

ABSTRACT

METZ, C.A. A literature review of the role of spirituality in health, health care, diseases, social conditions, general well-being, and health education programs during the last three decades. MPH in Community Health Education, August 1998, 25 pp. (M. Dosch)

This project presents an extensive literature review of the construct of spirituality in health, health care, disease and social conditions, general well-being, and health education programs during the last three decades. The findings support research that health care needs to take on a holistic approach, to include the mind, body and spirit in regards to treatment and education. The present study concluded that health is a dynamic process and must include the spiritual dimension. Attending places of worship have a positive influence on health and a negative influence on disease. Spiritual factors are also important in the prevention and treatment of disease. Spirituality and certain organized religious practices have a positive influence on life satisfaction, subjective well-being, and social conditions. Since spirituality has a positive affect/influence on health and health outcomes, health educators should incorporate the spiritual dimension into health education programs. Examples of successful application of spirituality showing positive results within health education programs are also included in this research paper.

A LITERATURE REVIEW OF THE ROLE OF SPIRITUALITY IN HEALTH,
HEALTH CARE, DISEASES, SOCIAL CONDITIONS, GENERAL WELL-BEING,
AND HEALTH EDUCATION PROGRAMS DURING THE LAST THREE DECADES

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CHRISTINA A. METZ

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COLLEGE OF HEALTH, PHYSICAL EDUCATION, AND RECREATION
UNIVERSITY OF WISCONSIN-LA CROSSE
DEPARTMENT OF HEALTH EDUCATION AND HEALTH PROMOTION
GRADUATE PROJECT FINAL APPROVAL FORM

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I recommend acceptance of the Graduate Project in partial fulfillment of this candidate's requirements for the degree:

Master of Public Health

Concentration: Community Health Education

The candidate has successfully completed the Graduate Project.

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SECTION 1

Introduction

Background

Spiritual health is an important health aspect that had been missing from many health education/health promotion programs in the past (Banks, 1980). However, progressive programs have established the "viability of spirituality within health disciplines" (Diaz, 1993, p. 324). Spirituality is a vital part of health, since it incorporates the concept of holism that includes the mind, body, and spirit in relationship to health (Wilson, 1987). Several concepts can be applied to spiritual health including: holistic health (Witmer & Sweeney, 1992), life satisfaction (Ellison, 1991), spiritual well-being (Seaward, 1991) and high level wellness (Dunn, 1977; Meeks, 1977). Many of these concepts can be used with much success in conjunction with implementing health education/health promotion programs (Bensley, 1991b; Seaward, 1991).

Spiritual health concepts may be difficult for some people to grasp. However, Prest and Keller (1993) believe that just as human beings evolve their own languages and create their intersubjective meaning regarding their daily experiences through dialogue, so people generate meanings surrounding their spirituality. The spiritual beliefs which shape, and are shaped by, our thoughts and language are influenced by and related to our larger constructions of reality. Ellison states in his 1983 study that it is the spirit of

human beings which enables and motivates us to search for meaning and purpose in life, to seek the super-natural or some meaning which transcends us. According to Peck (1978), "spiritual growth is a journey that requires courage and initiative and independence of thought and action" (p. 310).

Ellison (1983) believes we all wonder about our origins and our identity, and this requires morality and equity. He writes:

To wonder about our origins and our identities, requires morality and equity. It is the spirit which synthesized the total personality and provides some sense of energizing direction and order. The spiritual dimension does not exist in isolation from our psyche and soma, but provides an integrative force. It affects and is affected by our physical state, feelings, thoughts and relationships. If we are spiritually healthy we will feel generally alive, purposeful, and fulfilled, but only to the extent that we are psychologically healthy as well. The relationship is bi-directional because of the intricate intertwining of these two parts of the person. To a lesser extent the spiritual well-being of persons is affected by physical well-being. There are numerous cases of the courage (we might better term it faith in ultimate purpose and in one's self) which has allowed people to move beyond or to transcend physical handicaps and suffering, and to experience spiritual and emotional health and growth. The key seems to be holding on to one's deepest spiritual commitments and being able to interpret the suffering within the context of deeper positive meaning. (p. 332)

Defining Spirituality

Chandler, Holden, and Kolander (1992) believe spirituality is innate within all humans. They also state that choosing to ignore the spiritual component of wellness out of fear or ignorance is somewhat irresponsible of those in health service fields. "Spiritual wellness is not an undefinable, unworkable construct" (Pilch, 1988, p. 28). It is a part of the human being that needs to be attended and fostered as much as the mind and the

body. "Those who draw inspiration from wellness promoters whether Christian, Jewish, or humanistic are capable of designing and implementing a personal wellness spirituality" (Pilch, 1988, p. 28).

Still, Moberg (1979) has found that spirituality is difficult to define. He states the following:

... the definition of "spiritual" is not so clear and rigidly fixed that it can be separated from the physical, psychological, material, and other aspects of human existence. Instead it is a component or dimension of man which runs through all of the person and his behavior, providing an orientation and focus which pertains to all of the positively valued joys and experiences of living and all of the negative problems and fears of life and death.

Because the spiritual is interwoven with all material and other aspects of man's life, one of man's other needs cannot be fully resolved without including attention to his spiritual well-being. The needs related to income, nutrition, physical and mental health, housing, transportation, employment, retirement, education, and social roles all overlap with such aspects of the spiritual as ethical and moral values. (p. 14)

Prest and Keller (1993) describe spiritual belief systems as a product of the individual's ideological languaging within a relationship context and include "the process of conceptualizing the individual's connection with others, the world, and the Creator" (p. 137). As such, the spiritual system is "intra- and interpersonally constructed to provide faith explanations of past and present experiences" (p. 137) and, for some, to predict the future and explain the ultimate meanings of life and existence. It may also serve to "construct meaning out of the seeming chaos and randomness of life, thereby alleviating anxiety and providing a heightened sense of security for those involved in its construction" (p. 137).

Goodloe and Arreola (1992) state that advocates of the spiritual dimension of health cite "an important difference between spirituality and religion/religiosity"(p. 222). Goodloe and Arreola also believe that spirituality is tied to religious concepts, but not to any specific religious or denominational belief structure. "Indeed, denominational affiliation can potentially enhance one's spiritual dimension, but this affiliation is not necessary for development of spiritual health" (Goodloe & Arreola, 1992, p. 222).

Purpose Statement

The purpose of this literature review was to investigate the prevalence of the construct of spirituality in health and health care, disease and social conditions, general well-being, and health education programs during the last three decades.

Rationale

The rationale for conducting this project is the belief that spirituality is an important aspect of health. The human-spiritual interaction is a factor that can easily be addressed when implementing health promotion/prevention programs (Banks, Poehler, & Russell, 1984). Studies have shown that there is a definite positive correlation between spirituality and health and wellness (Bensley, 1991b; Chandler, et al., 1992; Mathews & Larson, 1995; Osman and Russell, 1979). It is important for health educators to use all possible and available avenues to implement health promotion programs and to insure their success. Addressing spirituality in health education programs brings in another dimension, one that can personalize each program in a way that may change health outcomes for the better (Jose, 1987).

Several studies (Osman & Russell, 1979; Banks, 1980; Diaz, 1993) have shown that there was a significant difference in health outcomes when spirituality was added as a variable. These studies show that in order to reach high level wellness, spirituality can be used to help implement and insure the success of health education/promotion programs. It is important to look at individual spirituality and recognize different levels of spirituality in our interactions with others. Dunn (1977) suggests that health educators can help people draw from their spirituality to help them overcome difficulties and obstacles in achieving high-level health and wellness. Since many studies (Banks, et al., 1984; Bensley, 1991b; Chandler, et al., 1992; Diaz, 1993; Greenberg, 1985; Mathews & Larson, 1995) support the inclusion of addressing spirituality because of its association with positive health outcomes, spirituality should be used in conjunction with health education/health promotion programs in whatever situation is deemed appropriate. Peck (1978) believes "the ultimate goal of life remains the spiritual growth of the individual"(p. 168).

Definition of Terms

It was important for the researcher to define certain concepts that are included within this paper which were an important part of this project.

General Well-Being- Related to quality of mood, mental health, self-esteem, happiness, with low stress levels, and good health (Maton, 1989).

Health- Total health consists of a variety of components, notably the physical, mental and spiritual dimensions of health (Bensley, 1991a).

Holistic Health- The whole body must be considered (mind, body, and spirit) if complete health is to be achieved, this is holistic (or wholistic) health (Witmer & Sweeney, 1992).

Life Satisfaction- Can include happiness with one's life, environment, relationships, socioeconomic status, education, health, age and morale (Wilson, 1987).

Religion- An organized group that shares the same beliefs and rules. Consists of practiced worship, ceremonies, and traditions. Usually, involves worship of a supreme being (God) (Pilch, 1988).

Spirituality-Witmer and Sweeney (1992) define spirituality as a source that comes from within as well as outside the person. "Inner voices, inner wisdom, higher consciousness, or the spirit of God are forms of spirituality" (p. 141). Witmer and Sweeney continue by stating that spirituality has traditionally "sought peace, guidance, and contact with a universal force through meditation, prayer, worship, contemplation, or introspection" (p. 141).

Spirituality vs. Religion: Spirituality may be linked to religious values. Spirituality is differentiated from religion, in that, one can be spiritual without being religious, and one can be religious without being spiritual. People who consider themselves religious will probably have some degree of spirituality. Therefore, spirituality and religion have qualities that are independent to each, and they also have qualities that are common to both. It is the researchers belief that everyone has some degree of spirituality.

Banks (1980) states that one major component of the spiritual dimension has to do with what the individual identifies as meaningful. "Spirituality is also based upon individual perceptions and faith"(p. 196). Included in this would be components having

to do with "perceptions of what it is that causes the universe to work the way it does; recognition of powers beyond the natural and national; survival; and pleasure. Banks also states that "religious beliefs can be placed in any or all the above identified aspects" (p. 197).

SECTION II

METHODOLOGY

Introduction

In conducting an extensive review of literature the major function is research. Educational Resources Information Center (ERIC) database, which consists of journal articles and ERIC documents (which represent significant developments in education research and practice) was accessed at the University of Wisconsin-La Crosse (UW-L) Murphy Library. *Socio file* (indexes and abstracts of sociological literature from 1,800 journals worldwide) and *psychlit* (covers psychology and behavioral sciences from over 1,300 journals and book chapters) were also accessed at the UW-L Murphy Library. The researcher contacted The National Institute for Health Care Research and asked them to send some information. They sent several bibliographies, of which many will be used. Also gathered were other journals and information from a variety of sources.

In doing this review of literature, pertinent articles relating to the construct of spirituality in health and health care, disease and social conditions, general well-being, and health education programs were read. Relevant information regarding these topics associated with spirituality were included in the completed paper.

Timeline

December 1996 - March 1997 - Research was conducted in the form of literature searches and text searches. Computers at the UW-L library were instrumental in gathering all relevant data, because the researcher could identify articles relating to the subject under investigation quickly. Information regarding the library's holdings and how they could be found were also available through the computer system.

March - May 1997 - This time was devoted to reading all the material gathered and choosing which information would be used in the project.

June - September 1997 - Project proposal - Sections I & II were written and approved.

November 1997 - Completed section III.

November 1997 - Completed section IV.

November 1997 - Presentation of oral defense.

May 1998 - Graduate project approved by advisor.

June 1998 - Completion of graduate project.

July 1998 - Copies of completed graduate project will be bound and sent to appropriate personnel.

SECTION III

FINDINGS

The purpose of the literature review was to investigate the prevalence of the construct of spirituality in health and health care, disease and social conditions, general well-being, and health education programs during the last three decades. A summary of the major findings follows.

Health, Health Care, and Spirituality

As a result of reviewing the literature, over a dozen studies have concluded that health is a dynamic process. The literature suggests that total health should include the spiritual dimensions as well as the mental, emotional, social, and physical dimensions.

The literature also suggests that when considering the health of individuals, the whole body and all its systems should be considered. This is holistic health. An approach to attaining complete health must include the whole person in his or her environment.

The findings suggest that health care should utilize the spiritual dimensions as well. Spirituality can help provide support systems to induce and maintain change. It is important for medical professionals to recognize the spiritual aspects of human beings. Studies show that most patients and physicians report personal adherence to religious and spiritual beliefs and practices. However, these issues are not frequently addressed in the patient physician relationship (except when there is a life threatening illness) despite significant interest among both parties to do so.

These findings support the fact that spirituality can be personalized, in that it can be defined by each individual. Spirituality may also be linked to religious variables.

Disease, Social Conditions, and Spirituality

The literature supports the importance of spirituality and certain organized religious practices. The following are the conclusions of over 50 professional journals. Spirituality and certain organized religious practices can have a health enhancing effect on mortality, high blood pressure, drug and alcohol abuse, decrease chances of cardiovascular disease, cancer, mortality, suicide, divorce, depression, and other mental conditions. Spirituality and certain organized religious practices are also associated with lower occurrence of health compromising behaviors such as smoking, not wearing seatbelts, and personal illness and injury. These facts led many researchers to conclude that spirituality and spiritual faith are important variables in the prevention and treatment of illness and disease. Many epidemiological health research studies have concluded that spirituality and religious commitment improves health. The overwhelming findings suggest that certain religious groups have a lower incidence of cancer and lower cancer mortality rates as indicated by the National Cancer Survey. Spirituality and religion were shown to have a positive influence on health behaviors and demonstrated an inhibiting effect on all malignancies combined.

There was substantial evidence from the literature that suggests that spirituality and certain organized religious practices can help poor people move out of poverty, and protect individuals from a host of social problems. Protection from social problems

include decreases in out-of-wedlock births and crime, and an increase in self-esteem, family unity, and happiness. The findings suggest that spirituality can help combat ill-health, poor education, and addictions. Spirituality and certain organized religious practices have been shown to enhance psychological and physical health because of their positive value systems. Some of these benefits include health responsibility, self-actualization, exercise, nutrition, stress management, and interpersonal support, reduced depression, anxiety, and stress. Greater spirituality is associated with lower levels of medical symptoms, and fewer health care, dental, and emergency care visits.

General Well-Being and Spirituality

The literature reviewed revealed that spirituality can increase general well-being and life satisfaction. Spirituality has been shown to provide a coping mechanism in problematic situations. Spirituality can also provide a source of empowerment and enhancement of the self that can help contribute to a meaningful life. Spiritual experiences were found to be associated with increased life purpose and a health promoting attitude, positive psychological well-being, and improved quality of life.

The literature indicated that almost all Americans consider themselves spiritual or religious. Spirituality was positively related to subjective well-being. Greater spirituality is also associated with lower levels of both functional disability and depression, marital satisfaction and adjustment, family life satisfaction, personal satisfaction, and well-being and overall happiness.

One researcher concluded that there was not a single instance where spirituality and religiosity were negatively associated with life satisfaction. Always there was a positive association. Spirituality was also associated with better moods, connection with family, community involvement, job security, and happiness with life in general.

Health Education and Spirituality

Historically the review of literature suggests that school health professionals have used the medical model and approached health education less comprehensively .

Currently, health educators address all of the issues that impact total health. Health educators need to continue to address the complex nature of the health of individuals and the factors involved that affect health. Anything less is bound to produce ineffective health education programs.

Health education has been shown to provide students with more specific behavioral prescription when a complete health model was used. Learning activities can be provided that can help students get in touch with their own inner resources for health and healing.

The overwhelming evidence is that health educators should not avoid the discussions of spiritual issues in the classroom. Sensitive issues such as sexuality, drug use, and death and dying are laden with spiritual implication, particularly when students are asked to make personal decisions regarding these issues. Educational imagery can be used as a method for incorporating the spiritual dimension into the health lesson.

The literature suggests that it is very important for health educators to facilitate behavior change. Helping students understand the impact of lifestyle choices is an important dimension of health education classes. Instructors can use value clarification and experiential activities that incorporate the spiritual dimension to help students better grasp and integrate health issues.

The findings suggest that effective health education and behavior modification programs are needed to promote the compliance of preventive health care practice. Health programs, primarily prevention programs, must consider the entire individual as well as his or her environment if positive behavior changes are to be maintained. Health educators can use skill training to enhance physical, cognitive, and affective awareness, positive lifestyle choices, and self-reinforcement. Group settings provide a supportive environment for feedback and encouragement toward behavior change.

The evidence from the literature suggests that any existing class can incorporate spirituality. Exercises can include journal writing with special themes to promote self-awareness and soul-searching. Meditation and mental imagery with diaphragmatic breathing offers ways to promote spiritual homeostasis or inner peace. Value assessment and clarification exercises may be introduced with strategies to problem solve common conflicts in values. Presentations of case studies of individuals recognized for their contributions to humankind can also be introduced. There are many ways to incorporate spirituality information into the health education curriculum.

The literature, also, suggests there are ethical concerns when applying the

spiritual component into school health education programs. However, in order to utilize the spirituality component without breaching the law of separation of church and state, teachers can differentiate religion from spirituality. Teachers should also recognize and respect each student's cultural diversity and existing spiritual beliefs. The teacher can then help students maximize the positive aspects of their belief systems without imposing his or her own personal moral judgments and values on the learning environment.

Teachers should not preach their own version of spirituality, but should guide the students toward their own understanding within the spiritual realm.

After reviewing the literature, the researcher found that most health educators believe there is a spiritual dimension of health and that this dimension should be included in health education professional preparation programs. From the literature it was found that spirituality can help students internalize behavior change. Students must believe that a change can be made, maintained, and integrated into their lifestyle. If students do not internalize this change, the behavior change can be incomplete and superficial.

Health educators can use spirituality in worksite health promotion/wellness programs by including spiritual health questions in health status and interest surveys. Also, they can include spiritual health issues in health and fitness testing, stress management, drug alcohol education, work retreats and meetings, recreational programs, preretirement planning sessions, and door prizes. Health educators can develop spiritual health themes as part of communication programs, behavioral support groups, and workshops.

As a result of reviewing the literature it was found that education has unlimited potential for creating a community in which the characteristics of the healthy person can be nurtured. The most effective method is implementing a life-style approach of holistic health and wellness. With an educational climate that is encouraging, striving for wellness becomes a process that is likely to extend over the life span. Spiritual health provides an avenue through which the individual can create the new and more complete self.

The literature also suggests that health education programs have been quite successful when churches were involved. Significant life events center around the church, such as celebrations of birth, marriage, and death. The church provides a setting for the exchange of news, social support, and resources.

Several professional journals concluded that church health education programs have won the support and confidence of people in many communities. Church based health education programs improved health behaviors, such as reduced smoking, lowered blood pressure, serum cholesterol, and weight, and decreased physical inactivity. Health promotion is a combination of educational, spiritual, environmental, and organizational activities directed toward behavioral change. Churches have these same characteristics and have a tradition of helping in the community through a variety of social programs.

The overwhelming evidence suggests that community service is another way of enhancing the spirituality of students. Community service not only helps the community but it is beneficial to the students and their grades. When course relevant community

service was part of student's academic learning, grades and class attendance went up. Students in community service reported that they developed a new set of values, were more likely to feel they were performing up to their potential in the course, and more likely to affirm that they had learned to apply principles from the course to new situations. Students developed open-mindedness, increased problem solving ability, increased social and personal responsibility, increased self-efficacy, self-esteem, and empathy. There was a decrease in alienation and isolation. There were less discipline problems, better communication and gains in morale, ego development as well as gains in moral reasoning.

The research suggests that students who were involved in community service were more likely to value equal opportunity for all, helping others in need, finding a career that provides an opportunity to help others in need, and giving to charitable causes. They were also more apt to believe that they could make a difference in people's lives. The researchers concluded that volunteering can make you a more responsible person, and it can also make a better community.

Difficulties

Because this project was a historical review of literature over the last three decades, the scope of the project became quite large. A significant amount of literature was reviewed. This was necessary to obtain knowledge on the various topic areas related to spirituality.

The second difficulty was discovered within the literature itself. Religion and spirituality were used interchangeably within much of the literature reviewed. This made the literature's terminology quite confusing at times. Therefore, the author felt it was necessary to define these terms within the project.

The final difficulty experienced was systematically presenting the wealth of information in an organized format. There was an overlap of material as the literature was presented in a variety of ways. Finally, the researcher decided to organize and present the material under similiar categories and subject headings. The material was also presented in a somewhat chronological manner, so readers could see the attitude, opinions, and investigations of each decade.

SECTION IV

DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

Discussion

As a result of this project the author has grown both professionally and personally.

Professional Growth

The largest area of professional growth was the in-depth knowledge that was gained on spirituality and health, social conditions, and well-being. Prior to beginning the project, the author's primary knowledge was limited to the effects of church attendance on marital happiness. The other areas discovered in the review of literature were instrumental in helping the author determine what would be covered. Current researchers and experts in the area of spiritual health research were identified from this extensive review of literature.

