Religion and Health: Holistic Wellness From the Perspective of Two African American Church Denominations

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This study examined differences in beliefs, concerns, practices, and perceptions of susceptibility to illness by gender and religion in 2 Baptist and 3 Seventh Day Adventist (SDA) African American churches. A modified Health Belief Model Questionnaire was completed by 363 African Americans. Health beliefs were more related to gender than to religion. Results revealed that women were concerned about being ill, being susceptible to illness, and expressed confidence in doctors. Men exercised more frequently, were sick less, and felt less susceptible to illness. SDAs believed in following a certain diet and avoiding alcohol and cigarettes. SDA women and Baptist men thought more about health than did SDA men or Baptist women.

Historically, health has been defined as the absence of disease (Edlin & Golanty, 1988; Gross, 1980; Martin & Martin, 1982). However, recent attempts have been made to broaden the concept of health to that of promoting a holistic perspective of wellness (Edlin & Golanty, 1988; Gross, 1980; Martin & Martin, 1982; U.S. Department of Health and Human Services [DHHS], 1991; Witmer & Sweeney, 1992). Existing views of health are limited by the narrow conceptualization of the term itself. Little attention has been devoted to the concept of holistic wellness as one approach to addressing national health concerns as this relates to spirituality. *Holistic wellness* promotes a "conscious and deliberate process by which people are actively involved in enhancing their overall well-being—intellectual, physical, social, emotional, occupational, spiritual" (Hartfield & Hartfield, 1992, p. 164). Individuals are encouraged to take responsibility for themselves so that the fullness of life can be achieved by adopting an optimal lifestyle. A holistic approach to health acknowledges the interrelatedness and integration of the physical being with the social being and the spiritual being.

Currently, in the counseling profession, spirituality has been an important component of holistic wellness (Chandler, Holden, & Kalonder, 1992; Witmer & Sweeney, 1992). Spirituality is significant for health and wellness

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because it addresses important questions about the meaning of life and the pursuit of life quality. Therefore, religion as an aspect of spirituality may influence one to examine health issues by (a) encouraging a healthy lifestyle, (b) prescribing healthy behaviors that prevent illness, (c) providing support systems when faced with stressful life events, and (d) fostering spiritual attitudes of faith that will sustain an individual in a crisis (Jarvis & Northcott, 1987). Although there is an awareness among counselor educators of the significance of religiosity and spirituality, few counselor education programs include these issues in training (McCullough, 1993). Recently, more attention has been devoted to understanding how religion and spirituality interrelate as a part of the helping relationship (Brigman, 1992). As a result, the American Counseling Association (ACA) adopted a resolution to advocate for optimum health and wellness as a paradigm for counseling (J. E. Myers, 1991, 1992; J. E. Myers, Emmerling, & Leafgren, 1992). A holistic approach emphasizing optimum wellness may provide a more complete model for counselor education training.

PURPOSE

This study examined religious and health beliefs of two dissimilar African American religious denominations. Specifically, the study examined differences in beliefs, concerns, practices, and susceptibility to illness, by gender and religion in two Baptist and three Seventh Day Adventist (SDA) African American churches. Implications for holistic wellness in African American churches was also explored. A study of African American men and women in two religious denominations is important because research has shown that race (Hatch & Derthick, 1992; Weissfeld, Kirscht, & Brock, 1990) and religion (Beeson, Mills, Phillips, Andress, & Fraser, 1989; Jarvis & Northcott, 1987; Troyer, 1988) as well as age, gender, and culture (Bearon & Koenig, 1990; Crose, Nicholas, Gobble, & Frank, 1992) influence health beliefs.

