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"And Let Us Make Us a Name": Reflections on the Future of the Religion and Health Field

Jeff Levin

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Abstract After years of marginality, research on religion and health is entering the academic mainstream. Scholarship on this topic has evolved into a large, productive field. As in any emerging field, there are competing visions for what the field should be about and what research questions should be pursued. Different opinions exist as to which constructs should be researched. Words like religion, spirituality, faith, and prayer, and health, healing, medicine, and healthcare, imply different things. The study of their various interconnections can thus take myriad forms. This article argues for a welcoming approach open to the widest range of research subjects.

Keywords Religion · Spirituality · Theology · Health · Healing · Medicine

Toward the end of *Parashat Noach*, the second weekly Torah portion in the Hebrew Bible's annual cycle of readings, we encounter the familiar story of the *Migdal Bavel*, the notorious Tower of Babel. A prideful people, full of hubris and insolence, united in an idealized world system, has allowed its collective ego to envision the ultimate in arrogant self-absorption. In a valley in the land of Shin'ar, they have declared their intention to build a gigantic monument to themselves. The Bible tell us, "And they said: 'Come, let us build us a city, and a tower, with its top in heaven, and let us make us a name; lest we be scattered abroad upon the face of the whole earth'" (Genesis 11:4 [JPS]). But, lo, like most such schemes, theirs was to no avail. God came down to take a gander, was none too pleased, and soon enough the people were indeed "scattered," far more thoroughly, one supposes, than if they had just left well enough alone.

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J. Levin (✉)
Department of Psychiatry and Behavioral Sciences, Duke University Medical Center, Durham, NC, USA
e-mail: levin@hughes.net
URL: www.religionandhealth.com

The moral of this tale: God does not reward monotonic thinking. While a seemingly marvelous ideal, the quest to establish one voice, one view, one perspective, one theory, etc., is more likely a recipe for disaster. As with so many other utopian notions, this one can become dystopian. Consensus is to be valued, of course, but not at the price of shutting out some voices in favor of protected others. In politics, an obsession with lockstep thinking can result in speech bans, the stifling of dissent, the criminalization of disfavored viewpoints, and, *in extremis*, totalitarianism. Any realm of ideas—indeed, any people, nation, institution, organization, academic discipline, scholarly field—thrives by tolerating a diversity of perspectives. This is not merely a politically correct ideal. This principle of the inherent value of diversity is so ubiquitous that it applies even to agriculture, where we know that monocultures pose a threat to the food supply. If a blight wipes out a single-variant crop, then that crop is gone for the season, or forever. The Torah's story of Babel shows us clearly that the idea of diversity-as-strength has its roots in the foundations of Western monotheism and is advocated as a fundamental, God-given principle of human social life.

In the religion and health field, as in the days of the descendents of Noah, momentum has built to the point that the lure of institutionalizing all of the disparate research threads and perspectives under a single banner looms large. There is great temptation, after years on the margins of science, to want to come together and speak as one field, with one voice, and thus "make us a name." Well and good, to a point. Philosophers of science speak of this as a state of "normal science" (Kuhn 1970), whereby a single paradigm or way of conceiving of the reality of the subject under study holds sway. This is one of the signposts that a field or theory has truly "arrived." Normal science is also characterized as one of those static phases within the history of a particular field or discipline when routine fill-in-the-blanks studies predominate over research that efforts to challenge or test a field's or discipline's underlying theoretical presumptions. This state has emerged, presumably, because a single paradigmatic way of thinking has been successful and productive and thus has come to dominate nearly all work in the field. The benefits of focusing exclusively on normal-science-sanctioned issues for individual investigators, as any sociologist will attest, are many: approval by colleagues, career advancement, grant funding, media coverage, a large lab or research team, and acknowledged status as an expert (Levin 2001a). These are all wonderful things and nothing for which any researcher need to apologize.

But normal science has its dangers, as well, individually and collectively. These include the stifling reinforcement of perspectives that fail to challenge the status quo as well as the marginalization of understandings of a scientific topic that are outside of the mainstream. For the religion and health field, taking a long view, none of this is helpful. By the religion and health field becoming a *field*—a recognized area of study populated by steady funding, publication outlets, dedicated organizations, and investigators devoting large proportions of their efforts to the cause—much has been gained, for sure, but, without vigilance, much can be lost. When this field was simply a ragtag collection of isolated researchers conducting one-off studies, its impact may have been diluted, but at least the forces of social control were recognizable and originated outside the field.

The present article surveys the current state of the research arm of the religion and health field, with an eye to anticipating its future. Stepping back and taking stock of where we are, where we have come from, and where we are going is especially pertinent at the present time, as this field has reached a critical point in its institutionalization as a field. Identifying sources of research funding and outlets for publication, serious issues 20 years ago, are no longer barriers. The late Dr. David B. Larson's much cited tongue-in-cheek observation that investigators in pursuit of religion and health research courted an

"anti-tenure factor" (Sherrill and Larson 1994) was long ago rendered moot. The most significant and laudable marker of change is the recent establishment of the Society for Spirituality, Theology, and Health (SSTH) as a professional home for researchers in this field. At last, those of us laboring here have something of a professional identity, as well as a place to gather every year, just like in other substantive fields that cut across formal disciplines. The title of this article, taken from the Book of Genesis, "'And Let Us Make Us a Name,'" is a gentle reminder that efforts at field-building must be infused with tolerance for a diversity of theoretical perspectives, methodologies, and agendas lest said field, like our post-diluvian ancestors, end up scattered to the wind.

There is another connection between the content of this article and these words of scripture, related to the word "name." The names that we attach to things are vitally important signifiers of the values that we project onto these things. The labels that we attach to ideas and concepts and scholarly fields, and how we language them, serve to define their identity to us and the scope of what we perceive to be their application. In other words, speaking of "religion and health" or "spirituality and healing" or "theology and medicine," or any other such combination of words, implies a respective valuation of certain concepts and themes over and above others. These values and perspectives may not be explicit, or even recognized, but they are nonetheless present, bubbling under the surface.

In the religion and health field, there are competing visions for what this field is and should be about. Accordingly, there are competing notions as to what the field should be named—that is, how the field itself and the important questions that it will address should be conceived of and spoken about. Words like religion, spirituality, theology, and faith, on the one hand, and health, healing, medicine, and healthcare, on the other, have distinctive meanings, and the investigation of their respective interconnections requires distinctive methodologies. Moreover, scientists and scholars and practitioners are attracted to this field for a variety of reasons and they operate from a diversity of perspectives. The position taken in this article is that all of these visions are valid as components of a "big tent" approach to the subject of religion and health, but no one vision is valid as a unique perspective on what this field should be about and what we should be doing.