It was the author's belief that one's spirituality can enhance almost every situation in life. This is what led the researcher to look for specific subject matter regarding spirituality and health.

As a health educator, it was important to the author to show how spirituality can be used to help facilitate behavior change in health education/health promotion programs. Spirituality and behavior change brought new insight to the author. It was the

author's intention to inspire other health educators to consider adding the spiritual dimension to their health education/promotion programs.

Personal Growth

From this project the author now recognizes her role as a resource person. Since the author enjoys doing research, this project was rewarding and very educational. It was educational not only because of the many journal articles and books that were read, but also because of the knowledge gained in accessing information from various sources.

The author, as a health educator, gained useful insight into the possibilities of using spirituality as a variable to improve health and health outcomes in future endeavors. It was also very surprising to the researcher to discover so much literature on spirituality and health.

Finally, personal computer skills were improved as a result of this project. The author struggled to learn the different aspects of the Microsoft Word and WordPerfect software. Although learning the software became frustrating at times, the new skills obtained can be utilized in preparing other written documents in the future. Increasing computer skills is vitally important as the health care field becomes increasingly dependent on computer technology.

Conclusions

Based on the findings from this literature review, the following conclusions were made:

1. Health is a dynamic process and must include the spiritual dimension. The

whole being must be considered if complete health is to be achieved. This is holistic health.

2. The professionals in health care practices should take on a holistic approach to include the mind, body, and spiritual aspects of health. Spiritual beliefs and preferences need to be addressed in the patient-physician relationship.
3. Attending churches (or places of worship) have a positive influence on health.
4. Spirituality and certain organized religious practices have a positive influence on health and have a negative influence on disease. Spiritual factors are also important variables in the prevention and treatment of disease.
5. Spirituality and certain organized religious practices decrease the chance of cardiovascular disease and cancer.
6. Spirituality and certain organized religious practices have a positive influence on life satisfaction, subjective well-being, and social conditions.
7. Because of these previously stated conclusions, health educators need to incorporate the spiritual dimension into their programs. Health education should be comprehensive, therefore, it must address the spiritual dimension.

8. Health education and health promotion programs have been successful when incorporated into churches and their communities. Church based health education/promotion programs have been successful in reducing smoking, blood pressure, serum cholesterol, weight, and physical inactivity.
9. Spirituality is enhanced, and sometimes discovered, in community service programs which can be incorporated into school health education programs. Community service has many beneficial effects on students which can include higher grades, increased class attendance, and self-esteem.

Recommendations

The author offers the following recommendations:

1. Future studies could show to what degree spirituality enhances personal empowerment and community empowerment in contrast to powerlessness.
2. Future studies can explore how health educators can enhance the internal dimension of spirituality, thereby increasing self-esteem and self-worth.
3. Future studies could evaluate the impact of the spirituality dimension in health education programs. In these studies it would be very important to use precise measurements and evaluations of the impacts and outcomes.
4. Further research could include other examples of the application of spirituality into health education programs.

5. Future studies could explore diverse ethnic groups and their impact on church based health education programs.
6. The literature review indicates that it would be important for health educators to include the dimension of spirituality when planning and implementing programs.
7. Health educators can use examples cited in this research paper when implementing programs. These examples include, but are not limited to:
 - The silent gift project
 - Educational Imagery
 - Value clarification and assessment exercises
 - Journal writing
 - Meditation
 - Tai Chi exercises
 - Lifestyle analysis
 - Community service

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INTRODUCTION

Spiritual health is an important health aspect that had been missing from many health education/health promotion programs in the past (Banks, 1980). However, progressive programs have established the "viability of spirituality within health disciplines" (Diaz, 1993, p. 324). Spirituality is a vital part of health, since it incorporates the concept of holism that includes the mind, body, and spirit in relationship to health (Wilson, 1987). Several concepts can be applied to spiritual health including: holistic health (Witmer & Sweeney, 1992), life satisfaction (Ellison, 1991), spiritual well-being (Seaward, 1991) and high level wellness (Dunn, 1977; Meeks, 1977). Many of these concepts can be used with much success in conjunction with implementing health education/health promotion programs (Bensley, 1991b; Seaward, 1991).

This literature review examines how spirituality can affect health and is organized into four related chapters: Health, Health Care, and Spirituality; Disease, Social Conditions, and Spirituality; General Well-Being and Spirituality; and Health Education and Spirituality.

Definition of Terms

It was important for the researcher to define certain concepts that are included within this paper and which were an important part of this research project.

General Well-Being- Related to quality of mood, mental health, self-esteem, happiness, with low stress levels, and good health (Maton, 1989).

Health- Total health consists of a variety of components, notably the physical, mental, and spiritual dimensions of health (Bensley, 1991a).

Holistic Health- The whole body must be considered (mind, body, spirit) if complete health is to be achieved, this is holistic (or wholistic) health (Witmer & Sweeney, 1992).

Life Satisfaction- Can include happiness with one's life, environment, relationships, socioeconomic status, education, health, age, and morale (Wilson, 1967).

Religion- An organized group that shares the same beliefs and rules, that consists of practiced worship, ceremonies, and traditions. Usually, it involves worship of a supreme being (God) (Pilch, 1988).

Spirituality- Witmer and Sweeney (1992) define spirituality as a source that comes from within as well as outside the person. "Inner voices, inner wisdom, higher consciousness, or the spirit of God are forms of spirituality" (p. 141). Witmer and Sweeney continue by stating that spirituality has traditionally "sought peace, guidance, and contact with a universal force through meditation, prayer, worship, contemplation, or introspection" (p. 141).

Spirituality vs. Religion- Spirituality may be linked to religious values. Spirituality is differentiated from religion, in that, one can be spiritual without being religious, and one can be religious without being spiritual. People who consider themselves to be religious, will probably have some degree of spirituality. Therefore, spirituality and religion have qualities that are independent to each, and they have qualities that are common to both. It is the researchers belief that everyone has some degree of spirituality.

Banks (1980) states that one major component of the spiritual dimension has to do with what the individual identifies as meaningful. "Spirituality is based upon individual perceptions and faith" (Banks, p. 196). Included in this would be components having to do with "perceptions of what it is that causes the universe to work the way it does; recognition of powers beyond the natural and national; survival; and pleasure" (p. 196). Banks also states that "religious beliefs can be placed in any or all the above identified aspects" (p. 197).

CHAPTER I

Health, Health Care, and Spirituality

Information on health, health care, and spirituality, obtained through various professional journals, is included in this chapter. It was important to define health itself and distinguish it from health and spirituality. This is included under the heading *health*. Under the heading *health care* the researcher included holistic health care, which includes the concept of mind, body, and spirit in relation to health care. Also included under this heading were health care and religion. Under the heading *spirituality*, spirituality and religion, and religion and health were included.

Health

Defining Health

1960's. In 1962 Hoyman believed that the concept of health had been simmering for sometime and is now boiling over with many exciting new ideas. Health can be a positive state or a negative one (Hoyman, 1962).

What is health? Terms such as "whole", "sound", and "vigorous" were formerly used to define health in a positive sense (Hoyman, p. 253). Then "health" came to be visualized more in a negative way as freedom from disease, defect, and disability. Finally, there was a critical rediscovery that health is a dynamic process involving individuals as a whole and their unique style of living. Hoyman believed that health has

qualitative, as well as quantitative dimensions and there are various levels of health. He further explained that health depends upon multiple factors, not a single cause. Health and disease are ecological resultants, indicating the need for an epidemiology of health as well as disease (Hoyman).

In the past, Hoyman believed health was as hard to conceptualize as human life itself. In final analysis any theory of health will rest upon an underlying theory of humankind in the universe. However, personal health is an indivisible, multidimensional unity; and, in our present stage of knowledge, physical fitness, mental health, and spiritual faith are to some extent incommensurable aspects of personal health.

Considering the staggering complexity of the problem it is easy to see why our current theoretical model of health is not more fully developed in terms of specific objective health indicators, and why we are such a long way from having developed a health index for an individual or a population group. Some of the obstacles now seem insurmountable, but we must move ahead (Hoyman, 1962).

1970's. Dunn (1977) said that we should not look for good health, but should try to attain "high-level wellness." Wellness, in the sense used here, signifies something quite different from good health. "Good health can exist as a relatively passive state of freedom from illness in which the individual is at peace with his environment - a condition of relative homeostasis" (Dunn, p. 11). Wellness is conceptualized as "dynamic - a condition of change in which the individual moves forward, climbing toward a higher portion of functioning" (Dunn, p. 11).

Dunn (1977) goes on to say that high-level wellness involves: (1) direction in progress forward and upward towards a higher potential of functioning, (2) an open-ended and ever-expanding tomorrow with its challenge to live a fuller potential, and (3) the integration of the whole being to the total individual - body, mind, and spirit - in the functioning process.

In 1978 Hochbaum stated that "health is conceived, as a means toward other things: success, attractiveness, desired self-image, social affiliations and, of course, absence of pain, suffering, and disability" (p. 825). In short, the value of health in people's eyes derives from its being an instrument of the attainment of other, more tangible, valued things.

Carlyon (1978) believed that the "outstanding feature of health is that it is a quality and, therefore, cannot be weighed and measured" (p. 26). Health is not a single entity or condition. There are levels of health that can be distinguished from the other, but it is easier to observe the differences than to define health itself. "That it exists seems certain, but getting a firm hold on it is virtually impossible" (p. 26). In fact, the health territory has no independent existence at all. Carlyon believes health is a state of mind, a projection of our beliefs about the natural and perfectibility of humans and our value judgments about what constitutes a good person in a good society.

Carlyon also believes that the healthy good person:

1. Takes science as his/her yardstick for knowledge, and the history of ideas as source material for making value judgments.

- 2. Is willing to accept the possibility of the existence of any conjectured phenomenon, but does not behave as though it is true (exists) without adequate scientific evidence.
- 3. Accepts evolution as the best explanation for human origins.
- 4. Considers all facts and truths to be subject to change in light of new knowledge.
- 5. Reject claims for revealed knowledge or absolute truths.
- 6. Is an independent self-directed learner eager to explore new ideas.
- 7. Is a free thinker unencumbered by guilt, fear, and taboo.
- 8. Views people as essentially good and as being in a continual process of growing and becoming.
- 9. Is loving, supportive, nonexploitive, and nonmanipulative in relationships.
- 10. Accepts as fundamental the dignity and worth of every human being.
- 11. Has no interest in accumulating wealth for its own sake, but funds fulfillment in word.
- 12. Demonstrates a keen sense of the absurdities, ironies and contradiction in the human enterprise.
- 13. Finds joy in living. (p. 26)

In 1978 Carlyon made some suggestions about what needs to be done in the future. He believed "we live in an age marked by disillusionment. Hopes have been dashed, heroes have fallen, and dreams are not coming true" (p. 26). The age of romantic scientism is past. The new realism is here. "Perhaps health in the new age would better be defined in terms of coping and survival, at least until new myths can replace the old" (p. 26). And the positive images of the future can emerge. "It may be too much to ask people to be joyously free and self-actualizing in an atmosphere of ambiguity, fear, and anomie" (p. 26). Carlyon believes "we need not necessarily abandon our visions for human kind, but rather modify our expectations for their fulfillment. With more realistic goals, we may find that we can accomplish much more than we think" (Carlyon, p. 26).

Russell (1978) shares his views on health by stating that "health is the quality of his day-to-day and overall functioning" (p. 28). He writes that he has good health when "his body functions efficiently in all that he has it do, when his feelings are largely positive, when he can utilize knowledge that he has and be excited about learning more" (p. 28). When he can "think of others as often as he thinks of himself and experience the continuing relationship with God, the Lord of all life," (p. 28) and finally, when he can act as though his welfare, and that "all humans are inextricably meshed with the physical world and all other forms of life so that he lives in as much harmony with nature as possible" (Russell, 1978, p. 28).

1980's. Greenberg (1985) believes health is a multifaceted concept which need separate definitions for each aspect:

- Social health is the ability to interact well with people and the environment and having satisfying interpersonal relationships.
- Mental health is the ability to learn and includes intellectual capabilities.
- Emotional health is the ability to control emotions so that one feels comfortable expressing them where appropriate and does express them appropriately. It also is the ability not to express emotions when it is inappropriate to do so.
- Spiritual health is the belief in some unifying force. For some, that will be nature, for others it will be the scientific laws, for others it will be a godlike force.
- Physical health is the ability to perform daily tasks with energy remaining for unforeseen circumstances; the biological integrity of the individual. (p. 404)

Greenberg goes on to say it may be argued that even if someone is ill, that person may have some degree of health. A person with a physical disability who exercises regularly and participates in sports for the disabled may be healthier than a person who is

outwardly nondisabled but not physically fit. Goldstein, Jaffe, Sutherland, and Wilson stated in their 1987 study that "health is a positive state, not merely the absence of disease; "and an acceptance of "both a psychological and spiritual component in the etiology and treatment of disease" (Goldstein, et al., 1987, p. 118).

For the word health comes to us from the same root that gives us the words "hale" and "whole," concepts that suggest strongly that human health is "a process of becoming; a dynamic movement toward a full realization of latent possibilities" (Greifinger & Grossman, 1977, p. 207), not only in the human body, but in "human feelings, minds, and spirits" (p. 207). Health then, is characterized by "energy, and by direction toward full development" (Greifinger & Grossman, p. 207).

The concept of "holism" was first introduced by the South African philosopher Jan Christian Smuts in 1926. To Smuts "holism" was an antidote to the analytic reductionism of the prevailing sciences. It was a way for comprehending whole organisms and systems as entities greater than and different from the sum of their parts (Hastings, Fadiman, & Gordon, 1980).

1990's. In defining health Robert Bensley (1991a) believes it is generally agreed that total health consists of a variety of components, notably the physical, mental, emotional, social, and spiritual dimensions of health. Currently, there are several accepted definitions for the physical, mental, emotional, and social components of health but relatively little pertaining to the spiritual dimension of health. In addition,

exploration of the spiritual aspect presently does not exist at the same level or intensity as with the other dimensions of health (Bensley, 1991a).

Health and Spirituality

1960's. Human life is essentially a quest for personal identity and fulfillment, social sensitivity, ethical insight and moral responsibility, and spiritual meaning (Hoyman, 1962). "Spiritual faith" is intended to signify that humankind is searching for some deeper, more unifying meaning to their life than mere existence or survival. Truly healthy people seek to transform and transcend themselves and to justify their life through spiritual aspiration and faith that link up the real facts of their existence with ideal ends (Hoyman).

Hoyman further explains:

each man, in his own way, seeks God - in one form or another. In his search for the good life it would be as unwise for man to rely on either science or religion alone as it would be for him to try to walk through life on one leg instead of two. And for us to ignore the spiritual dimension of man in conceptualizing his health would be to deal with man dehumanized, for moral and spiritual values are central to human personality and mental health (p. 254).

Hoyman states that faith is not a matter of the spiritual side of an individual in isolation, but it is the centered movement of the whole person toward something that has ultimate meaning and significance. Spiritual faith alone will not make a person healthy. In fact, faith held and expressed in the wrong way, or belief in the wrong thing, may make an individual sick. The spiritual side of individuals cannot feed upon itself and

stay healthy; it must be nourished by all the things that give life meaning and value (Hoyman).

1970's. Dunn (1977) believes the 12 basic needs that are essential to humankind well-being is communion with the universe. Dunn believes religion in the sense of communion with the universe, is a basic need shared by people of all periods in history. It is reflected in humankind's curiosity and in their never-ending search for answers. People feel themselves exposed to the violence of nature and crave protection from its fury. With the advancement of science, new knowledge has opened new vistas. But the desire to commune with the universe still remains. Humankind must have faith to go ahead and be themselves (Dunn, 1977).

1980's. Modern physics has also contributed to the construction of the spiritual critique of biomedicine. All observations are shaped by and in turn shape the observer. Increasingly the scientists' vision of the universe and the language they use have come to resemble those of the mystics. All things do appear to be seamlessly and wondrously interconnected, and all attempts to describe them are inadequate and, although heroic, are still somehow beside the point (Hastings, et al., 1980).

Hastings, et al., wrote that anecdotes about "faith healing", "miracle" cures, and unexplained recoveries from unusually fatal illnesses have prompted investigators to measure and to find significant biochemical changes in plants and animals subjected to a "healing" touch to document "spontaneous remissions and miracle cures" (p. 11), and to encourage and to mobilize the "healing powers of faith and hope, intention and touch"

(p. 11). This does suggest that forces lying outside the domain of biomedical observation, including attitudes and expectations we have traditionally thought of as religious, can have effects on health and illness (Hastings, et al.).

Banks, Poehler, and Russell (1984) did several studies on the spiritual interaction as a factor in health and health education. These researchers compiled their findings into one journal article and had the following conclusions:

Most, but not all, subjects in these studies accept spirit as reality, the spiritual as a dimension of well-being, and human spiritual interaction as a contributor to positive health.

Consideration of the spiritual dimension should be a part of health education and part of professional preparation for health educators, but it is important that there be awareness and appreciation of differences in perceptions of this spiritual factor and differences in value placed on it.

Spirit is frequently identified in relation to purpose and meaning for life ... in general and in situations that are quite specific and sometimes very dramatic. The spirit is recognized, by some, as having a unifying function, in social relationships and also in relation to self. It is acknowledged as the best unifier and coordinator of the physical, mental, emotional, social, and environmental dimensions of health. The term harmony is frequently used in this context. And two of the studies identified "inner strength" as a manifestation of spirit; the other referred to occurrences of which there is no rational explanation. Instances wherein a person performs beyond normal expectations, particularly in an emergency, seem to be accepted as manifestations of the spirit. (p. 17)

Ram (1988) believes primary health care has to do with people and it is a people's movement. What we need for leadership are the ordinary people with human and spiritual values, people who can help move their communities towards the attainment of the goal of health and fullness of life (Ram).

Pilch (1988) believes wellness is a "holistic spirituality". It is a "spirituality" because it is a way of life based on an experience of God and shaped in response to that experience. It is holistic because spirituality in the context of wellness states that "the whole person is far greater and much more complex than the sum of all the parts" (p. 31). However, these parts are identified as physical, mental, spiritual, emotional, and social. Wellness spirituality, then, is a way of living. A lifestyle that views and lives life as purposeful and pleasurable, that "seeks out life sustaining and life enriching options to be chosen freely at every opportunity, and that sinks its roots deeply into spiritual values and/or specific religious beliefs" (Pilch, 1988, p. 31).

Norman Cousins (1989) states that the more serious the illness, the more important it is for you to fight back. You've got to mobilize all your resources - spiritual, emotional, intellectual, physical. Your heaviest artillery will be your will to live.

1990's. According to Bensley (1991a) "Even though the spiritual dimension of health has been recognized as an important component of comprehensive health, its nature makes it difficult to define" (p. 287). Currently, a commonly accepted definition of spiritual health does not exist. In fact, interpretations pertaining to the concept of spiritual health differ in many ways. "Some professionals define spiritual health in relation to the sense of fulfillment in life, while others concentrate on values and beliefs of community and self" (p. 289). Spiritual health also is defined as "a component of wholeness in life, spiritual wholeness, and spiritual well-being" (p. 289). Finally, attempts have been made to explain the spiritual dimension of health in terms of a

controlling higher power, a "godlike" force, and the human/spiritual interaction (Bensley).

Goodloe and Arreola (1992) believe that spirituality has a direct influence on health. They believe spirituality can be viewed as the umbrella of health components, affecting every area of the person. Originated and reinforced by church leaders, this movement was driven by the idea that people could play a vital role in their healing and that the spiritual dimensions was critical to their healing (Goodloe & Arreola, 1992).

Witmer and Sweeney (1992) proposed a model of wellness and prevention over the life span that incorporated theoretical concepts from psychology, anthropology, sociology, religion, and education. And at the center is spirituality.

Spiritual beliefs can be "translated into ethical, moral, and legal codes, all of which in part are intended to protect and sustain the sacredness of life" (Witmer & Sweeney, 1992, p. 71). Individual character and life-style are developed in a way that "is thought to nurture the soul while at the same time be acceptable or harmonious with the supreme being-force of the universe" (Witmer & Sweeney, p. 71).

Health and the consciousness disciplines must be willing to explore new territory in order to test the validity of such a concept as spirituality (Diaz, 1993). Cohen (1997) believes faith can prolong life, and it also helps people cope with dying. It is important to address spiritual issues in the last year of life, when people typically pay out one-fifth to one-third of their lifetime health expenditures. More inner peace would equal fewer panic-induced medical procedures (Cohen).

Health Care

1980's. There should be a relationship between the physician and other health-care providers that is "relatively open, equal, and reciprocal" (Goldstein, et al., 1987, p. 118). The physician should be concerned with how the individual's health reflects the familial, social, and cultural environment; and openness toward using natural "low-technology," and non-western techniques whenever possible, and emphasis on physical and/or emotional contact between practitioner and client; and an acceptance of the notion "that successful healing transforms the practitioner as well as the patient" (Goldstein, et al., 1987, p. 118).

