Health Outcomes of Religious and Spiritual Belief, Behavior, and Belonging: Implications for Healthcare Professionals

5

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Abstract

Thousands of empirical studies now document that aspects of religion or spirituality are linked with desirable health outcomes. This chapter provides an overview of how religious or spiritual (R/S) beliefs, behaviors, and belonging to a faith community contribute to health outcomes. When living with a health challenge, individuals often use R/S beliefs to cope with their circumstances. These beliefs can be positive or negative; they also impact healthcare decision-making. R/S behaviors observed to be associated with health outcomes include attendance at religious services and various practices such as prayer and meditation. For those who belong within a faith community, that community may provide social support and informal caregiving. This evidence ought to prompt healthcare professionals to plan and implement care that supports R/S in an ethical manner. Indeed, there is evidence that indicates when healthcare professionals support patient R/S, it is associated with various positive outcomes.

A mother refuses vaccinations for her child because of her Christian Science convictions. A Sikh gentleman who was shaved in preparation for surgery latter takes his life because of the significance his religion places on hair as a body organ. A Christian with fundamentalist leanings insists on intubating her brain-dead husband, because “God can still perform a miracle.” These diverse real cases illustrate the powerful role that religion can contribute to how a person addresses a health-related situation. Not all religious influences, however, are so dramatic.

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Consider the following: A patient newly diagnosed with a chronic illness wonders if it is because God is punishing him for something he did in his youth. Another patient prays for guidance prior to making a treatment decision. Another reads scripture and meditates to cope with anxiety and discomfort. For these patients, a clinician may never objectively observe these religious beliefs or behaviors, yet they significantly affect how the patient adapts to the illness.

Whether these beliefs, behaviors, and belonging are invisible or openly expressed by a patient, they have a significant impact on physical, psychosocial, and, of course, spiritual health-related outcomes. Indeed, Koenig and colleagues [1, 2] identified over 3300 studies which investigated this linkage between R/S and health and observed that most researchers found R/S to be associated with or contributed to health outcomes significantly and positively. Koenig et al.'s massive review identified that about 80% of these studies examined R/S in relation to psychological factors. Table 5.1 provides a summary of this review of the health-related R/S research published in peer-reviewed publications. Whereas this review focused on mental and physical health outcomes, others have found evidence which indicates that R/S contributes to overall quality of life and life satisfaction among persons with cancer and various other chronic illnesses [3–7].

Furthermore, there is a growing body of evidence that indicates when healthcare professionals support patient R/S, it is associated with various positive outcomes. For example, in studies of American hospitalized patients, those who received spiritual support from chaplains and/or from members of the healthcare team were found to have greater patient satisfaction with healthcare than those who did not receive such support [8–10]. Findings from a study of 343 patients with late-staged cancer found that when spiritual needs are addressed, healthcare costs are lessened, quality of life is improved, and patients are more receptive to hospice [11]. Spiritual therapeutics (e.g., dignity therapy—a manualized reminiscence therapy, meditation or mindfulness training, meaning-centered group therapy) delivered by healthcare professionals likewise have been observed to contribute to various positive outcomes [12–16]. Together, this evidence suggests not just that R/S is linked with health but that healthcare professionals are careless if they do not provide R/S support when caring.

Thus, this chapter will provide an overview about how religious or spiritual (R/S) beliefs, behaviors, and belonging (to a R/S community) contribute to health outcomes. Implications of caring for a patient in a religiously/spiritually sensitive manner will be offered. To provide a foundation first, a theoretical framing for this is reviewed.

5.1 How Faith Affects Health: Levin's Model

The findings presented in Table 5.1 provide overwhelming evidence that R/S, in general, is positively associated with numerous psychological and physical health outcomes. Why is this? What is it about the R/S in people that makes them less anxious, depressed, and obese? Why is R/S higher in people who live longer? Why do people with higher R/S tend to have better immune function and less disease?