An excellent example of the role of a healthy lifestyle is found in the prescriptions of the SDA church (Jarvis & Northcott, 1987; Phillips, 1975; Troyer, 1988). SDAs in general have been studied more than any other religious denomination (Troyer, 1988) because they follow certain dietary practices that require them to abstain from eating pork, from smoking, and from drinking. Given the practice of a healthy lifestyle, Seventh Day Adventists (SDAs) who follow church doctrine have been found to be low risk for certain cancers and diseases that are prevalent in the general population. For example, SDAs have fewer incidences of certain diseases (colon cancer, heart conditions) for which African Americans are likely to show high rates (Beeson et al., 1989; Jarvis & Northcott, 1987; Phillips et al., 1980; Troyer, 1988). Although few studies have been conducted of African American SDAs, research has shown that those who are vegetarians often have higher blood pressure levels than do White Seventh Day Adventist vegetarians (Melby, Goldflies, Hyner, & Lyle, 1989). In another study of African American SDAs, it was reported

that over a period of 7 years, most of the deaths (77%) were from cardiovascular diseases. However, only 8% of deaths were due to cancer (Murphy, Blumenthal, Dickson-Smith, & Peacy, 1990). Thus, this indicates that there may be a predisposition to certain illnesses among African Americans.

RELIGIOUS AND HEALTH BELIEFS AMONG AFRICAN AMERICANS

Historically, the African American community has been considered the most religiously dedicated group in America (Wingfield, 1988). The significance of religion for African Americans was noted by Lincoln (1974), who stated that, "Black people have always taken their religion seriously. For them religion is personal—almost tangible; it is never an abstraction disassociated from the here-and-now, the experiences that shape the life situations of real people who are suffering and dying and struggling against forces they don't understand" (p. 149). As a result of this influence, the African American church has been an organization that has championed the causes of a community that lacked full access in an unjust American society. For instance, Lincoln (1989) noted that the church "has been and is for Black America the mother of our culture, the champion of our freedom, the hallmark of our civilization" (p. 3). Therefore, the church often serves as a powerful, multifaceted institution that not only influences the spiritual needs of the individual, but also serves as a framework for one's lifestyle and cultural identity.

Mendes (1982) noted that the influence of religion in the African American community is also evident among those who do not attend church. Although fewer African Americans are active in church today, religiosity, in addition to family and friends, remains an important dimension in their lives (Jackson, Chatters, & Neighbors, 1986). According to a recent study (Billingsley & Caldwell, 1991), 77% of African Americans considered church to be very important and 84% reported that they were religious. It can be concluded that for the average African American, religiosity is an important psychosocial dynamic that not only shapes values but influences the thoughts, actions, and behavior of the whole person. Therefore, spiritual unity cannot be fragmented from other parts of the self and is consistent with the notion of holistic wellness (L. J. Myers, 1988).

Although health beliefs and spiritual beliefs are intertwined (Roberson, 1985), relatively little attention has been devoted to examining how a religious lifestyle among African Americans becomes an integral part of their health beliefs. Several factors may explain the lack of attention to the interrelatedness of health and religion: (a) more emphasis has been placed on the social and political mission of the African American church than on the theological mission (Ellison & Gay, 1990); (b) more attention has focused on citing the consequences of not being healthy by reporting on rates of hypertension, cardiovascular disease, or AIDS; (c) helping professionals often fail to acknowledge the religiousity of the African American; and (d) African American churches fail to recognize that religiosity is a dimension of

holistic wellness (Ellison & Gay, 1990; McCullough, 1993). Because both health and religion are significant in the lives of African Americans, there is a real opportunity for the two factors to interact.

SCOPE OF THE PROBLEM

Despite attempts at health promotion aimed at increasing the life span of Americans, disparities in health, mortality, and homicide rates between African Americans and the majority population continue to be a challenge (DHHS, 1991). The average life expectancy for the general American population is now 75 years of age (DHHS, 1988). The average life expectancy for Whites is 76 years. However, for African Americans there seems to be a despairingly low life expectancy of 69.2 years. The quality of life for African Americans as a collective group is clearly below that of White Americans, thus attributing to an early death rate. Even greater disparities are reflected for gender. The average life expectancy for White women is 79.2, for African American women it is 73.5 years, for White men it is 72.7, and for African American men it is 64.8 years (DHHS, 1989).

Weissfeld et al. (1990), in a study of health beliefs, found that certain demographic correlates of health seem to associate with favorable health concerns. For instance, Weissfeld et al. (1990) noted that valuing healthy behaviors was found to be associated with being African American, female, older, and in a lower socioeconomic status. Furthermore, gender differences have been observed in all aspects of mental and physical health (Crose et al., 1992). For example, how men and women view and react to illness is likely to be different. Often, men are more likely than women to deny or ignore symptoms.

