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Spirituality, religion, and health: Reflections and issues

Dilwar Hussain
Thapar University, Patiala, Punjab

Abstract
The past decade has witnessed substantial growth in the study of religiosity/spirituality and its relationship with various indicators of health. Most of these studies found positive relationships between religion, spirituality and health (both mental and physical health). However, various studies in this field are criticized specially for not clearly and operationally defining the constructs religion and spirituality and for their poor design. This paper discuses major issue associated with concepts, norms, and assessments of religiosity and spirituality. Finally, various suggestions to surpass these limitations are also addressed.

Keywords: religion, spirituality, health, assessment, issues.

Introduction

Recently there has been a revival of interest in the psychology of religion and spirituality. Several empirical studies have explored religious and spiritual variables in relation to mental as well as physical health. This resurgence of interest is illustrated also by birth of various journals dedicated to the religion and spirituality, such as The International Journal for the Psychology of Religion, Journal for the Scientific Study of Religion, The Journal of Psychology and Theology, and many others. Recently, the American Psychological Association has established division 36 which is dedicated to the psychology of religion, aiming to promote the scientific study of religion and encourage its incorporation in applied settings. Psychology does not attempt to validate the truths of religion or spirituality. It merely attempts to understand and explain how spirituality is manifested in cognitive, affective, behavioral, and interpersonal aspects of individuals, thereby affecting mental and physical health. In his remarkable work on The Varieties of Religious Experiences, James (1902, 1961) has explored mysticism and psychological effects of religious experiences. Other

prominent psychologists like Jung, Fromm, Allport, Maslow, Frankl have posited that religion or spirituality must be considered for a holistic understanding of the person (Hill et al., 2000). Frankl (1964) believed that an innate need of human beings is to find meaning in life and suggested that meaninglessness is a major existential issue that may result into various pathologies. He associated spirituality with finding meaning in life. Classifying human needs into basic and higher categories, even Maslow (1970) attests that transcendent self-actualization – including appreciation of beauty, truth, and recognition of sacred in life – carries spiritual significance. Allport and Ross (1967) proposed two factor model of religiosity: intrinsic and extrinsic. The intrinsic aspect of religiosity consists of faiths and values, whereas the extrinsic aspect consists of fulfillment of social needs. Carl Jung was deeply interested in the spiritual aspects of human beings. In fact he believed that an important task for psychology is the perception and observation of religious and spiritual phenomena (Jung, 1968). He further believed that all persons who are concerned with self awareness and personal growth show interest in spirituality (Jung, 1969). He suggested that human collective unconscious contains universal religious archetypes.

Understanding constructs: Religion and spirituality

The word religion has its root in the Latin word "*religio*" that signifies "a bond between humanity and great-than-human power" (Hill et al., 2000, p. 56). Historically, the term religion has been portrayed as: (a) a commitment of individuals to a supernatural power, (b) feeling of presence of such power who conceives them, and (c) carrying out ritualistic acts in respect of that power (Hill et al., 2000). There is no universally accepted definition of religion, but two important aspects are commonly identified. First, as an institution, religion comprises of particular beliefs about the nature of reality (Gorsuch, 1988). Secondly, it is concerned with the connectedness of humanity with greater or dynamic powers such as god, spirit, and the like, that inspire reverence and devotion (Jung, 1969).

The word spirituality on the other hand is derived from the Latin root "*spiritus*" which means 'breadth of life' (Elkins, 1999). The construct spirituality is considered a kind of subjective experience which is complex, multifaceted, and difficult to define precisely (Benner, 1991). Elkins et al. (1988) formulated a broad and inclusive phenomenologically oriented and humanistically based definition of spirituality and defined it as, "a way of being and experiencing that comes about through awareness of a transcendent dimension and that is characterized by certain identifiable values in regard to self, others, nature, life, and whatever one considers to be the ultimate." (p. 10). Similarly, Bensley (1991) has described spirituality as a

subjective belief system that incorporates self awareness and reference to a transcendence dimension, provides meaning and purpose in life, and feelings of connectedness with God or the larger reality.

Spirituality and religion are considered separate but overlapping constructs. Spirituality is generally conceptualized as a broader concept and represents transcendental beliefs and values that may or may not have any relation to religious organization. Religiosity, on the other hand, refers to a set of rituals and creeds which are manifested in the context of a religious institution. A person may express spirituality in the religious context but a person's religiosity is not always a result of spirituality (Genia & Shaw, 1991). Religious beliefs mainly involve personal commitment to a chosen religious belief system, like the Christian, Hindu, or Islam belief systems. Spirituality involves a personal, subjective, and experiential orientation consisting of a transcendent dimension of self and life which may be experienced without the commitment to religious belief systems.