Table 5.1 Religiosity/spirituality (R/S) and health-related outcomes: Koenig's [1, 2] synthesis of evidence

Health-related outcome	Number of quantitative, peer-reviewed studies (prior to mid-2010)	Percentage of studies finding positive/ beneficial association with R/S[a]	Percentage of studies finding a negative/ harmful association with R/S[a]
Coping with adversity (in a wide variety of illnesses and circumstances)	344	"Overwhelming majority"	Not provided
Well-being/happiness	326	79%	<1%
Hope	40	73%	0
Optimism	32	81%	0
Meaning and purpose	45	93%	Not provided
Self-esteem	69	61%	3%
Sense of control in difficult life circumstances	21	61%	14%
Depression	444	61%	6%
Suicide variables	141	75%	3%
Anxiety	299	49%	11%
Mental health illnesses/ diagnoses (bipolar, psychotic disorders, substance abuse)	325	79%	5%
Social support	74	82%	0
Cigarette smoking	137	90% (0%)	0
Exercise	37	68%	16%
Healthful diet	21	62%	5%
Weight/body mass index	36	39%	19%
Risky sexual activity	95	86%	1%
Heart disease	19	63%	5%
Hypertension	63	57%	11%
Cerebral vascular disease (risk for stroke)	9	44%	11%
Dementia	21	48%	14%
Immune function	27	56%	4%
Endocrine function	31	74%	0
Cancer onset or mortality	29	55%	7%
Physical function (activities of daily living)	61	36%	23%
Self-rated health	50	58%	10%
Physical pain	56	39%	25%
Longevity	121	68%	5%

[a]Percentages do not add up to 100 because some studies had mixed or inconclusive evidence

Jeffrey Levin, who describes himself as an epidemiologist of religion and one of the earliest to conduct a comprehensive review of research about religion and its association with health, offered a theoretical model to explain religion's salutatory effects [17, 18]. Levin provides a taxonomy where he identifies five mechanisms whereby religion affects human health. He labels these mechanisms as behavioral/conative, interpersonal, cognitive, affective, and psychophysiological. A closer look at each of these mechanisms is in order:

- Behavioral/conative (or motivational) mechanisms refer to health-promoting behaviors that often are prompted by religious prescriptions and proscriptions. These healthful lifestyles and choices have an impact on the immune and endocrine systems in ways that promote health and prevent disease. For example, most religions advise monogamy within a covenantal relationship and consider any breach of a marriage as unethical; thus, those who follow this prescription are at lower risk for genital cancers and sexually transmitted diseases, never mind the psychosocial sequelae associated with an extramarital affair. Likewise, many faith traditions encourage temperance or abstinence from alcohol; others provide advice regarding diet and fasting for which recent research findings provide support.
- Interpersonal mechanisms of faith involve the individual connecting either with others of similar R/S views or with the divine (or divine entities, such as angels or saints). Either provides the individual with companionship—social support—a vital factor known to prevent disease and promote health. Thus, for the R/S person who participates in a faith community of some sort (e.g., engages informally or formally with a community of fellow believers at a church, synagogue, mosque, gurdwara, temple, or devotional meeting), this community can provide friendship and a social safety "net." More accessible, however, is the fellowship with the divine (e.g., God, saint, guardian angel) that can provide one with a sense of comfort and safety. The decreased chance for experiencing isolation, thus, undoubtedly helps people of faith to avert illness and be well.
- Cognitive mechanisms of faith refer to the intellectual schema developed to explain why things happen in life as they do and to the beliefs we hold to make sense of our world. For example, inherently, religions offer myths about how the universe was created and how it will continue or end. For example, many faith traditions (e.g., Christianity and Islam) hold that there will be a judgment at the end of temporal time, and most traditions hold that there will an afterlife (e.g., in a heaven, reincarnated state). Such belief not only motivates a believer to live well in the present life but also provides comfort when considering one's mortality. Religious theologies also provide, to some degree, psychologically comforting explanations for tragedy and suffering. For example, some may view their suffering as a consequence of personal or collective disobedience to God's laws, while others may view it as an invitation to draw closer to a loving God or an opportunity for spiritual transformation. These theological meanings persons ascribe to life and its experiences are thought to have an impact on the psyche and, in turn, be expressed somatically to some degree.

