Philosophy

There is a long history of philosophical reflection on connections between human flourishing, health, spirituality and religion. In this chapter, we can do no more than give a brief survey of some of the basic philosophical issues. In turn, we shall discuss: human flourishing, health, disease, adverse conditions, spirituality and religion.

1. Flourishing

Aristotle's writings provide one ancient conception of human flourishing. On Aristotle's account, a flourishing human being is a member of a community that aims to bring about the flourishing of its members (*Politics*, Book VII, esp. xiii). Moreover, on Aristotle's account, the flourishing of a member of a community consists in that person's exercise of moral and intellectual virtues: the flourishing person has genuine friendships (*Ethics*, Books VIII and IX), possesses both theoretical and practical wisdom (*Ethics*, Book VI), and acts with courage, self-control, liberality, munificence, magnanimity, patience, amiability, sincerity, wit, and justice in pursuit of worthwhile individual and collective ends (*Ethics*, Books III and IV). Finally, on Aristotle's account, a flourishing human being is not subject to certain kinds of liabilities: a flourishing human being is not impoverished, or unhealthy, or the victim of misfortunes such as bereavements and the like (*Ethics*, Book I, esp. ix-xi).

Other ancient conceptions of human flourishing are broadly similar to Aristotle's account. Thus, for example, the account that emerges from Confucius' *Analects*, the account that emerges from the teachings of the Buddha, and the account that emerges from the teachings of Hindu sages all run along at least roughly the same kinds of lines. (For discussion of this claim in connection with Buddhist ethics, see, for example, [1] and [2].) Moreover, even though some modifications emerged in the succeeding centuries—for example, Aquinas added the Christian virtues of hope, faith and charity to the Aristotelian list (*Summa Theologiae* II, II, 1-46)—this account of human flourishing continues to be widely accepted.

But not everyone agrees. Indeed, some contemporary authors have argued that there is no conception of human flourishing that captures all of the ideal pictures that we might form of human flourishing. So, for example, Strawson [3: 26] says:

> As for the ways of life that may present themselves at different times as each uniquely satisfactory, there can be no doubt about their variety and opposition. The ideas of self-obliterating devotion to duty or to the service of others; of personal honour and magnanimity; of asceticism, contemplation, retreat; of action, dominance and power; of the cultivation of an exquisite sense of the luxurious; or simply human solidarity and cooperative endeavour; of a refined complexity of social existence; of a constantly maintained and renewed sense of affinity with natural things—any of these ideas, and a great many others too, may form the core and substance of a personal ideal.

Similar scepticism about the possibility of a unified conception of human flourishing is evinced in, for example, [4]. To some, the possibility of inconsistent yet acceptable ideals of human flourishing may suggest that there is no objective component to conceptions of human flourishing: in the extreme, that one flourishes just in case one

supposes that one does. However, it is clearly one thing to suppose that there are objective bounds to what might count as human flourishing, and quite another to suppose that there is a single, objectively required conception of human flourishing.

Moreover, even in ancient times, there were disagreements about details of the Aristotelian account. Some ancient philosophers—e.g. Plato and the Stoics—supposed that flourishing was independent of the vicissitudes of fortune, because primarily a matter of attitudinal and emotional self-control. Other ancient philosophers—e.g. the Epicureans—supposed the flourishing is primarily concerned with the getting of modest pleasure and the avoiding of pain (and only secondarily concerned with knowledge, friendship and virtue as means to these ends). However, in almost any account—ancient or modern—we find the idea that good health is a significant part of normal human flourishing. True enough, some of the ideals mentioned by Strawson are compatible with some kinds of departures from good health: but, in general, there are very few ideal pictures of human flourishing that *require* departures from good health; and there are many ideal pictures of human flourishing that are simply incompatible with departures from good health.

