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# Using Religious Services to Improve Health

## Findings From a Sample of Middle-Aged and Older Adults With Multiple Sclerosis

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**Purpose:** The purpose of this study is to examine the use of religious services to improve health among middle-aged and older adults with multiple sclerosis (MS). **Method:** Data from the study “Aging With MS: Unmet Needs in the Great Lakes Region” were used to investigate religious service use among 1,275 adults with MS. **Results:** The findings indicate that nearly two thirds of the sample currently use religious services to improve their health or well-being. Individuals whose MS is stable and those who have had the disease longer are significantly more likely to use religious services to improve their health. **Conclusions:** Religious organizations should continue providing outreach and increasing accessibility for individuals with disabling conditions. In addition, health care professionals should be aware of the importance of religious services to individuals with MS and do their part to facilitate participation for those who desire it.

**Keywords:** *religion; social services; disability*

Nearly half of all Americans are burdened with a chronic condition (Hoffman, Rice, & Sung, 1996). It is not surprising that an even greater percentage of older adults—more than 80% by some estimates—have such an

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illness (Hoffman et al., 1996; Wolff, Starfield, & Anderson, 2002). Multiple sclerosis (MS) is one of the most common chronic neurological conditions for adults, affecting approximately 400,000 individuals in the United States alone (National Multiple Sclerosis Society, 2004). Individuals with MS (and other chronic conditions) suffer from a variety of physical symptoms, such as fatigue, impaired mobility, numbness, pain, sexual dysfunction, and bladder dysfunction. In addition, several characteristics of MS are particularly challenging for those affected, including its long duration, unpredictable nature, the ambiguity of diagnosis, and the lack of a known cause or cure (Antonack & Livneh, 1995).

For these reasons, individuals with chronic conditions such as MS have special physical, psychological, and social needs. Religion, which is one of the most important social institutions for adults in the United States (Gallup, 1997), may be a valuable resource for dealing with these needs. For example, approximately 60% of adults say that religion is a very important part of their lives and 93% identify with a specific religious preference (Gallup Organization, 2004). Furthermore, weekly religious service attendance rates increase at every age group, with those 65 and older reporting the highest level of attendance, and levels of salience also increase with age (Markides, 1983; Princeton Religion Research Center, 1994; Religion in America, 1987). These elevated rates of involvement for older adults are supported by other research that suggests adults use religion to find comfort and assistance with problems they encounter in later life (Koenig, 1994; Taylor & Chatters, 1986).

Religion may be particularly salient for middle-aged and older adults dealing with the challenges of health problems (Koenig, 1998, 2004; Koenig et al., 1992). For example, numerous studies of individuals suffering from a variety of health problems report that the vast majority use prayer to cope with their illnesses (Conway, 1985; Koenig, 1998; Saudia, Kinney, Brown, & Young-Ward, 1991). Similarly, women with cancer and men experiencing a serious change in their health are all more likely to seek religious consolation than adults without such problems (Ferraro & Kelley-Moore, 2001). Looking specifically at adults with MS, one recent study examining the use of unconventional therapies found that prayer was considered to be the most efficacious therapy and was used for a longer period of time than any other method (Nayak, Matheis, Schoenberger, & Shiflett, 2003). Moreover, an older study investigating coping mechanisms within this population found that religion was the second most frequent means of coping with the disease, after acceptance (Brooks & Matson, 1982).

These connections between health status and religious coping make up just one small part of the large, and growing, body of literature on religion

and health. In fact, more than a thousand studies, from a wide variety of disciplines, have examined associations between religion and health, with fairly consistent results (Koenig, McCullough, & Larson, 2001). In general, studies find a positive relationship in which higher levels of religious involvement are associated with better mental and physical health outcomes. Much of the work in this area has focused on the effect of religion on health. For example, increased levels of religious attendance have been shown to reduce levels of depression, poor subjective health, activity limitations, and overall mortality risks, among other outcomes (Ellison, 1995; Hummer, Rogers, Nam, & Ellison, 1999; Idler & Kasl, 1997; McCullough, Larson, Hoyt, Koenig, & Thoresen, 2000; Musick, 1996). To explain the relationships found above, many mechanisms have been put forward, including social support, psychological resources, and health behaviors (for a review, see Ellison & Levin, 1998).