- Affective mechanisms refer to how R/S beliefs and practices can create comforting emotions, the neurochemistry of which may function to buffer and decrease disease processes and/or enhance the immune system and other health-promoting physiology. For example, persons of faith can experience warmth, peace, joy, harmony, perspective, gratitude, and so forth during prayer, chanting, worshipful singing, meditation, communion with fellow believers, and so forth. Such positive emotions are known to be health-promoting.
- Psychophysiological mechanisms refer to those aspects of faith that create hope and optimism, which in turn create a somatic response. Levin acknowledged that all five of these salutatory mechanisms of faith could be classified as psychophysiological but reserved this last category for acknowledging the linkage between the mind and body.
- For example, hope that rests in knowing there is a God who will make all things well will help to ease one's burdens; the comfort of knowing one is not alone also can provide the will to live and endure suffering [17, 18].

Although he did not develop this as a category, Levin did acknowledge that additional mechanisms may exist for the observed faith and health linkage. For example, there may be health that is explained by nonlocal consciousness or unitive experiences with what is transcendent (e.g., "miracles"). Because he delimited his categories of mechanisms to that which can be linked to existing science about mind-body interactions, Levin expressed confidence that this theorizing is plausible.

5.2 Nursing Implications

Given that R/S is significantly associated with health outcomes and we have reviewed several mechanisms likely involved in explaining this faith-health connection, we will explore how all this should impact the care delivered by clinicians. We will merge some of Levin's categories and discuss healthcare implications that emerge from evidence about how a patient's R/S beliefs, behaviors, and belonging do influence healthcare.

5.3 Religious/Spiritual Beliefs

Hebrew scripture posits, "For as he thinketh in his heart, so is he" (Proverbs 23:7; KJV). Indeed, what persons believe is the reason for life and living, for illness, for suffering, for death, and for where people come from and to where they are going—essentially R/S beliefs—certainly will affect how they respond to a health challenge. These S/R beliefs about existence will undoubtedly impact how the health challenge is interpreted, how the treatment decisions are made, as well as how health is defined and pursued in general.

5.4 R/S Beliefs About Living Healthfully

Given R/S beliefs offer a believer existential explanations, it is unsurprising that R/S beliefs permeate how persons define and pursue health in general. R/S beliefs (often intertwined with cultural traditions) can influence what one believes is healthful food, drink, hygiene, and lifestyle, whether and what healers should be sought, and other health behaviors [19]. Consider these examples:

- Christian view their bodies as the temple for God; thus good health habits allow one to more fully experience the indwelling of the divine.
- Jews perceive their bodies as God's property; thus, the body is to be maintained and respected.
- Muslims pursue health by pursuing equilibrium in their lives and making choices for good rather than evil (e.g., balancing work with prayer and sleep, focusing on what is beneficial).
- Sikhs view the human body as the ultimate creation and believe health results when they care for themselves holistically; this is done through adherence to religious principles, service, and daily prayer and showering (to cleanse the mind and body).
- Hindus likewise perceive health as balancing mind, body, and soul (where consciousness resides); health is determined by the law of *karma* (i.e., actions and deeds contribute to good or bad reactions—in this life or then next).
- Christian Scientists explain health as the by-product of spiritual mindedness (e.g., compassion, forgiveness, fearlessness, etc.). Healthy mindedness contributes to physical health.
- Buddhists seek health by recognizing the following insights: All things are impermanent, one is incapable of making true happiness, and one's existence is neither inherent nor eternal [19].

R/S beliefs also shape how persons of faith think about what is illness, suffering, and death. Whereas the Eastern religious traditions (e.g., Buddhism, Sikhism, Hinduism) tend to see illness resulting from an imbalance, disharmony, or lack of moderation in physical, mental, or spiritual pursuits, the Abrahamic faiths (i.e., Judaism, Christianity, and Islam) link illness and death with "sin" and accept Western scientific causal explanations. Although (as the evidence to follows substantiates) many from Christian backgrounds entertain the notion that their illness is punishment, this is not a position most Christian denominations espouse [19].

