DOI: 10.17951/j.2025.38.2.73-92

ANNALES
UNIVERSITATIS MARIAE CURIE-SKŁODOWSKA
LUBLIN – POLONIA

VOL. XXXVIII, 2 SECTIO J 2025

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Relationships Between Religious Affiliation and Attitudes Towards Complementary and Alternative Medicine and Health Consciousness in the Polish General Population

Powiązania przynależności religijnej z postawami wobec Medycyny Komplementarnej i Alternatywnej oraz ze świadomością zdrowotną w polskiej populacji

HOW TO QUOTE THIS PAPER: Gawda, B.U., Księska-Koszałka, J.M. (2025). Relationships Between Religious Affiliation and Attitudes Towards Complementary and Alternative Medicine and Health Consciousness in the Polish General Population. *Annales Universitatis Mariae Curie-Skłodowska. Sectio J, Paedagogia-Psychologia*, *38*(2), 73–92. DOI: 10.17951/j.2025.38.2.73-92.

ABSTRACT

Research indicates that at the root of complementary and alternative medicine (CAM) use there are a person's worldview, health-related convictions, religiosity, and religious affiliation. The goal of the present study was to determine the relationships of religious affiliation with attitudes toward CAM and the use of CAM, and health consciousness in the Polish general population. A total of 599 participants (included 57.1% Catholics, 24.5% non-practicing, 16.1% atheists, and 2.3% declared other religions) were surveyed using Polish adaptations of Complementary, Alternative and Conventional Attitudes Scale and Health Consciousness Scale. Results showed that religious affiliation differentiated attitudes toward CAM, the use of CAM, and health consciousness. Catholics displayed more positive attitudes toward CAM and lower health consciousness than atheists. Non-practicing persons were more likely to use Body & Mind Medicine and Energy Healing compared to Catholics or atheists. The study shows that it is necessary to consider non-medical factors (such as religious affiliation, beliefs, and attitudes) in designing prevention and treatment and in maintaining a proper doctor–patient relationship.

Keywords: religious affiliation; complementary and alternative medicine; health consciousness; Catholics

INTRODUCTION

Despite its controversial-evidence-based benefits and potentially harmful effects, complementary and alternative medicine (CAM) is widely used. The World Health Organization has reported that the use of CAM therapies for disease prevention and maintenance of well-being has been growing worldwide in the recent years (WHO, 2005). The prevalence rate of CAM use among the general population in developed countries ranges from 42% in the US, through 50% in Canada, to 75% in France (Barnes et al., 2004; WHO, 2013). Among the many factors thought to be associated with the use of CAM, religious affiliation and religiosity have been reported as important predictors. Religion interacts with the various factors that contribute to the use of CAM (Ben-Arye et al., 2011; Curlin et al., 2009; Klafke et al., 2012; McCurdy et al., 2003). One of them is chronic disease. The most numerous group of CAM users are patients with chronic diseases, particularly patients with cancer, however, people who do not suffer from such diseases also resort to CAM (Perdyan et al., 2021). This is mostly linked to the anxiety and lack of emotional/psychological support that patients experience during treatment (Perdyan et al., 2021). Moreover, cancer patients may view conventional treatment as less safe and too disease-oriented, as opposed to holistic and patient-centred (Jonas, Fischer, 2006). In this context, religion can play an important role as a positive source of comfort and coping (Nicdao, Ai, 2014). Religion is defined as "an organized system of beliefs, practices, and symbols designed to facilitate closeness to a higher power" (Koenig et al., 2004). Religion involves social interaction and commitment to a community. A comprehensive model of relationships between religion and mental/physical health has been proposed by Koenig. He took into consideration the three main monotheistic religions, i.e. Christianity, Judaism, and Islam, as well as a long list of mental problems and behaviours (Koenig et al., 2004). Some findings show that there are associations between religion and CAM use (Curlin et al., 2009; Ellison et al., 2012). Some practices such as meditation and spiritual healing, which are key components of traditional Christian theology and practice, are also used in CAM (Ellison et al., 2012; Hsiao et al., 2008). A study conducted in the US has demonstrated that spiritually and religiously engaged persons are relatively more likely to employ biologically based therapies such as herbal treatments or high doses of vitamins (Ellison et al., 2012; Smith et al., 2008). According to the findings of some US studies, faith is related to an increased use of CAM (Ai, Bolling, 2002; Hildreth, Elman, 2007; Hsiao et al., 2008). In Ireland, it has been established that the more religious a region is, the greater is the variety of CAM on offer (Hughes, 2006). This research is consistent with other studies indicating that CAM use is motivated by existential needs (Pedersen

