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Thomas Fisher

Cedarville University, thomasfisher@cedarville.edu

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Associations of Religious Involvement and Mortality: A Review Article

Thomas Fisher

Cedarville University

Abstract

In this review we address the conflicts of previous research on associations between religious involvement and longevity. We will also discuss causes of conclusion variance within these studies. Our study of inconclusive research will equip individuals with insight about sources of disagreement and origins of variance within empirical studies on religiosity and longevity. A wide variety of sources were selected to represent the diversity of findings. Most selected studies identified psychosocial elements of religiosity and proposed a positive, negative, or no correlation with longevity. We reviewed the validity of each study and analyzed the proposed association with longevity. Numerous methodologically sound studies reported that religious faith decreases the risk of morbidity, while other studies proposed that religious faith increases the risk of morbidity. Causes of substantial disagreement among well conducted studies include challenges in developing reliable and valid measures of religiousness, confounding variables not well identified and controlled, sampling bias in study groups, and overstatement of conclusions without nuance. Consistent, unconfounded evidence is needed before a definite conclusion can be reached.

Associations of Religious Involvement and Mortality

Religious faith has been long disputed as beneficial, detrimental, or unrelated to health and longevity. Some early studies on the relationship between religious involvement and health outcomes contain significant flaws and deceptive reports or data (Sloan, 1999; Sloan 2000). Other studies argue that religious faith can increase the risk of morbidity because it can discourage behavior that may prevent illness or have a positive effect on treatment (Jarvis and Northcott, 1987). Nonetheless, most previous research has found that religious faith is associated with longevity. A well conducted study by Hummer found that religious involvement is inversely related to mortality (1999) by controlling for demographic characteristics that were related to risk of mortality and religious involvement such as age, and socioeconomic factors (education, family income, etc.). Curiously, the protective effect of religious involvement was nonexistent for cancer patients and significantly reduced for patients with heart disease. For the average elderly patient, religious involvement provides social connections and support, especially in times of personal despair (Ellison, 1994), and is generally rewarding and stress reducing (Kark, 1996). Despite findings that seem to validate inverse relationship between religious involvement and mortality, Bagiella et al. propose that “It would be misleading to declare a beneficial effect of religious attendance on survival.” What is the cause of variance in these studies, and how do we justify apparently opposed findings?

First, let us investigate the effect of social factors in religious settings on healthy behaviors. A study by Callaghan found that routine religious involvement had a positive effect on adolescents' healthy behaviors, self-efficacy of those behaviors, and self-care abilities (2009). This study also found that adolescents who felt they had a strong support system (such as family, friends, teachers, neighbors, healthcare providers, and clergy) reported the same positive results as the adolescents' who reported routine religious involvement. These results suggest that religious involvement incorporates indices of healthy behavior that can also be found outside of religious settings. A similar study on adult and elderly populations found that attending shows, movies, concerts, socializing with friends and neighbors, visits with relatives, and volunteerism had the same inverse relationship to mortality as religious attendance (Rogers, 1996). Earlier studies have shown that social factors have an important influence on health outcomes (Angerer, 200; Berkman, 1979) and social support in religious settings increases physical activity (Kanu et al., 2008; Kim and Sobal, 2004). It is likely that social factors are the largest beneficial contributor of religious attendance to health. Although religious attendance is often associated with increased social engagement, a large variance of social engagement is possible depending upon opportunities for involvement in different communities.

A study by Koenig on 4,000 people age 65 and older found that frequency of church attendance was unrelated to social support even though church attendance was negatively related to depression (frequent churchgoers were about half as likely to be depressed as non-churchgoers) and positively related to physical health. These findings challenge the preconception that church attendance increases social support. Curiously, the study also found that private prayer and Bible reading was positively correlated with

social support and negatively correlated with physical health, but unrelated to depression (1997). How are private religious activities such as prayer and Bible reading positively correlated with social support? And how are these same private religious activities negatively correlated with physical health? It is likely that elderly persons involved in religious activities developed a social network within the religious community in their younger years. Even though the elderly became incapable of maintaining frequent involvement in religious activities due to physical infirmity, the religious community began to realize the elderly's decreased social involvement and took initiative to engage with the elderly in their home during their last years. As the elderly's health decreases (followed by decreased responsibility), more time could be spent in prayer and Bible reading, and we thus observe a negative correlation between private religious activities and physical health.

