2

Religious Fellowship and Spiritual Support

Donna was fourteen years old and lived with her grandmother in a small town in Mississippi. For several years, Donna had been getting into more and more trouble, breaking the law and smoking marijuana, and skipping out on school. Then she became pregnant. Her grandmother was a prayerful woman, but realized that with a baby coming, Donna would soon be more than she could handle. Donna was sent to live with her aunt and uncle and cousins in Jackson.

Donna's relatives were members of the African Methodist Episcopal Church. Her uncle was a building contractor, her aunt was a nurse who helped run a church program that screened at-risk members for high blood pressure and diabetes once a month, and her three cousins were active in youth groups. One of them sang in the choir. From the day Donna moved in, it was made quite clear that she would attend church and take part in church activities. She was annoyed at first, but her aunt and uncle never left any room for doubt that they loved her unconditionally, and never once spoke a word in judgment of her pregnancy or other troubles.

A funny thing happened. Donna spent so much time in church—twice a week, typically—and felt so much pressure to do her homework and complete her chores, that she stopped getting into trouble. She did not have the time. Plus, with her baby due after the end of the school year, she had to start taking better care of herself. Her aunt made sure of that.

Right before her baby was born, Donna began to notice a change in her heart as well. She realized that she soon would have responsibility for another life, and this encouraged her to take more responsibility for herself and to think about her future. She also started enjoying church, and often went of her own accord to take

part in after-school church activities. One Sunday morning during services, she accepted Jesus as her Lord and Savior.

By the time she got her diploma three years later, Donna had matured into a responsible young mother. She planned to go to the local community college and study to become a nurse, just like her aunt. Donna would tell anyone who asked that she owed everything to the love she had received from her family and from Christ and her church.

Going to church had benefited Donna's life in tangible ways as well. She had made many wonderful friends through her congregation, and the fellowship she shared with them made her feel accepted. Every other week, she and some of her friends would get together for Bible study with the assistant minister. If she needed to take her baby to the doctor and her aunt was at work, one of them or one of the church ladies would drive her. She also took part in a well-baby program at church, both as a client and a volunteer, and gave her time to another church program by talking to other teenagers about drugs and alcohol.

Donna especially loved the pastor's weekly sermons. She would always leave church inspired. The pastor was a wonderful man who had been over for dinner at her aunt and uncle's house many times. He always had the same message for Donna. He taught her that God cared about what happened to her and her baby and had a plan for their lives. He never ceased to remind her that there was something uniquely special for the Kingdom of God that only Donna and her baby could contribute. Every time he told her that, Donna would become so overcome by emotion that she could barely get out a "thank you."

Today Donna is in her late twenties. She is married and has two more children. She and her husband moved to Georgia, where she works part-time as a nurse. Donna volunteers for a church-based screening program that she co-founded, much like the one her aunt worked at in Mississippi. Neither she nor her husband uses cigarettes or alcohol, and their children are being raised in the church. She laughs sometimes when she thinks that she has become just as clean-living and wholesome as the nice church ladies she remembers as a teenager. She imagines that if her fourteen-year-old self could meet her current self, she would think she had gone crazy. That image always makes her smile.

Most Americans affiliate themselves with a religion or religious denomination and many agree, at least in principle, with the beliefs espoused by their particular faith tradition. As we saw in the last

chapter, religious affiliation has a definite impact on health. When we identify with a particular faith or become a member of a religious institution, we are exposed to positive health-related messages and to a community of believers who may encourage us in our efforts to live by the tenets of our faith. In this way, religious affiliation can influence us to engage in healthy behaviors and lifestyle practices that reduce our risk of illness and promote greater health and well-being.

But just saying we belong to a religious group is not the same as actually being involved in religion. While most Americans report a religious affiliation, fewer actually participate in organized religious activities such as regularly attending worship services at church or synagogue. National surveys consistently report that just over 40 percent of adults attend religious services at least weekly. These numbers have not changed much for decades, and may be declining somewhat. Recent evidence suggests that this level of attendance may even be exaggerated to no small extent. One authoritative study compared people's reports of religious attendance in national surveys with actual counts of people attending a representative sample of Protestant and Catholic churches. The researchers concluded that real levels of weekly attendance are approximately one-half of those reported in surveys.

Whether 40 percent or 20 percent or some proportion in between, far fewer adult Americans are frequent participants in organized religious activities than are affiliated with a religion. Does regular involvement with church or synagogue, or other organized spiritual pursuits, have additional health implications above and beyond the beneficial effects of religious affiliation? The answer is a resounding yes.

