Fall 2001

Faith and Health: What Do We Know?

Thomas G. Plante
Santa Clara University, tplante@scu.edu

Faith and Health: What Do We Know?
By Thomas G. Plante

This is a report of research conducted with the support of a Bannan Institute Grant. For more information on Bannan Grants, please see page 34.

There has been a great deal of interest in the relationship between religious faith and health for thousands of years. Regardless of religious tradition, many have sought religious guidance and spiritual support to help prevent, recover from, or cope with both mental and physical health problems. In fact, it was the healing miracles of Jesus that resulted in so much commotion during the early part of his ministry. "The blind see, the deaf hear, the lame walk…" clearly highlights the relationship between faith and health.

In 1872, Sir Francis Galton was one of the first people to scientifically evaluate the impact of prayer on health outcomes. He reasoned that if prayer worked, missionaries and ministers would likely live longer than doctors and lawyers (who, I guess, he assumed didn't pray much). He found no difference in mortality rates between these groups. He then reasoned that royalty had many people praying for them and thus might live longer than wealthy commoners do. Again, he found no difference in mortality rates and concluded that prayer did not work very well regarding health outcomes such as mortality.

Thankfully, research methodologies and statistical techniques have improved a great deal since Galton's time. In recent years, behavioral and medical scientists have begun to much better evaluate empirically the relationship between religious faith and health outcomes. A growing number of well-conceived and methodologically rigorous studies have been conducted to examine if religious beliefs and behaviors might be related to health benefits or health risks. In fact, 1,200 professional scholarly studies and 400 reviews have now been published on this topic during the past 100 years (Koenig, McCullough, & Larson, 2001). The vast majority of this scholarship has occurred during the past 15 years. Specifically, many investigations have suggested that religiousness is associated with better health practices, enhanced ability to cope with adversity and illness, and lower rates of mortality from all causes. Other studies have noted a relationship among lower anxiety, depression, and substance abuse, and higher self-esteem, marital adjustment, life satisfaction, and well being. Research has also begun to explore whether forgiveness, hope, and service to others are associated with positive health outcomes, such as lower cardiovascular risks and mortality rates. A few recent books have been published for laypersons (e.g., Koenig, 1997) and scholars (e.g., Koenig et al., 2001; Plante & Sherman, 2001).

STATISTICAL CONNECTIONS

What does this research conclude? Research generally supports the notion that religiousness is associated with positive mental and physical health outcomes. This includes less depression, loneliness, anxiety, suicidal thoughts and behaviors, alcohol abuse, and delinquency as well as more hope, life purpose, social support, marital adjustment, optimism, and well being among those who tend to be religious. Furthermore, the health benefits among the religious include 36 percent fewer deaths (23 percent fewer deaths after controlling for health practices such as drinking alcohol and smoking). In fact, infrequent church attendees are twice more likely to develop cardiovascular disease than frequent attendees and are 4 to 7 times more likely to have a heart attack. Hypertension is 40 percent lower for those who maintain a spiritual practice than those who do not. Meditation has been found to lower cortisol and other physiological stress reactivity levels (which are

independent risk factors for cardiovascular and other diseases) as well as lower hypertension, neuroendocrine responses, and mortality from all causes. Overall, the religious live 7.6 years longer than the nonreligious after statistically controlling for numerous relevant variables such as health practices, social support, socioeconomic level, family history of disease, and so forth (McCullough, Hoyt, Larson, Koenig, & Thoresen, 2000). These findings are especially strong for women and for public religiousness (i.e., attending religious services). Private religiousness (i.e., strength of faith, private prayer) is more closely associated with better health practices but not as strongly associated with increased longevity.

Service to others (e.g., people who volunteer their time to charitable causes) is also closely associated with many health benefits. In fact, volunteers have a 40 percent lower mortality rate relative to people who do not volunteer even after statistically controlling for social support and other relevant variables.

DISTANCE PRAYER

The most provocative and compelling research in this area involves distance prayer. These studies have used state-of-the-art research methodologies such as double blind randomized clinical trials. For example, in the first of these studies (Byrd, 1988), almost 400 patients in the cardiovascular unit at San Francisco General Hospital were randomly assigned to one of two conditions. All received standard medical care. However, a prayer group outside of the hospital that had no contact with the patients regularly prayed for half of the patients. The patients and hospital staff did not know who was being prayed for. Of the 19 outcome measures (e.g., death, length of hospital stay, need for incubation), the group that received prayers did better on 16 of the outcome measures. This type of research (i.e., double-blind randomized clinical trials using distance prayer for severely ill patients) has been replicated several times with similar results and published in quality, refereed medical journals.

