Research on the
Relationship
between Religion
and Health

Realized RELIGION

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Introduction

Realized Religion Defined

TO BE RELIGIOUS, in the ordinary sense of the word, is to engage in a never-ending quest for spiritual fulfillment, to seek purpose and meaning in the face of the confusion, complexity, and occasional chaos that life presents to each of us. To be religious is to journey toward peace and comfort sometimes found in and through the structure of doctrine, religious ritual, and the spiritual disciplines. To be religious is to place trust in a higher authority by yielding one's own independence and self-serving will to the presumed omniscience of an all-wise and knowledgeable God. To be religious is to act "morally" with a sense of justice and with care for the well-being of others. To be religious, at least for Christians, is to hope for life after death, to be finally reconciled with the God of the universe; it is to engage life in the here and now with an expectation for spiritual reunion in the hereafter.

But what of health, happiness, well-being, psychological integration, and even prosperity? Are these the fruits of religion? Few religions teach that believers should expect health or wealth as a primary reward for being religious (although some "name it, claim it" forms of charismatic Christianity actually might). In the end religious people suffer—witness the ancient travails of Job and the modern-day afflictions of the Palestinians, Bosnians, Irish, Jews, and Kosovars—and religious people die (perhaps having lived slightly longer).

Religion and Health

The question for us in this bibliographic essay is whether being religious enhances health, even if being healthier is not the primary motivation for being religious. Dale Matthews, a medical professor and practicing physician, testifies to the power that faith and religious commitment exert on the health, well-being, and even the healing of persons. While his observations are largely anecdotal, they are the observations of a man of faith who truly believes in the efficacy of medicine as well as the power of belief. He is part of an emerging and increasingly significant effort to study the relationship between religion and health, an effort that has led to what some have called a new era of medicine, a potentially "revolutionary convergence of medicine and faith which is transforming the way that people seek healing" (Matthews, 1998, p. 2).

Studying the relationship between medicine and belief is a complex enterprise requiring a rigorous empirical research methodology. Studying something as subjective and elusive as faith and belief is extremely challenging; some would assert that it is an impossible task, and others might say that it is possible, but not especially desirable. That might be because faith is by definition mysterious, spiritual, subjective, and idiosyncratic (witness the continuous multiplication of Protestant denominations). These matters are not easily examined by science, which has justly earned the reputation for establishing reliable, objective "facts" or knowledge based on rationality, reason, and an underlying attitude of skepticism.

Realized Religion

What do we mean by realized religion? Religion is defined as a system of religious attitudes, beliefs, and practices held with ardor and faith (Merriam-Webster, 1997). Faith is defined as a firm belief in something for which there is no proof (p. 418). St. Paul describes faith as "the substance of things hoped for, the evidence of things not seen" (Heb. 11:1). How can science measure trust and hope in

matters believed with ardor but nevertheless unseen? How does science account for religious fervor based on evidence that is nevertheless lacking in proof? This conundrum creates a complicated challenge for those who attempt to study religion and faith from a scientific perspective.

We have chosen to focus on the term "realized" and apply it to the term "religion" in order to approach the conundrum of studying the mystery of faith from the perspective of objective scientific methodology. The word realized is defined as "to bring into concrete existence" (p. 973). Thus, religion is realized when the essential elements of religion (faith and trust) are made operational by being brought into "concrete existence." Better health, a higher degree of well-being, more marital satisfaction, less addiction, less suicide, and a better likelihood of healing have been found in a series of empirical studies presented in the following chapters to be the by-product of religion realized. These crucial elements of life are the manifestation of religion being made real, of religion being brought into concrete existence.

Religion versus Science

Some researchers maintain that efforts to study the existence of a relationship between faith and medicine have been hindered by a long-standing antipathy toward religion from the scientific community. Evidence for such antipathy is garnered from polls, which point to a disparity in religiosity between scientists and the general population of the United States.

The religion versus science equation describes a tension between trust and doubt that has historically created hostile camps, each tending to demonize the other. What is now emerging is the application of objective scientific methodology to subjective religious experience. The context is religion and health, a place where the debate has often focused on the presumed adverse effects of religion on health and where now the evidence increasingly suggests otherwise.

