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Running Head: THE SANCTIFICATION OF THE BODY AND BEHAVIORAL HEALTH
PATTERNS OF COLLEGE STUDENTS

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Abstract

This study examines how the construct of sanctification applies to college students' perceptions of their bodies, and how such perceptions are tied to lifestyle variables that can enhance or compromise health. Two hundred and eighty-nine college students from a mid-western university completed measures on the extent to which they viewed their bodies as being a manifestation of God (e.g., My body is a temple of God) and as characterized by sacred qualities (e.g., holy, blessed sacred). Greater levels of both forms of the sanctification of the body were related to a greater health protective behaviors, high levels of exercise, greater subjective satisfaction of one's body, less unhealthy eating practices, more disapproval of alcohol consumption and illicit drug use, and less alcohol consumption. Sacred qualities of the body was also related to a lower rates of binge eating and illicit drug use.

Many of the more than 12 million students currently enrolled in colleges and universities (National Center Education Statistics, 1996) engage in behaviors that place them at risk for serious health problems. According to a recent Centers for Disease Control and Prevention survey (CDC, 1997), for instance, approximately 29% of college students had smoked cigarettes in the preceding 30 days, 35% had reported recent episodic heavy drinking (5 or more drinks on one occasion), and 14% had recently used marijuana. The CDC's (1997) National College Health Risk Behavior Survey also examined weight status, nutrition, and physical activity of college students. Approximately 1 in 5 respondents was overweight, 3 in 4 failed to consume 5 or more servings of fruits and vegetables (i.e., minimum daily recommended levels) during the day preceding the survey, and 1 in 5 had eaten three or more high fat foods during the day preceding the survey (CDC, 1997). Only one-fifth and one-third of college students, respectively, had participated in mild to moderate or vigorous exercise (CDC, 1997). Although 46% of college students nationwide were attempting to lose weight at the time of the survey, other evidence suggests that the number of college women dieters who engage in maladaptive behaviors (e.g., binging) is greater than the number of college women dieters who merely reduced calorie intake (Mintz & Betz, 1988; Strien, 1999). Taken together, college students throughout the nation appear to engage in numerous behaviors that place them at risk for future health problems.

Religion is a potentially important, but often overlooked, factor that may be tied to college students' behavioral health. Although college students report lower levels of religiousness than the general population, most still endorse being religious. In a national survey, for example, approximately 77% of college students reported being members of a church, synagogue or campus religious group. In addition, 85% of college students surveyed reported that religion is "very important to fairly important" to them (Gallup & Bezilla, 1992). Studies

with older adolescents and college students also echo several substantial reviews (Levin, 1987, 1994) and large-scale epidemiological investigations (e.g., Strawbridge, 1997) that have identified links between religion and health outcomes in the general population. For example, in an investigation of 994 older adolescents (10-12 grade), Newcomb et al. (1986) found a significant correlation between a four-item measure of greater religious commitment and less cigarette, alcohol, and other drug use. Similarly, using a large, nationally representative sample of high school seniors, youth reporting greater religiousness (i.e., three items assessing importance of religion, religious attendance, and denominational affiliation) were less likely to engage in health compromising behaviors (e.g., drinking and driving), and more likely to behave in ways that enhance their health (e.g., proper nutrition, exercise, and rest; Wallace & Forman, 1998). Finally, in a sample of 1,007 college students, a two-item measure of greater religious attendance and self-reported religiousness was correlated with healthier attitudes and behaviors, and fewer health compromising behaviors and illnesses (Oleckno & Blacconiere, 1991).

Although research suggests that religion may be an important factor related to health, critical questions remain as to what it is about religion that influences college students' health. Because prior research with this sub-group has relied heavily on global indicators of levels of religiousness (e.g., single items on church affiliation, importance of religion), little is known about particular religiously-based beliefs about the body that may be tied to health-related behaviors and attitudes. To advance theory and research on the role of religion in health, this study examines how the construct of sanctification might be applied to the human body, and how such perceptions are tied to lifestyle variables that can enhance or compromise health.