(In passing, it is perhaps worth noting that ideal pictures of human flourishing that do require departures from good health often turn out to have religious underpinnings. Some religious ideals of saintliness and piety involve mortification of the flesh, flagellation, extremes of fasting and sleep deprivation, bodily neglect, eschewal of medical care, and so forth. Often these ideals are tied to the notion that humans flourish to the extent that they are good candidates to receive divine favours in the hereafter. Many with commitments to other ideals of human flourishing will suppose that, on the contrary, adoption of this notion—at least when it is tied to further claims about the virtues of self-imposed bodily neglect and the like—is itself a symptom of mental ill-health. Why *would* a perfectly good creator make self-harm an entrance requirement for the next life?)

2. Health

Conceptions of human health often begin with the idea that at least part of what it takes to be a healthy individual is that your biology functions as it should.

Those who deny that it is part of what it takes to be a healthy individual that your biology functions as it should typically say something like this: that what really matters for health is that you feel comfortable with your biology. Thus, for example, Carel [5] argues that one can be perfectly healthy even if one's biological systems are not functioning as they should, provided only that one feels at home or at ease with one's biological state. While it is not clear exactly what it is at stake here, it seems that one might prefer to say, not that *health* is compatible with malfunctioning biological systems, but rather that *flourishing* is compatible with such malfunctioning. (If one takes this route, then one can say that someone who has a biological liability or disability is flourishing even though they are not perfectly healthy. This sounds less strange to my ear than the suggestion that someone who has a biological liability or disability might nonetheless be in perfect health.)

Those who say that it is only part of what it takes to be a healthy individual that one's biology functions as it should often go on to add that health is also a matter of

capacity for goal fulfilment: whether or not one is healthy is also a matter of whether or not one is able to fulfil relevant kinds of goals. Which relevant goals? On one view, the goals in question are biological in nature: goals set by needs that have a biological basis. On another view, the goals in question are related to minimal flourishing: conditions whose satisfaction is necessary and sufficient for a minimal level of happiness. (See [6] for further discussion of these two views.) On yet other views, the goals in question are more demanding: for example, Richman [7] claims that the goals are those that one would choose if one had perfect rationality and complete knowledge of oneself and one's environment.

One problem for almost any version of the view that includes capacity for goal fulfilment as a condition for health is that it risks undoing the distinction between health and flourishing. It is clear that capacity for goal fulfilment is a condition for flourishing: perhaps, for example, it is true that one could not flourish if one lacked the capacity to fulfil the goals that one would choose if one had perfect rationality and complete knowledge of oneself and one's environment. But it seems no less clear that one might lack the capacity to fulfil *these* goals for reasons that seem to have nothing to do with health—for example, one might lack the capacity to fulfil these goals simply because one falls at the lower end of the biologically properly functioning end of intelligence (hence departing further than most from the standards of perfect rationality).

Another problem for almost any version of the view that includes capacity for goal fulfilment as a condition of health is that it leads to apparent misclassifications of enhancements as therapies. While it is agreed on all sides that the distinction between enhancement and therapy is tendentious, it seems fairly clear that something that would merely contribute to capacity for goal fulfilment without impacting on the way that biological systems ought to function would be a case of enhancement. But surely something only counts as therapy—and hence as making a contribution to improving health—if, in some way, it brings biological systems closer to the functioning that they ought to have.

In the light of these difficulties, one might be tempted to think that we should perhaps rest content with the view that to be a healthy individual is just to have biological systems that function as they should. However, apart from any other difficulties, it is clear that defenders of this view need to say more about the distinction between 'physical' health and 'mental' health. In particular, it is clear that many people will want to contest the idea that 'mental' health is just a matter of having biological systems that function as they should. In order to explore this worry further, we shall turn to a consideration of the notion of illness (or disease).

3. Disease

Conceptions of illness (or disease) typically begin with the idea that illness and disease involve biological malfunctioning that occasions harm. However, conceptions of illness and disease differ, primarily, in the conception that they offer of the understanding of the biological malfunctioning that is involved.

