

The Influence of Religious Coping and Religious Social Support on Health Behaviour, Health Status and Health Attitudes in a British Christian Sample

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Abstract Previous research has established a relationship between religion and health. However, the specific aspects of religion which may influence health are not fully understood. The present study investigates the effect of religious social support and religious coping on health behaviours, health status and attitudes to health whilst controlling for age and non-religious social support. The results indicate religious coping and religious social support positively impact on self-reported current health status, depression, health outlook and resistance susceptibility. However, negative religious coping was predictive of increased alcohol consumption. Overall congregational support and negative religious coping had the greatest impact on health.

Keywords Religion · Coping styles · Social support · Health · Well-being

Introduction

According to Gallup (2011), 87 % of the global population are affiliated with a religion. Religious beliefs have been shown to have many benefits with research consistently showing a positive relationship between religion and health outcomes (Hill and Pargament 2003; Lee and Newberg 2005). The beneficial impact of religious beliefs has been observed for many health outcomes measures. These include subjective measures such as well-being (Swinyard et al. 2001) and quality of life (WHOQOL-SRPB Group and Skevington 2006) and objective measures such as viral load (Ironson et al. 2006), incidence of cancer (Hoff et al. 2008) and mortality (Koenig et al. 2001; la Cour et al. 2006). Religion and spirituality are also associated with a range of mental health conditions (Hackney and Sanders 2003; Smith et al. 2003) such as depression (Dew et al. 2010; Simoni and Ortiz 2003), anxiety (Shreve-Neiger and Edelstein 2004), eating disorders (Smith et al. 2004), the use of mental

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health services (Fontana and Rosenheck 2004) and responsiveness to treatment (Rosmarin et al. 2013). However, religion is a multidimensional construct (Idler et al. 2003), and although the relationship between religion and health is well established, it is unclear which aspects of religion are most closely associated with health outcomes.

Religion may have a positive impact on health due to the religion demanding a healthy lifestyle (Hoff et al. 2008) or the discouragement of unhealthy behaviours (Yong et al. 2009) such as smoking or drinking. Therefore, it is possible that the healthy lifestyles which form an integral aspect of many religious communities, rather than the religious beliefs per se, may account for the relationship between religion and health. However, other facets of religion may also be important in safeguarding people's health and well-being. For example, social support has been shown to positively impact on both physical and mental health (Uchino 2005). Within a religious setting, both emotional and spiritual support (Krause et al. 2001) can be obtained from the congregation, church leaders or directly from God (Krause et al. 2001; MacKenzie et al. 2000). Religious social support is typically based on compassion, help and forgiveness and may be particularly effective at safeguarding health and well-being (Krause 2008; Lundberg 2010). Social support obtained specifically as a result of religious beliefs and practices has been shown to reduce the impact of stressful events on physical health (Finch and Vega 2003) and mediate the relationship between church attendance and physical or mental health outcomes (Nooney and Woodrum 2002; van Olphen et al 2003). Religious social support is thought to be particularly influential for the health of particular groups (such as ethnic minorities) or those at greater risk of social isolation (Krause 2002). Therefore, the current study investigates the influence of religious social support on a range of health behaviours, health status and health attitudes.

In addition to the benefits of religious social support on health and well-being, religion can also influence our ability to cope with stressors such as ill health or life stress (Schmuck 2000; Smith et al. 2000) and religion may moderate the impact of these events (Bradshaw and Ellison 2010). For example, religious people with chronic illnesses display less depression (Simoni and Ortiz 2003) and distress (Sowell et al. 2000) than others. The role of congregation leaders may be particularly important, and Maman et al. (2009) outline the manner in which the support or guidance of church leaders informs long-term coping strategies for those diagnosed with HIV. In this context, it is important to emphasise that religious coping fulfils a range of functions including control, comfort, meaning and life transformation (Pargament et al. 2000). Furthermore, whilst much of the research focuses on the role of religion as a form of positive coping, it is also important to consider negative religious coping, characterised by tension, conflict and doubt. Those adopting a negative form of religious coping often blame God or feel abandoned, and the use of negative coping is related to quality of life (Koenig et al. 1988) and poor physical (Pargament et al. 2000; Winter et al. 2009) and mental health (Herbert et al. 2009). These findings are consistent with research suggesting that belief in a punitive God is associated with poor mental health (Silton et al. 2013). Longitudinal studies have also demonstrated that negative religious coping predicts declining health (Pargament et al. 2004). Therefore, the impact of both positive and negative religious coping will be observed on health behaviour, health status and health attitude measures.

