Greek Christian Orthodox Ecclesiastical Lifestyle: Could It Become a Pattern of Health-Related Behavior?

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Background. Although past research has globally supported the salutary impact of religion on health and health-related behaviors, it has not extensively examined the impact of the Christian Orthodox Church’s way of living on people’s health and health-related behavior.

Methods. Semistructured personal interviews were used to investigate a stratified sample of 20- to 65-year-old individuals in the greater Athens area. Constructs were compared to single items and indices, which varied across data sets.

Results. Multiple-regression analysis specify that persons adopting the Christian Orthodox Church’s lifestyle were more likely to behave in ways that enhance their health (e.g., relaxation, life satisfaction, healthful nutrition, personal hygiene, and physical activity), after controlling for a set of socio-demographic factors and their current health status.

Conclusion. These results suggest that the Christian Orthodox Church’s lifestyle constitutes a pattern of health-related behavior. © 2002 American Health Foundation and Elsevier Science (USA)

Key Words: Christian Orthodox religion; lifestyle; health; health-related behavior; relaxation; life satisfaction; healthy nutrition; personal hygiene.

1. INTRODUCTION

The debate over the influence of religion on health has been taking place for thousands of years. However, it is only during the past two decades that we have had a number of well-designed studies, which have systematically examined the relationship between mental health and religious belief, commitment, or practice as well as the relationship between different kinds of physical illness or mortality and religiousness [1,2].

The literature review shows that, in general, there has been little interest in the investigation of religion as a factor of healthful behavior; emphasis has been given to the impact of religion on illness, preventive behavior, or sick-role behavior [3–6].

On the other hand, it is interesting to note that there are numerous European cross-sectional projects assessing the relationship between Mediterranean diet and optimal health. These studies show that Mediterranean, and especially Greek, dietary guidelines and nutritional habits are an important, optimal determinant of health throughout life in the European Union [7–9]. However, the impact of religion has not been adequately examined.

Moreover, it is worth mentioning that even though there are a relevantly significant number of studies on the influence of Western religions on health, there is hardly any substantial, objective, and systematic research on the influences of the Greek Orthodox Ecclesia [Church (GOE)] on health and particularly on health-related behavior. The majority of the current literature on the area of interrelation between GOE and medicine includes forms and descriptive analyses of miraculous religion healing (“charisma”) [10]. Particularly, there is very limited research in Greece concerning the influence of Greek Orthodox Ecclesia lifestyle principles on Greek health behavior [11]. This lack of research in the field of health promotion in Greece has led to the development and implementation of this preliminary study as it is analyzed below.

2. THE GREEK ORTHODOX ECCLESIA: THEORETICAL ASPECTS OF HEALTH AND HEALTH-RELATED BEHAVIOR

The concepts of health and disease in modern Western medicine are based on Descartes’ mechanistic view of the world and of the human organism which is focused on relieving symptoms but not on discovering or dealing with their cause [4,12].
Modern Western medicine interprets the concepts of humankind, health, disease, and illness, without taking into consideration the holistic understanding which had already been founded in the ancient Greek era and characterizes the GOE health perception; it dates back to the Byzantine period and the foundation of the first organized Ecclesiastic hospitals [13].

In ancient Greek medicine, health was not considered a simple absence of unpleasant symptoms—as it appears to be in most WHO definitions [14–16]—but the feeling and meaning of an entirely satisfying, “full” life. According to Hippocrates, humans are psychosomatic unities and one’s way of life is a decisive factor for one’s health. Disease is regarded as a result of violating the universe. In this view, a physician’s intervention aims at restoring the order of the universe rather than removing the unpleasant symptoms. Hippocrates also believed that a person’s health depends on environmental conditions, physical and social, and that there is a direct connection between the psychological and the physical condition.

The GOE uses this holistic concept to define human beings and to deal with health-related issues, as well. According to Pharos [13], “… a person’s whole existence is a perfect unity and whatever happens to him, happens to his whole existence incorporated in the unity of the universe.” The only Truth in this life is the Ecclesia (the vital participation in a community in which one cares for each other), viewed not as an institution nor as a center of power, but as a way of living.

