Conceptualizing “Religion”

how language shapes and constrains knowledge in the study of religion and health

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ABSTRACT  Despite recent advances in the field of religion and health, meaningful findings will increasingly depend on the capacity to conceptualize “religion” properly. To date, scientists’ conception of religion has been shaped by the Enlightenment paradigm. However, recent developments in philosophy make the “objectivity” of the Enlightenment paradigm problematic, if not untenable. Contrary to common understanding, the secularism essential to the Enlightenment paradigm does not enjoy any special privilege over religious ways of seeing the world, because both religious and secular worldviews constitute self-referentially complete interpretations of the human condition. If there is no objective frame of reference from which to measure religiousness, then the study of religion and health is fundamentally contingent on the specific languages and contexts in which particular religions find expression. While applying this cultural-linguistic approach to religion would require significant changes in the existing methods for studying religion and health, such changes may generate a deeper understanding of this relationship.

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RESEARCH INVESTIGATING THE ASSOCIATIONS between religion and health has exploded in the past 15 years. Although this research remains controversial (Sloan and Bagiella 2002; Sloan, Bagiella, and Powell 1999; Sloan et al. 2000), what was once a poorly coordinated effort of independent researchers in separate disciplines has now emerged as a small but increasingly sophisticated field of study (Koenig 2002; Koenig, McCullough, and Larson 2001; Larson, Swyers, and McCullough 1998; McCullough et al. 2000; Strawbridge et al. 2001). Over 1,200 scientific publications have addressed the associations between religion and health, and interest in this field has spread to the popular press (Kalb 2003). Despite the growing interest in this fledgling field, however, significant theoretical and methodological problems remain unsolved.

In a landmark article, Levin and Vanderpool (1987) assessed the emerging field of religion and health as it then existed, and identified several theoretical, conceptual, and methodological challenges limiting the growth of such research. Fifteen years later, many of these challenges have been addressed. The design of research protocols is increasingly sophisticated (Strawbridge et al. 1997; Strawbridge et al. 2001); there are now several working models for the pathways through which “religiousness” is associated with health (Idler and Kasl 1997b; Koenig, McCullough, and Larson 2001; Levin 1996a; Pargament 1997); and additional research has generated several refined, multidimensional measures of religiousness and spirituality with established psychometric properties (Hill and Hood 1999; Idler et al. 2003).

Despite these advances, however, Levin and Vanderpool’s (1987) nearly prophetic assessment of the conceptual hurdles for this field endures: “Without attention to the epistemological matters of conceptualizing and operationalizing ‘religion’ in meaningful ways, no amount of methodological and analytical sophistication will be sufficient to generate meaningful findings” (592). Such conceptual work is difficult, and it is not surprising that the field has thus far deferred this challenging task. Yet now that many of the methodological and analytical issues have been addressed, meaningful findings in the study of religion and health will depend increasingly on the capacity to conceptualize “religion” properly. This essay aims to assist medical scientists in clarifying and advancing the concept of religion.

CONCEPTUALIZING “RELIGION”

The following argument advances out of the discipline of epistemology—the study of how we know what we think we know, and the theoretical basis of knowledge. Although the formal study of philosophy is not a requirement for medical training, it remains important for the medical community to understand the extent and limits of its knowledge. These limits are especially relevant in the study of religion and health. Therefore, we begin with a brief account of epistemological history, and we ask the reader’s patience if we cover familiar ground as we establish a context.

FROSTING, CAKE, AND RELIGION

The following argument advances out of the discipline of epistemology—the study of how we know what we think we know, and the theoretical basis of knowledge. Although the formal study of philosophy is not a requirement for medical training, it remains important for the medical community to understand the extent and limits of its knowledge. These limits are especially relevant in the study of religion and health. Therefore, we begin with a brief account of epistemological history, and we ask the reader’s patience if we cover familiar ground as we establish a context.
Modern science and its epistemology were developed in the 17th and 18th centuries, during the period of intellectual history commonly known as the Enlightenment. The transforming work of philosophers like René Descartes and empiricists like Francis Bacon and Isaac Newton signaled an innovation in epistemology known as “foundationalism,” which suggests that it is possible to build a “foundation” of universal knowledge accessible to all people insofar as each person locks away his or her own particular (individual) convictions and beliefs, thereby limiting the study only to those claims of knowledge that can be established by empirical observation and the application of reason (Wolterstorff 1984, 56). This notion of an unassailable, objective, universal foundation of knowledge has been extremely influential for the last 300 years and is responsible, in large part, for the great technological advances of the modern world. Although foundationalism is explicitly defended only within narrow academic circles, it is hard to underestimate the many ways that it implicitly influences wide ranges of academic and popular thought (MacIntyre 1988, 326–48). To some extent, foundationalism is part and parcel with modernity.