Levin (1994) contends that very few of the four hundred or so empirical studies dating back to the nineteenth century, which deal with the health effects of religiosity, ever set out explicitly to study religion as a variable. Furthermore, he maintains that "salient ideological and institutional barriers within academic medicine [have] discouraged the dissemination of positive findings" (p. 1475). He describes these barriers as attitudes typified by such statements as "religion is unimportant," "this is bad science," and finally "religion is not real" (p. 1475).

Defining Religion

We believe that religion is indeed real and furthermore that religion realized can often have a profound influence on one's psychological, emotional, spiritual, and physical health and well-being. The reality of religion is essentially a matter of faith. Matters of faith by definition create serious problems for science. Anthropologist Clifford Geertz (1973) provides a helpful definition of religion, a definition that is largely based on the ethereal qualities of religion including symbols, moods, and conceptions of existence that seem uniquely real or realistic; the operative word being "seem." According to Geertz, religion is

> (1) a system of symbols which acts to (2) establish powerful, persuasive, and long-lasting moods and motivation in and by (3) formulating conceptions of a general order of existence and (4) clothing these conceptions with such an aura of factuality that (5) the moods and motivations seem uniquely realistic (p. 90).

It is at this junction that faith intrudes on objective reality and science becomes increasingly nervous, if not skeptical. The intellectual gap that exists between the domain of faith and the domain of science no doubt accounts for why Levin (1994) believes that "mainstream scientists and scholars seem positively oblivious to the presence of the expanding literature base of empirical data supportive of a salutary role for religion" (p. xi). However, many observers have perceived a radical change in this historic nonrelation-

ship, so much so that religion has now become a subject of serious interest to researchers in medicine, epidemiology, gerontology, and other sociomedical disciplines. According to Levin, "the growth in this nascent field is exemplified by an explosion of publications, organizations, and funded research" (p. xv).

Larson is one of the heroes in the emerging field of the epidemiology of religion. Larson, who founded the National Institute for Healthcare Research, has had an important influence on the generation and quantification of empirical research on spirituality and health. He has also done significant work in the clinical and educational applications of religion and spirituality to psychiatric residency programs. His *Faith Factor Bibliography Series* is a comprehensive overview of decades of research summarizing scientific evidence that deals with the link between religious commitment and health. *Volume 1: An Annotated Bibliography of Clinical Research on Spiritual Subjects* summarizes the findings of 158 studies on spirituality and various outcomes (Matthews, Larson, and Barry, 1993). *Volume 2: An Annotated Bibliography of Systematic Reviews and Clinical Research on Spiritual Subjects* contains the detailed abstracts of 35 research reviews on various aspects of spirituality and health (Larson, 1993). *Volume 3: Enhancing Life Satisfaction* contains abstracts of 79 newer general research studies published after 1993 that confirm the observations reported in volumes 1 and 2 (Matthews and Larson, 1995). *Volume 4: Prevention and Treatment of Illness, Addictions, and Delinquency* contains detailed abstracts of 92 original research studies on the relationship of spirituality to the prevention and treatment of illness, addictions, and delinquency (Matthews and Saunders, 1997).

According to Sherrill and Larson (1994), some researchers have asserted that religion plays an important role in the promotion of health and well-being, while, at the same time, most have avoided doing the research necessary to validate these claims. Larson calls this phenomenon the "forgotten factor." Sherrill and Larson assert that less than 5 percent of the nearly 1,100 quantitative articles published in the two leading psychiatry journals contain a quantified religious variable, and, even then, the only religious variable used

was that of denominational affiliation. Larson contends that among the reasons for such an impoverished representation of religious variables in the leading clinical journals is what he calls the anti-tenure factor (ATF), an anti-religious bias found among academic researchers, which has worked against persons interested in exploring religious issues and religious variables scientifically and which, furthermore, has augured against promotion and tenure decisions within leading colleges and universities. While there are some encouraging signs of change, Larson believes that researchers continue to fear that the study of religion and health is a dead-end street on which to build an academic career; research in this field has been hindered accordingly.