A fundamental element in human nature is one’s need to love God and to be united with God and other people. When one disregards the above nature, one commits a sin and gets sick [17]. The source of evil and disease is considered to be man’s free choice between acting in a good or harmful way. Therefore, the source of death, disease, and illness of the body is sin.

2.1. The Christian Orthodox Ecclesia Way of Life

The main aspects of the Orthodox Christian spirituality and way of life, which influence health habits and health behavior, include practices that are considered primary values. A short description of them is presented below.

(a) Faith is considered to have influences on a person’s mental and physical being: (i) One influence is the development of sentimental and intellectual abilities and the hope for a better future. Feelings such as pain, weakness, frustration, loneliness, and abandonment become tolerable because of faith, which reinforces the believer’s positive thinking. (ii) Another influence is the courageous attitude toward imponderable events of life, such as diseases; (iii) A third influence is the ability to release oneself from bad habits and thoughts.

(b) The invocation of God by the sign of the Cross in a believer’s everyday life is a way of expressing one’s devotion to God, which strengthens one’s expectations to cope with current difficulties.

(c) The personal contact of man with God is attained via prayer, which is an integral component of the spiritual life of humans [18]. When prayer expresses faith and hope for God’s help, it becomes a source of power, a means of alleviating pain and moderating physical distress, and, mainly, a source of life. As Hughes [19] and Lewis [20] claim, religion via prayer practice may positively affect health (physical and mental). Particularly, the relaxation response and the sense of self-efficacy gained through the act of praying may enhance the immune system.

(d) The practice of fasting is considered to be an important value that comprises both physical and spiritual fasting, since the human being is a psychosomatic entity whose body cannot be distinguished from its soul. By overeating and being greedy, humans rouse fleshly desires and aggravates the body. But the practice of fasting and self-restraint helps believers to appease their passions, to strengthen their will, and to relieve their bodies from toxins. Moreover, this behavior should not be considered a simple abstinence from specific kinds of food, but a “physical exercise” with spiritual effects. According to Basil the Great [21], the practice of fasting consists of restraint from specific kinds of food and also from swearing (using bad words), anger, the habit of lying, and (specifically, in current society) overconsumption.

(e) The Sacrament of Confession is an important value that is believed to absolve the believer from sins, and it is also vital for restoring one’s health. According to the Orthodox Ecclesia, there is no sin or mistake in life that cannot be forgiven (as Koenig remarks [1]); therefore, repentance is a kind of purgation from every sin, which involves redemptive and curative forces. Following John Chrysostom’s thought [22], when one repents and confesses sin, one accepts Christ’s sacrifice and starts “living in God,” away from disease, illness, and corruption as a result of considering Ecclesia as a way of living.

(f) With the Sacrament of the Holy Communion a Christian, who has already repented through prayer and confession, is believed to receive the divine gift of the Holy Spirit, which helps him fight against any committed sin and remain healthy.

3. OBJECTIVES

In the present article, the relationship between the GOE belief and practice and reported health-related behavior, health problems, and use of medication during the previous 12-month period is examined. Interest is focused on the question whether persons who followed the GOE way of life are more likely to adopt specific health-related behaviors than persons who do not practice this way of life. The related question of
whether the beliefs and practices of the believers can influence their current health status it is also studied. Above all, an attempt is made to construct a model with the GOE way of life as a factor of promoting the adoption of specific health-related behaviors, taking into consideration socio-demographic characteristics and the current health status of the responders. Furthermore, we search the profile of the GOE believer in Modern Greek society.

Given the potential impact that a certain way of life, such as the one traditionally suggested by the Greek Ecclesia, could have on people’s health, the answers to these questions may contribute to the health inequalities debate and to health promotion patterns (i.e., differences in health among social groups, explanations of how in Greece the Orthodox Ecclesia is not limited to the field of faith but also posits a particular pattern that promotes health-related behaviors).