Rooted in this Enlightenment intellectual tradition, the newly emerging disciplines of psychology and sociology turned their attention to the subject of religion at the end of the 19th century. The seminal work of scholars such as Emile Durkheim, Mircea Eliade, William James, and Max Weber established the dominant paradigm for conceiving religion, and it is no surprise that the current attempts to conceptualize the relationship between religion and health explicitly reference these thinkers (Hummer et al. 1999; Idler and Kasl 1997a, 1997b; Levin 1996a; Levin and Vanderpool 1987; Neeleman 1997). Because this Enlightenment concept of religion remains prevalent in the medical community, the following description will likely sound familiar.

In oversimplified terms, the Enlightenment paradigm approaches religion as a sort of “frosting” that may or may not be applied to the “vanilla cake” of generic, secular human experience (Wolterstorff 2001a, 7). The frosting may come in several different flavors (Christian, Buddhist, Muslim), but the vanilla cake remains the same from person to person. In fact, the frosting is even optional to the extent that an atheist may choose to enjoy the cake without any frosting at all. Religion is thus perceived as a type of knowledge that may be added to the foundation built by reason and empiricism—but because it is not universal, religion is considered both optional and less trustworthy than the foundational knowledge shared by all humans and verified by our common sensory experience and reason.

Although this view of religion remains prevalent, it is predicated on the increasingly challenged assumptions of foundationalism. It is not possible to trace here the intellectual history of the past 50 years. All we can do is point to seminal works in several disciplines and summarize their conclusion that the objective proof of Enlightenment foundationalism is less secure than once thought (Derrida 1973; Foucault 1971, 1994; Frei 1974; Gadamer 1975; Kuhn 1962;
Although some philosophers continue to defend versions of the Enlightenment paradigm (Dennett 1996; Hare 1999; Swinburne 2001), there is growing consensus that we are living through an epistemological revolution. As Wolterstorff (2001b) suggests, foundationalism is dying because trust (not proof) plays a much larger role in our systems of knowledge than we often like to admit. This critique of foundationalism does not mean that reliable knowledge is impossible to attain. We do have substantial knowledge, but the nature of its reliability is different than once thought.

Without an objective foundation for knowledge, current epistemology examines the ways that knowledge is contingent on the particular cultural and linguistic context in which it is generated (Lindbeck 1984; MacIntyre 1988). This cultural-linguistic approach exposes a problem with the frosting and cake model of religion: if there is no objective reality that makes up the generic cake of human experience, it may be that religions are not so much the various frostings added to that cake as they are the flavors mixed throughout the batter, which transform it into a completely different cake. Chocolate cake is not the same thing as vanilla cake with chocolate frosting. In a similar way, Lindbeck (1984) argues that religions are not adequately described by their various ingredients of particular beliefs or experiences. Rather, the critical aspect that differentiates diverse religions is the framework of meaning that binds together various beliefs and experiences in distinct relationships. As such, religions constitute self-satisfying, cultural-linguistic worldviews that provide a comprehensive interpretation of the human condition without requiring reference to any external narrative or tradition. The Jewish worldview is shaped by the Torah and the rabbinic commentaries. The secular humanist worldview is often fashioned from the writings of Emerson and Whitman. The Latter Day Saint worldview is formed by the Book of Mormon. Each provides a different, but internally coherent interpretation of reality, and none depend on an external “foundation” to provide that version of reality. In other words, a religion constitutes a single, specific, comprehensive context for contingent knowledge.