This book is an attempt to chronicle the relative value of religion (realized religion) in terms of its effect on the various dimensions of living, including mental health, psychopathology, alcohol use and abuse, marital stability, and other forms of psychological and physical well-being and healing. We believe that when all of the evidence is examined, it will become clear that religion indeed has a positive effect on health, particularly mental health. We believe that the explosive burst of new research, which has appeared over the last twenty years, clearly demonstrates the various health benefits that accrue to believers because of their faith and their religious commitment. The scientific evidence convincingly demonstrates that the natural by-product of religion realized is longer life, less illness, better physical and mental health, more marital stability, less divorce, less suicide, and less abuse of alcohol and other substances.

Dale Matthews is professor of medicine at Georgetown University and, with David Larson, the author of three volumes of the aforementioned four-volume annotated bibliography of clinical research on spiritual subjects. In his most recent book, *The Faith Factor*, Matthews (1998) details the ways in which faith and religious commitment have contributed to health benefits, as well as healing benefits. He believes that a fair reading of the growing scientific evidence establishes that faith is good for your physical, emotional, and spiritual health, which leads to the inevitable conclusion that faith is indeed "good medicine." As Matthews contends, "the soundness of

the faith-factor data is confirmed by the replicability of these findings: in one review, over 75 percent of the 325 studies of different types, undertaken by hundreds of different researchers, have produced findings indicating the benefits of religious involvement to health and well-being" (p. 37).

In a particularly provocative article entitled *Religion and Health: Is There an Association, Is It Valid, and Is It Causal?* Levin (1994) answers his first question affirmatively, claiming that there is indeed a clear association between religion and health. According to Levin, data from multiple studies show a definite trend toward better health where there are higher levels of faith and religiosity.

In answering his second question, Is the relationship between religion and health valid? Levin cites as evidence that more than 75 percent of the published studies in this field demonstrate ways in which being religious affects health positively. And finally, in answering the question, Is it causal? Levin says, "Perhaps." Matthews (1998) also addresses the causality question and does so by cautioning patience and urging further study. "But as we await new findings, the data we have today are strong enough from a scientific point of view to warrant the attention of scientists, physicians, and even skeptics" (p. 40). He concludes that there is a great need for many more well-designed, scientifically rigorous studies before causation can be answered with a "yes" or "no."

Religion as Illusion

Of course the epitome of those who disavow the reality of religion is Sigmund Freud, the father of psychology. In *Totem and Taboo* (1950), Freud saw an evolutionary progression from magic to religion and believed that science would eventually expose religion as an illusion, a childish, wishful desire to explain God, the origins of life, and the mystery of death. Freud believed that religion was "the universal obsessional neurosis of humanity . . . a system of wishful illusions together with a disavowal of reality" (p. 71). According to Freud, religion provides an illusion of an all-powerful God who is conjured up to symbolically reduce the unconscious anxiety that is

the core of psychopathology and that exists as a result of primitive fears of annihilation, as well as threats to the ego that come from distorted memories and the real dangers of living. According to Jones and Butman (1991), the Freudian perspective is "that religion is seen as a kind of universal neurosis that civilization substitutes for a more authentic personal reality based on scientific knowledge" (p. 77). Some religions have at times distorted reality and created oppressive environments in such a way as to give credence to Freud's theory of neurosis.

Religion is realized in the macro sense when the essential elements of religion become operational and are made real in the service of economic, political, cultural, and religious progress. We believe that most major world religions work to enhance social cohesion while also promoting social, cultural, and religious values and norms, which generally lead to more fully functioning societies. This is one aspect of realized religion.

However, the primary aspect of religion realized is not macro but micro. Religion is made operational and made real on a personal basis when it provides a sense of meaning and purpose for living life, coupled with a hope for the future. Religion realized in a micro context provides beliefs and traditions that hold people together, that tend to promote humanistic values, and that lead to the practice of forgiveness, reconciliation, and social justice.

In his book, *Stages of Faith,* Fowler (1991) explores the difference between religion, faith, and belief. He defines religion as the cumulative traditions of the various expressions of faith of people in the past, dependent on ongoing remembering and reenactment of belief (as in the sense of holding certain ideas to be true). He defines faith as the element of trust and loyalty to the transcendent; "the most fundamental category is the human quest for relation to transcendence" (p. 17). Fowler has coined the term "faith development," which refers to the developmental process of finding and making meaning as a human activity. Fowler's approach to faith development is influenced by the interdisciplinary approach of Erikson (1950, 1958, and 1969). Erikson is a psychoanalytically oriented theorist who is known as a nondogmatic, emancipated Freudian.

