Religion and Coping with Serious Medical Illness

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OBJECTIVE: To review and discuss some of the research published in the last several decades that has addressed the role that religion plays in helping patients cope with serious medical illness.

DATA SOURCES: Although this is not a systematic review of the literature, it provides a sampling of the studies that have examined the relationship between religious involvement, coping with illness, and health outcomes. This sampling of studies reflects the findings of a much larger systematic review of research (MEDLINE, Current Contents, Psychlit, Soclit, HealthStar, Cancerlit, CINAHL, and others) during the past century that was recently completed by the authors.

DATA EXTRACTION: Epidemiologic studies published in the English-language literature were reviewed and discussed.

DATA SYNTHESIS: A number of well-designed cross-sectional and prospective studies have examined the relationship between religious beliefs and activities and adaptation to physical illness in patients with general medical conditions, neurologic disorders, heart disease, renal failure, AIDS, and a host of other physical disorders. This review demonstrates the widespread use of religion in coping with medical illness and provides circumstantial evidence for the possible benefits of this lifestyle factor.

CONCLUSIONS: When people become physically ill, many rely heavily on religious beliefs and practices to relieve stress, retain a sense of control, and maintain hope and their sense of meaning and purpose in life. Religious involvement appears to enable the sick, particularly those with serious and disabling medical illness, to cope better and experience psychological growth from their negative health experiences, rather than be defeated or overcome by them.

KEY WORDS: religion, coping, depression, spirituality.

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According to recent Gallup polls, religion in America is widespread and deeply ingrained in our culture and health practices. According to the most recent national survey,[1] 95% of Americans believe in God or a universal spirit, 95% indicated religious or spiritual beliefs are important in their own lives, 68% attend church at least once monthly, and 54% believe that religious beliefs or spiritual practices are having an increasing impact in people's lives. Until recently, however, the influences of religious beliefs and practices on mental health in the setting of physical illness were not well known.

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This article briefly reviews the literature on the relationship between religious involvement and mental and physical health in patients with serious medical illness. Because of space limitations, this is not a systematic review of the literature that discusses all the research done in the field; it does reflect what a recent systematic review of more than 1200 studies found. Given the unevenness of the methodology in many of those studies, however, only the best ones (prospective cohort studies, when available) are presented here.

Severe Medical Illness and Mental Health

A number of studies[2] now demonstrate high rates of depression and other emotional illness in persons with chronic illness or physical disability. Such emotional distress becomes particularly serious at the time of acute medical

hospitalization, nursing home placement, and even transition from independent living to assisted living in retirement communities. At these times, many people experience distress over their physical health, especially concerning the meaning that the illness has for their future and the future of their families and loved ones. A sense of loss of control and humiliation begins to mount as caretakers (physicians, registered nurses, nursing assistants) begin telling the disabled person what to eat and drink, as well as when to sleep, have visitors, or even use the restroom. In addition, patients often experience physical pain and are suffering from illness, diagnostic tests (blood sampling, iv insertions, X-ray examinations), and, sometimes, experience a loss of personal dignity when treated in essence as "nonpersons" (during physical examinations, diagnostic tests, or therapeutic procedures). Patients also feel lonely because they are separated from family and friends. It is little wonder that nearly one-half of acutely hospitalized patients experience some degree of clinical depression; the severity of depression is directly related to the extent of their medical illness and associated functional loss.[3]

Role of Religion

The term religion, as we use it in this article, refers to Christianity, Judaism, Buddhism, Hinduism, Islam, and other major religious traditions. However, more than 90% of the research done on this topic has been performed in predominantly Christian and Jewish populations. Studies[4] examining meditation techniques from Eastern religious traditions (e.g., mindfulness meditation, transcendental meditation) and Muslim practices (prayer and reading from the Koran) show similar relationships to health as do those for Christians and Jews, although the former studies are much fewer in number.