et al., 2013). An analysis of ethnic-specific CAM use has shown that ethnic groups differ in overall CAM use – they are more likely to use ethnic-specific CAM modalities which are incorporated in their faith (Hsiao et al., 2006). In Denmark, for instance, women with breast cancer who were unambiguous believers were more likely to use CAM therapies than women who declared ambiguous faith. Unambiguous faith was also positively associated with the use of different types of CAM and with a stronger belief in the positive effect of CAM (Pedersen et al., 2013). In African countries, this relationship can be different than in Western countries, in which sociodemographic factors influence CAM attitudes and CAM use. Although the prevalence of CAM use in cancer patients in Nigeria is one of the highest in the world, this is not associated with sociodemographic factors such as age, marital status, socioeconomic status, or level of education (Ezeome, Anarado, 2007). The only important factor is religion. Faith is associated with CAM use because faith is an immanent part of the traditional Nigerian society, its cultural and religious beliefs and practices. The high prevalence of faith and prayer-house-healing among Nigerian patients mirrors the traditional nature of this society (Ezeome, Anarado, 2007). In Germany, religious patients were found to have significantly higher expectations about alternative medicine, compared to conventional medicine, only with regard to "Alleviation" (Keinki et al., 2022). On the contrary, in Russia, no significant association of religious affiliation with CAM use was found (Brown, 2008) .

Taking into consideration studies that confirm the existence of a close connection between the use of CAM and patients' spirituality/religiosity (Ezeome, Anarado, 2007; Hildreth, Elman, 2007; Hsiao et al., 2008; Pedersen et al., 2013; Smith et al., 2008) and the fact that no such analyses had been conducted in the Polish general population, we planned to carry out a study focused on the relationship between CAM use/CAM attitudes and religious affiliation that would also include other potential influencing factors. To our knowledge, this is the first study of this problem in the Polish general population. In Poland, data on CAM prevalence are scarce (Perdyan et al., 2021). They mostly regard patient populations (Duleba et al., 2008; Nowicki et al., 2013; Olchowska-Kotala, Barański, 2016; Puskulluoglu et al., 2021; Reszka et al., 2021). According to the Public Opinion Research Center (*Centrum Badań Opinii Społecznej*) survey from 2011, 24% of Poles or their families used CAM (Perdyan et al., 2021). Data on the prevalence of CAM use among cancer patients in Poland show that the most popular CAM therapy is the use of herbal drugs (Duleba et al., 2008; Nowicki et al., 2013; Olchowska-Kotala, Barański, 2016; Puskulluoglu et al., 2021; Reszka et al., 2021) and that there is no difference in CAM use between practicing and non-practicing believers (Puskulluoglu et al., 2021; Reszka et al., 2021).

The percentage of believers in Poland is one of the highest in Europe. In the light of the latest data on religiosity among Poles, 87.4% (Public Opinion Research Center, 2022) to 91% (Sadłoń, 2021) of the population declare to be Catholic, with this ratio systematically decreasing since the 1990s. Of the declared Catholics, approx. 36.9–42.9% (Public Opinion Research Center, 2022; Sadłoń, 2021) regularly participate in religious practices, while approx. 24% describe themselves as non-practicing Catholics. The believers and the practicing Catholics are mainly elderly people, with a lower level of education, who come from smaller towns. The largest percentage of non-believers are young people (Public Opinion Research Center, 2022; Sadłoń, 2021). The declaration of being a believer does not mean that one follows the moral principles taught by the Church, e.g. only about 25% of believers declare to comply with the dictate to maintain sexual purity before marriage (Sadłoń, 2021).

The theoretical justification for testing the associations between religious affiliation, attitudes toward CAM, and health consciousness can be a model by Koenig (2012) and the stress-and-coping theory by Pargament (1997). A comprehensive model of relationships between religion and mental/physical health has been proposed by Koenig (2012). He took into consideration the three main monotheistic religions, i.e. Christianity, Judaism, and Islam, as well as a long list of mental problems and behaviours (Koenig et al., 2004). Religion is defined as an organized system of beliefs, practices, and symbols designed to facilitate closeness to a higher power and involves social interaction and commitment to a community (Koenig, 2012). According to Koenig's model religion embraces the entirety of human existence, thus also affecting the sphere of health. Perhaps, for this reason, it can also influence and differentiate health attitudes. As Koenig explains, health-promoting opinions and recommendations offered by various religions result in members of religious congregations placing a higher value on health; they also foster positive attitudes toward certain health behaviours and aspects of a healthy lifestyle (Koenig et al., 2004). The stress-and-coping theory by Pargament (1997) highlights the diversity of religious behaviour in the face of stress. Religion is "a process of searching for meaning in relation to the sacred" (Pargament, 1997, p. 32). Religion can play important role in the process of coping with personal stress and performs many of its functions: it can give people hope, guidelines for action, and/or emotional support, but it can also be maladaptive (Pargament, 1997; Pargament et al., 2004). Religious aspects, according to Pargament's theory, may be of significant importance, e.g. in the cognitive assessment of the manner of behave in a given health situation (Pargament et al., 2004). Religious coping can be one of the tools supporting coping with stress, for example, by searching for alternative therapies of a certain type. This theoretical context can explain the mechanisms of why people turn to alternative or complementary medicine and

allow an interpretation of the associations between religious affiliation and CAM attitudes, CAM use, and health consciousness.