On the 'naturalist' or 'objectivist' view, the determination that there is biological malfunctioning is simply a matter for biological science. According to this way of

seeing things, human beings are composed of biological systems that have natural or normal functions that the systems in question can fail to carry out. Illnesses and diseases are departures from natural or normal biological functioning that are *deemed* to cause harm (where this deeming is most plausibly supposed to depend upon human interests, and perhaps on culturally specific human interests).

On the 'normative' or 'constructivist' view, the determination that there is biological malfunctioning is itself dependent upon human interest, and perhaps even on culturally specific human interests. According to this way of seeing things, judgments that biological systems are not manifesting natural or normal functioning themselves depend upon conceptions of human nature that are grounded in human interests, and most likely culturally specific human interests.

The 'normative' or 'constructivist' view may seem to have some historical support. After all, it is clearly true that there have been cases in which people have been classified as 'ill' or 'diseased' on the basis of culturally specific conceptions of human nature. For example, until recently, the received view was that homosexuality is a mental illness. However, 'naturalists' and 'objectivists' reply that those who classified homosexuality as an illness made that judgment on the basis of culturally specific conceptions of human nature that did not relate in any acceptable way to views about departures from normal or natural functioning of human biological systems. So these kinds of cases do not decisively favour the 'normative' or 'constructivist' view.

'Normative' and 'constructivist' views are subject to at least one serious difficulty. As Murphy [8:8] notes, there is a clear distinction between illness and deviance: pathology and disapproval are not uniformly linked. 'We routinely judge that people are worse off without thinking that they are ill in any way—for example, the ugly, the poor, people with no sense of humour or lousy taste or a propensity for destructive relationships.' Clearly, then, we must suppose that illness involves being badly off on medical grounds. But we must suppose more than this: for one can be disadvantaged on medical grounds even though one is not sick. For example, one is disadvantaged on medical grounds if one misses out on immunisation, or contraception, or a varied diet, and so forth; but one is not *ipso facto* ill if one misses out on these things. It is very hard to see how to specify what it is to be *ill* without having recourse to the idea that illness involves departures from normal functioning in biological systems.

(There are some subtleties here. As Murphy [8:5] notes, there have been developments in our concept of illness and disease over time. In the early modern era, diseases were taken to be 'observable suites of symptoms with predictable courses of unfolding'. This notion was displaced by the idea that diseases are 'destructive processes in bodily organs which divert them from their normal functioning'. More recently, the notion has been further refined: certain kinds of elevated risks—e.g. high blood pressure—are also counted as diseases even if there are neither overt symptoms nor destructive pathological processes. So references to 'departures from normal functioning in biological systems' includes cases in which biological systems are in stable but suboptimal and poorly regulated states.)

Even if it is accepted that the 'naturalist' or 'objectivist' view of disease and illness is correct for 'physical' illnesses, it may well be objected that this account is, at best,

highly controversial in the case of ‘mental’ illnesses. Is it really plausible to suppose that ‘mental’ illnesses are departures from natural or normal biological functioning?

Some people object to the suggestion that ‘mental’ illnesses are departures from natural or normal biological functioning on metaphysical grounds. For example, *substance dualists* think that human beings are amalgams of two different kinds of stuff: the biological (or physical) and the mental (or spiritual). While substance dualists will typically acknowledge that illnesses in one domain can have causes in the other domain—e.g. mental stress can be a cause of departures from normal biological functioning in bodily organs other than the brain, and genetic inheritance can be a cause of mental disorders—they typically also insist that ‘mental’ illnesses must be understood as departures from natural or normal mental functioning (where such departures may not be accompanied by any departures from natural or normal biological functioning in the brain or elsewhere). For another—perhaps less dramatic—example, *property dualists* think that human beings have two irreducibly different kinds of properties: biological (or physical) properties and mental (or spiritual) properties. Property dualists also typically suppose that ‘mental’ illnesses can only be understood as departures from natural or normal mental functioning: there is no way of ‘reducing’ mental illness to physical illness, no way of explaining mental illness in purely biological or physical terms.

