human flourishing across the life span, from adolescence to young adulthood to later life (cf. Chen/VanderWeele 2018; Chen et al. 2020).

Positive influences of religion on individual and public health have been reported particularly with respect to fewer depressive disorders and anxiety symptoms, less loneliness, better social integration, more positive emotions, greater purpose in life, less cigarette smoking and alcohol use, and, finally, lower all-cause mortality (cf. Koenig et al. 2023). Among children and adolescents, religiosity and spirituality are associated with better social support, positive religious coping, less risky behavior and substance abuse, lower rates of school misbehavior, and higher levels of hope, love, and purpose (cf. Markstrom 1999; Hill/Pergament 2008). The effects of religion on physical health have been found to be more indirect or distal, compared with more direct effects on mental, social, and behavioral health. However, religion can also have a negative impact, as some religious beliefs may interfere with seeking timely diagnosis and medical care, motivate refusal of potentially life-saving interventions such as blood transfusions, etc. (cf. Koenig 2000).

Furthermore, large research studies have shown that religious service attendance in particular is associated with various health benefits, such as increased longevity, less depression, fewer suicides, less smoking and substance abuse, better survival from cancer and cardiovascular disease, as well as greater meaning and purpose in life, higher life satisfaction, etc.[2] Several studies suggest that attendance at religious services, not just private practices of religiosity or spirituality, are the most predictive for health outcomes (cf. VanderWeele 2017; Musick et al. 2004). The studies mentioned above were mainly conducted in North America and Europe within a Christian context. Some studies have also reported

2 There are a variety of studies that show a positive correlation between various health benefits and religious service attendance, e. g. VanderWeele 2017; Li et al. 2016a; Li et al. 2016b; VanderWeele et al. 2016; Lim/Putnam 2010; Chida et al. 2009; Johnson et al. 2001; Hummer et al., 1999; Strawbridge et al. 1997.

differences between different Christian denominations, but this research is still at its beginning.

The empirical studies and findings on the influence of religion on health are sometimes altogether omitted from literature. A recent review of the achievements of health psychology in the last decades has pointed out the most relevant aspects for a successful and healthy life without mentioning the role of religion/religious life;[3] a similar trend can also be observed in various health psychology textbooks (cf. Hadjistavropoulos/Hadjistavropoulos 2015). Despite that, numerous empirical studies report the multifaced influence of religion on individual and public health.

3 Global Public Health and Religion

Turning explicitly to the context of public and global health, religious institutions have had a significant impact and role in shaping public health since its beginning. Their role in contemporary global health should not be overlooked either, but then again many global health textbooks do not explicitly address the topic of religion and religious communities. Given the renewed interest in the subject in recent decades,[4] it is surprising that the relationship between global health and religion(s) remains relatively unexplored. To make one example, we can evoke the concept of the social determinants of health (SDH). The World Health Organization defines them as

> "the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems." (World Health Organization o. D.)

3 The article only mentions the decline of organized religion, which traditionally helped facilitate a sense of community, and the rise of spirituality, which may be an attempt to fill this void.

4 Each edition of Koenig and colleagues' *Handbook on Religion and Health* has tried to provide an overview of the existing literature, up to the current 3rd edition (from 2023), which had to limit the research review only to the best quality studies, because of the increased amount of research in recent years. The last volume still has about a thousand pages.

Many other descriptions and examples of SDH do not mention religion and religious communities. Nonetheless, as Peter Brown points out, "religion and religious institutions are significant but hidden determinates of both individual and population health" (Brown 2014, 273), as we have seen in the brief overview.

Ellen Idler, writing about religion as unrepresented SDH, argues that religion "as a social force […] can harm both by its absence and by too overbearing a presence" (Idler 2014, 7). As a conceptual system oriented towards social action in the world, religion and its institutions help shape health resources and behaviors. Faith leaders can spread health information, host health professionals in their communities, and promote healthy activities, or they can also act as barriers to health improvement activities (cf. National Institute for Health and Care Research 2023).

Catholic communities and religious orders have often been the primary initiators of health interventions, and they do have a considerable capacity to promote health and reach otherwise hardly reachable parts of society. In the context of the social determinants of health, faith communities can provide: social support, which has been shown to play a significant role in most health outcomes; social control, by helping to regulate risky health behaviors, etc.; and a wide range of social capital, by providing social, educational, and medical institutions and services (cf. Idler 2014). When it comes to reproductive issues, Idler criticizes the typical Catholic view, while some other authors argue that beyond such topics of disagreement, there is still enough room left for fruitful cooperation in terms of global health (cf. Rozier 2021).

Religious practices and communities can have both a direct impact on health and an indirect impact through their articulation with social and economic determinants. Some public health scholars acknowledge that faith leaders and communities, including the Catholic ones, can disseminate health information, encourage health prevention activities, and promote public health in the areas where they live (cf. Bruchhausen 2023; Di Pietro/Zace 2023). The Catholic Church is directly involved in health promotion, but also indirectly through its social work. Its potential lies not only in having a well-established ecclesiastical structural network throughout the whole world, but also in having networks and collaborations with healthcare and public health sectors.