Dozens of published studies have revealed numerous positive effects that frequent attendance at religious services consistently has on health. The salutary effect of regular religious attendance is even more striking than the link between religious affiliation and lower rates of illness. Like the data on affiliation reviewed in the previous chapter, studies of regular participation represent a largely unpublicized treasure trove of information, unfamiliar to most

physicians and medical scientists. Until recently, these findings were not taught to medical students or residents, and have not been the stuff of continuing medical education or medical board exams. But the effect is as consistent and persuasive as for any important epidemiologic variable.

Is Frequent Religious Attendance Conducive to Better Health?

Back in my days as a graduate student at the University of Texas Medical Branch in the mid-1980s, my research on religious factors in health began to attract the attention of the hospital chaplains. A blurb in the campus newspaper about one of my studies caught the eye of the person in charge of the chaplains' biweekly noon seminar series. I was invited to address an audience of mostly ministers, priests, and nuns. The talk went well, but more significantly, I had the good fortune to meet someone with whom I would collaborate frequently over the next several years. Dr. Harold Y. Vanderpool, Harvard-trained bioethicist, medical historian, religious scholar, and professor of medical humanities, having no other lunch plans that day, decided to walk over to hear my presentation, which he saw advertised in a medical school flyer.

After my talk, Dr. Vanderpool introduced himself, and we hit it off immediately. I made an appointment to visit him in his office, and so began a relationship that was responsible, among other things, for the theoretical model of how religion relates to health that is the basis for this book. He informed me that while religion may be an obscure topic of research within the field of medicine, within the field of religious studies there has been a long-standing tradition of scholarly writing on health and medicine. Dr. Vanderpool, it turned out, was one of the premier authorities in the world.

I told Dr. Vanderpool of my efforts at the time to track down all of the published studies of religious differences in rates of morbidity and mortality. He was especially interested when I mentioned that along the way, I had also found more than two dozen studies that had examined how the frequency of attendance at religious

services affected health. He believed that this material merited its own summary, and we quickly decided to write a detailed review article on the topic. It is one thing, he noted, to report that rates of health and illness vary across religious denominations. It would be quite another to provide evidence that regular attendance at services—a marker of actually *practicing* and not just professing religion—is beneficial for health.

By the time we completed our review, we had found a total of twenty-seven studies that examined the health effects of the frequency of attendance at religious services. Of these studies, twenty-two reported a statistically significant, positive association between religious attendance and health. That is, the more frequently one attended religious services, the lower the rate of whatever disease was being studied, or the higher the self-rating of health. These results were electrifying; we had no idea they would be so consistent.

The positive link between religious attendance and health persisted regardless of the particular illness or health condition examined in different studies. This mirrored the pattern that we found when examining the health effects of religious affiliation. We identified studies reporting beneficial effects of frequent attendance on all sorts of health and illness measures: atherosclerotic and degenerative heart disease deaths, cervical cancer incidence, cardiovascular pattern, depression, hypertension, neonatal mortality, Pap smear results, self-rated health, suicide symptoms, total mortality, trichomoniasis prevalence, and tuberculosis case rate.

The Epidemiology of Religion

Along with the write-up of what we found, we included a critique of the methodology of these studies, and Dr. Vanderpool added a lucid "brief primer on religion for epidemiologists." We entitled our paper "Is Frequent Religious Attendance *Really* Conducive to Better Health?" Somewhere in the final editing process, we conjured up the phrase "epidemiology of religion." Emboldened, we submitted the paper to a leading epidemiology journal. The paper was peer-reviewed and received both positive and negative feedback.

The editor's cover letter to us went on for nearly two single-spaced pages, specifying in painstaking detail how unacceptable, even misguided, our paper was, and urging us to give up the idea altogether and not pursue it any further. Unless you are a scientist, it is hard to comprehend how downright bizarre it was to receive such a letter from the editor of a peer-reviewed scientific journal. Most rejection letters contain a couple of paragraphs of boilerplate, signed by the editor or by his or her secretary, usually but not always including reviewers' comments. For this editor to take the time to go on and on about a paper that he was not even inviting to be revised and resubmitted, and to be somewhat unfriendly about it, seemed unprecedented. But that was not all. In his letter, he made sure to let us know that not only was our paper unacceptable, but the very *idea* of an epidemiology of religion was, in his words, "execrable."

I had to look the word up in a dictionary. For several years after, I believed it derived from the same root as "excretion" or "excrement," and concluded that the editor was telling us that not only our work, but our very ideas, were full of you-know-what. A few years later, as I related this story to a group of chaplains at the local Veterans Administration hospital, one of them, a Catholic priest and Latin expert, assured me that the word derived not from excretion but "execration." Before I could grab a dictionary, he told me that it meant "worthy of being detested, abominated, or abhorred." "Ah, that's a whole lot better," I said, and we all laughed.

Soon after we received our "execrable" review, our paper was published in *Social Science and Medicine*. This outstanding British journal has had the great foresight to publish many of the important studies in this field. Such open-mindedness to new ideas, sad to say, is uncharacteristic of many U.S. medical journals.