As is explained more fully elsewhere (Mahoney, Pargament, Murray-Swank, & Murray-Swank, in press; Pargament & Mahoney, this volume), the construct of sanctification extends the

psychological power of religion and spirituality to many aspects of life, including many seemingly secular objectives. Sanctification is defined as perceiving aspects of life as having spiritual significance and character (Mahoney et al., in press; Pargament & Mahoney, this volume). We propose that individuals can sanctify objects, such as the human body, in nontheistic or theistic ways. In the former case, people may ascribe sacred qualities to their body (e.g., holy, blessed, sacred). In the latter case, people may view their body as being a manifestation of God (e.g., My body is a temple of God; my body is a gift from God). Initial studies on sanctification indicate that individuals are more likely to think and act in ways that preserve and protect aspects of their life that they perceive as sacred (Mahoney et al., 1999; Mahoney et al., this volume; Murray-Swank, N., Pargament, & Mahoney, this issue; Murray-Swank, A., Mahoney, & Pargament, 2002; Tarakeshwar, Swank, Pargament & Mahoney, 2001).

Consistent with prior research, we hypothesized that greater sanctification of the body would be related to behaviors and attitudes that reflect a greater investment in maintaining one's physical well-being. This would translate into greater self-protective health patterns as well as greater avoidance of health compromising beliefs and behaviors. For example, we expected that the more individuals perceive their body as sanctified, the more likely they would be to hold negative views of smoking, drinking, and illicit drug use, and the less likely they would be to engage in these health compromising behaviors. Similarly, the more individuals view their body in terms of sacred qualities or as being connected to God, the more inclined they would be to engage in health promoting behaviors, such as exercising regularly and eating healthy, and less likely they would be to engage in unhealthy dieting practices. Finally, the stronger peoples' convictions are about the spiritual meaning of their bodies (e.g., my body is holy or my body an instrument of God), the more they may appreciate and accept their bodies. Thus, we expected

greater sanctification of the body to be related to greater satisfaction with one's physical appearance, and lower levels of preoccupation with improving personal attractiveness. Given the emphasis in some religious orientations to associate bodily desires with sinfulness (Glucklich, 2001), we also considered the possibility that greater sanctification could be related to greater asceticism. That is, in contrast to our model of sanctification, some might argue that individuals may pursue spiritual ideals through excessive self-denial and control of bodily urges. Thus, we examined the link between sanctification and asceticism, hoping to find an insignificant association between these variables; such results would demonstrate differential validity of our measures of sanctification.

Method

Participants

Participants were 289 college students (77.5% female) enrolled in a mid-sized, state university in the Midwest. Three hundred and sixteen participants were initially recruited from several introductory psychology classes, and completed survey for the study anonymously either by attending a pre-arranged group session or by taking the survey at home and returning it within one week. Twenty-seven cases were dropped due to incomplete surveys. The resulting sample averaged 19.2 years in age ($SD = 1.77$) and had an average of 13.9 years of education ($SD = 9.2$). The racial breakdown of the sample was 91% Caucasian, 4.8% African American, 1.7 % Hispanic, and 2.4% multi-ethnic or other. The sample was predominantly Protestant (38%) and Roman Catholic (36%), with 1% endorsing Jewish, 11% "other," and 14% "none." Four items were taken from the General Social Survey (NORC, 1998) to provide global indicators of the participants' general level of religiousness. The breakdown of frequency of church attendance was: 8% never, 29% twice or less per year, 20% several times per year, 21% one to three times

per month, 20% weekly, and 3% several times per week. The breakdown of the frequency of prayer was: 7% several times per week, 30% weekly, 13% one to three times per month, 13% several times per year, 28% twice or less per year, and 11% never. An item on self-rated religiousness yielded a mean of 2.5 ($SD = .84$), based on a 4-point Likert scale with anchors of "not religious at all," "slightly religious," "moderately religious," and "very religious." A parallel item on self-rated spirituality yielded a mean of 2.7 ($SD = .87$).

