Chapter 10
Religion, Spirituality, and Physical Health

All major religious traditions have a long-standing interest in working to promote health and to cure physical, mental, or spiritual illnesses. More recently, psychology has also become a major provider of health care services, and psychologists have taken on healing roles previously reserved for doctors or religious professionals. This joint interest offers many possibilities for dialogue between psychology and religion about issues related to health and healing. In this chapter, we look primarily at issues related to physical health; in the next chapter, we will consider mental health.

10.1 Scientific Approaches to Religion and Health

Although religious individuals have generally seen their traditions as promoting health, psychologists beginning with Freud have frequently challenged this association, claiming instead that religion is associated with pathology. Much of the dialogue between psychology and religion during the 20th century revolved around this issue. One of the largest shifts in that dialogue has been mounting scientific evidence that religion does indeed promote health, challenging long held antireligious views in the psychological community.

10.1.1 Definitions of Health

Health can be defined in one of two ways. In the modernist view that is current in Western societies (see Section 6.3), health is generally defined as an absence of illness or disease and is thought of as an ultimate human good. Illness is thought of as something that invades the body of an individual from the outside and disrupts its complex mechanical functioning. Modern medical care is defined according to the allopathic principle of countering this outside force through chemical and mechanical intervention. Specialist experts are considered essential to the task of countering disease and maintaining normal functioning. This is sometimes referred to as the medical model of health. This view of health and the human person can
be extended to many areas of life by seeing various legal, social, and religious problems as illnesses to be counteracted by specialists. This is sometimes referred to as the **medicalization of culture** (Kinsley, 1995, pp. 9–11, 170–178).

In the medical model, disease can be said to progress in two phases—(1) a prepathogenic phase in which characteristics of the person, environment, and specific problem interact to determine risk; and (2) pathogenesis, when actual problems and symptoms develop. Health care measures in the prepathogenic phase involve **primary prevention** to reduce the risk of developing a disease. After pathogenesis, the choices are **secondary treatment** on an outpatient basis or **tertiary treatment** in a hospital. During the prepathogenic phase, there may be **protective factors** that either slow disease or move the person toward health. These are also sometimes known as **salutatory** or **salutogenic factors**. Researchers often see spirituality and religion as general protective factors rather than as treatments for specific illnesses (Levin, 1996, 2003).

The traditional medical model also tends to distinguish between physical health and mental health, depending on whether the symptoms of disease are primarily “physical” or “mental” in nature. This distinction reflects a dualistic understanding of mind and body as somehow separate, a belief which many historians trace to the early modern philosophy of Rene Descartes (1596–1650). This dualism is rejected in most contemporary thought, and there is substantial research indicating that physical and mental health have strong connections with each other (e.g., Merrill & Salazar, 2002).

A broader definition of health that goes beyond the medical model sees wellness as more than an absence of illness. Along with avoidance of disease, health can be thought of as including positive qualities like meaningfulness of life, active engagement, and productivity. In this view, illness is more than a disruption of mechanical processes; it also can interfere with our relationships and raise questions of meaning; as such, health and illness have an essential spiritual component (Rowe & Kahn, 1997; Kinsley, 1995, p. 152). This is a more **holistic model** of health that (1) focuses on the interrelationship and interconnectedness of many factors rather than a piecemeal approach to health and (2) focuses on health as more than the absence of illness but the global status of many aspects of our life.

Most research exploring the connections between religion and health has been conducted from the perspective of the medical model. This research has suffered from a number of methodological problems, including (1) simplistic or inconsistent definitions of health and religion that leave out important aspects of spiritual experience and religious life; (2) problems in research design, sampling, and measurement such as a lack of longitudinal studies following the course of health and illness over time; and (3) a lack of good theoretical models that include important variables such as coping and personality (Rew & Wong, 2006; Chatters, 2000; Kier & Davenport, 2004; Dein & Stygall, 1997; George, Ellison, & Larson, 2002). Some critics also argue that research has been hindered by the stereotypes, prejudices, misconceptions, and personal antagonism toward religion of some investigators, leading to continuing skepticism among researchers and practitioners (Thoresen, 1999; Chatters, 2000). Nevertheless, over the past 10–15 years, increasingly sophisticated research