Empirical evidence linking R/S with various health-related outcomes often intertwines the R/S beliefs with R/S behaviors. Although this chapter will attempt to tease these two aspects of R/S apart in the discussion to follow, one example of this is appropriate here. A number of studies, especially with samples of patients with HIV, have observed some aspect of R/S contributes to medication adherence [4, 20]. Whereas most found a positive relationship, many observed some aspect of religiosity linked with poorer adherence. Indeed, it is easy to surmise that the more religious a patient is (i.e., the more one accepts that his or her body is a temple of God,

as most in these studies were from cultures influenced by Christianity), then the more likely the patient will be to take their medication. The implication for clinicians may be obvious: Assess R/S, and when it is present, use it therapeutically to motivate health-promoting behaviors. Conversely, when patients are making poor choices impacting their health, screening for R/S struggle—or negative interpretations of their circumstances—may provide insight.

5.5 Negative vs. Positive Religious Interpretations

Given R/S beliefs about health and illness vary, it is helpful to consider how beliefs impact adjustment to illness. One of most frequently used instruments for measuring how a person interprets and copes with an illness or tragedy is the Brief RCOPE or Religious Coping Questionnaire [21]. This questionnaire includes two scales: one measuring positive religious coping while the other quantifying negative religious coping. Table 5.2 provides the items from this instrument to illustrate what is positive and negative religious coping. To summarize, however, positive religious coping involves a secure attachment to God and a sense of connectedness with a benevolent God and faith community. For persons using negative religious coping, there is a sense of abandonment and punishment by God, isolation from their faith community, doubts about the power of God, and thinking that one's illness is caused by a dark or devilish force. Note: Although atheists/agnostics/humanists, by definition, question or reject there is a divine being, Exline et al. [22] found that some atheists harbor a long-seated anger toward God.

Findings from numerous studies firmly establish negative religious coping as maladaptive and positive religious coping as adaptive among persons with various illnesses [23]. Indeed, negative religious coping, or religious struggle (the term

Table 5.2 Illustrations of positive and negative religious coping: the Brief RCOPE [21]

Positive religious coping items
• Looked for a stronger connection with God
• Sought God's love and care
• Sought help from God in letting go of my anger
• Tried to put my plans into action together with God
• Tried to see how God might be trying to strengthen me in this situation
• Asked forgiveness for my sins
• Focused on religion to stop worrying about my problems
Negative religious coping items
• Wondered whether God had abandoned me
• Felt punished by God for my lack of devotion
• Wondered what I did for God to punish me
• Questioned God's love for me
• Wondered whether my church had abandoned me
• Decided the devil made this happen
• Questioned the power of God

currently used), may be surprisingly frequent among patients with particularly difficult health challenges. For example, findings from a large American study of hematopoietic cell transplant survivors (*N* = 1449) revealed 27% reported some degree of negative religious coping [24]. Although this religious struggle was not associated with how long it was since the transplant, it was directly correlated with depression and quality of life and inversely related to age. Other research results have documented rates of spiritual struggle to be as high as 56% (among hospitalized Swiss patients) [25], 58% (for American patients hospitalized for coronary conditions) [26], and 61% (for Tanzanian women with an obstetric fistula) [27], whereas <13% of a large sample of Danes who had coped with a crisis in their past used negative religious coping [28].

Regardless of prevalence, it is important for clinicians to appreciate that religious struggle is associated with depression, anxiety, and other poor outcomes [25, 27, 29, 30]. Indeed, findings from a well-designed study of 101 Americans with end-stage congestive heart failure found that R/S struggle predicted future hospitalization and physical functioning in [29]. Such evidence should prompt clinicians to assess for spiritual struggle among patients and make referrals to experts who can sensitively address the psychospiritual complexities of spiritual struggle.

5.6 R/S Beliefs Affecting Treatment Decision-Making

R/S beliefs can impact treatment decision-making. The evidence about this primarily involves how patients (or their surrogates) are influenced to some degree by R/S when making decisions related to birthing (e.g., genetic testing, pregnancy termination) or dying (e.g., whether to accept life-sustaining treatment such as a tube feeding or resuscitation) [30–32]. Researchers, however, have also documented how R/S beliefs affect decisions about organ transplantation [33] and cancer treatment [34] and other medical issues [35]. Several themes emerge from this body of evidence.