Measures

The sanctification of the body was assessed with two self-report measures adapted from Mahoney et al. (1999).

Manifestation of God in the Body. Participants completed a 12-item Manifestation of God in the Body Scale to assess the degree to which the body was perceived to be an expression or manifestation of God. Participants used a 7-point Likert scale with the anchor points of "strongly disagree" (1) to "strongly agree" (7) to indicate the degree to which they agreed with the following twelve questions: My body is a temple of God; my body is created in God's image; my body is a gift from God; God is present in my body; God uses my body to do God's will; my body is united with God; my body is bonded to the everlasting Spirit of God; a spark of the divine resides in my body; God lives through my body; God is glorified through my body; my body is an instrument of God; and the power of God moves through my body. To avoid confounding outcomes with this sanctification variable, the items were neutral about direction of influence of God on the body (i.e., none of the items asked if God helped or hindered bodily well-being). The twelve items were summed to create a total Manifestation of God in the Body score ($\alpha = .98$).

Sacred Qualities of the Body. Participants completed a 10-item Sacred Qualities of the

Body Scale to assess the degree to which the body was perceived as having qualities typically associated with divine, transcendent phenomenon. Participants used a 7-point Likert scale with the anchor points of “does not describe at all” (1) to “very closely describes” (7) to indicate the degree to which the following words applied to the body: “blessed”, “holy,” “sacred,” “spiritual,” “miraculous,” “divine,” “hallowed,” “spirit-filled,” “heavenly,” and “religious.” The items on this non-theistically oriented scale made no direct mention of a divine “Being” (e.g., God, Higher Power). A total Sacred Qualities of the Body score was created by summing items ($\alpha = .95$).

_____ *General Health Protective Practices.* Twenty-six items from the Health Protective Behavior Scale¹ were used to assess participants' propensity to engage in a variety of behaviors with the intent of protecting their physical health (e.g., eat sensibly; get enough sleep; take vitamins; wear a seat belt; get regular medical checkups; Harris & Guten, 1979). For the purpose of this study, the item of “pray or live by the principles of religion” question was intentionally removed to avoid a potential confound with sanctification. The items were summed to create a total score for each participant.

_____ *Physical Fitness.* Three indices of investment in physical fitness were assessed in this study. Two items from the National Health Interview Survey (NHIS; CDC, 2000) was administered to assess exercise rates including one item on the frequency of mild to moderate physical exercise, and one item on the frequency of vigorous physical exercise. In addition, the 13-item Fitness Orientation subscale of the Multi-Dimensional Body-Self Relations Questionnaire (MBSRQ; Cash, 2000) was used to assess the degree to which participants viewed physical fitness as an important aspect of life and actively devote energy and time to their fitness.

_____ *Satisfaction with Physical Appearance.* Two subscales of the MBSRQ were used to assess acceptance and preoccupation about physical appearance (Cash, 2000). One subscale, the

nine-item Body Areas Satisfaction subscale, asked participants to rate their degree of satisfaction with nine aspects of their body (e.g., overall appearance; face - facial feature; mid torso - buttocks, hips, thighs, legs). Items were summed for a total score. The other subscale, the 12-item Appearance Orientation subscale, assesses the extent to which individuals are mentally preoccupied with and dedicate effort to improving their personal appearance (e.g., I am always trying to improve my physical appearance; Before going out in public, I always notice how I look). Items were summed for a total score.