The frosting and cake model of religion forces religious worldviews into the categories and language of the Enlightenment worldview, and in so doing, it often distorts the religious worldview beyond recognition. Just as Buddhism cannot be fairly understood in terms of Christian theology, specific religions cannot be fairly understood in the terms of secularism. We suggest that meaningful findings in the study of religion and health will require learning religious worldviews “from the inside” and allowing them to speak on their own terms.
Implications for Religion and Health

Secularism Is Not Objective

The cultural-linguistic approach to religion outlined above has several critical implications for the study of religion and health. First and foremost, the so-called secular worldview has no intrinsic privilege over the many possible rational, comprehensive contexts for contingent knowledge. Like any worldview, the power of secularism depends on its capacity to offer a comprehensive interpretation of the human condition that rivals other possible interpretations, and on these terms, the secular worldview is extremely powerful. However, because there is no objective frame of reference from which to adjudicate between worldviews, on purely philosophical grounds secularism is no more or less rational than other possible interpretations (MacIntyre 1988). Consider Thomas Aquinas, who lived and worked before the scientific revolution. His understanding of the universe was predicated on the now antiquated notion of Platonic forms, yet nobody denies that his understanding was both vast and subtle. Insofar as either forms or modern physics function as the comprehensive interpretation of reality, they function on the same level of knowledge. Neither paradigm can prove their presumptions based on “objective” knowledge. Rather, the vindication of rival claims to truth depend on the adequacy and explanatory power of their comprehensive worldview, and for this reason, modern physics has abandoned Plato’s forms. In much the same way that scientific theories must be falsifiable, however, only those worldviews that allow for the possibility of their “hegemony being put in question can have rational warrant for asserting such hegemony” (MacIntyre 1988, 388).

The problem for the scientific study of religion is the fact that in many ways, the secular worldview is often presumed to be a prerequisite for the scientific method of enquiry. Hence the old saw that faith and science do not mix. The Enlightenment made religion increasingly subjective and privatized, while at the same time developing a new, unequivocal language of science that spoke uniformly with neither time nor patience for narrative, poetry, or paradox. Facts became the sole purview of science, and opinions were relegated to the subjective realm of belief: “Theologian, philosopher and scientist alike developed a single-minded passion for pure prose” (Lash 1996, 12). The scientific method exposed some of the limits of the Christian worldview (like the age of the earth) and, slowly, God was relegated to smaller and smaller portions of the universe unexplained by natural science: “Theology came to be more about (the possibility of) the willful act of belief than about what had to that time been understood as the proper subject of belief, the particular saving activity of God in history” (Shuman and Meador 2003, 49). In the West, secularism gradually supplanted the pre-existing Christian worldview as the comprehensive interpretation of reality.

As a method of inquiry, science need not necessarily be secular. Many of the greatest scientists were people of faith. However, as secularism became more per-
vasive throughout the 19th century, its proponents claimed the rationality of science for themselves, increasingly portraying religion as non-rational or even irrational (Stark, Iannaccone, and Finke 1996). Secularism became so tightly associated with science that by the mid-20th century some argued that “Humanism is the most scientific religion and the best religion for scientists. And if so, most scientists today, whether aware of it or not, are [Secular] Humanists” (Bahm 1946, 315). This presumed secularity of science persists throughout contemporary thought, but it is now hidden because the secularism of science remains largely transparent in the automatic practices and unconscious assumptions with which people daily engage scientific study (Snibbe and Markus 2002).

To the extent that the scientific study of religion presumes a secular worldview, it betrays its purported objectivity. As a result, the dominant view of religion in the medical literature is a view from the outside looking in, observing religious phenomena and reinterpreting them on secular terms—ordering societies, coping with psychological dissonance, teaching taboos, etc. This has been (and will continue to be) a functional approach, but in the same way that an animist’s description of an airplane as “spirit” does violence to an engineer’s understanding of aerodynamics, the external, secular description of religion does violence to the comprehensive worldviews so described. The study of religion in exclusively sociological, psychological, or scientific language is not the study of religion per se, but the study of sociology, psychology, or science.

Such an argument might appear to suggest that the scientific study of religion is impossible, but we are not so pessimistic. However, a shift in perspective is essential. If secularism is not objective, and if the scientific view of religion is always from the outside looking in, then the challenge for the study of religion and health is not to discover the ultimately objective perspective that would comprise the “master theory,” but to shift our way of thinking and try to understand religion “as a second first language” (MacIntyre 1988, 374). If, as Levin and Vanderpool (1987) have argued, meaningful findings in the study of religion and health depend on careful consideration of the epistemic ramifications of how we conceive of religion, the way forward may require some effort by scientists to understand religion on its own terms, as a different way of knowing or a different way of being-in-the-world. There are obvious challenges for such a scientific approach “from the inside,” but to these challenges we now turn.