A study by Bagiella et al. claims that frequent religious attendance is associated with longer survival. Initially this statement could be interpreted to mean that religious attendance is a cause of decreased mortality, but this is not necessarily the case. Think about it like this; only the healthiest elderly people attend religious services frequently and regularly. If they are sickly they will choose not to attend. The same idea applies to working at a paying job and membership in a club. None of these activities will be experienced by elderly people with poor health simply because they are incapable of attending the activities if they are experiencing illness or infirmity. Frequent religious attendance, working at a paying job, and membership in a club are therefore associated with longer survival, but the activities themselves are not necessarily the cause of longevity.

Similarly, a study by Powell et al. found that religion encourages a healthy lifestyle which protects against cardiovascular disease. Despite these findings, “Evidence fails to support a link between depth of religiousness and physical health. In patients, there are consistent failures to support the hypotheses that religion or spirituality slows the progression of cancer or improves recovery from acute illness but some evidence that religion or spirituality impedes recovery from acute illness” (2003). Church service attendance is therefore believed to increase the longevity of healthy people, but have little or no effect on elderly or chronically ill individuals. More well-conducted studies are needed in this area to confirm these assertions.

Koenig et al. found biological “support for the hypothesis that older adults who frequently attend religious services have healthier immune systems, although mechanism of effect remains unknown” (1997). This conclusion was reached by observing that “religious attendance was related to lower levels of the immune-inflammatory markers alpha-2 globulin, fibrin d-dimers, polymorphonuclear leukocytes, and lymphocytes.” Although they found only a weak relationship between religious attendance and immune system regulators and inflammatory substances, their results provide some evidence for the protective benefits of religious service attendance.

Slaves of other sources support the hypothesis that weekly religious attendance is associated with decreased mortality. Hall gives a brief summary of the best evidence to date:

Weekly religious attendance is associated with longer life (McCullough et al., 2000; Strawbridge et al., 1997), lower physical disability (Idler and Kasl, 1997), faster recovery from depression (Koenig et al., 1998), and greater life satisfaction

(Levin et al., 1995). Furthermore, the magnitude of these associations is clinically relevant. For example, the 2-3 years increase in life expectancy associated with regular religious attendance is on par with the 3-5 years increase in life expectancy associated with regular physical exercise” (2006).

Although the majority of research reports that religious involvement positively influences health outcomes, significant variance in research reports is still prevalent. One possible reason for this apparent variance is that researchers tend to overstate their conclusions without nuance. For example, studies that measure the relationship between specific health outcomes and a particular aspect of religious practice (such as prayer or Bible reading) are sometimes taken to mean that religious practices in general are good (or bad) for health. Another source of disagreement and complication is measuring religiousness. Finding precise and accurate methods of measuring religiousness continues to be a significant problem (Hall, 2008). Bagiella explains a possible cause for inconsistent findings in research on religious attendance and mortality:

When a relationship between religious attendance and mortality is seen, it is likely that many factors are involved in explaining or un-confounding it. Therefore, the different findings may be the result of whether or not these factors are accounted for in the analysis. Religious attendance may be itself a marker for, rather than a cause of, a healthier status. That is, those who attend religious services also follow a healthier lifestyle, are more socially involved, and are more health conscious.

In conclusion, we overviewed previous research on associations between religious involvement and longevity and discussed possible causes of variance within these studies. Although numerous methodologically sound studies have reported negative correlations

between religiosity and mortality, substantial disagreement persists. The difficulty of precisely testing and accurately reporting religiousness is a major problem in the ongoing discussion of the relationship between religiousness and mortality. Due to these complications, the effects of religiosity on longevity are difficult to study, and consistent, unconfounded evidence is needed before a definite conclusion can be reached.

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