Several factors have been isolated as major influences on life expectancy. They are heredity, environment, health care, and lifestyle. The leading causes of death for all Americans are heart disease and cancer (DHHS, 1993). However, African Americans are likely to have a disproportionately higher incidence of mortality rates for such chronic illnesses as coronary heart disease, strokes, hypertension, cancer, and diabetes (Livingston, 1993). Although heredity is a predisposing factor to death, these factors can be mediated by lifestyle, which has a direct bearing on life expectancy. According to Johnson (1986), lifestyle is the major contributor to disease and death and is therefore a crucial aspect of a holistic wellness philosophy. To practice holistic wellness, an individual must realize the interdependence of the whole person, be willing to take responsibility for oneself as an entire being, and create a sense of well-being that becomes manifested in the person's lifestyle.

METHOD

Participants

A modified version of the Health Belief Model Questionnaire (Jette, Cummings, Brock, Phelps, & Naessens, 1981; Weissfeld, Brock, Kirscht, &

Hawthorne, 1987; Weissfeld et al., 1990) was completed by 390 African American participants between the ages of 18 and 50 at three African American SDA churches (46%) and two African American Baptist churches (49%) in a central Ohio city. After adjusting for incomplete questionnaires, the total sample size was reduced to 319, of which 32% were men and 68% were women. SDAs represented 46% of the sample and Baptists represented 49%. Choice of denomination was determined by the purpose of the study. SDAs avow a religious doctrine that teaches principles of wellness and a healthy lifestyle that emphasizes diet and nutrition, whereas the largest percentage of African American church-goers are Baptists (Lincoln & Mamiya, 1990).

Instrument

Participants completed a modified version of the Health Belief Model Questionnaire (HBMQ; Becker, 1974; Jette et al., 1981; Weissfeld et al., 1987; Weissfeld et al., 1990). The HBMQ is a psychosocial measure designed to assess an individual's perceptions about his or her health behavior. Generally, the HBMQ contains items that address the following categories: general health concern, general health threat, severity, and benefits and barriers. General health concern items refer to the tendency of the individual to adopt healthful actions and behavior that would reduce the risk of illness. General health threat items refer to an individual's susceptibility to certain illnesses and the perceived consequences of a severe illness. Severity refers to the individual's ideas about the seriousness of an illness. Benefits and barriers refer to the degree to which value has been placed on adopting healthy actions (Weissfield et al., 1987).

In this study, General Health Concern items were modified from the Michigan Health Belief Questionnaire, which has 32 items (Weissfeld et al., 1990). Coefficient alpha reliabilities for the Michigan Health Belief Questionnaire ranged from 0.65 to 0.89. The modified version of HBMQ used in this study contained four subscales labeled Practice, Concerns, Susceptibility, and Beliefs. Questions about Health Practices required a "yes" or "no" response to questions such as "Do you exercise regularly?" Questions about Health Concerns required Likert-type responses to questions such as "How often do you think about your health/wellness?" The category, susceptibility to illness, required participants to check the appropriate response about illnesses in the family of origin. Susceptibility was measured by Likert-type items about the likelihood of future illnesses, such as cancer, AIDs, or a stroke. A 5-point Likert scale was used to assess questions about the importance of Health Beliefs about diet, exercise, and so forth.

Procedure

We initially contacted three African American Baptist churches and three SDA churches by telephone. A follow-up letter outlining the details of the

study was sent to the minister of each church. Ministers were again contacted by telephone to make specific arrangements for data collection. Data were collected during Sabbath School (Saturday morning Bible study) at the SDA churches and during Bible study (Wednesday night) at the two Baptist churches. The minister of each church decided when data collection would be the least disruptive to worship services. The questionnaire required about 15 minutes to complete.

