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Podcast Transcript

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Nonreligion, Religion and Public Health

Podcast with **David Speed** (22 April 2019).

Interviewed by **Thomas J. Coleman III.**

Transcribed by **Helen Bradstock**.

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Thomas Coleman (**TC**): *Thank you for joining us today on the Religious Studies Project. I'm Thomas Coleman. And I have an interesting topic that I don't believe we've broached before, on nonreligion and public health. And I have a special guest with us today to talk about this. But I kind-of wanted to provide the Listeners with a little bit of background first, before we introduce him. So the link between religion and public health is really a recurring theme in the empirical literature within the psychology of religion, public health, medical studies and other disciplines. This research is often limited to correlational studies because the procedures required to test these things experimentally are either unfeasible or raise serious ethical considerations. For example, as psychologists it's really hard for us to figure out how we could validly manipulate someone's nonreligious or religious identification, their beliefs or their behaviour, in a laboratory setting. And university ethics committees have a problem with us kind-of assigning people to the cancer condition for an experiment. So we can't do that! But when many of these affirmation correlational studies – some of which we'll talk about in a second – identify a relationship between religion and improved health, religion is often interpreted to be an important causal factor. And in today's podcast I'm pleased to have with us Dr David Speed who is an Assistant Professor at the University of New Brunswick. And his own research has applied a critical perspective to the religion and health literature, specifically focussing on how the nonreligious have comparable health to the religious. David, welcome to the Religious Studies Project.*

David Speed (**DS**): Hi Tommy. Thanks for having me.

TC: *Excellent, excellent. So I was hoping we could have a little discussion along the lines of religion, nonreligion – kind-of the intersection on public health more generally – but also from the perspective*

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of just psychological and individual's health.

DS: Sure.

TC: *And I know – just pointing out some further relevance for the Listeners here – in the US I think the Department of Defence has a multimillion dollar initiative looking at "spiritual fitness training" and in screening of troops. And I can see David grimacing right now! But you know, this underscores an important fact that many governments and public health researchers are not simply interested in understanding or studying the relationships between religion and health, but actually using the purported benefits of religion and spirituality to shape public policy. And then, a last example here, I'm reminded, because I've been living in the UK off and on for the past two years, of how the United Kingdom has recently funded mindfulness meditation interventions I think in over two hundred county wide schools. So I'm excited to get down to a critical discussion about the nature of religion and health with you David and see where it goes.*

DS: That sounds wonderful.

TC: *So where does some of your own research fit in at the nexus between religion and nonreligion, and personal health and health in general?*

DS: So I guess I can start with my dissertation. I started my PhD in 2011 and I graduated in 2015. And when I got accepted into my PhD programme I was told by my adviser I had to pick a health-related topic. And like many grad students I didn't really know initially what to study. I knew I wanted a PhD but wasn't sure what I wanted to study. And essentially, I got to the point where I was considering, well, if I could study anything, what would I want to study? And I had a pre-existing interest in atheism and in religion and so I was like, "I wonder how those things relate to health?" And so you go to the literature, as one does. And I immediately found literally hundreds of thousands of citations or references to various religions. So I thought "Well, ok. Obviously someone's been very busy!" Because this was my first real exposure to it. And then I was like, "OK, well I'm curious how atheism fits into this." And I found, I think, fewer than maybe a dozen papers, two dozen papers addressing atheism and health. So right away I knew that there, obviously, just on the numbers scale, atheism and health was under-studied (**5:00**). So I was curious about how atheism fits within the religion and health paradigm. And I started going through the literature. And over and over again you see this recurring set of findings that you've alluded to in your intro, that "Religion equals better health; religion equals better health." So, going to church is good, being religious is good, prayer is good, meditation is good,

spirituality is good, religious affiliation is good, belief in God is good, yadayadayada!

TC: *So, could you give us a few examples there, though? Because I was very general about that – where these relationships appear.*

DS: Sure, so if you're looking at, say, church-based studies, you'll find that religious congregants who attend church more frequently are more likely to report, say, lower levels of depression. They might report better perceived well-being. If you're looking at national studies you might find that people with higher levels of church attendance report better happiness. It varies from country to country. There's a cultural effect that happens. But a lot of the positive literature really centres around the US where religion tends to be more dominant. There's a smaller proportion for Canada, and the UK, and other areas. But generally, a lot of these studies just kind-of recurrently suggest that if you go to church, or if you're religious, you might be more likely to go for screening behaviours for cancers; if you're religious you might be more likely to feel empowered; if you are religious, or if you believe in God, you are more likely to be comfortable in a situation where you have to face your own mortality. Something like that.