Trends in the scientific study of religiosity/spirituality and health

Interest in the psychology of religion experienced sharp rise and fall from the late 19th century to mid 20th century (Beit-Hallahmi, 1974). Many stalwarts and founding fathers of psychology such as William James and Stanley Hall had shown enormous interest in the psychology of religion and its implications to health and well-being. However, with the rise of psychoanalysis, behaviorism, and pastoral psychology in the 1920s and 1930s, interest in the scientific study of religion declined. The later part of 20th century witnessed a rise in the scientific study of religion and its implications to health and well-being. In a review of 1200 studies from Europe, North America, and Israel, Koenig et al. (2001) found that more than two-third of these studies revealed significant associations between religious activities and improved mental and physical health.

Weaver, Pargament, Flannelly & Oppenheimer (2006) made a systematic review of 1,100,300 articles published between 1965 and 2000 containing either only religion or spirituality and both religion and spirituality together as key words. They found a statistically significant upward trend across years for the rate of articles dealing with religion and spirituality. They also found a significant downward trend for articles that addressed only religion. They argued that this result could be simply a reflection of change in language and more attention devoted to the construct of spirituality which has become more popular than religion although many still use them interchangeably. They also suggested that this renewed interest in religion and health in the last few decades is due to increased differentiation of the construct

religion from spirituality. Spirituality has been used for the subjective and individualized experience of transcendence. On the other hand, religion has become synonymous with the institutionalized expression of belief and practice.

Positive effects of religiosity/spirituality on health

Various systematic reviews and meta-analyses demonstrate that religiosity or spirituality are positively associated with various indicators of health. Religious involvement correlates with decreased morbidity and mortality (Ball, Armistead, & Austin 2003). Studies also suggest that religiousness may correlate with better outcomes after major illnesses and medical procedures (Oxman, Freeman, & Manheimer 1995). The effects of religion on mental health have been more profoundly studied than effects on physical health. Studies have demonstrated religiosity to be positively associated with feelings of wellbeing in white American, Mexican American (Markides, Levin, & Ray 1987), and African American populations (Coke 1992). However, there is also substantial literature that explores the positive impacts of religion or spirituality on physical health. A number of investigators have looked at the effects of religion on depression. Prospective studies have also found religious activity to be strongly protective against depression in Protestant and Catholic offspring who share the same religion as their mother (Miller et al. 1997) and weakly protective in female twins (Kennedy et al. 1996). Cross-sectional studies have yielded significant (Koenig et al. 1997) and non-significant (Bienenfeld et al. 1997; Koenig 1998; Musick et al. 1998) associations between different indicators of religiosity and a lower prevalence of depression in various populations. Researchers have also reported an inverse correlation between religiosity and suicide (Nisbet et al. 2000). A substantial body of literature demonstrates the positive impact of religion/spirituality on perceived quality of life (life satisfaction) (Levin et al., 1995, 1996; Sawatzky et al., 2005).

The links between religion and mental health have been characterized as impressive and religious people report being happier and more satisfied with life than non-religious people (Myers & Diener, 1995). Koenig et al. (2001) reviewed approximately 100 studies that have been done (published as well as unpublished) and reported that most studies report a positive association between some measure of religiosity and some measure of well-being, happiness, joy, fulfillment, pleasure, contentment, or other related types of experiences. Levin and Chatters (1998) also concluded that religion appears to constitute a preventative or therapeutic effect on mental health outcomes.

How religiosity/spirituality affects health

It is very clear that there is an increasing numbers of studies showing positive correlations between religiosity/spirituality and mental as well as physical health. Some mechanisms through which religiosity/spirituality influence health have been identified. Some of these mechanisms include:

(1) Many religious practices (such as meditation and prayer) may elicit a relaxation response and contribute to the reduction in the sympathetic nervous system activities, lowers blood pressure, reduced muscle tension and so on. All these factors contribute to better health (Benson, 1996).
(2) Religion contributes in the reduction of unhealthy behaviors such as alcohol, smoking, drug abuse (Strawbridge et al., 2001).
(3) Frequent religious involvement is also associated with more extensive social support networks and more extensive social support is consistently found to be connected with a variety of positive physical and psychological health outcomes (Strawbridge et al., 2001).
(4) Religion also contributes to a sense of coherence and an experience of life as meaningful as well as to a hopeful outlook on life, all of which are associated with better physical and mental health (Antonovsky, 1987).
(5) Intrinsic religiosity has been associated with higher self-esteem, less anxiety and depression. Religiosity has also been found to be a powerful coping mechanism which may well serve as a buffer against the deleterious effects of stress on the body (Pargament, 1997).
(6) Religiosity/spirituality may operate as a coping mechanism. The term religious coping is used to indicate the religious/spiritual beliefs and behaviors that help in the adjustment to the stressful life experiences. People generally take refuge in various positive religious coping strategies such as such as seeking God's will through prayer and expressing positive prayer expectancies as a strategy to overcome life's strains (Ellison, Boardman, Williams, & Jackson, 2001; Fry, 2000).