Recent research into the relationship between religion and health has mainly been undertaken in societies, such as North America, where religion is embedded into the culture (Hummer et al. 2004). The current study explores the impact of religion in a more secular society (i.e. within England). Further, factors such as age (Koenig et al. 2001), specific affiliation (O'Reilly and Rosato 2008) and geographic location (Gatrell and Elliott

2009) may influence the impact of religion on physical or mental health. Therefore, the current study will focus on the impact of religious coping and religious social support on health behaviours, health status and health attitudes in Christian men and women and will control for the potentially confounding effects of age and non-religious social support.

Methods

Participants

Men ($N = 93$) and women ($N = 163$) aged 17–96 years ($M_{\text{age}} = 55.76$, $SD = 17.94$) were recruited from religious community events across the North West of England. All participants indicated that they followed the Christian faith, primarily the Church of England (60.2 %) with a further 12.1 % of participants identifying as Seventh Day Adventists, and 13.7 % as Roman Catholic. An additional 14.1 % of participants selected “other Christian religion”. The majority of participants (67.6 %) were married, with the remainder divorced (6.4 %), widowed (11.6 %) or unmarried (14.4 %) at the time of the study. With regard to participant health, participants had typically consumed alcohol (75.5 %) and engaged in physical activity (81.0 %) in the previous month. A relatively small proportion of the samples (3.3 %) were smokers. All participants were tested in accordance with the national and local ethics guidelines.

Measures

Participants completed a questionnaire containing initial demographic and health behaviour questions and the *Religious Social Support* (Fiala et al. 2002), *Brief Religious Ways of Coping* (Pargament et al. 2000), *Medical Outcomes Study Social Support* (Sherbourne and Stewart 1991), *Center for Epidemiologic Studies Depression* (Radloff 1977) and *Health Perceptions* (Ware et al. 1978) questionnaires.

Demographic and health behaviour questionnaire Participants provided a range of demographic information including age, gender, ethnicity and marital status. Participants were asked to state whether they were religious and if appropriate, for their faith and religious affiliation. Levels of smoking, alcohol consumption and physical exercise over the past 30 days were each measured using a single-item question which asked about the frequency of each behaviour. For example “During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, aerobics, golf, gardening or walking for exercise?” If participants responded “yes”, they were asked to specify the number of times they had undertaken physical exercise.

The *Religious Social Support questionnaire* (Fiala et al. 2002) is a 20-item measure of perceived support from religious sources. The scale is divided into three subscales relating to religious support obtained directly from God, e.g. “I feel appreciated by a higher power”, religious support from the congregation, e.g. “I have worth in the eyes of others in my religious group” and religious support obtained from religious leaders, e.g. “My religious leaders give me the sense that I belong”. Participants respond to each item on a 5-point Likert scale from 1 (Strongly disagree) to 5 (Strongly agree). Higher scores indicate a greater level of religious social support.

The *Brief Religious Ways of Coping* (Pargament et al. 2011) questionnaire contains 14 items assessing the use of religious coping. Seven items refer to negative coping strategies, and seven items refer to positive religious coping. Positive coping statements include

“Looked for a stronger connection with a higher power (or deity of worship)”, whereas negative coping methods include “Wondered whether God had abandoned me”. Using a 4-point Likert scale from 1 (Not at all) to 4 (A great deal), participants rate their likelihood of using each coping method. Higher scores indicate a more frequent use of the positive or negative coping strategy.

The *Medical Outcomes Study Social Support Survey* (Sherbourne and Stewart 1991) is a 19-item scale measuring perceived availability of social support. Four different dimensions of social support are assessed (emotional/informational, tangible, affectionate and positive social interaction). Participants rate each item on a 5-point Likert scale from 1 (None of the time) to 5 (All of the time). Example items include “Someone who gives you good advice about a crisis” and “Someone to do something enjoyable with”. Higher scores on each dimension indicate greater availability of social support.

The *Center for Epidemiologic Studies Depression Scale* (Radloff 1977) is a self-report measure used to check for the presence and persistence of depression symptoms. The questionnaire contains 20 statements which describe a state of mind. For example, “I was bothered by things that usually don’t bother me” and “I felt fearful”. Participants rate their agreement with each statement on a 7-point Likert scale from 1 (Very rarely) through to 7 (All of the time) with reference to the previous week. Higher scores indicate a greater presence of depressive symptomology.

The *Health Perceptions Questionnaire* (Ware et al. 1978) is a 33-item scale. Twenty-six of these items were used in the current study to determine participant’s prior health, current health status, health outlook, resistance/susceptibility to illness, health worry/concern and sickness orientation. Participants rate a number of statements, e.g. “According to the doctors I’ve seen, my health is now excellent” on a 5-point Likert scale from 1 (Definitely false) to 5 (Definitely true). Higher scores on each subscale relate to more favourable health perceptions.