**Measuring Fluency, Not Content**

If religions are best conceived as cultural-linguistic systems, then the study of religion may best be approached like studying foreign languages: grammar, syntax, and vocabulary define necessary linguistic content, but fluency is demonstrated only through skillful reading, writing, and speaking. Most existing measures of religiousness attempt to define and measure the various domains of “spiritual belief” or “numinous experience” that make up the vocabulary and syntax of religion. Examples of these domains include notions of the afterlife,
practices of meditation, or coping strategies like forgiveness (Fetzer/NIA 1999). In so doing, these measures have identified some of the important ingredients in religion, but this approach is not sufficient. Fluency in a faith tradition requires both content and skill.

Religions (or other comprehensive worldviews) require a certain skill manifest only through a type of performance (Lindbeck 1984). Even when worldviews share common beliefs and experiences, they can have disturbingly different results in different hands. For example, the Ku Klux Klan (2003) cites biblical scripture as it proclaims “a message of hope and deliverance for white Christian America!” The doctrinal beliefs and ritual experiences of the Klan exist divorced from any practice that is recognizably Christian and, consequently, most Christian churches denounce the Klan. Of course, the Klan is speaking its own language fluently, but even though they share some Christian beliefs and experiences, the religious language they speak is distinctly different from the language spoken by orthodox Christians. If measures of religiousness ignore this aspect of fluent skill, their assessment of religiousness will be at best hollow and at worst distorted.

Learning a foreign language is difficult, and the difficulty is compounded by the fact that there is no universal language that can form the basis for translation. All a student can do is to start listening to spoken language until she begins to speak the language properly. In learning about a red apple, there is no universal concept of “appleness” or “redness” that can serve as an intermediary. Rather, in learning French, the Anglophone comes to understand that the red apple is \textit{une pomme rouge}, but the same Anglophone is also surprised to discover that the potato is also \textit{une pomme (de terre)}. The process may be accelerated if the teacher is already fluent in both languages, but the fundamental principle remains the same: when learning a new language, there is no alternative to listening to foreign sounds until they start to make sense. Likewise, studying religion requires listening to foreign religious speech until it starts to make sense on its own terms.

This process of learning a foreign language is familiar to most high-school graduates, but the critical challenge concerns measuring fluency. On the one hand, the solution is simple: find a native speaker to examine a sample of speech and render an opinion regarding its fluency. If a native Frenchman judges me fluent in French, it is a safe bet that I will be understood in Paris. In a similar fashion, it may be possible to assess fluency in a faith tradition (say Judaism) by asking a qualified rabbi to render an opinion on the fluency of a particular person’s religious speech. In many ways, this is what religious clergy do on a daily basis, but such a practical approach seems somewhat arbitrary and subjective to the scientist who prefers more standardized methods.

Multi-item psychometric tests are one popular way of adding structure to such slippery topics as religiousness, quality of life, and psychic distress. These tools can be quite valuable, but their success is limited. As Alvan Feinstein (1999a) has observed, “why should the total score on a 30-item instrument be a
better way of identifying a person’s psychic distress than the answer to 2 simple questions: Are you distressed? In what way?” For example, psychologists have long known that a portion of the population will score “well” on depression scales even though they are obviously depressed when interviewed by a trained clinician. Slater, Hall, and Edwards (2001) apply this notion of illusory mental health to the realm of spirituality, suggesting that there are those whose scores on various measures of religiousness might imply a greater degree of religiousness than would be apparent to a trained observer formed by that religious tradition. For certain kinds of knowledge, there is nothing better than the expert opinion of a trained observer.

Feinstein argues that the language and structure of biomedical research predisposes researchers to measure that which is most convenient rather than that which might be most appropriate. He calls this the “avoid-and-divert” strategy of clinical research that prefers “an exact answer to a diverted question rather than an imprecise or approximate answer to the direct question,” giving examples of how “the search for a suitable definition of excellent clinicians has often been diverted to the demand that they pass an appropriate certifying examination” (Feinstein 2002, 202). Similar diversion marks the measurement of both “quality of care” and “religiousness.” Because it is difficult to quantify such aspects of caring as empathy, concern, and compassion, quality assessments focus on the conveniently tallied managerial activities performed by physicians. Likewise, measures of religiousness tend to focus on belief or experience, rather than the more nebulous notions of character formation, virtue, or cultural-linguistic fluency.