TC: *And so you're kind-of reviewing the literature, here, as you're doing your doctoral studies. And you uncover this stuff, and what happens? What has happened since then? What did that prompt you to test, do, or dig in deeper?*

DS: So as I'm going through the literature, there's a few things that I start noticing kind-of simultaneously. And what it was is, you know, you read a few papers and you say, "Ok. People are saying that going to church is good. Ok that's fine. Whatever. They're generalising by accident." But whatever. So you go through a few more and then you're like "Wait a minute. Wait a minute." So a lot of the studies – not all the studies, but a good chunk of the studies – they recruit from exclusively religious samples. So they'll go to different church locations, they'll ask congregants who are there, "How often do you go to church?", "How happy are you?" and they'll form a correlational relationship between these two ideas. And correlational research is not that. It's difficult to make a causal argument with correlational data, but you can point to associations that are recurring. But if you are using an exclusively religious population in order to test something, you can't generalise the benefits of whatever they're doing to everyone, because not everyone's part of that exclusive religious population. So if you sample like five Methodist churches in the Midwest, you can't then say, "Well, everyone should go to church because of this sample." You have to say, "Well, people who go to Methodist churches more frequently, congregants have better wellbeing." That's a fair conclusion. Now often the

literature would say this in kind-of a round-about way. But they would often talk more broadly about the benefits of going to church, or the benefits of being religious, or prayer, or whatever. The other issue too is a lot of the research that is like large-scale is looking at outcomes that are intrinsically related to going to church frequently. So the classic one on this is slighting on the dependent variable. And self-rated health is one of the big benefits of being religious, or of scoring higher on measures of religion and spirituality or RS. So what researchers will do is go into say a religious organisation and they'll say, "How often do you go to church?", "How healthy do you think you are?" Or "Do you have any health issues?" They find that people who go to church more frequently report better perceived health and fewer health issues. Well, yes! Obviously! Because people who are really ill or people who have recurring health issues can't get out and go to church frequently. That's not shocking. It's kind-of pointing out that, I don't know, people who are going through some sort of medical treatment are somehow less healthy than people who don't have to do that. Obviously they're going through medical treatment because of the way they are, not because of some factor that's driving the magic of that medical treatment! So this is a separate issue altogether is that if you're slighting on the dependent variable, what essentially you're going to do is that you're limiting people who maybe on the lower end of that health, who would love to go to church more frequently but can't (**10:00**). And the other issue with it – sorry I'm just rattling off a list of issues because this is my life!

TC: *No. Perfect.*

DS: Another one of the issues is that there was often a conflation of low religiosity with secularism. So it's the idea that if you get really low levels of religiosity, so like: "I'm not religious, I don't go to church, I don't really pray", the implicit conclusion or sometimes explicit conclusion of the researchers who do that kind of research would say, "Oh. These people embody secularism." That is not an equivalent statement. The issue with that is, secularism is adhering to or taking specific positions on other topics, right? It's not merely being apathetic towards religion, it's endorsing other specific values that are more secular in nature. So there's this conflation of low religiosity with secularism. So researchers will report, "You know religion's healthier than secularism." But they're not assessing secularism the vast majority of the time. They're just equating high secularism with low religiosity.

TC: *And then we might say, more specifically, just secular nonreligious people per se. Because we're used to, on the Religious Studies Project of course, taking a very critical approach to these terms. That's something we don't usually do in Psych of Religion although we should more. So just kind-of giving that to our Listeners as a blanket term here, you know, confusing people who probably self-*

identify as secular nonreligious with actually people who would identify as religious.

DS: Yes, absolutely. The biggest issue, though, for the research is that the mechanism driving the relationship between religion and health isn't always clear. The big one that has the most support, I would argue is social support.