Those who do not have metaphysical grounds for objecting to the claim that ‘mental’ illnesses are departures from natural or normal biological functioning may have other grounds for objection. In particular, it is worth noting that there are grounds for scepticism about the very distinction between ‘physical’ and ‘mental’ illness. As we have already noted, the distinction cannot be drawn in terms of causes of conditions. But it is equally clear that the distinction cannot be drawn in terms of symptoms: some symptoms are hard to classify (e.g. pain), some characterise both ‘physical’ and ‘mental’ illnesses (e.g. fatigue), and some ostensibly ‘mental’ disorders (e.g. memory loss) can arise from what are clearly physical causes (e.g. a blow to the head). (See Perring [9:4].) In the face of these difficulties, some people have suggested that we should distinguish only between brain-based and non-brain-based disorders, and give up on the pre-theoretical distinction between ‘physical’ and ‘mental’ illnesses. However, as things now stand, it is clear that we are not able to think and talk about serious disturbances of thought, experience and emotion—as manifested in schizophrenia, bipolar disorder, borderline personality disorder, and so forth—in purely physical and biological terms. For the foreseeable future, we have no choice but to continue to make use of such categories as ‘thought’, ‘experience’, ‘feeling’, ‘emotion’, and so forth in our description, analysis and treatment of mental illnesses.

As things stand, it is clearly not ruled out that the ‘naturalist’ or ‘objectivist’ view of diseases is correct. That is, as things stand, it is not ruled out that all illnesses and diseases involve biological malfunctioning that is the proper subject matter of biological science. However, even if the ‘naturalist’ or ‘objectivist’ view of diseases is correct, it is clear that, even in the case of paradigmatically physical diseases, we have no choice but to continue to make use of such categories as ‘thought’, ‘experience’, ‘feeling’, ‘emotion’, and so forth in our *treatment* of those diseases. Moreover, even if the ‘naturalist’ or ‘objectivist’ view of diseases is correct, it is clear that, in a wide range of cases, we also have no choice but to take into account the relevant metaphysical beliefs of those subject to illness in the treatment of their illnesses. As

we noted earlier, freedom from illness and disease is only one dimension of human flourishing, and illness and disease interact in complex ways with other dimensions of flourishing human beings. Since no one could pretend that we can give a 'naturalist' or 'objectivist' account of human flourishing in purely biological or physical terms, there is no option but to hold commonsense considerations about human flourishing in mind when describing, analysing and providing medical treatment.

4. Adverse Conditions

There are many adverse factors and adverse conditions whose negative impact on human flourishing and human health are uncontroversial. Thus, for example, no one disputes that loneliness, stress, low self-esteem, lack of self-control, ignorance, and poverty are all factors that count against human flourishing, and that these are all factors that are linked to poor health and increased susceptibility to illness and disease. By and large, flourishing people are engaged in worthwhile activities, and they are recognised by other people as being engaged in worthwhile activities. By and large, flourishing people belong to networks of flourishing people, and they have meaningful relationships with people in those networks. By and large, flourishing people have appropriate emotional responses both to themselves and to others. By and large, flourishing people do not have fantastic beliefs about themselves and the world in which they live. By and large, flourishing people do not engage in self-destructive behaviour and excessive risk-taking. Etc.

While all of this seems straightforward and unproblematic, there are complicating factors. In particular, there are hard questions that arise if we probe more deeply into the connection between flourishing and the holding of fantastic beliefs about oneself and the world in which one lives. On the one hand, we have the judgment—present in Aristotle—that theoretical and practical wisdom are fundamental components of human flourishing: we do better insofar as we acquire truth and act on the basis of it. On the other hand, we have a large recent literature, going back at least to the 1950s, which suggests that human flourishing may depend upon possession of 'positive cognitive biases', i.e. upon more or less mild self over-estimations of abilities, reputation, importance, and sphere of control (see, for example, [10]).