Dieting and Nutritional Behaviors. Three aspects of dieting and nutrition were assessed. Healthy dieting practices were assessed with the 9-item Healthy Dieting Practices sub-scale from the Dieting Practices Inventory (DPI; French & Jeffrey, 1997). This index assesses the extent to which participants engaged in adaptive, healthy nutritional practices in the past year (e.g., increase fruits and vegetables, cut out sweets and junk food from diet, reduce number of calories). Two indices were used to assess unhealthy and maladaptive dieting behaviors. This included the 5-item Unhealthy Dieting Practices sub-scale from the DPI which assesses the extent to which participants engaged in counterproductive or risky dieting methods that typically do not result in lasting weight loss (e.g., skips meals, take laxatives or appetite suppressants). In addition, the 16-item Binge Eating Scale (Gormally, Black, Daston, & Rardin, 1982) was used to assess the degree to which participants lacked confidence in their ability to control urges to overeat and were unable to avoid excessive consumption of food (e.g., overeating at meals, excessive snacking, bingeing, eating when bored). Items were summed on each scale to obtain the respective total scores.

Illicit Drug Usage and Disapproval. Illicit drug usage was assessed with seven items from the Confidential Information Questionnaire (CIQ; Johnston, 1973). These items asked

about the frequency in the past year that the participant had consumed marijuana, amphetamines, barbiturates, heroin, hallucinogens "Ecstasy" or mushroom, and included common street names for these drugs. Scores were summed for analyses. Disapproval of illicit drug use was assessed with 15 items taken from the CIQ. These items asked about participants' degree of disapproval about peers experimenting with as well as regularly taking the illicit drugs listed above. Items were summed for a total score.

Alcohol Usage and Disapproval. Three questions from the NHIS Survey (CDC, 2000) were used to assess participants' alcohol consumption including: In past two weeks, how many days you have consumed beer, wine or liquor; on average, how many drinks do you consume at a party or social occasion; and how often would you say you get "smashed" as a result of drinking. For this study, the items were combined for a total score. Disapproval of social drinking and excessive alcohol consumption (e.g., binging) was assessed by summing 3 items from the CIQ. for a total score.

Smoking History and Disapproval. Behavioral engagement in smoking was assessed with a yes/no categorical item from the National Health Interview Survey (CDC, 2000). This question asked whether participants had smoked at least 100 cigarettes during their lifetime. Disapproval of heavy smoking (i.e., more than one pack of cigarettes per day) was assessed with 1 item from the CIQ.

Asceticism. The 8-item Asceticism sub-scale of the Eating Disorders Inventory-2 (Gardner, 1991) was used to assess participants' tendency to pursue spiritual ideals through self-denial, and control of bodily urges. Items were summed for a total score.

Results

Preliminary data analyses

Preliminary data analyses were conducted to examine associations between the two sanctification measures and global indices of general religiousness. The Manifestation of God in the Body and Sacred Qualities of the Body scores both correlated at $p \leq .0001$ with participants' reports of the frequency of prayer (respective r 's of .53 and .49), the frequency of religious service attendance (r 's of .58 and .52), self-rated religiousness (r 's of .63 and .57), and self-rated spirituality (r 's of .46 and .40). These findings offer evidence of convergent validity of the two sanctification measures given the moderate correlations with global indices of religiousness.

Preliminary data analyses were also conducted on correlations between both sanctification measures and the demographic variables of age, gender, race and year in college. Significant differences emerged only for race and gender. Specifically, white college students reported significantly lower Manifestation of God scores ($M = 55.0, SD = 19.7$) than non-white college students ($M = 63.2, SD = 22.8, t = -2.13, p < .05$). Likewise, the former group had lower Sacred Qualities scores ($M = 39.4, SD = 14.0$ versus $M = 39.4, SD = 14.0$ respectively, $t = -1.99, p < .05$). In addition, male college students reported significantly lower Manifestation of God scores ($M = 50.1, SD = 21.0$) than female college students ($M = 57.3, SD = 19.6, t = -2.58, p < .05$). The two groups did not exhibit significantly different Sacred Qualities scores.