Health Benefits of Church Attendance

What was it about our review that had so upset the editor of the journal where we first submitted our paper? Maybe it was findings such as these:

1. Using data on Mexican Americans collected by my mentor, Dr. Kyriakos S. Markides of the University of Texas Medical Branch, we found that frequent church attenders were more likely to rate their health as good or excellent, report higher levels of well-being, and experience less disability, fewer days in bed in the previous year, and fewer physical symptoms.
2. A Scottish study found that active churchgoers, regardless of religious affiliation, had fewer physical and mental symptoms than people who affiliated with a religion but did not participate in church. These included members of the Church of Scotland, other types of Protestants, Roman Catholics, and non-Christians. But what religion one belonged to did not matter—only whether one actively participated in church.
3. Scientists from the University of Michigan, using data from the Tecumseh Community Health Study, found protective effects for frequent church attendance on heart disease in both sexes, and on mortality in women. Church attendance more than once a week offered an additional *31 percent reduction* in risk above and beyond weekly attendance.
4. Scientists at Johns Hopkins University, using data from an epidemiologic census of more than 90,000 people, found that less than monthly religious attendance *doubled and even tripled* the risk of death due to arteriosclerotic heart disease, pulmonary emphysema, cirrhosis of the liver, suicide, and cancers of the rectum and colon.
5. A follow-up study found an actual *dose-response* relationship between total deaths and frequency of religious attendance. Among people who never attended church, the annual death rate per 100,000 was 2,591.3. For those who attended church less than twice a year, it was 1,640.1; for those attending two to twelve times a year, 1,511.7; once a month, 1,354.3; and once a week or more, 1,308.1. Each level of frequency reduced deaths incrementally; attending services at least weekly reduced by *almost 50 percent* the risk of death the following year.

Take it from an epidemiologist—these last results are uncanny. They are more like something you would find in data on the relationship between cigarette smoking and the development of lung

cancer. But there is more. Health benefits result not just from attendance at formal religious services, but from participation in other types of church activities. A study of churchgoers in Evans County, Georgia, for example, found that active participation in church groups led to lower rates of overall mortality. This interesting finding did not depend upon age, sex, or ethnicity. A protective effect was found in those under sixty years of age and those sixty years of age or older, in Caucasian men and women, and in African American women.

Don't Ask, Don't Tell

To be honest, Dr. Vanderpool and I did not mind that our call for an epidemiology of religion was considered "execrable." We figured that we must have hit a nerve. After all, for a scientist, the one thing worse than being despised or derided is being ignored.

But why the animosity? Epidemiologists, like any other species of scientist, do not appreciate being told that they have overlooked something vitally important that is right in front of their face. Perhaps our collation of so many positive findings unknown to so many in the field was in some way embarrassing. Perhaps scientists tend to be less religiously inclined than other folks, and do not wish to see faith placed in a positive light. Both of these may be true, but I think there is more to it than that.

Reflecting on why studying the health effects of religious participation should be considered unworthy of direct examination by epidemiologists, Dr. Vanderpool and I had noted that "epistemologically speaking, the domain and effects of religious commitment are believed to be unknowable or unreal or both. Western biomedicine, of which epidemiology is a part, is still wrestling with a body-mind dualism that defies consensus; thus, for most epidemiologists any resolution of a body-mind-spirit pluralism is simply beyond consideration."

In other words, "don't ask, don't tell." Some topics are simply taboo for scientists, and it seems that promising leads ought not to be followed if the results make too many people uncomfortable. Fortunately, many researchers have begun ignoring this advice. A

large body of newly published findings sheds additional light on the relationship between organized religious participation and health.

New Findings from a National Study

In the years since our review article was published, many more studies have explored the health effects of organized religious participation. My research team colleagues and I began to take a special interest, and with the support of the National Institutes of Health (NIH), I initiated a program of systematic research on this topic. Along with Drs. Robert Joseph Taylor and Linda M. Chatters of the University of Michigan and Christopher G. Ellison of the University of Texas, and several other colleagues on occasion, I have published a series of research studies that document the effects of frequent religious attendance on a variety of indicators of health and overall well-being.

Using data from the approximately 2,000 people interviewed for the National Survey of Black Americans (NSBA), a nationally representative sample of African Americans in the United States, my colleagues and I examined the effects of a scale of "organizational religiosity." This scale summarized responses to questions on the frequency of attendance at religious services, official membership in a place of worship, participation in church clubs or organizations and other types of church activities, and serving as an officer at church.

Organized religious participation was a strong determinant of both health and psychological well-being. Moreover, the effect on well-being persisted *even after controlling for the effects of health*. This result was unexpected, and frankly shocking. Researchers had long presumed that health was the most important determinant of well-being; religion tended to be downplayed or simply ignored. This study confirmed that, on the contrary, active participation in church is more important than health. This finding flew in the face of conventional wisdom, and has caused a reconsideration of the influence of religion on well-being.

