Religious Orientation and Health Status: Predictors of Adult Attachment Behaviors?

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Introduction

Previous research suggests that there is a relationship between religious orientation and current health status (1).

Evidence also suggests a relationship between religious orientation and adult attachment behavior (2).

Thus, one may conclude from this evidence that there could be a relationship between current health status and adult attachment behavior.

However, little research has been done to examine this relationship.

Therefore, this study examined if responses to an attachment behavior questionnaire would be influenced by the religious orientation and current health status of the participants.

Methods

A community sample of 131 adults completed a revised form of the Age Universal I/E to determine the religious orientation of each participant. Also, a self-report measure was administered to the participants that assessed their perceived health status.

Then, the participants completed the Attachment Style Questionnaire, which measures different constructs of attachment.

Mean age: 50 Range: 40-70
Gender: 70% Females, 30% Males

Measures

Age Universal I/E:
A self-report scale used to measure Intrinsic/Extrinsic religiosity in adults and children. It consists of 20 items (11 extrinsic, 9 intrinsic). Items include such statements as “I pray mainly to gain relief and protection” (item 8; extrinsic) (3). A revised form of the Age Universal I/E was used for this study and consisted of 14 items.

Self-Report of Current Health Status:
A self-report measure that assesses the participants’ perception of their health over the last 30 days. The question used was “In general, how would you describe your health during the past month? where 1=poor, 2=fair, 3=good, 4=very good, and 5=excellent."

Attachment Style Questionnaire:
A self-report questionnaire designed to measure adult attachment using five subscales of Confidence, Discomfort with Closeness, Need for Approval, Preoccupation with Relationships, and Relationships as Secondary (4).

Results

Pro-religious adults who reported ‘fair’ or ‘good’ physical health scored significantly lower on levels of discomfort with relationships than did those reporting a ‘very good’ health status (see Table 1).

Non-religious adults reporting ‘excellent’ or ‘good’ health were found to score higher on relationships-as-secondary than did those reporting ‘very good’ health (see Table 2).

Results did not reveal any differences between pro-religious and non-religious individuals with “fair” or “good” health. It is unclear as to why this group did not produce the same results. Similarly, it is also unclear why those with a pro-religious orientation and “excellent” health status did not statistically differ from those with “fair” and “good” health.

Furthermore, this study examined if responses to an attachment behavior questionnaire would be influenced by the religious orientation and current health status of the participants.

Discussion

The findings suggest that there is some type of relationship between religious orientation, current health status, and attachment behavior.

Pro-religious individuals with “fair” or “good” physical health may feel more comfortable with relationships than individuals with “very good” health because these individuals might rely on others to help care for them because of their poorer health status. This dependence on others could create less anxiety in relationships, while individuals who consider themselves to be in “very good” health do not need others to take care of them and, therefore, may feel more uncomfortable in their relationships.

Non-religious individuals with “excellent” or “good” health may have scored higher on relationships-as-secondary because these individuals are in excellent or good health and do not need to rely on relationships for support, not even a higher power. Therefore, they may have less concern for relationships and can focus on other things in their lives, such as their career, etc.

The non-religious individuals who reported “very good” health should have had the same results as the non-religious individuals with “excellent” or “good” health. It is unclear as to why this group did not produce the same results. Similarly, it is also unclear why those with a pro-religious orientation and “excellent” health status did not statistically differ from those with “fair” and “good” health.

Further work should continue to evaluate the relationships between religious orientation and current health status on attachment behavior.

References