Religious Factors in Health and Medical Care among Older Adults

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For two decades, published research has linked religious participation to various health outcomes. These include diminished risk according to overall and cause-specific morbidity and mortality and to indices of health status, symptomatology, and psychiatric illness, especially depression and anxiety. What may not be apparent to physicians exposed to this literature through featured news stories over the past several years is its sheer volume: over 1,600 scholarly publications as of 2001, including 1,200 empirical studies, between 75 and 90% reporting a health benefit of religious practice.

Significantly, most studies have focused on middle-aged or older adults or on differences across age cohorts. Higher levels of religious involvement (eg, attendance at religious services) exhibit salutary associations with numerous medical and psychiatric outcomes: self-ratings of health, functional disability, survival rates, hypertension and cancer prevalence, smoking and drinking behavior, and most dimensions of psychological distress and well-being.[1] Moreover, findings have emerged regardless of the race, gender, social class, age, or religious affiliation of study subjects. Up-to-date summaries can be found in the proceedings of a recent NIH-supported conference held at Penn State University.[2]

Despite the consistency of findings, their meaning and significance are typically misstated and misinterpreted. This literature is based mostly on population-based epidemiologic studies. As such, research has identified religious characteristics of healthy populations that are associated with some level of protection against subsequent adverse health-related events. Unfortunately, through the mass media, this work has been given an unmerited clinical spin, such that "spirituality," usually undefined, is promoted as a powerful factor in "healing," ostensibly "proven" by the large scientific literature on the topic. No such literature exists.

Use of the word "healing" is especially egregious. This term promises what empirical studies simply do not support, nor have ever addressed: the possibility that being more religious, or becoming religious, will somehow cause diseases to be cured. This threatens to elicit distorted expectations in patients. Moreover, it risks translating failures to achieve medical cures into a "spiritual" deficiency on the patient's part that may result in feelings of self-blame and guilt. Those positive findings that have been observed simply indicate that religious participation, on average, exhibits primary-preventive effects in well populations by an association with lower morbidity. No more, no less.

Another source of confusion is a provocative group of experimental trials of intercessory prayer, widely embraced by proponents of alternative medicine. Regardless of one's opinion of the credibility or value of these studies, issues that remain highly charged and debated, this is an entirely separate topic which has nothing to do with epidemiologic research on religion and the prevention of morbidity. Continued media fascination with these prayer studies (not undeserved, in our opinion) has brought needless controversy to this area by the ceaseless confounding of this work with the largely uncontroversial studies by sociologists, psychologists, physicians, and epidemiologists that identify religious sources of primary prevention and coping. These issues loom especially large for geriatric patients.

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Population-based findings linking religion and health in older adults actually make good sense and are consistent with decades of epidemiologic research.[3] Religious commitment may influence health through promotion of healthy behaviors. Religious fellowship may impact health through facilitating social support. Religious worship may produce positive emotions with preventive or therapeutic benefit. Certain religious beliefs may be consonant with healthy beliefs that foster preventive healthcare practices. Finally, religious faith may create positive expectations that prevent or ameliorate psychological distress. Expressions of religiousness thus mobilize personal and congregational resources that may foster better healthcare use, health practices, and health status.

While these studies are mostly nonclinical, they nonetheless have interesting implications for medicine,[4] as well as for public health practice and policy.[5] It is rarely noted that the very best of this research has been conducted using population-based or community samples of older African-Americans. For this historically underserved and traditionally reli-

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gious community, religion can serve as a helpful ally to medical care providers. Importantly, while the vast majority of research on this topic has been conducted within samples of white Christians, the religious and cultural diversity of the U.S. population argues for expanded focus on the connections between religion and health within other faith traditions.[5]

The potentially salutary roles filled by faith communities and networks, regardless of religious affiliation, should not be dismissed. If we neglect to engage the religious life of patients because of our own particular beliefs, or because of discomfort in broaching such issues, we risk failing to identify meaningful sources of comfort and sustenance for distressed or at-risk patients.

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The character and history of each child may be a new and poetic experience to the parent, if he will let it.

—Margaret Fuller