"In the Beginning": Religion and Health

In 1835, Dr. Amariah Brigham, one of the founders of the American Psychiatric Association, published the book *Observations on the Influence of Religion upon the Health and Physical Welfare of Mankind* (Brigham 1835). It is probably in this work from two centuries years ago, or in some other contemporaneous publication, that one may find the origins of what subsequently came to be known as the religion and health movement. Brigham's work and other early contributions, such as *Religion and Medicine: The Moral Control of Nervous Disorders* (Worcester et al. 1908), presage many of the issues that scholars and scientists in the religion and health field wrestle with even today. Foremost among these is the possibility of a therapeutic influence of religious faith. There is thus historic precedent of longstanding for a consideration of such issues by Western scholars (see Levin and Koenig 2005), many decades before even such seminal works of the Christian pastoral care field as *Religion in Illness and Health* (Wise 1942), *Religion and Health* (Hiltner 1947), *Religious Factors in Mental Illness* (Oates 1955), and *Psychology, Religion and Healing* (Weatherhead 1961).

The rise of the religion and health movement within the pastoral care field culminated decades ago in the establishment of several important institutions that helped to provide definition and structure to the subsequently emergent religion and health field. These include the Blanton-Peale Institute (founded in 1937), the Academy of Religion and Mental Health (founded in 1954 as an academic wing of the Institute), and *Journal of Religion and Health* (founded in 1961 by the Institute). This journal, especially, has served as a kind of official organ for the many disciplines, fields, and voices that came to define the religion and health movement: pastoral care, healthcare chaplaincy, faith-based medical institutions, religious bioethics, the psychiatry and religion field, and, more contemporaneously, academic scientists conducting empirical research on religious factors in physical and mental health. Moreover, throughout its history, the journal has served as an outlet for a who's who of esteemed academics scholars from outside of religious studies disciplines, a notable example being Dr. Gordon Allport's (1963) famous essay on religion, psychology, and mental health.

Another offshoot of the Institute, its outstanding (and much missed) multivolume monograph series, published under the auspices of the Academy almost annually from the late 1950s into the 1970s, provided an outlet for diverse threads of scholarship on the wide interface of religion and health (see, e.g., Academy of Religion and Mental Health 1959). The monographs served as a forum for a variety of authoritative voices from myriad academic disciplines, from Dr. Abraham Maslow (psychology) to Dr. Talcott Parsons (sociology) to Dr. Margaret Mead (anthropology). The revival of this forum for interdisciplinary discussion would be a significant and positive development for the religion and health field.

Perhaps the highest-profile work in the religion and health field over the past 20 years has been the much publicized research and scholarly writing on the clinical and epidemiologic impact of religious participation, broadly defined. While empirical research on this topic dates to the 19th Century (see Levin and Schiller 1987), it is only in the last three decades or so that the existence of these studies has been acknowledged within the academic community (see Kaplan 1976; Vaux 1976; Vanderpool 1977). Only in the past two decades, moreover, have the depth and scope of this research been widely recognized, beginning with publication of a comprehensive review in this journal (Levin and Schiller 1987) and culminating with the encyclopedic *Handbook of Religion and Health* (Koenig et al. 2001) which identified over 1,200 published scientific studies on the topic.

For most of this time period, the presence of empirical findings indicative of a generally salutary effect of religiousness has met with a varied response, in terms of its acceptance and controversy, throughout medicine and the biomedical sciences. The one consistency in response has been this topic's perceived marginality. Over the same period, this response has been quite different, and much more favorable, in several fields, notably medical sociology, gerontology, health psychology, pastoral care, and psychiatry. This is due to longstanding traditions of empirical research and/or theoretical writing in these fields. For example, studies of religion and health date to the 1950s within gerontology and the sociology of religion, and theoretical consideration of this subject dates to the early work of sociology's classical theorists and psychology and psychiatry's great pioneers.

Among social scientists, the idea that dimensions or aspects of religious expression (beliefs, behaviors, attitudes, experiences, etc.) might exert an influence, for better or worse, upon population-level indicators of health behavior, health care use, or health status would seem to be obvious and uncontroversial. Significant impacts of religious beliefs, attitudes, behaviors, statuses, and identities have been identified at the population-wide level on parameters related to myriad social institutions, notably political identification,

voting patterns, criminality, socioeconomic status, family functioning and relations, marital satisfaction, racial and ethnic identity—and indeed the full panoply of outcomes investigated by social researchers for the past several decades (see Levin et al. 1996). The presence of significant religious effects on indicators of physical and mental health status and general well-being is consistent with traditions of belief about religion's practicality and salience that exist across cultures and religions (Spector 2004). The instrumentality of religious involvement for human physical and psychological well-being is thus not particularly controversial and is tacit among many sociologists and social psychologists, as well as within some clinical fields such as nursing. The field of psychology has its own longstanding tradition of both empirical research and theoretical writing on religion and well-being dating to classical (e.g., James 1917), modern (e.g., Allport 1979), and contemporary (e.g., Pargament 1997) figures.

The *idea* of a "religion-health connection" (Ellison and Levin 1998)—aside from its empirical support—is thus consonant with understandings of religion's influence, generally, and its impact on human well-being, specifically, that are widely accepted within the social sciences. But this understanding has not translated well across disciplines, especially into Western medicine.

By their words, supportive and critical alike, many clinicians commenting upon this body of work seem to have minimal understanding of the scope and meaning of findings related to research on a population-wide health impact of religiousness. This observation holds whether we are speaking of conservative religious physicians who endorse this research as validating the truth claims of respective faith traditions, alternative practitioners who take this research as proof of the healing properties of "spirituality," or self-identified skeptics who believe this work to represent a corruption of medicine and medical care by non-scientific elements. To be clear, these are each important matters that deserve to be taken seriously. However, the body of population-based health research on religion does not in any way speak to any of these issues, pro or con. Epidemiologic studies showing, say, lower morbidity rates due to heart disease among non-smoking regular church attenders do not tell us anything about whether Christ died on the cross for the atonement of sin. Likewise, they do not tell us anything about the ability of mindfulness meditation to help shrink brain tumors. Further, they provide no evidence or incentive for physicians to pray for their patients in lieu of prescribing medications. Such studies tell us, simply, that "religious participation, on average, exhibits primary-preventive effects in well populations by an association with lower morbidity. No more, no less" (Levin et al. 2006, p. 1168).

Nevertheless, so many well-intentioned people, mostly not those actually conducting this research, seem to have an awful lot invested in this body of research meaning and implying something that it does not mean or imply. Religion, generally speaking, may fill a deep void in people's lives or be harmful to many people's minds and souls, and it may be a positive force in human history or a destructive one, but surely epidemiologic research studies tell us little at all one way or the other about such profound matters. Yet this is a difficult observation for so many commentators, pro or con, to come to grips with when surveying this field.

For active researchers, this has created considerable frustration, as some commentators and critics have become opinion leaders for this field and are regularly cited. The few existing skeptical critiques, for example, exhibit little fluency with, or even acknowledgment of, how it is that social and behavioral scientists, including psychosocial epidemiologists, empirically study religion—or even that this actually occurs, can occur, and has occurred systematically for half a century. Denials of the very possibility of

religious research are even put forth, based on tacit understandings of religion as somehow immune to objective observation (e.g., Sloan et al. 1999). This contention would come as a surprise to the mainstream of social and behavioral scientists, as it is entirely at odds with over a century of successful research and writing on religion by the leading figures in these fields.

