



# health benefits of Christian faith

By Alex Bunn and David Randall

Religion is for 'the hesitant, the guilt-ridden, the excessively timid, those lacking clear convictions with which to face life',<sup>1</sup> said a standard British textbook of psychiatry until 1969. The implication is clear: faith selects the weak and is probably bad for your health. Sigmund Freud went so far as to call it a neurosis.<sup>2</sup> Some have argued that religious faith has no role in modern medical care and that doctors should be forbidden from discussing spiritual issues with their patients.

Conversely, some claim that religion promises miraculous healings and long life, a prosperity gospel of 'health and wealth'. Indeed, modern 'healing crusades' or shrines such as that at Lourdes offer healing from physical disease as a key benefit of Christian faith.

This *File* examines the published evidence on faith and health outcomes, considers which potential mechanisms might underlie any association, and considers what the implications of the positive health benefits of faith are for Christian believers.

## Is there a link between faith and health?

Evidence from over 1,200 studies and 400 reviews has shown an association between faith and a number of positive health benefits, including protection from illness, coping with illness, and faster recovery from it. Of the studies reviewed in the definitive analysis,<sup>3</sup> 81% showed benefit and only 4% harm.

The raw data from some large studies show a significant benefit in mortality for those involved in organised religion. For instance, one study followed 21,204 representative American adults over nine years, and correlated death rates with religious activity and a large range of other data. Income and education had surprisingly little impact, but those who attended church regularly had a life expectancy seven years longer than those who did not. For black people the benefit was 14 years. The researchers attributed the benefit to more protective relationships, including marriage, and to healthier behaviours.<sup>4</sup> Only recently has faith been taken seriously as a factor in health, and further research is needed to clarify its significance and relation to other factors.<sup>5</sup>

## Benefit for mental health

In the popular imagination, religion commonly underlies florid mental illness such as psychosis. In reality though, religiosity has been shown to protect against psychosis, and patients who used religion to cope had better insight and were more compliant with medication.<sup>6</sup>

'In the majority of studies religious involvement is correlated with well-being, happiness and life satisfaction; hope and optimism; purpose and meaning in life; higher self-esteem; better adaptation to bereavement; greater social support and less loneliness; lower rates of depression and faster recovery from depression; lower

rates of suicide and fewer positive attitudes towards suicide; less anxiety; less psychosis and fewer psychotic tendencies; lower rates of alcohol and drug abuse; less delinquency and criminal activity; greater marital stability and satisfaction.'<sup>7</sup>

This is the conclusion of the largest literature review, and is endorsed by a former President of the Royal College of Psychiatrists. He laments the lack of attention given to the strong evidence: 'for anything other than religion and spirituality, governments and health providers would be doing their utmost to promote it'.<sup>8</sup>

## Benefit in coping with severe or terminal disease

Palliative care takes spirituality very seriously, and has expanded the concept of pain to include 'total pain' in the terminally ill: physical pain, mental anguish, social alienation and spiritual distress.<sup>9</sup> Spiritual wellbeing has been shown to reduce hopelessness and suicidal ideation at the end of life,<sup>10</sup> whereas spiritual distress (for instance, fear of death or lack of purpose in life) is linked to sleeplessness, anxiety and despair.<sup>11</sup>

## Are there negative effects?

In four out of 86 studies mental health was worse among the religious, typically where there was harsh, judgmental and authoritarian leadership.<sup>12</sup> But compared to the wealth of evidence above, proven harm has been reported rarely, generally in isolated case reports and studies of atypical religious communities. For instance, there have been outbreaks of rubella among the Amish who refused vaccination, and the refusal of Jehovah's Witnesses to receive blood transfusions is well documented. The very unorthodox Christian Scientists may seek medical help late, due to their belief that sickness is illusory, and this can endanger life.<sup>13</sup>

## Why is it difficult to study the link between religion and health?

Two main problems appear when trying to interpret these studies: the problem of definitions and the question of causality.

### 1. The problem of definitions

In order to measure how religious faith affects health, we need to define and quantify both faith and health. 'Health' is easier – we can measure things like life expectancy, or the prevalence of different diseases. Defining 'faith' is much harder – what exactly should be measured?

One option would be to look at self-defined religious affiliation: what religious category would you put yourself into? Unfortunately, this can be very indiscriminating. About 70% of British people describe themselves as Christian, but only a minority have an active faith. Most research has been done comparing active Christians with their neighbours in Western countries.