RESULTS

Descriptive demographics indicated that most of the participants reported having had either some college (35%), a college degree (26%), or post-college training (16%). Participants reported employment in service, business, and professional occupations (62%). Fifty-five percent of participants reported an income between $20,000 and $40,000, 36% reported an income below $20,000, and 7% reported an income between $40,000 and $60,000. Spouses' incomes were reported as $20,000 to $40,000 (55%), below $20,000 (36%), and $40,000 to $60,000 (7%). Most of the participants (55%) reported being married, while 36% indicated that they were single. A majority had visited a physician during the past year. In response to the descriptive Susceptibility data concerning the likelihood of having certain illnesses, participants reported that they had no known high blood pressure (29%), heart disease (65%), diabetes (56%), cancer (67%), AIDs (82%), stroke (72%), or high cholesterol (58%).

Chi-square tests were used to analyze the relationship of both the Practice and the Belief variables across gender and religion. The Practice variable of exercising regularly was significant for gender, $\chi^2 = 10.57$, $df = 1$, $p < .001$. More men responded "yes" to exercising regularly. The chi-square test also revealed that the Practice variables of being a vegetarian, eating meat, and using alcoholic beverages differed significantly across religion, $\chi^2 = 46.03$, $df = 1$, $p < .0001$; $\chi^2 = 36.42$, $df = 1$, $p < .0001$; and $\chi^2 = 37.72$, $df = 1$, $p < .0001$, respectively. Baptists were more likely than SDAs to practice behaviors associated with unhealthy lifestyles. Significant chi-square tests were reported for the Belief variables. SDAs more so than Baptists believed that choice of diet, avoiding alcohol, and cigarettes were more important to health, $\chi^2 = 20.79$, $df = 2$, $p < .0001$; χ^2 16.76, $df = 2$, $p < .0001$; and $\chi^2 = 24.85$, $df = 2$, $p < .0001$, respectively.

A 2 × 2 analysis of variance (ANOVA) was performed for each of the five dependent Concern variables: thinking about your health, getting sick compared to others your age, helpfulness of doctors, effectiveness of the medical profession in prevention of illness, and ease with which medical care is available. The independent variables were gender and religion. For the dependent Concern variable, thinking about your health, a significant interaction was observed between gender and religion ($p < .05$). Figure 1 illustrates this interaction. Levels of concern when thinking about health

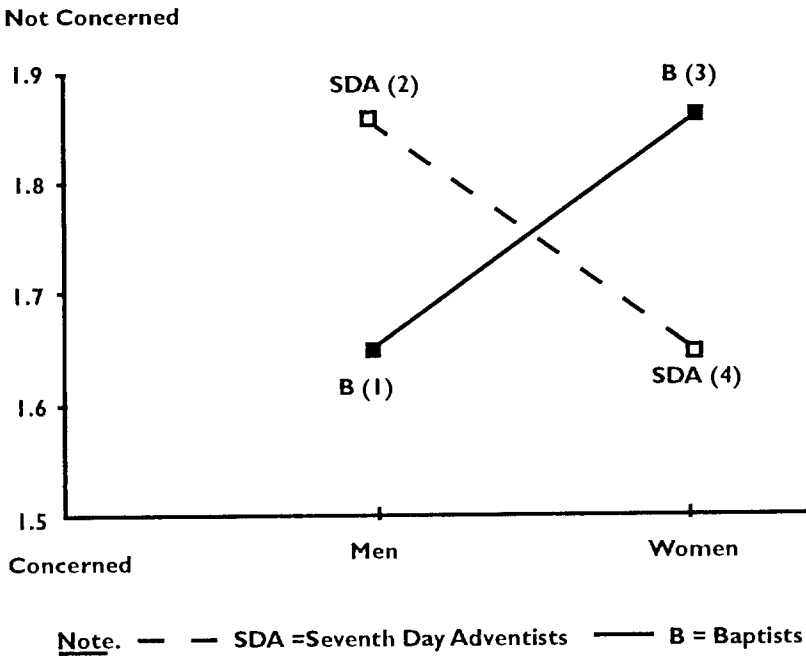

FIGURE 1

Interaction of Religion and Gender for the Health Concern Variable "Thinking About Your Health"

depend on the specific combination of gender and religion. For men, concern was greater (i.e., lower number) for the Baptists ($p < .10$), whereas for women, concern was greater for SDAs ($p < .02$). For Baptists, men were more concerned than women ($p < .07$), whereas among the SDAs, women were more concerned than men ($p < .05$).