Hypotheses. Basing on the data that Polish society is mostly Catholic, we aimed to examine the relationship between religious affiliation and CAM attitudes and CAM use in the Polish general population among persons suffering from chronic diseases and healthy people.

1. We hypothesized that attitudes toward CAM use were associated with religious affiliation (Ben-Arye et al., 2011; Curlin et al., 2009; Klafke et al., 2012; McCurdy et al., 2003).
2. We assumed that the most frequently used type of CAM treatment in the Polish general population are biological therapies (Duleba et al., 2008; Nowicki et al., 2013; Olchowska-Kotala, Barański, 2016; Perdyan et al., 2021; Puskulluoglu et al., 2021; Reszka et al., 2021).
3. Additionally, if our hypothesis about the association between religion and CAM attitudes/CAM use turned out to be correct, we wanted to explain this link in relation to health consciousness, which we believe may play a role in this relationship (Księska-Koszałka, Gawda, 2022; López-Cepero et al., 2022).

METHOD

Due to the pandemic, the survey was conducted online, using the snowball sampling technique.

Participants

A sample of 599 Poles (438 women and 122 men) aged 18–78 were surveyed. The link to the survey platform was sent by the interviewers via e-mail and social media. Each of the respondents was asked to share the link with other people. The link to the survey was also sent to social media groups interested in CAM. We included 560 participants' (responses in the calculations because 39 respondents declared "no response" in terms of religious affiliation. The majority of respondents were middle-aged (57.5%). Similarly, the majority of participants were married (57.1%), 7.3% widowed or divorced, and 35.5% single. Educational attainment ranged from secondary (28.0%) to higher education (72.0%). A similar percentage lived in rural and urban areas. Finally, as regards religious affiliation 57.1 % of respondents declared being Catholics, 24.5% non-practicing, 16.1% atheists, and 2.3% other religions. Respondents declared that they are healthy at 36.8%, suffering from the non-chronic disease at 38.4%, and 24.8% chronic diseases.

Table 1. Participants' sociodemographic characteristics ($N = 560$)

Parameter		CAM users *N*	CAM users %	Non CAM users *N*	Non CAM users %	Total
Gender	Female	297	73.3	141	91.0	438
	Male	108	26.7	14	9.0	122
Age group	18–29	140	34.6	23	14.8	163
	30–45	216	53.3	106	68.4	322
	over 45	49	12.1	26	16.8	75
Domicile	rural	100	24.7	38	24.5	138
	small town	65	16.0	35	22.6	100
	town over 100,000	112	27.7	32	20.6	144
	city over 100,000	128	31.6	50	32.3	178
Education	secondary/ high	121	29.9	36	23.1	157
	university	284	70.1	119	76.8	403
Work status	unemployed	32	7.9	20	12.9	52
	student	76	18.8	12	7.7	88
	half-time	51	12.6	22	14.2	73
	full-time	235	58.0	93	60.0	328
	retired	11	2.7	8	5.2	19
Marital status	single	160	39.5	39	25.2	199
	married	219	54.1	101	65.2	320
	divorced/ widowed	26	6.1	15	9.7	41
Family income	low	19	6.7	9	5.8	28
	average	59	14.6	26	16.8	85
	high	221	54.6	75	48.4	296
	superior	84	20.7	32	20.6	116

Source: Authors' own study.

Table 2. Participants' characteristics of health status and religious affiliation ($N = 560$)

Parameter		CAM users *N*	CAM users %	Non CAM users *N*	Non CAM users %	Total	%	*p*
Health status	healthy	153	37.8	53	34.2	206	36.8	0.113
	non-chronic diseases	161	39.8	54	34.8	215	38.4	
	chronic diseases	91	22.5	48	31.0	139	24.8	
Religious affiliation	Catholics	228	56.3	92	59.4	320	57.1	<0.05*
	non-practicing	92	22.7	45	29.0	137	24.5	
	atheists	77	19.0	13	8.4	90	16.1	
	other religions	8	2.0	5	3.2	13	2.3	

M – mean, *SD* – standard deviation, $*p < 0.05$

Source: Authors' own study.

Measures

Complementary, Alternative and Conventional Medicine Attitudes Scale (CACMAS)

Attitudes towards CAM were measured using the Polish adaptation of McFadden et al.'s (2010) CACMAS Questionnaire (Księska-Koszałka, Gawda, 2023). The Polish adaptation includes 23 items grouped into 4 factors: Philosophical Congruence with CAM, Dissatisfaction with Conventional Medicine, Mind-Body Integration, and Belief in CAM. Cronbach's alpha for the whole sample and the individual subscales was 0.92 and 0.70–0.89, respectively. Responses were given on a 7-point Likert scale.