In a somewhat different context, one is reminded of the chasidic anecdote about the non-believer who approached the local rabbi complaining that he could not possibly accept the existence of God. In making his case to the rabbi, he based his atheism on a typical 4-year-old's understanding of God, faith, and religion. The rabbi listened respectfully, then smiled and responded, "You know that God you say you don't believe in? Well, I don't believe in him either." The skeptical critique of religion and health research is predicated, it seems, on an understanding of religion that runs counter to almost the entirety of religious scholarship within both the academy and within seminaries across faith traditions. It is also informed by an overtly partisan strain, as seen in the name of one organization, the Freedom from Religion Foundation, that has promoted the most well known skeptic in this area (Sloan 1999).

But worse, among both supporters and critics of this research there appears to be an equal lacuna of understanding of the principles of population-health research. This is worse because the first problem (related to misunderstandings of religion) can be attributed to an understandable lack of exposure to academic scholarship on religion, or to lack of personal investment, while the second problem bespeaks a dramatic misreading of the design, aims, and methodologies of religion and health studies. For example, longitudinal epidemiologic or population-based studies of religious exposures in healthy populations are often confused with clinical trials of the effects of praying or of an undefined "spirituality" or mind-body effect. For proponents of such trials, the thousand-plus studies of religion and health seem to provide much needed evidence supportive of their agenda, whether proselytizing religion (among conservative religious partisans) or ushering in a new medical paradigm of some sort (among alternative medicine enthusiasts). For skeptical critics of such trials, these religion and health studies are indicative of the triumph of superstition over reason and the motives of those who conduct such studies are often impugned. Each of these camps advances straw men, however, a point made several years ago in detailing how these religion and health studies are *not* about what most of the commentators and critics seem to think that they are about:

> The preponderance of evidence that they draw on . . . [are] population-based sociological and epidemiologic studies of general communities investigated cross-sectionally or prospectively in order to identify religious correlates or determinants of health and well-being. This body of research has *nothing* to do with medicine, with physicians, with patients, with illness, with the clinical setting, with medical therapies, or with healing. It does not and cannot provide *any* evidence for or against . . . physicians praying with patients (Levin 2001a, p. 28).

Fortunately for investigators, the impact of these commentaries on the growth of research in this area has been nil, although some would-be experts are still occasionally cited by those unfamiliar with the field or with social and population-health research methods in general. New-age and conservative political and religious publications, for example, occasionally reference this work as an important signpost along the way to their respectively idealized utopian futures. Similarly, a few notable skeptics from an organization opposed to scientific research on the paranormal—which would not seem to relate in much of any way to the present topic—are still routinely solicited for an "opposing view"

to this established research literature of over a thousand studies dating back decades and published in mainstream academic journals. But as a result of such a large body of research findings that have been vetted repeatedly by expert panels and systematic reviews, including from the National Institutes of Health, the emergence of research and writing on religion and health into the mainstream of scientific discourse is by now fairly well acknowledged (Koenig 2008).

"Neither Shall Thy Name Any More be Called": Spirituality and Healing

Right around the time that the existence of empirical research on religion and health began to become somewhat recognized within the academic community, in the 1980s, the word "religion" began to fall out of favor in intellectual circles, to be replaced by "spirituality." This development, which probably merits its own article-length discussion, was rooted in a prevailing alienation from institutional authority of all types characteristic of many of the babyboomer generation. Despite hostility to established religious institutions, structures, and dogmas, the attractiveness of private expressions of religious sentiments and the innate desire to experience the transcendent did not particularly waver. But the word "spirituality" was seen as more personal, even more democratic, and as carrying less of the perceived stigma of the old term "religion." Thus, the latter was discarded as the former was adopted.

There is much to appreciate in this shift in how so many Americans have come to language the sacred aspects of their life. Rather than purely a sign of shallowness or rootlessness, as some have asserted, this change also speaks to the salience of the enduring search for meaning. Perhaps people are more willing these days to cast aside the tried and true, the familiar and comfortable, in order to locate something that they desperately wish to acquire but that they cannot find in the stodgy old religious traditions of their upbringing. There is something significantly admirable here, even courageous.

On the other hand, there is much here that is concerning. Religion is a perfectly fine word that easily encompasses all that the seekers of spirituality are looking to obtain. Traditionally, "religion" designates three things in particular. First, it is the name for an academic field (as in sociology, economics, art history, political science, geology, etc.). Second, it is the designation for respective faith traditions (e.g., the Christian religion, the Buddhist religion, the Muslim religion). Third, it references the domain of life dealing with "ultimate concerns" (Tillich 1957), the provision of meaning and order (Geertz 1973), and, in general, the things of the human spirit. In this last connotation, "religion" ably captures what has been shifted onto the new preferred term, "spirituality." The great religious scholar, Dr. Huston Smith, has made much the same point:

> Uncontaminated, *religion* is a noble word; deriving as it does from the Latin *religio*, to rebind, the word targets what religion is essentially about. But because it challenges the prevailing worldview, it has lost some of its respectability. . . . Enter the word *spirituality* to name (without specification) what is good about religion (Smith 2001, p. 255).

Traditionally, the concept of spirituality has had two distinct but related meanings. It is used to denote both an end—the idealized result of a life of religious piety—and a means to that end—a unique style of religious practice sanctioned as normative within respective faith traditions. Spirituality refers to the quality of being spiritual—a *state of being* acquired through religious devotion, piety, and observance. Attaining spirituality—union

or connection with God or the Divine—is an ultimate goal of religion, a state not everyone reaches. Spirituality also refers to the characteristic *developmental process* of religious maturation that leads one to this end. Exemplifying the first usage, one might imagine a soul entering the afterlife, met at the gates of heaven by St. Peter or Whomever, and greeted with a friendly, "Congratulations, you have attained spirituality. Your efforts were not in vain. Come on in." Exemplifying the second usage, theologians and clerics speak of Jewish spirituality or Tibetan Buddhist spirituality or Anglican spirituality or Sufi spirituality or evangelical spirituality, and so on. Spirituality is thus a subset of a larger phenomenon, religion, and by definition is sought through normative means of participation in a faith or wisdom tradition. The word spirituality has been defined and understood in these two contexts, almost universally, within academic religious studies and by theologians and ordained clergy from across the world's religions and throughout history.

In trading in "religion" for "spirituality," it was not enough to jettison the former for the latter. The word spirituality itself was changed. It came to denote something akin to feelings of oneness with all beings. This sounds a lot like the unitive experience spoken of by mystics, which has come to be something of an ideal for spirituality in its neologistic sense. There is already a fine word for this—transcendence—but this has been co-opted and absorbed into "spirituality." Religion, in turn, was redefined as the institutional and partisan (and thus, in some quarters, "bad") expression of spirituality. In a sense, the two words have been flip-flopped: religion is now a subset of spirituality, which is the larger and more embracing concept. This is the concerning part.