Erikson's model of the life cycle, his eight stages of man, is a kind of mosaic of human development in which mind, body, and social milieu merge in a dynamic process of identity formation. For Erikson, development is a product of the interaction of heredity and the environment. In that regard, Erikson is known as a psychosocial theorist rather than a psychosexual (Freudian) theorist.

In *Identity: Youth in Crisis* (1968), Erikson put forth his stage theory of development. According to Erikson, in each stage there is an encounter or conflict with the individual and the environment, which fosters a "psychosocial crisis." The psychosocial crisis is not a cataclysmic, end-of-the-world type of crisis. Rather, a psychosocial crisis is a normative, age-appropriate crisis in which the individual is pressured by internal needs and external demands to solve the crisis in favor of psychosocial growth. A crisis according to Erikson is a period of active decision making and a time of heightened vulnerability to the opportunity for growth. Erikson speaks of "the epigenetic principle," in which, as the life cycle unfolds, there is a proper or appropriate time for each psychosocial crisis. Erikson's stages are sequential with the first four stages roughly parallel to Freud's oral, anal, phallic, and latency stages. Erikson's stages are:

1. trust versus mistrust
2. autonomy versus shame
3. initiative versus guilt
4. industry versus inferiority
5. identity versus identity diffusion
6. intimacy versus isolation
7. generativity versus stagnation
8. integrity versus despair

According to Erikson, development proceeds by critical steps, at age-appropriate times. The decision the individual makes consciously and unconsciously is to adapt or not to adapt to the challenge of growth and maturation. Each stage of the life cycle is based on a psychosocial crisis, with the resolution of each crisis leading to personality integration and inadequate resolution hindering subsequent development.

For Erikson, the development of a religious sense is related to the first stage of his eight-stage schema. According to Erikson, during the first year of life the psychosocial crisis is trust versus mistrust. Acquisition of trust is not simply that the infant comes to trust that the world is safe as much as the infant comes to understand that the world is orderly and predictable. This is often associated with the reliability of the primary caregivers. Erikson suggests that this first stage is where religion is born, where the capacity for hope is fostered, and where trust in God is established.

For Erikson, the term identity crisis is used to signify the universal quest to answer the question, Who am I? Erikson sees identity as the need to define one's self clearly and consistently and in such a way as to have the emerging self-definition be in essential harmony with the perceptions of others. Identity involves a progressive continuity with the past and a promise of continuation in the future. The identity crisis is resolved, as all psychosocial crises are resolved, through a process of conflict with the environment, leading to a psychosocial crisis that is then resolved when the person emerges as identity achieved. Identity achievement means that the adolescent has actively struggled with issues pertaining to worldview, belief system, philosophy of life, and career choice. These issues will present the individual with a certain amount of internal crisis or "active decision making" where the individual examines the expectations of parents, church, and culture and begins to make choices and commitments that become internalized into the ego as identity formation.

Kohlberg defines cognition or thinking as the active process of putting things together or relating events. According to Kohlberg, the cognitive connecting process is accomplished through cognitive stages and thus is developmental. Kohlberg acknowledges his debt to Piaget, the great Swiss psychologist, and claims that these stages are sequential, invariant, and hierarchical. Fowler's six stages of faith development closely follow Kohlberg's six stages of moral development, which are built on Piaget's stage theory. Fowler's stages of faith are as follows.

Primal Faith (infancy): Fowler (1991) suggests that this stage deals with the development of trust formed through the mutuality of rela-

tionships with parents, the environment, and others, which then creates the context for the development of a concept of God.

Intuitive-Projective Faith (early childhood): This stage focuses on imagination, which is stimulated by stories and symbols and not yet limited by logic. Faith in this stage is characterized by magical thinking and fantasy.

Mythic-Literal Faith (childhood and beyond): According to Fowler, children in this stage begin to develop the ability to think logically and begin to order the world with "categories of causality, space, and time; to enter into the perspective of others; and to capture life meanings and stories" (p. 25). This stage leads to the acquisition of faith that is literalistic and primarily based on the faith of one's parents.