Use of CAM therapies, religious affiliation, and other covariates – the survey

The participants were asked whether they used CAM therapies. Yes/no answers were elicited. To establish the specific ways in which the respondents used CAM and their preferred CAM therapies, we created a questionnaire which included two questions regarding the use of CAM: 1) whether it was used alongside or instead of conventional medicine and 2) for what purposes it was used, i.e. treatment, prevention, improvement of well-being and/or self-development. Questions were also asked regarding the participants' preference for specific groups of

therapies. Therapy groups were distinguished based on the division proposed by NCCAM (National Center for Complementary and Alternative Medicine, 2002): *whole medical systems*, including *Traditional Chinese Medicine*, *Ayurveda* and *homeopathy*; *mind-body therapies*, i.e. methods based on the assumption of mind-body integration, such as somatic experience, relaxation, or yoga; *biologically based therapies* utilizing the biological activity of various substances, e.g. naturotherapy, diet therapies, herbal medicine, or supplementation with vitamins; *manipulative and body-based therapies*, which use manual body techniques, e.g. massage, ostheopathy, or chiropractics; and *energy medicine*, i.e. methods that are intended to affect human energy fields, e.g. biofield energy healing or *reiki*.

The survey also included questions regarding several sociodemographic variables (e.g. age, gender, place of residence, etc.) and religious affiliation: Roman Catholic, other religions (Protestantism, the Orthodox faith, Judaism, Islam, Buddhism, Hinduism), atheist, non-practicing person. The respondents were free to not answer the questions.

Health Consciousness Scale (HCS)

The Polish adaptation by Księska-Koszałka and Gawda (2022) of the HCS scale by Hu (2013) was used to measure the participants' health consciousness. This tool is based on Prochaska and DiClemente's (1983) transtheoretical, stage model of health behaviour change. The scale includes 24 items distributed on 5 subscales: Health Value, Physical Health Orientation, Mental Health Orientation, Health Knowledge, and Health Information Seeking. The reliability of the factors oscillates between 0.74 and 0.89; for the whole scale, it is 0.89. Responses are given on a 6-point Likert-type scale, e.g. "My health depends on how well I take care of myself".

Statistical methods

Descriptive statistics (means, standard deviations) were calculated for the CACMAS and the HSC scores. We compared CAM users and non-CAM users in religious affiliation (Pearson's Chi-squared test and one-way ANOVA were used). Then, those variables that significantly differentiated groups were included in the MANOVA analysis using CAM attitudes as dependent variables. The *post hoc* comparisons were made with the use of Scheffe's test (with Bonferroni's correction) for those variables that were significant. Analogously, MANOVA was conducted including the same list of independent variables and utilization of CAM therapies as dependent variables. Then, *post hoc* comparisons between religious affiliation groups were made with Scheffe's test. Finally, MANOVA was calculated for HSC scores, and post hoc comparisons between religious affiliation were made the use of Scheffe's test (with Bonferroni's correction).

RESULTS

The most frequent CAM users were religiously affiliated people. It appeared also that religious affiliation significantly differentiates CAM users and non CAM users. Descriptive statistics for Health Consciousness and CAM attitudes (CACMAS) are presented in Table 3.

Table 3. Descriptive statistics ($N = 560$)

Variables	Min.	Max.	*M*	*SD*
HCS total	54.00	138.00	100.60	16.25
HCS Health Value	12.00	42.00	36.41	4.83
HCS Physical Health Orientation	4.00	24.00	15.06	5.90
HCS Seeking Health Information	3.00	18.00	9.95	3.92
HCS Health Knowledge	11.00	36.00	28.12	5.31
HCS Mental Health Orientation	3.00	18.00	11.04	3.73
CACMAS total	25.00	157.00	85.64	27.12
Philosophical Congruence with CAM	8.00	56.00	29.11	12.06
Dissatisfaction with Conventional Medicine	8.00	56.00	25.31	11.44
Belief in CAM	3.00	21.00	11.47	4.89
Mind & Body Integration	4.00	28.00	20.00	5.19

M – mean, *SD* – standard deviation

Source: Authors' own study.

Table 4. Multivariate analysis of variance including CAM attitudes (CACMAS) as dependent variables and religious affiliation as independent variable

Source	Dependent Variable	Mean Square	*F*	*p*	η^2
Religion	CACMAS total	3076.832	5.078	0.002	0.035
	Philosophical Congruence with CAM	744.335	6.214	<0.001	0.040
	Dissatisfaction with Conventional Medicine	57.790	0.459	0.711	
	Belief in CAM	91.955	4.647	0.003	0.047
	Mind & Body Integration	170.948	7.781	<0.001	0.035

Source: Authors' own study.

Next, MANOVA was conducted to test differences in attitudes toward CAM use. The study demonstrated that religious affiliation significantly differentiated the various aspects of attitudes toward CAM use. The *post hoc* comparisons made with the use of Scheffe's test (with Bonferroni's correction) showed that persons who declared they were Catholic scored higher than atheists on the total CACMAS scale, Belief in CAM, Philosophical Congruence with CAM,

and Body & Mind Integration (see Figure 1). Similarly, people who declared they adhered to a religion other than Catholic scored higher than atheists on the three CACMAS components, i.e. Belief in CAM, Philosophical Congruence with CAM, and Body & Mind Integration. The effect sizes for these differences were small and average.