1990's. "At the close of this century, we recognize afresh the limitations of science and a disillusionment with exclusive reliance upon its answers" (Mathews & Larson, 1995, p. iv). Perhaps the coming years will witness a tearing down of the "wall of separation" (Mathews & Larson p. iv) between medicine and religion and bring about a reconciliation, as well as a new synthesis of these ancient traditions of healing.

The long-standing neglect of religious variables in medical settings has important implications. Since data from multiple studies are demonstrating benefits of religious commitment upon health, it may be "ethical for physicians, and appropriate for federal health policy, to begin to encourage such commitment. It might even become unethical (or inappropriate) someday to ignore (or oppose) such commitment" (Mathews & Larson, p. v).

Holistic Health Care

1970's. Greifinger and Grossman (1977) explain that the ultimate goal of the practice of medicine is health. The diagnostic and therapeutic work of the physician, the mechanical skill of the surgeon, the attention and care of the nurse, and the counsel of the psychotherapist are all subsumed under the banner of "health care," and their efforts are summarized as the "health care delivery system" or "health services." The governmental agencies concerned with these activities are not Departments of Medicine, but Departments of Health. "Near unanimous usage has linked medicine with health as if they were causally related" (p. 207), leading to the assumption that "good medicine yields good health" p. 207). Yet the etymology of the word "health" suggests other possibilities, with implications that relate directly to the current disaffection with medical practice as being "over-technologized, authoritarian, and remote from true human needs" (p. 207). Thus, human growth is a measure of the health process, and takes its place alongside human recovery as part of the agenda of the medical practitioner if he is truly to be a worker in health care. In the past 40 years in the United States, there have been some especially provocative attempts to extend and expand the connection between health and medicine, ideas which challenge physicians to take a greater part in the development of the "haleness" and "wholeness" of their human patient (Greifinger & Grossman, 1977).

Dunn, who is a medical doctor, discussed in his 1977 paper that many physicians and health workers, have become increasingly dissatisfied with their disciplines which

customarily deal only with the body or mind of individuals, leaving to religion, metaphysics, and philosophy the affairs of the spirit. "For most of us, reared in the Western culture, a deep chasm exists between the realm of the body and that of the spirit" (Dunn, p. 14). All of us are familiar with instances in which people with sick or deformed body has had the will to climb back to normality, but, to the best of Dunn's knowledge, no one has ever seen people sick in spirit who could maintain their mental or physical health, for long. Perhaps sometime we will come to realize that a major task facing us is to fashion a rational bridge between the biological nature of humankind on the one hand and the spirit on the other (Dunn, 1977).

McCormick (1978) states in his research paper that his final point in dealing with health and care for health is that our responsibility must be 'holistic'. By holistic he means that responsibility must be conceived and spoken of as covering all of those things that affect life and health. It must be part and parcel of an attitude toward persons that defends their rights, is strongly prophetic about warfare, about poverty, about quality of life in all aspects and at all ages. Without such a reach and universality, our own sense of responsibility begins to erode by being selective. One cannot responsibly care for the person, the self or others, by caring for only a single aspect of the person (McCormick).

There is a profound difference between physicians, paramedical personnel, and a hospital with a self-image of vocation and those with a self-image of only "being in business." This difference manifests itself in subtle but very important ways. "Unless

we are aware of this, we drift toward moralist, the extension into the moral sphere of a merely technological assessment of man" (McCormick, p. 43).

A very significant area for evaluation research pertains to holistic health. As recognition grows that health care relevant to physical needs must also give attention to the mental and spiritual components of health, it will become increasingly important to include activities to promote spiritual well-being in all of the "helping professions" related to health, welfare, education, counseling, social work, pastoral care, clinical psychology, and other human service occupations, including health education (Moberg, 1979).

1980's. In the last several years holistic (sometimes spelled wholistic) medicine has come to denote both an approach to the whole person in his or her total environment and a variety of healing and health-promoting practices. This approach, which encompasses and is at times indistinguishable from humanistic, behavioral, and integral medicine, includes an appreciation of patients as mental and emotional, social and spiritual, as well as physical beings. It respects their capacity for healing themselves and regards them as active partners in, rather than passive recipients of, health care (Hastings, et al., 1980).

Holistic medicine addresses itself to the physical, mental, and spiritual aspects of those who come for care. The practitioners of holistic medicine are concerned with helping their patients heal the split that has stripped the mind of its power to experience and control the body, that has stripped the body of its wisdom and purpose, and that has

reputed the bond between these two and the spirit that gives them both meaning. In the language of science, human beings are "open systems" and may be addressed at a variety of levels, the psychosocial and spiritual as well as the biochemical and physiological (Hasting, et al.).

Holistic medicine emphasizes the uniqueness of each person, the complex socioeconomic and psychological factors that in addition to biochemical and physiological factors characterize each person's health or illness. It encourages students and practitioners to spend considerable time with their patients, to explore and appreciate the minute particularity of the new world that each patient brings to them, to become sensitive to the complex psychology and uncommon life of people with common diseases. "Of course each person will require a different approach, different forms of exercise, a different diet, a different pharmacological treatment, and different kinds of psychotherapeutic intervention" (Hastings, et al., 1980. p. 493).

Hastings, et al. continues to write that since the Middle Ages, scientists and philosophers have tended to divide man into body, mind, and spirit. This split is apparent in the current structure of the health in professions. Physicians are dedicated to the treatment of the body; psychologists and psychiatrists are concerned with treating the mind; and the clergy are attendants to the soul and administer the practice of spiritual healing. While many other societies have created healing rituals that involve the whole person as well as the family and social matrix, Western healing practices have been characterized by specialization. "If the prevention of pathology is the ultimate goal of

the healing professions, then health practitioners and laymen {sic} need to address themselves to the entire person - mind and spirit as well as body - in relation to his or her total environment" (Hastings et al., p. 494).

Hastings, et al. point out some characteristics of holistic health. They describe them as approaches to medicine and health care which include understanding and treating people in the context of their culture, their family, and their community. Holistic health emphasizes "the promotion of health and the prevention of disease." It also emphasizes "the responsibility of each individual for his or her health" (p. 491). Holistic medicine uses "therapeutic approaches that mobilize the individual's innate capacity for self-healing" (p. 491).

Hastings, et al. (1980) continues by stating holistic medicine views illness as an opportunity for discovery as well as a misfortune. Holism includes an appreciation of the quality of life in each of its stages and an interest in improving it as well as knowledge of the illnesses that are common to it. Holistic medicine emphasizes the potential therapeutic value of the setting in which health care takes place. An understanding of and a commitment to change those social and economic conditions that perpetuate ill health are as much a part of holistic medicine as its emphasis on individual responsibility. "Although it appreciates the predictive value of data based on statistical studies, holistic medicine emphasizes each patient's genetic, biological, and psychological uniqueness as well as the importance of tailoring treatment to meet each individual's needs." (Hastings, et al., p. 494).

Goldstein, et al., (1987) did a study which compared members of the American Holistic Medical Association (N = 340) to a group of California family practice physicians (N = 142). The groups were similar in demographic characteristics. The holistic doctors were distinct in their training, practice characteristics, attitudes, clinical behaviors, motivations, and feelings of marginality. Personal experiences with religion/spirituality, psychotherapy, and maintaining a personal health regime appeared to be important distinguishing factors. The overall findings indicated a dimension of diversity among physicians which had been neglected until now.

Goldstein, et al. (1987) concluded that, generally, the physician's role has been portrayed as involving dominance over clients and other health workers. The physician's superior position is based upon access to, and use of, "rational scientific knowledge about health and disease" (p. 104) as well as on training and competence in specific skills for treating disease. Holistic physicians seek an "egalitarian" as opposed to a dominating or authoritarian, relationship with their clients and coworkers. Although a high degree of personal autonomy is important to most holistic physicians, they also assume that successful healing requires "recognizing and fostering the autonomy of the client" (p. 104). In addition, although holistic healers acknowledge the importance of scientific research as a basis of knowledge and skills, they see it as only "one of a number of ways to derive useful information and techniques" (p. 104). Folk knowledge, insight, spiritual revelation, and an ability to gain access to a variety of currently unmeasurable phenomena are all regarded as potentially important. Even when scientifically derived

knowledge about illness is correct, holistic physicians often "question its utility for healing" (p. 104), especially as it interferes with the training of healers and clients in the use of other holistic approaches. They generally "condemn the monopolization of medicine and healing by physicians" (Goldstein, et al., p.104). Despite these differences of mainstream medicine, a number of commentators and observers have indicated that holistic medicine is gradually finding favor among a larger number of medical doctors (Goldstein, et al.).

Goldstein's, et al. (1987) study revealed that a) many mainstream physicians (at least family practitioners) hold views and behave in ways that deviate from mainstream medical norms; b) the gulf between mainstream and holistic outlooks in medicine is not as wide as some commentators think, and c) the potential for the adoption of holistic concepts and techniques by mainstream practitioners is substantial. Overall they believe that their findings illustrate the extent to which pluralistic identities, attitudes, and behaviors already exist among American physicians. The holistic physicians are significantly more likely than family practitioners to be "predominantly in private practice, to see fewer patients per week, and to use hospitals less frequently" (p. 117). Holistic doctors are considerably more likely than family practitioners to report "past religious or spiritual experiences as frequent, important, and influential in their lives" (p. 117). They are also much more likely to report that "psychotherapeutic experiences have been influential," (p. 117) and that they have been actively engaged in a regimen of personal health promotion activities. The relative importance of spiritual factors in

influencing views about medicine is an important distinguishing characteristic between these two groups (Goldstein, et al.).

In the same study Goldstein, et al. also interviewed 30 members of a support group for holistic physicians in Los Angeles and found that 22 of the 30 respondents reported religious and/or spiritual experiences most frequently as the reason which shaped their feelings about medicine and their practice of it.

In a historical perspective Ram (1988) explains that early practitioners of healing arts understood man as a whole being whose body, spirit, and mind were not separate. For them, all symptoms of disease affected the whole person. A deep change occurred in the 19th century when medicine allied itself with the natural sciences. Advances in science and technology have led to rapid perfecting of diagnostic, therapeutic and rehabilitative skills. Modern medicine is able to transplant organs, replace joints and prolong life. In the process, however, the close relationship between doctor and patient has given way to depersonalized, sophisticated technology (Ram, 1988).

Ram's study on spiritual leadership in health discusses the problems with today's health care system. He states that most people used to believe that more doctors and more hospitals would result in better health. "As we look at today's world, we see that although health care is necessary, most disease stems from such factors as poverty, poor housing, lack of safe drinking water, malnutrition, illiteracy, loneliness or isolation" (p. 6). Ram believes modern health problems point to the need to recognize the unity of mind, body and spirit, and the essential unity of the universe. Just as individuals are a

product of their total environment, *dis-ease* is a product of the whole person. "We desperately need a new approach to health and healing in order to deal with it" (p. 6).

Ram believes that "despite the wonders of modern medicine, we see that certain fundamental diseases of today's society have not been cured because the best medicines of the best institutions are not capable of listening, caring, touching and loving" (p. 6).

These are human attributes and only humans can provide them. It is this dimension of human care that is so important in healing (Ram, 1988).

Ram continues by asking whether or not this makes any difference to the practice of medicine. Recognizing human attributes calls for recognition that "each person is a part of God's creation, unique in one sense, and yet shaped by the community of which each is a part" (p. 7), so that individual and community can "never be separated" (p. 7).

Ram is convinced that no one can be fully healthy living in a sick society.

Cousins (1989) believes that "caring, compassionate, and competent physicians" (p. 48) can be found today. He explains that "there are a great many physicians who are prepared to spend time with patients, treating them with understanding and skill" (p. 48).

Cousins (1989) states that the wise physician doesn't minimize the seriousness of the illness; he presents it as a challenge that calls for the best both doctor and patient have to offer. "Instead of dwelling on all the melancholy possibilities, he offers a plan of battle in which the patient has an active role. The physician stays in close touch with the patient, regarding morale as an integral part of sound treatment" (p. 54). Cousins also

believes that the physician should also provide the patient with a comprehensive list of things to do in addition to medical compliance. The list can include "major attention to nutrition; exercise to whatever extent is possible and desirable; freedom from unusual stress, or coping with unavoidable stress at home or at the workplace; the need for a good quality of life" (p. 54). Ways of combating depression and anxiety and suggestions for participating in groups of patients confronting similar problems are also suggested by Cousins. This may help enable the patient to "come into possession of powers that he never dreamed" (Cousins, p. 54).

Cousins (1989) talks about the patient-physician relationship. Doctors are not entirely to blame for spending so little time directly with patients. The central fact here is that doctors don't get paid for talking to patients. "In a medical economy dominated by third-party paymasters - insurance companies, the government, health plans, etc. - the harsh reality is that doctors get paid mostly for tests and procedures" (p. 55). It is not surprising, therefore, that patients should be "subjected to a multitude of encounters with expensive medical technology, not all of which is essential or without risk" (p. 55). Finally, it helps to explain why medical costs have skyrocketed in recent years. Whether in physician's offices or in hospitals, tests now account for the major portion of the physician's fees (Cousins).

Cousins believes we live at a time when progress in overcoming illness is equated with pills. If something is wrong, we seldom get at the underlying cause, especially if it means strenuous effort. We regard doctors as the miracle workers who can wave their

“prescription pad over us like a magic wand and provide a presto remedy” (p. 55). This is not the noblest exercise of the physician’s skills. Unfortunately, the public’s short-cut notions of how to get rid of illness or pain frequently puts the physicians in a position of meeting the demand for prescriptions or seeing their patients go elsewhere (Cousins).

1990’s. Cohen (1997) wrote in his interview with David Larson that as president of his own think tank, the National Institute of Health Care Research, Larson is on the road to spread the word to health professionals and other decision makers. Larson believes that faith is a crucial element of the American psyche and that faith should be taken into consideration in health care not just in a patient’s last moment but from the first time a physician, or a psychotherapist, take his or her history (Larson’s study, as cited in Cohen, 1997). For more information see Appendices A and B.

Health Care and Religion

1970’s. McCormick (1978) believes that unless prevention, cure, and care are experienced as extensions of genuine human caring and love, health care professionals are less than they could and should be. They do not touch the whole person: Rather they minister to a body. “They may heal the body, but we long for and need a deeper healing from each other as the body is healed” (p. 43). This is one good reason why persons of deep faith and religious consecration should be in health care. “For in our time, it is far too easy for health care to be reduced to only body care, in a very impersonal way” (McCormick, p. 43).

1980's. The relationship between religion and health has received varying degrees of attention from sociologists, health professionals, epidemiologists, and public health researchers. Hastings, et al (1980) wants to remind us that through most of our history medicine itself has been sacred art. "Healing was God's work and the healer, priest, or shaman, was a catalyst to, or vessel for, a power variously labeled as God or nature." (Hastings, p. 241). In recent years Hastings notes that "this scientific sanction has encouraged clerics, physicians, and lay people who are dissatisfied with the aridity of both contemporary religion and medicine to try to forge a new synthesis of healing practice, scientific research, and spirit" (Hastings, et al., 1980, p. 241).

Bergin (1983) explains that spiritual tendencies are common among us, but they are symbolized and expressed under many aliases. In addition, medical practitioners need to more assiduously include collaboration with the religious leaders and subcultures from which clients come. The opportunity to utilize associated support systems to induce and maintain change is a potentiality that community psychologists appreciate but that medical practitioners often ignore. Finally, we need to broaden our horizons so that despite our differences, we can empathize with persons who approach life from a spiritual perspective and thus achieve the mutual cognition's, emotions, and behaviors are so pervasive, potential medical clinicians respect to which most of us are committed (Bergin).

Bergin's study concludes that because religion should understand the cultural content of their clients' religious world views rather than deny the importance of these

views. To achieve this goal, the clinical students and practitioners should be aware of their own religious impulses. "Training in the clinical professions is almost bereft of content that would engender an appreciation of religious valuables" (Bergen, p. 95). Race, gender and ethnic origin now receive deserved attention, but "religion is still an orphan in academia" (Bergen, p. 95).

1990's. Maugins and Wadland (1991) explained that patients and physicians commonly report personal adherence to religious beliefs and practices, but religious issues are not frequently addressed in the patient-physician relationship (except in the context of serious, life-threatening illness), despite significant interest among both groups to do so (Maugins & Wadland, 1991).

Fagen (1996) adds that in public health circles, the level of educational attainment is held to be the key demographic predictor of physical health. For over two decades, however, the level of religions practice has been shown convincingly to be equally important.

First, no one denies that health care professionals, especially physicians and nurses, do not confine their activity to diagnosis, prognosis, and treatment. Theirs is, or should be, a "high touch" relationship with the patient such that they "come to know the latter's treatment values and perhaps something of their philosophy of life or religion" (Smith, 1997, p. 1). Nevertheless, "theirs is an objective (though not cold) relationship, the immediate focus of which is the medical condition of the patient" (Smith, p. 1).

Second, what remains essentially a medical condition for the health care professional is experienced in a much different way by the patient. For the patient, the medical condition is experienced as a "human dilemma generally involving the reality of human suffering" (Smith, p. 2). For the patient, then, sickness is a vastly larger reality than the medical diagnosis. Beyond the questions about diagnosis, treatment, and subsequent prognosis, there are the precisely human questions of the "existence of evil (physical evil in me), the reality of suffering confronting one, and the matrix of meaning by which the patient faces this reality of suffering, beyond the confines of physical pain" (Smith, 1997, p. 2).

Smith stated that a physical illness may provide the occasion for a person to appreciate spiritual needs at a new level. For this reason, Catholic health care includes pastoral care, especially the administration of the sacraments.

However, Smith cautions the sacrament of the Anointing of the Sick does not bypass or duplicate the work of health care professionals. "It places the human drama of suffering within its context and places the patient in his or her suffering squarely, and effectively, in the presence of the suffering Christ and the grace of the Holy Spirit" (p. 2).

The patient in a hospital bed, after all, is not looking for an explanation for this suffering; but is looking for the consolation of compassion and hope (Smith, p. 2).

Larson stated that while one can go through the motions of being religious without being spiritual, or be spiritual without the trappings of a religious system, spurious piety and genuine piety have different effects. So science distinguishes between

those who merely go to church and those who go to God (Larson's study, as cited in Cohen, 1997).

Spirituality

Spirituality and Religion

1950's. Jung (1958) said that "religion is an instinctive attitude peculiar to man" (p. 26), and its manifestations can be followed all through human history. Jung continues:

Its evident purpose is to maintain the psychic balance, for the natural man has an equally natural "knowledge" of the fact that his conscious functions may at any time be thwarted by uncontrollable happenings coming from inside as well as from outside". (p. 26)

1960's. Presently, people must learn to live in a world that can be threatening and frightening and full of change, "without cracking up from self-pity and despair, and without giving up his struggle for a meaningful and satisfying life. Each generation of man has a rendezvous with destiny; if it isn't the H-bomb, it's the saber-tooth tiger" (p. 261). Hoyman (1962) believes that our common task is to help bring order out of chaos, rational purposes out of irrational existence, and significant values and meaning out of the raw stuff of experience.

Maslow (1964) believes that, traditionally, religion has been of the spirit and science has been of the body. This has led to a wide philosophical gulf between the knowledge of body and the knowledge of spirit. The natural sciences and religion have generally been considered eternal opponents (Maslow).

Maslow also states that religious experiences can be produced by sexual love, or by philosophical insight, or by athletic success, or by watching a dance performance, or by bearing a child. Maslow believes we should take the word "religious" out of its narrow context and some examples of this include the supernatural, churches, rituals, dogmas, and professional clergymen. Then religion can be distributed in principle throughout the whole of life. Religion can then become not only one social institution among others, not one department of life distinct from others, but rather a state of mind achievable in almost any activity of life, if this activity is raised to a suitable level of perfection (Maslow, 1964). It is because both science and religion have been too narrowly conceived, and have been too exclusively dichotomized and separated from each other, that they have been seen to be two mutually exclusive worlds. To put it briefly, this separation permitted 19th-century science to become exclusively mechanistic, too positivistic, too reductionistic, too desperately attempting to be value-free. It mistakenly conceived of itself as having nothing to say about ends or ultimate values or spiritual values. This is the same as saying that these ends are entirely outside the range of natural human knowledge, that they can never be known in confirmable, validated way, in a way that could satisfy intelligent people, as facts satisfy them (Maslow).

Apparently, even atheists show some type of religious or spiritual influences. It has appeared to Maslow that atheistic people had more religious (or transcendent) experiences than conventionally religious people. Partly this may have been because

they are more often serious about values, ethics, philosophy of life, and because they have had to struggle away from conventional beliefs and have had to create a system of faith for themselves individually (Maslow).