Synthetic-Conventional Faith (adolescence and beyond): Children in this stage are characterized by increasing cognitive ability which, according to Fowler, provides the opportunity to take on the perspective of others and to integrate new and diverse self-images into a coherent identity. The substance of faith continues to be primarily conventional and conforming to that of parents, peers, and other authority figures.

Individuative-Reflective Faith (young adulthood and beyond): This is the stage in which individuals begin to reflect critically upon their beliefs and values and come to see themselves as part of a larger social system. As they begin to "own their own faith," they internalize authority on the one hand and assume responsibility for their choices of commitments, beliefs, ideology, and lifestyle on the other. This process includes doubting, questioning, and sometimes rejecting traditional beliefs. According to Fowler, this reflection opens the way for "critically self-aware commitments in relationships and vocation" (p. 25).

Conjunctive Faith (mid-life and beyond): This stage is characterized by paradox, which entails the embracing of the polarities of one's life, including the need for taking "multiple interpretations of reality" (p. 25), involving "symbol and story, metaphor and myth" (p. 25).

Universalizing Faith (mid-life and beyond): This stage, which most persons never obtain, is characterized by being "grounded in a one-

ness in the power of being." Persons who do reach this stage see their visions and commitments freeing themselves for investment in love, "devoted to overcoming division, oppression, and violence, and in effective anticipatory response to an inbreaking commonwealth of love and justice" (p. 25). Mother Teresa, Dietrich Bonhoeffer, and Martin Luther King might be examples of the universalizing faith stage.

Fowler's stages provide a developmental framework or structure to conceptualize how people make meaning and how they explain the ordinary and extraordinary events of life. They are also a helpful way to demonstrate the developmental process of religion realized, of faith being brought into concrete existence.

Consequences of Religion Realized

Most religions teach, and most adherents of religion believe, that there are consequences of religious commitment. The implications of religion, the religious effects of realized religion, are also called the consequential dimensions of religiosity. According to Stark and Glock (1968), the consequences of religion have to do both with what the individual receives as a result of being religious as well as what the individual is expected to give. The consequences of religion realized may be either immediate or long-term, and they deal with the behavior and the attitudes individuals might hold as a consequence of being religious. "In the language of Christian belief, the consequential dimension deals with man's relation to man rather than man's relation to God" (Glock, 1962, S-99). This aspect of religiosity is related to the theological notion of "works." The consequential dimension is the fifth and last dimension of Glock's core dimensions of religiosity, which he maintains are applicable to all the world's religions. The core dimensions are 1) the experiential, 2) the ritualistic, 3) the ideological, 4) the intellectual, and 5) the consequential.

According to Glock, experiential dimensions are subjective experiences based on the sense that a religious person will gain knowledge of "ultimate reality" and experience "religious emotions" such as exultation, humility, joy, peace, and a passionate

sense of union with the divine. The ritualistic dimension provides for religious practices such as worshipping, praying, and so on. The ideological dimension recognizes that religious people hold to certain beliefs and doctrines that constitute both a world view and a belief system. The intellectual dimension, like the ideological dimension, deals with people's knowledge of the religious teachings and doctrines to which they subscribe. The consequential dimension then is the implementation of the attitudes and behaviors that are based on religious belief, practice, experience, and knowledge.

Faith versus Placebo

In his book, *Timeless Healing: The Power and Biology of Belief,* Herbert Benson (1996) explains how belief and faith are not only emotionally and spiritually beneficial but "vitally important to physical health" (p. 11). Benson, a practicing physician and professor of medicine at Harvard Medical School, has done considerable research on the biology of belief in an attempt to show how the power of belief affects our well-being and physical health.

Benson defines what he calls the relaxation response as a bodily calm that leads to a lowering of blood pressure, heart rate, breathing rate, and metabolic rate. He suggests that the relaxation response is the opposite of the well-known flight or fight response to threat and danger.

Benson believes that there is scientific evidence to support the notion that "remembered wellness" (the ability to "remember" the calm and confidence associated with health and happiness) is not limited to emotional and psychological memory but includes physical memory as well. The term "remembered wellness," which he uses as a synonym for the placebo effect, is based on the contention that it is belief in the treatment that contributes to superior outcomes. In fact, Benson contends that "depending on the condition, sometimes affirmative beliefs are all we really need to heal us" (p. 21). Benson asserts that his review of the literature indicates that remembered wellness is 70 percent to 90 percent effective, a success rate double or triple that which has always been attributed to

the placebo effect. According to Benson, remembered wellness includes the beliefs and expectations of both the patient and the caregiver.