For nearly a century, religion was portrayed by mental health experts as a neurotic influence on psychological functioning; many still hold this view today. A review of the medical literature on religion and medical illness in the early 1900s would have uncovered Sigmund Freud's *Obsessive Acts and Religious Practices*[5] and *Future of an Illusion*,[6] in which he describes religion as a "universal obsessional neurosis" and predicts its ultimate demise, as persons would more and more learn to use the rational operation of their intellects. Similarly, a report by geriatric medicine specialist Nina Covalt[7] in 1960 indicated that medical patients seldom requested religious or spiritual help when sick, and that during her 25 years of medical practice, few patients ever brought up religious or spiritual problems with her or asked to speak with a minister. In fact, she observed that when sick patients brought a Bible with them to the hospital and displayed it prominently on the nightstand, this signified a neurotic patient and trouble for the physician. These observations were based on personal opinion, not systematically collected data.

In 1969, however, a scientific review published in the *American Journal of Psychiatry*[8] concluded that, "the contention that religion as an institution has been instrumental in fostering general well-being, creativity, honesty, liberalism, and other qualities is not supported by empirical data. Both Scott and Godin point out that there are no scientific studies which show that religion is capable of serving mental health." In the 1980s, psychologist Albert Ellis[9] reiterated the common view in the mental health field that, "the less religious they [people] are, the more emotionally healthy they will tend to be," and psychiatrist Wendel Watters[10] concluded in the 1990s that, "evidence that religion is not only irrelevant but actually harmful to human beings should be of interest, not only to other behavioral scientists, but to anyone who finds it difficult to live an unexamined life." These statements by Ellis and Watters were, again, based largely on opinion and personal clinical experience.

There were only a few who opposed the view that religion was either irrelevant or harmful to health. Carl Jung[11] wrote that, "among all my patients in the second half of life — that is to say, over 35 [years] — there has not been one whose problem in the last resort was not that of finding a religious outlook on life." This statement, however, was also based on clinical experience and personal opinion. Nevertheless, according to a review of the scientific literature, sociologist David Moberg[12] noted (in contrast to Sanua[8]), "studies of happiness, morale, and personal adjustment have generally shown a direct relationship between good adjustment and such indicators of religiosity as church membership and attendance, Bible reading, regular listening to religious broadcasts, belief in an afterlife, and religious faith." Psychologist Allen Bergin[13] wrote that, "religion is at the fringe … when it should be at the center." These voices remained largely unheard until studies in the late 1980s and 1990s began to demonstrate the widespread use and apparent benefits of religious practices in medical settings.

In one of the first studies to examine the role of religion in adaptation to the stresses of aging and disability, Koenig et al.[14] studied the responses of 100 older persons to open-ended questions asking them about how they had coped with the worst experiences in their entire lives, the worst experiences in the past 10 years, and the worst aspects of their present lives; many of these stressful experiences involved struggles with physical illness. Nearly two-thirds of women and one-third of men gave religious responses (i.e., prayer, trust and faith in God, reading religious scriptures, depending on the support of other church members or clergy).

Next, these investigators examined two samples of patients hospitalized with acute medical illness.[15,16] In order to quantitatively examine the relationship between religious coping and adaptation to medical illness, a measure of religious coping had to be developed. The Religious Coping Index (RCI) consisted of three items: (1) an open-ended question about the most important factor that enabled the patient to cope, (2) a self-rating by the patient concerning the extent to which religion was used to cope, and (3) a rating by the examiner on the patient's degree of religious coping, based on a discussion with the patient about how and when religion was used to cope (the final

religious coping score ranged from 0 to 30).[15] The RCI applies to persons of all religious faiths, although the populations in which it has been used have been predominantly Christian and Jewish. Test–retest reliability for the RCI was determined for a subgroup of 188 consecutively admitted patients. The RCI was administered twice to these patients, each time by a different rater from a different religious background. The Pearson correlation between scores obtained on the RCI at the two administrations (separated by 12–36 h) was 0.81.