At the same time, researchers recognize that the relationship may work in the other direction as well. Various aspects of health, in particular functional limitations and chronic conditions, have been found to influence levels of religious involvement. For example, older adults with functional limitations attend religious services less frequently than unimpaired adults (Idler & Kasl, 1997) and those with chronic conditions attend less often than those without such conditions (Benjamins, Musick, Gold, & George, 2003; Ferraro & Kelley-Moore, 2001). Beyond the obvious physical limitations that may restrict an individual's ability to get to religious services, other aspects of having a chronic condition may also play a role. In particular, less visible physical symptoms may exist, in addition to the numerous emotional or psychological barriers to social involvement that can accompany chronic health (Benjamins et al., 2003).

Each of these issues may affect how middle-aged and older adults with MS use religious services. As a chronic, degenerative neurological disease, people with MS experience a wide array of disabling symptoms that include, but are not exclusive to, extreme fatigue, problems with balance and mobility, weakness, visual changes, and incontinence (Burks & Johnson, 2000). In addition, the symptoms vary from day to day and over time (Joy & Johnston, 2001), which can make it difficult for people to plan activities in the community such as religious service attendance. Problems with balance and mobility can limit access to religious services if ramps or other building modifications are not conducive to the use of mobility devices such as walkers or wheelchairs, which are used by up to 45% of individuals with this disease (Schwid et al., 1997). Avoidance of the shame of incontinence can also lead people with MS to avoid religious outings (Koch, Kralik, Eastwood, & Schofield, 2001). Given

the progressive nature of MS and the fact that it does not significantly reduce life expectancy, the effect of symptoms can increase over time, making it particularly important to examine middle-aged and older adults with this disease (Weinshenker, 1995).

Beyond these health-related influences on religious service use, a number of other factors have been found to affect religious participation. Demographically, women, older adults, and minorities have higher rates of attendance (Montenegro, 2004; Princeton Religion Research Center, 1994; Religion in America, 1987). In addition, those who are married or widowed attend more frequently than those who are single, divorced, or separated. Socioeconomic differences are less clear. There is some evidence that college-educated individuals are more likely to attend than those with less education. Geographically, individuals who live in the South or Midwest attend more than those on either coast, and individuals living in small towns or rural areas also have higher attendance rates (Montenegro, 2004; Princeton Religion Research Center, 1994; Religion in America, 1987). It is not surprising that attendance is also highly correlated with other aspects of religion. For example, Catholics attend most frequently, followed by Protestants, Jews, and nonaffiliated individuals (Montenegro, 2004; Princeton Religion Research Center, 1994; Religion in America, 1987). In fact, almost all of the other common measures of religion are related to attendance, including private religious practices, religious coping, religious beliefs, tithing, salience, and born-again status (Idler et al., 2003). Finally, recent studies have found links between religious involvement and personality traits. In particular, agreeableness and conscientiousness appear to be related to religious attendance (MacDonald, 2000).

Despite the abundance of research on the relationship between religion and health, as well as evidence supporting the significance of religion to many older adults (especially those with health conditions), previous studies of the needs of individuals with MS have ignored the potential importance of religious services (e.g., Black, Grant, Lapsley, & Rawson, 1994; Kersten et al., 2000). This may be important because adults with MS may be affected by their disease differently from individuals with other conditions (Antonack & Livneh, 1995). For example, prior studies have found that individuals with MS may be more prone to depression than individuals with other physical problems (Antonack & Livneh, 1995). Furthermore, this study examines a group of people who are aging with disability rather than a group who has become disabled as a consequence of age-related factors.