Benson asserts that there has always been the placebo; "early medicine and its cross-cultural cast of characters—priests, healers, sorcerers, medicine men, witch doctors, witches, shamans, midwives, herbalists, physicians, and surgeons—relied exclusively on scientifically unproved potions and procedures, the vast majority of which had no physical value in and of themselves, some of which did more harm than good" (p. 107). He points out that many patients did get better and that their improved health was due primarily to the natural course of their disease or illness, as well as to the power of their belief that they would get better, rather than to any inherent value of medicine.

The placebo effect is one of the most powerful forces in medicine. It is established in scientific research that when a pharmacologically inert substance, in some cases a "sugar pill," a placebo, is given as a drug to patients in research studies, they often experience a change in their condition as a result of their expectations for change. Often individuals taking a placebo experience as much improvement as individuals taking an actual medication. The placebo effect then seems to be related to patients' expectations of positive results, their belief in the effectiveness of the placebo, and the reputations and expectations of the physicians involved.

Certainly the placebo effect occurs when a person expects benefit from a procedure or drug that is in reality neutral in its effect. The central aspect of a placebo is that the individual believes that the treatment will help, and it is that expectation that results in therapeutic gain. Many studies have documented the effects of the placebo on the reduction of physical symptoms. Most researchers believe that the placebo effect is related to suggestion and suggestibility. To statistically control for this variable, researchers use a common experimental approach, "double-blind" method, in which neither the researcher nor the subject is aware of whether the medication is real or a placebo.

To reiterate, the underlying psychological principles of the

placebo are belief and expectation, and clearly belief and expectation are also the essential elements of faith, which is an essential element of religion. The placebo phenomenon points out just one of the many complexities inherent in any attempt to ascertain just how faith relates to health. Faith is generally construed to be built on a foundation of transcendence; that is, there is an expectation that religion realized (made concrete) is based on more than an illusion (placebo), that God is at work on behalf of the believer, that it is the transcendent intersecting of the human with the divine that accounts for the positive effect of religion on health and not simply the placebo phenomenon.

Jerome D. Frank (1973), in his classic book *Persuasion and Healing*, points out how sick people interact with both family and culture. When people are physically ill they have difficulty managing their emotions, which can lead to interpersonal conflict, a diminishment of self-esteem, and a growing sense of hopelessness. According to Frank, hopelessness can impede recovery from illness and perhaps even hasten death. Alternatively, hope and expectation often play a crucial role in recovery and healing and Frank observes that "favorable expectations generate feelings of optimism, energy, and well-being and may actually promote healing especially of those illnesses with a large psychological or emotional component" (p. 136). Even Freud (1953) agrees that "expectation colored by hope and faith is an effective force with which we have to reckon . . . in all our attempts at treatment and cure" (p. 289).

Why Religion Is Good Medicine

We might ponder the essential question, Why is religion good for human health? The answer is multifaceted and includes social and psychological aspects as well as spiritual and theological ones.

It is clear that all religions are characterized by certain moral teachings that prescribe acceptable behavior and proscribe unacceptable behavior. For example, many religious systems oppose "worldliness" or what some religions call sin, and their teachings serve to keep their people from the "contaminating" influence of

perceived sinful behavior. For example, both Christian and Muslim conservatives instruct their members to avoid alcohol and drugs, and to abstain from sexual intimacy apart from marriage between a man and a woman. These teachings often result in behavior that promotes health—physically, socially, interpersonally, and, as expected, spiritually. We actually do know that nonsmokers are at a reduced risk for cancer, heart disease, emphysema, and a host of other physical maladies. Those who abstain from alcohol enjoy significant health benefits, not the least of which is the avoidance of alcohol addiction. Persons who practice sexual fidelity within a traditional marriage avoid sexually transmitted diseases and are at a lower risk for HIV and AIDS. It seems increasingly clear that a byproduct of being religious is engaging in behavior that leads to better health.

