
Handbook of Religion and Health

by Harold G. Koenig, Michael E. McCullough, David B. Larson
New York, Oxford University Press,
2001, ISBN 0195118669, \$72.00

The Link Between Religion and Health: Psychoneuro-immunology and the Faith Factor

Edited by Harold G. Koenig, Harvey Jay Cohen
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2002
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*Reviewed by
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The Gallup polls report that 82% of persons over 65 are members of a religious congregation, and 52% attend services weekly. Should geriatric psychiatrists therefore consider religion salient to clinical care and research? The answers are complex. In their comprehensive *Handbook of Religion and Health*, Harold Koenig, a geriatric psychiatrist and researcher, Michael McCullough, a research psychologist, and David Larson, a psychiatric epidemiologist whose important contributions to this field were cut short by his recent death, argue that most health professionals do not consider religion part of patient care, but they should, because research demonstrates that many

mental as well as physical disorders are less severe among religious persons.

One chapter comprises a 117-page-table that critiques more than 1,600 studies. This overview and descriptions within other chapters demonstrate how correlations between religion and health can differ on the basis of methodologies used and subpopulations studied. In the words of the architect Ludwig Mies van der Rohe, "God is in the details." To clarify these details, the authors present definitions of religion, using 12 components: these include affiliation, practice, knowledge, public action, and belief.

The Handbook chronicles the relationship between healthcare and religion through history. Egyptian civilization believed in the spiritual etiology of both physical and mental illness, and subsequent centuries brought gradual separation of religious practices and beliefs from medical care and education. Throughout the book, there are historic examples of divisions as well as collaborations between religious leaders, clinicians, and researchers.

Two sections present research on religion as regards specific disorders and diseases. The mental health section includes depression, suicide, anxiety, and schizophrenia. The physical disorders section includes cerebrovascular disease, cancer, heart disease, and other disability. Each concludes with a summary and suggested model for how religion influences well-being. Although the direction of the religion-health relationship is predominantly positive, the diversity of correlations across different religious practices and beliefs requires that suggested clinical interventions include cautious caveats.

Pertinent examples of why geriatric psychiatrists should proceed with caution are found in the chapter on depression. Pentecostal Christians, for example, are at increased risk for major depression, but when these data are stratified by age, the risk remains high for "baby boomers," but not for elderly members. A study of 577 geriatric patients hospitalized with acute medical illness found both beneficial and harmful types of religious beliefs. Benevolent appraisals of God were associated with lower depression scores, but God as a punishing entity was positively related to depression. Clarification of these results will require longitudinal research to determine whether negative beliefs lead to depression or depression results in negative beliefs.

In one prospective study, depression was measured in relation to actual attendance at religious services, rather than informal religious involvement. Christians who attended services developed fewer depressive symptoms than those at informal religious activities. Jews who participated in each type of activity had the opposite experience. In another study, persons who were unaffiliated with any religious congregation showed no increased risk for depression if they were European American, but significantly more if they were African American.

How can we clinicians use this information to help our patients? One study tested a form of cognitive-behavioral therapy that used Christian rationales to counter irrational thoughts of religious patients. Those treated by nonreligious therapists did significantly better than those treated by religious therapists. The authors con-

clude that non-religious clinicians could therefore collaborate with hospital-based chaplains or religious patients' own clergy to develop and deliver enhanced treatment.

The Handbook's data are presented succinctly, yet with methodological and statistical detail. It would be helpful to non-researchers for the authors to include an additional chapter or a glossary explaining the pragmatic implications of the different methodologies reviewed. For researchers, the final chapters provide excellent descriptions of questions to be studied and strategies for their examination.

How could scientists identify the mechanisms by which religion may affect health outcomes? The possibility of a causal chain from religious practice to emotional well-being to physical health is explored in a book edited by Dr. Koenig and his Duke colleague Harvey Jay Cohen, a leader in geriatric medicine research. In *The Link Between Religion and Health: Psychoneuroimmunology and the Faith Factor*, several researchers describe and explain a hypothesized pathway wherein environmental stressors (mediated by individual coping styles) affect the human immune system, possibly resulting in illness. The physiological outcomes of these psychosocial effects are explored in relation to cancer, infection, wound-healing, and HIV/AIDS. Some authors hypothesize that religion helps individuals cope with stress through an existential exploration of "why" they have the illness; others attribute positive outcomes to the ameliorative effects of social support and conclude that religious participation enhances social resources.

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The book recognizes that these are early attempts to create a hermeneutic model of a largely unexplored area. One expects that studies of this model will increase greatly in the years ahead.

In broadening our clinical inquiry, these two sophisticated research volumes also warn of unintended consequences. In the Handbook, the authors ponder where reductionist data might lead: "If the brain areas responsible for religious experience can be identified, it may become eventually possible to activate these areas of the brain through direct stimulation or by pharmacological means." In *The Link Between Religion and Health*, the

sociologist Howard Kaye warns readers that this research, "may well encourage the medicalization of religion, [rather than] the spiritualizing of medicine."

Should geriatric psychiatrists consider religion salient to their clinical care and research? These books make it clear that religion is not a single attribute practiced uniformly across different populations and leading to the same mental and physical outcomes. Yet, they demonstrate that we must each evaluate the inclusion of religion in our work if we are to engage the full breadth of our patients' emotional lives. The books also remind us that we can observe and test only that

subset of religious factors that are measurable and generalizable. There are other cultural, historical, familial, and personal attributes of religion that ineffably define our interpretive systems for thought, emotion, and relationship. Another challenge for clinicians will be to engage religious resources without diluting personal religious experience.

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