Feinstein worries that such diverted measurements confuse rather than clarify medical decision-making. He also observes the often-overlooked fact that medical training is a life-long process of honing the skill for listening to patients’ stories. All the lab tests in the world can never replace the skillful recognition of patterns and symptoms that characterize great diagnosticians, and it is this clinical judgment that Feinstein hopes to reclaim when he suggests that the accurate measurement of “soft” data depends on renewed attention to the appropriate ways of describing and standardizing the clinical judgment refined through years of “taking the history”:

[Clinicians] have not specified and insisted on emphasizing the clinical goals of research. They have given decreased attention to the distinctively clinical human attributes of patients and have frequently abjured clinical wisdom in classifying and analyzing those attributes for decisions in patient care. Clinicians have willingly, without protest, accepted the hard-data creed and allowed crucial soft data to be excluded from investigative attention. Clinicians have done relatively little to remedy the situation by observing and describing important soft entities and by developing appropriate expressions and rating scales for those entities. (Feinstein 1999b, 216)
Despite their limited success, multi-item instruments tapping various dimensions of religious belief or experience may never be as accurate as asking, “Do you believe in God, and if so, in what way?” The response to such a question will very quickly expose which “religious language” the person is speaking and an observer formed by that faith tradition might rapidly assess the fluency of such speech. Using the methods of qualitative research, faith fluency may best be measured by transcribing the responses to a few open-ended questions and then analyzing them with several experts formed by particular faith traditions (Jewish, Hindu, humanist), who can then identify which responses are examples of fluent speech in their specific faith tradition. Such an approach may appear hopelessly subjective, but analogous methods for identifying experts and substantiating consilience have been developed for other areas of medicine. For example, expert panels use Delphi and Nominal Group consensus techniques to develop practice guidelines (Jones and Hunter 1995). Without doubt, there will be unique methodological challenges for measuring something like faith fluency, but solving such methodological hurdles may yield insights more meaningful than the current approaches, which divert religious measurement to the content of belief or experience.

Spirituality Is Not a Universal Language

For many reasons, the concept of religion has fallen from grace in a recent trend that favors the broader concept of “spirituality” (Fetzer/NIA 1999; Hatch et al. 1998; King 1995). Proponents of this trend suggest that spirituality is more inclusive and universal than religion, and is therefore more likely to avoid the provincial, narrow, and exclusive bastardization of power that in the past has legitimated violent oppression and coercion in the “name of God.” Although we commend the irenic motivation behind the current enthusiasm for spirituality, we find the term problematic because, according to the previously outlined critique, spirituality has substance and form only within the cultural-linguistic context in which it finds expression. Spirituality cannot resolve the competing claims of different religions.

At first sight, the similar patterns of spiritual practice shared across religious traditions might appear to constitute a universal language of faith. However, the observation that all humans are spiritual is analogous to observing that all languages follow similar linguistic patterns of syntax and semantics. Linguistics can never substitute for living language, and spirituality can never stand alone, divorced from its cultural-linguistic context. Although there is much to learn about the spiritual linguistics of religion, to confuse “generic spirituality” with living faith would be like mistaking a text of linguistics for the collected works of Shakespeare. We fear that notions of generic religion or spirituality-in-general will be as useful, compelling, and beautiful as Esperanto. Spirituality is not a universal language.

Yet the fact remains that in American culture, many people identify themselves as spiritual but not religious (Underwood and Teresi 2002). This individ-
ualized “spirituality,” however, may not define something universal, but precisely the opposite: millions of religions with only one member:

One person we interviewed has actually named her religion (she calls it her “faith”) after herself. This suggests the logical possibility of over 220 million American religions, one for each of us. Sheila Larson is a young nurse who has received a good deal of therapy and who describes her faith as “Sheilaism.” “I believe in God. I’m not a religious fanatic. I can’t remember the last time I went to church. My faith has carried me a long way. It’s Sheilaism. Just my own little voice . . . it’s just try to love yourself and be gentle with yourself. You know, I guess, take care of each other. I think He would want us to take care of each other.” (Bellah et al. 1985, 221)

Although it is rare to find people like Sheila who boldly name their own religions, people of good conscience have always claimed their faiths in personalized ways. If religions function like languages, however, a “religion of one” such as Sheilaism is a private language, not a language in the full sense of the word. Private languages are at best problematic and at worst logically impossible, because all language is in some fashion symbolized, and all symbol systems have their origin in interpersonal relations and social interactions (Fogelin 1980; Lindbeck 1984). The private language of Sheilaism may be capable of mediating Sheila’s own experience, but it is not a universal language of faith.