The RCI was first administered to a sample of 850 older male veterans consecutively admitted to the acute medical and neurologic services of Durham Veterans Affairs Medical Center.[15] Because persons seeking health care in a veterans hospital differ from patients in other settings (most of the former are men and have less education and lower incomes), the RCI was later administered to a sample of 330 men and women consecutively admitted to the medical, neurology, and cardiology services of a large academic teaching hospital (Duke University Medical Center, a nonprofit, nondenominational hospital).[16] Between 20% of the veterans and 42% of the other patients reported spontaneously and without prompting that their religious beliefs and practices were the most important factors that enabled them to cope (1st question of RCI). When asked to rate the extent to which religion was used in their coping (2nd question of RCI), about 70% of veterans and 90% of the other patients indicated that religion was used at least to a moderate extent; approximately 55% of veterans and 75% of the other patients indicated it was used to a large or very large extent when coping with illness.

Other studies in persons with end-stage kidney disease,[17] AIDS,[18] heart disease,[19,20] cancer, and other serious medical illnesses[21-24] also consistently find a high prevalence of religious coping among chronically or seriously ill patients.

Use of Religion and Successful Coping

Compared with other nonreligious methods of coping (i.e., distraction, staying busy, accepting the problem, depending on family members), to what extent are religious beliefs and behaviors associated with enhanced coping? Koenig et al.[15] examined the relationship between scores on the RCI and both self-rated and observer-rated depression scores in their sample of 850 hospitalized men described above. Religious coping was significantly and inversely correlated with depressive symptoms regardless of how symptoms were measured. Furthermore, the extent that religious coping was used during hospitalization predicted lower levels of depressive symptoms an average of six months later in a subgroup of 201 consecutively readmitted patients, after controlling for multiple predictors of depression ($\beta = -0.18$; $p = 0.01$); in fact, religious coping was the most powerful of all 14 covariates measured at baseline in predicting low depression scores on follow-up (accounting for 45% of the explained variance).

Religious coping, however, was associated with only certain types of depressive symptoms. Loss of interest, feeling of worthlessness, withdrawal from social interactions, loss of hope, and other "cognitive" symptoms of depression were significantly less common among religious copers, whereas "somatic" symptoms such as weight loss, insomnia, loss of energy, and decreased concentration appeared unaffected by religious coping.[25] The investigators concluded that religious coping may reduce the affective symptoms of depression, but appeared less effective for the biologic symptoms that are probably more responsive to pharmacologic treatments.

Level of religious commitment, however, predicts speed of recovery from depression regardless of initial depression severity, an effect that is strongest in those with chronic physical disability that is not responding to pharmacologic therapies.[26] Koenig et al.,[26] using the National Institute of Mental Health Diagnostic Interview Schedule, identified 87 depressed older adults from a sample of consecutively admitted patients hospitalized for medical illness. Scores at baseline on a previously validated 10-item intrinsic religious motivation scale predicted speed of remission from depression during a 47-week observation period. After controlling for multiple sociodemographic, medical, and psychosocial covariates, a 10-point increase on the intrinsic religious motivation scale (~1 SD) was associated with a 70% increase in speed of depression remission ($p < 0.05$). Among subjects whose level of physical disability stayed the same or worsened during the one-year follow-up, speed of remission from depression increased by more than 100% for every 10-point increase on the intrinsic religiosity measure ($p < 0.05$).

Many studies, in fact, have documented a positive association between religious involvement and better adaptation to medical illness[27-29] or to the burden of caring for those with medical illness.[30-32] Some studies show that religious coping is even associated with improved attendance at scheduled medical appointments,[33] and involvement in religious activity has also been associated with better compliance with antihypertensive therapy.[34]

More recently, Koenig et al.[35] examined the association between 21 types of religious coping and a host of physical and mental health characteristics in a consecutively admitted sample of 577 medical inpatients. Characteristics measured included overall quality of life, level of depressive symptoms, cooperativeness with interview, and stress-related growth (e.g., positive psychological growth as a result of coping with and overcoming negative circumstances such as poor health). Standard, published measures were used to assess these characteristics. The 21 religious coping types were each assessed with three self-rated items (63 questions overall). Offering religious help to others (e.g., praying for others, offering spiritual support) was one of the strongest predictors of high quality of life, low depressive symptoms, greater level of cooperativeness, and greater stress-related growth. Other types of religious coping associated with positive mental health included reappraisal of God as benevolent, collaborating with God, seeking a connection with God, and seeking support from clergy or other church members. These coping behaviors

were strongly related to stress-related growth, enabling patients to experience greater psychological growth from these stressful health problems. Coping behaviors that focused primarily on the self (self-directed coping) without depending on God were related to greater risk of depression, lower quality of life, and significantly lower stress-related growth.