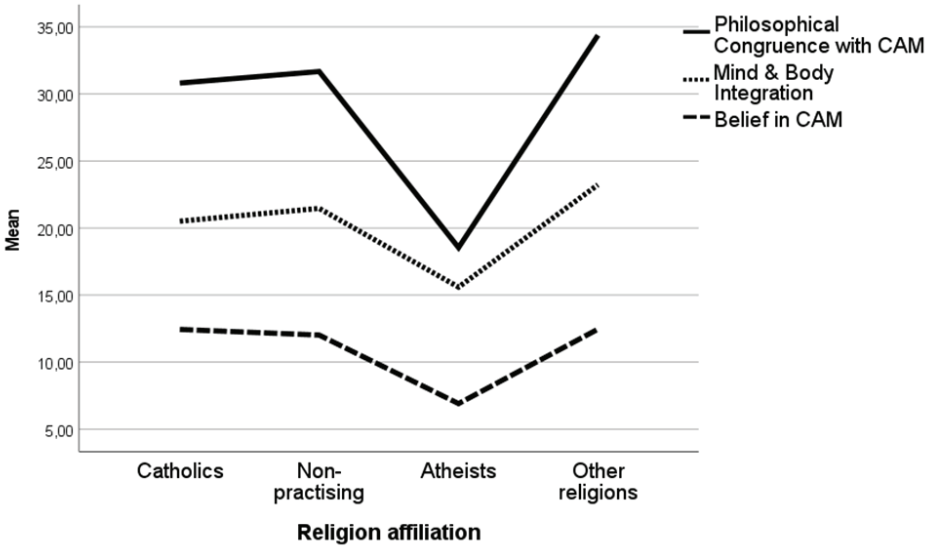

Figure 1. CACMAS attitudes and religious affiliations

Source: Authors' own study.

A multivariate analysis of variance was conducted including the same list of religious affiliation groups and use of specific CAM therapies such as homeopathy, Traditional Chinese Medicine, Ayurveda, biological therapies, and manual therapies. The results showed that the significant factor, which differentiates two types of therapies i.e. Body & Mind medicine and Energy Healing was religious affiliation (see Table 5). The *post hoc* Scheffe's test for multiple comparisons with Bonferroni's correction was used to examine differences in the use of CAM therapies among people declaring different religious affiliations. No significant differences were observed among Catholics, atheists, non-practicing people and believers in other religions in the use of homeopathy, Traditional Chinese Medicine, Ayurveda, biological therapies and manual therapies. Biological and manual therapies were the most popular types of CAM interventions for all types of religious affiliation. Significant differences were found in reference to Body & Mind therapies and Energy Healing. Non-practicing people were more likely to use Body & Mind therapies compared to Catholics (see Table 6). Non-practicing people were also more likely to use Energy Healing than were Catholics and

atheists. The effect size for these differences was average (Body & Mind therapies $\eta^2 = 0.06$ and Energy Healing $\eta^2 = 0.06$).

Table 5. Utilization of CAM therapies and religious affiliation ($N = 254$)

CAM therapies	Catholics *M(SD)*	Non-practicing *M(SD)*	Atheists *M(SD)*	Other religions *M(SD)*	*F*
Homeopathy	3.59(2.05)	3.22(1.77)	2.75(1.99)	3.33(1.87)	1.18
Traditional Chinese Medicine	4.13(1.95)	4.55(1.75)	4.19(2.05)	4.44(2.11)	0.79
Ayurveda	3.03(1.93)	3.51(1.63)	2.75(1.84)	3.22(2.38)	1.33
Body & Mind Medicine	3.78(2.16)	4.99(2.21)	3.88(1.89)	4.67(2.06)	5.99***
Biological Therapies	5.72(1.53)	5.88(1.39)	5.75(1.47)	6.00(2.00)	0.25
Manual Therapies	5.18(1.79)	5.17(1.13)	5.69(1.92)	5.44(2.00)	0.45
Energy Healing	2.76(2.00)	3.74(1.73)	2.06(2.04)	2.67(2.50)	5.40***

***$p < 0.001$

Source: Authors' own study.

Table 6. Between-group comparisons: religious affiliations and Body & Mind Medicine and Energy Healing therapies use

Dependent variable	(I) Religion affiliation	(J) Religion affiliation	Mean Difference (I-J)	SE	*p*	95% Confidence Interval	
						Lower Bound	Upper Bound
Body & Mind Medicine	Catholics	Non-practicing	-1.211	0.292	<0.001***	-2.03	-0.39
		Atheists	-0.099	0.549	0.998	-1.64	1.45
		Other religions	-0.890	0.717	0.673	-2.91	1.13
	Non-practicing	Catholics	1.211	0.292	<0.001***	0.39	2.03
		Atheists	1.112	0.574	0.292	-0.50	2.73
		Other religions	0.320	0.736	0.979	-1.75	2.39
	Atheists	Catholics	0.099	0.549	0.998	-1.45	1.64
		Non-practicing	-1.112	0.574	0.292	-2.73	0.50
		Other religions	-0.792	0.870	0.843	-3.24	1.66
	Other religions	Catholics	0.890	0.717	0.673	-1.13	2.91
		Non-practicing	-0.320	0.736	0.979	-2.39	1.75
		Atheists	0.792	0.870	0.843	-1.66	3.24

