

COMMENTARY

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Religious Communities, Health, and Well-Being – Address to the US Air Force Chaplain

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ABSTRACT The text is adapted from a written transcript of the address to the US Air Force Chaplain Corps Summit, delivered by Tyler J. VanderWeele, on March 28, 2017 in San Antonio, Texas. The address discussed rigorous empirical research on how religious participation and religious community are related to a number of health and well-being outcomes, along with the mechanisms behind these associations, and the implications of such religion health research to military chaplains, and to society more broadly.

INTRODUCTION

Over the past couple of decades, a large body of research has emerged suggesting that religious participation is strongly associated with numerous health and well-being outcomes.¹ Large well-designed research studies have indicated that religious service attendance is associated with greater longevity, less depression, less suicide, less smoking, less substance abuse, better cancer and cardiovascular disease survival, less divorce, greater social support, greater meaning and purpose in life, greater life satisfaction, more charitable giving, more volunteering, and greater civic engagement.^{1–16} Although some of the early studies on this topic were methodologically weak, the study and research designs have become stronger and stronger, and for many of these outcomes, the associations are now considered well established. Religious service attendance powerfully affects health and well-being.

I will describe the research in greater detail; I will also explore why religious service attendance seems to so

powerfully affect health and well-being, and I will conclude with some discussion of the implications of the research.

THE RESEARCH

My own research on the topic, from Harvard's Initiative on Health, Religion and Spirituality and Harvard's Program on Integrative Knowledge and Human Flourishing, was published last year by the Journal of the American Medical Association. The research used data from the Nurses' Health Study with over 70,000 participants followed for 16 yr. We found that those who attended religious services regularly were 33% less likely to die over the 16 yr of follow-up. We also found that those who attended religious services regularly were 27% less likely to become depressed; they were about 50% less likely to divorce; and they were five times less likely to commit suicide.^{9–11} These are large effects, and they are large effects for numerous important health and well-being outcomes.

These research reports, published out of the Harvard T.H. Chan School of Public Health, used data from a long-term study collected over several decades. The research confirmed previously reported associations in the research literature. However, prior studies had come under critique for the possibility of "reverse causation" or "selection bias" – that those who are healthy may be more easily able to attend services, so that attendance is not necessarily influencing health. The new research out of Harvard addressed this by using repeated measurements of service attendance and health over time to control for whether changes in health preceded changes in service attendance or vice versa. The associations between religious service attendance and longevity, depression, suicide, and divorce were all robust to this control. Other studies have used similar approaches and have indicated that the effects of communal

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religious participation extend not just to health but to many other outcomes. These other outcomes include an increased sense of meaning and purpose in life, higher life satisfaction, greater likelihood of making new friends and of having social support, as well as greater charitable giving, and greater volunteering and greater civic engagement. The effects of religious service attendance appear to be profound across a broad range of different outcomes.

Other research that we have done has suggested that it is religious service attendance, rather than private practices or self-assessed religiosity or spirituality, that most powerfully predicts health.^{14,17} Something about the communal religious experience seems to matter, and it is something very different from private practice. Religious identity and private spiritual practices may of course still be very important and meaningful within the context of religious life, but they do not appear to affect health and well-being as strongly. Something about the communal religious experience is important for health, and for many other outcomes as well.

One interesting question that arises in this research is whether these effects are principally because of health maintenance or because of disease recovery. Certainly, there is some evidence for both. We noted above that service attendance is longitudinally associated with certain better health behaviors such as less smoking, drug use, and abuse of alcohol. But we also noted that religious service attendance was associated with better survival for those with chronic health conditions. If one examines the magnitudes of some of the associations, there is perhaps some preliminary evidence that religious service attendance may play an even more powerful role in healing or disease recovery than it does in health maintenance. In one study on depression, although there was an effect of attendance on preventing the incidence of depression, the effect of attendance on recovery from depression for those already depressed was even larger.¹⁸ Likewise, although there does not seem to be much association between religious service attendance and incidence of cardiovascular disease,^{9,19} religious service attendance is strongly associated with lower mortality by cardiovascular disease.^{9,20} Similar patterns are present with survival from breast cancer. This may perhaps provide some preliminary evidence that attendance may be even more strongly associated with healing than health maintenance.

If it is indeed the case that religious service attendance has even larger effects on healing than on health maintenance, this would be in line with the emphasis of many religious communities. Although there are certainly religious teachings about the importance of the body and taking care of the body for health, and some religious communities have health promotion programs,²¹ there is arguably much more discussion within many religious communities of finding meaning in, and coping with, illness; on the importance of community and communion with God in sustaining one through illness; and on prayer for healing. If the effects of service attendance on health are even more powerful in healing than in health maintenance, this would again also be consistent with religious

teachings that faith may not keep one from suffering but that it allows one to find meaning and wholeness even within it.²² We will return to this possibility again later.