How Does Religion Help Patients to Cope?

In our opinion, religion helps the medically ill person to cope in the following manner. Western religious traditions emphasize a personal God ("love the lord your God with all your heart and with all your soul and with all your strength" — Deuteronomy 6:5, New International Version [NIV]), place high value on personal relationships ("love your neighbor" — Leviticus 19:18, NIV), and emphasize respect and value for the self ("love your neighbor as yourself" — Leviticus 19:18), and yet also stress humility ("all have sinned and fall short of the glory of God" — Romans 3:23, NIV).[36] The resulting emphasis on relationship — relation to God, to others, and to self — may have important mental health consequences, especially with respect to coping with the difficult life circumstances that accompany poor health and chronic disability.

Religious beliefs and practices may reduce the sense of loss of control and helplessness that accompanies physical illness. Religious beliefs provide a cognitive framework that can reduce suffering and increase one's purpose and meaning in the face of loss of other previously relied-upon sources of self-esteem. Private religious activities such as prayer reduce the sense of isolation and increase the patient's sense of control over the illness. Praying to God may not only relieve the patient's loneliness, but belief in an all-powerful, loving, and responsive God can give patients the sense that they can influence their own condition by possibly influencing God to act on their behalf. Public religious behaviors that improve coping during times of physical illness include participating in worship services, praying with others (and having others pray for one's health), being visited by clergy at home or in the hospital, and talking with the hospital chaplain.

Developing a personal relationship with God can also provide a worldview that helps give purpose and meaning to suffering and illness. In the Christian tradition, the patient may identify with the suffering of Jesus and other prominent Biblical figures. The patient may receive comfort from the scripture that says, "in all things God works for the good of those who love him, who have been called according to his purpose" (Romans 8:28, NIV). Thus, no matter what the circumstances or difficulties of the moment, there is always hope that things will turn out for the better when placing trust in God.

The close personal relationship with God motivates the believer to want to please God and serve God. This motivation to serve God provides the chronically ill person with a way to obtain and support their meaning and purpose in life, despite physical limitations. Whatever ability a disabled person still has, he may offer that ability for God's service. This "ability" need not require any physical activity — sometimes the attempt to be kind, grateful, or appreciative for the services rendered by others can in itself be considered a service to others. Doing "small things" in order to serve God by making life easier for others is an ability that even the most severely disabled persons possess. These small actions, if done with the right motive, can infuse the person's life with a continuing sense of meaning, purpose, and usefulness.

Directing their efforts to serve God by serving others helps patients to focus attention on others and divert it off of their own problems. Patients can turn their problems over to God and focus on trying to help others cope with their problems, which enables them to stop obsessing about problems and start thinking about the good that they can do for others. The end result is that the patient may be able to relax and allow the body to heal itself, a process that may not have occurred if the patient had continued to be highly stressed, anxious, or depressed over his/her own situation. Consequently, having a strong religious faith that is expressed by loving and serving others gives those with chronic or serious illness a sense of self-esteem and self-worth based on their religious identities, rather than on their physical capabilities.[37,38]

No matter how physically ill or disabled, a person with faith still possesses an ability or talent that can be used to serve God by serving others. Where there is consciousness and personal will, there is always possibility for purposeful and meaningful spiritual activity that can give hope and satisfaction, even in the worst of circumstances. The two cases below help to put a human face on the scientific findings described earlier.

CASE REPORTS

CASE 1

John, 75 years old, had been physically active on his 100-acre cattle ranch throughout his life. He was an outgoing man, well liked by his neighbors; he prided himself in being physically healthy and independent, still able to work. While out on the field one day, he experienced the sudden loss of function in his right arm and right leg. In the hospital, the physician informed him that he had experienced a severe stroke, and that his prognosis was grim. He was transferred to a nursing home for rehabilitation prior to being discharged home into the care of his elderly wife. Initially, John lapsed into a deep depression. He became noncompliant with his antihypertensive medication, despite vigorous protest by his concerned wife. She called their pastor and asked him if he could do anything to help John.

