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Decline in Religiosity: A Public Health Crisis

Boateng ACO[1]*, Britt KC[2], Schwartz BK[3], Xiao C[4], Oh H[5], Epps F[6]

[1]*Department of Biobehavioral Health Sciences, University of Pennsylvania School of Nursing, 418 Curie BLVD, Philadelphia, PA, 19104, USA*
[2]*School of Nursing, The University of Texas at Austin, 1710 Red River Street, Austin, USA*
[3]*School of Nursing, Azusa Pacific University, 701 E. Foothill Blvd, Azusa, USA*
[4]*Rory Meyers School of Nursing, New York University, 433 1st Ave, New York, USA*
[5]*Department of Epidemiology, University of Michigan School of Public Health, 1415 Washington Heights, Ann Arbor, MI, USA*
[6]*Nell Hodgson Woodruff School of Nursing, Emory University, NE Atlanta, USA*

Abstract

Over the last two decades, high income countries like America have seen rapid decline in religiosity among its people leading to a decrease in both public and private religious practices. Considering the health benefits of religiosity, this spiral change presents serious public health challenges for the future of healthcare. Using evidence from current literature, we explored the intricacies of religiosity and its association with healthcare development and health outcomes. We argue that the decline in religiosity is a public health crisis and recommend (1) public health professionals and nurses explore the religious histories and practices of communities and how that might influence medical or health decisions, (2) the assembly of an expert panel to standardize the conceptualization and assessment of religiosity across multiple disciplines especially in public health and nursing education to improve cultural sensitivity in spiritual care, and (3) assessment should address the spirituality of the individual and not the state of their religiousaffiliation to ensure a model of holistic patient-centered care.

Keywords: Public health; Nursing; Religiosity; Crisis; Spiritual Care

Introduction

Over the last two decades, high income countries like America have seen rapid decline in religiosity among its people [1]. The health impact of such decline has not received much attention in part due to lack of funding for research grounded in religiosity [2]. In addition, there is confusion around how religiosity is defined and used in research as well as clinical settings, [3] and reluctance from the scientific community to recognize religiosity as a social determinant of health and its integration into care [4]. However, the link between religiosity and health has attracted more attention in the last decade. Increased rigor in research and scientific methods have shed light on the association between religiosity and health outcomes. In this commentary, we explore the intricacies of religiosity association with healthcare development and health outcomes. We argue that the decline in religiosity is a public health crisis and conclude with recommendations specifically within public health nursing to ensure a model of holistic patient-centered care.

Brief history of the role of religiosity in healthcare development

Religiosity is defined as beliefs, practices, rituals, and ceremonies held or practiced in private or public settings in relation to the transcendent [5]. Such religious exercises facilitate closeness to the transcendent and foster an understanding of one's relationship and responsibility to others in living together in a community [6]. Religiosity and medicine are intricately intertwined. In fact, the origins of medicine have deep ties to religion. Centuries ago, religious organizations built the first hospitals and provided physician-clergies and nurses to run hospitals. In 2016, 18.5% of hospitals in the United States were religious-affiliated as a result of this unique relationship [7].

Likewise caring for the sick and poor originated from religious teachings. For example, the Quakers from Philadelphia established the first private hospital to treat people with mental disorders. The Quakers also started "moral treatment" in response to abuses in mental health institutions which was later adopted by other hospitals [8]. The very foundation of medicine and nursing were derived from the religious ethos of charity. However, in the 1880s, the relationship between religion and medicine started to fall apart especially in the field of psychiatry [9]. The effect of such fallout has negatively impacted nursing and other health professions [5]. Although the fallout between religion and medicine has increased over the years, the spiritual needs of patients continue to rise. There is a need to reclaim the spiritual roots of medicine and nursing in order to provide person-centered care.