4. METHODS

4.1. Participants

A probabilistic, stratified random sampling was performed in order to select 250 participants ages 20–65 years from 10 municipalities of the greater Athens area, using information from and being under the regulations of the National Statistic Department (NSD). A two-stage conglomerate sampling was conducted, with subsampling and stratification of the first units that were the census sections in which the municipalities are divided. Once the census sections used for sampling had been selected, all households existing in these sections were counted, and the list of homes selected for the sample (two per census section) was drawn by simple random sampling, without replacement, from the total list of homes. The variables used to stratify the sample to be selected were sex, age, marital status, educational level, occupation, and religiosity.

Comparison of our study sample (see Table 1) with the census data of 1991 provided by the NSD showed that this sampling design ensured the adequate social–demographic representativeness of the 10 municipalities of Athens, with the exception of gender. In our sample the male population was 43% and the female was 57%. (According to the NSD data, the population of these municipalities was 48% male; mean age was 40.40 years, mean education was 12.30 years; and 60% were married. Officers and housewives were the most common occupations.)

The basic limitation of this type of sampling is that not all relevant strata or segments are adequately represented in the investigated sample. In the case of the present research, after following the above procedure, the sample of 250 subjects is representative of the 10 municipalities in the time frame specific study period.

4.2. Procedure

The data were collected through personal interviews conducted by health visitors (students of the seventh semester). It was deemed important for the success of the study that the interviewers be health students or professionals with previous experience in collecting data. The interviewers were informed in a 4-h meeting about the questionnaire, the nature of the study, and the matter of confidentiality. One of the main objectives was to avoid any potential prejudices in the completion of the questionnaires. The interviewers were authorized to answer any queries that the interviewees might have had while completing the questionnaire.

4.3. Questionnaire and Measures

For the construction of the questionnaire, the researchers (Christians Orthodox) initially had discussions with monks and theologians about Orthodoxy and about how health and sickness should be perceived. Then, professors of medicine who are religious were asked to discuss medicine and religion, and their possible relationship. These discussions formed the basis of the questionnaire.

The final questionnaire was divided into four sections. The first section referred to the socio-demographic characteristics of the sample (sex, age, marital status, educational level, and profession). The second section concerned two significant introductory religiousness indicators: Church attendance and participation in religious practices. The third section was
subdivided into five relevant indices that referred to health-related behaviors: five scales of “relaxation,” “life satisfaction” (mental health-related behaviors), “physical activity,” “personal hygiene,” and “healthful nutrition” (physical health-related behaviors). All of the aforementioned health-related scales were items selected from previous studies of Teegen [23] and Kalantzi-Azizi [24]. This section also comprised questions about the “Current Health Status” of the respondents (reported chronic diseases, diseases from the past 12-months and consumption of any medication during the same period). The fourth section evaluated religiousness using a scale of 10 items.

The literature shows that religiousness and its relationship with health-related behaviors is usually measured based on the variables of church attendance rates and other activities such as reading religious books and participating in religious discussions [4, 5, 23, 26]. In this study, however, it was determined that these variables are insufficient and quite restrictive to cover the full range of the Orthodox faith. Therefore, a scale of 10 items was constructed concerning (a) GOE initiation, e.g., praising God, making the sign of the Cross, calling upon God, scripture reading, attending religious speeches; (b) the involvement in religious practices, e.g., praying, attending church every Sunday, fasting during Lent periods; and (c) the participation in the Sacraments of the Confession, and of the Holy Communion. All of the questions of the “Christian Orthodox Religiousness” (ChOR) scale were based on a Likert model, with answers ranging from 0 = “never” to 4 = “very often.”

4.4. Statistical Analysis

The statistical analysis was done by simple univariate techniques (chi-square test) or modeling the data through multiple linear regression. Five multiple-regression models were developed having as dependent variables the composite scores of health-related indicators (behaviors), that is, “relaxation,” “life satisfaction,” “personal hygiene,” “healthy nutrition,” and “physical activity.” These models controlled for a set of socio-demographic variables such as age (in years), gender, education (<13 years, ≥13 years), occupation (students, housewives, employees), and three variables indicating “current health status,” that is, existence of chronic disease (yes, no), recent disease (yes, no), and medication consumption (yes, no), using the ChOR scale (summarized in three categories: “religious,” “conventional,” and “unconcerned”) as a predictor of the health-related indicators.