These results were published in the *Journal of Gerontology: Social Sciences*, the leading journal for studies of social factors in aging. When the NIH convened its first conference on the topic of religion and health in 1995, we were delighted to learn that our article was one of only three studies to receive a perfect "10," according to an NIH-commissioned rating of the scientific merit of all published studies in this field since 1975.

Replicating Our Results in Three National Studies

On the heels of this success, we decided to replicate these findings using data from several large, nationally representative studies conducted over a period of two decades. We wanted to see whether the effects that we had observed in African Americans extended to the overall population.

We obtained data on nearly 6,000 adults from the National Council on Aging's Myth and Reality of Aging study, and from the Quality of American Life and Americans' Changing Lives studies, both conducted at the University of Michigan. Each study assessed organized religious participation and aspects of health and well-being. This allowed us to examine the robustness of a religion-health association across study samples, time periods, and particular ways of assessing health. Research of this type, which looks at the relationship between a risk or protective factor and health in multiple studies, is known as "replicated secondary data analysis." If a specific finding is to merit our highest trust, it ought to be observable regardless of when or where a study was conducted and how the key variables were measured.

We observed significant effects from organized religious participation in all three study samples. These included strong salutary associations with how much of a problem health presents, overall health, satisfaction with health, activity limitation, presence of chronic diseases in the previous year, and dimensions of the well-known Affect Balance Scale. The results showed clearly that religious attendance exhibits beneficial effects according to a range of health indicators.

Health Effects Over Time

My colleagues and I also have explored this relationship longitudinally through what is known as "panel analysis." In a longitudinal study, multiple waves of data collection take place, separated by specific time intervals. When scientists can investigate changes that occur over time, we can more accurately chart the relationship between an exposure (e.g., religious attendance) and subsequent health. We can avoid the chicken-versus-egg speculation that often results from cross-sectional surveys.

Our most recent studies have verified that the benefits of religious attendance extend many years into the future—many, many years. My colleague Dr. Ellison examined data from the North Carolina sample of the NIH Epidemiologic Catchment Area (ECA) study. Nearly 3,000 people were surveyed in 1982–1983 and again a year later. More frequent religious attendance resulted in less depression, as measured by the authoritative Diagnostic Interview Schedule. Results controlled for the presence of chronic illnesses, stressful life conditions, and several sociodemographic factors known to influence mental health and well-being. This important study showed that frequent church attendance at a given point in time could help to prevent subsequent mood disorders *up to a year later*.

Religious attendance did even better in another study. Using data from more than 600 Mexican American adults in three generations, we investigated the effects of church attendance, assessed in 1981–1982, on well-being, assessed in 1992. Our most interesting finding involved the youngest generation (average age twenty-seven at baseline). The more frequently these young Mexican Americans attended church services, the less depression they had *eleven years later*.

The implications of these research findings are unmistakable. For the adults that we studied, how often one attends church has much to say about the extent to which one exhibits depressive symptoms up to a decade or more into the future. Psychiatrists know of few if any other factors that exhibit protective effects extending so far ahead in time. For sure, there is no medication that can work so effectively for so long.

The NSBA study's addition of a longitudinal component presented an opportunity to replicate our findings in a nationally representative sample of African Americans. As with our Mexican American study, we examined effects of baseline religious attendance on subsequent psychological well-being. In the NSBA, we had available to us measures of life satisfaction and happiness, as well as a version of the RAND Mental Health Index, a well-known validated scale assessing psychological distress. The original NSBA took place in 1979–1980, and subsequent waves of data were collected in 1987–1988, 1988–1989, and 1992.

We found that frequent church attendance exhibited a strong effect on life satisfaction and happiness assessed *twelve to thirteen years later*. Participation in other church activities also had comparable effects on both well-being measures. These findings outdid our results of an eleven-year protective effect among Mexican Americans. The principal investigators of the NSBA, located at the prestigious Institute for Social Research of the University of Michigan, have plans for a new round of data collection sometime after the year 2000. It will be interesting to see just how far the immunizationlike effects of frequent religious attendance actually extend.

If the results of several recent studies are any indication, our findings are not exceptional. We may even be considerably underestimating the scope and duration of the protective effect of going to religious services. This effect extends beyond health self-ratings and scales of emotional well-being. There is increasing evidence of religious effects on objective measures of more physically observable phenomena, such as functional disability and mortality. This effect also apparently extends decades into the future.

