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INTERRELATION OF RELIGIOUSITY AND PHYSICAL HEALTH CONDITION: UKRAINIAN CASE

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Abstract. The role of religion for supporting of physical health is a popular and debatable topic. This topic can be considered from two sides – the impact of health condition on the acceptance of religious faith and the strength of its manifestation, and the possible impact of religious affiliation on the health. The analyses of the interrelation between religion and physical and mental health was made in many publications, but there was no such a publication as for Ukraine. We used here the data from the longitudal sociological survey, which shows that some indicators of health are worse among religious Ukrainians and better among non-religious. Namely religious people gave worse rate for their health (but such correlation is fair only in the age group of 18-29 years old), also religious people have a worse body mass index (correlation is fair for peoples over 30 years old). At the same time this correlation is rather modest. For other indicators (disability level and chronic diseases level) there are no differences between religious and non-religious people. The last can be interpreted in two ways: as a negative impact of religious affiliation on health, or as a greater propensity for religious beliefs of less healthy people. But in any case both the first and the second impacts are obviously quite limited. Such a state is probably determined by the superficiality of the religiosity of the population of Ukraine, and reflects the limited role of religion both in the everyday life of the broad masses of believers and at the level of society as a whole.

Keywords: religion, physical health, religious compensation, desecularization, Ukraine.

Introduction

Religion is a phenomenon combined with many parts of individual and social life. It can affect other parts of life, as well as be influenced by them. Human physical health is no exception, and may be (and is) related to a person's position and activity in the field of religion. And the question of the interrelation between religiosity and physical health can be considered from two sides.

The first is the impact of health condition on the acceptance of religious faith and on the strength of its manifestation. For example, in case of health problems, a person has a choice - to ignore them (a fatalistic reaction), to turn to medicine (a secular-rationalist

reaction), or to seek salvation from "higher powers" (a magical reaction).[1] There are many cases when health problems that cannot be solved by medicine, push a person to seek healing through various religious or magical practices. The people, who were atheists due to personal illnesses or the illnesses of their relatives are converted to faith, and those who were believers might increase the intensity of their faith (pray more often, make pilgrimages to holy places, go to icons, relics of saints, and so on). Such a connection can be considered a manifestation of the compensatory function of religion, i.e. its ability to alleviate physical or mental suffering, to calm, to relieve the tension that arises due to the inability to get what is desired. Understanding the religion as a compensatory force have not only become a classic (let us recall Karl Marx's classic formula of religion as opium for the people), but remains widespread in modern sociological approaches to religious issues. Thus the representatives of the "religious economy" theory view the religion as a compensatory phenomenon as such, which needed due to man's inability to cope with problems like suffering and death.[2]

In whole the idea that religion is and will remain attractive for those with health problems, at the level of individuals can be accepted. Religion can be effective in alleviating suffering by giving hope for deliverance from the latter, as well as giving some explanations for life's problems. However, it is far from obvious how widespread the compensatory effect of religion is, and for which part of believers (including those with health problems), it is relevant. Over the last two centuries, there have been large-scale changes in the entire system of social relations, including the place of religion in society as a whole and in lives of individuals. In many developed countries, both the number of religious people and the degree of religiosity have decreased. At the same time, other institutions that reduce physical and spiritual suffering (including medicine and psychiatry) have become effective and popular. That is, a combination of less orientation to religion and more trust in scientific means of life's problems resisting has been formed. Therefore, the analysis of the relationship between physical health and religiosity using the data of mass representative surveys of the population of different countries remains quite relevant.

The other side of the interrelation between religion and physical health is the possible impact of religious affiliation on the latter. Religion in addition to certain ideas about the world, the place of man in it, and its relationship with other elements of the world, also provides obligation (more or less strict) on the direct behavior of believers. Many religions

[1] Of course, these choices are not mutually exclusive and can be combined. Suicide is a possible reaction also, but it is not a solution to the problem, but an escape from such a solution, and we will not consider this issue.
[2] R. Stark, W. S. Bainbridge. *The Future of Religion: Secularization, Revival and Cult Formation*. (Berkeley: University of California Press, 1985).

contain requirements for maintaining health and leading a lifestyle that would ensure such maintaining.[3] And following religious obligation can have the effect of improving physical health and longevity. Also the physical health condition can be influenced by the positive impact that religion can have on the mental health of a person. Accordingly, both the actual presence of religious convictions per se and the degree of religiosity that can affect the part of health that is associated with the actions of the person himself (situations of health problems that are innate and do not depend on the actions of a particular person, we do not consider).