5. RESULTS

5.1. Socio-demographic Characteristics

Table 1 shows the distribution of the sample based on stratification variables. The subjects’ mean age was 40.6 years; the youngest was 20 years old and the oldest was 65 years old. The mean educational level was 12.3 years and the most common profession (27%) was white-collar employee (officer), followed by the categories of blue-collar worker and professional, self-employed (18 and 17%, respectively). Last were homemakers, students, and sales and industry workers.

5.2. The Christian Orthodox Religiousness Scale

According to the results of the current study, the scores of the 10-item religiousness scale varied from 0 to 40 with a mean score of 19. These scores were divided into three categories—subsamples of the study population: the first category (49%) consisted of persons with the lowest scores (0–15). These were characterized as religiously “unconcerned.” The second category (19%) included persons with scores varying from 16–29, termed religiously “conventional.” The third category (32%) was characterized as “religious” with scores ≥30 (Table 1).

5.3. Multiple-Regression Analysis

Table 2 provides multiple-regression-derived results concerning the five composite health-related behavior scores in a series of socio-demographic variables, the “current health status” indicators, and the ChOR scale. Results from these models suggest that increasing religiousness (as it was defined categorically by ChOR scale: “religious,” “conventional,” “unconcerned”) is positively associated with “relaxation,” “life satisfaction,” “healthy nutrition,” and “personal hygiene.” In the four corresponding regression models, the partial regression coefficients of “religious” and “conventional” categories are significantly larger, in absolute terms, than those of “unconcerned” (reference category), following a linear trend. Thus, in the “relaxation” model, the regression coefficients of “religious” and “conventional” are 1.15 and 0.02, respectively; in “life satisfaction” they are 0.72 and 0.57; in “healthy nutrition,” 1.73 and 1.35; and in “personal hygiene,” 1.60 and 1.23, respectively. A striking exception appears in the “physical activity” model, where the regression coefficients of “religious” and “conventional,” although remaining with a positive sign, have an inverse order: 0.73 vs 1.01.

With respect to religiousness categories, the “current health status” indicators, and the socio-demographic variables, age is marginally associated with decreasing “physical activity” (P = 0.10), and men have higher reported rates of feelings of “relaxation” (P = 0.02) and “life satisfaction” (P = 0.006). In addition, there is evidence for a positive association between employees and increasing “physical activity” (P = 0.02). There is no evidence that “current health status” variables, that is, existence of chronic disease, recent diseases, and...
medication consumption, are significantly associated, in either way, with the ChOR scale.

5.4. Religiousness and Socio-demographic Characteristics

Comparison of the three categories of ChOR with the socio-demographic characteristics of the sample indicated that religiousness is associated with age, educational level, and occupation (Table 3) as follows:

Age. Younger (ages 20–30) and older (ages more than 50) persons are more likely (31 and 61%, respectively) than the other age groups to belong to the “religious” category ($P < 0.0005$).

Education. Persons with less than 13 years of education participate in higher percentages (40%) in the “religious” category in comparison with individuals with 13 or more years of education (25%) ($P = 0.03$).

Occupation. More housewives and students belong to the “religious” category (42 and 81%, respectively) than employees ($P < 0.0005$).

5.5. Association between Religiousness and Current Health Status

The rates of the reported chronic diseases and diseases during the previous 12-month period were found to be 13 and 15%, respectively (most of the reported diseases were simple colds). Medicine consumption during the past year was reported to be 23%. Comparison of the “religious,” “conventional,” and “unconcerned” categories with “current health status” did not show any significant differences.

6. DISCUSSION

In regard to the relationship of religiousness with the studied health-related behaviors, the “religious” group is differentiated from the “conventional” and “unconcerned” groups. Religious people enjoy feelings of relaxation and life satisfaction and experience practices of personal hygiene and healthy nutrition, which can enhance their health. Similarly, the “conventional” and “religious” groups undertake more physical activities than the “unconcerned” group. The effects of religious involvement on health-related behaviors (both mental and physical) remain substantial even after controlling for socio-demographic variables and current health status.