Descriptive Findings on the Sanctification of the Body and Outcome Variables

The mean rating of the Manifestation of God in the Body score across the 12 items was 55.7 ($SD = 20.1$; range 12-84). The scores were skewed somewhat upward with 65% of the sample obtaining a total score above 48, and 25% of the sample yielding a total score of 60 or greater. This indicates that the majority of participants' responses to the questions fell midway between "neutral" and "strongly agree." The mean rating of the Sacred Qualities of the Body score across the 10 items was 40.0 ($SD = 14.3$; range 10-70). The scores were fairly normally

distributed with 53% of the sample obtaining a total score above 40, and 20% of the sample yielding a total score of 50 or greater. This indicates that about half of the participants' responses to some or all of the questions fell above "neutral" when asked whether each sacred quality described the body. The Manifestation of God in the Body and Sacred Qualities of the Body scores were correlated at $r = .66$ ($p < .0001$).

Table 1 displays the means, standard deviations, ranges and alpha coefficients for the outcome variables. Low to moderate correlations existed between the majority of the outcome measures. The main exceptions included an r of .67 between general exercise level and frequency of vigorous exercise, an r of .72 between vigorous and mild to moderate exercise, and an r of -.70 between alcohol use and alcohol disapproval. The mean r across all other correlations of the outcome variables was .18 (range of absolute values = .00 to .57), thereby warranting separate correlations to be calculate between the sanctification and outcome variables.

Primary Analyses

Consistent with the hypotheses, one-tailed tests of significance were used. Table 2 displays the partial correlations between the two indices of sanctification of the body and the health-related variables after partialling out gender and race; these two demographic variables were controlled because they were correlated with one or both sanctification indices and with many of the health outcome variables. Sixty-three percent of the partial correlations indicated small but significant protective links between sanctification of the body and health-related behaviors and acceptance of one's body and physical appearance. Specifically, higher scores on the Manifestation of God and Sacred Qualities scales were related to greater health protective behaviors ($r = .15$ and $.30$, respectively), more positive attitudes and better general exercise

habits ($r = .15$ and $.20$), more frequent vigorous exercise ($r = .12$ and $.16$), greater subjective satisfaction with one's body ($r = .13$ and $.25$), lower likelihood of unhealthy dieting practices ($r = .12$ and $.16$), and greater disapproval of alcohol use ($r = .11$ and $.16$) and illicit drug use ($r = .11$ and $.24$). Perceiving one's body as possessing sacred qualities was also related to more frequent engagement in mild to moderate exercise ($r = .11$), decreased binge eating habits ($r = -.14$), and less frequent consumption of both alcohol ($r = -.13$) and illicit drugs ($r = -.13$). Smoking was the only domain of functioning was not significantly related to either measure of sanctification. In support of the differential validity for our measures of sanctification, sanctification was not related to asceticism.

Discussion

This study represents an initial examination of how one specific set of religiously based beliefs about the body may be connected to health-related attitudes and behaviors for college students. Considerable research suggests that greater general religiousness (e.g., religious affiliation, rates of church attendance, self-rated importance of religion) is tied to lower levels of health compromising behavior and greater endorsement of health protective attitudes and behaviors in the general population (e.g., Levin, 1987, 1994; Strawbridge, 1997). A handful of studies have extended this research to college students (Newcomb et al., 1986; Oleckno & Blaconiere, 1991; Wallace & Forman, 1998), a distressing percentage of whom engage in lifestyles marked by risky health behaviors (e.g., CDC, 1997; Mintz & Betz, 1988; Strien, 1999). Little is known, however, about the interface between college students' beliefs about spiritual dimensions of the human body and corresponding health-related behavior patterns and attitudes. This study begins to fill this gap.