For two of the dependent Concern variables, getting sick compared to others your age and effectiveness of the medical professional in prevention, a main effect of gender was observed, $p < .05$ (see Table 1). Men thought that when they were compared with individuals of their own age, they were sick less often than women. Women less than men perceived the medical profession as less effective in prevention of illness. Gender and religion were not significant and did not account for significant amounts of variability in responding to questions about the helpfulness of doctors and the ease of obtaining medical care.

For the dependent variable Susceptibility, a three-way ($2 \times 2 \times 7$) analysis of variance was performed. The independent variables were gender and religion (both between factors) and future illness (within factor). Main effects were observed for both gender ($p < .05$) and future illness ($p < .0001$).

TABLE 1

Gender Differences for Concern Variables Getting Sick and Prevention

Concern Variable	*M*	*N*	*SE*
Getting Sick Compared to Others Your Age[a]			
Men	4.28	101	0.09
Women	3.91	219	0.61
Effectiveness of Medical Profession in Prevention[b]			
Men	2.56	101	0.10
Women	2.83	218	0.06

[a]Higher values indicate less sickness concern. [b]Higher values indicate less effectiveness evaluation.

Men, more so than women, thought that they were less susceptible to certain illnesses in the future (see Table 2). Regarding the significant effect of future illnesses, there was less concern about AIDs and more concern about high blood pressure (see Table 3).

DISCUSSION

This study was designed to examine differences in the health concerns, beliefs, practices, and susceptibility to illness relative to gender and religion in two African American Baptist and three African American SDA churches. In general, gender was found to be more important than religion. African American men more so than women reported the practice of exercising regu-

TABLE 2

Mean Likelihood Comparisons Among Susceptibility to Future Illness

Future Illness	*N*	*M*[a]	*SD*
AIDS	241	4.25_a	0.57
Stroke	256	3.80_b	0.95
Coronary Heart Disease	261	3.72_{bc}	1.04
Cancer	252	3.68_{bc}	1.03
Diabetes	276	3.63_c	1.16
High Cholesterol	275	3.45_d	1.25
High Blood Pressure	304	3.22_e	1.34

Note. Individual *t* tests were performed using pooled error term (EMS). High scores indicate less concern about likelihood of susceptibility.

[a]Means with same subscript are not significantly different at the $p < .05$ level.

TABLE 3

Means for Susceptibility to Future Illnesses by Gender

Sex	N[a]	M	SE
Men	614	3.82	0.09
Women	1251	3.54	0.07

Note. See Table 2 *Note.*
[a]*N* based on averages across seven future illness categories.

larly. Men may also view exercise as an activity for "real men," and therefore may feel the pressure to exercise. This finding was especially interesting given that African American men tend to have shorter life spans than all other groups in the population. As expected, SDAs tended to follow the proscriptions of their religion by avoiding alcohol and cigarettes and adhering to the practice of vegetarianism.

Although Belief and Practice items, such as smoking, using alcohol, and dieting, were significant, access items as indicated by questions such as, "Overall, how easy is it to get medical care when you want it?" or "How important is getting regular medical checkups?" were not significant. In fact, research has shown that access and structural barriers, which are often mediated by poverty, are major influences on wellness (DHHS, 1991). It may be that access issues are not important for the group under study given their fairly high rankings on SES variables. Furthermore, a majority reported having visited a physician during the past year. These findings are consistent with Weissfeld et al. (1990), who reported a negative association between education, SES, and concern for certain health variables.

The interaction of gender and religion on the Concern variable, thinking about health, offered surprising results. Baptist men thought about their health more than SDA men and Baptist women, a finding that is inconsistent with previous research that reported that SDAs and women are generally more concerned about health (Weissfeld et al., 1990). This finding is inconsistent with the notion that men are likely to deny or ignore their health concerns. Baptist men may possibly be responding more to the idea that as men they should be more health conscious than they are at present.