In his book, *Why Religion Matters*, Smith cogently articulates the trouble he has with this change in how we have come to language the sacred:

> It is a bad sign when *spiritual*, an adjective, gets turned into a noun, *spirituality*, for this has a dog chasing its own tail. Grammatically, *spirit* is the noun in question, and *spiritual* its adjective. *Spirituality* is a neologism that has come into existence because *spirit* has no referent in science's world, and without grounding there, we are left unsure as to what the word denotes (Smith 2001, p. 256).

Moreover, one has the strong sense that many people gravitating to the neologistic spirituality are earnestly desirous of the same sense of order and meaning and connection to God and the same sorts of feelings of transcendence that most people continue to find through fellowship in established religious traditions. But through unfortunate experiences, whether the result of maliciousness or simply due to coming of age in a spiritually dead congregation, lasting wounds have been created that have poisoned people to organized religion yet have failed to extinguish the thirst for the transcendent. The attractiveness of nonce fashions promising "spirituality" is thus understandable. People are drawn to connect with something, but there is no telling what one might find these days, especially with such a proliferation of "spiritualities" in the religious marketplace. Without connecting with a longstanding tradition of faith or wisdom, whose normative path to spirituality has been tested and proved by eons of adherents and pilgrims, one is taking a chance that choosing to pursue spirituality over practicing religion will leave one worse off for the experience.

This is more, therefore, than a semantic issue. The neologistic use of spirituality suggests a "lazy man's road to enlightenment," so to speak—a way to spiritual growth and eventual union or yoking with God or the Divine that skirts the requisiteness of lifelong religious learning, regular worship or devotion, and consistency in moral behavior, especially in their communal expressions. Marty (1998, p. xi) has famously described this postmodern, individualistic buffet approach to religion as "unmoored spirituality." This

"self-acquired, self-advertised spirituality," Marty explains, is "a kind of vapor: thin, particled, almost invisible, shapeless, hard to grasp." Moreover, he adds, spirituality that is "unmoored makes up reality as it goes along; it flits and is fleeting, leaving one at sea" (Marty 1998, p. xii). Greeley (1985, p. 241), likewise, has characterized this as "institutionless religion," which he considers "at best naive romanticism."

But, more significantly, it is the eschewed communal dimension of religious participation—church or synagogue affiliation, religious service attendance, group prayer, the receipt of formal and informal religious support—that is invariably implicated as most salutary among studies of physical and mental health. Doing one's own thing, working out one's own unique pathway to transcendence, in solitude or without reference to long-standing traditions of faith, wisdom, or religious practice may indeed be personally meaningful and is a genuine sign of the times (see Levin 2003). Moreover, no criticism is intended of the solitary spiritual quest which has marked the lives of the greatest mystics and continues to nourish contemporary souls. No one should question the motives of those precious souls earnestly seeking to attain spirituality in this way. In the current milieu, seeking after God or the Divine is a courageous act no matter how one decides to go about it. But from the perspective of findings from the research literature on the topic of this article, there is little evidence to suggest much of a health impact of such an improvised quest. The buffet, apparently, is not particularly nourishing, at least with respect to health.

Simultaneously to this widespread embrace of "spirituality," new-age booksellers discovered the word "healing." The concept of healing refers to something completely different than the concept of health, but this is mostly ignored. These are two distinct reference points within the natural history of disease. Health is a status: its use references a generalized state of physical well-being, within individual persons or within populations. Its opposite within individual persons is disease, a status characterized by an ongoing pathogenic process that may be preclinical (i.e., presymptomatic) or clinical (i.e., symptomatic). Within populations, the concept is known as morbidity, defined as a state of disease or pathology and expressed as a population-wide rate. Epidemiologic studies use morbidity as an endpoint: well (i.e., healthy) populations are typically followed prospectively (forward in time) in order to identify the proportion attaining morbidity. Exposure factors then linked statistically to morbidity are called risk factors because they are associated with greater amounts of disease; exposures associated with the population proportion remaining well are called protective factors because they foster the primary prevention of disease. In the context of natural history, health is the baseline prepathogenic state of people and populations typically sampled by epidemiologists and social researchers.

By contrast, the word healing designates a very different kind of endpoint. Actually, usages of "healing" are all over the map: depending on the author, it can refer to a process, an outcome, even an intervention, but rarely ever a status in the sense that "health" is used. The concept of healing, generally speaking, is used in biomedicine to refer either to the salutogenic process—the flipside of pathogenesis—or to the ideal endpoint of this process, whereby one is recovered, restored, cured, or otherwise set right. Unlike epidemiologic studies, clinical studies, including experimental trials, start with diseased people or morbid populations, introduce an intervention to a portion of these folks, then follow them forward in time to identify the proportion who revert to health. Those who do so are said to have been cured or healed, or to have recovered, due to the intervention. They have shifted their place, if you will, in the natural history continuum from a pathogenic to a prepathogenic status. In the language of the natural history of disease, the success of such an intervention is referred to as secondary prevention.

Clearly, the concepts of health and healing are two distinct entities. They mean entirely different things and are studied entirely differently. The important point for this article is that existing research on religion and health is almost all constructed in the context of the former, not the latter. The thousand-plus studies in this field conducted by epidemiologists, social and behavioral scientists, and physicians, nurses, and other clinicians are for the most part about identification of religious "exposures" that serve to lower the risk of subsequent morbidity or mortality or that are associated with higher levels of self-reported or diagnosed health status. Research respondents or subjects are not diseased people, for the most part, and studies rarely investigate the course of recovery from disease. Research designs are invariably cross-sectional prevalence studies or longitudinal population or community studies of normal folks, and the aim of analyses is to identify population-wide risk or protective factors. No one is being healed of anything, as there is nothing to be healed from, and thus no factors promotive of healing are being explored. Such studies therefore cannot and do not—and do not purport to—tell us anything about the healing power of religiousness, spirituality, faith, prayer, or any other religious construct.

The substitution of "spirituality and healing" as a label for studies of religion and health or of religion and morbidity or mortality is thus problematic in two distinct ways, one of which is especially egregious. While use of "spirituality" as a substitute for "religion" is frustrating to the present author as a religious scholar, and a sign of the degradation of the language, the substitution of "healing" for "health" is simply ignorant and is blatantly deceptive. It promises what has not been proven—that being religious or spiritual or a person of faith can somehow cure diseases—and substitutes feel-good bromides for empirical evidence. To summarize, there are two problems here: a problem of conceptual nescience or laxity regarding religion, and a problem of theoretical nescience or laxity regarding incorporated features, processes, and endpoints within the natural history of disease and how they are studied. To reiterate, the former is an unfortunate example of conceptual confusion; the latter is a potentially serious example of medical misinformation.

A couple of frustrating anecdotes exemplify this confusion.

