

A Public Health Perspective on the
Religion-Health Connection

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The Kalsman Institute
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Background and Significance

Until recently, the Jewish Healing movement has primarily combined Jewish teachings and traditions, social work and counseling. Yet there are other fields that have much to offer to Jewish Healing, in terms of models for practice, potential for collaboration, and theoretical frameworks. One of these is Public Health, although the connection between Public Health approaches and Jewish Healing has been little explored. This paper seeks to begin to bridge this gap, by exploring the social epidemiology of religion and spirituality, and discussing the significance of incorporating spirituality and religion into public health programming

Traditionally, public health has worked within the same paradigm as mainstream medicine, seeking to prevent and treat disease by identifying and curing abnormalities mainly at the cellular level. Public Health applies these principles at the population level by identifying risk factors – whether environmental, bacterial or, recently, behavioral – and seeking to prevent disease by preventing exposure to known risks. Yet, in recent years, we have seen a growing movement to recognize the inter-relationship between mind, body and spirit in health and illness. In keeping with the World Health Organization definition of health as “a complete state of physical, mental and social well-being, not merely an absence of disease”, we are moving towards a more holistic view of health. At both the individual and community levels, “health” is expanding into “wellness”, incorporating elements such as spirituality, work, love, social support and community involvement. As our approach to health changes and expands, public health programming is also moving into new arenas, focussing more on community-wide

collaborations and a wide range of “wrap-around” services that go beyond the traditional realms of public health. Within this context, there is increasing interest in the link between religion, spirituality and health. .

I. Changing Approaches to Health and to Public Health

The western definition of health is changing. Historically, the medical model of health was the Ecological Model, which saw health as a balance between host, agent and environment. This model assumes a single cause of disease that can be isolated, identified and replicated (i.e. Koch’s postulates). Over time, it was recognized that many diseases had multiple causes, and the Social-Ecological model developed. This model replaces the disease agent with personal behaviors, and assumes a balance between host (i.e. genetic factors); external environmental factors (physical, social); and personal behavioral factors (Dever, 1991).

Public health, seeking to prevent disease and promote health at the population level, built on these approaches. Public health interventions were based on a three-tiered approach to prevention (Turnock, 1997):

- Primary prevention: prevention of disease or injury through reducing exposure or risk factors.
- Secondary prevention: identification and control of disease processes in their early stages, thus limiting their effects.
- Tertiary prevention: limiting the impact of disease or injury once damage has already occurred, through rehabilitation or treatment.

Thus, for example, studies on “preventive health care” focused on behaviors such as routine blood pressure and cholesterol checks, mammograms, clinical breast exams, Pap smears, influenza vaccines, and diabetes screening (Gilliland, Mahler, Hunt and Davis, 1999). In keeping with the Social-Ecological Model, health promotion activities focused

either on expanding participation in these screening programs, or on changing individual behaviors. Rarely did prevention programs look beyond individual risk factors and address underlying issues (Manson, Tatum and Dinges, 1982).

Newer models of health and health promotion are more multidimensional and recognize the fundamental influence on health of factors such as social and physical environment, lifestyle, genetics, and systems of health care delivery (Evans and Stoddart, 1990). Many public health programs now recognize the need for multi-layered interventions to respond to multi-dimensional problems. Some programs now combine clinical treatments with health education and community outreach based on epidemiological and social studies. For example, Vanderwagen (1999) describes a program to prevent infant mortality in Native American communities. Recognizing that the problem stemmed from dehydration resulting from gastroenteritis, the prevention program addressed these underlying issues through parent education, immunization, advocacy for clean water and sewage treatment, and development of local skills.

In addition, there is a growing focus on the capacity of the community to address health issues (Goodman et al, 1998) and the impact this capacity may have on health outcomes. This includes issues such as leadership, citizen participation, development of skills and access to resources, shared values, and community empowerment. There is also a growing recognition that different types of resources are needed for a community to be “healthy”. Human and social capital, as well as physical and financial capital, all play important roles (Coleman, 1988). This understanding has opened the door to interventions that focus on broader social issues, such as community development and organizing, poverty, employment, housing, and environmental justice. This

comprehensive approach to health, which addresses a complex interaction between many different factors, requires shared responsibility by multiple community stakeholders (Durch, Bailey and Stoto, 1997). Public health agencies are turning their focus to the community, initiating community-based health programs and calling for collaboration between a broad network of individuals, agencies and organizations (see for example, CDC/ATSDR, 1997 and Durch, Bailey & Stoto, 1997). Mobilizing community partnerships to identify and solve health problems is now considered an essential service of public health (Turnock, 1997).

In this context, there is a growing movement to involve religious/faith communities and institutions in health-related activities (CDC, 1999; Gunderson, 1998). Hale and Bennett (2000) note that religious communities have inherent characteristics that make them ideal sites for community health education, and for training lay health workers and patient advocates. These include:

- Congregations already have regularly scheduled programs.
- Members are a built-in audience.
- Membership is inter-generational.
- The congregation can reinforce the health promotion messages in different formats, at different times.