More generally, this study addresses the question of whether or not chronically ill individuals use religious services specifically to improve their health and well-being. Although previous researchers have examined the religious

involvement of other chronically ill populations (e.g., Musick, Koenig, Hays, & Cohen, 1998), these studies were not able to determine if individuals use religious services for health purposes and often assess the effect of religious involvement on health rather than the reverse relationship. In addition, few, if any, studies have asked individuals who are aging with existing disability how important the religious services are and how satisfied they are with the services. Thus, this study will add to the literature by describing the role of religious services in a large group of people aging with existing disability and by examining the effect of health on religious service use among this group. A recent study, "Aging with Multiple Sclerosis: Unmet Needs in the Great Lakes Region," is used to answer the following sets of questions:

1. How prevalent is the use of religious services to improve health among middle-aged and older adults with MS, and how important and satisfying are these services?
2. What demographic, social, and health characteristics are associated with the use of religious services within this group?
3. Is the use of religious services to improve health associated with characteristics of the disease, such as current MS progress and years with MS?

## Design and Method

### Sample

Respondents for this study were part of a larger study focused on the unmet health-related needs of people aging with MS. To be eligible to participate in an interview, individuals had to be 45 years of age or older, have a self-reported diagnosis of MS, and live in Minnesota, Wisconsin, Illinois, Indiana, or Michigan. No restrictions were placed on respondents based on location of residence (e.g., community vs. institution). Recruitment was done through five methods: direct mailing to registrants of the National Multiple Sclerosis Society (NMSS), direct mailing to members of the NARCOMS database (an international volunteer MS patient registry), advertising through the *MS Connection* newsletters, flyers distributed via NMSS events, and advertising in nursing homes and assisted-living facilities known by NMSS chapter staff as having multiple residents with MS. Individuals who were willing to be contacted for a telephone interview returned a letter to the study office to volunteer. The human subjects protection committee approved all recruitment procedures.

A total of 2,277 individuals volunteered to participate in the study. Of these, 1,498 were between the ages of 45 and 64 years and the remaining 779

were aged 65 years and older. Due to the focus and hypotheses of the original study, all of the 779 volunteers 65 and older were contacted for an interview, and 725 participated. Of the 54 who did not complete the interview, 3 could not be contacted, 6 had died, 19 refused, and 26 were unable to complete the interview process on their own. For the 45- to 64-year-old group, 585 volunteers were randomly selected from the pool of 1,498, and 557 actually completed the interview. Of the 28 who did not complete the interview, 13 could not be contacted, 3 had died, 7 refused, and 5 were unable to complete the entire interview on their own due to cognitive impairment or illness. Therefore, the final sample for the overall study was 1,282. Within this study, control variables with small amounts of missing data (i.e., less than 5%) were given imputed values based on the mean (or mode for categorical variables). Respondents missing data for the primary independent and dependent variables were excluded from the analyses. This resulted in a total sample size of 1,275.

## Data and Measures

The selected respondents were contacted by telephone by a trained project staff member. A structured interview guide was used to gather a variety of demographic, social, and health-related information. Topics of special interest include disease course and symptoms, activity limitations, the use of assistive technology, availability of social support, and the utilization of a wide range of health and ancillary services. The average length of the interview was 42 minutes. All interviews were conducted between November 2002 and August 2004.

*Religion.* The primary dependent variable is Use of Religious Services to Improve Health. This is a dichotomous variable that indicates whether or not respondents are currently using religious services to improve their health. Religious services were included as one of many social services in the survey. First, respondents were asked if they “have EVER used [religious services] specifically to maintain or improve your overall health and well-being?” If respondents answered affirmatively, they were then asked to identify the last time they used the service, and whether or not they considered themselves to still be using the service. Questions concerning the nature of religious services were given the following clarification: “Religious services are provided by a church, synagogue, or other spiritual gathering or service based on faith. Examples of religious services include going to church, going to synagogue, or having a pastor/minister coming into your home.” The variable for current

service use was selected from the set of religious service variables available in the data set because it was linked to additional questions concerning frequency of use, importance of services, and satisfaction with services received.