Existing Researches and Theoretical Scope

The analyses of interrelation between religion and physical and mental health has become very popular in recent decades. There are a few analytical reviews on this issue,[4] all of which noted predominantly positive impact of religion. Many research works show that there is a high probability that religion will have a positive effect on physical health. Of course, there is no unambiguous validation for such positive impact. Some research has shown a lack of interrelation, as well as an absence of a negative interrelation (i.e. worse physical health among religious people). However, most studies have shown a positive effect. In particular, it was noted that religious people have the better indicators of coronary heart disease, hypertension, cerebrovascular disease (risk of stroke), Alzheimer's disease and dementia, cognitive function, immune and endocrine systems, cancer, mortality and longevity. There was also a positive correlation between religiosity and spirituality on the one hand, and self-assessment of health on the other (the best estimates were given by believers).

At the same time, there is no clear interpretation of the interrelation between religion and physical health. And such unambiguity probably cannot be in principle. First, different religions have differences in their doctrine and organization. Accordingly, they will affect their followers in different ways. Second, different societies are recognized by their patterns

[3] Н. Б. Бриленок. *Здоровый образ жизни: социально-философский анализ. Диссертация на соискание ученой степени кандидата философских наук*. (Саратов. 2017), pp.16-22.

[4] Terrence D. Hill, Matt Bradshaw, Amy M. Burdette. "Health and Biological Functioning" in *Handbook of Religion and Society / Editor David Yamane*. (Springer International Publishing Switzerland, 2016). pp. 11-28; Harold G. Koenig, Dana E. King, Verna B. Carson. *Handbook of Religion and Health. 2nd edition.* (Oxford University Press. 2012); Harold G. Koenig. "Religion, Spirituality, and Health: The Research and Clinical Implications." *International Scholarly Research Notices.* https://www.hindawi.com/journals/isrn/2012/278730/. Accessed 19.11.2020; James M. Nelson. "Religion, Spirituality, and Physical Health.", *Psychology, Religion, and Spirituality*. (Springer Science + Business Media, LLC 2009), pp. 311-345; David R. Williams, Michelle J. Sternthal, "Spirituality, religion and health: evidence and research directions." *Medical Journal of Australia*. Vol 186:10 (2007):.47-50.

of social interactions, norms, values, and even the same religions may have different impact on different societies. And the conclusions drawn from the data, say obtained in the United States, may not correspond to the real state of affairs in other countries. Therefore, the analysis of relevant data of different countries is always useful and relevant for theoretical generalizations. It should be also borne in mind that numerous publications on the impact of religion on various aspects of health concerns mainly developed countries. Instead, no relevant analysis was conducted for Ukraine. And we will try to partially fill this gap.

In addition, this analysis is interesting in terms of its contribution to the analysis of socio-religious relations in general. One of the theoretical approaches in modern sociological analysis of religion is the understanding of modernity as a time of desecularization (i.e. the return of the social significance of religion)[5]. The desecularization of the Ukrainian society as such, compared to the Soviet period is obvious. Religiosity covers the vast majority of the population, the network of religious communities is constantly growing, old churches are being rebuilt, new churches are being built, religious figures have become quite visible in the information field, religious organizations and associations are expressing their position on crucial public issues and are sending their views to the government.

At the same time, the extent of desecularization in one or another country is debatable, and its prospects remain uncertain. After all, in Ukraine the religiosity of most believers remains superficial, mainly ritualistic and magical; religious congregations function as social communities only to a limited extent; socio-political visions of believers have little or no connection with their beliefs; the possibilities of the influence of religious figures on social processes in cases where such a direction of such influence does not coincide with the already formed ideas and desires in society remain quite limited.[6] Such ambiguity in the deployment of desecularization requires the study of its various components, because the interaction of religion and the secular world is possible in different modes. Therefore, in determining the degree of interrelation between physical health and religiosity, we also assess one of the possible manifestations of desecularization.