Regarding the involvement of the religious factor in the feelings of relaxation and of life satisfaction, the results of the present study are compatible with those of previous research [19,27–30]. These findings and mainly the factor of the feelings of “life satisfaction” were predictable if we consider all the spiritual and

### TABLE 2

Multiple Linear Regression Derived Coefficients ($b$) and Their Standard Errors (SE) for the Five Models Summarizing the Association between the Health-Related Indicators and the ChOR Scale

<table>
<thead>
<tr>
<th>Category</th>
<th>Relaxation</th>
<th>Life satisfaction</th>
<th>Healthful nutrition</th>
<th>Physical activity</th>
<th>Personal hygiene</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$b$ (SE)</td>
<td>$P$ value</td>
<td>$b$ (SE)</td>
<td>$P$ value</td>
<td>$b$ (SE)</td>
</tr>
<tr>
<td>Religious</td>
<td>1.15 (0.40)</td>
<td><strong>0.004</strong></td>
<td>0.72 (0.26)</td>
<td><strong>0.007</strong></td>
<td>1.73 (0.37)</td>
</tr>
<tr>
<td>Conventional</td>
<td>0.02 (0.41)</td>
<td>0.95</td>
<td>0.57 (0.28)</td>
<td><strong>0.04</strong></td>
<td>1.35 (0.35)</td>
</tr>
<tr>
<td>Unconcerned</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age (in years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age &lt; 13 years (baseline)</td>
<td>$-0.01 (0.02)$</td>
<td>0.92</td>
<td>0.01 (0.01)</td>
<td>0.95</td>
<td>0.01 (0.01)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
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<tr>
<td>Male (baseline)</td>
<td>0.83 (0.34)</td>
<td><strong>0.02</strong></td>
<td>0.64 (0.23)</td>
<td><strong>0.006</strong></td>
<td>0.07 (0.31)</td>
</tr>
<tr>
<td>Education</td>
<td></td>
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<tr>
<td>≥13 years</td>
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<td></td>
</tr>
<tr>
<td>&lt;13 years (baseline)</td>
<td>$-0.24 (0.38)$</td>
<td>0.53</td>
<td>$-0.15 (0.25)$</td>
<td>0.56</td>
<td>0.09 (0.34)</td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Unconcerned</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Housewife</td>
<td>$-0.97 (0.76)$</td>
<td>0.21</td>
<td>0.17 (0.51)</td>
<td>0.74</td>
<td>0.69 (0.68)</td>
</tr>
<tr>
<td>Employee</td>
<td>$-0.15 (0.54)$</td>
<td>0.78</td>
<td>0.07 (0.36)</td>
<td>0.85</td>
<td>0.17 (0.49)</td>
</tr>
<tr>
<td>Student (baseline)</td>
<td></td>
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<tr>
<td>Chronic disease</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Yes (baseline)</td>
<td>$-0.43 (0.45)$</td>
<td>0.34</td>
<td>0.05 (0.30)</td>
<td>0.87</td>
<td>$-0.59 (0.41)$</td>
</tr>
<tr>
<td>No (baseline)</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent disease</td>
<td></td>
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</tr>
<tr>
<td>Yes (baseline)</td>
<td>$-0.56 (0.56)$</td>
<td>0.32</td>
<td>$-0.75 (0.38)$</td>
<td>0.47</td>
<td>0.24 (0.51)</td>
</tr>
<tr>
<td>No (baseline)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Medication consumption</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes (baseline)</td>
<td>$-0.30 (0.59)$</td>
<td>0.61</td>
<td>0.08 (0.40)</td>
<td>0.85</td>
<td>$-0.35 (0.53)$</td>
</tr>
<tr>
<td>No (baseline)</td>
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</tbody>
</table>
ethical dimensions of the GOE view. Persons living in accordance with the Ecclesia’s rules and values experience life satisfaction from their spiritual and emotional life (including emotions such as purgation of the soul, inspiration, and glorification of the soul). Recent research [31] has supported the idea that religiously engendered emotions may provide a possible linkage with health-related behaviors. The practice of religion (prayer and worship) may lead to the experience or expression of certain feelings that, through psychoneuroimmunological or neuroendocrine pathways, could affect physiological parameters. Specifically, Hughes [32] found that the relaxation response and the feeling of self-efficacy through the act of praying (as a religiousness indicator) might enhance the immune system (and indirectly the health-promoting behavior).