If spirituality is not a universal language, then it makes little sense to study religion or prayer in general. Prayer formed within a community of Muslims on pilgrimage to Mecca is a different thing from prayer formed within a community of Amish farmers. Although scientific research is predicated on some degree of generalization, the process of abstracting living prayer into some generic type fundamentally alters the prayer under study, and therefore it may not be possible to study religion, prayer, or meditation in general. This tension between generalizability and specificity is familiar to physicians. The NIH would never fund a study testing the effects of beta-blockers on blood pressure, because the design is not sufficiently specific. Beta-blockers are not administered in general. Of course, it would be possible to administer a random assortment of beta-blockers to the study population, but most researchers would criticize this methodology, insisting that the protocol specify a particular drug, such as metoprolol. Conclusions about the wider class of beta-blockers may be drawn from subsequent meta-analysis of individual studies, but such specific studies must always precede the wider generalization.

In similar fashion, before generalizing to the wider class of “prayer-in-general,” it may first be necessary to specify the particular contexts of such prayer: “Do women with breast cancer live longer if they are formed by and pray with this specific community in this particular way?” Levin and Vanderpool (1987) acknowledged the need for contextually contingent scales and measures of religiousness when they called for “a multidimensional religiousness scale relevant to
the religious tradition of the respondent,” and in subsequent research, Levin has focused attention on specific groups, such as African American Christians or immigrant Mexican Roman Catholics (Levin 1996b; Levin, Chatters, and Taylor 1995). To our knowledge, however, neither he nor other empirical researchers have fully adopted this line of thinking in their research, and despite the methodological inconsistency, most research continues to study religion in general rather than a specific form of religious tradition. The existing research on religion in general is in many ways like a meta-analysis conducted before collecting the necessary underlying specific data.

Religion May Be Relevant to Health Care Even If It Does Not “Work”

The existing research on faith and health often boils down to the issue of utility. Does prayer work? Do religious people live longer? Is religion good for your health? From the secular perspective, these utilitarian goals of research are intuitive and obvious, and to some extent, even the churches have adopted a therapeutic model of faith, replacing the “traditional idea of the preeminence of God with nothing more than a personalized, manipulable sense of well-being” (Meador and Henson 2000). For example, many Christians have adopted the therapeutic language of secular society as they “shop” for churches based on how a given congregation is prepared to “meet their needs.” Both the scientific and popular interest in the interface between religion and health is motivated in part by a desire to determine if religion “works.”

From a cultural-linguistic perspective, there are two problems with this utilitarian approach. First, even if researchers could demonstrate the utility of a particular religious practice, it is not at all clear that such a finding could ever be useful. For example, suppose that a definitive study demonstrated that weekly attendance at a Pentecostal church reduced the incidence of colon cancer by 35%. Beyond the obvious ethical concerns, there is a technical problem with any attempt to recommend church attendance to nonreligious patients: going to church to reduce the incidence of colon cancer is not the same thing as conforming one’s life to the Pentecostal worldview. To use religion in the service of some proximal good such as “health” or “long life” raises that proximal good into the privileged place of ultimate good reserved only for God. When religion is reinterpreted under the utilitarian, transactional model found in much of the medical literature, it ceases to be interpretable as religion. Namely, it ceases to be faithful. In so doing, the reinterpretation may undermine any expected or hoped for “utility,” and almost any attempt to “use” religion may in fact sabotage previously observed correlations between faith and health.

Second, and more importantly, the ends of religion are not necessarily compatible with the ends of medicine. The primary end of medicine is achieving and maintaining biophysical homeostasis. Most existing research on religion and health is aimed at understanding if and how religion influences that homeostasis, but this is forcing a square peg into a round hole. The asceticism of Gandhi,
the fasts of Ramadan, and the refusal of blood products by Jehovah’s Witnesses do not conform to “standard medical practice” because these traditions neither understand nor promise health as homeostasis. But this does not mean that religion is irrelevant to medical care. To the contrary, the ends of religion are often aimed at fostering such virtues as gratitude, hospitality, or faithfulness. Such virtues need not be formed through religious practice, and not all religious practice succeeds in fostering these virtues, yet there are numerous examples of faithful “communities of caring” that nurture and embody the virtues required to truly care for the sick and suffering. Although difficult to quantify, this type of theologically contextual outcome may be critically relevant to the practice of medicine regardless of whether or not religion “works.”