The pastor visited every week, encouraging John, praying with him and reading scriptures from the Psalms to give John hope. As John began to feel better emotionally, he started attending religious services regularly again (with the assistance of a wheelchair). At the encouragement of the pastor, John began regularly phoning people in his church who were experiencing health problems and disability, listening to them, encouraging them, and praying with them for strength — even as he was helped. John encouraged these people to identify their talents and gifts, and use those gifts to serve others — just as his pastor had encouraged him to do. This gave John a renewed sense of meaning and purpose, a feeling that God was using him and his own physical disability to relieve the suffering of others.

CASE 2

Sarah was in her early 60s and had also experienced a stroke, but one that left her paralyzed from the neck down. She was as alert and completely aware of her surroundings as she had been before the stroke. Nevertheless, the stroke left her unable to move a single muscle in her body, with the exception of her eyelids. She was kept alive on a ventilator, requiring total care. The nurses worked out a system of communication that relied on Sarah blinking her eyelids; two blinks signifying "yes," and four blinks signifying "no." Sarah lapsed into a deep depression, losing hope of ever having a meaningful life again. Through a series of eye blinks, she requested that the nurses remove the ventilator and allow her to die.

Members from Sarah's church came by frequently for visits. She had been active in the church as a member of the prayer ministry. One of her friends who had worked with her on the prayer ministry suggested that she once again start praying for others. Sarah blinked twice, signifying "yes." Her friend talked with the nursing staff and asked them if it was possible to construct an apparatus that could hold a piece of paper on a board above Sarah's head with the names of people in the church who needed prayer. Every week, her friend would come by and report to Sarah how the people in the church were doing for whom she had been praying, and also add people to the list with new prayer needs. This simple activity of prayer gave Sarah new purpose and meaning in life. Although she did not live very long after that, those who were close to her said that she felt useful and significant right to the end.

Religion and Health Outcomes

If many people with chronic illness report that religious beliefs and practices provide hope, reduce anxiety, and promote a general sense of well-being and purpose in life, to what extent is this objectively verifiable? Nearly 850 studies have now examined the relationship between religious involvement and some indicator of mental health. Many of the studies have been conducted in medically ill patients or older persons with chronic disability. The vast majority of such studies do indeed find that religious involvement is associated with greater well-being and life satisfaction, greater purpose and meaning in life, greater hope and optimism, less anxiety and depression, more stable marriages, and lower rates of substance abuse.[4] In fact, a number of the studies have involved clinical trials in which a religious intervention for the treatment of anxiety or depression was compared with standard care or no treatment. The majority of those studies found that the religious intervention was associated with a more rapid reduction in symptoms of depression or anxiety.

It appears particularly relevant to measure this association between religious involvement and better mental health status in persons with chronic physical disability or those experiencing other significant life stressors. For example, studies of patients hospitalized for medical treatment show that those with the greatest amount of disability experience the most protection from depression if they are religious.[15] The same finding has been reported[37,39] by investigators at Yale University, who found even the perception of disability altered among the more religious. As noted earlier, recovery from depression also appears to be more rapid among disabled persons with high levels of intrinsic religiousness.[26] All of these studies controlled for social support, family support, and other relevant covariates.

Similarly, studies of mental health disorders and substance abuse have shown that religious involvement buffers against the negative effects of physical illness or stressful life events in many different samples, including twins,[40] community-dwelling adults,[41] medical patients,[17,42] and other populations.[43,44] These findings were determined in different populations by different investigators located in different parts of the country. It therefore should not be surprising that the effects of religion on reducing psychological stress could have physiologic consequences that impact physical health status as well, given the increasingly documented adverse effects of negative emotional states on cardiovascular and immune functioning.[45,46]

Associations Between Religion and Physical Health

It has long been known that patients under much stress are more prone to blood pressure elevation, myocardial infarction, stroke, peptic ulcer disease, irritable bowel, and diseases associated with impaired immune function (infection and possibly even cancer). If religious involvement helps to reduce psychological stress and increase social support, then it may help to buffer the negative effects of stress on physical health. Religiously committed persons are also less likely to engage in unhealthy behaviors such as cigarette smoking, excessive alcohol use, or risky sexual practices. In this way, religion may help to prevent the negative health consequences that follow these unhealthy behaviors. We review briefly the evidence that supports these hypotheses.

