Introduction to Symposium: Religion, Health, and Well-Being

CHRISTOPHER G. ELLISON†

Interest in the implications of religion and spirituality for physical and mental health has grown rapidly in recent years. Clearly, the topic has captured the attention of the popular media and the imagination of the public. Moreover, a series of innovative multidisciplinary research programs are advancing our understanding of these complex issues. A number of recent studies investigating religious variations in mental and physical health outcomes have appeared in prestigious journals, and research funding from governmental sources and private foundations has become more plentiful.

The Evidence

In the late 1980s a series of review articles examined the evidence concerning religious effects on a wide range of physical health outcomes, including heart disease, hypertension, stroke, cancers, and others, as well as overall self-rated health, physical disability, self-reported symptoms, and mortality risk (e.g., Jarvis and Northcott 1987; Levin and Vanderpool 1987). Those reviews revealed considerable evidence that rates of morbidity and mortality vary across religions and religious denominations, and across levels of religious involvement (e.g., attendance at services, salience). A long tradition of theory and research has also focused on the relationships between aspects of religious involvement and mental health, as assessed via personality variables, psychological well-being (e.g., life satisfaction), distress, symptom counts (e.g., depression, anxiety), and clinical or simulated diagnoses of various psychiatric disorders (e.g., major depressive episode). While the empirical findings are not unequivocal, systematic reviews of these studies have consistently reported that various aspects of religious involvement are linked with desirable mental health outcomes (e.g., Larson et al. 1992; Levin and Chatters 1998). Although earlier studies of the religion-health connection typically relied on cross-sectional data and descriptive analyses, a number of recent investigations using prospective data and rigorous analytic methods also report salutary effects of diverse indicators of religious involvement on a wide range of physical and mental health outcomes (e.g., Oxman et al. 1995; Strawbridge et al. 1997; Koenig et al. 1998; Hummer et al. 1999).

Explanatory Mechanisms

Given this trail of empirical findings, researchers have increasingly turned their efforts to identifying the mechanisms via which religious involvement may influence physical and/or mental well-being (Levin 1996; Ellison and Levin 1998). Several theoretical links have received close attention in this literature.

Health behaviors and personal lifestyles. Religious involvement may facilitate mental and physical well-being by regulating health-relevant conduct in ways that decrease the

†*Christopher G. Ellison is an associate professor of sociology at the University of Texas at Austin, Austin, TX 78712-1088.*

© *Journal for the Scientific Study of Religion, 1998, 37(4): 692–694*

risk of disease — e.g., by discouraging alcohol and substance use/abuse, and by promoting an ethos of moderation. Moreover, most religious communities have teachings that (a) discourage risk-taking and deviant behaviors, (b) provide moral guidance about sexuality and family life, including marriage and child rearing, and (c) shape other lifestyle choices (e.g., business ethics), in ways that may reduce exposure to various stressful events and conditions.

Social integration and support. Religious communities may also be important sources of social contacts and loci of support networks. Churches and synagogues provide opportunities for regular interaction and friendship formation among like-minded persons. In addition, many congregations offer assistance through formal channels, such as church programs (e.g., for elders, shut-ins, poor persons, families) and pastoral counseling. Members also support one another informally, through tangible aid (e.g., goods and services), socioemotional support (e.g., companionship and comfort) and spiritual support. The experience of helping others can benefit support providers as well as recipients. Finally, religious support may be especially particularly reliable and satisfying due to the shared beliefs about suffering, altruism, and reciprocity that may exist among coreligionists.

Psychological resources. Contrary to the claims of some venerable critics (e.g., Ellis 1962), several recent studies associate aspects of religious involvement with feelings of self-esteem and personal efficacy. Such positive self-perceptions are sometimes viewed as indicators of mental health in their own right, and they are associated with a wide range of other salutary health outcomes. It is believed that individuals may gain a sense of self-worth and (perhaps vicarious) control by developing an ongoing personal relationship with a perceived divine other, who (a) is believed to love and care for each person unconditionally and (b) can be engaged interactively (via prayer and meditation) in a quest for solace and guidance. Some researchers also emphasize the role of fellowship within some religious congregations, which may promote feelings of self-esteem and efficacy through positive reflected appraisals and favorable social comparisons.

Coping. Although students of coping processes have traditionally given short shrift to the role of religion, there is now compelling evidence that religious cognitions and behaviors are common and valuable coping resources for many individuals (see Pargament 1997). Studies show that religious coping may be especially important for persons dealing with certain types of stressors, such as loss events (e.g., bereavement), unexpected calamities (e.g., serious accidents), and health problems (e.g., chronic pain, long-term disability). Religious cognitions may play a significant role as individuals assign meaning to potentially problematic events and conditions, and as they appraise (a) the degree of personal threat or challenge posed by these stressors and (b) the resources available for responding to them.