Maslow indicates the religious lifestyle or peak experiences are to be valued as producing health through the impetus it gives for altering possible harmful lifestyles.

1970's. The Christianity Today - Gallop poll shows that 94% of the general public believe in God or in a universal spirit that in their mind functions as God. Only 4% explicitly deny the existence of such a Being (Gallop, 1979). The precise nature of the Supreme Being is another matter, but very few need to be convinced that he/she is there. Eighty-seven percent of those who say they believe in God find comfort in their belief, and about half say it gives them great comfort; so belief is not merely an abstract conviction; it is a source of strength in the minds of our increasingly complex and bewildering society (Gallop, 1979).

1980's. Harmon (1985) believes religion is viewed by individuals to help assist them in organizing their thoughts and actions and to assist them in realistically viewing their own morality with hope and trust.

Ram (1988) believes non-Christians have recognized the essential unity of creation. One of the guiding principles of Mahatma Gandhi's satyagraha (nonviolent resistance), was based on his belief that humankind is an indivisible whole. He affirmed that an individual's actions cannot be neatly compartmentalized. Albert Einstein's theory

of relativity maintained the universe is one single whole. If any one part of the universe is affected, the rest of the universe is affected too.

Gallop surveys of recent years, for example, show that 87% of adult Americans pray to God; 69% feel that God has guided them in making decisions; and 36% feel that God has spoken directly to them "through some means" (Pollner, 1989, p. 99). Surveys conducted by the National Opinion Research Center reveal that 80% of American adults feel at least "somewhat close" to God most of the time; 47% report that they have experienced a spiritual force "that seemed to lift them out of themselves." In short, there is evidence that "individuals participate in 'divine relations' as well as social relations and that divine relationships may approximate concrete social relationships in intensity" (Pollner, 1989, p. 99).

1990's. Ronald Johnstone (1992) discussed religion in his research paper and stated:

Religion is a social phenomenon and is in an interactive relationship with the other social units that constitute a society. This seemingly obvious assertion, which lies at the very foundation of the sociology of religion, is actually not nearly as simple as it may seem. Nor is it so readily accepted as one might expect.

Many people, particularly the religiously committed, think of religion in an entirely different way. Some prefer to see religion as the context of the people's communion with the supernatural, and religious experience as something outside of ordinary experience, while others see religion as an expression of an instinctual reaction to cosmic forces. Still others see religion as an explicit set of messages from a deity. These viewpoints certainly de-emphasize, ignore, or even reject the sociological dimensions of religion. Nevertheless, whether we are talking about religion in general, or a particular religious family such as Christianity or Buddhism, or a specific religious group such as the First Baptist, religion will be seen to interact with other social institutions and forces in society. (p. 1)

Religion and Health

1980's. Results from Zuckerman, Kasl, and Ostfeld's (1984) study reveals religiousness as a variable that reduced the risk of mortality among the elderly who were in poor health. Harmon (1985) explored in her research paper the relationship between religiosity and health, she wrote that it was evident from the literature that some theorists view religion and mystical experiences as giving direction toward positive psychological and physical health. Religion may lead to a "deeper sense of reality, give firmness, stability, and equilibrium to life, assist in organizing thoughts and actions, allow a deeper introspection and development of intrinsic strengths, and bring about a positive way of living" (p. 23). One possible way then of enhancing psychological and physical health is to "refocus our attention on religion and its positive value system" (p. 23), as these attitudinal and behavioral changes may "form the framework for the prevention or alteration of deleterious health habits" (Harmon, 1985, p. 23).

1970's- 1980's. Since 1978, the Christian Medical Commission (CMC) has pursued a study program helping churches all over the world to reach a deeper Christian understanding of health, healing, and wholeness. On the basis of wisdom gathered from people in all walks of life and many different cultures, the CMC has come to believe that health is based on harmony with one's self, with one's neighbors, with nature and with God. It depends on the physical, mental, spiritual, economic, political and social well-being of a person. "We have learned that there is an inseparable unity of body, mind and

spirit, and that disturbance in the harmonious relations of these factors can cause ill-health" (Ram, 1988, p. 8).

1990's. Oleckno and Blacconiere's 1991 study found that the more religious students reported "a greater degree of wellness on each of the six sub-scales" which included: 1) health responsibility; 2) self-actualization; 3) exercise; 4) nutrition; 5) stress management, and 6) interpersonal support. The findings of this study "fuel the growing public interest in increasing healthy behaviors and reducing health compromising behaviors in the population" (p. 825). Not only do "the highly religious more frequently practice healthy behaviors", but they "less frequently practice health compromising activities" (p. 825). These data imply that religion might not only be "good for the soul, but good for the body as well" (Oleckno & Blacconiere, 1991).

CHAPTER II

DISEASE, SOCIAL CONDITIONS, AND SPIRITUALITY

This chapter will examine how spirituality can influence diseases and social conditions. Under the *disease* heading, the researcher included cancer and cardiovascular disease. Anxiety, depression, mental health, drugs, and social problems are included under the heading *social conditions*. It was important for the researcher to include these topics because spirituality has been shown to positively influence diseases and social conditions in the studies that were reviewed. Under the heading *spirituality*, religion and church attendance are included.

Diseases

Cancer

1970's. In a 1976 study done by Lyon, Klauber, Gardner, and Smart (1976), comparisons of cancer deaths for Mormons was compared with non-Mormons. The Utah Cancer Registry (1966-1970) was used to provide data on cancer in the state of Utah. To find how many of these deaths were Mormon, the central church file of all living and deceased Mormon Church members was used. For verification purposes, Lyon, et al. researched the religious preferences of patients known to be dead by checking the obituary files of the local newspaper and then compared them to the earlier matching. "Those identified by obituaries as Mormon, but not found in church files were accepted

as church members" (Lyon, et al., p. 130). These researchers found that incidence of cancers of the female breast, uterine cervix, and ovary was significantly lower in the Mormon population, with carcinoma in situ of the cervix showing the largest difference as compared to the non-Mormon, and breast cancer the least. No significant difference was noted between the two populations for cancer of the corpus uteri. Mormon males had low rates of stomach cancer as compared to non-Mormons, but no significant difference in females was noted. Two sites had higher rates for Mormon males - prostate, with an 11% excess over expected from the Cancer Survey, and brain and nervous-system neoplasm's, with 12% excess, whereas non-Mormon males had fewer cases than expected at both sites. There were some sites with significant differences from the Cancer Survey for both religious groups. Cancers of the colon, liver, and kidney had a significantly lower incidence than the National Cancer Survey for males, and cancers of the rectum and pancreas for both sexes. Cancer of the lip showed a marked excess of cases for both sexes of the Mormon population over the Cancer Survey (Lyon, et al., 1976).

1980's. In 1987, a major review of 250 epidemiological health research studies - studies which examined the relationship between health and religion and measured such additional outcomes as colitis, cancers of many different types, and longevity measures - concluded that, in general, religious commitment improves health (Levin & Shiller, 1987).

Pilch (1988) believes individuals who suffer from cancer and other life-threatening diseases, however, admit that this "disorienting" experience has helped them "reorient" their lives as if nothing else has been able to. Indeed, medical anthropologist would call this "healing," that is, "an ability to make sense out of life even if a person is aware of imminent death." "Healing is a restoration of purposeful living, a discovery of fresh meaning in life," (Pilch, 1988, p. 29) even when the actual physical or psychological condition, cannot be cured. Life's fulfillment, thus is found not so much in wealth as it is in discovering how to make the best of bad situations (Pilch).

1990's. Dwyer, Clark, and Miller's (1990) findings suggest that "religion has a significant impact on mortality rates for all malignancies combined" (p. 185), for digestive cancer, and for respiratory cancer when controlled for demographic, environmental, and regional factors known to affect cancer mortality. These results provide new insight into the relationship between religion and health at the macro or community level and suggest that the "influence of religion on social structure warrants further attention" (p. 185). The preponderance of evidence suggests that "religious participation and affiliation influence health behavior and reduce the likelihood of cancer mortality" (Dwyer, et al., p.185).

Dwyer, et al., researched the type of religious background of communities and compared them to cancer rates and concluded that "counties with higher concentrations of Jewish communicants typically have the highest rates of cancer mortality" (p. 185). Although the magnitude of this relationship changes temporally and by type of cancer,

the direction of the relationship is consistent. On the other end of the continuum, high concentrations of Mormons are associated systematically with the lowest cancer mortality rates. The data also showed that in comparison to non-Protestants, higher proportions of conservative and moderate Protestants are associated consistently with lower cancer mortality rates. The impact of the concentration of Catholics and liberal Protestants is mixed, however. Counties with greater proportions of Catholics have higher digestive cancer mortality rates in the 1968-1970 and 1976-1980 models, but lower respiratory cancer rates across all three periods. Similarly, the effect of the concentration of liberal Protestants varies and is significant only in the 1971-1975 models. In this period, greater proportions of liberal Protestants are associated with higher mortality rates for all malignancies and for digestive cancer, but with lower rates for respiratory cancer. "Hence religious concentration affects county cancer mortality rates, and the denominational differences appear to conform to a conservative-liberal dichotomy" (Dwyer, et al., 1990, p. 185).

Then Dwyer, et al., concluded that their findings show that at the county level, religious concentration and denomination affiliation have a "significant impact on cancer mortality rates net of demographic, environmental, and regional factors known to affect cancer mortality" (p. 197). Moreover, although there was some variation in the effects of the religion variables on mortality rates for all malignancies combined, for digestive cancer, and for respiratory cancer, overall, these relationships were relatively consistent across types of cancer and from one period to the next (Dwyer, et al.).

However, Ferraro and Jensen's (1991) study contradicts this. They found within varying levels of practice, "people with more conservative affiliation have poorer health" (p. 199), and this was greater than the effects religious affiliation and race, and about equal to that of education - long considered a pivotal factor in predicting health status (Ferraro & Jensen, 1991).

However, Ferraro and Jensen also found that "regardless of one's religious affiliation and the intensity of one's beliefs, higher level of practice are related to better self-reported health status" (p. 194). The respondent's level of practice, the degree to which they pray and participate in religious services, "were significantly related to better health status, regardless of age" (Ferraro & Jensen, p.194).

Cardiovascular Disease

1970's. Comstock and Partridge (1972) did a study which analyzed arteriosclerotic heart disease deaths among white males. (Using 189 arteriosclerotic heart disease deaths within a three year period and a sample of 378 persons from the 1963 census population which was matched to these deaths for race, sex and year of birth.) It was found that the "risk of dying from arteriosclerotic heart disease was much less for men who usually attended church at least weekly" (p. 669). Even after allowing for the effects of smoking, socio-economic status, and water hardness, "the risk for the frequent church attendees was only 60% of that for men who attended infrequently" (p. 669).

As early as 1972 researchers for the Johns Hopkins University School of Public Health found that "cardiovascular diseases, the leading killers of older people, were reduced significantly in early old age by a lifetime of regular church attendance" (p. 665). By contrast, nonattendees had higher mortality rates for such other diseases as cirrhosis of the liver, emphysema, and arteriosclerosis, in addition to other cardiovascular diseases and even suicide (Comstock & Partridge, 1972).

1980's. In 1982 Dr. Robert Byrd a cardiologist then at the University of California at San Francisco Medical School, conducted a random-sample, double-blind study of the effects of prayer, not by the patients but for the patients, on outcome of cardiac surgery. None of the patients knew they were being prayed for and none of the attending doctors and nurses knew who was and who was not being prayed for. Those praying had no personal contact with the patients before or during the experiment. The outcomes for the two sets of patients differed significantly. Those patients who were prayed for had noticeably fewer postoperative congestive heart failures, fewer cardiopulmonary arrests, less pneumonia, and less need for antibiotics (Byrd).

1990's. There is a study that shows that spirituality and religious activities can have profound effects on health. Oxman, Freeman, and Mannheim (1995) found one of the strongest predictors of survival after heart surgery is the degree to which patients draw strength and comfort from their religion, and the more religious they are, the greater their protection from death.

Social Conditions

Anxiety, Depression, and Mental Health

1960's. In a study on college sophomores and juniors, 19 to 21 years of age, Williams and Cole (1968) found that the high religiosity subjects manifested the least anxiety on all dimensions. The researchers concluded that on the basis of their present study, they can simply affirm that among students, most of whom have been subjected to some religious influence, the religiously active subjects manifested the least anxiety (Williams & Cole, 1968).

1980's. Throughout the history of medicine, practitioners have puzzled about the seemingly "inexplicable recovery of mortally ill patients and the sudden morbidity of patients who should have fully recuperated" (p. 493). Among the subtle variables in this process are "profound alterations in psychological outlook, life-style, and the interaction between mind and body" (Hastings, et al., 1980, p. 493). Beginning as early as the 19th century, the French neurologist Charcot explored the psychosomatic etiology of hysterical seizures. Freud, Sherrington, Pavlov, Cannon, Selye, and others have added to the understanding of the precise mechanisms and biochemical mediators by which psychological states, subjective imagery, and emotions effect the body (Hastings, et al.)

And Griffith, English, and Mayfield found in their study on black prayer meetings that the continued activity and vitality of this church group, even in the context of a constantly changing attendance pattern, strongly indicate that certain urban blacks have found a resource for meeting their mental health needs. Mental health professionals may

depreciate such a church group, but "black people cannot be expected to reject culture-bound and religion-based support systems which have been functional for so long" (p. 128). This would be especially ill-advised when access to mental health professionals in black urban communities is still not assured.

Peterson and Roy's 1985 study indicated that it was predicted that church attendance would be negatively related to anxiety because religious communities perform a therapeutic function for the individual. "Participation within such a community affords one an opportunity to draw on the community for emotional support in coping with problematic aspects of life which can alleviate anxiety" (p. 59). The findings clearly support this idea. "Church attendance has a notable negative effect on anxiety which was net of the effects of all of the background and other religiosity variables" (Peterson & Roy, p. 59).

Yvonne Harmon (1985) found in her study that there was "less anxiety and decreased fear of death and dying in the older group attending church" (p. 25). There also was reported "a doubling of the rate of myocardial infarction among the non-religious who did not attend church in relation to the religious sample attending church" (p. 25).

In Idler's 1987 study between religious involvement and the health of a sample of New Haven elderly, the association runs in the predicted direction: "greater religiousness is associated with lower levels of both functional disability and depressive symptomatology at any given level of chronic conditions" (p. 236), the more individuals

attend religious services, and know others of the congregation, the less physically disabled or depressed they are likely to be.

Crawford, Handal, and Wiener (1989) did a study which examined the relationship between religion and mental health/distress. Data analyzed for the total sample ($n = 226$) indicated that high religious subjects were significantly less distressed and manifested better psychological adjustment than medium and low religious subjects. Data analyzed for female subjects ($n = 136$) showed that "not only were high religious subjects statistically less distressed and better adjusted psychologically than medium and low religious subjects, the results were clinically meaningful as well" (p. 272). Data analyzed for male subjects found no significant relationship between subjects degree of religion and mental health/distress. Based upon these preliminary findings religion does not appear to be deleterious to the mental health of individuals. In fact there appears to be a positive relationship between religion and psychological adjustment (Crawford, et al., 1989).

1990's. Ellison and Gay's (1990) study also states that their research "confirms the importance of religious participation in the personal lives of many Black Americans. The possibility of greater 'other worldliness' among southern religious Blacks suggests two competing hypotheses concerning the role of religion as ideational coherence" (p. 127). On the one hand, if their religious heritage leads southern Blacks to place particular emphasis on prayer and devotional activities, private religiosity may be a more central source of personal comfort and satisfaction among southern Blacks. On the other

hand, southern Black religiosity may serve primarily as a compensatory resource; prayer may be most frequent among individuals seeking to cope with adversity (Ellison & Gay).

Koenig et al. (1992) found that African Americans, those with conservative theological beliefs and those with more social support were the most likely to use religious coping strategies. In contrast, liberal Protestants, those without a religious affiliation and alcohol users, were less likely to employ religious coping techniques (Koenig, et al.).

Koenig et al. (1992) did a follow-up study on religion and depression and found that religious coping is inversely related to depression in hospitalized elderly men. This follow-up study illustrates the importance of religion in reducing depression and in predicting the final outcome concerning depressive status. More than 50% of patients rated religion as being very important in coping with depression. And Koenig, Ford, George, Blazer and Meador (1993) found that in younger patients, "increased church attendance and devotional activity (prayer and Bible reading) are associated with lower rates of anxiety" (p. 342), while listening to TV evangelical programs and practice of the Pentecostal faith are associated with "higher rates of anxiety, particularly among the young" (p. 342).

And in a survey of psychiatric research Larson (1994) found that religious people were less likely to abuse drugs or alcohol, commit suicide, be depressed, be juvenile delinquents, or divorced, and they tended to have better sex (Larson's study, as cited in Cohen, 1997).

Drugs

1970-1980. Burkett and White (1974) found that church attendance is inversely related to delinquency, alcohol, and marijuana use among adolescents. Drug use and religion have a negative correlation. Guinn's 1975 study found that among Mexican-American high school students, "drug use is associated with a higher socioeconomic class, less involvement and achievement in school, less reliance upon parents, teachers and professionals and less involvement in religious activities" (p. 241). And Hays, Stacy, Sidaman, DiMatteo, and Downey (1986) also found similar results. They found that "religiousness and conformity-commitment are consistently and negatively associated with alcohol, marijuana and other drug use among teenagers" (Hays, et al., 1986 p. 368).

1990's. Dwyer, et al. (1990) believe that a person may not need to be a religious communicant or a member of a particular denomination in order to obtain health benefits from the effects of decreased exposure to secondary smoke in counties with higher concentrations of people who do not smoke because of their religious beliefs. Oleckno and Blacconiere's 1991 study on religiosity and wellness found that their study exhibits the health enhancing role of religious commitment in a sample of college students. "Higher religiousness was associated with lower occurrence of health compromising behaviors including: 1) smoking; 2) drug and alcohol use; 3) not wearing seatbelts, and 4) personal illness and injuries" (p. 825). Koenig, George, Meador, Blazer and Ford (1994), found that "adherence to religious practices (prayer, Bible study and church attendance) and beliefs is inversely related to the risk of developing alcoholism" (p. 230).

Larson (1994) is propelled by his findings that, basically, the pious tend to be healthier and live longer. For instance, in a survey of people in Evans county, Georgia, he found that smokers who went to church regularly were four times less likely to have high blood pressure than those who didn't, and had about the same blood pressure as a nonchurchgoing nonsmoker.

Fagen (1996) believes that in repairing damage caused by alcoholism, drug addiction, and marital breakdown, religious belief and practice are a major source of strength and recovery. Fagan is convinced that regular practice of religion is good for personal physical health. He believes it increases longevity, improves one's chances of recovery from illness, and lessens the incidence of many killer diseases.

Social Problems

1980's. Hannay (1980) found that his clinical study supports the findings of past research indicating that "religious commitment is associated with better physical, mental, and social outcomes" (p. 685). Not only did 40% of clinic attendees go to church at least once a month, but only monthly attendance was associated with lower counts of physical, emotional, and social functioning symptoms. Consistent with the findings of past research, older patients, as well as female patients, were found to have higher levels of religious commitment than were younger patients, as well as male patients (Hannay, 1980).

Breault (1986) found that "in the years 1954-1978 divorce, church nonattendance and suicide have all steadily increased" (p. 632). Breault believes there may be some correlation in the fact that when church attendance decreased, social problems increased.

1990's. Johnstone (1992) believes that religious behavior is problem-solving like any other social activity. Praying, attending church service, observing religious laws, and having and talking about "mountain top experiences," for example, are all religious activities that contribute in some way (at least from the perspective of the religious-participant) toward solving a problem, either existing or anticipated (Johnstone, 1992).

Fagan (1995) wrote of the importance of church membership:

The Reverend Lee Earl started a church in one of the most desolate sections of Detroit, a neighborhood whose economy was built on drugs, prostitution, and welfare. Within a decade the same neighborhood and the same inhabitants, under the inspiration of the spiritual leadership of Rev. Earl, motivated by a trust in god, had rebuild their community. They became married families, started small businesses, and rebuilt and bought out their own homes. Crime plummeted and a community was reborn. (p. 34)

Some suggestions for combating ill-health, poverty, poor education, and addiction were offered by Patrick Fagen (1996) when he stated in his paper that government leaders seeking to reestablish sound norms and virtuous behavior within vulnerable groups would do well to look to the past. Fagen is convinced that few people realize that 19th century America fought several wars on poverty which, in contrast to the 20th century version, were quite successful. Fagen reminds us that these historic antipoverty efforts were headed by nongovernmental institutions, primarily churches, which saw

poverty as emanating from behavior and individual character. They took as their central task the molding of character and self-discipline within vulnerable low-income communities. For example:

- The Young Men's Christian Association (YMCA) was established to combat urban crime. Seeing its mission as molding the moral character of the young, the YMCA successfully undertook a struggle to win the hearts and minds of inner-city youth, leading to a major drop in juvenile crime (Fagen, 1996).
- Catholic parochial education is a dramatic instance of long-lasting private voluntary endeavor. In founding Georgetown University in 1792, Bishop John Carroll argued for the necessity of a "pious and Catholic education for the young." Carroll hoped that Georgetown's graduates would supply a pool of teachers for the Catholic schools of local parishes. Today those schools provide superior education, open to children of all faiths, and of tremendous importance of poor inner-city parents seeking an alternative to public education (Fagen).
- The Young Women's Christian Association (YWCA) gave a chaperoned place to live to young women migrating to the cities from rural areas. The stability immediately available to them permitted them gradually to find the community life in which they felt comfortable, and safe fellowship after leaving their families and original communities (Fagen).