## the evidence suggests greatest benefit for those who are genuinely devoted to God... whose faith alters their thinking, behaviour and relationships

A second option would be to look at the content and character of the faith. After all, religions make contradictory truth claims, and religious people are very diverse. Overall, the evidence suggests greatest benefit for those who are genuinely devoted to God, who are 'intrinsically religious', whose faith alters their thinking, behaviour and relationships (see below). In contrast, the 'extrinsically religious' are motivated by personal gains such as social status and respectability. However, qualitative data is time consuming and expensive to collect.

A third option is to ask what religious people do as a result of their faith that can

be measured objectively; for example, using church attendance as a proxy for religious belief. Although easy to measure, it is extremely crude. Imagine trying to score the quality of a romantic relationship by measuring how often one partner buys the other chocolates or flowers, when what matters in a relationship is not the externals but the internal quality, which is hard to measure. It's an example of the limitations of quantitative science, where 'if you can't score it, ignore it!'

### 2. The problem of proving causality

We have already seen that a number of studies show that religious belief is associated with better health. However, does religious faith cause better health, or is the relationship brought about by other factors? Take this absurd example: over 90% of deaths occur in bed. Does this mean that going to bed *causes* death? Of course not – in this case, another factor, such as a severe illness, causes the patient both to be bedridden and subsequently to die. Some of the association between faith and health may be related to other underlying risk factors, so called 'confounding variables', such as social class. Solutions to the problem of causality include carrying out observational trials prospectively to prevent false retrospective judgments being applied to data, and by adjusting for known risk factors. But even after these correctives, the benefit of faith remains.

### How might a link between faith and health work?

If we accept that religious faith itself might be good for an individual's health, then how might this be explained? Are there plausible mechanisms by which faith might benefit health?

#### Mental outlook

Spiritual beliefs do not merely provide subjective experiences but also undergird attitudes and expectations of life. Our answers to worldview or existential questions shape our experience of life, and can have substantial impact on physical health. For instance, one large prospective study demonstrated that hopelessness is a powerful risk factor for heart attack and cancer, increasing the death rate two to

threefold even in healthy individuals, after correcting for all the usual 'medical' risk factors such as social class, blood pressure, smoking, cholesterol and physical activity.<sup>14</sup> A materialistic worldview that sees the universe as ultimately bleak and impersonal evokes a different cognitive appraisal of events than a worldview in which there is coherence and a higher purpose, one that offers hope and comfort in the worst of circumstances.

## A purely biomedical model of disease causation may underestimate the importance of relationships to health

### Positive health behaviours

Religious involvement is associated with a reduction in risky health behaviours,<sup>15</sup> for instance problem drinking,<sup>16</sup> smoking<sup>17</sup> and permissive sexual behaviour. This can have dramatic benefits. One study even found that religious attendance was associated with a more than 90% reduction in meningococcal disease (meningitis and septicaemia), in teenagers, a protection at least as good as meningococcal vaccination.<sup>18</sup> Furthermore, religious involvement has been associated with improved adherence to medication.<sup>19, 20, 21</sup>

### Enhanced social relationships

One cohort study in the US found that the mortality benefit for religious attenders was partly explained by better social contact and greater marital stability.<sup>22</sup> A purely biomedical model of disease causation may underestimate the importance of relationships to health.

### Immunological effects

Psychoneuroimmunology is an advancing field of research exploring the complex interactions between a person's mental state, their brain and their immune system, mediated by a range of mechanisms including stress hormones such as cortisol. Studies have linked emotional stress to development of the common cold<sup>23</sup> and to rates of infectious

disease more generally. Others have linked religious involvement to lower levels of inflammatory cytokines and markers of immune dysregulation.<sup>24</sup> In one robust study of people living with HIV, those who grew in appreciation of spirituality or religious coping after diagnosis suffered significantly less decline in their CD4 counts and slower disease progression over a four year follow-up.<sup>25</sup>

### Divine intervention

Various studies looked at the efficacy of intercessory prayer on health outcomes. These were summarised in a 'Cochrane' meta-analysis, which concluded that overall there was no significant improvement in groups of patients prayed for, although one trial did show improvements in certain end-points including death.

In another, patients receiving prayer did better post-operatively than those not receiving prayer, but only if they did not know they were being prayed for. The review authors conclude that the evidence is insufficient to advise for or against prayer,<sup>26</sup> and considerable controversy surrounds the interpretation and implications of the studies in question.<sup>27</sup> The reasons why God chooses to answer some prayers and not others are outside the scope of this *File*, but the assumption that God can be summoned like a genie in a lamp is closer to magical thinking than an authentically Christian understanding of prayer.