*MS-specific measures.* The primary independent variables for the regression analyses reflect the current disease status, as well as the length of time since diagnosis. For Current MS Status, respondents were asked if their condition was improving, stable, variable, or deteriorating. This variable captures the respondents' current experiences with the disease over the past year, rather than since initial diagnosis. Number of Years With MS measures the number of years since diagnosis. Respondents were categorized into three groups: 10 years or less, 10 to 20 years, and more than 20 years. However, preliminary analyses showed that the two latter categories were not significantly different in terms of association with religious service use and, thus, were collapsed.

*Sociodemographic controls.* Age, gender, and marital status are included in the multivariate models as demographic controls. Race was excluded due to the lack of variability (97% White, non-Hispanic). Socioeconomic measures include education and financial status. Education measures the highest level of formal schooling completed. A dichotomous variable was made to distinguish between those with some college or more and those with a high school degree or less. Financial status was measured with the question, "How well do you think your income and assets currently satisfy your needs?" Response choices were as follows: *totally inadequate, not very well, with some difficulty, adequately, and very well.* The first two categories were combined to represent inadequate incomes and the last three categories were combined to represent adequate incomes.

*General health status.* Four health variables are included to gauge the respondent's physical and mental health. Functional Limitations are measured with a series of questions on whether or not assistance is needed to perform various activities of daily living (ADLs). Both basic activities (e.g., grooming and transferring to and from bed) and more instrumental activities (e.g., preparing a meal and doing light housework) are included. For each of the 18 activities included, respondents can indicate whether they never need help, sometimes need help or a piece of equipment, or always need help. Individuals were then probed to clarify if help was needed because of actual physical need or because the activity fell outside of the individual's normal roles. Those indicating a need for physical help were placed in the "always need help" category

and those who needed help because of roles were placed in the “never need help” category. Number of Other Health Conditions is the second measure of physical health. Respondents were asked about 13 other conditions that may influence their ability to perform daily activities, including common chronic conditions such as heart disease, cancer, arthritis, and diabetes.

Finally, Mental Subjective Health and Physical Subjective Health were included to measure respondents’ subjective assessment of their health status. These variables come from a question that asks respondents to rate their mental/emotional or physical health. Response choices were as follows: *excellent, good, fair, or poor*.

## Data Analysis

Univariate analyses provide the frequencies for each variable. Descriptive statistics are shown first for the religious variables and then for the MS characteristics and control variables to be included in the multivariate analyses.<sup>1</sup> Next, logistic regression was used to estimate the relationship between the MS characteristics, controls, and the religious service use variable. In all models, use of religious services was coded as 1 and non-use was coded as 0. The first model estimates the zero-order relationships between current MS status and religious service use. The second model does the same for years with MS. Next, in Model 3, both MS characteristics are included together. The fourth model estimates the effects of these variables controlling for the sociodemographic measures. Finally, in Model 5, the health status variables are added. All estimates are displayed as odds ratios with 95% confidence limits.

## Results

Descriptive statistics for the full set of religion variables are displayed in Table 1. The first variable indicates that nearly two thirds of the sample reported currently using religious services. Slightly more respondents said that they had used religious services in the past. Of the current users, the majority attended services one to two times a week. Those currently attending religious services tend to rate the services as very important (79%) and have similarly high levels of satisfaction (74%). It is noted that only 2% of the current attenders say that the services are not important or that they are not satisfied with them.

Frequencies for the MS and control variables are described here. There is wide variability in current MS status with large percentages of respondents

**Table 1**  
**Descriptive Statistics of Religion Variables in the Aging**  
**With Multiple Sclerosis Data Set (2004; *N* = 1,275)**

	<i>n</i>	% <sup>a,b</sup>
Current use of religious services to improve health		
Yes	815	64
No	460	36
Ever used religious services to improve health		
Yes	887	70
No	388	30
Frequency of religious service use		
1-3 times/month or less	175	21
1-2 times/week	560	69
3 times/week or more	79	10
Skipped (not currently using) or missing	461	—
Importance of services		
Not important	14	2
Important	156	19
Very important	641	79
Skipped or missing	464	—
Satisfaction with services		
Not satisfied	15	2
Satisfied	199	25
Very satisfied	596	74
Skipped or missing	465	—
<i>N</i>	1,275	

a. Denotes percentage of individuals with data.