- The Red Cross is a massive private-sector organization which runs the world's largest blood collection and distribution system as just one of its projects (Fagan, 1996).
- The temperance movement of the mid-1800s, a response to the growing alcohol addiction of the time, resulted in massive reductions in alcohol consumption and a change of attitude toward the abuse of alcohol (Fagen).

Dealing with social problems by placing greater reliance on nongovernmental social institutions is therefore nothing new. It is a return to the fundamental political philosophy upon which the American Republic was established. The Founders, because they understood the dangers inherent in looking to government as a cure for social ills, relied instead on civil institutions such as the family and church (Fagen, 1996).

And Fagen continues by stating that the regular practice of religion helps poor persons move out of poverty. He found that regular church attendance, for example, is particularly instrumental in helping young people to escape the poverty of inner-city life.

Religious belief and practice were found in Fagen's review of literature to "contribute substantially to the formation of personal moral criteria and sound moral judgment" (p. 35). Regular religious practice was also shown in his study to "inoculate individuals against a host of social problems, including suicide, drug abuse, out-of-wedlock births, crime, and divorce" (p. 35). The regular practice of religion also encourages such beneficial effects on mental health such as "less depression (a modern epidemic), more self-esteem, and greater family and marital happiness" (p. 35).

Spirituality

The spiritual dimension of humans, which involves the process whereby individuals give meaning and significance to the experiences of their existence, is recognized in every level of health and disease (Cmich, 1984).

Religion

1990's. Dwyer, et al., (1990) states that "religion may have structural properties that transcend individual health behavior choices and influence the social context in which people make lifestyle decisions that affect those behaviors" (p. 195). This assertion is supported somewhat by the fact that the independent effects of the religion variables are greatest in explaining respiratory cancer, a disease outcome that may be affected especially by the prescriptive or proscriptive sanctions of particular religious organizations.

However, some contradicting research (Glik, 1990) concluded that Healing groups are associated with the rise of New Religious Movements (NRMs), which are themselves the product of conflicts and tensions within the social structure. Thus beliefs and ideologies espoused or adopted by persons involved in these types of movements, whether considered religious or magical, may have both integrating and alienating effects, linked as they are to social change and transformation. Ideational beliefs represent certain features of religiosity linked to psychological states of healing adherents. Glik explains that "the use of these measures provide evidence that extreme or intense religiosity may correlate negatively with some mental health indicators, thus

demonstrating the differential effects that religious beliefs can have on mental health" (p. 175-176).

Ferraro and Jensen (1991) found that "regardless of one's religious affiliation and the intensity of one's belief, higher level of practice are related to better reported health status" (p. 194). The respondent's level of practice, the degree to which they pray, and participate in religious services "were significantly related to better health status, regardless of age" (p. 194). Higher levels of practice were found to be associated with better health. This research led to the conclusion that religion is a factor to be seriously considered in the study of health (Ferraro & Jensen, 1991).

Johnstone (1992) believes that first, and perhaps most obviously, a human being is a biological organism - a creature with physiological drives, needs, potentials, and limitations. The socializing influence of groups is thus both directed at and limited by biological factors. Religion is of course among those socializing agents that attempt to influence or modify biological nature.

Witmer and Sweeney (1992) remind us that throughout history, including contemporary times, every civilization, culture, or nation has expressed and practiced religious beliefs that represent values that reflect what is considered sacred and essential for the sustenance of life. For some groups, religious practices have focused on nature worship, and for others, a divine being who knows about and intervenes in human activities. Still others seek an inner or higher consciousness that is in harmony with the forces of the cosmos (Witmer & Sweeney).

Mathews and Larson (1995) describe religion as a complex variable, one that incorporates the many benefits of social and family support, ritual and sacraments, hope and optimism, positive thinking and expectations, contemplation of beauty in music, art, and architecture, and salutary physiologic changes in blood pressure and oxygen consumption accompanying such activities as prayer, worship, singing, and meditation. In addition, religion provides access to the transcendent and the hope and promise of divine, healing intervention in human affairs.

And, Matthews and Larsons study found that the bulk of evidence now demonstrates that religious faith and spiritual factors are important variables in the prevention and treatment of health problems such as illness and disease. Matthews and Larson believe it is necessary for educators and clinicians to understand and to address these issues in their daily activities.

Church Attendance

1970's. Comstock and Partridge (1972) remind us that religion and religious beliefs have been major determinants of human behavior since the dawn of history. Although their role in health-related behavior often has been recognized, most health studies have gone no deeper into religious behavior than to classify subjects by religion or creed. In large part, this superficial approach results from our ignorance of the components of religious behavior as well as from their apparent complexity and elusiveness. However, there is a component that can be easily determined which is frequency of attendance at religious services (Comstock & Partridge).

Comstock and Partridge's study found weekly church attendees have been found to have 50% fewer deaths from coronary artery disease, 56% fewer deaths from emphysema, 74% fewer deaths from cirrhosis, and 53% fewer suicides. According to Berkman and Syme's 1979 study, individuals who belong to a church or temple have lower mortality rates than those who do not.

1980's. House, Robbins, and Metzner (1982) found that among women only, church attendance is significantly related to mortality. These researchers also found that all other social relationships and activities but one (frequency of attending meetings) were negatively related to mortality among the women, only church attendance was statistically significant ($p < .05$). These researchers concluded that women who attend church have lower mortality rates and it is the lack of any meaningful social relationships or ties that is most deleterious to health.

In a 1983 study Bahr and Martin stated that "promotion of well-being remains a vague concept, even with the World Health Organization's definition of health as not merely the absence of disease, but the presence of well-being" (p. 142). These researchers also found church attendance was "positively correlated with faith in people ($r = .21$), parental socioeconomic status ($r = .19$), family solidarity ($r = .18$), high school grades ($r = .14$) and leadership activity ($r = .10$, all comparisons $p < .05$), while Evangelicalism was positively correlated with family solidarity ($r = .15$, $p < .05$)" (Bahr & Martin, p. 142).

1990's. Frankel and Hewitt (1994) revealed that it is the religiously committed (frequent church attendees), rather than those simply claiming a religious affiliation, who derive the most tangible benefits from their spirituality. These researchers concluded that "being affiliated is enough to enable a person to experience certain personal and health care benefits" (p. 73).

CHAPTER III

GENERAL WELL-BEING AND SPIRITUALITY

The information included in this chapter is organized into several related topics. Under the heading *spirituality*, information on spiritual well-being, wellness spirituality, and life satisfaction and spirituality will be reviewed. Under the heading *religion*, religious well-being and life satisfaction and religion will be reviewed.

Spirituality

1970's. Moberg (1979) believes that it is a human universal to search for happiness. He also believes it is common to find happiness where one expects it the least.

Moberg states:

Coveted pleasures have a tendency to cloy and become distasteful and enslaving. Some people make a distinction by speaking of true and lasting happiness, and then insist on that. Not everyone reaches this level of discrimination, however, and many continue unchecked to seek happiness where others would say it cannot be found: in hedonism, for instance, or in things like success, wealth, power, and distinction. Amsterdam, when I visited it in 1978, was described to be as a Mecca of modern pleasure-seekers. I found it hard to believe that those in its streets were any more intent on happiness than other people are, but there were evidences that many had settled for it in what some would call passing pleasure, and that some were its slaves. A guided tour not long before had taken me into the gambling halls at Monte Carlo, and I saw faces there wearing the same fixed weariness as I saw on certain faces in Amsterdam. But I have also seen the same tortured hardness on the faces of the ambition-driven in academia and in places of finance and business. The seeker after lasting

happiness is one who refused to rest in entanglements like those. He claims that it is a different thing altogether -- true happiness -- when he surrenders control and lays down his burdens in spiritual release. (p 30, 31)

1980's. Buscaglia (1982) believes that fully functioning persons have a deep sense of spirituality. "They know that their personhood and the world in which they live cannot be explained or understood through human experience alone" (p. 118). Buscaglia also believes that some people know that they must make the "mystical leap" (p. 118). "They must go beyond themselves, beyond their limited reality. They have an inexplicable sense of something more" (p. 118). Buscaglia states that people can feel a greater operative intellect than their own, even if they are at a loss to give it a name. "They are aware of a great design, incessantly operative, in which all is compatible and in which there are no contradictions" (Buscaglia, p. 118).

1990's. Prest and Keller (1993) challenge therapists to consider the spiritual belief systems of their clients which have served both to strengthen and support their family system. Prest and Keller believe that these spiritual beliefs (or lack thereof) have contributed to the development or maintenance of the presenting problem.

Spiritual well-being

1970's. In Moberg's 1979 study on how spirituality affects health, he concluded that as spiritual well-being is sometimes thought to be related to physical well-being, it is of interest to note that over three-quarters of his sample from the Unification church reported that they now enjoy either "excellent" (30%) or "good" (46%) physical health.

Eight percent said their health was now good except for a particular acute illness, and 12% reported their health as "fair." None reported having "poor" health now, although several said that they had had poor health in the past. It is frequently claimed that illnesses from which members had been suffering for several years disappeared when they joined the Unification Church. Eighteen percent said they now had better health than they had during the six months before they joined the Church; 10% said their health was worse, and the rest did not show any change. Sixteen percent mentioned histories of bronchitis, asthma, or related afflictions; explanations for these varied between contracting tuberculosis, having allergies, and having nervous dispositions. Eighteen percent admitted to having had fairly serious nervous disorders (including attempted suicide); here the explanations ranged from social (e.g., being subjected to sexual assaults by a stepfather), to physical (e.g., brain injury), to general psycho-somatic complaints (Moberg, 1979). Overall, the conclusions of this study suggest that most people had improved health after joining the Unification Church (Moberg).

1980's. There hasn't been many studies on spiritual well-being, however, Ellison, (1983) states that the reason there hasn't been many scientific studies on spiritual well-being is probably because such terms as "spiritual" and "well-being" appear to have subjective meanings which are impossible to operationalize that behavioral scientists have avoided the study of spiritual health and disease. And yet, "if we are willing to live with questions of validity that are involved with the measurement of any phenomenon which cannot be directly observed" (Ellison, p. 330)- whether attitudes, emotions, values,

intelligence, or spiritual well-being does not really matter - " we should be able to systematically and scientifically develop indicators of this hidden dimension" (p. 330). Of course, any such definition will not capture the whole meaning of spiritual health, and every definition will be unsatisfactory to some.

In order to sharpen our conceptualization, Ellison (1983) suggests that spiritual well-being may not be the same thing as spiritual health. Spiritual health "arises from an underlying state of spiritual health and is an expression of it much like the color of one's complexion and pulse rate are expressions of good health" (p. 331). Spiritual well-being measures may then be seen "more like a stethoscope than the heart itself" (p. 331). If this is an accurate conception then "we are freed from the burden of trying to exactly or empirically measure the inner contours of one's spirit - a task which is most likely impossible" (p. 331). People are then freed to consider the "reported expressions of spiritual well-being as general indicators and helpful approximations of the underlying state" (p. 331). As people develop more sensitive measures "we may someday be able to identify specific dimensions of spiritual well-being and prescribe spiritual medicine" (p. 331) which will address a particular part of the spirit in a differentiated way (Ellison).

The following includes suggestions from Ardell (1986). He believes:

If you are less healthy than you want to be, if you are tired of spending so much of your money on drugs and medicines, if you question the wisdom of reliance upon a medical system, if, in short, you are sick of being marginally well, you are probably ready for high level wellness.

There are many roads that will take you there, you will want to choose your own maps and ways, tailoring specific activities to your unique background, current needs, and future expectations. However, we all share a great deal, and I'd like to set out a number of guidelines you might find useful. (p. 49)

According to Ardell, the principles of high level wellness include taking control over your own well-being. This includes taking responsibility over your physical, emotional, and mental well-being. Ardell also states that you should "forget about magic bullets or instant solutions" (p. 98). Ardell also believes people in the medical profession should practice what they preach and doctors should also "teach us how to maintain and improve our health and choose better for ourselves" (p. 98). Ardell believes you should let your body try to heal itself by establishing a wellness lifestyle. However, Ardell also states that you shouldn't "sacrifice, deny yourself, or give up destructive life habits- until your ready to do so" (p. 99). "High level wellness is more rewarding than low level worseness" (Ardell, p. 100). For more information on Ardell's position on high level wellness see Appendices C and D.

Ellison (1983) believes that "spiritual well-being also does not appear to be the same as spiritual maturity" (p. 331), though he would expect a spiritually mature person to have a very positive sense of well-being. It is likely that the "fruits of the Spirit" (Ellison, p. 331), a possible index of maturity for the Christian faith given in Galations 5, may be only partially realized by a person who may experience very positive spiritual well-being at a lower level of maturity" (p. 331). A new born Christian, for example, may have a very positive sense of spiritual well-being but be very immature spiritually. "This suggests that strategies to promote spiritual well-being may be directly aimed at the

quality of one's relationship with God and one's existential state, or indirectly focused on as a by-product of the development of spiritual maturity" (Ellison, p. 331).

Ellison also states that "Spiritual well-being should be seen as a continuous variable, rather than as dichotomous" (p. 332). It is not a matter of whether or not people have it. Rather it is a question of *how much*, and how people may enhance the degree of spiritual well-being that they have. "Conceiving it as continuous stimulates us to consider multiple influences on our health, none of which by itself may move us to the place of total spiritual health or total disease" (Ellison, 1983, p. 332).

Wellness Spirituality

1980's. Wellness spirituality includes the concept of a healthy spirit, which also includes "finding fulfillment and satisfaction in life, a keen sense of self-esteem and knowing well the values one has freely embraced" (Pilch, 1988, p. 2). "Wellness spirituality", can be explored or tested along the lines proposed earlier by Pilch (1988), which include: free choices, personal meaning in life, finding fulfillment and satisfaction in life, maintaining a keen sense of self-esteem, and knowing well the values one has freely embraced. Pilch believes this involves an endless process. The 19th century thinker Cardinal Newman unwittingly expressed the idea of wellness spirituality as a process when he noted, "Here below to be human is to change. And to be perfect, is to have changed often" (Pilch, p. 2).

1990's. Chandler, et al. (1992) believe that the capacity to develop in both the spiritual and personal realms is present from birth (or perhaps before). "Cultures that

emphasize the development of the spiritual component in each wellness dimension from early in a person's life may be less likely to produce individuals who experience a spiritual crisis from sudden spiritual awakening" (p. 174). Also, a culture that fosters the development of the spiritual component as well as the personal component contributes to the likelihood that "its members can achieve higher levels of wellness in all dimensions than if just one or the other of these two components is emphasized" (Chandler, et al., 1992, p. 174).

Life Satisfaction and Spirituality

1990's. Kass, Friedman, Leserman, Zuttermeister, and Benson (1991) developed an instrument called the Index of Core Spiritual Experiences (INSPIRIT), which is a seven-item scale measuring the occurrence of experiences that convince a person God exists and evoke feelings of closeness with God, including the perception that God dwells within. God was the only definition of spirituality used in this instrument.

Clinical observations suggesting a relationship between spiritual experiences, life purpose and satisfaction, and improvements in physical health led to the development of an Index of Core Spiritual Experience (INSPIRIT). Data from 83 medical outpatients showed the INSPIRIT to have a strong degree of internal reliability and concurrent validity. Multiple regression analyses showed the INSPIRIT to be associated with: (1) increased life purpose and satisfaction, a health-promoting attitude; and (2) decreased frequency of medical symptoms (Kass, et al.).

Kass, et al. goes on to explain that "while preliminary, the data from this study suggest a relationship between core spiritual experiences and health outcomes" (p. 203). The correlation between INSPIRIT scores and increased life purpose and satisfaction suggests that core spiritual experience may contribute to positive psychological attitudes. "The correlation between the INSPIRIT and decreases in the average frequency of symptoms suggests that core spiritual experiences may also contribute to a reduction of medical symptoms and to improved quality of life" (Kass, et al., 1991, p. 203).

The utilization of a symptom checklist as a measure of health may accurately reflect patients' personal assessments of their health. However, future studies utilizing physiological indices as outcome measures will be required for more definitive substantiation of the relationship between spirituality and health. Nonetheless, these data suggest that "spirituality may be an important mediator of health and that the INSPIRIT scale may help to quantify aspects of spirituality not measured by other instruments" (Kass, et al., p. 209).

Religion

Religious Well-Being

1970's. McNamara and St. George (1979) did a study based on the findings from a national survey, which demonstrated that religious satisfaction was the aspect of religious commitment most closely linked with: 1) marital satisfaction; 2) family life satisfaction, and 3) personal satisfaction, or well-being. Thus, although previous research has highlighted the linkage of religious commitment factors to personal

and marital satisfaction, this study went one step further in displaying the particular relevance of religious satisfaction. Religiosity, particularly the satisfaction one derives from religion, "is significantly and positively correlated with various quality of life measures, including mood and satisfaction with marriage, family life and life in general" (McNamara & St. George, 1979, p. 235).

Previous research has neglected an important area of inquiry, the relationship of religiosity and psychological well-being. McNamara and St. George (1979) attempt to rectify this deficiency. Their study examined this relationship using data from the 1972-1982 NORC General Social Survey. Focusing on the issue of race, the sample was broken down into blacks and whites. Religiosity was found to be a better predictor of well-being than previous research has indicated. Religiosity did especially well in predicting the well-being of Black men and women (McNamara & St. George, 1979).

1980's. A basic code of human behavior common to humankind is noted by Buscaglia (1982) in his sketch of seven of the world's great religions and philosophies. Little dissonance is seen within the systems in what it means to live in "full humanness." Their commonality seems to be summarized in the proverbial Golden Rule, "Do unto others as you would have them do unto you" (p. 118).

According to Ellison (1983) the need for transcendence refers to "the sense of well-being that we experience when we find purposes to commit ourselves to, which involve ultimate meaning for life" (p. 336). Ellison believes that it refers to a "non-physical dimension of awareness and experience which can best be termed spiritual" (p.

336). All of the great religions of the world recognize and call human beings to transcendence as the path to the highest levels of well-being. A 1983 Gallop poll found that 86% of Americans regard their religious beliefs as fairly or very important (Ellison). Ellison's 1983 findings suggest that childhood experiences with family and friends, at least as recollected, may set the stage for one's later sense of spiritual satisfaction in life.

Witter, Stock, Okun, and Haring (1985) examined the question: "What is the strength and direction of the relation between religion and subjective well-being in adulthood?" (p. 332). They addressed this question by performing a quantitative research synthesis (meta-analysis). The dependent variable was zero-order correlation between religion and subjective well-being and the independent variables were religiosity measure, sample, and study characteristics. Witter, et al. found that religion was significantly and positively related to subjective well-being. The relation between religion and subjective well-being was stronger for religious activity than for religiosity measures. Also the relation was stronger for samples of older than younger adults. The strength of the religion/subjective well-being relation has decreased over time. Religion accounts for between 2 and 6% of the variance in adult subjective well-being (Witter, et al.).

Witter, et al. suggest that religion should not be ignored in testing causal models of subjective well-being in adulthood. The fact that several developmental background variables have been found to be related to spiritual well-being demonstrates the fact that "human beings are multi-dimensional systems best described in terms of several

interactive subsystems" (p. 332). Each subsystem affects and is affected by the others, though none can be totally reduced to the other. At a minimum human beings are "biological, cognitive, interpersonal, emotional and spiritual beings" (Witter, et al., p. 332). As a result, our sense of spiritual well-being is in part a reflection of those other dimensions.

Maton (1989) believes the contributions of spiritual support (perceived support from God) to well-being, especially under conditions of high versus low life stress, have received little empirical study. He studied this relationship of spiritual support of well-being for several high and low life-stress samples. Spiritual support was defined as "support perceived in the context of an individual's relationship with God, focusing on perceptions and experiences of God's personal love, presence, constancy, guidance, and availability for the self" (p. 310). With demographic variables controlled, regression analyses indicated that spiritual support: 1) "was inversely related to depression and positively related to self-esteem for high life-stress (recently bereaved parents)"; and 2) "in a prospective (longitudinal) analysis with pre-college depression controlled, spiritual support was positively related to personal-emotional adjustment to college for high life-stress (three or more life events), first-semester college freshmen" (p. 310). Spiritual support was not significantly related to well-being for low life-stress subsamples (Maton).