Estimating the Correlation between Religiosity and Health Indicators: the Ukrainian Context

[5] See P. L. Berger, "The desecularization of the world: a global overview." *The desecularization of the world: resurgent religion and world politics* / ed. P. L. Berger. (Washington, D.C.: Grand Rapids, 1999). pp.1–18; V. Karpov, "Desecularization: A Conceptual Framework." *Journal of Church and State*, Volume 52: 2,(Spring 2010): 232-270.

[6] For example see Максим Паращевін, *Релігія в Україні: траєкторія інституційних змін*. (Київ, Інститут соціології НАН України. 2017).

We will try to estimate the correlation between religiosity and health indicators for the Ukrainian population. We will use the data of a representative public opinion poll, organized by the Institute of Sociology of the National Academy of Sciences of Ukraine[7] in late 2020.[8] The first thing to note is the lack of significant shifts, compared to the previous years' surveys, in the proportion of religious and non-religious respondents. In the survey of 2019 and 2020 this proportion was unchanged (about 14% in 2019 and about 86% in 2020), while in the survey of 2018 this proportion was about 16% to about 84%[9]. That is, last year, which was associated with the spread of the COVID-19 pandemic, did not become a factor in the shifts from atheism to faith.

As for physical health, the 2020 survey used found several indicators that measured its condition. With regard to religiosity, the survey used a characteristic that distinguished between persons without religious beliefs (non-religious) and those who had such beliefs (at least declared their presence). So we can compare health indicators in groups of religious and non-religious people. The results of such a comparison can be an argument for or against the significance at the mass level, of both the impact of poorer health on greater propensity for religion, and the impact of religion on health. Namely the presence of more people with physical health problems in a religious community will be in favor of the hypothesis of a compensatory effect of religion. Conversely, if there are more ill people among non-religious individuals, it can be assumed that religious affiliation has a positive effect on health.

If we look at the survey of the Institute of Sociology of the National Academy of Sciences of Ukraine and compare the self-assessment of health[10] in groups of respondents who identified themselves as religious and non-religious,[11] we will see a small difference when religious people give poorer estimates of their health. Namely among the non-religious, the ratio of those who estimated their health as good or perfect was about 40%, while among

[7] http://i-soc.com.ua/.

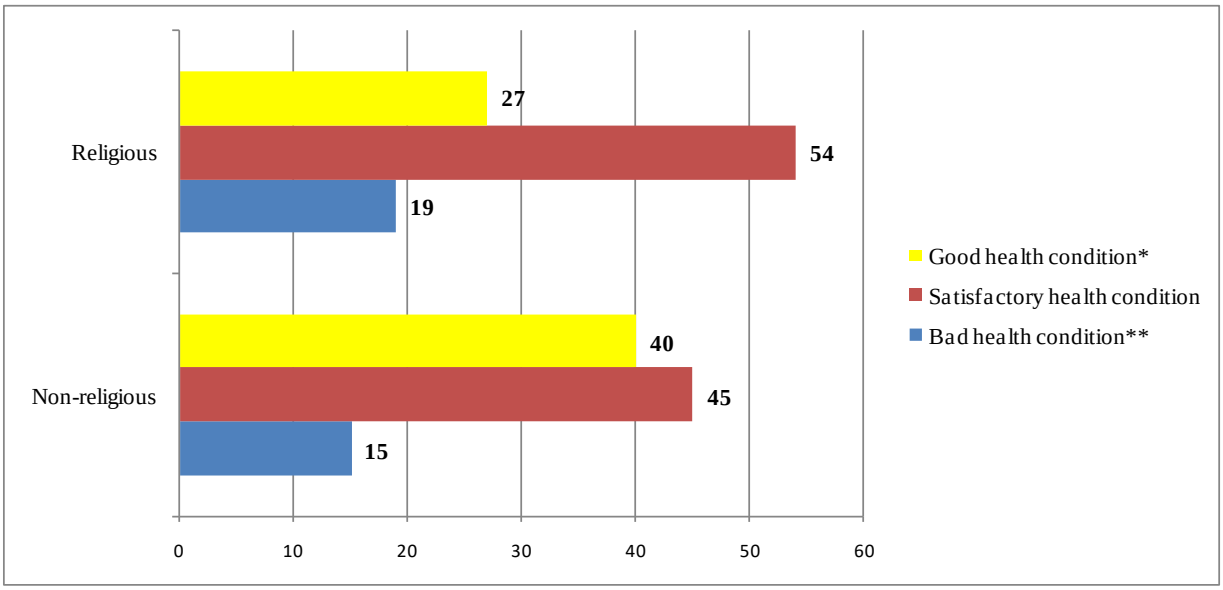
[8] The poll was conducted as part of "Sociological monitoring" survey; it is a longitudial research from 1992 year, with annual surveys, so we can estimate current situation in the country, and see some indicators in dynamics. In 2020 the poll was conducted on 19 September-10 October throughout Ukraine, except for the Russian-annexed territory of the Crimea, and the Russian-occupied territories of Donetsk and Luhansk regions. The sample is three-stage, stratified, random, with quota screening at the last stage. The total number of respondents was 1,800. The field stage of the study was carried out by the Center for Social and Marketing Research "Socis" (https://www.socis.kiev.ua/).