Major issues in the study of religion/spirituality and health

Despite growing popularity, the field of religion/spirituality carries many important issues and limitations that need to be resolved. Although most studies have shown positive effects, religion and spirituality may adversely affect health. Religious groups may directly oppose certain health-care interventions, such as transfusions or contraception, and convince patients that their ailments are due to noncompliance with religious doctrines rather than organic disease (Donahue, 1985). Religions can

also stigmatize those with certain diseases to the point that they do not seek proper medical care (Lichtenstein, 2003; Madru, 2003). Moreover, as history has shown, religion can be the source of military conflicts, prejudice, violent behaviors, and other social problems. The religious-minded person may ignore or ostracize those who do not belong to their faith/practice. Those not belonging to a dominant religion may face obstacles in obtaining resources, experience hardships and stress that may deleteriously affect their health (Bywaters et al., 2003; Walls & Williams, 2004). Additionally, perceived religious transgressions can cause emotional and psychological anguish, manifesting as physical discomfort. This "religious" and "spiritual" pain can be difficult to distinguish from purely physical pain (Satterly, 2001).

The field of study pertaining to religiosity/spirituality carries many issues at conceptual, normative, and measurement levels (Moberg, 2002). At the conceptual level, the definition of religion/spirituality is still very fuzzy and implies different things to different people, both in popular parlance as well as in academic world. Consequently, the lack of operational definition is limiting the generalization as well as inter-study comparison of research findings. In this regard, McGinn (1993) rightly said that "spirituality is like obscenity; we may not know how to define it, yet we know it when we see it, and the 'fickleness' of academics' inability to provide precise definitions has never prevented people from practicing it" (p. 1). At the normative level, this field lacks the proper norm distinguishing positive from negative spiritual well-being. The norms of spirituality/religion are so diverse across traditions that indicators of spiritual health in one tradition sometimes are negative symptoms in another (Moberg, 2002). This diverse norm makes it difficult to form objective criteria of what constitutes religious/spiritual well-being. For example, people from a Buddhist culture may think of spiritual well-being in terms of an individualistic focus with meditative aloofness from the society, whereas Christian cultures are more oriented towards social service and altruism.

At the measurement level, there are many issues that need careful attention from researchers. Because of the multidimensional nature of religiosity/spirituality, validity of the measurement remains a major issue to ponder upon. Do indicators included in various scales genuinely measures religiosity/spirituality? Existing measurement tools have many inherent problems such as including few out of many potential indicators. Further, language and indicators used in many measurement tools may alienate various sects. For example, the Spiritual Well-Being Scale (Ellison, 1983) is one of the most widely used and psychometrically sound tools. Yet, it refers to words such as 'God' which may people identifying as Hindus, Buddhists, and Muslims (or as atheists). But, using universal indicators (or secular measures) has its own limitations, as it may not be able to capture the distinctive features of various sects. Some

researchers raised the concern of self-presentation bias in the study of religiosity/spirituality. For example, Presser & Stinson (1998) demonstrated a significant self-presentation bias in studies of religious attendance and mortality that employ interview methods. In these studies, participants understood church attendance as an indicator of being a good Christian and consequently inflated their reports of church attendance.

Conclusion

It is very clear that research in religion/spirituality is at a more exciting phase than ever, as it is increasingly receiving attention from the scientific community. However, the present state of research in this arena is still confronted with many limitations which need careful attention. Improvement in the assessment of constructs such as religiosity and spirituality is the need of the hour. One way of doing this is by resorting to *emic* approach that applies group's own criteria should be emphasized rather than only *etic* approach where researchers impose their own definition to the participants (Moberg, 2000). This can be done by developing separate measures for various religious and ideological groups to get meaningful data and also by stating exactly what measures have been used without making claims about measures or dimensions that were not used. It is apparent that using varieties of research methods, both quantitative and qualitative, can provide better insights into constructs such as religiosity and spirituality. Further, future studies need to look at the multidimensional aspects of religiosity/spirituality and the interconnected manners by which religiousness and spirituality influence health and well-being (Koenig, McCullough & Lason, 2001). The role of diverse religious and spiritual types and practices on various aspects of health and well-being should also be looked into.

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About the author:

Dr. Dilwar Hussain specializes in the area of health and clinical psychology. He has published research papers related to refugee trauma, posttraumatic growth, culture and trauma, therapeutic effects of expressive writing in various reputed international journals. He is affiliated Assistant Professor at the School of Management & Social Sciences, Thapar University, Patiala, Punjab-147004, India.

Address for correspondence: Dilwar Hussain, School of Management & Social Sciences, Thapar University, Patiala, Punjab-147004, India.
E-mail: dhussain81@gmail.com