In his discussion section of a study titled *Divine relations, social relations, and well-being*, Pollner (1989) concluded that his analysis provides evidence that symbolic

relations with a divine other are a significant correlate of well-being. "Indeed, participation in a divine relation is the strongest correlate of three of four measures of well-being, surpassing in strength such usually potent predictors as race, sex, income, age, marital status, and church attendance" (p. 100). This divine relation is conditioned modestly by level of education: the less educated gain more from divine interaction than the better educated. Individuals' level of social integration, however, as measured either by marital status or by frequency of contacts with family and friends, has virtually no effect. "The impact of divine interaction is also impervious to stress" (p. 101). This 1989 study suggests "the psychologically consequential nature of a divine other, perhaps the most pervasive symbolic other in American society" (Pollner, 1989, p. 102). Interaction with a deity is related substantially to several dimensions of well-being and satisfaction (Pollner).

According to Pollner's research of Gallop polls in the 1980's, one of the most prominent of imagined significant others in American society is a deity. Gallop surveys of recent years, for example, show that 87% of adult Americans pray to God; 69% feel that God has guided them in making decisions; and 36% feel that God has spoken directly to them "through some means" (p. 93). Surveys conducted by the National Opinion Research Center reveal that 80% of American adults feel at least "somewhat close" to God most of the time; 47% report that they have experienced a spiritual force that seemed to lift them out of themselves. In short, there is evidence that "individuals participate in 'divine relations' as well as social relations and that divine relationships

may approximate concrete social relationships in intensity" (Pollner, p. 93). Pollner also adds that perceptions of the divine as a ruler are correlated negatively with global happiness, while the perception of the divine in remedial terms is related positively to life satisfaction.

In addition to providing a resource for resolving problematic situations, "divine interaction may enhance well-being by shaping the sense of self" (Pollner, 1989, p.93). Pollner states, in a related vein, that "interaction with a divinity may affect well-being by investing otherwise alienating events with meaning" (p. 93), individuals may feel that trivial, painful, or odious activities have significance before an "omniscient divinity" (p. 93). Thus as a source of new cognition's in problematic situations, as a source of empowerment and enhancement of the self, and as a contributor to a sense of meaningfulness, "interaction with a divine other may be expected to have a significant effect on well-being" (Pollner, p. 93).

1990's. Ellison (1991) believes that members of many independent charismatic churches may be "theologically or ideologically disposed to frame their personal experiences in various domains of life in positive terms, and thus may report high levels of satisfaction with the status quo" (p. 89). With regard to the Mormons and Jehovah's Witnesses, the pattern of results is consistent with recent research on other aspects of well-being. It seems likely that "conformity to the distinctive lifestyle demands of these groups" (p. 89). - particularly in the areas of substance use/abuse, dietary habits, and family life - "may reduce the occurrence of health problems, interpersonal and familial

tensions, and other personal stress's" (Ellison, p. 89). Spirituality for our purpose assumes "certain life-enhancing beliefs about human dignity, human rights, and reverence for life" (Witmer and Sweeney, 1992, p.141).

Life Satisfaction and Religion

1960's. Wilsons' 1967 study showed that various aspects of religious life were shown to be significantly related to avowed happiness: attending church regularly, getting much consolation and help from religion, and being a believer. No notable differences were obtained between the three major religious groups - Catholics, Protestants, and Jews. Data on avowed happiness are summarized under the headings of (a) measurement, reliability, and validity; (b) dimensions; and (c) correlates. The happy person emerges as a young, healthy, well-educated, well-paid, extroverted, optimistic, worry-free, religious, married person with high self-esteem, high job moral, modest aspirations, of either sex, and of a wide range of intelligence (Wilson).

1970's. Hadaway and Roof (1978) employed a multivariate analysis design to examine the relationship between religious commitment and one quality-of-life measure, a question asking respondents to rate their life on a 7-point scale from "worthwhile" to "useless." Religious commitment was conceptualized into two dimensions of "meaning" and "belonging" represented, respectively, by respondents' rating of the importance of their faith, and frequency of attendance at religious services plus belonging to a church or synagogue. While religiosity thus measured did not strongly increase the explained variance in the worthwhile feeling of life experienced by respondents, "importance of

religion was more strongly correlated with this dependent variable than social background factors such as number of friends, marital status, age, education, health, income, and race" (p. 302). Religious belonging, on the other hand, turned out to be a weaker predictor of quality-of-life, though the subgroup of "highly religious" on both attendance and membership measures scored "quite high on satisfaction" (Hadaway & Roof, 1978, 302).

Glenn and Weaver (1978) also found that their study displays the importance of a single factor, frequency of church attendance, in predicting marital happiness. Church attendance was found to be the only common predictor of marital enjoyment for both men and women. Religiosity, in particular church attendance, is a strong predictor of marital enjoyment, and shared spiritual values may help couples to better navigate stressful times in their marriage. Religious values, learning to give-and-take, and to forgive according to God's example are relevant ways to make marriages better and more enjoyable (Glenn & Weaver). Also, Hunt and King (1978) concluded that positive religious beliefs, effort, and participation in religious activities are positively associated with marital adjustment, happiness, and satisfaction.

According to Hadaway and Roof (1978), the importance of faith, church, or synagogue membership, as well as church attendance, are "directly and positively related to worthwhile feeling of life" (p. 295). Their study demonstrated that the religiously committed rate their lives as very worthwhile more frequently than do the less committed.

Hadaway (1978) found similar results when his research confirmed that the consistent finding that emerges is that religious persons tend to be somewhat happier and more satisfied with life than nonreligious individuals. And this supports the common interpretation that "religious faith adds something to an individual's life, whether in terms of personal meaning or social integration" (p. 641).

Hadaway (1978) also stated that "he had not found a single instance in which any measure of religiosity was negatively associated with any of the life satisfaction items among the general population of respondents" (p. 641). Always there is a positive relationship, though of course the magnitude of the relationship is, in some instances, quite small.

In another study with Hadaway and Roof (1978) religious commitment, conceptualized as "meaning" and "belonging," was examined in relation to subjective feelings of satisfaction with life. Consistent with our expectations that "religious commitment acts as a resource", it was found that "those who participate in religious activities also tend to feel their lives are more worthwhile" (p. 299). It is concluded that in future studies of quality of American life, religious commitment should be included as an important correlate (Hadaway & Roof). Hadaway and Roof's study reported that "persons who placed importance on their religious faith also tended to feel their lives were more worthwhile." (p. 299)

1980's. Rogalski and Paisey (1987) state that their study underscores what previous research has revealed that "the religious elderly are more satisfied with their

lives than are the non-religious elderly" (p. 400). The researchers continued their analyses one step further by assessing the important of religiousness, in contrast with other predictors, such as: 1) marital status; 2) socioeconomic status; 3) physical health, and 4) mental health status. Rogalski and Paisey (1987) revealed that even when other variables are added to the equation and controlled for, "religiousness remains one of the three strongest predictors of life satisfaction among the elderly" (p. 400). In contrast to religiousness, the other two strongest predictors, state and trait anxiety, are inversely related to elderly life satisfaction. Most critically, in these analyses, these three factors account for nearly one-half (46%) of the variance (Rogalski & Paisey).

Pollner (1989) states in the abstract of his research paper:

The social support literature focuses on the effects of networks composed of "real" or concrete individuals on psychological well-being. People interact in imagination, however, with a wide range of others who may or may not actually exist. In modern societies as in traditional societies, persons experience, interact with, and appeal to spiritual or divine beings. Using data from the NORC General Social Survey, this study examines the extent to which relationships with "divine others" affect psychological well-being. Regression analysis reveals that divine relationships had a significant effect on several measures of well-being (controlling for Socio-demographic background variables and church attendance.) (p. 92)

1990's. Paloma and Pendleton (1991) found that religious satisfaction, and many aspects of religious experience, including frequency and experience of prayer, closeness to God, and church attendance are strongly correlated with general life satisfaction, overall happiness, and existential well-being.

Ellison (1991) found that church attendance and private devotions are significantly, but indirectly, related to life satisfaction and personal happiness. These religious affiliations help by strengthening the certainty of the person's belief systems and faith.

Ellison (1991) also found that the positive influence of religious certainty on well-being is directed and substantial: "individuals with strong religious faith report higher levels of life satisfaction, greater personal happiness, and fewer negative psychosocial consequences of traumatic life events" (p. 91). Further, in models of life satisfaction only, the positive influences of existential certainty is especially pronounced for older persons and persons with low levels of formal education. Finally, there are persistent denominational variations in life satisfaction, but not in happiness: "nondenominational Protestants, liberal Protestants, and members of nontraditional groups such as Mormons and Jehovah's Witnesses report greater life satisfaction than do their unaffiliated counterparts" (p. 91), even with the effects of other dimensions of religiosity held constant (Ellison, 1991).

Ellison's research confirms the influence of religious variables on life satisfaction. Several findings are especially noteworthy. First, "firm religious beliefs enhance significantly both cognitive and affective perceptions of life quality." (p. 89). Second, the pattern of results presented here suggests that "these aspects of religiosity contribute to well-being indirectly, for the most part, by strengthening religious beliefs

and world views" (p. 89). Third, it appears that "religious faith buffers the negative affects of trauma on well-being" (Ellison, 1991, p. 89).

Feigelman, Gorman, and Varacalli (1992) found in their study that the giving up of one's religious faith is not an isolated event, but it is associated with a variety of other personal changes, including "liberalization of attitudes and geographic dislocation and has a negative effect upon overall happiness" (p. 142). Active religious participation, on the other hand, appears to be part of a personal system of other stabilizing factors, including: 1) connections with parents; 2) community involvement; 3) marital satisfaction, and 4) job security. This study makes the case that "religious commitment, in particular the value system that accompanies it, not only can benefit individuals in their social relationships, but it can benefit the society in which they live as well" (p. 143). Previous assumptions about the values associated with religion as old-fashioned, or out of date, need much closer scrutiny in light of findings such as these (Feigelman, et al., 1992)

Frankel and Hewitt (1994) found that their study demonstrated the beneficial effects of a religious affiliation among college level students. Not only did the religiously affiliated have a greater concern for others than did the nonaffiliated, but they also experienced fewer health care, dental, and emergency care visits. In addition, they experienced less stress and better personal well-being - and in this case, life satisfaction. These data support the personal, as well as social, benefits of a religious world view (Frankel & Hewitt).

CHAPTER IV

HEALTH EDUCATION AND SPIRITUALITY

This chapter is organized into the following related topics: Health education, school health education, community service, and community health education and the church. It was important for the researcher to show how spirituality can be successfully applied to health education programs within the school and the community. The problems regarding the separation of church and state are also addressed in this chapter.

Health Education

1960's. Maslow (1964) believes education is value-free when he writes:

The dichotomizing trends - making organized religions the guardian of all values, dichotomizing knowledge from religion, considering science to be value-free, and trying to make it so - have wrought their confusion in the field of education, too. The most charitable thing we can say about this state of affairs is that American education is conflicted and confused about its far goals and purposes. But for many educators, it must be said more harshly that they seem to have renounced far goals altogether or, at any rate, keep trying to. It is as if they wanted education to be purely technological training for the acquisition of skills which come close to being value-free or amoral (in the sense of being useful either for good or evil, and also in the sense of failing to enlarge the personality). (p. 48)

Maslow continues with his commentary by writing that the final and unavoidable conclusion is that education, like all our social institutions, must be concerned with its final values, and this in turn is just about the same as speaking of what has been called spiritual values or higher values. What he is pointing out is that this process of a steadily

increasing reliance of natural facts as guides in making life decisions is now advancing into the realm of spiritual values. Maslow believes this is so because of new discoveries, and also it is so because more and more of us realize that 19th century science has to be redefined, reconstructed, enlarged, in order to be adequate to this new task. This job of reconstruction is now proceeding (Maslow, 1964).

1970's. Downey (1978) firmly believes that the individuals who will be most successful in positively influencing another's knowledge, attitudes, and behavioral patterns will be those who have found peace of mind and who have connected with the quality in their own life. As a result, "quality or goodness will shine through these individuals" and these people now become "the optimal environment for others to grow by, motivated in their quest for quality" (Downey, p. 32).

Downey believes that "it is only in the exploration of spiritual dimension of the person that individuals can move to their higher selves or higher centers of personality" (p. 32). The closer one moves to the higher self the better the decisions one will make about lifestyle and the shape of destiny. The person who is in tune with the higher self is most definitely on the "quality trip or journey" through life. Downey feels that a "plethora of psychosomatic ills are directly related to our ignorance of this higher center within" (Downey, p. 32).

According to Needle (1978), the health and well-being of our population and the discipline of health education have been, are presently, and will continue to be affected by rapid social, economic, and technological changes. The central thesis of his paper is

“to suggest that social, political, and economic systems must be considered as determinants of health” (p. 28).

Needle (1978) explained that as health professionals, “our theoretical frameworks, our empirical perspectives, and our individual practical efforts benefit substantially from an institutional perspective on health and well-being” (p. 28) one in which the lifestyle approach is integrated with the societal perspective. Needle has been convinced that many health problems are societal in nature, and only through collective efforts of people with shared beliefs will such problems be minimized or eliminated.

Needle goes on to say:

It follows that social, economic, and political policies that promote or tolerate such conditions as high unemployment rates, that condition the nature and organization of work roles, that permit the rapid introduction of chemicals, toxic substances, and technology into the physical workplace, that relax environmental standards for industries, that offer health care as a privilege rather than a right, that support the tobacco and liquor industries, that do not provide guaranteed minimum income or child care services, are major influences on health and well-being. (p. 29)

Osman and Russell (1979) are convinced that “health” came to be identified as a by-product of medicine; so health education generally has accepted the medical model, “which tends to be limited to the natural-scientific” (p. 359). However, there has been a progression from health as just physical well-being to health as also mental well-being. More concern has been shown for the social dimension, too. But partly (and perhaps largely) this is because the behavioral sciences contributing to these dimensions are quite committed to quantification. Study of the spiritual aspects of health will add an

interesting dimension to the health education profession because "some will deny vigorously that it exists at all. Others will not be quite sure ... but will not reject the idea. Then, there will be some who testify that it is by far the most important dimension to the quality of their total functioning ... their health" (p. 359). There should be no concerted attempt to convince skeptics of the reality of spiritual health, nor should there be any move to have everyone see spiritual health in the same way (Osman & Russell, 1979).

Osman and Russell point out that in regards to researching spirituality in health education that some of those professionals interested in this dimension will be committed Christians; yet among these, there will be differences. "Other folks will acknowledge God in alternative traditional ways, while still others may be quite nontraditional perhaps interested in spiritual healing or Eastern thought" (p. 359). Some will acknowledge only "spiritual forces," and some may be concerned only about the spirit within themselves" (p. 359). Sharing of experiences and convictions shades rather naturally into proselytizing, and there probably will be some of that" (p, 359). Osman and Russell hope that "it will not be more blatant than the convictions some now have about certain statistical techniques or particular computer programs as the way to develop knowledge" (p. 359).

1980's. In a study conducted by Banks (1980), in which the subjects were health educators, questions were asked regarding spirituality and health education. The data from the study indicated that the majority of the health educators surveyed believe there

is a spiritual dimension of health and that this dimension should be included into health education professional preparation programs.

First, the spiritual dimension can be perceived as a unifying force within individuals which integrates all the other dimensions (physical, mental, emotional, and social) and therefore plays a vital role in determining the state of well-being of the individual. The individual must be viewed as a whole. What affects one dimension will affect all the other dimensions (Banks, 1980).

Second, one major component of the spiritual dimension has to do with what the individual identifies as meaningful and purposeful in life. What an individual selects as meaningful in life is of a highly personal nature; however, it may serve as an inner drive for that individual's life accomplishments (Banks).

Third, this spiritual dimension is somewhat different from most of the other known dimensions of humans (physical, mental, and emotional) in that it transcends the individual, thus it has the capacity to be a common bond between individuals (Banks).

This common bonding aspect can be described as a force which begins in the individual and then goes beyond that individual to share warmth/love/compassion with another (Banks).

Finally, this dimension of humans is the least obvious and measurable of the known dimensions, because it is based upon individual perceptions and faith. Included in this part of the spiritual dimension would be components having to do with perceptions of what it is that causes the universe to work the way it does; recognition of

powers beyond the natural and rational; survival; and pleasure. Religious beliefs, if any, could be placed in any of all of the above identified aspects of the spiritual dimension (Banks).

Allen and Yarian (1981) conceptualize a "domain of health" model which includes the physical, mental, and spiritual aspects of health. "Physical health refers to biological integrity or the physical status of the individual; the domain of the traditional medical model" (p. 3). In the recent past, this element was considered the sole concern of human health. "Mental health refers to a state of mental, attitudinal, and emotional well-being" (Allen & Yarian, p. 3). Spiritual health, an element of emerging interest within the health profession, is an undefined entity at this point. "For the purpose of developing the model, these three concepts can be referred to as the soma, psyche, and spirit" (p. 3).

Health educators have focused most of their efforts around physical health. An elemental weakness, at this point, is the area of spiritual health. "It is unexplored territory that the profession has so far avoided for lack of a clear conceptual definition of the construct" (Allen & Yarian, p. 5). This area needs further development and integration into the health education profession (Allen & Yarian).

In reviewing Allen and Yarian's 1981 study that included a model on the "domain of health," they believe that health education is an integrative discipline. "If health is related to achieving a balanced existence" (p. 5) along all the dimensions of the model then the goal of health education should be to "promote a balance of all elements of the

health domain” and help people choose their path to the center of the space outlined by the model. A state of positive well-being may then be defined as “one in which all five elements of the health domain are balanced and contributing to an integrated whole”

(Allen & Yarian, p. 5).

Allen and Yarian further explain that:

The task of a holistic approach to health education is as an integrating stimulus. This does not require high level expertise of the individual educator or department in every area of the domain. The professional can use specific topic areas, such as human sexuality, control of stress and tension, death education, lifestyle analysis, or values clarification, to demonstrate the process of integrating all factors influencing health into a dynamic, balanced condition capable of enhancing the overall quality of life. (p. 5)

Banks, Poehler, and Russell (1984) stated in their paper that research is proceeding toward some more systematic basis for identifying and describing spirit and human spiritual interaction. “This is necessary before a field of knowledge and a functioning professional field such as health education can include these in professional preparation programs and in text and other professional materials” (p. 19). And Harmon (1985) adds that the integration of primary prevention principles obtained through health education, the state of well-being obtained through emotional, social, and spiritual growth, and self-actualization obtained through integration of value system into everyday life are some ways of assisting the individual toward maximum health.

Ardell (1986) offers health education a suggestion for self-responsibility. His list of self-responsibility principles includes being in charge of your own life and realizing

that you are different from anyone else. Ardell believes we "are motivated by a desire for happiness" (p. 90), and we "need a sense of purpose." "Go for positive happiness, wellness style" (Ardell, p. 90).

1990's. Bensley (1991b) believes health educators can use spirituality in worksite health promotion/wellness programming. He wrote some suggestions at the existing program level:

1. Include spiritual health questions in health status and interest surveys.
2. Include spiritual health issues in health and fitness testing programs, the context of time management, motivational workshops, and organizational development projects.
3. Integrate spiritual health issues into stress management programs, drug and alcohol education, management and work unit retreats and meetings, outdoor recreation programs, and pre-retirement planning sessions.
4. Provide spiritual health related publications as "door prizes."
5. Develop spiritual health themes as part of communication programs.
6. Discuss spiritual health issues as part of behavioral support groups.
7. Use provocative readings at workshops and meetings.

Bensley concluded that:

It has been recognized that there is a need for addressing the spiritual dimension of health at the worksite. One approach in satisfying this need is through integration of spiritual health related issues into existing health promotion programs. Specifically, integration can take place through various methods of learning opportunities and practical applications. In addition, these methods of delivery can be introduced at a variety of levels

of existing programming. Finally, specific barriers to inclusion of spiritual health related issues at the worksite should be considered and dealt with. (p. 353)

Sources of spirituality probably come from within as well as outside the person. Inner voices, inner wisdom, higher consciousness, or the Spirit of God are all forms of the spiritual side of wholeness. Traditionally religion and spirituality have sought peace, guidance, and contact with the universal force through meditation, prayer, worship, contemplation, or introspection. Elements of religion and science have been combined to create a meditative relaxation response, eliciting a mind-body quieting that enhances health and well-being. (p. 141)

Witmer and Sweeney (1992) stated in their paper on wellness and prevention using a holistic model that:

Education has unlimited potential for creating a community in which the characteristics of the healthy person can be nurtured. Growth is both incidental and intentional. When implementing a holistic approach to education, the most effective method is modeling a life-style of holistic health and wellness. With an educational climate that is encouraging, striving for wellness becomes a process that is likely to extend over the life span. (p. 146)

Chandler, et al. (1992) believe that "observable behavioral change that is not accompanied by spiritual development may be especially vulnerable to recidivism" (p. 174). Behavior change that is manifested outwardly is a cue that "personal changes are occurring for the individual" (p. 174). Without accompanying spiritual changes, however, the maintenance of these behavioral changes is "difficult at best" (p. 174).