TC: *Yes, I was going to say, what do mean by mechanism, here, in terms of driving? How does that work?*

DS: Sure. So if you say that Advil is related to pain reduction, right? Advil is doing something – or Ibuprofen if we want to be non-brand specific – Ibuprofen is acting on your body in some biological way in order to produce the desired outcome. If the argument is that religion is connected with health, well, *how* is it connected with health? We can point at an association of high religion, high health, but why is that? What is the driving mechanism under-pinning that relationship? And arguably the strongest contender for that, from what I can see, is social support. And social support is associated with health. Social support is the perceived availability of resources around you from people. So I'm crying and I call my friend, will he or she console me? If I need money for rent until next week, will my friend have my back? If I really want to share about my day, will my wife humour me and listen to me talk about research for the 35th time that week? So that's social support. So the more available social support a person has, and the higher degree of availability, the healthier they are. And this isn't shocking. Like, having friends around you and having family and peers who you can rely on, that's associated with good health. Religion's associated with good health, this is true. But social support is also associated with religion. So people who are religious tend to report higher levels of social support. And to me this makes a lot of sense. Like, it would be astounding if you went to church on a weekly basis, or mosque on a weekly basis, or synagogue on a weekly basis and there was no social benefit to you. It would be astounding if that were the case. So the problem is . . . because the three of these things are inter-related, when you're talking about social support. When we talk about religion benefitting health, a question that's really important for researchers is "Why?" And if it's social support, it gets more dicey about how we're interpreting this then. Social support is a general benefit of social activities. It's not a specific benefit of religion and spirituality.

TC: *I was just going to get to asking that. Aren't there some arguments that, maybe, religion is not the only source but, people might argue, a very good source of creating these social connections? How does that kind-of bode here? No – it's not religion per se, but it is a really being driver of social connectedness?*

DS: Sure. And I think that's a very reasonable position to take. About half of my family I would describe as quite religious. They tend to go to church frequently. They tend to really enjoy church. But often they're talking about. "So this happened in church . . ." or "So and so said this . . ." "I really like engaging with this person." And it would be. . . . I think it's a fantastic way of socialising with like-minded people. I think that's wonderful (**15:00**). The problem is, is that the way this is presented within findings, and the way you often see justification for religious-oriented policy, say, like from government or from specific initiatives looking at improving spirituality in the fine young men and women of the United States is that you might see this as saying, "Oh well, religion is doing this." It's not social support via religion. It's just religion. So last year I wrote a paper about this where I was discussing that it's very frustrating talking about the benefits of religion when social support seems to be playing a major role in this. So, if you don't mind I was going take an excerpt from that paper to help illustrate.

TC: *Absolutely.*

DS: I said, for example, "It is not difficult to imagine that persons who are active in chess clubs will have access to social support from their fellow members. Furthermore it is not unreasonable to imagine that more active members of chess clubs report better access to social support than less active members. However, if it were found that attendance at chess clubs was positively related to mammography it would be unusual for a researcher to frame these findings as 'Chess enthusiasm promotes breast X-rays'. Instead, it would be likely argued that social support, which is accessible from any number of institutions including chess clubs, was responsible for increased screening behaviour. However in much of the existing religion and health literature a general benefit of social support, better screening in this case, appears to be presented as a specific benefit of religious activities." And this is what I find very frustrating as a researcher: it would be shocking if going to church every week didn't do something. But the important thing there is the social activity for it and not necessarily the religious angle for it. In fact there's several studies where, when they're controlling for social support – bringing in the relationship between religion and health, that relationship – the religion and health relationship goes to nothing. Because they're controlling for social support. This doesn't happen all the time. But it happens in several studies. And this is an important thing to consider. And finally I have one more point on this. I have one more quote on things that I find frustrating about the literature. It's that even when researchers, when they work with looking at exclusively religious samples, they were . . . these are general samples, right? What they would do is they would describe everybody's relationship between religion and health with a single type of

consideration. So everyone got the same description of that relationship. So there was no real strong interest in looking at whether or not the relationship between religion and health was affected by other factors. Now researchers have tested moderation before. They find that, say, less-educated people tend to find a stronger benefit from religion and health.

TC: So we're talking here about moderating factors being like level of education; maybe it only holds for lower or higher; or income, for example; or men versus women? Those kind of things. So I guess adding nuance to this "Religion is good for you!"