The empirical research thus establishes important connections between religious service attendance and health and well-being. But the empirical research can be helpful for religious communities in other, sometimes surprising, ways as well.

As noted above, religious service attendance appears to have a protective effect on depression. But if we return to depression, we also find an interesting association in the reverse direction. Although it is the case that religious service attendance protects against depression, it is also the case that depression increases the likelihood of subsequently dropping out of religious services. People who become depressed are, over time, more likely to stop attending. This association too is now fairly well supported by empirical research. And it is an association that arguably has important implications for pastoral practice. Certainly, most would agree that one of the many roles of priests, pastors, chaplains, or religious leaders is to provide individual pastoral counsel to their congregants, to hear out the concerns of their parishioners, and perhaps to refer someone in need to the appropriate mental health professional if more help is required.

However, what the empirical research on depression and service attendance suggests is that such strategies may not be sufficient. They may not be sufficient because those most in need of such help may not even be around to receive it. Those who are depressed are more likely to leave their church or religious community. Certainly, considerable reflection would be important before making specific recommendations, but systems could perhaps be put in place whereby the members of a parish look out for one another and help indicate, to those providing pastoral counsel, the members they know suffering from depression. Priests, pastors, rabbis, or other religious leaders could approach such individuals to offer help before the depression becomes so severe that individuals no longer participate in religious life at all. In this case, the empirical research again, I think, is useful and important for religious communities. Interest in the research is not simply “academic.” The empirical research helps inform religious leaders that those who may be most in need may be the least likely to be present to receive it; they may need to be sought out.

The empirical research on religion and health thus shows not only that communal religious life powerfully affects health and well-being but also gives insight into those who may be most in need of care and support.

More detail as to why communal religious life and religious service attendance have an effect on health and what the mechanisms might be^{23–41} is given in the full text of address (https://cdn1.sph.harvard.edu/wp-content/uploads/sites/603/2017/10/SummitTalk_FullText.pdf).

THE IMPLICATIONS

So what are the implications of this research and these ideas? This will be my final topic of today. What are we to make of

this discussion and what practical conclusions might we take away? Of course, people do not generally decide to become religious for health reasons. Such decisions are made more on the grounds of experiences, evidence, truth claims, upbringing, values, relationships, and so on.

My own view with regard to the interpretation and implications of the results are four-fold, and they concern first religious communities themselves, second counseling and care, third society at large, and fourth individual decision-making.

Let us begin with the first: religious communities. The research I think may be of interest and importance to religious communities. The research helps support a message about the power and importance of communal religious life. That it is religious service attendance, rather than private practices or self-assessed spirituality, that seems most strongly to affect health and well-being suggests that there is something important about the communal religious experience. The research carries a powerful message that other religious communities can communicate. Religious communities can point to empirical data that suggest that it is not just belief that matters but attendance and community participation as well. Theologians argue on theological grounds that community within religion is important; the empirical research now demonstrates this as well.

Moreover, in our discussion of religious service attendance and depression, although it was again the case that service attendance protects against depression, we also saw that those who become depressed tend to stop attending services. The results on the effects of depression on service attendance do also arguably have important implications for religious communities. Those who become depressed are more likely to stop attending services, which may exacerbate depression further. The research suggests a role for clergy and other members of religious communities to more actively be aware of, or even screen for,⁴² those who might be depressed, and to offer help, support, and possible referral, before depression becomes worse. The empirical research helps inform religious communities and clergy that those who may be most in need may be the least likely to be present to receive it; they may need to be sought out.

So the research may be of interest to religious communities. But, second, the research may also be of interest to health care providers and counselors and anyone providing care. The research can make clear that religious participation is a powerful influence on health and also on health decision-making.

The role of religion and spirituality in patient care in medicine has been controversial. The majority of patients say that they think that physicians should consider patients' spiritual needs, but many physicians feel uncomfortable doing so. Religion and spirituality are one of the two most important factors for patients in medical decision-making but do not play much of a role in decision-making for most physicians.⁴³ How can such complexities be navigated? Some have suggested that taking a short four-question spiritual history may be appropriate in the clinical context. Four simple questions might be:⁴⁴

- Is faith (religion, spirituality) important to you in this illness?
- Has faith been important to you at other times in your life?
- Do you have someone to talk to about religious matters?
- Would you like to explore religious matters with someone?

Such questions may help a health care provider assess whether religious faith plays an important role in a patient's life and whether the issues should be discussed further or if a referral should be made.