[9] See *Українське суспільство: моніторинг соціальних змін*. (Київ: Інститут соціології НАН України. 2019). Вип. 6 (20). p. 514.

[10] The question was formulated in this way: "How do you assess the state of your health in general?" with possible answers "1. Very bad," "2. Bad," "3. Satisfactory," "4. Good," and "5. Perfect."

[11] Religiosity was measured by means of the question "What religion do you belong to?", with possible answers "Non-religious", "Orthodox", "Catholic", "Greek Catholic", "Protestant", "Islam", "Judaism", "Other". Accordingly, the respondents who chose the first answer were assigned to the group of non-religious, and who chose all other answers were assigned to the group of religious.

the religious the corresponding ratio was about 27%.[12] At the same time, it should be noted that such differences were formed due to the differences in the percentage of people with satisfactory health, while the percentage of people with poor health in the two selected groups did not differ significantly (*Fig. 1*).



*Combined ratio of answers «Good» and «Perfect».
** Combined ratio of «Very Bad» and «Bad».

Figure 1. **Self-assessment of health of religious and non-religious respondents** *(%)*

Such differences seem to testify in favor of the hypothesis of a more active conversion to religion of people with health problems. However, it should be taken into consideration that religiosity itself is related to other characteristics. In particular, it depends on age (the proportion of religious people is higher among the elderly and less among the young people), gender (the proportion of religious people is higher among women), residence (religiosity is more widespread in the Western part of Ukraine and in rural areas). At the same time the self-assessment of health may depend on these characteristics. Therefore, before making any conclusions, it is necessary to check whether the interrelation between religiosity and self-assessment of health is determined by the dependence of the latter on other characteristics. That is, we need to clean the interrelation between health and religiosity from the possible interrelation between these two characteristics and other characteristics.

First we consider the age of the respondents. Naturally, health deteriorates with age, and the data from our survey has a clear trend of declining health self-assessment with age. At the same time, with increasing age, the religiosity increases. Therefore, it can be assumed

[12] Differences of percentage proportions are statistically significant at 0.01 level. Differences' significance was estimated by the z-test procedure.

that the worst health estimates in a group of religious people are determined by the impact of age. To test this hypothesis, it is necessary to compare the health assessments of religious and non-religious individuals separately in each age group. We have singled out three age groups (a youth group – 18-29 years old, an average age group – 30-55 years old, an older age group – 56 years old and more). The comparison of health assessments for convenience was made on average points. [13] In this case, it turns out that there are no statistically significant differences in the groups of middle-aged and older respondents (i.e. there is no impact of religiosity). But in the group of young people the differences persist, and consist precisely in the worse assessment of their health among religious individuals. At the same time, it can be noted that this differences are not big (Table 1).

Table 1

Self-assessment of health condition by religious and non-religious respondents of different ages

Age groups	*Religious / Non-religious respondents*	*Average number of points Value*
18-29 years	Non-religious (n=67)	3,78*
	Religious (n=258)	3,52*
30-55 years	Non-religious (n=128)	3,34
	Religious (n=736)	3,24
56 and more years	Non-religious (n=64)	2,77
	Religious (n=547)	2,66

*Means differences is significant at 0.05 level. Differences' significance was estimated by Student's t-test.

Since in the analyzed data set the self-assessment of health is lower among women, and at the same time there is a higher level of religiosity among women, we can also assume that the determinants here are not religious but gender differences. However, this assumption is not confirmed, as statistically significant differences between religious and non-religious respondents are in both male and female groups. And these differences are better estimates of their health among non-religious people, although these differences are small (Table 2).