First, R/S beliefs guide persons as they make healthcare decisions. Although this is typically not described well, it appears that this guidance comes in different ways. R/S provides practices that facilitate decision-making or discernment (to use a religious term); for example, praying about what to do is common [34, 35]. Also, religious traditions typically offer standards or counsels that can explicitly guide a patient to know what is right [19, 33]. For example, a Jehovah's Witness has explicit guidelines on what blood products to accept, and the beliefs espoused by many faith traditions refute abortion and euthanasia.

Second, when persons are making a major decision such as a treatment decision, some variation in the perception of control may be evident. For example, Geros-Willfond et al. [35] observed among 46 family members making decisions about their hospitalized elders that some abdicated the decision-making to God, whereas others used a shared control model and viewed the process as engaging

both themselves and God in the decision process. Other researchers found that some of the Israeli women with HIV they interviewed acquiesced their decision-making about whether to have a child, illustrated by statements about how it was God who controls reproduction [36]. A third theme in this literature describing how patients' R/S influences healthcare decision-making identifies how a R/S belief in a miracle can create challenges for healthcare providers. Whereas some R/S beliefs lead some persons to accept that death may be the plan God has for them, others may make healthcare decisions to medically prolong life so that God can perform a "miracle" [35].

Indeed, it is essential for healthcare providers to understand how patients' (or their surrogates') R/S beliefs influence their treatment decision-making. This can easily be asked with a question such as "How might your religious or spiritual beliefs inform the decision you are about to make?" Van Norman [37] observed that typically clinicians fail to make such a query when discussing end-of-life issues. Yet there is evidence that R/S beliefs (partially mediated by decisional conflict) explain regret about treatment decision [38]. In a large sample of mostly white American men with prostate cancer, researchers documented that the stronger the R/S beliefs, the less regret about the cancer treatment decision made [38]. Perhaps knowing that God is guiding one's decisions allows one to later be at peace with whatever it is. Furthermore, results from a longitudinal study of late-stage cancer patients in the USA revealed that those who received spiritual support were 3.5 times more likely to accept hospice care than those whose spiritual needs were unmet; furthermore, those who had high religious coping and spiritual support were nearly five times more likely to receive hospice care [11]. This evidence infers that when R/S beliefs are respected, healthcare outcomes likely improve.

Respecting R/S beliefs, however, can be complicated. Patients and their surrogate decision-makers may hold or interpret their R/S beliefs differently, causing intrafamilial conflict when making healthcare decisions [39]. Patients may also misunderstood or be conflicted about their faith tradition's tenets impacting their decision. Consequently, Messina et al. [33] recommended that amidst such circumstances, clinicians engage the patient's religious leader and facilitate accurate religious information for the patient. Decisional conflict may not only exist between patient and surrogates but also between patients/surrogates and clinicians. Based on findings from a survey of 1156 US physicians, Ayeh et al. [40] documented how they were less likely to accommodate client wishes for life-sustaining treatment if the patient/surrogate presented their desire in the context of wanting a miracle or not wanting to give up than if they presented their desire as a mandate of their religion (e.g., "my faith does not permit" or "my religious community does not accept"). In concert, this evidence indicates that respecting the weight of R/S beliefs in healthcare decision-making may not only be respectful, good care but also contribute to positive outcomes. Negotiating the decisional conflict between the stakeholders, however, may be necessary.

5.7 Religious/Spiritual Behaviors

As mentioned earlier, R/S beliefs are intertwined with R/S behaviors; how a patient believes will affect how they behave. Much evidence, however, does provide support for the health benefits of certain R/S behaviors. Consider these examples:

- Attendance at religious services was the greatest predictor of all-cause mortality among African-American women participating in a large epidemiological study (N = 36,613), such that those who attended lived longer [41]. Similarly, church activity (mediated and moderated by various other benefits of R/S) predicted decreased mortality in a large sample of Seventh-day Adventists [42].
- R/S practices (i.e., attending services, prayer, meditation), as well as interpreting their illness positively through a R/S lens, having gratitude, and overcoming guilt, when practiced separately or together, predicted increased survival among 177 persons with AIDS 2–4 times [43].
- Various approaches to meditation, a common spiritual practice originating in eastern faith traditions, have received extraordinary and consistent empirical support from research findings obtained over the past couple of decades. The regular practice of meditation contributes to numerous physiologic and psychological outcomes as well as spiritual transformation. Outcomes observed include decreased hypertension, anxiety, depression, increased attention and emotional regulation, and decreased stress (including lower stress hormones) [44–46].
- Although numerous clinical trials have determined that physically ill patients receiving intercessory prayer are no better off than those not receiving this "intervention," [47] many studies show that positively framed personal prayer is associated with positive psychological outcomes [48].
- Fasting, a spiritual discipline many faith traditions expect or encourage, produces several healthful metabolic outcomes in humans and rats, according to a narrative literature review [49].

Indeed, R/S behaviors do affect health whether they involve religious service attendance or private activities.

What are the resulting implications for healthcare providers? Does this evidence mean they should urge patients to attend services or even encourage them to develop private R/S practices like meditation? These questions beg deeper questions about what is ethical, especially when clinicians have a R/S perspective that they believe will be beneficial to patients [50, 51]. Pujol et al.'s [52] observation from interviews with 20 French cancer patients reminds clinicians that their role is not that of clergy: Patients do not seek care from healthcare professionals for R/S support. In the process of receiving healthcare, however, people do not want to be "just 'patients' but human beings with a precious interior life" [52] (p. 733). The admonitions presented in Table 5.3 are offered to avoid any unethical imposition of R/S in patient care.

Table 5.3 Avoiding unethical religious/spiritual support [19, 53]

• Be aware of clinician-patient relationship dynamics
– The relationship is asymmetric; the clinician is in a more powerful position (empowered by knowledge and skills the patient desires to receive)
– Patients enter healthcare organizations to receive healthcare, perceived by patients as care for physical or mental illness
– Whereas some patients (especially those who are older, religious, female, and facing a life-threatening challenge) do want clinicians to make inquiry about their R/S and provide spiritual care, some do not. Those who do not want spiritual care may equate it with religious support
• Recognize what is within the scope of practice for your discipline within healthcare. While the well-trained chaplain is the spiritual care expert, physicians, nurses, and others are spiritual care generalists with limited skills. Care for patients with serious spiritual issues (e.g., negative religious coping) is best provided by experts; a generalist's attempt to care for such serious concerns is potentially harmful
• Evaluate your motives for recommending a R/S belief or practice: Ask yourself, "Whose needs am I meeting?" If your motive is to persuade the patient to accept your perspective because it will make you more comfortable or advance a personal goal, then do not do it
• Assess patient R/S. What are the patient's R/S beliefs, resources, and preferences? How would they want the healthcare team to respect and support these? Provide R/S care that reflects these wishes. When assessing R/S, delimit it to a screening or spiritual history; keep it focused on that which relates to health and that which is within the scope of your professional practice
• Avoid the appearance of coercion, even when providing R/S support that the patient requests
• When introducing R/S into patient care, offer it in such a way that the patient will be free and comfortable to refuse it. (E.g., Evidence indicates meditation is helpful for people with your condition; would you like to attend a class here at the hospital to learn how to do it? Some people in your situation like to have their nurse pray with them; would that be something you'd like?)

5.8 Religious/Spiritual Belonging

A massive demographic study of global patterns of religious affiliation discovered that 84% of the world's population identified with a faith tradition in 2015 [54]. Gleaning data from 2500 censuses and population registers, demographers not only identified current religious affiliation but also projected these rates for the near and more distant future (i.e., 2060). Key findings are presented in Table 5.4. Belonging to a R/S community often means fellow believers become informal caregivers during times of illness; it also can provide a venue for providing health promotion.