b. Numbers may not add up to 100 due to rounding.

reporting stable (41%), variable (21%), and deteriorating (34%) conditions, and very few reporting improvement (3%). Approximately three quarters of the sample have had MS for more than 10 years. The sociodemographic variables indicate that the average age in this sample is approximately 64 years and nearly three fourths of the respondents are female. In addition, slightly more than two thirds of the sample is married and nearly one third has a high school education or less. Financially, 21% of the respondents report that their income and assets are inadequate. The vast majority of the sample is not employed. In terms of health, respondents have an average of 2.5 additional health conditions other than MS. The average respondent has limitations with three of the eight basic ADLs. Finally, the majority of respondents rate both their physical and mental health as “good.”

Table 2 shows the estimated relationships between the MS variables, controls, and the use of religious services. Model 1 displays the association between current MS status and use of services. The estimates indicate that individuals whose condition is stable are significantly more likely to use services than individuals whose MS is deteriorating (O.R. = 1.40, C.I. = 1.08-1.83). The zero-order estimate for the relationship between years with MS and use of religious services is shown in Model 2. Individuals who have had the disease for 10 years or less are significantly less likely to be currently using religious services, compared with individuals who have had MS for a longer period of time (O.R. = 0.59, C.I. = 0.45-0.76). The two MS characteristics are included together in Model 3. No significant changes from the previous two models are seen for any of the estimates.

The demographic and social variables are added in Model 4. The associations between MS status, years with MS, and use of religious services are weakened slightly, in magnitude and significance. However, having a stable condition is still associated with an increased likelihood of using services (compared with those with a deteriorating condition), whereas a shorter time since diagnosis continues to be significantly related to a decreased likelihood of using religious services. Other variables that are associated with religious involvement include age, gender, and marital status. Specifically, older adults are more likely to use religious services compared with younger adults in the sample, as are females compared with males. Married individuals are also more likely to be religiously involved. It is interesting that none of the socioeconomic variables are associated with the use of religious services.

In the final model (Model 5), the various measures of health status are included. These additions do not significantly affect the relationships between the MS characteristics and use of religious services. In fact, only one measure of health—functional limitations—is significantly associated with religious involvement. In contrast to what might be expected, individuals with a greater number of functional limitations are more likely to report the use of religious services.

## Discussion

Individuals aging with chronic conditions and existing disability have special physical, psychological, and social needs. Perhaps due to these challenges, nearly two thirds of the older adults in this sample report that they are currently using religious services to improve their overall health and well-being. Of this group of adults with MS, the vast majority use the services

**Table 2**  
**Multivariate Estimates for the Relationships Between Multiple Sclerosis (MS) Characteristics, Controls, and the Use of Religious Services to Improve Health (Aging With MS, 2004)<sup>ab</sup>**