Energy Healing	Catholics	Non-practicing	-0.984	0.283	0.008**	-1.78	-0.19
		Atheists	0.694	0.531	0.636	-0.80	2.19
		Other religions	0.090	0.694	0.999	-1.86	2.04
	Non-practicing	Catholics	0.984	0.283	0.008	0.19	1.78
		Atheists	1.678	0.555	0.030*	0.11	3.24
		Other religions	1.074	0.712	0.519	-0.93	3.08
	Atheists	Catholics	-0.694	0.531	0.636	-2.19	0.80
		Non-practicing	-1.678	0.555	0.030*	-3.24	-0.11
		Other religions	-0.604	0.842	0.916	-2.98	1.77
	Other religions	Catholics	-0.090	0.694	0.999	-2.04	1.86
		Non-practicing	-1.074	0.712	0.519	-3.08	0.93
		Atheists	0.604	0.842	0.916	-1.77	2.98

SE – standard error, *$p < 0.05$, **$p < 0.01$, ***$p < 0.001$

Source: Authors' own study.

Next, a multivariate analysis of variance was performed to test whether religious affiliation differentiated health consciousness and its components measured by the HCS. It was found that religious affiliation differentiated Health Value and Mental Health Orientation (see Table 7). Detailed multiple comparisons were performed with the use of Scheffe's test to show which religious affiliations were associated with health consciousness. These comparisons revealed that non-practicing persons declared a higher Health Value than did atheists (see Table 8). Similarly, non-practicing people had higher scores on the Mental Health Orientation scale than Catholics.

Table 7. Multivariate analysis of variance: religious affiliations and health consciousness

Independent variable	Dependent Variable	Mean Square	*F*	*p*	η^2
Religious affiliation	HCS Health Value	61.474	2.658	0.048*	0.014
	HCS Physical Health Orientation	42.675	1.226	0.300	
	HCS Seeking Health Information	5.821	0.377	0.770	
	HCS Health Knowledge	65.364	2.329	0.073	
	HCS Mental Health Orientation	39.300	2.852	0.037*	0.015
	HCS total	500.972	1.905	0.128	

*$p < 0.05$

Source: Authors' own study.

Table 8. Between-group comparisons: religious affiliations and health consciousness (HCS scores)

Dependent variable	(I) Religion affiliation	(J) Religion affiliation	Mean Difference (I-J)	*SE*	*p*	95% Confidence Interval	
						Lower Bound	Upper Bound
HCS Health Value	Catholics	Non-practicing	-0.65	0.49	0.618	-2.03	0.72
		Atheists	1.17	0.57	0.242	-0.43	2.78
		Other religions	0.37	1.36	0.994	-3.43	4.19
	Non-practicing	Catholics	0.65	0.49	0.618	-0.72	2.03
		Atheists	1.83	0.65	0.05*	0.00	3.66
		Other religions	1.03	1.39	0.908	-2.88	4.94
	Atheists	Catholics	-1.17	0.57	0.242	-2.78	0.43
		Non-practicing	-1.83	0.65	0.05*	-3.66	-0.00
		Other religions	-0.79	1.42	0.957	-4.80	3.20
	Other religions	Catholics	-0.37	1.36	0.994	-4.19	3.43
		Non-practicing	-1.03	1.39	0.908	-4.94	2.88
		Atheists	0.79	1.42	0.957	-3.20	4.80
HCS Mental Health Orientation	Catholics	Non-practicing	-1.09	0.37	0.04*	-2.15	-0.02
		Atheists	-0.28	0.44	0.939	-1.52	0.96
		Other religions	0.20	1.05	0.998	-2.74	3.14
	Non-practicing	Catholics	1.09	0.37	0.04*	0.02	2.15
		Atheists	0.80	0.50	0.461	-0.60	2.22
		Other religions	1.29	1.07	0.696	-1.72	4.31
	Atheists	Catholics	0.28	0.44	0.939	-0.96	1.52
		Non-practicing	-0.80	0.50	0.461	-2.22	0.60
		Other religions	0.48	1.10	0.979	-2.60	3.57
	Other religions	Catholics	-0.20	1.05	0.998	-3.14	2.74
		Non-practicing	-1.29	1.07	0.696	-4.31	1.72
		Atheists	-0.48	1.10	0.979	-3.57	2.60

*$p < 0.05$

Source: Authors' own study.

DISCUSSION

The study has showed that religious affiliation is a significant factor differentiating CAM users from non-CAM users. Interestingly, religious affiliation is associated with both health consciousness and positive attitudes toward CAM, though these relationships are different. Persons with Catholic religious affiliation had higher scores than atheists on the total CACMAS scale, Belief in CAM,

Philosophical Congruence with CAM, and Body & Mind Integration. As regards health consciousness and religious affiliation, the results showed that non-practicing persons had higher health consciousness than atheists and, than Catholics. Religious affiliation seems to be crucial in explaining attitudes toward CAM use and CAM utilization. The most frequently used CAM treatments were biological therapies and manual therapies. Non-practicing persons were more likely to use Body & Mind Medicine and Energy Healing compared to Catholics or atheists.