Worldviews May Have Consequences

The final implication of this line of argument is perhaps the most dangerous and threatening. The established research paradigm for religion and health presumes a secular worldview, focusing on the differences between religious and nonreligious people. We have critiqued this model of religion in general, suggesting that the secular worldview has no intrinsic privilege and that each religious worldview is but one of many possible comprehensive interpretations of the human condition. The dangerous but meaningful question for research on religion and health is to consider if there are any measurable implications for the way in which people interpret the world. Are there health consequences for specific comprehensive worldviews, be they secularism, Marxism, Christianity, or any other?

This question may be threatening because worldviews are largely resistant to change, and the results of any research might easily be twisted to justify the superiority of one worldview over another. Studying worldviews (religious or otherwise) on their own terms implies the possibility of results that might require new ways of seeing the world, and this can undermine entrenched systems of belief and power. However, genuine inquiry requires asking precisely the types of questions that could occasion such epistemological crises (MacIntyre 1988).

Consider one dramatic possibility: what would it mean to demonstrate beyond all doubt that there were negative health implications associated with secularism? Although existing research suggests some benefit associated with an optimistic internal locus of control (Aspinwall and Brunhart 2000; Taylor and Aspinwall 1996), we remain deeply skeptical of the radical individualism of Nietzsche, Whitman, or Feuerbach that so deeply characterizes modern American culture. Consequently, we would not be surprised to discover that the burden of knowing ourselves to be our own gods is more than we can bear, and that such a burden might even have measurable and negative health implications. What would happen if a clinical trial demonstrated that such secularism was killing us?

To a limited extent, the study has already been done. Strawbridge and colleagues (1997) followed patients in Alameda County, California, for 28 years, and
after controlling for most conceivable confounders, they demonstrated that those who attended weekly religious services lived longer than their secular counterparts (Hazard Ratio 0.77). Yet this isolated study has not occasioned mass conversion. Both Christians and atheists seek health and well-being in pursuit of a better life, and although both believe their worldview helps them achieve a better life, neither Christians nor atheists see the world in their particular way solely because it makes them healthy. Even if there were persuasive evidence that secularism was unhealthy, most atheists would likely persist in rejecting religion precisely because their sense of intellectual honesty about “God” constitutes for them a higher value than longer life.

Much of the controversy about religion and health is rooted in the fact that most medical debates presume a homeostatic understanding of human well-being. This concept of human well-being is a product of a secular worldview, but even for the confirmed secularist, it is rarely treated as the ultimate end of human life. Differing worldviews foster different conceptions of the human good, and as such, worldviews may have measurable health repercussions. However, worldviews are not amenable to surgical or pharmacological intervention. Consequently, it may be that worldviews (religious or otherwise) and the practices of living formed by such worldviews should simply inform the practice of medicine like other important demographic variables. Because each worldview fosters particular ways of valuing homeostatic health, there may be patterns of disease (or health) that correlate with specific worldviews in much the same way that Japanese men are predisposed to gastric cancer. Precise knowledge of such correlations would only improve the capacity to make informed medical decisions. Furthermore, to the extent that clinicians can recognize (if not fluently speak) languages of various worldviews, they may become better equipped to engage both the science of curing and the art of caring for the sick and suffering.

Conclusion

In an attempt to stimulate debate over the conceptual basis for the scientific study of religion, we have presented a critique of the dominant paradigm of studying religion as a frosting added to the generic cake of secular human experience. This approach presumes the universality of the secular worldview, distorting the coherence of independent religious worldviews. We suggest that religion is better conceived as a cultural-linguistic system that must be studied from the inside rather than by forcing religion to speak in secular terms. In tracing the implication of this critique, we have argued that (1) there is no objective frame of reference from which to study religion; (2) studying a religion is most like learning a foreign language; (3) measurement of religiousness is most like assessing fluency in a language and implies the assessment of the skill by someone skilled in that language; (4) the scientific study of religion may be important even
if religion doesn’t “work”; and (5) this critique leads to the dangerous possibility that there may in fact be health consequences associated with specific worldviews. We contend that meaningful research regarding the associations between religion and health will depend on applying these ideas in the design, conduct, and analysis of future research.

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