SANTA CLARA CONFERENCE

Our research (in collaboration with colleague Dr. Allen Sherman at the University of Arkansas Medical School as well as Santa Clara psychology students Azra Simicic, Erin Anderson, Bea Saucedo, Chelsea Rice, Scott Yancy, Mira Guertin, Teresa Carroll, Charlotte Valleys, Naveen Sharma, and Dustin Pardini, and supported in part by grants from the Bannan Institute), has examined the benefits of faith among several hundred recovering drug addicts, more than a hundred bone marrow transplant cancer patients, more than a hundred cervical cancer patients, as well as more than 2,000 college students from Santa Clara, the University of Alabama, Samford University in Alabama, Vanderbilt University, Seton Hall, and several other schools (Plante, Simicic, Anderson, & Manuel, under review; Sherman, Plante, Simonton, Moody, & Wells, under review; Sherman, Simonton, Adams, Latif, Plante, Burris, & Poling, 2001; Plante, Saucedo, & Rice, 2001; Pardini, Plante, Sherman, & Stump, 2001; Plante, Yancey, Sherman, & Guertin, 2000). We have found that faith is consistently associated with good coping, optimism, social support, lower levels of anxiety and depression, and better health practices.

During May 2000, Santa Clara hosted a conference with 25 leading experts in this field for a weekend of discussions about the research in this area. This conference ultimately lead to the publication of an edited book published in July 2001 by Guilford Press, entitled Faith and Health: Psychological Perspectives (Plante & Sherman, 2001). The conference was funded in part by the Bannan Institute, the John Templeton Foundation, and the California Wellness Foundation. The purpose of the conference was to develop a better understanding of the state-of-the-art scholarship in this area and to develop a research and practice agenda for the future. Furthermore, we hoped to publish a scholarly edited volume that truly reflected collaboration among the contributors and a synthesis of ideas by spending three days together discussing this topic.

There are many ways that faith might lead to better health. These may include developing a community of social support, maintaining healthy lifestyles, avoiding high-risk behaviors such as unsafe sexual practices and drunk driving, and developing meaning and purpose in life. Of course, divine intervention is also a possibility.

There are many questions that still remain. These include denomination effects such as which religious groups are more likely to obtain what types of health benefits. For example, Mormons and Seventh Day Adventists

frequently show lower rates of certain forms of cancer and heart disease, which may be associated, at least in part, to their dietary restrictions and excellent social support systems. Our research has shown that Catholic students may be generally more stress resilient than Protestant students but show higher levels of anxiety and depression relative to Protestants. Furthermore, the powerful role of placebo and belief in general may contribute to many of the health benefits of religion. Thus, if you truly believe that your faith will help you (regardless of the validity of these beliefs), it might very well help due to your belief regardless of what the belief may actually be. Potential confounding influences must be investigated too.

Ethical questions emerge in this area of research as well. If faith is good for health, should doctors prescribe it for their patients? Might people seek out religious involvement for the sake of their health and not from religious convictions? It is also important to point out that no research suggests that illness is due to lack of faith. It is very important not to blame patients for their illness because they are not active in church activities, prayer, meditation, and so forth.

Although much research is still needed and many questions remain unanswered, current scholarship suggests that religious practice (both attending religious services and private spiritual life) tends to be good for your health. Perhaps the popular adage of the future will be "take an aspirin, go to church, and call me in the morning."

By Thomas G. Plante

REFERENCES

Byrd, R. B. "Positive therapeutic effects of intercessory prayer in a coronary care unit population." Southern Medical Journal 81 (1998), 826-829.

Koenig, H. G. Is religion good for your health? The effects of religion on physical and mental health (Binghamton, NY: Haworth Pastoral Press, 1997).

Koenig, H. G., McCullough, M. E., & Larson, D. B. Handbook of religion and health (New York: Oxford, 2001.)

McCullough, M. E., Hoyt, W. T., Larson, D. B., Koenig, H. G., & Thoresen, C. "Religious involvement and mortality: A meta-analytic review." Health Psychology 19 (2000), 211-222.

Pardini, D., Plante, T. G., Sherman, A., & Stump, J. E. "Religious faith and spirituality in substance abuse recovery: Determining the mental health benefits." Journal of Substance Abuse Treatment 19 (2001), 347-354.

Plante, T. G., & Sherman, A. S. (Eds.). Faith and health: Psychological perspectives (New York: Guilford, 2001).

Plante, T. G., Saucedo, B., & Rice, C. "The association between religious faith and coping with daily stress." Pastoral Psychology 49 (2001), 291-300.

Plante, T. G., Simicic, A., Anderson, E., & Manuel, G. "Stress and coping among displaced Bosnian refugees." Under review.

Plante, T. G., Yancey, S., Sherman, A., & Guertin, M. "The association between strength of religious faith and psychological functioning." Pastoral Psychology 48 (2000), 405-412.

Sherman, A. C., Plante, T. G., Simonton, S., Moody, V., & Wells, P. "Impact of religiousness and religious coping on quality of life outcomes for multiple myeloma patients receiving bone marrow transplantation." Under review.

Sherman A. C., Simonton, S., Adams, D. C., Latif, U., Plante, T. G., Burris, S. K., & Poling T. "Measuring

religious faith in cancer patients: Reliability and construct validity of the Santa Clara Strength of Religious Faith Questionnaire." Journal of Psycho-Oncology (2001). In press.

Return to Web format