It is well documented that religious groups such as Seventh-Day Adventists, Mormons, and Amish experience lower rates of both cancer and cardiovascular disease, which have been at least partly explained by healthier dietary practices and prohibitions against smoking and alcohol use.[47] Nevertheless, these religious groups also encourage close family life and supportive communities, which may have effects on health through other explanatory mechanisms.

Several studies report an association between religious involvement and immune system function. In a study[48] of 1718 subjects ≥65 years old conducted by Duke University researchers, infrequent church attendance was associated with nearly twice the risk of high serum interleukin-6 (IL-6) concentrations, indicative of immune system instability.[48] Higher religious attendance in 1986, 1989, and 1992 predicted lower IL-6 concentrations in 1992, although after controlling for other covariates (age, gender, race, education, chronic illness, physical functioning), only the cross-sectional 1992 association remained statistically significant. High concentrations of IL-6 have been associated with conditions such as HIV infection, osteoporosis, Alzheimer disease, diabetes, and certain forms of cancer.

Woods et al.[49] at the University of Miami studied religious activities and immune function in 106 HIV-seroposi-

tive homosexual men. Religious activities (prayer, religious attendance, spiritual discussions, reading religious/spiritual literature) were associated with significantly higher CD4+ counts and CD4+ percentages. The investigators demonstrated that the effects of religious behaviors on immune function were not confounded by disease progression (i.e., as disease worsened and immune function decreased, persons were unable to participate in religious activity). In this study, religious coping was related to lower Beck Depression Inventory scores ($p < 0.01$) and lower Spielberger Trait Anxiety Inventory scores ($p = 0.08$), but not with specific immune markers.

Schaal et al.[50] at Stanford University examined correlations between religious practice and endocrine and immune function in 112 women with metastatic breast cancer. Subjects reported their frequency of attendance at religious services and the importance of religious or spiritual expression in their lives. Lymphocyte numbers and natural killer (NK) cell activity were assessed with results averaged over two blood samples taken between 0800 and 1000, about one week apart. Religious expression was positively associated with NK cell numbers (Spearman $r = 0.19$, $p = 0.02$), T-helper cell counts ($r = 0.16$, $p = 0.05$), and total lymphocytes ($r = 0.15$, $p = 0.05$). These effects were not moderated by patients' social network size or by cancer treatments (e.g., chemotherapy) that affect immune cell counts.

Studies are currently being planned at Johns Hopkins and other major universities to more carefully examine the relationship between religious activity and immune functioning status.[51] At Johns Hopkins, a sample of 80 African-American women with early-stage breast cancer will be randomly assigned to either a spiritual intervention (group support and prayer) or a control group. Immune function, speed of metastasis, and survival will be compared between intervention and control groups over several years.[52]

Thus, there are multiple psychological, social, behavioral, and physiologic mechanisms by which religious involvement may impact physical health and speed of recovery from disease. A number of studies[53-58] have discovered that religious activity — particularly when it occurs in the setting of community (such as involvement in religious worship services and associated voluntary activity) — is associated with a longer life span. Even when religious activities do not impact the course of physical disease or prolong life, they may still enhance the quality and meaning of life.[4]

Can Religion Have Negative Effects on Health?

There is no doubt that religious beliefs and activities, particularly when taken to extremes, can adversely affect both mental and physical health status. Religion has been used to justify anger, hatred, aggression, and prejudice. Religion can be used to pass judgment on others and exclude others from a social group. Religion can be restrictive and confining, rather than freeing and life-enhancing. Religious beliefs and activities that promote generosity, forgiveness, thankfulness, kindness, understanding, and compassion are more likely to be associated with mental and physical health benefits, whereas those that separate people from the community and family, encourage unquestioning devotion and obedience to a single religious leader, or promote religion as a healing practice to the exclusion of traditional medical care are more likely to adversely affect health over time.