5.9 RS Communities: Informal Caregiving

Although 84% may identify to some degree with a religious tradition, of course, many patients may weakly observe their religious beliefs and practices. Many adherents of a religion may not know or accept all the doctrines, rituals, lifestyle recommendations, and so forth. Furthermore, many are influenced to varying

Table 5.4 Prevalence of religion worldwide: major findings from the Templeton-Pew Changing Global Religious Landscape report [54]

• Religions of global population in 2015
– 31.2% Christian
– 24.1% Muslim
– 16% unaffiliated (e.g., atheists, agnostics)
– 15.1% Hindu
– 6.9% Buddhist
– 5.7% Folk religions
– 0.8% other religions
– 0.2% Jewish
• Although "Unaffiliated" will grow during the next 5 years, they will reduce in numbers (to 13%) by 2060 due to fewer births than deaths among women in this category. The majority of Unaffiliated live in Asia and the Pacific regions, Europe, and North America
• Christians and Muslims have grown in numbers due to birth rates; however, by 2060, there will be nearly the same number of Muslims as Christians due to their higher birth rate (31.1% vs. 31.8%, respectively). Muslims and Christians have higher fertility rates than those of other religions; this is the primary factor explaining growth in these traditions
• Religious switching is projected to be largely observed when Christians leave Christianity and Buddhists to a much smaller extent leave Buddhism. Muslims are expected to gain adherents from switching, as well as folk and other religions and "unaffiliated"

degrees by multiple faith traditions (e.g., the person raised Roman Catholic who uses Buddhist meditational practices and currently self-identifies as a Unitarian Universalist). Also, within one religious tradition, there are a myriad of interpretations of the faith's tenets and practices. Varying degrees of engagement, commitment, and orthodoxy will be found within one denomination—and even within one family belonging to the same denomination. This variation in religiosity underscores the importance of assessing the R/S of each patient; each patient has a unique religion (or a religious spirituality) [19].

For those who are integrated to some degree within a religious community, there often are resources that can support patients and their families during times of illness [19]. Latter-Day Saints (Mormons) may be the most organized at providing support to their parishioners or "ward" members. Lay leaders regularly will visit parishioners, identify who is sick or in need, and organize support; the women of the church constitute the "Relief Society" which regularly meets and is instrumental in providing care for those in need. Anabaptist-descended denominations, Seventh-day Adventists, Pentecostals, Roman Catholics, Presbyterians, Orthodox Christians, and other Christian denominations often appoint and/or train lay leaders (especially women, deacons or deaconesses, or those in Stephen's ministries) to visit and support sick church members. In Judaism, such ministry to the sick is regularly performed by members who are part of a *Bikur holim* group. For Muslims, an Islamic center or association likely will offer services for the sick and elderly in the congregation [19].

Indeed, belonging to a religious group not only provides social support in general (as Koenig's [1, 2] review documented), but it often also provides added support—a safety net—for those who are sick and in need. A national study of African-American churchgoers documented types of instrumental support members provided; the more religious and less-educated members provided the most care, which included transportation, help with chores, and even financial support [55]. Yes, a robust faith community will care for its own as would any caring family. The implications for the healthcare professional may be obvious: If the patient consents, clinicians should inform, mobilize, and/or collaborate with these informal caregivers as appropriate. This is particularly true for when patients are discharged home or institutionalized for an extended time.

5.10 R/S Communities: Venues for Health Promotion

R/S communities have been harnessed by health professionals for delivering various types of healthcare. Most of this work has involved providing health promotion (e.g., education about advanced care plans, lifestyle programs aimed at reducing obesity, improving diet and exercise) and disease prevention (e.g., HIV and cancer screening programs) [56–61]. Typically, these programs are studied using community-based participatory research methods. Much of the research exploring how healthcare can be delivered in a faith community is conducted in urban US American African-American churches or in churches for Latino or Asian immigrants. Indeed, the R/S community is a venue for reaching populations that otherwise might distrust or be unable to access healthcare. Many of the reports about these church-based health promotion programs identify feasibility and sustainability issues encountered [60–62]; characteristically, however, they also conclude the R/S communities hold great potential for improving health within communities.

5.11 Conclusion

Thousands of studies now document that R/S is linked with desirable health outcomes. Whether the association is because of R/S beliefs, behaviors, or belonging—or a mixture of these aspects of R/S—this evidence ought to prompt healthcare professionals to plan and implement care that supports R/S. A commitment to systematic R/S assessment and ethical care that reflects this assessment is essential for effective healthcare.

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