Based on initial research on the construct of sanctification (Mahoney et al., in press;

Pargament & Mahoney, this volume), we anticipated that greater perceived sanctification of the body would be linked to greater investment maintaining one's physical well-being, greater health protective behaviors, and greater acceptance of one's physical body. Our findings provided modest support for these ideas. Specifically, greater belief that God was manifested in the body and that the body is characterized by sacred, transcendent characteristics was associated with a general lifestyle orientation of more health self-protective behavior. That is, greater sanctification of the body was positively related to a composite index of a broad range of health-protective beliefs and behaviors, such as wearing a seat-belt, eating sensibly, getting enough sleep and relaxation, avoiding overworking, taking vitamins, etc.

Both forms of sanctification were also associated with a greater sense of subjective satisfaction with one's overall physical appearance and body composition. This suggests that sanctification covaries with the extent to which people find their basic body shape acceptable. This is consistent with various "embodiment" theological teachings (e.g., Johnson, 1996) that encourage individuals to view their bodies as being good and acceptable in God's eyes and as embodying abstract spiritual characteristics. Such beliefs would presumably foster a sense of self-acceptance and worth, even if one's body fails to conform to rigid parameters of social desirability. Interestingly, sanctification was unrelated to the extent to which college students were preoccupied with maintaining their personal appearance. Thus, for some people, sanctification may discourage vanity and over-involvement in personal grooming; but, for others, sanctification may motivate attention to personal hygiene, perhaps because such behavior conveys the message to oneself and others of a basic respect of one's body.

Greater levels of both types of sanctification were also tied to higher rates of vigorous exercise and a higher emphasis placed on prioritizing physical fitness as a part of daily life. In

addition, greater sacred qualities of the body was associated with more frequent mild to moderate exercise. These findings suggest that sanctification of the body may provide young adults with a spiritual frame of reference that helps inspire a regular workout routine and physical fitness activities. The results are also consistent with anecdotal reports in the media on the spread of "faith-based" fitness programs in the U.S. across a wide variety of religious organizations (Marcus, 2001) that promote concepts about connections between the body and soul.

Both types of sanctification were also linked to greater disapproval of and less self-reported consumption of alcohol and illicit drugs, even after controlling for gender and race (the exception was the non-significant link between manifestation of God in the body and illicit drug use). In addition, both types of greater sanctification were related to lower levels of maladaptive eating and unhealthy strategies to lose weight. Greater perceived sacred qualities was also related to greater self-confidence in controlling urges to overeat. Overall, these findings suggest that the sanctification of the body may provide college students with a cognitive framework that strengthens their resolve to avoid eat habits and substances that are harmful to the body.

Of course, it should also be recognized that the associations that emerged in this study were relatively small in size. Also, null findings emerged for both indices of sanctification for engagement in healthy nutrition patterns. This may be partly due to the relative scarcity, expense, and inconvenience of health foods, fresh produce and low-fat food items near or on college campuses. Such obstacles may make it difficult for students to engage in healthy eating patterns that are consistent with their spiritual beliefs about their body. However, students apparently are somewhat more able to resist indulging in commercial fast food and vending machine products. Finally, sanctification was unrelated to disapproval of smoking or a lifetime history of this behavior. However, the restricted range and categorical nature of these two single-item variables

may have obscured potential links between smoking behaviors and sanctification.

Given the promising results of this study, we would encourage further research on the sanctification of the body. Although the associations we found were modest, small changes in behavioral health patterns over a lifetime can have large health consequences. Longitudinal studies are needed to demonstrate such possible effects of the sanctification of the body over time. In addition, future research is needed that identifies the individuals for whom the sanctification of the body is a more powerful and robust predictor of health-related behaviors. For example, these links may be stronger for youth who have participated in gyms or spas that emphasize spirituality, in church or synagogues-based fitness programs, or in other organizations that directly promote a close integration of spirituality and body (e.g., Fellowship of Christian Athletes). Research exploring such moderating effects would provide further evidence of the potential of religious institutions, such as campus ministry programs, to facilitate the health and physical well-being of college students. Given the fact that a sizable proportion of students appear to participate in religious activities and view themselves as moderately religious, college and university-based faith communities represent potentially valuable settings for delivering health promotion education to many young adults. Professionals in health-related fields could develop more collaborative connections with religious or spiritual organizations based on respect for the theological underpinnings of beliefs about the integration of the body and soul, while offering scientifically sound recommendations about specific health-practices that promote physical well-being. Finally, the findings of this study may extend to other segments of the general population. For example, additional research on the role of the sanctification of the body in the elderly or minority subgroups could help support the development of psychospiritual intervention programs that aim to foster physical health by tapping into participants' beliefs about