DS: The core thing, the frustrating thing is that when you're looking at general samples you're sampling people who are not religious, you're sampling people who are not spiritual, you're sampling people who are atheist, right? And there's no reason to suspect that these people would value religion and spirituality to the same extent as someone who believes in God or is religious or spiritual. There should be no default assumption that these groups are equivalent to begin with. If you're looking at say, sex-based differences like men versus women or males versus females you could say, "Well there's no reason to suspect that one of these people would have a radically different relationship with religion." They do not . . . their identity, or their moderating factor there, isn't a religiously-slighted variable. If you're looking at people who are atheist, though, that is something related to the very idea of religion and spirituality. If you're looking at nonreligion that's something that's very much related to the idea, intrinsically, to religion and spirituality. But what had happened is that these previous studies they all treated everyone in the entire sample as having more or less the same expressed relationship between religion and health so they looked at sex as a moderating factor, age as a moderating factor, or education. But there was generally never any interest in looking at people who are not religious, whether or not they reported an equivalent relationship. So what the focus of my doctorate was on was looking at the idea of health outcomes and religious and spiritual beliefs and behaviours, but looking at whether or not people who were atheists, or nonreligious or not spiritual, whether or not they recorded a different linear relationship between those activities or beliefs and outcomes. And it turns out quite often they did. And quite often they reported a lower health score when they reported higher levels of religion and spirituality. So if you go to church, that's fine (**20:00**). But you would, in this case, you would have to be religious really to see that same relationship. If you're not religious and you're attending church all the time, this has different health implications. So, problematically, if you're saying that there is a monolithic relationship between religion and health you're losing a lot of nuance there. Because religion and spirituality have benefits, but you have to have a religious and spiritual identity, which is conducive to you benefitting from those activities. So I jokingly say, "Well, my

doctoral work, I got a PhD for saying 'religion is healthy, but you've got to be religious to get that benefit.'" So it's a kind of simplification, but no one had looked at that previously.

TC: *And to add to this, I think that these are really important nuances particularly, again, in the domain of public policy and public health. For example, I'm thankful to have been a part of . . . they have different workshops put on by different places that have like week-long courses for private health care providers, government officials and so on, specifically informing them about the research on the relationship between religion, spirituality and health. And the takeaway from these . . . . They're conducted very well, but there's also, at the same time, a certain level of nuance that is just missing. And the takeaway message I hear when I'm in some of these presentations or venues or even reading books and chapters on religion and public health, is this kind-of assumption that since we now know . . . we've identified the . . . circumscribed the positive effects of religion here, well then: "Now that we've found the fountain of youth, let's drink from it!"*

DS: (Laughs)

TC: *There's almost this. . . . It's not direct, and I've been very impressed in some of the more recent literature that has been taking into to consideration nonreligious concerns or saying, "We don't know here . . ." but typically, it seems like there's a blanket message that religion is good for a host of things, and we should use this; the government can grab a hold of this. And you're saying that: "Kind-of . . . possibly . . . but . . !"*

DS: Yes. Shockingly, there's more nuance to this than "religion equals good health". Because one of the things that really sticks out from the religion and health literature is when you look at people who are atheists, right? Atheists generally – we were discussing this prior to the show beginning. Atheists generally aren't religious. They generally don't go to church. They generally don't score highly on religiosity measures. Atheists have really comparable health to believers. So if you . . . just logically, if you expect that high religiosity equals better health, then low religiosity should equal worse health. Atheists should be fairly unhealthy on average, just on that sort-of simplistic, somewhat reductionist perspective. But it's not. It's somewhat paradoxical. My colleague and I, Karen Hwang, we published paper called "The Healthy Heretic Paradox", in which we looked at atheists who on the measures of health, using nationally representative data from America, we find that on average they tended to report comparable health to theists who were strong believers, despite the fact that they didn't believe in God at all. So this showed there's something of a fly in the ointment. Because if religion just uniformly benefits health, well people who are really not religious, like atheists, or they're not – we'll

say atheists as the more extreme example – you wouldn't really expect them to be healthy. But they are. Meaning that the description . . . it looks, at the very face value of it, that there's something very wrong with how that relationship is being summarised.