	Current Use of Religious Services <sup>c</sup>				
	Model 1	Model 2	Model 3	Model 4	Model 5
MS characteristics					
Current MS status (deteriorating) <sup>d</sup>	1.24 (0.67-2.47)		1.35 (0.70-2.61)	1.32 (0.67-2.58)	1.34 (0.68-2.65)
Improving	<b>1.40</b> ( <b>1.08-1.83</b> )		<b>1.45</b> ( <b>1.11-1.89</b> )	<b>1.42</b> ( <b>1.07-1.87</b> )	<b>1.46</b> ( <b>1.09-1.95</b> )
Stable	1.10 (0.81-1.51)		1.17 (0.85-1.61)	1.06 (0.77-1.48)	1.11 (0.79-1.54)
Variable					
Years with MS (> 10 years)		<b>0.59</b> ( <b>0.45-0.76</b> )	<b>0.58</b> ( <b>0.44-0.75</b> )	<b>0.68</b> ( <b>0.51-0.91</b> )	<b>0.71</b> ( <b>0.53-0.95</b> )
10 years or less					
Demographic variables					
Age				<b>1.04</b> ( <b>1.02-1.05</b> )	<b>1.03</b> ( <b>1.02-1.05</b> )
Female				<b>2.04</b> ( <b>1.55-2.68</b> )	<b>2.03</b> ( <b>1.53-2.65</b> )
Married				<b>1.43</b> ( <b>1.09-1.86</b> )	<b>1.42</b> ( <b>1.09-1.87</b> )
Socioeconomic status					
Education (> 12 years)				0.87 (0.67-1.13)	0.87 (0.67-1.14)
Financial status (adequate)				1.01 (0.75-1.37)	1.02 (0.74-1.37)
Employment (unemployed)				1.14 (0.82-1.59)	1.20 (0.85-1.69)
Health status					
Functional limitations					<b>1.06</b> ( <b>1.10-1.13</b> )
Other chronic conditions					1.03 (0.95-1.11)
Self-rated physical health					0.97 (0.82-1.15)
Self-rated mental health					0.93 (0.77-1.11)
-2 log likelihood	1660.62	1651.89	1644.01	1594.63	1589.70
N	1,275				

a. Logistic regression odds ratios.

b. Estimates significant at the .05 level are in bold.

c. Uses services = 1; does not use services = 0.

d. Reference group in parentheses.

once a week or more. Furthermore, 98% of those using services report that these services are important or very important and nearly three quarters are very satisfied with them. Within this group of adults aging with a chronic condition, it was important to determine which disease-related characteristics are related to the use of religious services. The results shown here indicate that both current MS status and length of time with MS are significantly associated with religious service use.

The findings indicate that individuals whose current MS status is stable are more likely to attend religious services than those with a deteriorating condition, even after controlling for physical and mental health status. Individuals who are experiencing deteriorating MS status have more frequent and more severe symptoms and often need to seek additional medical and rehabilitative care to manage their disease. As a consequence, it may be that individuals with deteriorating MS status are less able to use religious services due to changes in their mobility, fatigue status, or other symptoms. Alternatively, deteriorating MS status may be acting as a proxy in these models for environmental barriers such as difficulty with transportation or limited physical accessibility to religious buildings and services. Finally, this finding may be capturing the need for people with deteriorating MS status to set priorities for their use of energy and time, and religious service attendance is a lower priority than health management. Thus, individuals who report stable MS status may have greater physical and emotional resources to pursue religious services compared with those dealing with increasingly frequent or severe symptoms. It is unfortunate that this data set does not allow us to empirically evaluate these possible explanations. Likewise, it is not clear why individuals who see improvements in their MS, or whose MS is variable, do not use religious services more frequently than those with a deteriorating condition.

It is interesting that individuals who have had MS for a longer period of time are also more likely to use religious services, even after controlling for age. The relationship between years since diagnosis and use of religious services may reflect a greater need for the social or emotional benefits of religious involvement for those who have lived with this chronic illness for a longer period of time. If individuals who have had MS for more than 10 years are attending religious services outside of their home or actively seeking other religious services, it could also suggest an increased ability to cope with the physical or mental demands of the disease or environmental barriers (which may have decreased religious involvement in earlier stages of the disease). Similarly, individuals who have had the disease for a longer period may have been able to make other adjustments in their daily lives to facilitate use of religious services, for example, learning to ask for assistance to get to the

services, finding accessible service locations, or finding alternative ways of obtaining services (e.g., having the religious leader come to the home). However, any explanations must be considered speculative until more empirical work is done in this area.