Association between religiosity and health outcomes

A growing body of literature supports the association between religiosity and health outcomes [6,10,11]. These findings not only extend to mental health but physical health as well. The mechanisms through which religiosity appears to affect these outcomes include influencing individual behavior and medical decisions, reducing stress as a means of coping, providing social support, and affecting one's vision, outlook and sense of meaning in life [12]. Across mental health outcomes, religiosity promotes positive psychological concepts such as well-being, sense of control, hope, optimism, and self-esteem with studies reporting negative associations with depression, anxiety, and suicide [5,11,12]. Individuals who engage in religious practices also benefit from a meaningful form of social integration that has the potential to contribute to healthy behaviors, greater longevity, and enhanced psychosocial well-being [10]. Religiosity is also associated with healthy social behaviors, greater exercise, increased marital stability, and reduced risky lifestyles (i.e., less cigarette smoking, risky sexual activity, criminal behavior, and substance abuse [5]. More studies are reporting associations with physical health outcomes such as lower risk of cancer, stroke, coronary heart disease, hypertension, all-cause mortality, and positive connections with cardiovascular health, endocrine function, immune response, cognitive function, and functional health [5,6,11]. These findings support the many health benefits provisioned through an individual's devotion to their beliefs, practices, and rituals related to the transcendent.

***Corresponding author:** Augustine Cassis Obeng Boateng, Department of Biobehavioral Health Sciences, University of Pennsylvania School of Nursing, 418 Curie BLVD, Philadelphia, PA, 19104, USA; E-mail: boateng@nursing.upenn.edu

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Decline in religiosity as a public health crisis

Increasingly, it has become commonplace for leaders to declare a wide and diverse array of issues as a public health crisis. These declarations have resulted in an ongoing discussion as to what exactly constitutes a public health crisis within the academic community [13]. According to the Oxford Handbook of Public Health Practice, a public health crisis is defined in three parts. One, it is an acute event that requires an immediate response; two, the event is expected to imminently lead to death, infectious disease morbidity, property destruction, or population displacement; and third, it overwhelms the capacity of local systems to do the job of maintaining a community's health [14]. We argue that declining religiosity is a public health crisis that meets the above criteria.

Religious affiliation has been on the decline over the past few years in the United States. According to The Pew Research Center, the ever-growing group of people who have no religious affiliation, otherwise known as the "nones" which include atheists, agnostics or people who follow nothing in particular, make up 23% of the population [15]. Decline in religiosity has expectedly led to a disconnect between people at all levels, whether it is a secular doctor taking care of a religiously devout patient or a religiously motivated vaccine misinformation campaign [14]. The impacts of these situations are uncomfortable at best and at worst, traumatic and life-threatening. It is important to note that these circumstances are not new, as indicated by the long, storied, and often troubled relationship between public health and religion. However, a rapid decline in religiosity may lead to a marked increase in frequencyof these situations. In other words, there is an increasing need to respond to these circumstances with training and prudence.

Furthermore, a decline in religiosity will likely lead to a decrease in health and overwhelm the capacity of local systems to do the job of maintaining a community's health. There are significant longitudinal studies that have found religiosityto be stronglyassociated with a decrease in all-cause mortality [15,16]. Religiosity acts as a protective factor in a variety of different contexts and remains at the heart of many communities, particularly those that have experienced political and socioeconomic marginalization. The same is true among racial and ethnic minorities. For example, a study found that being Black is indirectly positively associated with mental health through organized religiosity and indirectly negatively associated with physical and mental health through non-organizational religiosity [17]. In that same study, being of Hispanic origin was associated with worse self-rated health but indirectly positively associated with mental health through organizational religiosity.

At the height of the Covid-19 pandemic, 41% of U.S. adults reported at least one adverse mental or behavioral health condition, and one in four in the youngest adult group (ages 18 to 24) had considered suicide in the last 30 days, while the same group had the largest drop in church membership amongst all age groups in recent years [18]. Recently, a national poll found two religious subgroups lagging behind the national average in vaccination rates by more than 10%; however, there was from 11% to 24% increase in vaccination acceptance rates across all religious subgroups from March to June. In that same poll, nearly four in ten vaccine-hesitant Americans who attend religious services at least a few times a year say one or more faith-based approaches would make them more likely to get vaccinated. This underscores the intricate relationship between religiosity, health decision-making and health outcomes, in particularly the decline in religiosity in the younger generation and how this impacts their health [19].