TC: *And I think there's something fishy with the way that the relationship is interpreted both at the academic level and certainly bubbles up to policy and other things. What other studies have you conducted that speak to this, say, lack of nuance that was previously in the literature for this. And also I guess it would be strange to see . . . I can only think what the President of the US or different administrations what kind of flack they would take if they decided to prescribe kind-of atheism! Because it seems that people who did not believe in God more strongly had comparable health to the religious* (**25:00**). *So I was just kind-of interested in what other research and work you've conducted that can speak to this interesting . . . I don't know if you want to call it a hydraulic relationship, maybe?*

DS: Yes. Geez! I don't know about the political thing, I'm not sure I feel comfortable answering whether or not the government should prescribe religious or atheistic beliefs. I certainly wouldn't feel comfortable with the government doing that. Regardless of whether or not they prescribed atheism or theism. As to the research, so what I generally do . . . my research uses pre-existing datasets from Statistics Canada, from the General Social Survey out of the University of Chicago. I think it's the National Opinion and Research Council. I think they do those studies. Anyway, so it's data that's publicly available to any researcher who is interested in doing it and has the competence and statistics to do assessment. But I published a little more than half a dozen studies on the topic between religion and health. In each case I'm looking at: OK, well let's look at how this actually relates, and let's try and distinguish between people who believe versus not believe, in terms of these outcomes. In virtually all cases I found, it's that often when there's a really strong positive relationship between religion and health say for believers, you would find a moderating effect for whether or not someone was an atheist. I published a study with the Journal of Religion and Health in 2016 or 17, I can't remember now. But it was looking at data from Ontario which is the largest province, population-wise, in Canada. And I found that people who go to church they tend to report better health but . . I think it was satisfaction in life, maybe. But if you're looking at the nonreligious people recording the same level of attendance then what you see is a very different relationship. It actually reports a negative relationship. Now this isn't to mean that going to church is bad. It's just you need more nuance when you're discussing these things, especially at a public policy level. Because it's not this panacea that fixes everything.

TC: *So it seems like there's a heavy interpretation factor here, where on one end, you know, the general trend might be to say, "Oh, look at the positive effects of – to use the recurring example – church attendance, here." But then we would not want to conclude for example that less-religious or nonreligious people should avoid church like the plagues, because it apparently, you know has a harmful impact on their health. What we're talking about here is not necessarily I guess a causal relationship.*

DS: No, no. I think if you made like a group of nonbelievers go to church ... Besides the ethical issues with that, I don't think . . . I wouldn't immediately suspect that all of them would be miserable and report increases in depression, or whatever. But the problem is that when you're looking at how the academic findings are used and discussed in the broader social lens, how they're used to inform public policy, or the potential they have to influence policy, there's discussion about including... you know, default assuming that you should discuss religion and spirituality in clinical therapy. So there's a real-world consequence to this type of finding. And the problem is that if you're looking at these relationships and you're potentially treating it as "more religion better health", you're losing a lot of the nuance; you're losing sight of the personal idea that perhaps some people aren't religious because they really are opposed to religion. And forcing them to address those topics or discuss those topics may not be a super-positive thing for those groups of people.

TC: *I was going to say, I also think it points, to some degree, to our problems with interpreting the positive findings on religion and health then. Because we don't . . . I guess that was the comparison I was trying to get at then. We wouldn't kind-of say that church attendance hurts less-religious people in the same way we say, "Look, people . . " we're willing to make that inference that people who attend more do better. We wouldn't make it one case, but we do in the other. But they're kind-of conceptually similar . . . is what I hear you saying?*

DS: Yes. Yes. So like so if you're looking at . . . this hearkens back to some of what I do with my doctoral work (**30:00**). But what happens when you look at say irreligious groups, when they report really low levels of attendance or religiosity – really, really low levels of that – if you compared their average health levels to religious groups who report very high levels of religiosity or attendance, those two relationships, they're about at the same place. And in cases where they are, say, statistically different, so at *p* value less than .05, the associated effect size of that – so the actual magnitude of difference between the groups – is really, really small. And often it's trivially small. So the convention for Cohen's d , which is a measure of effect size (not to get too far into those academic things at this

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point!) But anything less than a Cohen's d of 0.2 is usually seen as trivial. It's not really something to talk about. And if you're talking about a social activity or the sociocultural perspectives influencing some sort of health outcome and you're saying it's happening at a level of a Cohen's d of less than 0.2, you're talking about something that you probably can't really observe in everyday life. And the underlying mechanism isn't clear because we're not sure if it's social support driving the majority of this relationship or not or if it's another factor. It's really hard to talk about that and convey a strong sense of meaning to those findings. I mean it's statistically significant but that doesn't mean of clinical relevance or of clinical importance.