Two of the most prominent psychosocial epidemiologists in the world, Dr. Ellen L. Idler of Rutgers University and Dr. Stanislav V. Kasl of Yale, investigated the impact of religious attendance on physical functioning and disability. Using data on more than 900 older adults from the New Haven, Connecticut, sample of the multisite NIH Epidemiologic Study of the Elderly (EPESE), Drs. Idler and Kasl discovered that frequent attendance in 1982 was a strong

determinant of better functioning through 1988, *six years later*, and a comparably strong but not quite statistically significant determinant through 1994, *twelve years later.*

The best study conducted to date on the topic of religious attendance and health also found the most amazing result. It showed that the protective effects of frequent participation in church can last a lifetime. Dr. William J. Strawbridge and colleagues at the Human Population Laboratory in Berkeley, California, examined data on more than 5,000 people from the famous Alameda County Study, with an eye to the possible protective effects of frequent religious attendance on subsequent mortality. Published in the *American Journal of Public Health*, their landmark study found that frequent religious attenders had greater survival rates—that is, lower mortality—that extended *over a twenty-eight-year period*. Frequent religious attendance in 1965 was still reducing the risk of dying in 1994. This study was impeccably done, controlling for baseline physical and mental health and health practices, and other factors known to be associated with religious attendance, mortality, or both. It did not matter. The preventive effect of religious attendance remained.

Links in a Chain: *Religious Participation→Social Support→Health*

In exploring the experience of organized religious participation—what actually goes on when you attend church or synagogue—we can begin to find clues that help us make sense of all of these findings implicating religious attendance in preventing illness and death and promoting better health. We already have seen how the health benefits of religious affiliation are likely due to the effects of healthy behavior; now we can identify what the link is between religious attendance and health.

Religious attendance is a social behavior—it is not practiced in isolation. When we go to church or synagogue or to any other spiritual gathering, we take our place among fellow believers, for the most part—participants with us in a common activity. For sure, we

may be present for different reasons: to praise God, to worship with others, to satisfy a spouse or parent, out of loneliness or boredom, to get a prayer answered, or to gain social acceptability. Regardless, studies tell us just being with other people, sharing a common purpose, is a well-known protective factor associated with decreased risk of illness and death and higher levels of health and well-being. Scientists call this factor “social support.”

I believe that the supportive relationships provided through active religious fellowship best explain the findings we have examined. To demonstrate this, we first need to examine scientific evidence linking religious participation to social support, and social support to health. Both links are well established.

Social Support: What It Is and What It Does

For decades, sociologists and psychologists have explored the nuances of supportive relationships among people. Social support has come to be one of the principally invoked concepts in social science research of all types, especially in studies of health and well-being and responses to life stress. By now, thousands upon thousands of published studies have addressed conceptual, theoretical, and psychometric (measurement) issues in social support, or have provided empirical findings linking social support to a myriad of outcomes or predictors. “Social support” has almost become something of a buzzword in research circles. What exactly do scientists mean by the term?

Definitions abound, and the concept has been divided up in all sorts of ways. Researchers distinguish between the quantity and the quality of social contacts, emphasizing the structure and content of people’s social networks and relationships. Similarly, a distinction is often made between availability and adequacy of support in disparate domains, from material assistance to intimate relationships. Others differentiate between perceived support—the thought or feeling that one is supported by or connected to other people—and

enacted support—the helpful actions that are performed for the benefit of others.

A related distinction is often made between tangible and emotional support. Tangible support may consist of financial assistance, physical aid, or other forms of help and advice. A referral or a ride to a health care provider is a good example of tangible social support. Emotional support is sometimes referred to as an intangible form of social support. It may take the form of encouragement, guidance, or friendship. Whereas tangible social support is typically assessed through sociological measures of the giving and receiving of all kinds of social resources, emotional support has more to do with psychological or interpersonal transactions among people. It is more about the good feelings that pass from one to another—much like the Yiddish concept of *nachus*, extreme joy or pleasure.

Research over the past thirty to forty years has shown how social support, regardless of how it is defined or measured, can be a buffer against the harmful effects of stressful life changes. According to Dr. Peggy A. Thoits, this "buffering hypothesis," as it has come to be known, suggests that "individuals with a strong social support system should be better able to cope with major life changes; those with little or no social support may be more vulnerable to life changes, particularly undesirable ones."

Numerous studies strongly support this contention.

In his presidential address to the American Psychosomatic Society in 1976, Dr. Sidney Cobb reviewed evidence that social support moderated the effects of stress caused by a variety of problems across the life course. These included situations as diverse as pregnancy complications, hospitalization, recovery from tuberculosis, employment termination, retirement, and bereavement. The greater or more effective the social support, the less the frequency or severity of these problems. Dr. Cobb concluded, "We have seen strong and often quite hard evidence, repeated over a variety of transitions in the life cycle from birth to death, that social support is protective."

Religious Fellowship as a Form of Social Support

In his presidential address, Dr. Cobb defined social support as "information leading the subject to believe that he is cared for and loved, esteemed, and a member of a network of mutual obligations."