While the majority of literature on religiosity is cross-sectional in nature, there have been numerous well-designed longitudinal studies in recent years implicating religiosity in different health outcomes, possibly suggesting a causal relationship [12]. Ignoring the decline in religiosity in the U.S. may perpetuate and exacerbate health disparities. While it is unlikely that a decline in religiosity will lead to an immediate and outright collapse in the local health system, we argue that it will continue to have significant, subtle impacts on the U.S. health infrastructure, particularly if religiosity is viewed through the lens of a social determinant of health [20]. The impact of religiosity on health lies between the important and the immediate, whereby distinction between these must be made [21]. The immediate almost always comes in the form of downstream interventions that tackle urgent issues directly affecting health but may not encompass the root cause of the disease. The important, on the other hand, are not necessarily urgent issues but remain fundamental to health. As a social determinant of health, it is critical to view the decline in religiosity as an important issue that has the power to profoundly impact individuals and communities on a systemic level.

The role of public health nurses in advancing spiritual care

The role of the Public Health Nurse (PHN) has significantly come to the forefront amid the COVID-19 pandemic. The PHN has been working in the background to advance the health of populations, communities and the individual through prevention, advocacy, education, research and policy development since the days of Florence Nightingale. PHN's collaborate with faith-based partners to advance the health of religious communities. In light of the growing downward trend of religious affiliation, it is imperative that the PHN understand the current state of religiosity in the United States. With the downturn of religious attendance during the COVID-19 pandemic it is time to focus on the spiritual health of individuals. PHN's have the unique ability to utilize the core public health functions of assessment, assurance and policy development to increase the spiritual care of their clients. Utilizing a spiritual assessment such as the Spiritual Well-Being Scale will assist the PHN to understand the individual's spiritual health status in the absence of religious affiliation [22]. Assuring individuals have the resources to care for their spirits that strengthen the mind-body-spirit connection such as yoga, breathwork, nature walks, meditation, and recovery support groups are increasingly important when people are not attending religious services. Finally, the PHN is able to work alongside the religious institutions in their jurisdiction to provide policies that will allow people to worship together safely, all the while educating the leaders about how to care for their congregations in a holistic manner while we grapple with a pandemic that may remain with us for quite some time. The PHN is a valuable resource during these times of uncertainty in our world and is relevant in the state of the decline of religion in the United States [23].

Recommendation and Conclusion

Accumulating findings on religiosity show multiple health benefits across mental and physical health outcomes. As younger generations begin loosening their embrace on beliefs and practices related to the sacred or transcendent, one wonders what the future will show. The protective and positive benefits provided through religiosity will decrease which could result in a steady decline in health behaviors instilled by one's devotion to their religion, fewer stress-reducing coping mechanisms, and less abundant positive psychological concepts, resulting in accumulating health risks triggering a public health predicament. Unless we maintain some sort of relationship with the benefits provided through religious activities and practices, we will lose much ground in our fight for improving health outcomes and

healthcare across the population. The complex construct of religiosity is taxing to empirically study; however, the impact of religious beliefs and practices has been shown to influence society's belief systems.Now is the time to assess and address the religious and spiritual needsof our nation. Public health professionals and nurses should explore the religious histories of communities and be mindful to religious practices that are important to these individuals acknowledging the positive association between religiosity and health outcomes. We recognize religious practices might not benefit all people but strongly recommend patients be assessed for religiosity. An ethical way of providing religious and spiritual care is refraining from imposing one's own beliefs and assumptions on a patient. To ensure that healthcare workers especially public health nurses are comfortable and best prepared to provide religious and spiritual care, there is the need to incorporate religiosity and spiritual care education in public health and nursing education curriculum. To that end, we are calling for an expert panel that will standardize the conceptualization and assessment of religiosity across multiple domains. Such assessment should address the spirituality of the individual and not the state of their religious affiliation. If we don't act now, not only will the health landscape drastically change, but we may all suffer from the consequences.

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