Religiosity also has important social benefits, not the least of which is a social support system provided by church membership and church attendance, both of which have the additional benefit of establishing important and sometimes vital social networking, leading to beneficial effects on psychological and physical health. Social involvement also provides a necessary element of "community," which promotes altruistic behavior, ethical conduct, and sometimes social change, witness the abolitionist movement and the advent of various faith-based nongovernmental agencies such as the Mennonite Central Committee, the Catholic Relief Agency, and World Vision.

Religion provides people with a sense of purpose and meaning, and an interpretative framework for confronting the ethical dilemmas of human existence. Religion also provides answers to the essential religious questions such as Why is there evil? Why is there sickness? What happens to us when we die? and What about human suffering? Religious answers to these questions provide solace to existential anxiety and effectively serve to ameliorate the stresses of human existence by enabling people to better cope with the afflictions inherent in being human and being alive.

Most religions validate human life and provide an explanation for the inevitability of death. Belief in an afterlife as a reward or pun-

ishment for moral choices can promote moral behavior while enriching the meaning of living a "good" life.

We conclude that religion, with the possible exception of extreme fundamentalisms, is generally good for human health because it promotes a healthy lifestyle, opposes self-indulgent and self-destructive behavior, encourages moral behavior, provides vital social support and an ethical value system, establishes an interpretative framework to understand the complexities of life and human existence, and promotes spiritual growth, which generally assists believers in overcoming the stresses and vicissitudes of living. Furthermore, religion provides access to a divine force (God) who has the perceived power (sovereignty) to influence human events (transcendence) and who hears requests (prayers) that are health promoting if not healing.

Theologians have long grappled with the illness/sin and health/salvation equation. In the Christian biblical narrative, Jesus is asked by his disciples, who with Jesus had noticed a blind man passing by, "Rabbi, who sinned, this blind man or his parents, that he should be born blind?" (John 9:2).

Jesus takes this teachable moment to address the prevailing view that sin might be responsible for causing physical afflictions, that sickness is actually caused by sin. Jesus answers his disciples by telling them that neither the blind man nor his parents had sinned. Jesus seems to be clear that there is no direct link between sin and sickness.

Jesus teaches his disciples that the blind man, and presumably his parents, might be an instrument of a larger, more complex divine plan, and that his blindness provided an opportunity to demonstrate that "the works of God might be displayed in his life" (v. 3). Then Jesus heals the man of his blindness.

This biblical teaching underscores the truth that there have always been saints who are sickly and sinners who are robust and that the Christian doctrine of the sovereignty of God allows for a divine purpose to be achieved in oblique, nondirect, nonintrusive, and highly paradoxical ways.

Harold Koenig is professor of psychiatry and medicine as well as director of the Program on Religion, Aging, and Health at Duke University. His recent book, *Is Religion Good for Your Health?* (1997), provides a careful review of the effects of religion on the health and well-being of people. He concludes that the data demonstrate a link between religion and health "although they do not prove beyond all doubt that mature religion causes better health" (p. 119). Nonetheless Koenig is prepared to say that "a strong religious faith and active involvement in the religious community helps prevent or reduce depression, anxiety, high blood pressure, stroke, heart attack, cancer, and may add years to life" (p. 119).

Why Religion Is Accused of Causing Harm

Koenig is confident that religion, particularly Judeo-Christian religion, has positive effects on health, and that whatever adverse and negative effects do exist have been overemphasized. That is not to say that religion has not been misused or caused serious harm. There have always been neurotic and deeply pathological uses of religion that have caused hurt and even disaster for individuals, families, and societies. The tragedies of Jonestown and Waco are examples of how deviance can cause immense damage in the name of religious beliefs and conviction.

It was William James (1902) who first addressed the question of healthy and unhealthy religion in his classic book, *Varieties of Religious Experience.* James was a pragmatist and an empiricist who provided psychological insight into the process of religious conversion. James used a phenomenological approach to the psychology of religion in which he drew upon dramatic and intense biographical "case studies" to illustrate some of the more extreme forms of religious experience. For example, James cited John Bunyon and St. Augustine as reportedly having suffered from some form of serious melancholia and depression.

Freud (1953) has had perhaps the most significant effect on the development of psychiatry and psychology. As a physician, Freud was deeply connected with neuropsychiatry and committed to a

medical view that mental processes were a function of biological mechanisms. Freud's view of psychoanalysis was that with the help of an analyst, and through free association and the interpretation of dreams, patients could discover the unconscious psychodynamic mechanisms that determine and explain behavior.