Other possible mechanisms. Beyond these explanations, there are various other processes via which religious factors may influence physical and mental well-being (Levin 1996; Ellison and Levin 1998). For instance, religious practices may lead to the experience or expression of certain emotions which through psychoneuroimmunological or neuroendocrine pathways could impact physiological systems. These might include positive emotions such as forgiveness, contentment, and love, as well as negative emotions such as guilt and fear. In addition, various aspects of ritual activity (e.g., involvement in ecstatic or cathartic worship services) may promote mental and physical health (e.g., Idler and Kasl 1997). Finally, the hope and optimism inspired by personal faith, and the broad sense of order and coherence that can result from sustained religious practice, may help to account for observed religious variations in mental and physical health (Koenig 1994).

Future directions. Recent reviews of the religion-health field (e.g., Levin 1996; Ellison and Levin 1998) recommend further work on several fronts, including: (a) the conceptual refinement and improved measurement of those religious domains that are most directly linked with health, such as support, coping, meaning, and spiritual experiences; (b) the

examination of religious effects on diverse mental and physical health outcomes, especially using longitudinal data; (c) the study of possible negative aspects of religion (e.g., maladaptive coping; negative emotions and interactions); (d) the assessment of alternative, theoretically grounded models of the religion-health connection; and (e) the investigation of subgroup variations (e.g., racial/ethnic, gender, social class) in religion-health relationships.

The Symposium

The contributions to this symposium address several of these important issues. Levin and Taylor examine the cross-sectional and longitudinal relationships between multiple indicators of religious involvement and various mental health outcomes among African Americans, a population that has been neglected in much of the research on this topic. Pargament and colleagues develop new measures of positive and negative religious coping styles, and relate them to mental and physical well-being among three diverse U.S. samples. Krause and his associates explore positive and negative aspects of church-based social ties, and their relationships with psychological well-being among a sample of clergy, elders, and rank-and-file members of the Presbyterian Church USA. Finally, Bjarnason clarifies and extends Durkheim's theory of religion and anomie, and he tests hypotheses derived from this theoretical model using data on Icelandic adolescents.

Crafted by sociologists, psychologists, psychiatrists, and social epidemiologists, these contributions reflect the diverse and increasingly multidisciplinary character of religion-health research. Although these specific articles focus primarily on mental health, they raise themes that are germane to a broader constellation of health outcomes. Taken together, these pieces shed new light on the links between religion, health, and well-being, and suggest a number of fruitful directions for future research in this burgeoning area.

REFERENCES

Ellis, A. 1962. *Reason and emotion in psychotherapy*. Secaucus, NJ: Lyle Stuart.

Ellison, C. G., and J. S. Levin. 1998. The religion-health connection: Evidence, theory, and future directions. *Health Education and Behavior* (in press).

Hummer, R. A., R. Rogers, C. Nam, and C. G. Ellison. 1999. Religious involvement and U.S. adult mortality. *Demography* (in press).

Idler, E. L., and S. V. Kasl. 1997. Religion among disabled and nondisabled persons II: Attendance at religious services as a predictor of the course of disability. *Journal of Geronotology: Social Sciences* 52B: 306–16.

Jarvis, G. K., and H. C. Northcott. 1987. Religion and differences in morbidity and mortality. *Social Science and Medicine* 25: 813–24.

Koenig, H. G. 1994. Religion and hope for the disabled elder. In *Religion in Aging and Health: Theoretical Foundations and Methodological Frontiers*, edited by J. S. Levin, 18–51. Thousand Oaks, CA: Sage.

Koenig, H. G., L. K. George, H. J. Hays, D. B. Larson, and D. G. Blazer. 1998. The relationship between religious activities and blood pressure in older adults. *International Journal of Psychiatry in Medicine* (in press).

Larson, D. B., K. A. Sherill, J. S. Lyons, F. C. Craigie, S. B. Thielman, M. A. Greenwold, and S. S. Larson. 1992. Associations between dimensions of religious commitment and mental health reported in the *American Journal of Psychiatry* and the *Archives of General Psychiatry*, 1978-1989. *American Journal of Psychiatry* 149: 557–59.

Levin, J. S. 1996. How religion influences morbidity and health: Reflections on natural history, salutogenesis and host resistance. *Social Science and Medicine* 43: 849–64.

Levin, J. S., and L. M. Chatters. 1998. Research on religion and mental health: A review of empirical findings and theoretical issues. In *Handbook of Religion and Mental Health*, edited by H. G. Koenig, 33–50. San Diego: Academic Press.

Levin, J. S., and H. Y. Vanderpool. 1987. Is frequent religious attendance *really* conducive to better health? Toward an epidemiology of religion. *Social Science and Medicine* 24: 589–600.

Oxman, T. E., D. H. Freeman, and E. D. Manheimer. 1995. Lack of social participation or religious strength and comfort as risk factors for death after cardiac surgery in the elderly. *Psychosomatic Medicine* 57: 5–15.

Pargament, K. I. 1997. *The Psychology of Religion and Coping*. New York: Guilford Press.

Strawbridge, W. J., R. D. Cohen, S. J. Shema, and G. A. Kaplan. 1997. Frequent attendance at religious services and mortality over 28 years. *American Journal of Public Health* 87: 957–61.