About 15 years ago, the present author was lecturing at an alternative medicine conference and was introduced, to his utter embarrassment, as "probably the leading expert in the world on spirituality." Only in some strange alternative universe, perhaps! This author, to this day, has never written a single scholarly article devoted to the topic of spirituality, nor conducted any studies of spirituality, whether descriptive or related to healing, ever. There must be at least a thousand academic scholars ahead of him on the imaginary list of leading experts on spirituality.

A few years later, the present author wrote a popular book, *God, Faith, and Health* (Levin 2001b), summarizing existing research and writing on religion and health, emphasizing the social and epidemiologic studies spoken of in this article. Before the book went to press, the publisher had just one small request: to substitute the word "spirituality" for the word "religion" in every single instance in the text of the book, and, likewise, to replace the word "health" with the word "healing" throughout the book in the discussion of study results. The author, to be blunt, had a fit and refused, even offering to return the book advance. The publisher eventually relented. But when the book's proofs arrived, the author discovered that the book had a brand new subtitle: "Exploring the Spirituality-Healing Connection." In the interest of honest disclosure, there is hardly any content in the book related to an ostensible spirituality-healing connection.

Why does this matter? Besides the conceptual and theoretical errors inherent in confusing religion with spirituality and health with healing, there is an even more significant

reason to be concerned. To wit, very little empirical research has ever been conducted on spirituality and healing, despite claims to the contrary. This assertion may seem remarkable to casual observers of the religion and health field, but it is undeniably true. A recent review in a leading medical journal made much the same point that has been made throughout this article:

> Despite the consistency of findings, their meaning and significance are typically misstated and misinterpreted. This literature is based mostly on population-based epidemiologic studies. As such, research has identified religious characteristics of healthy populations that are associated with some level of protection against subsequent adverse health-related events. Unfortunately, through the mass media, this work has been given an unmerited clinical spin, such that "spirituality," usually undefined, is promoted as a powerful factor in "healing," ostensibly "proven" by the large scientific literature on the topic. *No such literature exists* (emphasis added) (Levin et al. 2006, p. 1168).

When we state that there is no substantial literature on the health or healing effects of spirituality, this references both the "real" meaning of spirituality and the neologistic one. Neither take on spirituality has ever been systematically or programmatically explored as a health-impacting construct. This is not to say that this would not be welcome. Quite the contrary. Either version of spirituality would be a marvelous topic for research in regard to health, well-being, or healing; it just has not occurred yet in any systematic way, occasional one-off studies excepted. The interconnections, if any, between spirituality and health or spirituality and healing would be well worth investigating, provided that such research were preceded by the necessary conceptual development and psychometric validation, which is still in its infancy for spirituality. Without such vetting, empirical investigations of its putative effects would be premature. As for healing, the idea of a field of study devoted to spirituality and healing is also quite appealing; but it remains for the future, no matter how much alternative medical practitioners and new-age healers insist that existing epidemiologic, social, and clinical studies of the preventive health sequelae of formal religious participation already tell us about the healing power of spirituality. They do not.

The Special Case of Prayer Experiments

The idea of spirituality and healing also tends to get further confounded with the controversial clinical trials of a purported healing power of distant prayer or nonlocal intention, noted above. Setting aside the specifics and merits of this research, which has been expertly deconstructed elsewhere (e.g., Benor 2001), such studies in turn also get confused with studies of religion and health in the eyes of the mass media, the lay public, and many clinicians and scientists unfamiliar with the field or with concepts like the natural history of disease or the levels of prevention. To many less informed commentators and critics, the existing studies of religion and health, the mostly nonexistent studies of spirituality and healing, and the controversial clinical trials of prayer are all the same thing. It bears repeating: these are dramatically different types of studies and they address dramatically different issues. True, they all explore the hypothetical relation of the spiritual domain and the human body. But, beyond that, they do not have much else in common.

Distinctions among concepts like religion, spirituality, faith, and prayer, on the one hand, and health, healing, and medicine, on the other, are familiar to religious scholars and

professionals and to medical and healthcare providers and scientists, respectively. But these same distinctions may be too discrete to decipher for many academics not trained in these respective areas. This conceptual laxity is not anyone's fault, and should not call into question the earnestness of anyone's research efforts. But this confusion has served to inform the way that some investigators have conceived of their research studies, selected their research designs and methods, conducted their analyses, and interpreted their results. Unless and until these conceptual issues can be straightened out, it may be wise to observe a moratorium on studies of healing and distant prayer. This recognition is becoming widespread. Even a longstanding supporter of these studies has recommended a "time out" until a summit can be convened that would bring together the top scientists interested in this field in order to hash out these issues (Dossey 2008, p. 24). If one would include a representative selection of social and clinical research methodologists, psychometricians, theologians, and religious scholars, then the present author would concur.

A few more words are in order about this contentious category of studies. Among thoughtful commentary on this work, a polarization of opinion can clearly be discerned. On one side are what could be termed the *universalists*, exemplified by the present author's friend Dr. Larry Dossey and other clinicians and scientists within the alternative medicine, consciousness studies, and mind-body fields. The universalists would state that if indeed prayer has demonstrably therapeutic consequences, as experimental studies seem to indicate, then this effect is not limited to pray-ers, pray-ees, or believers of any one faith tradition. The effect is potentially universal and no respecter of the religion to which one belongs or does not belong. As far as one can tell from the most vetted studies on this topic, this assertion seems to be true (see Benor 2001).

On the opposing side are what could be termed the *particularists*, exemplified by the author's friend Dr. Harold G. Koenig and other mostly conservative Christian clinicians and clergy (e.g., Tolson and Koenig 2003). The particularists, in contrast, would assert that it is not the act of praying that is therapeutic, but rather the response to prayer on the part of God. This response occurs supernaturally and is thus incapable of being studied by human methods. Moreover, it is not just anybody's prayers that merit such a response, but only those of a respectively favored group. In this literature, that group is typically Pentecostal, evangelical, or charismatic Christians. Prayer does not heal, they would say, only Jesus does. For many sincere Christian believers, this assertion does not signify any type of bias or narrowness of thinking, but is simply a statement of doctrinal faith and is non-negotiable. No disrespect is intended and, indeed, it could be asserted that such a position is in fact universalistic, in that the grace of a healing response to prayer is potentially available to anyone who joins the fellowship of the saved.

This author has over 150 books in his library on the subject of spiritual healing, however conceived or labeled, from sacramental Christian prayer to the work of bioenergy practitioners and Reiki healers to the colorful stories of charismatic saints and mystics and faith healers of various stripes—and all points in between. One is struck that across these various modalities there is much more in common here than the particularists might wish to acknowledge. Throughout the spectrum of spiritual healing there are identifiable traits among successful healers, such as a shared ability to marshal focus, intention, and compassion (see Levin and Mead 2008). Efforts have been made, as well, to taxonomize healers into a few simple categories (e.g., LeShan 2003). As troubling as it may be to acknowledge for some sincere adherents to respective faith traditions, the psychological and behavioral characteristics and concomitants of effective healers and effective healing work may be universal.