With respect to nutrition, there has been an effort to formulate a European Union-wide strategy and action plan to change the current highly consuming and unhealthy dietary behavior–lifestyle to healthier Mediterranean dietary guidelines [8].

Along similar lines, Greek studies [33] have shown that physical activity and healthy diet practices protect populations (including the Greek population) from sedentary habits. All relevant studies, especially the Greek ones, have interpreted this correlation between quality diet and positive health as a part of the Greek culture and lifestyle without regard to the powerful impact of religion.

However, this noticeable positive effect of the Mediterranean dietary guidelines on the optimum health of the population practicing them can be explained by the strong impact of religion on Greek dietary behavior, especially that of the Orthodox Ecclesia on Greek society and lifestyle. The latter is embodied in the Greek culture, as a component of Greek social rules. The Ecclesia has a strong positive effect on promoting healthy dietary behavior, via its principal values and fasting behavior. It is opposed to the highly consuming, stressful lifestyle of Western European societies that involves, among other things, overconsumption of fast food and generally unhealthy dietary habits.

Therefore, further analysis of the mechanisms by which the Christian Orthodox Ecclesia furthers a positive relationship between dietary behavior and healthy lifestyle could be very helpful for planning and implementing future nutritional policies and dietary guidelines by members of the European Union.

Some other positive outcomes of the religious involvement were “personal hygiene” for the “religious” group and “physical activity” for the “conventional” group. Both of these health-related indicators concern good physical condition and care of the body. These results seem to support the GOE concept that the body–soul unit is a powerful creation. The body is considered the temple of the soul and it is regarded as the inseparable instrument and permanent collaborator of the soul in the struggle for blessedness and godliness [34]. Thus the GOE perceives the human body to be of great worth, since each organ, and its condition and physiological function, has a particular spiritual meaning.

The findings of the current study revealed an adequate health status of the individuals of the sample and did not show any impact of the Orthodox Ecclesia’s lifestyle on the existence of disease and the use of medications within the previous 12-month period. This finding is similar to those of other researchers [12,32,35]. It is worth mentioning that in general the Greeks are among the healthiest people in the world,

### TABLE 3

Religiousness of Study Subjects According to Their Socio-Demographic Characteristics

<table>
<thead>
<tr>
<th></th>
<th>Religious</th>
<th>Conventional</th>
<th>Unconcerned</th>
<th>P value*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
<td></td>
</tr>
<tr>
<td>Age group</td>
<td></td>
<td></td>
<td></td>
<td>&lt;0.0005</td>
</tr>
<tr>
<td>20–29</td>
<td>18 (31%)</td>
<td>11 (15%)</td>
<td>17 (24%)</td>
<td></td>
</tr>
<tr>
<td>30–39</td>
<td>6 (11%)</td>
<td>12 (21%)</td>
<td>39 (68%)</td>
<td></td>
</tr>
<tr>
<td>40–49</td>
<td>11 (18%)</td>
<td>13 (21%)</td>
<td>37 (61%)</td>
<td></td>
</tr>
<tr>
<td>50–59</td>
<td>44 (61%)</td>
<td>12 (21%)</td>
<td>28 (48%)</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td>0.03</td>
</tr>
<tr>
<td>Male</td>
<td>33 (30%)</td>
<td>18 (17%)</td>
<td>57 (53%)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>46 (33%)</td>
<td>30 (21%)</td>
<td>64 (46%)</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td>&lt;0.0005</td>
</tr>
<tr>
<td>&lt;13 years</td>
<td>32 (25%)</td>
<td>25 (19%)</td>
<td>72 (56%)</td>
<td></td>
</tr>
<tr>
<td>≥13 years</td>
<td>47 (40%)</td>
<td>23 (19%)</td>
<td>49 (41%)</td>
<td></td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee</td>
<td>34 (20%)</td>
<td>33 (19%)</td>
<td>104 (61%)</td>
<td>&lt;0.0005</td>
</tr>
<tr>
<td>Student</td>
<td>26 (81%)</td>
<td>4 (13%)</td>
<td>2 (6%)</td>
<td></td>
</tr>
<tr>
<td>Housewife</td>
<td>17 (42%)</td>
<td>9 (22%)</td>
<td>15 (37%)</td>
<td></td>
</tr>
</tbody>
</table>