Consider, for example, the obese person who loses weight only to gain it back when the diet ends, the ex-smoker who continues to fight the urge to have another cigarette, and the workaholic who continually struggles against taking on more and more tasks.

Chandler, et al., suggest that attention to spiritual health plays a major role in helping

individuals maintain positive change. The dieter must internalize the new self as healthy and at the appropriate weight. The ex-smoker must internalize the new self as a nonsmoker. The workaholic must internalize the new self as a balanced individual. "Spiritual health provides an avenue through which the individual can create the new and more complete self" (p. 174). Attending to both personal and spiritual modalities for transformation contributes to greater balance and will more likely lead to transformation of the self with its accompanying opportunity to achieve higher level wellness (Chandler, et al., 1992).

Diaz (1993) also argues for inclusion of spirituality into health education programs. He believes that "any position which attempts to eliminate the metaphysical or spiritual from consideration is untenable philosophically" (p. 325). Such a position also is unrealistic, because it may remove the notion of purpose, a uniquely human trait, from the realm of health research, scholarship, and practice. "Science, properly circumscribed, makes no comment on spirituality" (p. 325). Scientism has a tendency to "transgress this boundary by unilaterally dismissing spirituality from consideration" (p. 325). Diaz believes our present concept of science should be expanded to include the study of metaphysical phenomena (Diaz).

Hjelm and Johnson (1996) wrote that there are five dimensions in health that include: physical, emotional, intellectual or mental, social, and spiritual. They insist that health educators, in particular, need to analyze all areas of health. If one dimension is ignored or misunderstood, the value of health education is limited. A balance between

the five dimensions results in optimal health. Health educators must understand and emphasize the importance of all the dimensions (Hjelm and Johnson).

School Health Education

1970's. Since 1979, the concepts of spirituality and spiritual health have been a pressing concern of the health disciplines. While many health professionals seek to study and implement spiritual health concepts, others are still skeptical and find spiritual issues problematic (Diaz, 1993).

In 1979 Osman and Russell wrote that during the past 20 years, the conviction that the "spiritual" is a legitimate and important dimension of health has been slowly evolving. They suggested that the American School Health Association:

- 1). "Recognize this development and encourage a Future Study Committee on the spiritual aspects of health" (p. 359), and
- 2). "Grant an Independent Study Session at the San Diego convention on the spiritual aspects of health" (p. 359).

Osman and Russell (1979) point out that in regards to researching spirituality in health education that some of those professionals interested in this dimension will be committed Christians; yet among these, there will be differences. "Other folks will acknowledge God in alternative traditional ways, while still others may be quite nontraditional - perhaps interested in spiritual healing or Eastern thought" (Osman & Russell, p. 359). Some will acknowledge only spiritual forces, and some may be concerned only about the spirit within themselves. "Sharing of experiences and

convictions shades rather naturally into proselytizing, and there probably will be some of that" (p. 359) Osman and Russell hope that it will not be more blatant than the convictions some now have about certain statistical techniques or particular computer programs as the way to develop knowledge.

1980's. Spiritual health is a vital dimension of health that has often been neglected in the classroom due to a lack of appropriate teaching methods (Richardson & Noland, 1984). School health professionals might do well to avoid the "medical model" definition of good health (wellness) which is defined by a single constellation of measurable elements aligned in a "perfect" format. The practice of school health education needs to be comprehensive. It should address all of the issues that impact on total health and not only one or two "hot topic" areas (Eberst, 1984). "Having a narrow focus fails to address the complex nature of human health and the multitude of factors by which it is affected, producing a health education program bound to be ineffective" (Eberst, p. 101). Eberst is convinced that comprehensive school health education needs to include the physical, mental, emotional, social, vocational, and spiritual aspects of each health issue. By relying on a more complete model than the medical concept, school health professionals can provide students with more than specific behavioral prescriptions. "They can help students create the conditions in their own personal lives that are conducive to individual high-quality health states" (Eberst, p. 103).

Cmich states in her 1984 study on holistic health that the concepts of holistic health have exciting implications for school health education. "Holistic health originates

in an attitude toward life that can be developed and nurtured early in the life of the school-age child" (Cmich, p. 31). This attitude includes a sense of responsibility for one's life, a willingness to cooperate with others, the importance of developing meaningful relationships and a positive outlook on life even in the midst of its uncertainties. "Holistic health also entails the integration of a wellness lifestyle into one's personal life journey" (Cmich, 1984, p. 31). Learning activities can be provided that not only help students become wise consumers of the range of health care options but also can put the students in touch with their own inner resources for health and healing (Cmich).

Richardson and Noland in 1984 wrote that health educators have shown an interest in the spiritual dimension of health. Despite this interest most health educators have taken the "safe" approach and avoided the discussion of spiritual issues in the classroom. The problem with this avoidance position is that sensitive issues such as sexuality, drug use, and death and dying are laden with spiritual implications, particularly when students are asked to make personal decisions regarding these issues (Richardson & Noland). Unquestionably, a country's pledge that includes the phrase 'One Nation Under God' is deeply influenced by its spiritual self. With the contemporary moral issues that face today's youth it seems biased not to consider the spiritual aspects of these issues (Richardson & Noland).

Richardson and Noland believe that "educational imagery can be used as a method for incorporating the spiritual dimension into the health lesson" (p. 27). They

wrote that when certain simple precautions are taken, the educational imagery technique applied to the spiritual dimension can be both useful in meeting educational objectives and in making the classroom exciting and interesting for the students. "The individualized nature of educational imagery allows for the incorporation of the spiritual dimension to be in the classroom" (Richardson & Noland, 1984, p. 27).

Richardson and Noland explain that "Educational imagery is used in facilitating decision making, clarifying values, memorizing, incorporating behavioral outcomes of teaching, reinforcing cognitive concepts, and other functions" (p. 26). The teacher directs the process by describing the scenarios that the students imagine as clearly as they can using the imaginary senses of seeing, hearing, touching, smelling, and tasting (Richardson & Noland).

Any topic that has a behavioral implication, something that can change the students lifestyle for the good, has potential for an educational imagery strategy. After discussing a topic with a behavioral outcome the teacher leads the student into a decision making scenario (Richardson & Noland).

Eberst (1984) states that for years, school health educators and other school health professionals have tried to exert a positive influence on human health. They have attempted to cause behavior change, analyze lifestyles, reduce risk-taking behavior, provide knowledge and information, aid health-related decision-making, prevent disease, and promote wellness. "However, these school health professionals have not seemed to be able to agree upon one, or even a combination of several philosophical approaches"

(p. 99). This fact, combined with the "consistent insufficient funding of school health education", has been "responsible for limiting the success of formal health education endeavors" (Eberst, p. 99).

Horowitz' 1985 model prescribes the use of value clarification, enhanced physical/cognitive/affective awareness, positive lifestyle choices, and self-reinforcement skills training whereby individuals learn to become self-motivated and reinforcing agents for their own primary preventive health practices. "It is theorized that by developing self-care and self-regulation skills, students will achieve and maintain higher levels of wellness" (p. 57), thus improving the quality of their lives and ensuring healthy human development (Horowitz).

Horowitz believes that school health education programs provide the greatest potential for improving the health of our nations people. Effective health education and behavior modification programs are needed to promote the compliance of children and young adults with preventive health care practices. "Health promotion and primary prevention programs must consider the entire individual, as well as his or her environment if positive behavior changes are to be maintained" (Horowitz, p. 57).

There should be a concern for the individual's own responsibility for illness and health through "behavioral, attitudinal, and spiritual change; and emphasis on health education, self-help, and self-healing" (Goldstein, et al., 1987, p. 118). Jose (1987) makes several good suggestions for including spiritual health into education. She had very good results when she asked her students to "catch somebody doing good" (p. 72),

rather than tattling on someone or looking for the "bad" in each other. The children "looked for good in each other and learned to express the good they found"(p. 72). Soon, the children were "happier, more willing to help each other, and more productive in the classroom" (Jose, p. 72).

Jose (1987) also conducted activities to encourage development of skills to enhance human/spiritual interaction, because it could have a valuable interactive impact on mental wellness. In a mental/emotional health class at Baylor University, one option involved an experimental project designed to enhance spiritual growth and development, The Silent Gift Project. The premise of The Silent Gift Project exercise is simple. Students must actively/behaviorally give of themselves to an individual, a group, or another living thing a minimum of three times per week for the semester. No one, especially the recipient, can know about the gifts. The spirit in which the gifts were given, not the gift, is the important factor. The emphasis was on the value of selfless sharing, in which giving was done solely for expressing genuine care for the recipient without expectation of something in return. Students submit a proposal for approval before the project begins. The proposal must describe the project, the cognitive and affective growth objectives, and an evaluation plan (Jose). Jose concluded that:

This project is not limited to a mental/emotional health class. In a human sexuality class, the assignment could enhance friendships as well as marriages or relationships between significant others. Students could contract to "give" at home to enhance parent/child relationships, or in their dorm/apartment to enhance friendships or a committed living together/married relationship. The project also provides positive reinforcements for the teacher. I came to know my students and myself in a gentle way during the semester. We felt the potential we each had to

care for one another and welcomed another day to try again. You may even witness the radiant looks on their faces as they stride away proudly, truly feeling good about the gifts they have given. (p. 73)

Chandler and Kolander (1988) know that classroom or other group settings provide a supportive environment for feedback and encouragement toward behavior change as students develop and practice controlled self-suggestion. In health education, students learn to establish lifestyle goals, design behavioral contracts, and initiate behavior change. "Though an initial commitment to altering behavior patterns may be evidenced, successful completion of goals and continued practice of altered behaviors may be temporary" (Chandler & Kolander, p. 295). A necessary step toward successful behavior change involves the positive belief by students that the alteration can be made, maintained, and integrated into the lifestyle. "When students do not master this step of internalizing the change, the behavior change can be incomplete and superficial" (Chandler & Kolander, p. 295).

Chandler and Kolander know the importance of health education in its potential to change behaviors. They realize that helping students understand the impact of lifestyle choices constitutes an important dimension of health education classes. Instructors can use value clarification and experimental activities to help students better grasp and integrate pertinent health issues. Exploring possible alternatives available and choosing an appropriate new behavior provides a common direction for health instruction. While these activities contribute to new attitude exploration, integration of positive concepts into the lifestyle behavior remains difficult (Chandler & Kolander).

1990's. Seaward (1991) believes that there are several road blocks to spiritual health. These could be stress, fear, anger, greed, and laziness. Road blocks constitute "any obstacle which denies strong internal and external relationships, promotes negative values or unresolved value conflicts, and blinds one from the true vision of a meaningful life purpose" (Seaward, 1991, p. 168). Construction of spiritual road blocks often is initiated by "immaturity, underdevelopment, and underutilization of the many traits associated with a healthy human spirit" (p. 168). Like a training program to improve physical well-being, "human spirituality also needs a training regime to promote and maintain spiritual well-being" (Seaward, p. 168).

Seaward goes on to say that integration of exercises to remove these types of spiritual roadblocks can be introduced in existing classes (i.e., stress management, personal health and wellness, health philosophy, and health promotion) or through the design of a new curriculum course with a special emphasis on this wellness component. Exercises may include journal writing with special themes to promote self-awareness and soul searching at a more profound level than conversation or class discussion.

Meditation, through use of mental imagery and diaphragmatic breathing, offers ways to promote spiritual homeostasis or inner peace. "Value assessment and clarification exercises" (Seaward, p. 168) may be introduced with strategies to problem solve common conflicts in values. "Presentations of case studies of individuals recognized for their contributions to mankind, supported by the foundations of their quest for a meaningful purpose, can be introduced as a catalyst for students to approach this

component of spiritual development” (p. 168). With a need to balance right and left cognitive functions, activities to promote imagination and creativity are well suited to enhance the trait of spiritual well-being. Integration of spiritual and physical well-being can be introduced through Tai Chi exercises. “There are many ways to incorporate spiritual well-being exercises into the health education curriculum” (p. 168), including “backdoor” approaches with existing program offerings as well as the design of new courses to include this component in the wellness paradigm (Seaward, 1991, p. 168).

Ethical Considerations

1990's. Two suggestions for maintaining an unbiased approach in the classroom have been offered by Goodloe and Arreola (1992). They suggest that (1) a health educator should recognize and respect student cultural diversity and existing spiritual belief structures, and (2) a health educator should recognize and respect differing student perceptions of health and spiritual health. Proponents of a spiritual dimension of health agree that this concept can be taught effectively when the teacher is willing to recognize and respect (1) diversity in student backgrounds and spiritual belief structures, and (2) differing student perceptions of health and the spiritual dimension (Goodloe & Arreola).

Goodloe and Arreola discussed the ethical concerns for health educators by recognition of the distinction between religion and spirituality which is critical for health educators. It solves the problem of the separation of church and state with regard to the teaching of spiritual concepts in health education. With its acceptance, identification and measurement of components within the dimension is possible. Moreover, development

of methodologies and teaching strategies for the enhancement of spirituality can be initiated. The role of the health educator is to help students maximize the positive aspects of their belief systems without imposing his/her own personal moral judgments and values on the learning environment (Goodloe & Arreola, 1992).

Diaz (1993) compiled the following strategies to cover the ethical issues involved in applying spirituality in health education programs:

The argument against spiritual health related to the separation between church and state in education can be silenced if health educators adhere to the following caveats. Take care not to proselytize. The health educator speaks from a podium, not a pulpit. Discussions of spiritual health should not be seen as an opportunity to preach one's own version of spirituality, but rather should be used to guide students/clients toward their own understandings and experiences within a spiritual health paradigm. Distinguish between religion and spirituality. The health educator should make clear the distinction between religion/religiosity on one hand, and spirituality on the other. While some freedom of definition should be afforded to each, one thing should be made clear: one does not have to belong to any organized religion in order to access the spiritual. On the other hand, for some, religion may play an integral part of their notion of spirituality. The point is that spirituality neither excludes nor is exclusive to the religious. (p. 325)

Community Service

1990's. Markus, Howard, and King (1993) wrote a paper on integrating community service and classroom instruction. They found that a group of college and university presidents established Campus Compact as a vehicle for encouraging volunteer service among undergraduates. Within a few years, over 250 campuses had joined the compact, and to date 11 states have established their own compacts of institutions of higher education within their boundaries.

Markus, et al., said that health educators should be preparing students to assume responsibilities of citizenship and that is part of the mission of higher education, and if this is true, then "such effects are important and ought not be disparaged" (p. 414).

These researchers found that "students' academic learning was significantly enhanced by participation in course-relevant community service" (p. 414). As compared with students taught by traditional methods, students in service-learning sections got higher course grades, were "more emphatic in their judgments that they were performing up to their potential in the course, and were more likely to affirm that they had learned to apply principles from the course to new situations" (Markus, et al, 1993, p. 414).

Markus, et al., continue by stating that the results say it all. "Attendance rates were 78% for traditional sections versus 85% in service-learning sections. At lecture, the comparable rates were 58 and 65% for traditional and service learning, students, respectively" (p. 414). Students in service-learning sections were also significantly more likely than those in the control group to report that "they learned to apply principles from this course to new situations and that they developed a set of overall values in this field of study" (Markus, et al. p. 414).

Finally, consider what some may regard as the ultimate 'bottom line' - course grades. "All students took the same midterm and final examinations and that the examinations were graded according to a common set of standards." (Markus, et al., 1993, p. 414). On a grade scale of 9 = A, 8 = A-, 7 = B+, and so forth, students in the traditional sections had a mean course grade of 6.42 (between a B and a B+), while

students in the service-learning sections averaged 7.47 (between a B+ and an A-), a “statistically and substantively significant difference” ($t = 2.66, p < .01$) (Markus, et al., p. 414).

Levine (1994) writes that under the banner of service-learning, a growing number of faculty and institutions are reaching a similar conclusion. More and more campuses are building courses around service, or are including service as an element in major and general education programs and in a variety of elective courses. Some are using service itself as a method of pedagogy, emphasizing active learning, which is the preferred learning style of a quickly growing proportion of undergraduates. In colleges whose curricula provide undergraduates with meaningful service activities, students report that service has become a more central part of their lives. Levine believes the quicker more colleges act to provide service-learning, the better chances are that, this time, voluntarism will be more than a fad (Levine).

Greenberg (1995) discusses the results of research on community service and the positive effects associated with service-learning in schools and universities, such as:

- increases math and reading achievement scores for tutors as well as for those being tutored
- results in no less knowledge than traditional college courses when the same course final examination is administered (therefore, it is as effective as traditional instruction in conveying knowledge)

- develops open-mindedness
- increases problem-solving ability
- increases social and personal responsibility
- increases self-efficacy and self-esteem, and decrease alienation and isolation
- results in less discipline problems, better communication, and gains in moral and ego development, and moral reasoning
- increases empathy (Greenberg, 1995).

Greenberg also found that students who participated in service-learning differ from students in traditional classes in that they are more likely to value the following:

1. working toward equal opportunity for all in the United States,
2. volunteering time helping people in need,
3. finding a career that provides the opportunity to help others in need,
4. giving to charitable causes, and
5. they are more apt to believe they can make a difference in people's lives (Greenberg).

Health educators should include community service projects into our programs.

Greenberg states:

Do yourself a favor - volunteer - and be better than the person you used to be. Do your students a favor and provide them with the opportunity to volunteer so they too can be better than the people they used to be. And, do your community a favor by helping to provide services that might not be provided otherwise, so it

too might be better than it used to be. And that, my friends, is health education. (p. 222)

Community Health Education and the Church

1980's. Hatch and Lovelace (1980) recognized that significant life events centering around the church, such as celebrations of birth, marriage, and death, continue with little change from earlier days. The church provides a setting for the exchange of news, social support, and resources. For instance, important social events in the community are announced at church, and after services the church members informally exchange various bits of information, give accounts of friends and family, and often arrange for the exchange of labor and other resources. The church continues to play a significant role as well in caring for the ill and giving support to families in times of crises. These observations lead to the notion that by building on and "expanding the support role these churches were already playing - that is, providing knowledge, advice, and other forms of help to friends, relatives, and neighbors - the level of sound health knowledge and the effectiveness of advice-giving could be increased" (Hatch & Lovelace, p. 24).

The health education program Hatch and Lovelace conducted that involved the southern rural churches, "appears to have won the support and confidence of people in the communities since attendance has averaged about 80% of the selected participants" (p. 24). The program helped promote better health behavior among the underserved (Hatch & Lovelace).

Churches have many characteristics that are compatible with behavior change programming for primary prevention of chronic diseases. Lasater, Wells, Carleton, and Elder's 1986 study on the role of churches in disease prevention include a large scale research project The Health and Religion Project in which church volunteers deliver behavior change programming on major cardiovascular risk factors (smoking, elevated blood pressure, elevated serum cholesterol, excess weight, and physical inactivity). A total of 20 churches, (Roman Catholic, Baptist, and Episcopal) were recruited throughout Rhode Island and randomly assigned to five experimental conditions (Lasater, et al.).

Lasater, et al. concluded in their study that "it appears that the enthusiastic response of the churches to this particular research project bodes well for the receptivity of churches to participating in other research" (p. 131). Even more importantly, the positive responses, both initially and during the first 30 months of programming, seem to indicate that "churches may have strong potential as sites for major health promotion activities" (p. 131). This potential has wide implications, particularly in primary prevention where cost effectiveness is at a premium and where reaching large numbers of individuals is a necessity. "The establishment of health promotion programs in religious settings may further help assure long-term maintenance of the behavior changes with the potent social support networks churches may offer." (p. 131). Finally, of course, "few other institutions in our society allow such convenient access to entire families as do churches" (p. 131). Thus, the types of behavior change being advocated for the primary prevention of chronic diseases (including both heart disease and cancer) that require

major nutritional and other types of proximal environmental changes should find churches to be "appropriate catalysts of change" (Lasater, et al, p. 131).

Miller (1987) explains that in 1979 the federal government designated health promotion as one of the nation's top priorities. Promotion of good health is a top priority for the population; a large number of this population is associated with the third largest organized church in the world, the United Methodist Church. What does this mean to the church, its congregations, its programs of ministry, and its clergy? It means that congregations need a wellness ministry, and since the church has historically been associated with health and healing, it is an ideal setting for health programs to take place (Miller).