Additional Information

We have only briefly reviewed in this article a few of the studies exploring the religion–health connection. A surprising number of studies have been published, most in the last decade. We look forward to continued growth of the research as well as more fine-tuning of the clinical implications. For those wanting more information about studies in this area, a variety of resources are available. These include *The Healing Power of Faith*,[38] *Handbook of Religion and Mental Health*,[59] *The Faith Factor*,[60] and *Handbook of Religion and Health*.[4] The latter volume (2001) reviews, analyzes, and discusses the results and clinical implications of nearly 1200 studies on the religion–health relationship.

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EXTRACTO

OBJETIVO: Revisar y discutir algunas investigaciones, realizadas en las últimas décadas, que investigan el rol de la religión en ayudar a los pacientes a lidiar con las enfermedades serias.

FUENTE DE DATOS: Aún cuando, esto no es una revisión sistemática de la literatura; si provee una muestra de los estudios que han examinado la relación entre el envolvimiento religioso, como lidiar con las enfermedades y consecuencias en la salud. Esta muestra de estudios reflejan los hallazgos durante el pasado siglo.

EXTRACCIÓN DE DATOS: Estudios epidemiológicos publicados en la literatura en el lenguaje inglés fueron revisados y discutidos.

SÍNTESIS: Un número de estudios prospectivos, transversales, y bien diseñados han examinado la relación entre las creencias y/o actividades religiosas y la adaptación a enfermedades físicas en pacientes con

condiciones médicas generales, desórdenes neurológicos, enfermedades cardíacas, fallo renal, SIDA, y portadores de otros desórdenes físicos. Esta revisión demuestra el uso generalizado de la religión para lidiar con desórdenes médicos y provee evidencia circunstancial del beneficio posible de ésta práctica.

CONCLUSIONES: Cuando la gente tiene una condición física, muchos de los pacientes confían grandemente en las creencias y prácticas religiosas para aliviar la tensión y mantener el sentido de control; como también, mantener la esperanza y el sentido de propósito y significado de la vida. El envolvimiento religioso parece permitir a la gente enferma a lidiar mejor con sus condiciones, particularmente aquellos con condiciones serias de salud o condiciones médicas incapacitantes, y experimentar un crecimiento psicológico, más que darse por vencido o rendirse ante la condición física.

Wilma M Guzmán

RÉSUMÉ

OBJECTIF: Le but de cet article est de revoir et discuter la recherche exécutée au cours des dernières décennies au sujet de comment la religion aide aux patients à faire face aux maladies sérieuses.

SOURCES DE DONNÉES: Tandis que ceci ne sera pas une evaluation systématisée de la littérature, il fournit un groupe d'études qui ont évalué la relation entre la participation religieuse, l'abilité de faire face aux maladies sérieuses, et les effets sur la santé. Cet échantillon d'études reflet les résultats d'une revue systématique exécutée par les auteurs de la recherche faite durant ce siècle.

EVALUATION DES DONNÉES: Les études épidémiologiques publiées dans la littérature anglaise a été revue et discutée.

RÉSUMÉ: Un grand nombre d'ênquetes transversales et prospectives ont examiné la relation entre les croyances et les activités religieuses et l'adaptation à la maladie physique chez les patients avec des conditions médicales générales, les infirmités neurologiques, les maladies cardiaques, l'insuffisance rénale, le SIDA, et plusieurs autres infirmités physiques. Cette revue démontre que la religion est fréquemment utilisée afin de faire face aux maladies et donne la preuve indirecte du bénéfice potentiel de cette pratique.

CONCLUSIONS: Lorsque une maladie sérieuse se développe, plusieurs s'appuient sur les croyances et les pratiques religieuses afin de soulager le stress, maintenir un sentiment de contrôle, et de garder l'espoir ainsi q'un sentiment de valeur et but à la vie. La participation dans la religion semble aider les malades, particulièrement ceux avec les maladies sérieuses et débilitantes, afin de mieux faire face à la situation et de sentir une croissance psychologique de leur expérience négative de la santé, au lieu d'être défi et accablé.

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