Even setting aside considerations about positive cognitive biases, there are hard questions to ask about the connections between true belief and human flourishing. On the one hand, it is fairly uncontroversial that *delusion* is not conducive to human flourishing: most people agree that you are not flourishing if you have too many false beliefs that are firmly sustained despite what everyone else believes (to the contrary) and despite what constitutes incontrovertible and obvious proof or evidence to the contrary (cf. DSM-IV-TR definition of 'delusion'). On the other hand, it is rather less clear how much divergence from beliefs ordinarily accepted by other members of one's culture or subculture is compatible with human flourishing (again, cf. DSM-IV-TR definition of 'delusion').

When we consider the distribution of religious, political, and philosophical beliefs of human beings across the world over history, it is clear that most people have had massively false beliefs in these domains. For, once we move to sufficient level of detail, there are no majority beliefs in these areas: no collections of beliefs about religion, or politics, or philosophy are shared by more than a tiny fraction of human

beings across the world over history, and yet each collection of beliefs about religion, or politics, or philosophy is inconsistent with all of the other collections of beliefs about religion, or politics, or philosophy. If we insist that you do not flourish unless you have (largely) true religious and political and philosophical beliefs, then we quickly reach the conclusion that human flourishing is very rare indeed.

Considerations about sharing of beliefs with others in one's culture or subculture interact in interesting ways with some of the other factors that can impact negatively on health. Depending upon the nature of the society to which one belongs, being known as someone who rejects widely shared religious or political or philosophical beliefs may lead to ostracism, abuse, and stress, and perhaps also to lower self-esteem and loneliness. Even in contemporary liberal democracies, it is clear that *some* people suffer in these ways because their beliefs are at odds with the sub-cultures to which they belong. (Similar points can be made about values as well. And, given that projects emerge against a background of beliefs and values, it seems equally clear that perceptions of the worth of activities and projects are also linked to factors that can impact negatively on mental and physical health.)

Even if we come to think both that people are unlikely to flourish if their beliefs are widely at variance with the beliefs of the sub-culture or culture to which they belong and that nearly all people at nearly all times have had massively mistaken religious, political and philosophical beliefs, we should not move too quickly to the conclusion that truth of beliefs if largely irrelevant to human flourishing. We do not need to move to the extremes of the view evinced in Clifford [11] to suppose that one condition for human flourishing is that one belongs to a sub-culture or culture that accords serious respect to evidential support for belief. Moreover, given the evident frailties involved in formation of beliefs about religion, politics and philosophy, there is fairly strong ground to support the claim that we should be tolerant of those who do respect the demands of reason and evidence, and yet who end up with widely different beliefs from our own.

Of course, there are people who insist on a much more direct connection between belief and flourishing. Some religious believers hold that you do not truly flourish unless you hold a particular set of religious beliefs. Some 'new atheists' hold that you do not truly flourish if you hold any religious or 'spiritual' beliefs. (See, for example, [12] and [13].) I think that there are good grounds for rejecting any positions of this kind; but there is hardly space to argue for this contention here. (For further discussion and defence of 'agreeing to disagree', see [14].)

5. Spirituality

There are various ways in which one might understand the suggestion that 'spirituality' should have a significant role in healthcare. I shall canvass some such ways, in what I take to be diminishing order of plausibility. It should be noted that the following points are prompted by different ways of understanding the notion of spirituality.

First, as noted in our discussion of illness and disease, it is quite uncontroversial to claim that we need to bear commonsense considerations about human flourishing in mind when describing, analysing and providing medical treatment. Health is one of a

number of interrelated factors that jointly constitute human flourishing. Medical treatment that is aimed at improving health will often need to take into account some of the other factors that constitute human flourishing. What a person *feels* and what a person *believes* can make a difference to the result of medical treatment. Whether medical intervention disrupts social relationships can make a difference to the outcome of that intervention. Medical treatments that cause or exacerbate stress, or loneliness, or low self-esteem work against themselves (though, of course, in some cases, this kind of self-undermining may be acceptable and even unavoidable). Insofar as 'spiritual' healthcare is defined by contrast with 'merely technical' healthcare, it is surely undeniable that 'spiritual' healthcare will lead to better outcomes in a great range of cases.