This sounds an awful lot like what goes on in formal religious institutions such as churches, synagogues, and groups organized for meditation or spiritual study—at least in principle. Research on the functional contributions of religion throughout the course of adult life indeed supports this connection between religious fellowship and the giving and receiving of social support. Much of this research comes from studies in gerontology—an interdisciplinary field that focuses on the aging process from early adulthood through the elderly years.

Dr. Christopher G. Ellison, my research colleague, has described how active religious participation benefits health and overall well-being. In his chapter in my book *Religion in Aging and Health*, he develops a model of the ways that religious involvement enables the receipt of social support.

1. Religious fellowship provides both tangible and emotional resources that buffer or reduce our experience of stress, whether it is caused by major life events, chronic stressors, or daily hassles. Formal involvement in religious communities reduces the likelihood of experiencing stressors such as chronic and acute illness, marital tension and dissolution, and work-related and legal problems. Sociological studies bear this out.
2. Active religious participation increases the likelihood that when stressful situations arise, they are put in a larger context that offers greater meaning, and therefore are experienced less negatively. In Dr. Ellison's words, religion provides "cognitive and institutional frameworks that make certain stressors seem less threatening to an individual than they might otherwise appear." These include psychological resources such as theological worldviews that make sense out of a chaotic world; favorable psychological states or traits; self-esteem and feelings of self-efficacy or personal mastery; and a sense of connection to a benevolent "divine other." Such in-

ner resources may alter our perceptions of stressful circumstances and strengthen our coping skills and ability to deal with stress, thereby reducing its potentially harmful impact.

3. Regular religious fellowship increases our access to people who can offer us assistance when we are in need. Frequent participants in worship services, for example, are plugged into a network of friends and family with whom they spend time on a regular basis, have gotten to know, and to whom and from whom they can give and receive both tangible and emotional support. This may include encouragement and good cheer, and the *nachus* mentioned earlier, as well as health advice or a ride to the doctor.

Research on Religion and Social Support

In theory, active religious participation can be a source of support, which in turn may help to buffer the effects of stress and promote well-being. Does scientific evidence back up these assertions? Dr. Ellison's own research has done much to confirm the ways in which active religious involvement helps to establish social ties and provide social support.

Along with sociologist Dr. Linda K. George of Duke University, a past president of the Gerontological Society of America, Dr. Ellison used data from the North Carolina ECA study to examine how frequent church attendance affected characteristics of social support. Frequent churchgoers enjoyed larger social networks of non–family members; had more contact with members of their social networks; received more varied types of social support, whether tangible (financial assistance, helping with errands, advice, transportation, helping with meals or illnesses) or emotional; and experienced more favorable perceptions of the quality of their social relationships. Frequent church attenders were also more likely to rate these relationships as favorable regardless of age, sex, ethnicity, or marital status.

Drs. Robert Joseph Taylor and Linda M. Chatters, the other members of our research team, have examined the effect of religious participation on receipt of informal types of support. By

"informal support" they mean those types of assistance other than the formal social services often delivered to congregants by religious institutions. Over the years, using data from the NSBA study, they have identified many interesting links between religious involvement and social support among African Americans.

- More frequent church attendance is associated with receiving needed support more often and in greater amounts. Types of support included advice and encouragement, companionship, goods and services, financial assistance, transportation, help during sickness, and prayer.
- Among older adults, frequent church attendance increases the probability of receiving support. Frequent attenders are also less likely ever to need support. This jibes well with Dr. Ellison's assertion that religious participation both increases access to supportive resources and prevents circumstances whereby they are needed.
- Among the elderly, whereas two-thirds of people received support from their extended family, three-quarters received support from church members. Almost 60 percent of people received church support "fairly often" or "very often"; for family support, the comparable figure was one-third.

Supportive Relationships: The Secret to Health, Happiness, and Long Life?

In 1988, a most unusual article appeared in *Science*, the world's leading scientific journal. This essay, "Social Relationships and Health" by Drs. James S. House, Karl R. Landis, and Debra Umberson of the University of Michigan, summarized a quarter of a century of research on the importance of "social integration" for health. This they defined as the presence of a number of socially supportive relationships, such as with family and friends, also taking into account the structure of such relationships (i.e., their "density" and "reciprocity") and their actual content. The concept of social support

long had been a principal focus of study among social epidemiologists, due in part to influential earlier work by Dr. Berton H. Kaplan and his colleagues, Drs. John C. Cassel and Susan Gore, of the University of North Carolina. The idea that low levels of social support might be a certifiable risk factor for illness, across the board, was less well known to physicians and to basic scientists in other fields.