Results

A series of hierarchical multiple regressions was conducted to investigate the influence of religious coping (positive and negative coping) and religious social support (from the congregation, congregation leader and directly from God) on self-reported prior health, current health, health outlook, health worry, resistance susceptibility, sickness orientation, depression, level of physical activity and amount of alcohol consumed. Age and non-religious social support (emotional and informational support, tangible support, affectionate support and positive social interactions) were controlled for in all analyses.

Health Behaviours

The impact of religious social support and religious coping on health behaviours (level of physical activity and alcohol consumption) was examined.

Alcohol consumption: the control variables (age and non-religious social support), entered at step one of the analysis, explained 10.6 % of the variance in the amount of alcohol consumed in the previous 30 days, increased by a further 4.4 % by the addition of religious coping and religious support. The overall model was significant ($F(10,149) = 2.63, p < .01$), and negative religious coping (beta = .20, $p < .05$) emerged as a significant individual

predictor, such that those engaging in negative religious coping consumed higher quantities of alcohol.

Physical activity: the control variables explained 5.0 % of the frequency of physical activity, increased by a further 4.8 % by the addition of religious coping and religious social support. The overall model was not significant ($F(10,135) = 1.45$, $p > .05$).

The potential influence of religious social support and coping on incidence of smoking was not considered due to the low proportion of smokers in the current sample.

Health Status

Current health: the control variables (age and non-religious social support), entered at step one of the analysis, explained 5.9 % of the variance in current health, increased by a further 8.0 % by the addition of religious coping and religious social support. The overall model was significant ($F(10,200) = 3.24$, $p < .005$), and religious support provided by the congregation was a significant individual predictor of current health (beta = .47, $p < .005$). Those with greater access to congregational support reported a more positive state of health.

Prior health: the control variables, entered at step one of the analysis, explained 5.4 % of the variance in prior health. Religious coping and religious social support (entered at step two) explained a further 1.3 % of the variance, though the model was not significant ($F(10,200) = 1.43$, $p > .05$).

Depression: age and non-religious social support explained 9.4 % of the variance in self-reported depression. Entry of religious coping and religious social support at step two explained a further 5.1 % of the variance ($F(10,200) = 3.41$, $p < .001$). No individual predictors were significant.

Health Attitudes

Resistance susceptibility: the control variables entered at step one explained 4.9 % of the variance in resistance susceptibility, increased further by 6.1 % by the addition of religious coping and religious social support. The overall model was significant ($F(10,200) = 2.47$, $p < .01$), and the social support provided by congregation members bordered on significance as an individual predictor (beta = .292, $p = .05$), such that those with access to support from the congregation believed themselves to be more resistant to ill health.

Health outlook: the control variables explained 11.8 % of variance in health outlook, increased further by 5.9 % with the addition of religious coping and religious support. Whilst the overall model was significant ($F(10,200) = 4.29$, $p < .001$), no significant individual predictors emerged.

Sickness orientation: age and non-religious social support explained a relatively low proportion (3.8 %) of variance in sickness orientation, increased further by 2.5 % with the addition of religious coping and religious social support. The overall model was not, however, significant ($F(10,200) = 1.35$, $p > .05$).

Health worry: age and non-religious support explained a small proportion (0.8 %) of the variance in health worry, increased by 3.8 % with the addition of religious coping and religious social support. The overall model was not a significant predictor of health worry ($F(10,200) = .97$, $p > .05$).

Discussion

The positive impact of religion on physical and mental health in cultures such as North America is well established (Hummer et al. 2004). Less well understood is the impact of religion within a secular society, such as England. The current study investigated the benefits of religious coping and religious social support on health behaviour (physical exercise and alcohol consumption), status (depression, current and prior health status) and attitudes (resistance susceptibility to illness, sickness orientation and health worries) whilst controlling for the influence of known predictors of health and well-being (i.e. age and non-religious support Koenig et al. 2001; Uchino 2005). With regard to health behaviours, no influence on physical activity was observed; however, the use of negative religious coping was predictive of increased alcohol consumption. With regard to health status, better self-reported current health, but not prior health, was associated with religious social support and coping, with congregational support being particularly important. Further, the results indicate a beneficial effect of religious coping and religious social support on depression. Finally, no effects were observed on sickness orientation or health worries, but perceived resistance to disease was positively influenced by religious social support and coping, with congregation support appearing to be particularly important.

The link between health and religion has been reported previously (e.g. Lee and Newberg 2005). However, the current paper set out to explore why this link might exist. One previously suggested pathway between religion and health emphasizes that many religions demand positive health behaviours, such as low alcohol consumption or a vegetarian diet. Interestingly, the results from the current study suggest that Christians who reported greater use of negative religious coping strategies (e.g. feeling abandoned or punished) consumed greater quantities of alcohol. Therefore, whilst initial studies suggested that the positive health benefits associated with religion were a consequence of religious practice (e.g. restrictions on alcohol consumption), the impact of religion on physical health appears to exceed simple adherence to a healthy life-style (Hoff et al. 2008; Yong et al. 2009).