The results of the present study show that religious affiliation is significantly related to attitudes toward CAM and the use of CAM in the Polish general population. It is actually a key factor. These findings are consistent with a previous study conducted in the American population, in which religious beliefs were found to be associated with the use of CAM (Barnes et al., 2004; Ellison et al., 2012; Smith et al., 2008). This effect was independent of the type of religious beliefs one professed; it also applied to non-practicing individuals and those who did not belong to any religious system. Interestingly, participants with different religious affiliations differed in their therapy preferences. Catholics had a significantly lower preference for Energy Healing and Body & Mind therapies; this effect was not observed in the case of other therapies. Non-practicing persons in Poland were more likely to use Body & Mind and Energy Healing therapies. It seems that these results may be related to the attitudes of the Polish Catholic Church toward CAM (Morciniec, 2012). The Catholic Church in Poland takes a two-pronged view on CAM – on the one hand, it actively supports those therapies in which the mechanism of treatment does not raise any doubt and those traditionally related to the history of the Polish Church and monasticism, which primarily include herbal medicine (Morciniec, 2012; Pastuszak, 2011). The Church also supports or does not officially prohibit folk medicine interventions which make use of religious symbols such as medallions, chains, holy pictures and crosses, attributing to them the healing power coming from Christ which is a characteristic feature of Polish folk medicine (Piątkowski, 2012). The Church also allows cases of miraculous healings and affirms the healing power of prayer (Wiecki, 2017). On the other hand, the Polish Church strongly condemns and actively combats the types of practice in which the potential therapeutic effect comes from an unspecified superior power or energy (Morciniec, 2012). It recognizes and rejects many CAM therapies as occult, especially those based on healing energy or those that involve working with consciousness, such as bioenergy healing, *reiki*, yoga, tai-chi, re-birthing or other methods originating from Eastern or New Age traditions (Morciniec, 2012; Pastuszak, 2011). As we read in the Catechism of the Catholic Church (2012), all practices of magic or sorcery through which one seeks to acquire arcane powers and, by using them, to gain supernatural control over one's neighbour – even if it is only to ensure his or her good health – stand in grave contradiction to the virtue of religiosity. Taking recourse to so-called traditional medical practices

does not justify either invoking evil powers or exploiting the credulity of another person (*Katechizm Kościoła Katolickiego, Catechism of Catholic Church*, 2012). It should also be noted that the Church induces a strong fear of this type of practice in the faithful, pointing to the risk of being possessed by evil spirits or demons. It warns that there might be cases in which such practices heal the body but have side effects on the spirit. In such cases, the Church can perform exorcisms (Morciniec, 2012). Our findings on Polish Catholics' preferences regarding CAM therapy seem to reflect the relevant recommendations of the leaders of the Church. However, the question of what these preferences are determined by requires further, in-depth research.

It would be also worth investigating further whether there are other variables or groups of variables related to the belief system that are associated with the use of CAM and particular groups of CAM therapies. Perhaps, the type of religious affiliation or a specific belief system does not matter here at all, as suggested by the present study, in which atheists scored lower on attitudes toward CAM than either Catholics or people of other denominations. Maybe, what counts instead is the simple fact of being a believer.

The relationship between belonging to a religion and coherence with the system of beliefs that make up "Philosophical Congruence with CAM" can be interpreted in the light of Koening's (2012) theory stated on the role of religion in building a coherent picture of reality – he observes that religion provides us with an ordered system of meanings, a clear concept of how the world works and a set of moral principles and norms. This means that religious affiliation allows one to reduce the cognitive effort one would have to expend to build these categories on one's own (Koenig et al., 2004). The system of convictions about CAM related to the concept of health and treatment works in a similar way – it is attractive because it allows (even a layman) to understand the multidimensional reality of health and disease, and, indeed, partially control it, since CAM therapies can be used as self-treatment interventions. The use of CAM is much easier than exploring the secrets of academic medicine or pharmacotherapy (McCurdy et al., 2003). Obviously, belief in CAM may limit one's trust in conventional medicine and lead to choices that are controversial or even harmful from the point of view of public health, such as neglect of preventive health check-ups or vaccination refusal (Księska-Koszałka, Gawda, 2022, 2023). Unfortunately, both trends are clearly visible in Poland, which has one of the highest percentages of people, among European nations, who have not received a COVID-19 vaccine (WHO, 2023). An equally high percentage of the population does not report for health check-ups (Kantar Public, 2021). A similar relationship has been observed in other populations – although few studies have evaluated the association of religiosity/religion with COVID-19 vaccination intent, the former has been recognized as an important predictor of making this health-related decision (Murphy et al., 2021;