Considerable effort has also been devoted to spiritually integrated psychotherapy that more broadly draws upon the spiritual resources, motivations, and coping strategies that may be available to those with religious beliefs. Several reasons have been given for employing spiritually integrated psychotherapy. One central reason is the broad participation in religion within America and worldwide and the fact that spirituality itself is a resource to many people. Another reason for spiritually integrated psychotherapy is that spirituality can also be the source of problems and difficulties, in addition to a resource. Finally, when surveyed, patients often state that they would prefer spiritually integrated interventions. Although the effects of these spiritually integrated interventions compared with secular interventions are often similar, in some cases, they have been shown to be more effective for religious patients.⁴⁵ Even in cases in which effects do not differ, however, it may be preferable to use a spiritually integrated or religiously based psychotherapy intervention to increase potential outreach in certain religious populations. This may be especially important in trying to reach those who might otherwise be skeptical of, and hesitant to participate in, more secular types of psychotherapy. Moreover, issues of spirituality can also be the source of difficulties. Spiritual struggles, also sometimes called negative religious coping, is itself generally related to worse mental and physical health.²⁵ However, it is also the case that spiritual struggles have also been linked to stress-related growth, spiritual growth, open-mindedness, self-actualization, and lower levels of prejudice.⁴⁶ Thus, difficulties in spiritual life can have health consequences but can also be sources of personal and spiritual growth and it may thus be important to address these in counseling as well.

What about the role of health care providers in encouraging service attendance? This is also a more controversial area. Certainly, the research on religion and health does not imply that physicians should universally "prescribe" religious service attendance. Once again, decisions about religious practice and formation of religious beliefs are of course generally not made on the grounds of health, but rather reflect values, relationships, experiences, evidence, thought, upbringing, and numerous other commitments. However, for those who do already identify as being religious, service attendance might be encouraged, perhaps even in the clinical setting, as a form of meaningful social participation. Due caution may be needed for those who

have had prior negative experiences in religious communities, but the four questions we described earlier may help assess whether this may be so. It is clear from the research that communal religious participation has powerful effects on health and to neglect this is to neglect a powerful health resource.

So the religion and health research is relevant to religious communities and to health care providers, but I think, third, that the associations between religion and health may be important in re-evaluating the role of religion in society and public life. The media, the academy, and broader public discourse often portray religion in a rather negative light, and certainly, there are instances in which religious institutions have done harm. But the effects of religious participation are often also profoundly positive as well, across numerous domains of life, and this point has too often been neglected. This has important implications for the extent to which society promotes and protects religious institutions and religious freedom, the maintenance of their non-profit tax-exempt status, and how the contribution of such institutions is portrayed in the media, in the academy, and beyond.

I think these are important considerations even in thinking about the role of religion in public health. Public health impact is often assessed as a function of a how common an exposure is and how large its effects are, and on these grounds religious service attendance is important. It is common and it has large effects. It can have important consequences for shaping population health. As one example, we might consider the possible importance of religious service attendance in shaping suicide rates. The Center for Disease Control recently released a report expressing concern that the US suicide rate had risen from 10.5 per 100,000 per year in 1999 to 13.0 in 2014. During this same period, the Gallup Poll reported a decline in religious service attendance from 43% in 1999 to 36% in 2014. If we were to extrapolate the results on service attendance and suicide from the Nurses Health Study data to the general US population, this would indicate that of the increase in suicide over those 15 yr, about 40% of it could be attributed to declining religious service attendance.¹⁷ We need to think about the role of religious service attendance in shaping health and well-being outcomes more often. Religious communities powerfully, and beneficially, affect health and society in numerous ways.

Fourth, and finally, I think the research has implications on a more individual level. My view with regard to the individual implications of the research that we have discussed is that for the roughly half of all Americans who do believe in God but do not regularly attend services, the relationship between service attendance and health may constitute an invitation: an invitation back to communal religious life. Something about the communal religious experience seems to matter. Something powerful takes place there. Something that enhances health, and it is something very different than solitary spirituality. In an era in which people increasingly self-identify as “spiritual but not religious” and in which the

term “organized religion” often carries negative connotations, the research perhaps challenges preconceptions and suggests that personal spirituality, discarding all organized and communal aspects of religion, may not be an entirely satisfactory way forward. The research questions whether those who do not attend may be missing something of the communal religious experience that is powerful, at least for health, and possibly for much else as well.

Where else today do we find a community with the possibility of a shared moral and spiritual vision, a sense of accountability, wherein the central task of the members is to love and care for one another? The combination of the teachings, the relationships, the spiritual practices, over time, week after week, taken together, gradually alters behavior, creates meaning, alleviates loneliness, and shapes a person in ways too numerous to document. Religion brings true human well-being.

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