the interface of spirituality and the body. Overall, this study provides some initial evidence of the promising potential of such endeavors.

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Footnote

1 The following four items from the Health Protective Behavior Scale were inadvertently not included in the questionnaire packet in this study: avoid getting chills, watch one's weight, do things in moderation, and get enough exercise.

Table 1
Descriptive Statistics on Sanctification and Outcome Measures

<u>Sanctification Variables</u>	<u>M</u>	<u>SD</u>	<u>∇</u>	<u>Range</u>
Manifestation of God	55.7	20.1	.98	12-84
Sacred Qualities	40.0	14.3	.95	10-70
<u>Health Related Variables</u>				
Health Protective Behaviors	26.7	6.3	.76	4-47
Physical Exercise				
Frequency of mild-moderate exercise per week	7.5	2.0	n/a	0-10
Frequency of vigorous exercise per week	6.6	2.2	n/a	0-10
General exercise level & positive attitudes	45.3	10.8	.91	16-65
Physical Appearance				
Subjective satisfaction with body	30.0	5.8	.80	13-44
Preoccupation with improving appearance	40.4	8.0	.87	13-60
Diet & Nutrition				
Healthy nutrition habits	3.6	2.7	.81	0-9
Unhealthy dieting practices	.40	.9	.67	0-5
Binge Eating	9.4	7.2	.88	0-33
Alcohol use				
Disapproval of alcohol consumption	9.1	2.8	.79	3-15
Frequency of alcohol consumption	9.8	7.0	.78	0-34
Illicit drug use				
Disapproval of illicit drug use/experimentation	64.1	10.4	.94	34-75
Frequency of illicit drug use in lifetime	2.7	6.0	.73	0-41
Smoking				
Disapproval of heavy smoking	4.1	1.0	n/a.	1-5
Have smoked 100 cigarettes in life - yes/no	32%	n/a	n/a	
Currently non-smoker, light or heavy smoker				
Asceticism	15.2	4.6	.66	4-33

Table 2
Correlations between Sanctification of the Body Scales and Health-Related Variables, with Gender and Race partialled out.

<u>Health Related Variables</u>	<u>Manifestation of God</u>	<u>Sacred Adjectives</u>
Health Protective Behaviors	.15**	.30***
Physical Exercise		
General exercise level & positive attitudes	.15**	.20***
Frequency of mild-moderate exercise per week	.07	.11*
Frequency of vigorous exercise per week	.12*	.16**
Physical Appearance		
Subjective satisfaction with body	.13*	.25***
Preoccupation with improving appearance	.04	.04
Diet & Nutrition		
Healthy nutrition habits	-.05	-.03
Unhealthy dieting practices	-.12*	-.18***
Binge eating	-.06	-.14**
Alcohol use		
Disapproval of alcohol consumption	.11*	.16**
Frequency of alcohol consumption	-.10*	-.13*
Illicit drug use		
Disapproval of illicit drug use/experimentation	.11*	.24***
Frequency of illicit drug use in lifetime	-.08	-.13*
Smoking		
Disapproval of heavy smoking	-.03	-.08
Have smoked 100 cigarettes in life - yes/no	-.09	-.07
Asceticism	-.02	-.03

* $p < .05$, ** $p < .01$, *** $p < .001$