Dr. House and his associates reviewed findings from many of the classic longitudinal studies in epidemiology. The roll call of these studies is familiar to any public health scientist: Evans County; Tecumseh; North Karelia, Finland; Alameda County. Their findings "manifest a consistent pattern of results," and House and associates wasted no time in getting to the point: "More socially isolated or less socially integrated individuals are less healthy, psychologically and physically, and more likely to die."

The latter finding is especially stunning. Analyses of both women and men, and African Americans and Caucasians, show that people who receive less social support have a greater probability of decreased longevity and premature death. How strong is this effect? "The evidence on social relationships is probably stronger, especially in terms of prospective studies, than the evidence which led to the certification of the Type A behavior pattern as a risk factor for coronary heart disease."

That is not all. The authors further state that the death risk associated with low levels of social support appears to exceed that attributed to cigarette smoking in the famous Surgeon General's report of 1964.

Adding to the impact of their article, they cited research findings that controlling for the effects of health and various biological and personality factors was unable to explain away this harmful effect of low social support. In other words, after taking into account the likelihood that a relationship between social support and mortality was observed only because it reflected effects of other known determinants of mortality that happened to be correlated with social support, the effect was still present. House and his coauthors concluded, "Social relationships have a predictive, arguably causal, association with health in their own right."

Lack of Social Support: A Fundamental Cause of Disease

This theme has been taken up recently by others. Based on the conclusions of House and several other researchers, a provocative article by scientists from Columbia University and UCLA, published in a recent special issue of the *Journal of Health and Social Behavior*, asserted that certain social conditions, including lack of social support, are "fundamental causes of disease."

Establishing the link between social support and health has probably been the greatest contribution of the field of social epidemiology. This relationship has been replicated in both males and females, across all age groups, in different ethnic groups and nations, and for a variety of diseases across various stages in the natural history or course of illness. Social support has exhibited protective, preventive, therapeutic, or otherwise salutary effects on numerous outcomes, such as the onset of depression, recovery from heart disease and cancer, and self-ratings of overall health.

At the conclusion of their *Science* article, House, Landis, and Umberson reiterated an important point for their largely nonsociological audience: "The extent and quality of social relationships experienced by individuals is [sic] also a function of broader social forces."

These, they emphasized, include attendance at church, a theme that House had explored in a research study on social support, religion, and mortality several years earlier. The possibility that frequent attendance exhibits protective effects against illness because it fosters health-promoting support is a reasonable hypothesis in light of existing theory and research findings.

In an article published in the *Journal for the Scientific Study of Religion* with my colleague Dr. Markides, I noted that a "social support explanation appears to be the central, unspoken assumption of epidemiologists working with religion variables." Based on studies explored in subsequent chapters of this book, that assumption may be overstated. But for those studies that focus on participation in organized religious activities, such as church or synagogue attendance, an explanation based in part on social support appears sound.

Lessons to Consider

The evidence in this chapter gives rise to our second principle of theosomatic medicine:

PRINCIPLE 2

Regular religious fellowship benefits health by offering support that buffers the effects of stress and isolation.

What can we learn from scientific studies linking organized religious participation to better health through receipt of social support? What do these findings tell us about the value for health and well-being of regular fellowship with other people? How can we derive the personal benefits of regular religious participation in our lives?

Regularly attending church or synagogue or other spiritual gatherings can have tangible and emotional benefits far beyond the spiritual contentment one may expect. These secular benefits may even outweigh the religious ones in their impact on our quality of life. This is not to say that we should be diligent in our religious participation only for the social and interpersonal gains that might accrue. But we all need companions. Unless we have taken monastic or ascetic vows, we need others—to work with, to play with, to live with, to love, and to worship with. Actually, most monks and ascetics do, too.

Not all of us enjoy attending formal religious services in a large organized church or religious institution, at least on a regular basis. For some, such services are cold and impersonal, and it is hard to feel much of a spiritual connection with God or the divine or holy. It depends a lot on what religion or denomination one belongs to, where one attends, who the clergyperson or leader is, and how the services are structured. But there are other ways to connect with people in spiritually oriented settings.

Most congregations provide a number of ways to join with other members in regular fellowship. These include boards and committees, social groups, community action groups, youth groups,

choirs, book clubs, and so on. The synagogue that my wife and I belong to has more than twenty standing committees, formal groups, and classes, according to the most recent directory. Certainly, not every member attends worship services nearly every week—only a small fraction do—but congregants have ample opportunity to participate in organized activities that involve communing with other members on a regular basis.

Outside of formal religious institutions, we can become involved in supportive relationships through prayer circles, meditation groups, and classes organized to study the spiritual teachings of a particular spiritual tradition. In some communities, there are many existing groups to choose from, sometimes outnumbering the churches and often with older roots than any local religious institution.