In many ways, these characteristics are similar to those of other community institutions.

Yet Gunderson (1997) points out that faith communities and religious institutions are quite different from other segments of the community. They possess unique strengths, including:

- The strength to **accompany**, to be present in the lives of others;
- The strength to **convene** diverse interests around problems or opportunities;
- The strength to **connect** people to resources through the web of networks within the congregation;
- The strength to **tell stories** that provide a framework of meaning;
- The strength to **give sanctuary**, providing a safe place to gather;

- The strength to **bless**, creating hope;
- The strength to **pray**, to find meaning between the holy and the human;
- The strength to **endure**, to persist as a congregation for the long cycles needed to produce community change.

These comments recognize an important, but often overlooked, aspect of both personal and community health: the positive contribution of religion and spirituality.

II. The Social Epidemiology of Religion, Spirituality, and Health

Newer models of health focus on “wellness”, incorporating elements such as spirituality, self-regulation, work, love and friendship (Witmer and Sweeney, 1992).

These models recognize the interrelationship of mind, body, and spirit, and are described as biopsychosocial-spiritual models (McKee and Chappel, 1992). Religious involvement is the newest piece to be added to the contemporary paradigm of health.

Traditionally, a distinction has been made between religion and spirituality. While for the purposes of this paper the terms are used together, it may be useful to examine the distinctions between them. Religion is the “settings, groups, activities and world views which focus on a search for significance in ways related to notions of the sacred.” (Kloos and Moore, 2000, p. 121) According to Ellison and Levin (1998), “religion is a complex and multidimensional domain of human life comprising behaviors, attitudes, beliefs, experiences, values and so on”(p. 709).

Spirituality is much more difficult to define. Shea (2000) notes that “it is easier to nail jello to a tree than to define spirituality” (p. 15). Some of the definitions of spirituality include:

- A belief system focusing on intangible elements that impart vitality and meaning to life’s events. Often spirituality is expressed through formalized religions. (Maugans, 1996)

- Having to do with “the spirit or the soul, as distinguished from the body”; spirituality has to do with man’s search for a sense of meaning and purpose in life, that part of a person’s psyche that strives for transcendental values, meaning and experience. (McKee and Chappel, 1992)
- An aspect of human experience realized as awareness, belief, and sense of connection with others and the universe, material and non-material. (Kloos and Moore, 2000)

According to Shea (2000), it may be appropriate to define spirituality differently in different contexts. When defining spirituality as it relates to health care, he focuses on the distinct spiritual interests of health care stakeholders: patients, medical professionals, chaplains, and health care organizations.

Religion and spirituality may be the most difficult elements for the health professions to incorporate, since they are difficult to measure and evaluate scientifically (Ellison and Levin, 1998). Yet, even with the difficulty in defining and operationalizing these constructs, their impact on health is increasingly being studied. Numerous studies have found a significant correlation between religious involvement and positive health outcomes:

Religious beliefs and practices have been found to affect patient’s experiences with cancer, communicable diseases of childhood, pregnancy and family planning, affective disorders and mental health, alcoholism, coronary artery disease, and the acquired immunodeficiency syndrome. Conversely, religious affiliation has been correlated with a reduction in the incidence of certain diseases, such as cancer, coronary artery disease and dementia. Decisions about terminal care and advance directives often reflect religious considerations and stimulate exploration of issues of meaning, purpose, design, hope and faith. (Maugans, 1996, p. 11)

While it is beyond the scope of this paper to review all of these studies, several examples show the epidemiological importance of spirituality and religion. In a review of the literature relating religion and spirituality to community psychology, Kloos and Moore (2000) found positive connections between religious involvement and/or

spirituality and health behaviors. These included: lower incidence and prevalence of substance abuse, alcoholism and cigarette smoking; lower prevalence of depression; and improved ability to cope with stress. Ellison and Levin (1998), in an exploration of the “religion-health connection”, note that, across denominations, gender, age, social class and racial and ethnic groups, religious involvement is associated with better health status.

They state that:

In the language of epidemiologists, it appears that religion, in a broad sense, represents a protective factor that offers a small but significant primary-preventive effect against morbidity in populations. (p. 701)

Wallace and Forman (1998), testing this hypothesis with adolescents, also concluded that religion appears to be an important psychosocial factor affecting health. They found that religious youth are less likely to engage in risk behaviors, and more likely to behave in ways that enhance their health. In a study of religious attendance and mortality, Hummer, Rogers, Nam and Ellison (1999) found that religious attendance has a significant impact on life expectancy. At age 20, there is a seven-year difference in life expectancy between those who never attend and those who attend more than once a week. Other studies have found significant correlation between prayer, one’s own and that of others, and improved health (for a full exploration of this topic, see Dossey, 1999). It is important to note that few of these studies were conducted in the Jewish community. Further research is needed to know if the same conclusions apply to members of our community.