TC: *I think though, one of the examples I usually use when I'm teaching students or talking about significance in general is, you know, the difference between let's say a football player who weighs 200 pounds versus one who weighs 200.1lbs. One is significantly heavier than the other, but it would be very odd to kind-of say, "Well the other guy weighs . . . he weighs significantly more than I do. I'm going to have to rethink the game here." You know. No!*

DS: Especially with large population samples. Any difference will become statistically significant with enough people sampled. And the reason is because error term gets progressively smaller with the more people you talk to. So if you have, say, one group has an IQ of 100, another one has an IQ of 110.1. If you sample millions of people and you're able to find that one mean is 100, the other mean is 100.1, because you've sampled so many people, what's going to end up happening is that it will come out as statistically significant but the associated effect is so tiny, like, why even bother talking about it? And religion health research isn't quite there – there are cases where it's really beneficial if you're talking about optimism and outlook after, say, surgery or something. You'll see higher levels of optimism or you're feeling cared for because you're protected by God. You might see some specific benefits in very specific cases, but in terms of, like, at public policy level, or on a national health level, the differences are often quite small. Not always, but often.

TC: *Kind-of wrapping this up, and bringing this towards the end, here . . . I'm interested in talking a little bit about how religion and spirituality are conceptualised here. Now I know, and I don't want to beat a dead horse, per se . . . because one of the things I think the RSP prides itself on doing is deconstructing and exposing underlying structure and assumptions of precisely these kind of terms. But it's something I think . . . well, public health professionals do not have extensive discussions about discursive practices, or what we would really mean when we use this word, or all the different things we're lumping together! It's the same with psychologists as well. It's generally left to Religious Studies*

scholars and Humanities. So if you could, in closing here, kind-of bring us into perspective and how some of these studies conceptualise religion and spirituality and particularly from the vantage point of the nonreligious, right? Is it one of those things where everyone's religious, you just have to find the right . . .?

DS: Personally, I'm not sure if there's an academic consensus on this specifically. I've usually . . . concepts regarding religion tend to be better defined (**35:00**). So if you're looking at say church attendance.

TC: *Better defined than . . . ?*

DS: Better than spirituality. So if you're looking at assessments of attendance: "How often do you go to church?" – you can get a fairly objective assessment of that; "How often do you pray?" – you can get a fairly objective assessment of that. It's self-reporting. You're relying on people to provide you with data but that's ok. But you can get a fairly objective standpoint. When you talk about religiosity you get into, what exactly does religiosity mean? There's different conceptualisations of religiosity. One that people might be familiar with is intrinsic versus extrinsic. Intrinsic is, in a nutshell, religiosity because you see intrinsic values: with this religiosity you get something out of it, you see it's rewarding or fulfilling in itself. Whereas extrinsic religiosity is kind-of treating religion as a means to an end. So it's a tool in order to achieve a greater . . . So there's kind-of some fuzziness around religiosity. But if you ask people how important they find religion is to them, or how religious do they see themselves you can tend to get a more or less consistent set of ways of assessing those specific behaviours or beliefs.

TC: *I often also think that this gets us into kind-of "good religion" and "bad religion". Particularly from a health perspective: there are consistently some negative social effects kind-of associated with varieties of fundamentalism. And it seems here that the same health professionals and researchers are keen to say, "Well, when we talk about religion we're not meaning that kind – not the stuff that we think is bad for public health, or social cohesion." Well, it depends on what we man by social cohesion, here. But I often notice that this gets into a good religion, versus bad. And so then that makes me think, "Well, aren't you really just interested in things that are improving health or psychological wellbeing in general, instead of something religious per se?"*