Several other concern variables were significant for gender. Findings suggested that women placed less confidence in the medical profession as a source of prevention and that, when ill, doctors were helpful. This pattern is also inconsistent with previous findings, most of which suggest that women are more likely to be consumers of health services and view illness as a greater health treat than are men (Weissfeld et al., 1990). In addition, African American women placed value on promoting good health habits (Weissfeld et al., 1990). The finding that men felt less susceptible to certain

illnesses in the future is consistent with past research. Weissfeld et al. (1990) speculated that this perception is a part of the socialization process for men.

That there was a perception of greater susceptibility to high blood pressure is consistent with previous research (Livingston, 1993), and confirms that African Americans are now well aware of this fact. On the other hand, there seems to be little concern about susceptibility to AIDs, given its high incidence among African Americans and women (Sterk-Elifson, 1994). Given the deadly consequences of both diseases, continuous education and prevention activities are necessary for African American populations.

Differences would have been expected to be significant for religion on the Concerns and Susceptibility variables for SDAs. It may be that SDAs are well aware of lower disease rates within the group, and there is little reason for concern. Baptists would have been expected to show greater concern and feel more susceptible to illness than SDAs. It may be that the relationship of religious health and spiritual health is not realized or may be taken for granted. It may be that Baptists believe that "leading a good Christian life" and being "close to God" may serve as a protector of health or a reward for good behavior or even to prevent illness (Roberson, 1985). African American Baptists have been shown to be religiously conservative (Bearon & Koenig, 1990), yet we know little about how that translates into lifestyle. Research examining how religion influences the lifestyles of African American Baptists would contribute to our understanding of their concepts of wellness. In addition, longitudinal studies may reveal whether SDAs are, in fact, less susceptible to the illnesses (certain cancers) that African Americans are more prone to and whether they live longer than other African Americans.

The lack of more significant findings for SDAs suggests that this group takes seriously certain aspects of their religious practices and have committed them to lifestyle. The lack of significant findings may also suggest that there are very few differences in these two groups beyond the Practice variables of adhering to a vegetarian diet, not using alcohol, or smoking. On the other hand, few significant findings for Baptists may imply that they do not see religion as a holistic venture that acknowledges the interrelatedness and integration of the total person (Witmer & Sweeney, 1992). Lincoln's (1974) observation that theology for African Americans is "personal—almost tangible and never an abstraction disassociated from the here-and-now" (p. 149) seems to imply otherwise. Baptist churches have a real opportunity to address holistic wellness among African American congregations.

These findings suggest that counselor educators and faith communities need to acknowledge the interrelatedness of wellness and religion in accordance with the ACA resolution (McCullough, 1993; J. E. Myers et al., 1992). In this spirit, the following recommendations are suggested. First, counselors and faith communities should adopt a holistic wellness philosophy that is integrated in all teaching and preaching. Such a philosophy supports an optimal lifestyle based on prevention rather than remediation of disease. Second, African American churches have a captive audience of large num-

bers of people. Counselors and helping professionals should seize this opportunity to promote holistic wellness by working with ministers to educate the entire individual. This may involve organizing wellness fairs, workshops, and health screenings at churches. For example, a counselor may participate by showing how religion and psychological wellness interrelate or provide information on how the Christian mediates to avoid violent encounters (environmental wellness).

Finally, given that religion is an important part of the African American experience and that large numbers of African Americans with various SES levels are congregated in one place on a regular basis, counselors have an excellent opportunity to conduct research on large numbers of families. Future studies should explore lifestyle practices as they relate to the prevalence of mortality from certain diseases for African Americans. Such studies may reveal whether there is a genetic predisposition to certain illnesses or whether they are environmentally influenced by lifestyle. Of particular interest here would be studies comparing and contrasting the health beliefs, concerns, practices, and susceptibility of one group of African American women with another on certain variables such as socioeconomic status or age.

This study of health beliefs has made a timely contribution to an area of great national concern. This study was limited in that it used a nonrandom sample of SDAs who already practiced a healthy lifestyle. The importance of adopting a holistic wellness lifestyle is essential to adopting an optimal lifestyle. A holistic wellness lifestyle based on a religious philosophy has implications for African American churches. Historically, the African American church has been the pulse of the African American community; therefore, African American churches are in a position to motivate African Americans to adopt healthy lifestyles to ensure holistic wellness.

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