At the same time, there are considerably more dissimilarities and incongruencies among spiritual healers and in how they conduct healing than the universalists might wish to acknowledge. Petitioning God or Jesus for another person's healing, using one's hands to transmit subtle energies to a client's body or biofield, sending loving intentions by way of meditation or psychic means, performing the sacrament of anointing with oil, praying the *mi shebeirach* with a *minyan* or congregation, emitting external *qi* to a subject halfway around the world or somewhere in the future or past—surely these are not "all the same thing," as some would say. Notwithstanding the discovery of some common underlying "mechanism" of effect, whatever that might turn out to be, these modalities of spiritual healing are dramatically different from each other just on the surface, in terms of what is being done, much less in terms of underlying motives or beliefs or spiritual worldviews. It is difficult to comprehend how this point could be missed.

Where the particularist critique finds expression in discussion of the healing prayer research literature, much of it takes the form of orthodox Christian apologetics—a defense of the faith. For example, some have objected to these studies on the grounds that they appear to be putting God to the test, taking Him into the laboratory, as it were, which is felt to be offensive, even blasphemous. God is a divine being, He can heal through supernatural means, and His existence does not need to be—and cannot be—proven or disproved, nor validated in any way through empirical means (see Levin 1996). God will not be mocked, nor will He suffer validation! A thoughtful collection of essays on this issue, some quite strident, was published about a decade ago (VandeCreek 1998).

These objections, in turn, have been met with an earnest counter-critique (e.g., Dossey and Hufford 2005). Such studies are decidedly not efforts to prove or disprove a divine being; most investigators have undertaken these studies in the hope of identifying a potentially efficacious therapy or simply in order to gain some understanding of the nature of human consciousness. No one's intention has been to put God to the test. About that, the universalist position is clear: "Just as we would never use faith to validate our scientific data, we do not need science to validate our spiritual beliefs" (Dossey and Hufford 2005, p. 114). But another core element of the particularist stance is that some types of healing included in these studies are examples of paranormal ministrations, or are potentially evocative of occult or demonic forces, and thus not true prayer to God. Response to this assertion often takes the form of references to those Christians or theologians who approve of parapsychological research—sufficient reason that such studies should not "be breezily dismissed" (Dossey and Hufford 2005, p. 115). Maybe so, but the original criticism itself should not be so easily discounted. In many instances, it may not represent a fearful or cavalier dismissal of science or rationality or of an inconvenient truth, but rather a passionate apologetics on significant theological grounds. These grounds may have no currency among universalists taking part in the prayer-and-healing debate, but they may be of the most vital and unsurpassable importance to particularists.

There is nothing objectionable with the particularist critique, in and of itself, so long as it is acknowledged that it is not based on scientific arguments. It is a theological critique and one with considerable validity. But it has nothing to say about the validity of the designs or methods used in these studies nor about any other issues related to the conduct or quality of this research. This line of thinking is a reasonable motive for having second thoughts about these prayer studies, and there is much here with which the present author, a scientist *and* a religious believer, is in agreement. In advancing this position, however, one necessarily removes oneself from scientific discourse. So long as this point is made explicit, it should not be an issue for anyone. But it is concerning that an effort is sometimes made to mask an ideologically based critique in a patina of science—which is

not entirely earnest, as such critiques often seem based on an intentional downplaying of both empirical evidence and existing theory. This is unfortunate, as, in contrast to the largely nonexistent studies of "spirituality and healing," there is indeed a small and significant body of positive results from methodologically sound experimental trials of prayer (see Benor 2001), regardless of efforts to deny its existence. It would be extremely helpful to see some thoughtful and scholarly conservative Christian reflection on the meaning and implications of these findings.

Within the academic medical community, the waters have been muddied perhaps beyond repair. "Spirituality" and "healing," and their purported intersection, have been topics of some disrepute. While this may be due in part to the conceptual weakness of most of the prayer and healing studies and their regrettable confounding with population-based studies of religion and health, no matter. Neither of these two categories of studies, as explained, is really about spirituality and healing anyway. This area of the religion and health field has evolved a discourse more governed it seems by emotion and by prejudgments than informed by traditions of scholarship and research. Through the years, the resultant damage to the reputation of those religion and health studies that, as explained, have nothing to do with either prayer or healing probably perpetuated the perceived marginality of the larger religion and health field.

A few efforts to clarify these issues, such as in the present article, have been forthcoming, but not all have been successful. One is liable to find, on occasion, physicians and health scientists, without training in religious studies, both alone and in committee proffering definitions of spirituality; and new-age and mainstream writers, including humanistic and transpersonal psychologists, all promoters of spirituality, however conceived, without training in either public health or medical research, proffering definitions of healing. Both camps, moreover, continue to weigh in on the necessity or the folly of healing prayer studies on the basis of the kinds of mistaken notions detailed in this article. In the meantime, those investigators who have actually conducted about 90% of the research on the topic of religion and health remain mostly anonymous and the product of their work becomes fodder for the ideological battles of people who do not seem to understand what it is about and what it implies.

"All the Wise Men Thereof": Theology and Medicine

Within the past decade, a new pair of words has gained currency in this field. Alongside of religion and health and spirituality and healing, one is now beginning to encounter the phrase theology and medicine. This moniker represents something new and refreshing. An example of its use is found in the name of a program at the Duke Divinity School and in a new named professorship there. Use of this terminology has been an interesting and encouraging development. There is a welcome *gravitas* to "theology and medicine" that is admittedly lacking in the other configurations.

The word "theology" and the word "medicine," joined together, would seem to get at the crux of the matter: scholarly attention to the dynamic relations between these two institutions *qua* institutions. The phrase suggests scientific and scholarly research and serious intellectual discussion: critiques and analyses from perspectives and fields as wide ranging as social history, church history, rabbinics, history of religions, and the history and philosophy of medicine. The idea of scholarship focused on the interface of theology—the study of God and other "ultimate concerns"—and medicine—the art and science of the encounter with disease—is a provocative and invigorating respite from defining a field or

subject on the basis of the categories of independent and dependent variables used in research studies.

What would scholarship on theology and medicine ideally look like? An example of such discourse is found in *Heal Thyself* (Shuman and Meador 2003), an excellent work published a few years ago. The authors contend that the contemporary rapprochement between religion and medicine, while an encouraging trend, risks being derailed by the implicit presumptions of much of the religion and health research enterprise. "The religiosity of the contemporary rapprochement, as interesting and worthy of ongoing consideration as it may be," they contend, "is not identical to and is in many ways incompatible with what the Christian tradition has taught about sickness, health, and healing" (Shuman and Meador 2003, p. 6). More specifically, religion and medicine

> both are increasingly viewed as means for self-interested individuals to attain the nearly universal desirable commodity that is individual health. Health is thus not simply distorted by being separated from its properly communal context; it is also, to borrow the language of the Marxist critique, fetishized, meaning it is valued, pursued, and exchanged without reference to the persons or communities who produce it or to its proper place in a hierarchy of the goods of a society committed to pursuing a substantive account of human flourishing (Shuman and Meador 2003, p. 6).