DS: Yes, and you can kind-of see this. This is more apparent within the spirituality literature, in my opinion. So if you're looking at, say, just like pure religion it's like, what do you believe? How often

do you go to church? Are you religiously affiliated? You get fairly straightforward measures. People know what you're talking about. People may disagree about whether or not this person's a true member of this religious organisation, or whether or not they're a member of that religious organisation. But there tends to be at least consensus on the idea of how you get to those questions. The spirituality literature, I find, is really vague about what that term means. And the way spirituality is assessed, it may not necessarily be intuitive for the laity. It's just . . . it's very, very broad in how it's defined. So I wrote a paper for *Skeptic* a couple of years ago, where I point out some of the different definitions of spirituality. And one of them defines spirituality as "an inherent component of being human and is subjective, intangible and multi-dimensional". That literally means anything you want it to mean! So, it doesn't really matter if you and I are talking about spirituality. If you say "My aunt's not religious but she's spiritual," I'm not sure exactly what you mean, but I understand what you're trying to convey to me. But if researchers are talking about assessing spirituality they can't just . . . "Oh yes, I totally know what you mean." They actually have to quantify and describe and validate measures of spirituality. So when you see these validated measures or these assessments, you see a lot of questions in there that you may not – or at least I wouldn't, and the people I'm talking to wouldn't – see these as intrinsically spiritual. So there are questions like: "I accept others even when they do things that I think are wrong", "I have a general sense of belonging", "When I wrong someone I make an effort to apologise". Those things are included as indicators of spirituality. And to me this is problematic on two different levels. One: this is, in a sense, gaming the system. You've chosen . . . or items are being chosen not because I see an obvious connection with spirituality. They might go together, there might be a reason for including these, that's fine. These have been validated, I have no issue with that. I'm positive these researchers have done their due diligence and this is what has come out. But if you're talking about spirituality with someone, you wouldn't say like "Oh yes. When I wrong someone I apologise. That's a spiritual thing." Like, that's a really select definition of spirituality (**40:00**). So if you're finding that how well people are engaging socially is an intrinsic component of spirituality and you find that spirituality is related to health – well, yes. Social support and being able to interact, socially, well with other people is related to support. So it just is like a parallel . . . if you said that "I don't smoke because it's bad for me" and that's a spiritual assessment and you find that people who score more highly on spirituality get less cancer, well, yeah! You've adjusted the framework of spirituality such that it includes not smoking. Well, of course that's related to cancer rates, because that's how that works! So the thing I find frustrating about the spirituality literature – and it's a really interesting literature, people do genuinely good work in it – but it's just the variability in what spirituality can mean. And the idea that you feel empowered, or you feel like you

have purpose in life – that's spirituality. I've never thought of those things as being spiritual before, like, prior to reading this literature. I've always just described that as, "Oh yes, I feel as if . . .I feel autonomy. I feel a sense of mastery." So, when you're connecting those measures of spirituality, or that definition of spirituality with health, I'm not shocked that that's related to better health. But we already knew that from other fields. So my question is kind-of: if spirituality is doing something, what is the unique thing that spirituality is doing? How are you defining that? Is that a good . . . is that a reasonable definition that people would say, "Oh yeah, that's definitely spirituality"? Or is this a hodge-podge of different areas that we're just kind-of lumping together and saying it's spirituality and saying, "Oh look, it's 'Spirituality – better health!'"

TC: *Excellent. I was wondering if you had any kind-of summing up or parting phrase, or words, or thoughts for us on the relationship between religion, nonreligion and health?*

DS: (Laughs).

TC: *Something to send our Listeners away with? Something even more profound than what you've already said?*

DS: I don't know if I can go more profound! But religion is related to health. Like, correlationally we can establish that religion is related to health. If you're religious and if you go to church, chances are you're probably getting a benefit from it. Ultimately, it doesn't really matter what the underlying mechanism is. If it's the social support angle, if it's because you have a better sense of coherency, is it because this really makes you feel like spiritually charged as a person? If you're getting a benefit out of it, continue. Please continue doing it. Don't be discouraged from not doing it. If you're not religious and you are hearing all these things about, "Oh. Going to church is associated with better health," the more elemental question you have to consider is, will this be good for you specifically? If most people are religious and most people benefit from going to church, fine! But that doesn't incorporate everyone. So there has to be more nuance in the field. Religion is a wonderfully diverse, very complex socio-cultural construct. And chances are that its relationship with health is more complicated than a single edict of "Do more, be healthy!"

TC: *Excellent. Dr David Speed, thank you for joining us on the Religious Studies Project.*

DS: Thanks a lot for having me.

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