* Chi-square test.

b Nonsignificant.
as proved by the low rate of cardiovascular diseases, neoplastic diseases, and other sicknesses that prevail in the industrially developed countries [11]. This could explain why the present study did not find any differentiation between “religious” and other categories. An additional argument is that, although the adoption of healthful behaviors is positive, it may not be sufficient to cause significant differences in health status in the present study. Although it appears that religion, in a broad sense, represents a protective factor against diseases, this does not mean that it always has salutary effects. Research in that direction must be continued with greater and more representative samples to study possible negative health effects, such as those caused by feelings of divine abandonment, prayers for divine vengeance, and feelings of guilt and shame.

Furthermore, in our sample of 250 people, 32% were found to belong to the “religious” category; it is worth noting that 1 of 3 people in this intensely consumer-oriented postindustrial society adopts the lifestyle of the GOE.

Taking into consideration the association of the specific socio-economic factors (age, gender, education, and occupation) with the health-related indicators, the analysis showed the following:

(a) The age factor is strongly positively related to the physical activity indicator. A review and study of the effects of religion on health services by Schiller and Levin [4] revealed that controlling for age and education reduced the findings for the duration of the last hospitalization to insignificance. Moreover, a study by Levin et al. [36] that examined the religious differences of controlling the potentially confounding effects of age and socioeconomic status showed that Type A behavior (as a set of harmful behaviors to coronary health disease) is positively associated with the incidence of physical illness, and education and negatively associated to age, which is similar to the result herein (the physical activity indicator as a health promoting behavior is positively associated with age), with an inverse interpretation. However, we can also consider the claim of Shats et al. [37] that the rate of deterioration in health (as an age parameter) depends on the different systems within the human body.

(b) Examination of the gender differences shows that men are better relaxed during sleep and have more feeling of life satisfaction than women. This outcome, which is similar to that of the study by Uitenbroek et al. [38], is in contrast to the majority of research showing that women adopt health-promoting practices more aggressively than men [39,40] and have a greater feeling of life satisfaction than men [41]. This finding relates to the particular characteristics and mentality of Greek society and genders roles.

(c) Moreover, if we control the profession factor we conclude that employees are more positively associated with the physical activity factor in comparison with students [40]. With an even broader result, Uitenbroek et al. [38] found that employed persons behave in a more healthy way than unemployed persons.

Analyzing the above results, it could be argued that the most common interpretation may be partly due to differences in how each group acquires and interprets health information, and to differences between group exposure to environments that support healthy lifestyles.

7. CONCLUSION

The main conclusions of the current study can be summarized as follows: (a) GOE laypersons are involved in specific positive health-related behaviors. They rigorously adopt personal hygiene practices and healthful (quality) dietary habits, which reinforce the Mediterranean nutritional style, but they are not overly concerned about enhanced physical condition resulting from undertaking physical activities. Moreover, GOE laypersons have a spiritual balance as a result of adopting the values of the GOE. (b) Their reported current health status was not influenced by their living in accordance with Church values. (c) Different socio-demographic characteristics (age groups, gender, educational level and social categories) of the sample-population can affect their ability to adopt health-promoting practices. Therefore, from a policymaking point of view, it is important to consider cultural differences and socio-demographic characteristics of the population being studied.

In conclusion, the results of the current study support the assumption that the GOE lifestyle constitutes a pattern of health-related behavior. The laymen who adhere to the values and practices put forth through the ideological and emotional framework of the GOE form a group with specific health-related behaviors, a group that social and medical scientists should study and promote as such. The GOE, as do other religions in other populations, continues to play a vital role in the lives of many Greeks and its influence on health-promoting behavior appears to be an issue that is worthy of further study.

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REFERENCES