For example, in Virginia Beach, Virginia, where we lived for many years, the Association for Research and Enlightenment (ARE) sponsors a prayer group known as the Glad Helpers. The ARE is a research and educational organization associated with the work of the late "sleeping prophet," Edgar Cayce. The purpose of the Glad Helpers is to offer up healing prayers for those who request them. This group has been meeting regularly, once a week, since 1931. Some of the original members still attend. There are churches and synagogues that cannot come close to that record of providing consistent and continuing fellowship for its members.

Questions to Reflect On

At the start of this chapter, I told you about Donna. Like many youngsters, she was caught up in behavior she could not control that was harmful and threatening to her future. Through good fortune—some would call it grace—she was able to move to a healthier environment, one in which participation in church with a supportive family took center stage. This resulted in dramatic transformations in both her inner and outer life.

Like Michael, about whom I spoke in Chapter 1, Donna's story is inspiring, but really not out of the ordinary. Many of us see

marked improvements in our quality of life as a result of regular religious fellowship. For newly religious people, gains associated with fellowship may be especially great. Joining with others of a shared spiritual outlook can fill a void in one's life in ways that more secular types of social activities are unable to do.

Some of us renew ties to the denomination or congregation of our childhood. This is an increasingly common trend among young couples who drifted away from organized religion soon after confirmation, *bar* or *bat mitzvah*, or graduation from religious school. The birth of one's own children is often a powerful motivation to return to the faith in which one was raised. Churches and synagogues are excellent sources of companionship and education for children, and help to establish a sense of tradition and continuity. For parents, there can be great satisfaction in reconnecting with old familiar friends, both human and institutional—liturgies, prayers, songs, holiday cycles, youth groups.

Others of us choose to convert to a new religion or spiritual path. Often this follows years of searching. Connecting with a new spiritual home means making new acquaintances and developing new relationships. As we establish new traditions, we integrate ourselves into support networks that may provide us with tangible or emotional resources to benefit our well-being. We also may be presented with opportunities to provide support to others.

I can relate to both examples. As a teenager, especially once I left for college, I drifted far from Jewish observance. I was what is called a "twice-a-year Jew": I attended synagogue for the High Holy Days each fall, and never failed to celebrate Passover and Chanukah, but little in my daily life reflected a commitment to Judaism. I began studying the spiritual traditions of the world, not just as a religious scholar but at times as a participant. The "inner," or mystical, path especially interested me. But I did not seek organized religious fellowship; I pursued these interests mostly alone. My spiritual questing was private, and sometimes lonely. Although I was fulfilled in deeply meaningful ways, I missed the opportunity to be a part of a community of believers.

Eventually my journey took me full circle. By my late twenties, my interest in the mystical experience led me to the inner path within

my own tradition, known as *kabbalah*. Through connections with the Jewish Renewal movement, I found myself back in synagogue regularly for the first time since I was a child. Today my wife and I are active members of our congregation. We worship with others at weekly *Shabbat* services, and I take part in several other group activities. These include the synagogue board, our social action committee, and regular Talmud study. We also have participated in a meditation group that includes a mix of synagogue members and friends from the community. These activities are a profound source of spiritual nourishment for me. The opportunity to get together to "do" and "be" in a spiritual way with others contributes to my mental health and well-being in ways that private devotion cannot match.

If you are involved in regular religious fellowship or if you actively participate in organized spiritual activities, then you have your own history and your own story to tell. For many people, getting together with others for spiritual pursuits is a source of great contentment, emotional nourishment, and growth. There are things that we can learn about ourselves and about God or the eternal only in the presence of other people. The powerful bonds that we form with fellow participants can benefit us in tangible ways as well, and just being around friends and acquaintances regularly is good for us in and of itself. Several questions can help us to reflect on how our formal religious and spiritual activities provide social benefits that affect our overall well-being.

1. What types of religious activities do you participate in at your place of worship? Do you attend services regularly, teach religious school, or volunteer for committees? Outside of your church or synagogue, or if you are not a member of one, do you ever get together with other people for spiritually oriented activities? Examples might include meditation groups, yoga classes, home- or work-based study or discussion or prayer groups.
2. Has your involvement in organized religious or spiritual activities led you to make new friends? Has it expanded your social circle? Are these friends and acquaintances sources of help and advice? Are you satisfied with the quality of these relationships?

Do you give as much as you receive when it comes to tangible and emotional support?

3. Do you believe that your involvement in spiritual group activities has had an effect on your emotional well-being? If you are a newly active participant, are you happier and more satisfied now that you have gotten involved? If you are a long-standing church- or synagogue-goer or participant in noncongregational activities, how does this fellowship affect the quality of your life? Do you look forward to religious services or group meetings? Would you get up out of a sickbed to attend, if you could? When you are unable to attend services, do you feel that you can still be there in spirit? When you are involved with others in spiritual activities, how does it make you feel? More alive? Stronger? Healthier? More connected to all people? Closer to God?