INTRODUCTION:  
SOCIOLOGICAL THEORY ON RELIGION AND HEALTH  

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Driven by funding agencies, empirical research in the social scientific study of health and medicine has grown in quantity and developed in quality. When it became evident, in what is now a tradition of inquiry, that people's religious activities had significant health consequences, a portion of that body of work began to focus more frequently on the relationship between health and religion. The field has reached a point where book-length summaries of empirical findings, especially those pertinent to older people, can identify independent, mediating, and dependent variables of interest (e.g., Koenig 2008, Krause 2008). Every mediating variable, even if considered as a statistical “control” variable, represents an explanation, a small theory of some kind. However, taken in granular form, as it were, the multiple theories do not comprise mid-level theory, let alone a general theoretical framework. It was the plan behind this volume to invite mid-level and more general theoretical development in the field. In that sense it is something of an experiment.

Theories have a matter, a topic toward which they offer avenues of understanding, conceptualization and explanation. When the topic has two centers of interest—health and religion—the potential paradigms begin to multiply because different aspects of one center can be related to different aspects of the other. Religion is cognitive, experiential, normative, ritualistic, inspirational, social, traditional, and the opposite of all of these. Health is subjective, physiological, culturally relative, individual, indicated by symptoms, and the opposite of all of these. A highly theologized religion can affect subjective health, physiological health, the cultural relativity of health, etc. A highly experiential religion can affect the various dimensions of health as well. One can easily create a theoretical matrix by lining the variable forms of religion across the top and the variable forms of health down the left margin, and filling each and every box in the matrix with a middle level-paradigm. The received body of empirical work provides but one pointer, albeit a good one, over what boxes represent the more important mid-level paradigms.
There is another range of good controls that come from the respective heritages of the scientific disciplines. The latter provide us with psychological, social psychological, sociological, and political criteria of what findings are “important.” Here we are concerned with the sociologically important, and we can look to such general theoretical traditions as the structural functionalism of Talcott Parsons, the symbolic interactionism (to use Herbert Blumer’s term) of George Herbert Mead, and the home-grown American radicalism of C. Wright Mills.1 Parsons considered medicine and religion both as institutions that have been differentiating, with some difficulty, into distinct organizational structures (1951: 165, 429). He noted that modern western society had achieved a value-integration around instrumental activism and that the latter leads to a desire for “universalizing the essential conditions of effective performance through equalization of civil rights and of access to education and health” (1960: 311). Blumer insisted that variable analysis alone was not really science but that what was in the thinking of social actors, what they were indicating to themselves, was critical for science (see the essays in Blumer 1969 and his take on Mead’s philosophy in his posthumous volume of 2004). Mills wanted to activate his readers, to induce them to translate their personal problems into public issues (see Mills 1959: 3–24). He analyzed social structure in terms of the relationship between powerful and marginal institutions (see Mills 1963), something of obvious relevance and potential in the study of religion and health, respectively a marginal institution in a relatively secular world and a central one. These three general approaches, and other general ones, lead to characteristic understandings, conceptualizations, and explanations of various relationships between religious and health phenomena that arise in the course of empirical research.

So we have two general ways of building theory in the study of religion and health: moving from collections of empirical findings toward theories of the middle range and moving from our disciplinary

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1 Naming these obviously does not exhaust the list of possible general sociological approaches. I personally find symbolic interactionism and Mills’s institutional analysis, as well as the sociologie en profondeur of Georges Gurvitch (1958), to be the most useful approaches for my work. Elsewhere I have used the Mills-like focus on the relationship between powerful and marginal institutions (Blasi 1994, 2002) and the Gurvitch-like sociological depths (2009). In my contribution to this volume I have relied heavily on reference group theory, as approached largely in the symbolic interactionist perspective (though other perspectives use it as well). Much to my surprise, some formulations from the functionalist tradition also proved to be useful.