In his recent book, *Freud versus God* (1998), Blazer compares Christianity and psychoanalysis by suggesting that both share 1) the necessity of integrating one's personal story, 2) an emphasis on being delivered from guilt, and 3) a determination to expose one's deepest thoughts through a confessional process. "For the Christian the context was biblical narratives, for psychoanalysis it was the dominant myth of society" (p. 16). According to Blazer, both Christianity and psychoanalysis saw guilt as the central problem facing humanity and "release from guilt as the key to healing. Confession to a sympathetic and confidential confessor was central to healing on the couch and in the church" (p. 66).

Freud regarded Christianity as a collective neurosis based on the suppression of natural instinctive impulses (sex and aggression). Freud viewed religion as an illusion that cannot be proved and he believed that as scientific knowledge increased, "the need of humankind for religious dogma will diminish. Religion will ultimately be replaced by science, as there will no longer be a need for religion" (p. 69).

Koenig discusses Pruyser's explication of specific ways that religion can be used negatively thereby causing harm and damage. It is Pruyser's theory that religious people who are neurotic and disturbed often sacrifice their intellect and their reason and assume a "blind faith" orientation to life rather than adopting a proper balance of faith and reason. He points out that low self-esteem and psychological wounds sometimes cause pathological bitterness, hatred, and a desire for revenge, which Koenig suggests are sometimes channeled into religious fervor. "Such persons use religion as a way to release their hatred and aggressive impulses onto others, cleverly cloaking them in theological terms that are expressed with pious, better-than-thou attitudes" (p. 106).

According to Pruyser, religion can also be used for controlling the

thoughts (brainwashing) and behaviors of religious adherents, especially those who might be excessively needy, psychologically weak, or dependent personalities. It is this context from which cults with charismatic but authoritarian leaders emerge. Pruyser also contends that excessive suffering that leads to a seeking after martyrdom "bespeaks a wish for self-destruction either by masochistic urges or as a necessary atonement for some real or imagined wrongdoing which an implacable conscience demands" (p. 341).

Persons who suffer from obsessional thinking, defined as recurrent thoughts and beliefs that dominate thinking and which might include incessant prayers, compulsive confessionals, and church attendance, may experience pathological guilt or anxiety. According to Koenig (1997), instead of being an authentically religious person, the obsessional person "may be driven by deep anxieties and insecurities rather than by a love for God or for holiness" (p. 108).

Finally, Pruyser contends that religion can be used to reinforce negative or undesirable character traits, leading to highly self-righteous persons who manipulate others or perhaps deceive others with dishonest or fraudulent schemes. In the early 1990s John Bennett, a Philadelphia businessman, developed a Ponzi scheme called New Era Philanthropy in which he used Christian notions of "giving" to dupe countless religious schools, churches, colleges and universities, social agencies, and relief organizations into "investing" in his organization, which he claimed would double their money, thereby providing even more resources for advancing God's kingdom. His fraudulent scheme eventually collapsed from the weight of the financial deception as well as from the underlying pathology of Bennett himself, who was apparently a narcissist who viewed himself as special and anointed by God. He "sold" his fraudulent scheme using the language of religious service and mission. When his scheme collapsed, the scandal led to significant harm for numerous not-for-profit religious and cultural organizations, colleges, and universities all of whom depend on fundraising to support their missions. Bennett lost his home and possessions and, following his conviction for fraud, was imprisoned (Cohen, 1995).

Koenig (1997) points out that in all of these neurotic uses of religion it is "the person's insecurity or mental disturbance—not the religious doctrine—that drives behavior" (p. 110); religion thus becomes a tool to justify or implement pathological tendencies.

We conclude that scientific evidence supports the contention that religion is good for human health, and when individuals misunderstand religion or misuse religion in the service of their own emotional, psychological, or spiritual pathologies, it is not religion per se that is pathological, but rather the abuse of religion that is sick, harmful, and sometimes evil.

We have approached this study with a Christian faith commitment that embraces the notion that religion is beneficial for living a meaningful life. Nonetheless, we found the information presented here to be compelling in its own right, and we believe that our faith bias does not unduly influence the findings presented in this work.

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