This is precisely the tenor of discussion that needs to ensue for the religion and health field. All of us involved in this field, especially as empirical researchers, need to step back and rethink a lot of what it is that we are doing. *Heal Thyself*, for one, suggests a litany of questions that ought to be posed and that generally have not been. These are not that complicated really, so it is all the more disconcerting that such things have not been systematically considered up until now. For example: What do these findings mean? Why are we doing this research? To what end(s)? What do we expect to learn? Does this research even serve to answer our questions? What are the implications both for the human encounter with religion (and God) and for the future of medicine and the healthcare domain? *Heal Thyself* should be required reading for anyone seeking to become an informed consumer of or participant in religion and health research. While written from a normative Christian perspective, many of its conclusions would not be out of place in contemporary rabbinic discussions of Jewish morality and social ethics.

There are many other outstanding examples that would qualify as writing on theology and medicine, even if such phraseology is not explicitly used. *God, Medicine, and Suffering* (Hauerwas 1990) and *Problems of Suffering in the Religions of the World* (Bowker 1970) are passionate meditations on the sources and amelioration of suffering, from Christian and comparative-religion perspectives, respectively. The theodicy issue is also valuably raised in these works, as it often is in rabbinic and other contemporary Jewish writing. For example, *Healing and the Jewish Imagination* (Cutter 2007) is a collection of essays on the theological grounding of the Jewish healing movement. It contains much fruitful dialog on the implications of classical Jewish perspectives, from canon and from the rabbis, for how contemporary Jews ought to confront important issues related to health, illness, and healthcare, both personally and collectively. Policy-related discussions are especially emphasized, in accord with Judaism's traditional focus on pursuit of *tzedek* (justice) and *chesed* (mercy) as communal values. Another uniquely Jewish discussion is found in the extensive literature on the relation of *halakhah* (Jewish law) and bioethics. One representative text, *Health and Medicine in the Jewish Tradition* (Feldman 1986), was published by the Park Ridge Center for Health, Faith, and Ethics as part of a monograph

series of historical, bioethical, and theological discussions in each of the world's major faith traditions.

Institutional Judaism has been especially receptive to the idea of fostering scholarship and intellectual discourse on theology and medicine. The recently founded Kalsman Institute on Judaism and Health, located at Hebrew Union College-Jewish Institute of Religion, is uniquely situated as an academic department within a major rabbinic seminary and graduate educational institution. It was established as a home for training, collaboration, and dialog on health, healing, and healthcare within a Jewish religious context. Its work is focused in five substantive areas: pastoral care education, spirituality and healing, bioethics, congregational programing related to illness and wellness, and Jewish policy responses to the organization, delivery, and financing of healthcare. Especially encouraging is that the Institute is transdenominational—that is, it collaborates with Jewish religious and educational institutions across the various branches of Judaism. Its centerpiece is a network of nearly 200 partners—rabbis, theologians, physicians, scientists, and other professionals, mostly but not exclusively academics—that serves as a kind of ongoing think-tank for the Institute and for the emerging field of Judaism and health. This could, and should, serve as a model for other such collaborative efforts within the major faith traditions.

The desirability of such discussions is based on more than just their esthetic appeal. The continued relevance and acuity of empirical research efforts depend upon the input provided by folks with a considerably longer view of what really matters. The idea of bringing together theological and pastoral scholars, pulpit clergy, and bioethicists with historians and philosophers of medicine and with public health, gerontological, and other sociomedical investigators for reflection and debate would do more to advance research than the introduction of some new data-analytic innovation for use with survey sample data. Such a forum might provide an especially welcome respite from another round of hopeless implorations by the best social scientists in this field for the mass of clinical researchers to begin attending to theory and to possible mediating factors in their data analyses. Each of the partners to such a dialog would have much to learn from the others.

Discourse on theology and medicine can serve as such a forum. Discussions can encompass the widest range of missions, including empirical investigation of religious expression in any of its nuanced forms (including, yes, even spirituality), in relation to all manner of health-related outcomes and addressing myriad concerns, from the clinical to the preventive to health services and bioethics. Such a forum would also prioritize the more qualitative, discoursive, and narrative explorations of the interface of faith or spirit with the life of the body as found primarily in the gerontology literature (e.g., Kimble et al. 1995; Thomas and Eisenhandler 1994), bringing this work to wider attention. Speaking of "theology and medicine" is also preferable because it reminds us of what, for many of us, may be the ultimate mission of this kind of scholarly work: service to the Divine for purposes of enhancing the life conditions of our fellow humans; or, if one prefers, the other way around: service to our fellow humans for purposes of glorifying God.

"Theology and medicine" implies something of a higher octave of religion and health discourse, more attuned to fundamental issues and principles that are often glossed over or ignored in the mundane research endeavors that constitute so much of what goes on in this field. But a caveat: like Pharoah's wise men, from whom this section of the article gets its name (Genesis 41:8), the musings of theologians and physicians are limited in what they can accomplish. They can help us navigate some issues, but not others. Basic research can tell us certain things that theological reflection cannot. We thus stand to gain from continued research on religion and health and we would benefit from research on spirituality

and healing, notwithstanding the reservations expressed earlier. But without more sustained theological, historical, philosophical, and ethical reflection, these areas of research risk enfeeblement and devolution into disconnected exercises in empiricism.

Conclusion

There is room for all three conceptions of this field. Religion and health has been the longtime umbrella term for the field and it has served well. As noted earlier, it takes a "big tent" approach to the subject and is able to encompass most of the activities and discussions that fall under its rubric. "Religion and health" implies a connection between religious identity and practice and the physical and mental health status of people and populations. That covers a lot of ground, and accurately reflects the scope of existing research and scholarly writing.

Spirituality and healing, as noted, is the preferred usage in the alternative medicine world, for better or worse. As discussed, despite its desirability, there is very little empirical support for such a notion. But that is not to say that there is no reason to believe that such support may be forthcoming. It may well be. "Spirituality and healing" implies a connection between the extent of one's piety or adherence to a normative path of religious growth and the curing of or recovery from disease. This is a provocative hypothesis and well worth exploring, but perhaps too narrowly cast to serve as a valid descriptor for the now century-plus-old religion and health field.

Theology and medicine is much less widely used, primarily in the Christian seminary world, and even there is not that commonly encountered. It suggests a wider take on the intersection of religion and health, much as spirituality and healing implies a significant narrowing of focus. "Theology and medicine" implies a connection between our understandings of the nature of God and the human spirit, on the one hand, and the institution of medicine, the healing arts, and human well-being, on the other. For the reasons just noted, there is much to explore here. These words suggest a deeper intellectual engagement of the bigger picture and of broader, more universal themes. Whether or not this name is ever used, these themes should point to the future of the field, rather than the same old religious empiricism or more "unmoored" new-agey spirituality.

