Spirituality and Lifestyle: What Clinicians Need to Know

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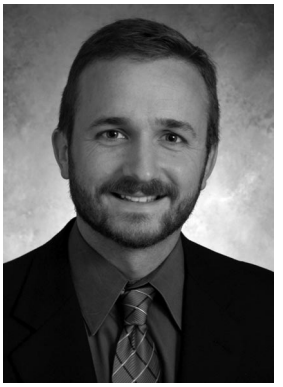

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Of all influences religion may have on health, the most intuitively plausible and uncontroversial concerns patients' health-related habits and behaviors. At least part of the epidemiologic association between religious involvement and mortality is accounted for by inverse associations between religious involvement and detrimental health behaviors and less consistent positive associations between religious involvement and beneficial health behaviors. Levin notes that these are best understood as *indirect associations*, rather than as confounders, because they "do not 'explain away' the health effects of religious involvement but rather elucidate the pathways and mechanisms by which being religious and practicing religion seem to benefit health."[1]

Regarding health-related lifestyle behaviors, Strawbridge and colleagues,[2] in their longitudinal analysis of data from the Alameda County Study, found that more frequent religious attendance was associated not only with lower likelihood of smoking at baseline, but also with higher likelihood, over time, of *quitting* smoking, becoming not depressed, and becoming physically active. They concluded, "Over nearly a 30-year period, those attending services weekly were more likely than those attending less or not at all to both establish good health behaviors not already being performed and to maintain ones already established."[2]

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In addition, although greater religious involvement is generally associated with lower *overall* utilization of health care resources, in some studies it is associated with higher use of resources geared toward health promotion and disease prevention. For example, Benjamins and Brown found, in a representative national sample of more than 6,000 elderly Americans, that those who endorsed a religious affiliation and for whom religion had greater importance were more likely to report flu shots and cholesterol screening.[3] Although religious salience was not associated with rates of breast self-examination or mammography, it was associated with higher rates of prostate cancer screening and pap smears.

The following may help clinicians think about the influence of religious involvement on health behaviors. First, religions provide comprehensive frameworks of meaning (ie, world views, philosophical tenets), which specify behavioral expectations and norms.[1,2] Religions may proscribe certain behaviors altogether (ie, Seventh Day Adventist and Mormon proscriptions of alcohol and smoking or Jewish and Muslim proscriptions of pork), or they may encourage temperance with respect to natural appetites, ranging from avoidance of gluttony and drunkenness to fasting and other ascetic practices. Religious traditions may also endorse beneficial health behaviors as acts of faithful stewardship over the body as a sacred gift.

Of course, knowing how one *ought* to behave does not necessarily lead to desired behaviors, particularly when those behaviors are difficult. Here, religious involvement may provide resources, or *capital*, on which patients can draw to overcome their appetites, addictions, and inertia to carry out the behaviors that their religious frameworks specify. Religious involvement may provide *psychological* capital by changing patients' states of mind. For example, religious involvement has been found to be associated with hopefulness, optimism, and improved self-esteem.[2] Religious involvement may provide *social* capital through religious communities, which, by exerting peer pressure, join in a common cause against behaviors that are deemed harmful. Religious communities may also help patients to access health-promoting and disease-preventing resources, either by providing congregation-based health-promoting services or by connecting patients to more traditional health care organizations. The influence of religion on social capital is likely to be most important for the elderly, who are often socially vulnerable

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and known to have the highest levels of religious attendance and religious salience.[3] Higher rates of social vulnerability among elderly women, because of frequent widowhood, may partially explain why most studies find that associations between religious involvement and health outcomes are stronger among women than men.[2]

Finally, religious involvement may provide *spiritual* capital, or what some religious traditions call *grace*. This would include resources that are understood to derive from a transcendent source and are appropriated either through intermediate means such as social relationships and psychological benefits of ritual or more directly through sacraments or in answer to prayer. Some elements of spiritual capital, although experienced by patients and physicians to be real, would be by definition beyond the scope of empirical enquiry to fully describe or explain.

References

1. Levin JS. How religion influences morbidity and health: reflections on natural history, salutogenesis and host resistance. *Soc Sci Med* 1996;43: 849–864.
2. Strawbridge WJ, Shema SJ, Cohen RD, et al. Religious attendance increases survival by improving and maintaining good health behaviors, mental health, and social relationships. *Ann Behav Med* 2001;23:68–74.
3. Reindl Benjamins M, Brown C. Religion and preventative health care utilization among the elderly. *Soc Sci Med* 2004;58:109–118.

Sometimes it is harder to deprive oneself of a pain than of a pleasure.

—F. Scott Fitzgerald