4 Local Church Communities

During the recent Covid pandemic, we have seen various levels of collaboration between Church communities and public health authorities. Indications published by Vatican commissions demonstrated engagement at the level of the universal Church, bishops' conferences and dioceses responded at their level, and local communities sought to provide spiritual help while also acting in accordance with public health measures. Without discussing individual actions or decisions, these examples illustrate the multifaceted engagement of the Catholic Church in the context of global public health.

Besides the engagement from the perspective of the universal Church, particularly the official bodies and commissions that deal with public and global health topics, it is interesting to look at the local level of organization, where many dioceses and parishes have developed structures and programs oriented to promoting the quality of life. Although global public health addresses health issues worldwide, scholars recognize that addressing these issues requires local commitment (cf. McCracken/Phillips 2017).

Many local church programs raise awareness about issues of primary health care and prevention (especially in low-income countries), ecology, social justice, refugee crises, etc. In the context of religion and health, pastoral care of the elderly and hospitalized patients plays a special role. Programs and activities for people with disabilities and their family members are good examples of social integration work. The latest version of the *Handbook of Religion and Health*, emphasizes the potential benefits of pastoral and spiritual care for different professional groups and that such multifaceted pastoral work does exist in different dioceses. It would take too much space to list all the activities that take place. However, when we look at the concrete realities, there are many differences in Catholic involvement among countries, dioceses, and even parishes.

In some countries, there is a rich church structure with many offices and various pastoral, social, and health services. In other places, dioceses and parishes have no explicit health-oriented services. There is great diversity which may well reflect different circumstances and needs. Also, not all of them have the same resources in terms of finances, structures, and people to engage in health and social ministry. The specific social

context and the political relationship between church and state can also play an important role.[5]

Given this diversity, it is difficult to speak generally about the role of church communities in global public health. However, some questions can be posed. How many health-related services should a Catholic Church and local communities offer? The existence of a particular office or program does not necessarily guarantee good health outcomes. What about the quality of each program? If programs and services already exist, how is this information shared within the diocese and parishes and with those outside the Church? Is the organization of health and social activities done transparently? Who is responsible for initiating new programs? Does the initiative rest only with Church institutions? What is the role of the laity? How is it regulated? Are community leaders and those responsible for pastoral activities sufficiently educated to take into account the possible positive and negative effects of their activities for the well-being and health of everyone involved?

In light of the foregoing empirical studies on the relationship between religion and health, the question arises as to the extent to which Catholic communities at the local level contribute to the health of the faithful. And what can be done so that parishes themselves can be places of support, counseling, and celebration that contribute to human flourishing?

Two main aspects can be distinguished here: first, the organized work and provision of health-related services and social support that have an (in)direct impact on health outcomes. At this organizational level, the question is whether the Church is doing enough in specific local contexts, whether services are being provided competently and whether those involved are educated and prepared for such services, especially in terms of abuse prevention in its various forms and so on. Second, issues related to faith communities and groups themselves and the health benefits they provide through religious practice and engagement.[6] Both aspects are relevant to the Church's healing mission and engagement, as well as to public and global health. There is potential at both levels, but it remains to be seen how to engage proactively in specific circumstances.

5 For example, church communities in Eastern European countries under communism did not have the opportunity to provide active health and social services and activities, and some still do not have sufficient resources for many of these activities.

6 VanderWeele points to forgiveness as one of the mechanisms that can contribute to positive health outcomes, cf. VanderWeele 2023.

5 Conclusion

Empirical studies in recent years have provided much new evidence that challenges the traditional negative view on the influence of religion on health. Many factors and aspects remain to be studied, but the data that are available may have implications for churches and community leaders, as well as for the health sector. The implications of these findings could be manifold for Church communities, as they demonstrate the importance of communal religious life and the wide range of positive benefits that an actively religious life can have. The research may be of interest to healthcare providers in clinical settings, but also in the context of community and global health. Perhaps instead of a suspicion of religion, there could be cooperation and investment in the education of community members and leaders, more openness towards religious activity, and religious presence in schools, workplaces, and public life (cf. Koenig et al. 2023, 651). New ways of working together could be developed to promote the well-being of individuals and communities, and much more.

Discussing the issue of religion and health, there is also a risk of remaining on the level of a purely empirical approach. In that case, might be regarded as merley functional, instrumantalizing religious experience and practice for health outcomes (cf. Panhoefer 2021). Religion, including Christianity, implores intimate aspects of human beings that seek transcendental meaning and relationship with God, and reducing it only to the level of empirical provability of its health outcomes, would constitutively impoverish it. It is precisely these aspects and the relationship with a loving and caring God (cf. Stroope et al. 2013; Newton/McIntosh 2010) that help people thrive and find meaning, even in the midst of suffering or incurable disease.

Involvement in health-related activities and social services is and stays a challenging aspect for Church communities. There are no simple and easy solutions; communities are complex realities, as are health and disease. However, a better understanding of contemporary research on health and religion could be a good start in raising awareness and motivating all members to provide a healthy religious environment. It could also encourage the public health sector to be more open towards considering the influence of religion and religious communities.

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