THE RELIGIOUS COMMUNITY AS SOCIAL RESOURCE

Relationship between religion and health is a subject of various scientific disciplines such as medicine (gerontology, psychiatry, and social epidemiology), psychology, anthropology, sociology etc. In the last 40-50 years, this subject is more intensively investigated and the results are frequently published in medical journals and journals in the field of sociology and psychology of religion.

Although the relationship between religion and health in a more empirical sense is a more recent theme, it is based on the works of the founder of sociology (Durkheim, Weber) and other classical theorists (Freud, Jung, Maslow). Namely, in all the above mentioned papers, one studied and explored the relationship between religion and health, more specifically, the positive and negative effects of religion on human health were explored. Despite the fact that in the 19th century, empirical research (Levine, 2009) was used, which used the indicators of religiosity and in which the findings indicated the relationship between religiosity and health. Since at that time the medicine was dominantly positively oriented, it was impossible to see the positive influences that religion / religion could have on health. Since the '60s of the last century, scientists have opened up broader horizons to an increasing number of scientific disciplines whose aim is empirically to reveal the nature of the relationship between religion and health. In support of the propagation of this topic, the fact that 1987 has been trying to conceptualize a new scientific sub-discipline - epidemiology of religion (Levin & Vanderpool, 1987). The number of empirical researches dealing with the relationship between religion / religion and health in the last 40-50 years has increased significantly (Weaver et al., 2006). Therefore, Chatters (2000) emphasizes that the following research tendencies can be seen during this period: a) the development and expansion of research programs; b) raising the quality of research; c) an increase in the interest of various scientific disciplines and sub-disciplines (e.g. psychoneuroimmunology) and clinical practice. In other words, in this period, the multidimensionality of the subject matter is understood and the foundations for a more systematic study of religiousness (religious engagement / engagement) and health (physical and mental). In the late 1980s of the last century, several articles on epidemiological research

have been published in the US that show that the high level of religious engagement is moderately linked to a better health status. Epidemiologists therefore emphasize that religion / religiosity is a "protective factor that provides a small but significant primary preventative effect on population morbidity" (Ellison & Levin, 1998, p. 701). In that generation of research, it is evident that religious engagement has a positive effect on reducing the incidence of heart disease, hypertension, stroke, some types of cancer, gastroenterological problems, and a tendency to better assess their own health and self-recognition of symptoms (Levin & Schiller, 1987). Despite numerous research into the positive effects of religiousness on personal health, studies can also be found that point to the negative effects of religion on physical and mental health or the inadequate use of health services. Although there is no systematic research, some people still show that religious communities can impose certain beliefs that promote socially disadvantaged health (Ellison & Taylor, 1996). It also shows that participation in the religious community can also contribute to the creation of social pressure which, as such, can ultimately have negative effects on health. Contemporary tendencies in the study of the relationship between religion and health go in the direction of defining the content of the research area, testing theoretical concepts, implementing clearer and more qualitative methodological procedures to align with research issues. In other words, it is evident that conceptually valid measures of religiousness and spirituality are applicable and appropriate for this research area (Koenig, 2001). Despite the theoretical frameworks of these and similar researches, there are four general theoretical approaches or explanatory mechanism for the relation between religion / religion and health (Elison & Levin, 1998; Oman & Thoresen, 2002): Health Behavior - implies that most religions within their doctrines are trying to regulate individual lifestyles and health behaviors aimed at the responsible relationship of the believer towards his body and overall health condition (Levin, 2001). Social Support - implies that engaged believers in their religious community create certain social networks in which they can, by exchanging information and experiences and creating close friendships,

gain and build social support (formal and informal). In this way, the religious community can be seen as a social resource whose health impact is evident (Ellison & George, 1994). Psychological states - implies that religiosity can promote positive self-perception, specific problem-solving resources (e.g., individual cognitive and behavioral responses to stress), encourage certain feelings in individuals such as happiness, comfort, hope and so on, and thus contribute to better mental and physical health (Koenig, 1998). Abdominal / Supernatural Influences - implies that the issue of potential and supernatural effects on health, that is, outside the scope of natural laws (e.g. bioenergy cure) should not be dismissed as a possible explanation.

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