Second, as noted in our discussion of adverse conditions, it is plainly reasonable to suppose that, insofar as patients have 'spiritual beliefs'—i.e., beliefs about ultimate purposes, immaterial realities, supernatural entities, and the like (cf. [15])—those beliefs should be taken into account in the provision of healthcare. Setting aside hard cases involving religious, or political, or philosophical delusions, it seems clear that it should not be the business of medical practitioners and their supporters to try to *change* the religious, or political, or philosophical beliefs of their clients. On the contrary, if patients belong to sub-cultures that share their religious, or political, or philosophical beliefs then—absent clear legal or medical reasons to the contrary—those patients are entitled to support from within those like-minded sub-cultures. (Some deny that there could be legal reasons that would suffice for denial of such support. Suppose that some conspirators have been injured as part of a failed terrorist action. Should they be allowed to recuperate together, even if there are good grounds to suppose that their recuperating together increases the risk of further terrorist action? Consider, for example, the treatment of the members of the Baader-Meinhoff group by the German state ([16]). Many now think that the German state was far too liberal and tolerant in its treatment of the RAF.) Of course, there are also hard cases where 'spiritual beliefs' come into conflict with the requirements of the best available medical treatment—as can happen, for example, with the beliefs of Christian Scientists, and the like. While this is not the place to pronounce on these hard cases, it is probably worth noting that, while 'spiritual beliefs' should always be taken into account, this hardly entails that 'spiritual beliefs' trump all other considerations concerning the provision of healthcare.

Third, there are people who claim that the having of 'spiritual' beliefs—i.e. beliefs in ultimate purposes, immaterial realities, supernatural entities, and the like—is an important component of human flourishing, and perhaps even an important component of human health. Taken in isolation, this claim seems implausible. After all, it would be very surprising if beliefs in evil demons, ghosts, ghouls, and so forth are positively correlated with either human flourishing or good health outcomes. At the very least, one might expect that human flourishing and good health outcomes would correlate only with *positive* 'spiritual' beliefs, i.e. the kinds of 'spiritual' beliefs that are emphasised in the world's major religions— Christianity, Islam, Hinduism, Buddhism, Judaism, and the like—and in similarly patterned systems of belief—e.g. Wicca. Indeed, while the terms 'spiritual' and 'religious' are used widely in the literature on 'spirituality' and healthcare, it seems to me that the distinction that is marked is typically a distinction between holding beliefs that are proper to religion and participating in a religious community. Thus, our focus should really be on those

people who claim that having ‘religious’ beliefs—perhaps in combination with participating in organised religious activities of some kind—is an important component of human flourishing, and perhaps even an important component of human health. This brings us to the final section of this chapter.

6. Religious Belief

There is an enormous new literature on religion and health. Every month, the *Institute for the Biocultural Study of Religion Research Review* brings outlines of dozens of new articles and books on this topic across my desk. Much of this new research is concerned with what are often reported as correlations between ‘religiosity’ and ‘well-being’. Claims are made for connections between ‘religiosity’ and such diverse things as: greater happiness; greater life satisfaction; lower levels of stress; better coping with life-threatening illness; lower levels of alcohol consumption; lower levels of smoking; lower levels of depression and other mental illness; higher levels of scrupulosity; lower levels of anxiety; lower levels of herpes and other STDs; lower levels of illicit drug use; more positive attitudes towards marriage, relationships, and attachments; reduced risks of death; and so on.

Taken at face value, these claims offer support for the view that having ‘religious’ beliefs may make some contribution to human health and human flourishing. Of course, even if there are no defeating considerations, these claims are not sufficient to establish that ‘religious’ belief is a significant, let alone essential, component of human health and human flourishing: at most, the studies claim to show that there is a statistically significant correlation (or, in some cases, that there is a ‘positive’ statistical correlation that ‘approaches significance’) between ‘religiosity’ and human health and flourishing. And, in any case, there is also a range of defeating considerations that need to be taken into account.