Table 2

Self-assessment of health by religious and non-religious respondents depending on gender

Gender	*Religious / Non-religious respondents*	*Average number of points Value*
Male	Non-religious (n=155)	3,39*
	Religious (n=662)	3,19*

[13] Since the used health self-assessment scale is a 5-point ordinal, we can analyze the results by calculating the means; in this case, the means can be in the range from 1 to 5, when the higher it is, the better the assessment of health.

Female	Non-religious (n=104)	3,19*
	Religious (n=879)	3,0*

* Means differences are significant at 0.05 level. Differences' significance was estimated by Student's t-test.

The self-assessment of health is to some extent subjective, and determined by the specifics of a person's perception of his/her health. The other two characteristics used in the survey (being on the medical register[14] and having chronic diseases[15]), may be considered as more objective. Comparison of religious and non-religious people on these indicators does not show any significant differences. Although in the group of religious respondents the proportion of those who are on the medical register or have a disability is higher (20% as opposed to 13% among non-religious people), but if we take into account the age (comparing religious and non-religious people in different age groups), significant differences will disappear; i.e. the determining factor in this case will be age, not religiosity. And the same applies to the sign of chronic diseases. If we consider religious and non-religious people in general, the prevalence of chronic diseases is slightly higher among the religious people (39% in contrast to 28% in the group of non-religious people), but if we take into consideration the age parameters, the differences will remain, but they will be no longer statistically significant.

These results can be compared with the data of 2018, when the same characteristics were measured in the project "Sociological monitoring."[16] And in the survey of 2018, no differences between religious and non-religious respondents were fixed.

But in the survey of 2018, the height and weight of the respondents were recorded. Accordingly, we can determine such an objective indicator of health as body mass index.[17] And among religious people this index was 26.1, while among non-religious people it was 24.7.[18] Instead an indicator from 18.5 to 24.9 corresponds to a normal body weight, and the one from 25.0 to 29.9 indicates overweight. So among religious people this index points to

[14] In Ukraine people who stay on medical register are receive the right for special medical assistants. The survey included the question: "Are you on the medical register?", with possible answers "No, I am not," "I am on the dispensary register, but I have no disability," "Group 3 disability," "Group 2 disability," "Group 1 disability."

[15] The question was: "Do you have chronic diseases?" with possible answers "No, I do not have," "Yes, one," "Yes, several."

[16] The survey was conducted on 13-29 September 2018 throughout Ukraine, except for the Russian-annexed territory of Crimea, and the Russian-occupied territories of Donetsk and Luhansk regions. The sample is three-stage, stratified, random, with quota screening at the last stage. The total number of respondents was 1,800.

[17] Body mass index was calculated on the formulas "weight (kg) / [height (m)]^2", see "About Adult BMI". *Centers for Decease Control and Prevention.* https://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html#InterpretedAdults. Accessed 19.11.2020.

[18] Differences of means are statistically significant at 0.01 level. Differences' significance was estimated by Student's t-test.

the prevalence of overweight, and among non-religious people – the prevalence of a normal weight. And such differences remain within gender groups (there are differences between religious and non-religious people both male and female), and mostly remain within the age groups (differences occur in groups of middle-aged people and older, but there are no differences among young people). At the same time, such differences are not tangible.

Conclusions

Thus, the presented data of the surveys of the population of Ukraine do not give grounds to consider that at the level of the entire population the fact of religious affiliation affects the better rates of physical health. On the contrary, in the analyzed surveys, these rates (including the self-assessment of health and the body mass index) are worse among religious people. This situation can be interpreted in two ways: as a negative impact of religious affiliation on health, or as a greater propensity for religious beliefs of less healthy people. But in any case both the first and the second impacts are obviously quite limited, as the fixed differences in the surveys are quite small. In addition, interrelation between religious affiliation and health condition is fixed to the certain groups only (in the case of self-assessment of health condition – to young people, and in the case of body mass index – to older age groups).

These results may be useful on their own account (to determine the extent to which the religion should be taken into account in the designing of measures to improve physical health) and as part of the overall assessment of individual and social significance of religion in contemporary Ukraine.

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