Miller goes on to say:

Health promotion is a combination of educational, spiritual, environmental, and organizational activities directed toward health behavior change for members of a community of faith. After an assessment of the primary risks of major illness and premature death among the participants, interventions should be introduced to eliminate such risk factors associated with poor health behavior and unhealthy lifestyle. Churches have a tradition of helping in the community through a variety of social programs. (p. 4)

Miller's study on wellness programs in the church states that religious leaders should "deliver health behavior-change/wellness-programs to congregations and to the entire community" (p. 3). The linkage between spirituality and good health care exists, and many professionals stress its importance. "We also know from the literature that support groups are invaluable in facilitating behavior change" (p. 3), and it is well known

that religious institutions (churches) have a unique influence on the communities they serve. Thus, it is appropriate for churches and clergy members to define their roles as “facilitators of health promotion and wellness within their communities” (p. 3).

Miller (1987) believes that wellness is a Christian mandate. Jesus understood very well the concept of wellness as abundant living and calls us to self-responsibility. He illustrates that disease is sometimes self-inflicted by lifestyle choices which lead to a poor quality of life. Disease is the “thief who comes only to steal from us, to kill and/or to destroy us” (p. 3). In John 10:10, Jesus states that “I come that you might have life and have it more abundantly” (The Bible, John 10:10, as cited in Miller). In this passage Jesus is telling us that there is more enjoyment and satisfaction in a life of wellness (Miller).

Miller made some suggestions for church centered wellness programs by stating that “wellness programs would serve as a vehicle for reaching the unchurched as well as serving those who are already members of a congregation” (p. 3). Wellness programs should be viewed as an evangelistic tool for the church. Once church has made a commitment to providing a wellness program, it will immediately begin to reap the benefits. Church members are increasingly aware that “prevention of illness is much less expensive than the cost of rehabilitation” (p. 3). Furthermore, a healthful lifestyle will offer members of the congregation better health, “thus translating the results into increased church attendance and stewardship, greater involvement in church activities and ministry, and a more positive spiritual life for individuals and the community” (p. 3).

Some suggestions for church centered wellness programs were offered by Miller. Wellness programs conducted through the church may center around the major cardiovascular risk factors of smoking, high blood pressure, obesity, nutrition, stress, and physical inactivity. Miller (1987) believes that these programs should include the use of health-risk appraisals to assess an individual's risk of illness or premature death from cardiovascular disease. Such appraisals should focus on the above mentioned risk factors. "However, other factors might also be examined" depending on the church's needs and constraints. "All program services would be performed by trained professionals and volunteers" (p. 5). The programs will be "ongoing and should be included in the plans of the church ministry by the boards of each church" (p. 5). The primary role of the ministers would be to "initiate planning sessions for the program task force and to act as advocates for the project" (p. 5). The pastor would also be responsible for supervising continuing program evaluation. The local church's organizational structure will be useful in "projecting local ownership, consistency with established local norms, control in the section of suitable volunteers and trained professionals, confidentiality of data collection, and ongoing program evaluation" (Miller, p. 5).

1990's. Sutherland, Barber, Harris, and Cowart (1992) did a health promotion program in several southern Black churches. They found that these church based health promotion programs influenced participants' health behaviors as indicated by reduction of blood pressures and weight; increased number and duration of exercise sessions; changes in community values, (e.g., more employee health programs or large numbers of

nonsmoking restaurant seats); and increased numbers of individuals using county health unit primary care services and the county receiving reimbursement for provided services.

Scandrett (1994) also states that health professionals are faced with a challenge to meet the year 2000 health objectives, and "with a gap in health care and information between Blacks and Anglos" (p.183). As such, Scandrett believes "we need not only to use the Black church, but also to embrace the Black church as a positive change agent to aid in depositing health screening and health information to the Black communities of our country" (p. 183). Scandrett writes that:

Today, the trend in our society is to improve on the overall health status of American citizens. Health promotional activities are being introduced in different phases of a person's life, ranging from promoting wellness at the worksite to individual fitness and health appraisal programs. These activities are being implemented with the hope of improving the country's health status by the year 2000. These activities have targeted nutrition, AIDS, sexuality, drug use, and mental illness. (p. 183)

Scandrett continues by adding that the church as a focal point in the Black community serves not only as the provider of spiritual needs, but also gives its constituents information about issues dealing with health. Thus, the Black church could provide a vehicle for health intervention and health promotional programs within the Black community (Scandrett).

Summary

This researcher would like to point out that there were more studies, research papers, and overall information on religion versus spirituality. This paper's focus was on the spiritual aspect and how it relates to personal health, however, religion was a large source of information. The reason for this may be that religion is more concrete than spirituality. Religion can be measured and defined easier. It is also easier to compare health impacts between different religious groups. Therefore, religion consumed a large portion of this paper. However, it is the researcher's belief that those who are religious have some degree of spirituality as well. That is why religion was included in this paper.

Spirituality and religion have been shown in this study to correlate positively with health effects and outcomes. When considering health, the whole person (mind, body, and spirit) should be taken into account (holistic) health. Spirituality and religion also have been shown to impact on disease in positive ways. Church attendance also has positive health effects.

Spirituality and religion have positive influences on life satisfaction, (wellness) and spirituality should be applied in all appropriate health education programs. The church is an ideal place for health promotion programs. Community service can enhance one's spirituality and, as health educators, we can include this in our school health classes as part of the curriculum.

Religious commitment and spirituality has widespread beneficial effects upon numerous and diverse health care outcomes, including well-being (Ellison, 1991; Glenn

& Weaver, 1978; Hadaway & Roof, 1978; McNamara & St. George 1979), (e.g., happiness, life satisfaction, marital adjustment, and self-esteem), psychopathology (Koenig et al 1994; Koenig, et al, 1992, McNamara & St. George, 1979), (e.g., anxiety, depression, suicide, and delusions) drug use (Burkett & White, 1974; Guinn, 1975; Koenig, et. al., 1994), (e.g., alcohol, marijuana, and tobacco), and medical health (Frankel & Hewitt, 1994; Hannay, 1980; Oleckno, & Blacconiere, 1991) (e.g., wellness, health care utilization, symptom expression, seizure, pregnancy, and functional status). In summary, it appears that the time now has come to accept the spiritual as an important aspect of individual and corporate life and a legitimate dimension of well-being (Osman & Russell, 1979).

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APPENDIX A

ANNOTATED BIBLIOGRAPHY

ANNOTATED BIBLIOGRAPHY

This annotated bibliography provides additional references to several Eastern and Far Eastern approaches to health, particularly ones that integrate spiritual and physical dimensions of the person. (Hastings, et al., 1980)

Funderburk, J. (1977). Science studies yoga: A review of physiological data. Honesdale, PA.: Himalayan International Institute of Yoga Science and Philosophy.

One of the claims for yoga practices and techniques is that they have significant effects on the body and health. This book is a summary of more than one hundred studies testing the physiological effects of health yoga (the physical positions) and meditation. While it is uncritical in its stance, it is a useful compilation of the literature because some of the research is from medical and yoga journals published in India that are difficult to obtain in the United States. The other studies come from a broad range of physiological, medical, and psychological publications in Western literature.

The findings are organized into chapters on muscle tension and capabilities, circulation, respiration, endocrine functioning, and the nervous system, including EEG correlates of the postures and meditations. The studies generally confirm that yoga practices have important effects on the human system, some of which have medical potential (e.g., reduction of blood pressure and improvement of vital capacity in respiration).

Horwitz, T, Kimmelman, S, & Lui, H. H. (1976). Tai chi chuan. Chicago: Chicago Review Press.

This book is a good introduction to tai chi chuan. It contains an excellent history of the art along with a genealogical table tracing the major developments from its found by Cheng Sab-feng approximately seven hundred years ago to the present. The authors present a section containing translations of works by tai chi masters covering a span of five hundred years. Although this book is not useful for learning the tai chi form, it does explore the relationship of tai chi exercises to health maintenance and healing.

Jiyu-Kennett, Roshi P.T.H.H., & MacPhillamy, Rev. Daizui. (1979). The book of life. Mt. Shasta, CA: Shasta Abbey Press.

From this Buddhist perspective, the law of karma is inevitable and inexorable, and physical and mental illness result from spiritual and karmic disturbances - the effects of unresolved experiences or traumas in past lives or present existence. The prevention of illness and the cure of the roots of symptoms thus require treatment of both the body and spirit. Roshi Jiyu-Kennett, a Zen master born in the West and trained in Japan, is Abbess of Shasta Abbey in California, a seminary and monastery for Buddhist training. Rev. MacPhillamy is a clinical psychologist and ordained Zen priest at the abbey.

Regarding the source of this material, Roshi Jiyu-Kennett says, "All of what is written here is either spoken of, or depicted, openly, or described in somewhat flowery language, throughout the Buddhist Scriptures, so there is nothing 'invented' or 'imagined' in the pages that follow." This is one of the few books that takes up the spiritual dimension of health and healing, though with premises that are quite different from our current Western paradigm.

Tulku, T. (1978). Kum nye relaxation (2 vols.). Berkeley, CA: Dharma Publishing.

Kum nye (pronounced "koom Nyay") is a system of self-massage, physical positions, exercises, and related meditative techniques that originated in Tibet, where it was used as an adjunct to medical healing and in spiritual practice.

Tarhang Tulku, a Tibetan lama, presents more than one hundred exercises intended to promote relaxation, balance, and awareness of one's physical and mental energies. Beyond the physical effects, kum nye is directed towards self-understanding; the positions, relaxation, and tension are likely to evoke emotional and psychological awareness of the practitioner.

The exercises are arranged in sequence and are carefully structured. They can be learned from the text and illustrations. The author says he has adapted the traditional (and unwritten) system of modern needs. There are similarities to Indian yoga and Chinese acupuncture, but the flavor is quite different. Volume 1 is titled *Theory, Preparation, Massage*, and volume 2 is called *Movement Exercises*.

APPENDIX B

SOME PLACES TO TURN

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Ardell (1986) has a few suggestions for getting holistic treatment:

1) The Wellness Resource Center

One of the major influences of my thinking about health as something quite different from medicine was John Travis, founder of the Wellness Resource Center in Mill Valley, California. A physician with all the credentials of the medical order (Tufts M.D., residency in Preventive Medicine and Master's in Public Health from Johns Hopkins), Travis seems to have realized the forecast made in 1957 by Dr. D.C. Jarvis in his famous book, *Folk Medicine*. Jarvis predicted that the doctor of the future will be a teacher as well as physician, whose real job will be assisting people to learn how to be healthy. Following his pattern, the staff of the Wellness Resource Center uses no drugs, gives no prescription, does no lab work, conducts no physical examinations, and sees no patients. People who show up at the center with physical symptoms or illness requiring treatment are referred to other physicians (Ardell, 1986). (p. 8)

The Wellness Resource Center staff works to help clients learn how to take charge of their own lives and to feel good about themselves. What happens is not medicine, as most of us think of medical services; it is an alternative approach wherein Travis and staff are facilitators and assistants to clients moving toward high level wellness (Ardell, 1986). (p. 11)

2) Healing the Whole Person at Meadowlark

Located about 100 miles southeast of Los Angeles on a 20-acre wooded estate, Meadowlark is the oldest of the wellness resource centers noted in this book. Established in 1958 and nurtured through the years by Dr. Loomis, Meadowlark provides an atmosphere of self-healing, self-exploration, and personal development. There are two basic beliefs which color and shape the activities at Meadowlark: the first is that mental and emotional tensions coupled with toxins in the body lie at the root of illness; the second is that the human body has an innate, root wisdom with which it maintains or recovers its own perfection when it is allowed to function unhindered. These twin beliefs are expressed in varied ways in Meadowlark programs. A brochure on the institution as a health and growth center provides further insight into the environment which Loomis has fashioned in carrying through his concept of treating the whole person's body/mind/spirit (Ardell, 1986). (p. 20)

3) Personal and Organizational Wellness at the New England Center

The New England Center is located on 11 acres of undeveloped land bordering the State Forest of Mt. Toby in Leverett, Massachusetts. In existence since 1971, it is a nonprofit adult educational and training institute. The center has a professional staff that works as a team to provide clients with educational and treatment in the various therapies in the humanistic movement (Ardell, 1986). (p. 25)

4) Seizing the "Teachable Moment" at WHN

Yet another approach to high level wellness is available just a few miles from the Wellness Resource Center at the Wholistic Health and Nutrition institute, better known as WHN. WHN offers multi-disciplinary therapies in what it calls Holistic or whole person, humanistic health care "dedicated to high level wellness and unity of body/mind/spirit (Ardell, 1986). (p. 27, 28)

5) Oneness of Mind/Body/Spirit at the East West Academy

One other approach to high level wellness has been pioneered by the East West Academy of Healing Arts (EWAHA), located in San Francisco. Unlike the other wellness centers, EWAHA is almost entirely a volunteer operation, save for its founder and head, Dr. Effie Poy Yew Chow, and one administrative assistant. EWAHA has managed to organize and conduct four major conferences in the past year. The subjects were (1) holistic approaches to health care; (2) holistic health and healing energies; (3) the rituals and practices of other cultural healing systems; and (4) stress and tension in connection with cancer, death, and dying. All together, about 2,500 people have participated in these events (Ardell, 1986). (p. 41)

APPENDIX C

PRINCIPLES OF HIGH LEVEL WELLNESS

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According to Ardell (1986) the principles of high level wellness are:

1. We are the chairperson of our own well-being. Ardell believes we can carry the key to our own physical, emotional, and mental well-being in the way we choose to live. Doctors and others can help us, can give us advice, can save our lives in certain instances, and can usually make things easier, but in the overall analysis, "we have the responsibility for whatever goes well or poorly; for our own health and well-being" (Ardell, 1986, p. 98).
2. "Forget about magic bullets or instant solutions." Ardell states that so many of our fellow citizens are sick and dying from the diseases of civilizations, the debilitating pathologies of premature aging brought on by aberrant lifestyles. Despite this fact, the not-so-subtle message from the medical media is that somewhere there is "a medical solution to these problems, that no challenge is too great for medical technology, and that health can be purchased by greater investments in medical research facilities, procedures, and techniques." Unfortunately, there is no pill or other magic bullet that will cure cardiovascular disease, cancers, cirrhosis of the liver, and all the other infirmities caused by years of high-risk behaviors (Ardell, 1986).
3. "Heed not the counsel of the adipose physician." Ardell thinks we should examine your doctor before you let him examine you. Improvements in our health status would come about much faster if physicians, the most respected and esteemed of all

health-care providers, could take it upon themselves "to teach us how to maintain and improve our health and choose better for ourselves." Instead, the "medical profession as a whole, are devoted to the treatment of illness symptoms, diseases, injuries, and the unending struggle against death" (Ardell)

4. "Our body is the world's greatest healer - let nature do its thing." Ardell states that our body is a marvelous creation. It is designed to work well; it is equipped with self-generating antibodies which mend damaged tissue, regenerate dying cells, and otherwise keep you healthy. These "self-regulatory" processes include our body's ability to maintain optimum temperature, health, and respiration rates; blood flow and blood pressure; acid-base balance; and electromagnetic properties. But marvelous though it is, the body cannot, over the long haul of the years, resist and survive the punishment occasioned by disuse, misuse, neglect, and denial (Ardell)
5. "God makes it Her/His business to stay out of ours." A wellness philosophy, as Ardell (1986) sees it, holds that we are on our own in this world, neither favored by nor discriminated against by a higher power or powers. "When we are ill, it is our advantage to accept responsibility and work as you can with the condition; when we are well, we should give ourselves some credit for our good fortune" (Ardell, 1986).
6. "Neither Rome nor a wellness lifestyle can be made in a day." It is hard work to live well. It is easier to eat junk food, ignore exercise, disregard tension, and "let-someone-else-do-it" than it is to develop an individualized wellness program in each of the five dimensions. Each wellness area is a complex field having many

disciplines and numerous approaches; it will take time for us to experiment and discover what we like in each dimension. But, there is not hurry, "Rome was not built in a day and neither can or should a lifestyle scheme in wellness be designed or implemented in an abbreviated time frame" (Ardell)

7. "Don't sacrifice, deny yourself, or give up destructive life habits - until you're ready to do so." Ardell believes that when you know it is right, when you understand why you are doing (or avoiding) something, and when you anticipate the benefits of a new health-promoting behavior, then the change in activity brings a satisfaction that reinforces while it pleases. "Not smoking, for example, will produce a sense of satisfaction, not feeling of self-denial or agonizing sacrifice usually associated with medieval torture" (Ardell)
8. "No medicine is good medicine - as a bendable rule." Americans are pill freaks. We consume 20,000 pounds of aspirin annually. That's 225 tablets for every man, woman, and child. "Valium and Librium are the staple of U.S. medicine: 75 percent of all doctors visits end with a prescription for one medication or another." Spend an hour watching television and you will be assaulted by the pharmaceutical industry with "offers of pills or other nostrums of improved sleep, excretion, energy, youthfulness, smell, naturally, overall health." Mood elevators, amphetamines, tranquilizers, narcotic pain pills, and antihistamines "seem more American than apple pie." Ardell also believes that, but the general attitude of the wellness adherent is that natural remedies, time, will, and an integrated lifestyle are quite sufficient, for most

of what does or could ail you." A high level wellness lifestyle is, in itself, a state of being that affords high resistance to disease" (Ardell, 1986).

9. "It's better to be a client than a patient." The term *patient* connotes a subservient quality in the nature of our relationship with a physician; as a client, on the other hand, you are the responsible party in transactions with the provider. "That's because in the wellness framework, the provider is a facilitator of learning, an ally, and a guide in the healing process - not an authority figure" (Ardell, 1986).
10. "High level wellness is more rewarding than low level worseness." As an ever-changing state of feeling good about our body and purpose, "high level wellness is such a positive 'turned-on' way to live that after you experience it the alternatives will become totally unattractive" (Ardell, 1986).

Ardell, (1986) concludes that:

Spirituality means different things to people of varying religious denominations, or factions within a denomination, as well as to people of varying cultures and nationalities. What is spirituality to Jerry Falwell would not seem so the Ayatollah Khomeini.

This is a difficult area to address, given the potency and negativity that comes with dogma, creeds, and strong beliefs in what some perceive as moral absolutes. When one person's dogmas, creeds, and moral absolutes bump up against those of someone with a different set, the climate for thoughtful and considerate dialogue usually turns for the worse.

Yet despite the difficulty of addressing this ill-defined, arguable, and complex matter, it is clear that something about the "human spirit" belongs in a wellness model. Spirituality is the elusive issue that lies at the heart of a well-managed and examined wellness lifestyle.

Rather than call it spirituality and invite all the misunderstandings attendant on the subject, I decided to address the matter in another context - namely, ethics, values, and purposes (p. 343)

APPENDIX D

SELF-RESPONSIBILITY PRINCIPLES

SELF-RESPONSIBILITY PRINCIPLES

Ardells' (1986) list of self-responsibility principle include

1. You are in charge of your own life. Others have influence, can make things easier or more difficult, but in the end you must make your own choices and accept responsibility for what good or ill and health or disease occur in your life.
2. You are different from everybody else. What keeps you from becoming ill is more or less what does the same for others, but your path to high level wellness within each wellness dimension must be unique, as you are unique.
3. You are motivated by a desire for happiness. Each of us pursues health and high level wellness not for their own sake, but in the context of our values and purposes. And, for most of us, these include seeking happiness, however differently we perceive this hare-to-define state.
4. You need a sense of purpose. To pursue high level wellness and to avoid the pitfalls of destructive lifestyles, it is essential to develop a means of self-expression that fits your unique talents and skills.
5. You are OK - and on you way to being even better. The way you feel about yourself has a powerful effect on how you treat yourself. Smoking, heavy drinking, overeating, and other forms of self-abuse are highly correlated with low self-esteem.
6. At times, you might prefer illness to health. This may seem strange at first, but a lot of serious researchers and physicians believe that many people unconsciously choose to be ill. We do this because it seems to offer an escape from an unpleasant reality, because it brings forth desired attentions and special considerations from others, or because it helps to mask or excuse an inadequacy, or otherwise enables the "patient" to escape taking responsibility.
7. Stop, examine, and choose. Unlike wallowing in self pity, choosing wellness requires a clear intention or consciousness that this is your preference, and a recognition of your responsibility to go for it. And, a part of choosing well is acceptance of others and yourself.
8. Go for positive happiness, wellness style. You know very well what it is like to feel genuinely happy! It's such a positive kind of self-realization, even if it lasts only a moment. For most of us, this kind of

happiness comes and goes; sometimes, the glow lasts a little longer than usual. Such feelings are highly valued in our culture.

9. Great decisions under distress seldom are. Don't make decisions when under great duress or other high emotional charge, whether the feelings are positive or negative. And don't mix judgments and feelings; postpone decisions until your emotions subside. (p. 90)