Olagoke et al., 2021). These studies showed that among adults in the US a greater level of religiosity was linked with lower levels of vaccination intent (Olagoke et al., 2021). Other studies conducted in the United Kingdom and Ireland reported similar findings (Murphy et al., 2021). Research in Puerto Rico also indicated that religiosity and vaccination intent were negatively associated (López-Cepero et al., 2022). Concerns over vaccine safety were observed for all levels of importance of religiosity. These relationships are explained by the fact that persons who declare higher religiosity show more uncertainty about the safety of vaccination and are more unwilling to have a vaccine as they believe that fate and health are more dependent on divine intervention (López-Cepero et al., 2022). According to Koenig's (2012) model, religion embraces the entirety of human existence, thus, also affecting the sphere of health. Perhaps, for this reason, it can also influence and differentiate health attitudes, which explains why non-practicing believers scored higher on the Use of CAM and on Health Value than did atheists. As Koenig explains, health-promoting opinions and recommendations offered by various religions result in members of religious congregations placing a higher value on health; they also foster positive attitudes toward certain health behaviours and aspects of a healthy lifestyle. Our results seem to correspond with this observation.

The present study has also shown that non-practicing people are significantly more likely than Catholics and atheists to choose Mind & Body therapies and achieve higher scores on the Mental Health Orientation scale. Perhaps, apart from giving up religious practice, they also disregard the Church's recommendations concerning CAM therapies (Morciniec, 2012). Viewing mental health hygiene as a priority, they may be more likely to use Mind & Body therapies, which focus on relieving stress, relaxation, and achieving mindfulness (Hu, 2013).

LIMITATIONS

Despite the fact that the study was carried out on a large sample and using a variety of techniques, the study can have limitations. Perhaps the group of CAM users should be larger and more diverse due to demographic variables. For instance, the results of this study may also be affected by the age structure of the sample, which was dominated by people aged 20–50, with relatively few people over 50 (13.4% of all respondents). Late adulthood is a period when the issues of religiosity and religious affiliation become very important (Bengtson et al., 2015) – perhaps replication of the study with a larger sample including people of this age group would yield different results. There is also significant gender imbalance in the sample which can have an impact on the obtained results. Another limitation is that the research was cross-sectional and cannot be used to draw conclusions about causality.

It is also worth noting that so far most studies have focused on the relationship between religiosity vs. CAM utilization, while the religious affiliation vs. CAM

attitudes relationship has been little investigated. Religious affiliation was a categorical variable, perhaps it would be of value to examine its intensity or include religiosity measured dimensionally as a complementary aspect. The declaration of being a believer does not mean that a believer follows the principles taught by the Church. The results obtained in this study on the latter relationship come from a country with a high degree of the declarative Catholic faith, which is Poland (Sadłoń, 2021). A small number of persons represented other religious affiliations. Perhaps in other countries, there would be no similar relationship, this issue requires further in-depth research.

CONCLUSIONS

The present study demonstrates that factors formally unrelated to health, such as belonging to a religion, play a crucial role in shaping people's treatment preferences. Therefore, in analysing patients' needs and expectations, healthcare providers should take into account religious and ideological matters. This type of approach ensures more effective cooperation with the patient and allows to deepen the relationship with them. A specialist who knows the patients' beliefs will be able to design treatment in keeping with the patients' values, which may have a positive impact on the effects of the therapy.

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ABSTRAKT

Badania pokazują, że u podstaw stosowania medycyny komplementarnej i alternatywnej (*complementary and alternative medicine*, CAM) leży światopogląd danej osoby, przekonania dotyczące zdrowia, religijność i przynależność religijna. Celem niniejszego badania było poszukanie związków przynależności religijnej z postawami wobec CAM i stosowaniem CAM oraz świadomością zdrowotną w polskiej populacji. Grupa badanych składała się z 599 osób (w tym 57,1% katolików, 24,5% niepraktykujących, 16,1% ateistów i 2,3% deklarujących inne religie). Badania przeprowadzono za pomocą polskich adaptacji narzędzi: Skali Postaw Wobec Medycyny Komplementarnej, Alternatywnej i Konwencjonalnej (CACMAS) oraz Skali Świadomości Zdrowotnej (HCS). Badanie pokazało, że przynależność religijna różnicuje postawy wobec CAM, stosowanie CAM i poziom świadomości zdrowotnej. Katolicy przejawiali bardziej pozytywne postawy wobec CAM oraz niższy poziom świadomości zdrowotnej niż ateiści. Osoby niepraktykujące istotnie częściej korzystały z medycyny ciała i umysłu oraz leczenia energią niż katolicy i ateiści. Badanie pokazuje, że zarówno w leczeniu, jak i projektowaniu działań profilaktycznych oraz utrzymywaniu konstruktywnych relacji lekarz–pacjent konieczne jest uwzględnianie czynników pozamedycznych, takich jak przynależność religijna, przekonania czy postawy.

Słowa kluczowe: przynależność religijna; medycyna komplementarna i alternatywna; świadomość zdrowotna; katolicy