One element of religion which clearly impacted on health within the sampled Christian population was the level of social support received from their religious community. Christians reporting higher levels of religious social support also reported better current health and greater perceived resilience to illness. The positive effect of non-religious social support on physical health has previously been noted with social support being thought to buffer against the impact of stressful events (Uchino et al. 1999). Further, religious social support, such as availability of congregational support, has been shown to have a positive effect on health. Research suggests that those regularly attending religious services enjoy larger and denser social networks and more frequent and varied exchanges of goods, services and information than less frequent attenders (Bradley 1995; Ellison and George 1994). However, the results of the current study suggest that there is something particular about religious social support which has a specific effect on health over and above the positive influence of non-religious social support. These findings are consistent with previous research (e.g. Fiala et al. 2002), though additional studies are required to determine important features of religious social support.

The current findings, together with previous research, highlight the health benefits of active congregational support (e.g. Cohen et al. 2009; Sternthal et al. 2010) and suggest that interventions which improve the availability of congregational support may also enhance health and well-being. This may be of particular benefit for congregation members, such as elderly men and women, who are at greater risk of social isolation (Bosworth

et al. 2003). Future research should investigate which aspects of congregational support are most beneficial to health and whether these elements of support could extend to non-religious communities. For example, religious social support may positively affect health as congregations hold a shared belief system which may reduce conflict between members and promote tolerance. Further, religious social support may be more accessible than other social support networks as religious congregations are generally welcoming to new members such as those relocating to a new community. Future studies should investigate both qualitative and quantitative differences between religious congregations and other forms of social support. For example, the type and amount of perceived and received social support provided through congregation membership should be investigated. If the beneficial elements of congregational support can be identified, then it may be possible to provide non-religious communities with the same protective social support. Non-religious communities such as “secular churches” or special interest groups could adopt some of the key elements of religious social support and hence extend the benefits identified in the current study to the wider population. Extending the positive elements of religious practices to the wider community may be of particular importance to secular societies.

The current study also highlighted that not all religious behaviours are beneficial to health. In the present study, negative religious coping (i.e. feeling punished by God for a lack of belief or sin, feeling abandoned by God and expressing anger at God) was linked to higher levels of alcohol consumption. Therefore, whilst atheists are more likely than those affiliated with religious groups to use substances as a form of coping (Horning et al. 2011), some elements of religion may encourage negative coping strategies. Religion provides a framework for individuals to interpret and understand events (Siegel et al. 2001). Those feeling abandoned or punished by God may believe that God is responsible for all illness and negative life events, a belief system which discourages more active forms of coping. This is consistent with the finding that avoidant (Hasking et al. 2011) and active (Cooper et al. 1988) forms of coping are associated with increased and decreased levels of alcohol consumption, respectively. Additional research is required to identify those religious beliefs (e.g. feeling punished by God) most closely associated with poor physical and mental health.

Whilst the current study employed a cross-sectional design, negative religious coping has been shown to precede rather than follow poor physical or mental health (Pirutinsky et al. 2011) perhaps suggesting that negative religious coping may also precede substance use. The current findings suggest not all religious beliefs and behaviours can be viewed as having a positive effect on health. Religious communities should be aware of the potential harmful effect of negative religious coping, and interventions by religious leaders to reduce negative religious coping may have positive benefits for health. Furthermore, as a reluctance to discuss religious concerns with professionals may further exacerbate the impact of negative coping (Pirutinsky et al. 2009), medical professionals should acknowledge the importance of religious affiliation or beliefs and be willing to discuss such issues with patients.

The present findings are of course limited by a reliance on self-report questionnaires. The reliability of these responses may be impeded by the social desirability of the response or accuracy of recall. Future research may examine specific indices of health, e.g. blood pressure using clinical measures or clinician reports. Furthermore, whilst the current study focused on religion and health at one time only, longitudinal studies may consider the impact of specific events such as joining a congregation or a crisis of faith on physical and mental health. Research measuring health beliefs and practice (including the use of specific coping strategies and availability of religious social support) during the progression of a

chronic illness may be of particular interest. Finally, studies adopting a broader perspective in which participants report whether family members are also involved in the congregation (or are sympathetic to membership) may provide a more thorough understanding of religious and non-religious social networks.

To conclude, the current study provides further support for a positive relationship between religious affiliation and health and well-being. In particular, the findings suggest that congregational support predicts current health status and perceived resistance to ill health, whilst controlling for age and the availability of non-religious social support. These findings have important implications for the development and maintenance of community events and further suggest that regular attendance at “secular churches” may enhance the health and well-being of non-believers. In addition, the relationship between alcohol consumption and negative religious coping highlights a potential health risk to the religious community which may benefit from targeted interventions by religious leaders or medical professionals.

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