## Should Christian faith be recommended for patients' health?

### Evidence

'Spiritual care' and 'spiritual interventions' describe spiritual activities, such as counselling or prayer, done specifically to help patients recover from disease or to cope with it. To decide whether these should actually be offered in medical practice we need to go beyond simply *observing* whether faith and health are associated. We need to look at intervention *trials*, which test whether these interventions lead to improved health outcomes.

Much of this kind of research has been undertaken in a palliative care setting, where evidence suggests patients do value the opportunity to discuss spiritual matters with their doctors.<sup>28</sup> There are very few trials that look directly at spiritual interventions. One randomised trial assessed the impact of chaplains, in which daily visits were associated with shorter length of stay and reduced patient anxiety in emergency admissions with chronic obstructive pulmonary disease.<sup>29</sup> However, this study did not describe what constituted an appropriate spiritual intervention, partly because of the problems of standardising spiritual care for research purposes. This shows the difficulties of producing good trial evidence to support or refute the value of spiritual interventions.

## Christians should respond to spiritual enquiries 'with gentleness and respect'. The General Medical Council came to the same conclusion

### Controversies

The issue of 'prescribing faith' remains contentious within the medical community, and much of the debate is based not on evidence but on *a priori* presumptions of harm. In one article, the authors argue that even if strong evidence for such interventions improving health outcomes did exist, religious faith falls into a category of risk factors (like, for instance, marital status) that are beyond the remit of medical advice. They argue further that prescribing faith might be coercive, given the implicit authority gradient in the doctor-patient relationship, and that doctors could cause psychological harm by suggesting that patients' illnesses are caused by a lack of religious devotion.<sup>30</sup> Their arguments arise from a secular ideology which demands that spirituality, faith and religion should be excluded from medicine. In the UK, the National Secular Society insists the NHS should not fund chaplaincy services in hospital.<sup>31</sup>

## The Christian perspective

The people we most need to listen to are patients, who typically are more religious than their carers. In one survey, patients and families stated that faith was the second most important factor in their decisions about cancer treatment, whereas the oncologists treating them imagined it would be last on the list.<sup>32</sup> Even if we consider those patients who are not involved in organised religion, 76% admit to spiritual experiences and beliefs.<sup>33</sup>

Modern doctors need to become more patient centred by supporting spiritual care, as secular training has tended to exclude some of patients' deepest concerns. At a time of illness spiritual issues often rise to the surface – questions of worth, mortality, and place in the world. The sensitive doctor will explore these by taking a spiritual history and considering how a patient's existing spiritual views may impact on their current illness and hopes for recovery.

However, Christians would want to follow and commend the example of Jesus, who was strikingly non-coercive in his interactions with suffering human beings. The founders of the church advised that Christians should respond to spiritual enquiries 'with gentleness and respect'.<sup>34</sup> The General Medical Council came to the same conclusion 2,000 years later.<sup>35</sup> Christians should not promote health benefits as the primary reason for coming to faith in Christ. Jesus came into the world to work a far deeper transformation in human lives than simply curing disease. In fact he promised that his disciples would experience trouble as a result of following him, not health and wealth.<sup>36</sup> It was an accurate prediction, as the founders of Christianity had a markedly high mortality and morbidity!

Although the Bible does mention many healings and includes a promise of future deliverance from illness and pain, it also emphasises the value of suffering in the life of a believer. Suffering helps Christians to trust not in themselves but in God;<sup>37</sup> it then allows them to comfort others in a similar position;<sup>38</sup> to enjoy communion with Christ;<sup>39</sup> and to become strong in their Christian lives – so that the

apostle Paul even ‘delights’ in his troubles and hardships.<sup>40</sup> The book of Job is devoted to the mystery of why good people suffer. Christian commitment then, according to the Bible, is no guarantee of health or wealth. The main reason for embracing Christianity should be the conviction that it is *true* – not the hope that it is healthy.

### Conclusion

While it is striking that faith appears to be associated with improved health outcomes, the Christian faith is not to be judged by its material benefits, but by whether it is true. Christianity’s holistic emphasis on human beings whose physical, mental, relational and spiritual dimensions are all vitally important, is an important corrective to the reductionism of modern medicine. Patients do not simply present biological problems to be solved. Rather, effective medical interventions should address all the dimensions of our humanity. It is clear that most patients value and seek this form of holistic care.

In contrast to the popular myth that Christian faith is bad for health, on balance, and despite its limitations, the published research suggests that faith is associated with longer life and a wide range of health benefits. In particular, faith is associated with improved mental health. At the very least, the burden of proof is on those who claim that faith is bad for health and that all forms of spiritual care should be excluded from modern medicine.

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