First, the literature is peppered with studies that claim that no definite conclusions can be drawn about relationships between religiosity and human health and flourishing because of major methodological shortcomings of the studies that have been conducted (for one very recent example, see [17]).

Second, evidence that there are methodological problems is not hard to find. For instance, many studies of ‘religiosity’ and happiness rely on a single self-reported item to measure each of these dimensions: rate your happiness and the intensity of your religious belief on a scale from 1-5. While one might have predicted, *a priori*, that there is likely to be some positive correlation between self-assessments of religiosity and happiness, there is plenty of evidence that self-assessments of happiness and flourishing are not reliable measures of either happiness or flourishing. (Of course, this is obvious on the Aristotelian account of flourishing, and, indeed, on any relatively ‘objective’ account of flourishing.)

Third, the category of ‘religiosity’ is not a particularly useful one. As some of the more recent studies have noted, it is important to try to draw out the relative significance of such things as: regularity of church attendance; regularity of participation in other religious gatherings; regularity of participation in religious rituals; strength of religious beliefs; nature of religious beliefs; and so forth.

Fourth, there is some fairly robust counter-evidence that needs to be taken into account. For example, Paul [18] appeals to national census data across the Western world—data of the kind that is contained in the *Britannia Yearbook*—to establish correlations between reported national 'religiosity' and national measures of moral and social dysfunction. On Paul's account, many of these correlations of reported national 'religiosity' and national measures of moral and social dysfunction contradict the claims that emerge from the literature on religion and health. So, for example, while many US studies report that 'religiosity' is correlated with more positive attitudes towards marriage, relationships, and attachments, the cross-national comparison shows that divorce rates are higher in the United States than they are in Western countries with much lower levels of national 'religiosity' (e.g. Sweden and Australia).

In the light of these and other considerations, it is hard to draw reliable conclusions from the current research on religiosity and happiness. While it is clear that there are significant connections between self-reports of happiness and religiosity, it is unclear what else can be reliably inferred from the data that we have. In particular, it is very important to note that many of the adverse conditions for human flourishing and human health that were discussed previously—e.g. loneliness and low self-esteem—are clearly moderated or removed by some aspects of 'religiosity'—e.g. regular church attendance, regular participation in religious gatherings, and so forth. However, it would plainly take some very cleverly designed studies to find evidence that it is the 'religious' aspect of these activities that are crucially implicated in the alleviation of the adverse conditions. If anything like the Aristotelian account of human flourishing is correct, then one might well suspect that there is only a highly contingent connection between 'religiosity' and health. At the very least, one might wonder whether it is true that, for example, regular church attendance and regular participation in religious gatherings has a higher correlation with good health outcomes than regular attendance and participation in other kinds of human organisations that have no necessary connection to religion: community orchestras, rationalist societies, sporting clubs, and so forth.

Of course, there are other, more dramatic claims that have been made in recent times connecting 'religiosity' and health. So, for example, there have been studies that claim that prayer can be efficacious in securing good health outcomes for those who are prayed about. The very least that needs to be said here is that there are plenty of reasons for scepticism. (See, for example, [19], for methodological concerns about studies in this area.) However, this is not to say that there could not be any correlations between prayer and good health. I do not think that it would be surprising to learn that prayer has some positive correlation with good health outcomes for those who pray, all other things being equal. There is plenty of evidence that meditation and mindfulness have such correlations, and prayer is often a species of these kinds of activities.

I shall conclude with a final piece of anecdotal evidence. When I first became a philosopher, it was said to me that I had chosen my profession wisely: for philosophers, like priests, are renowned for their long, healthy and flourishing lives. I do not know whether this piece of folk wisdom is really so. However, if it is so, it is worth noting that, for at least the last fifty years, the majority of philosophers in the West have been non-religious. What priests and philosophers have in common are the

things that Aristotle supposed conduce to human flourishing: community, intellectual virtue, life-long commitment to worthwhile ends, and so forth. Perhaps this is one further sign that, of itself, religiosity has no *unique* significance for health and flourishing: the 'spiritual' dimension of health and flourishing might be much more a matter of 'exercise of virtue in the pursuit of worthwhile individual and collective ends'—or 'solidarity and resistance', or 'social inclusion', or what have you—than it is a matter of *uniquely* religious concerns.