Before that can happen, however, we must get straight that these are not just different names for the same thing. Rather, they designate distinct ideological positions with concomitant methodological approaches, even if more implicit than explicit. Regardless of how we language what we do and what this field is about—and there will probably never be consensus, nor would that necessarily be desirable—it is important that we think about and clarify our language and our intentions. We must stop tossing around words like religion, spirituality, faith, and prayer as if they were interchangeable, preferring one to another because of some ill-defined notions about these words' presumed respectability. And we must *definitely* not confound the concepts of health, healing, prevention, curing, medicine, healthcare, wellness, and so forth; the consequences here are not just theoretical, but potentially life-impacting.

Other combinations of words have been used to describe work in corners of the religion and health field. These suggest new and useful interconnections worth exploring further. "Religion and medicine" has been used to refer to connections between personal and institutional dimensions of religious expression and the practice of medicine and delivery of medical care, including bioethical discussion. "Spirituality and health" has been used to refer to a connection between one's religious journey or the extent of one's piety and one's

physical and psychological well-being. This is becoming a popular phrase and is a more desirable and realistic usage of spirituality than conjoining it to "healing." "Faith and healing" has been used to refer to a connection between expressions of Godly belief, trust, and obedience and the remission of disease or any type of pathology. Finally, "theology and health" has been used, less frequently, to refer to a connection between one's understanding of or relationship with God and one's physical and psychological status.

A thoughtful combination of some of the above is found in the name of the SSTH, the new professional society for the religion and health field. The founders, Drs. Keith G. Meador and Harold G. Koenig, selected the phrase "spirituality, theology, and health," which is an accurate and meaningful reflection of the wide scope of intellectual content to be considered by the Society. It also avoids the lamentably negative connotations of the word "religion" in some academic circles, as well as the limitations implied by use of the word "medicine" for non-biomedical researchers in the health sciences. "Spirituality, theology, and health" was thus an apt choice to select as the name of a professional society seeking the widest audience. The Society's home base, the similarly named Center for Spirituality, Theology, and Health, located at Duke University, has as its motto, "Seeking to understand spirituality, health, and human flourishing." This phrase is intentionally evocative of Aristotle's *eudaimonia*, and thus serves to anchor "spirituality, theology, and health" in the classical world. Time will tell if it supplants the other various names used to describe the religion and health field.

For a spirituality, theology, and health field to truly flourish, there are particular voices that need to be heard more prominently. Front and center is that cadre of scholars trained in each of the various disciplines that have been cobbled together to construct the research end of this field. This includes those practicing clergy, theologians, scientists, or clinicians who are uniquely credentialed with academic or professional degrees both in religion or theology and in medicine and/or public health including training in the methods of epidemiology or population-based research. Naturally, this is an unusual combination of educational credentials and there are not many such individuals. But as this field continues to expand, their ranks continue to grow.

Among the most frequent contributors to the research literature on religion and health, examples include Drs. Keith G. Meador, David R. Williams, and Peter H. Van Ness. Each has advanced training in theology and in public health and has been publishing research in this field for many years. The field would benefit from these sorts of living exemplars of multidisciplinarity and interdisciplinarity becoming more vocal in the face of a discourse that seems to have been taken over by competing groups of disputants who each, in their own unique way, do not seem to be fully informed when it comes to the subject of religion and health.

Among the top tier of quantitative researchers in the religion and health field over the past two decades has been a cadre of sociologists with joint specialties in the sociology of religion and medical sociology and a smaller group of psychologists specializing both in the psychology of religion and in clinical, counseling, developmental, or health psychology. These folks have been leaders in bringing together scholarly work in religious theory and assessment with the methods of social and behavioral research, especially as applied to physical and mental health outcomes. But these folks for the most part have judiciously eschewed the sometimes off-track debate among the various factions noted earlier, especially in regard to the controversial prayer experiments and discussions of the neologistic "spirituality." The desire to avoid these contentious or dead-end conversations is surely understandable, but, as a result, the voices of the leading experts in religion and health research have gone largely unheard. These folks need to be heard more widely, as well.

There is no intention here to convey an impression that only those with multidisciplinary training or expertise "get it." Not so. There are theologians, such as Dr. Stanley

Hauerwas, and pulpit clergy, such as Rabbi Samuel E. Karff, who speak with great authority and erudition and have been allied with academic medical institutions. Their voices are useful correctives to misperceptions about normative Christian and Jewish expressions of religion, respectively, that permeate religion and health research. Thankfully, for this field, Dr. Hauerwas is affiliated with the Duke Center for Spirituality, Theology, and Health, and Rabbi Karff is affiliated with the McGovern Center for Health, Humanities, and the Human Spirit at the University of Texas Health Science Center at Houston, where he serves as associate director.

The leading voices in the religion and health field among the respective camps of alternative medicine advocates and conservative Christian physicians are Drs. Larry Dossey and Harold G. Koenig. They are prolific contributors to the wider religion and health discussion and, thankfully, they both well understand, for example, the distinctions between population-based research of religious involvement in healthy populations and experimental trials of prayer interventions in clinical samples. For reasons detailed earlier in this article, despite their common advocacy of religion and health research, they are often viewed as on "opposite" sides because of their divergent opinions about the value of the literature on prayer and healing. Their differences of opinion here are not to be glossed over, but it is instructive to recognize that, in the worldview of the skeptics, Dossey and Koenig would be thought of as two peas in a pod. Both inherently value the spiritual quest and both believe that the methods of science can inform us about instrumental functions of the human spirit for health-related ends. Far more joins them together, and those allied with their viewpoints, than separates them.

It would help for all of us who care about the religion and health field to keep in mind that we are a part of a joint enterprise that, while nuanced and diverse, represents a sea change for Western biomedicine. Ultimately, as for all such shifts, there is an implied challenge to an existing ethos, in this case the philosophical materialism that in part defines biomedicine (see Levin in press). If some of us chip away at this ethos via languaging salient effects in terms of God or faith or spirit; others in terms of consciousness or energy or nonlocal mind; and still others in terms of measurable religious beliefs, attitudes, and behaviors, let us never forget that there are forces that see us all as a common threat to be marginalized or extinguished.

It is also important to recognize that research on religion and health can only tell us so much. It can instruct us and guide us in recognizing the salutary value of certain forms of religious expression or involvement. It cannot, however, provide answers to ultimate questions regarding the transcendent meaning of life. Nor can it validate the specific truth claims of faith traditions. If folks are looking to science or to particular manipulations of scientific data to adjudicate and interpret the relation of spirit to flesh, or the nature of God's relationship to humankind, or some other similarly lofty religious ideal, then they are probably looking in the wrong place. But if they are looking for evidence that faith or spirit matters—that features or elements of the religious life of individuals and communities exert measurable influences on other dimensions of human experience, notably markers of the experience of physical and emotional well-being—then that evidence exists in abundance.

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