Several limitations of the data must be taken into account before the implications of these findings are considered. First, although one may assume that, in most instances, reporting the use of religious services indicates that the individual attends religious services (the most common form of religious participation), this is not certain. Specific information concerning different domains of religious involvement (e.g., organized activities, private activities, religious salience, and religious affiliation) would have added to the study considerably. In addition, the specificity of the religious service measure (i.e., services used to improve one's health and well-being) may result in an underestimation of the use of religious services in this sample. In other words, more individuals may be using religious services but do not consider them a means to improve their health. The second limitation stems from the cross-sectional nature of the data. Information concerning the direction of the causal relationship between MS and religious service use can only be obtained from longitudinal data, which were not available here. It is possible that the use of religious services somehow alters the disease characteristics, such as current MS course, but this cannot be determined here. In addition, many probable determinants of religious service use were not included in this study. Data limitations precluded the measurement of potentially important predictors such as religious denomination, intrinsic religiosity, and social support. Finally, the findings shown here should be considered exploratory and cannot be generalized to all adults with MS due to the nonprobability sample on which they are based.

Despite these drawbacks, this study gives additional insight to researchers, health care providers, and religious organizations. Although religion is the most used social institution for all older adults (Gallup, 1997) and one of the most common alternative therapies and means of coping for adults with MS (Brooks & Matson, 1982; Nayak et al., 2003), to our knowledge, this is the first time that anyone has looked specifically at how individuals with MS use (and rate) religious services. In addition, this study adds to the growing literature on religion and health. Although several studies have looked at the effect of health status on religious involvement (e.g., Ferraro & Kelley-Moore, 2001; Idler & Kasl, 1997), very few were found that examined the use of religious services among individuals with a chronic condition and none were found that focused on individuals with MS. More important, no other studies were found that examined the use of religious services specifically to improve health and well-being among individuals with a chronic condition.

Due to the preliminary nature of this study, more work is needed before the implications of this type of research are clear. However, these findings show that the majority of middle-aged and older adults with MS in this study are religiously active. This may indicate that there is a potential need for religious organizations to provide (or continue providing) outreach for individuals with MS, in particular for those for whom the disease is worsening or who were diagnosed more recently. Demand may be especially pronounced for church-based programs that work to accommodate individuals with special physical and emotional needs (e.g., transportation services, home visits, or parish nurse programs). Issues of accessibility within religious buildings may be particularly important for this population (and others with disabilities). However, more research is needed to determine if the individuals currently not using services are prohibited by a lack of access, or other issues.

The findings may also speak to health care professionals who work with individuals with this condition (or other health problems). Because religious involvement is associated with better health outcomes (Koenig et al., 2001), it is possible that facilitating individual religious involvement (for those who desire it) would be beneficial. In fact, one recent review of the religion and health literature (Matthews et al., 1998) concluded that "practitioners who make several small changes in how patients' religious commitments are broached in clinical practice may enhance health care outcomes" (p. 118). Although the inclusion of religion or spirituality in the clinical encounter is currently the subject of intense debate (e.g., Curlin & Moschovis, 2004; Koenig, 2004; Sloan, Bagiella, & Powell, 1999), recognizing the importance of religion to many individuals is critical for understanding health within a holistic framework.

Despite the prevalence of chronic conditions such as MS, little is known about how chronically ill individuals use social services like those offered by religious organizations (NMSS, 2004). This study takes a first step in identifying levels of religious participation among individuals with MS and determining disease-related factors that influence usage. The findings shown here indicate a need for more research to better understand the relationship between religion and health in this population.

## Note

1. Although each of the religion questions would be interesting to study in more detail, they were not included in the multivariate analyses for several reasons. First, the questions concerning past use and frequency of current use were too highly associated with the general use question ( $\chi^2 < .0001$ , for both). Subsequently, all relationships with the MS variables were virtually

identical to those results shown here and, thus, nothing would be gained by showing these models. Regression models were also run for the other two religion questions concerning importance of services and satisfaction with services (not shown here). The models indicated that there were no strong relationships between these religion measures and the MS characteristics included in this study. This lack of significant findings could simply reflect the smaller sample size ( $n = 810$ , due to the lack of responses from individuals who did not use religious services) or more substantive reasons. However, this issue is beyond the scope of this study.

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