Works Cited

1. Keown, D. (1992) *The Nature of Buddhist Ethics* London: Macmillan
2. De Silva, P. (2002) *Buddhism, Ethics and Society* Clayton: Monash Asia Institute
3. Strawson, P. (1974) 'Social Morality and Individual Ideal' in *Freedom and Resentment and Other Essays* London: Methuen, 26-44
4. Wolf, S. (1982) 'Moral Saints' *Journal of Philosophy* 79, 419-39
5. Carel, H. (2008) *Illness: The Cry of the Flesh* Dublin: Acumen
6. Nordenfelt, L. (1995) *On the Nature of Health: An Action-Theoretic Perspective*, second edition, Dordrecht: Kluwer
7. Richman, K. (2004) *Ethics and the Metaphysics of Medicine* Cambridge: MIT Press
8. Murphy, D. (2008) 'Concepts of Disease and Health' *Stanford Encyclopaedia of Philosophy*
9. Perring, C. (2010) 'Mental Illness" *Stanford Encyclopaedia of Philosophy*
10. Cummins, R. and Nistico, H. (2002) 'Maintaining Life Satisfaction: The Role of Positive Cognitive Bias' *Journal of Happiness Studies* 3, 37-69
11. Clifford, W. (1879) 'The Ethics of Belief' in *Lectures and Essays*, edited by Stephen Pollock, London: Macmillan
12. Dawkins, R. (2006) *The God Delusion* London: Bantam
13. Hitchens, C. (2007) *God is not Great: How Religion Poisons Everything* New York: Twelve Books
14. Oppy, G. (2010) 'Disagreement' *International Journal for Philosophy of Religion* 68, 183-99
15. Sheldrake, P. (2007) *A Brief History of Spirituality* Malden: Wiley-Blackwell
16. Aust, S. (1985) *The Baader-Meinhoff Complex*, translated by Anthea Bell Oxford: OUP
17. Visser, A, Garssen, B., and Vingerhoets, A. (2010) 'Spirituality and Well-Being in Cancer Patients: A Review' *Psycho-Oncology* 19, 6, 565-72
18. Paul, G. (2005) 'Cross-National Correlations of Quantifiable Societal Health with Popular Religiosity and Secularism in Prosperous Democracies" *Journal of Religion and Society* 7, 1-17
19. Andrade, C. and Radhakrishnan, R. (2009) 'Prayer and Healing: A Medical and Scientific Perspective on Randomised Controlled Trials' *Indian Journal of Psychiatry* 51, 4, 247-53

Other Works Used

Aquinas (2007) *Summa Theologiae* Cambridge: Cambridge University Press

Aristotle (1976) *Ethics*, translated by J. A. K. Thomson, revised translation by H. Tredennick Harmondsworth: Penguin

Aristotle (1981) *The Politics*, translated by T. A. Sinclair, revised translation by T. J. Saunders Harmondsworth: Penguin

Confucius (2010) Analects, translated by J. Legge http://ebooks.adelaide.edu.au/c/confucius/c748a/index.html

Crisp, R. (2008) 'Well-Being' *Stanford Encyclopaedia of Philosophy*

Green, M., and Elliott, M. (2010) 'Religion, Health and Psychological Well-Being' *Journal of Religious Health* 49, 149-63

Koenig, H., McCullough, M. and Larson, D. (2001) *Handbook of Religion and Health* Oxford: Oxford University Press

Williams, D. and Sternthal, M. (2007) 'Spirituality, Religion and Health: Evidence and Research Directions' *Medical Journal of Australia* 186 (10 Supplement), S47-S5