While there are many theories regarding the causal link between religion and health, the exact causal mechanism has yet to be identified. It is difficult to determine which parts of religion and spirituality underlie the above correlations, or if it may be the

synergy between them that has such a profound impact. Ellison and Levin (1998), reviewing the literature, identify seven explanatory mechanisms most commonly used to explain the religion-health link. They note that most of these behavioral and psychosocial constructs are frequently mentioned elsewhere in health education and promotion. These include:

1. Regulation of individual lifestyles and behaviors;
2. Provision of social resources (social ties, formal and informal support);
3. Promotion of positive self-perception (self-esteem, feelings of personal mastery);
4. Provision of coping resources and response to stress;
5. Generation of positive emotions (love, forgiveness);
6. Promotion of healthy beliefs;
7. Additional hypothesized mechanisms, such as healing energy.

Gunderson (1998) notes that most studies examining religion and health focus on the individual. This focus is misguided, he suggests, since the “health effects of religion are best understood by looking to the nature of the congregation and the experience of participation in it.” (p. 296)

III. Incorporating Spirituality and Religion into Public Health Practice

As the link between religion, spirituality and health becomes clearer, there is much discussion about how to incorporate this information into medical and public health practice. Many medical schools, and some colleges of public health, now offer courses in religion, spirituality and health. In addition, frameworks are being proposed for integrating religion and spirituality at the clinical level. For example, Maugans (1996) has proposed a series of questions to be added to the medical interview, called the SPIRITual history. Recognizing both the personal and communal aspects of spirituality and religion, this questionnaire addresses six areas: **S**piritual belief **S**ystem, **P**ersonal spirituality, **I**ntegration and **I**nvolvement in a spiritual community, **R**itualized practices

and **R**estrictions, **I**mplications for medical care, and **T**erminal events planning (advance directives).

Many people feel uncomfortable with such a framework. Sloan et al (2000) caution against the dangers inherent in expecting physicians to become involved in the spiritual lives of their patients. Among their concerns are that: physicians are not trained in spiritual counseling; “prescribing” religion may trivialize it; and many patients may not be interested in discussing such matters with their physician.

Public health, with its emphasis on the community, may be a less controversial place for linking health-related activities and religion/faith communities, especially if Gunderson is correct in saying that the communal aspect of religion is one of the more important pieces of this puzzle. Programs integrating spirituality, religion and health take different forms depending on which aspect of religion and spirituality is emphasized. Yet each of these programs, each in its own way, fulfills several of the Ten Essential Public Health Services:

- Service 3: Inform, Educate and Empower people about health issues
- Service 4: Mobilize community partnerships to identify and solve health problems.
- Service 7: Link people as needed to personal health services and assure the provision of health care when otherwise unavailable.
- Service 10: Research for new insights and innovative solutions to health problems.

Some of these programs to integrate spirituality and public health are based on individual beliefs and actions, including those around health-related issues; they also aim to enhance the spiritual life and social support of the individual. Other programs focus on the role of the community in promoting health. These programs build religious-community-wide collaborations in support of health, sponsor educational programs, and build service

networks. Many religious communities are involved in increasing access to health services either through provision of services, linking congregants with insurance programs and other services, or providing support to other agencies (see for example, Hale and Bennett (2000); or the Interfaith Health Program, www.ihp.org). In the Christian community, these programs are known as Health Ministry, an umbrella term that encompasses a wide-range of congregationally-based programming that integrates health, spirituality, religion and community support [for more on the Christian perspective, and the role of the church in health care, see for example, Evans (1999) or Benner Carson and Koenig (2002)]. The most common program may be the parish nurse program, in which trained nurses provide health education and basic clinical services in a congregational setting.

There are several programs in the Jewish community that could fit into this category. These includes the Caring Community program of the Department of Family Concerns, Union for Reform Judaism; several new programs involving Jewish congregational nurses; the Shleimut initiative to develop congregational care-teams; and the work of the Kalsman Institute on Judaism and Health, which has catalyzed new programs and conversations about health care ethics and policy. Although Jewish Healing Centers are primarily seen as providers of spiritual support, they too can be seen as fulfilling a public health function.

All of these programs are run by collaborations of diverse agencies and people. They run educational and support programs, help community members access needed health and social services, and provide social support. Through these activities, they may be generating social capital, by increasing trust and encouraging norms of support and

mutual involvement. The work of these programs and organizations also appears to lead to increased community capacity, by building stronger inter-organizational collaborations, encouraging participation in the Jewish community by many who were previously unaffiliated, and generating a sense of community and shared values.

The potential for collaboration between the Jewish community and Public Health professionals is, for the most part, an untapped area. More research is needed to fully understand the unique characteristics of the Jewish community and their relationship to health and healing. Yet clearly both of the professional fields have much to gain from each other.

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