



# Religion and Mental Health

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## GLOSSARY

**caregiver** A person who takes care of patients with end-stage cancer or Alzheimer's disease; often a relative.

**positive psychology** Psychological research on positive emotions, such as joy, wonder, happiness, satisfaction, meaning, purpose, and hope.

In the past, the predominant view was that religion is inherently unhealthy. Recent research has begun to convincingly challenge this assumption. In hundreds of studies, religion has been associated with positive mental and physical health outcomes and with positive emotions. Although most studies have been cross-sectional, some have been longitudinal and several randomized clinical trials have also been completed. Despite these provocative associations, it is important to keep in mind several caveats. There may be significant scientific and theological concerns surrounding the

prescription of religion and the empirical investigation of religion's effects on health. Moreover, not all religions may relate to health in the same ways, and in some cases religion may have decidedly negative consequences for health. Psychiatric and psychological training is beginning to emphasize a need to address religious and spiritual issues as part of clinical practice.

## I. INTRODUCTION

For quite some time, many influential mental health professionals conceptualized religion and mental health as being diametrically opposed, and only within the past 10 years have such notions been challenged. Religion and spirituality have many components that are of potential relevance to mental health, including religious attendance, private religious activities (e.g., prayer and reading of holy scriptures), a feeling of connection or relationship with God or a higher power, religious beliefs, and religious coping. In addition, religion and spirituality may cause mental health via healthy lifestyles and behaviors and the promotion of social support. Some writers distinguish religion from spirituality by claiming religion is more organized, whereas spirituality has more to do with one's personal relationship with God or a higher power.

In 2001, Koenig *et al.* performed a comprehensive, systematic review of research on religion and mental health and identified 724 quantitative studies that

examined this association. Many different populations—from young to old, from sick to healthy—have been examined. Studies have been conducted in almost every area of the world, including the United States, Canada, England, continental Europe, Australia, China, Malaysia, Egypt, India, and Israel. The majority of studies (478; 66%) reported statistically significant relationships between religious involvement and better mental health, greater social support, or less substance abuse. Most of the studies were cross-sectional, but a number have been longitudinal and there are several clinical trials that have examined the effects of religious interventions on mental health. Longitudinal studies have also shown faster recovery from depression in community samples and more rapid adaptation to stressful life circumstances in religious caregivers. Several clinical trials examining the effects of a religious-based psychotherapy on treatment outcomes in depression, bereavement, and anxiety have likewise documented benefits for both Christian and Muslim patients.

## 2. BENEFITS TO MENTAL HEALTH

Mental health involves not only the freedom from mental disorders, such as depression, anxiety, psychotic conditions, or personality problems, but also the regular experience of positive emotions, such as joy, wonder, happiness, satisfaction, meaning, purpose, and hope. Relatively little research has been done on positive emotions and mental states. This is changing with the growth in “positive psychology,” which has been led by Martin Seligman, former president of the American Psychological Association. Religiousness appears to be related to positive emotions, where the relationships may be even stronger and may have implications for the prevention of mental disorder. Of the approximately 100 studies conducted during the past century on religiousness and well-being, hope, and optimism, nearly 80% have found that religious persons experience significantly more positive emotions compared to those who are less religious. Similarly, in a recent study, measures of religious belief, coping, and spirituality were associated even more strongly than was social support with measures of life satisfaction among Protestants and Catholics, which is consistent with a role of religion-influenced positive emotion in well-being.

## 3. APPLICATIONS OF RELIGION

It is important to emphasize that clinical applications of religion must be theologically and ethically informed. For example, it is not only impractical but also may be theologically and ethically inadvisable to prescribe religious behaviors on the part of patients, for a clinician to impose his or her religious beliefs onto patients, or to create an atmosphere of intolerance for patients of diverse faith communities.

## 4. CAVEATS TO RESEARCHERS

From a research perspective, it is crucial to be theologically savvy. One aspect of this is to recognize that not all religions are the same, and that people from different faith communities may differ in psychologically relevant ways. One example is the salience of certain mental states (e.g., faith) to Jews and Protestants. For example, in the religion/well-being studies mentioned previously, social support from religious sources correlated modestly with well-being for Jews, Protestants, and Catholics. However, religious belief, spirituality, and religious coping were much more related to well-being among Catholics and Protestants than among Jews.

## 5. TESTING PRAYER?

Another aspect of being theologically informed in examining religion and mental health connections has been raised in the context of research on the effects on health of distant intercessory prayer. Chibnall *et al.* argued that such research may border on heresy because it tests or challenges God, that operational definitions of prayer may fly in the face of theological definitions, and that results are incredibly difficult to interpret. For example, do positive effects of prayer on health prove the existence of God? What do negative effects indicate? What if prayers by members of one faith community turn out to be more efficacious than prayers by those of another faith community?

## 6. NEGATIVE IMPLICATIONS OF RELIGION

Religious beliefs or activities may sometimes be associated with worse mental health or neurotic behavior.

Most clinicians today know from experience that religion may be utilized in an unhealthy manner or manipulated to serve defensive functions that ultimately impair mental health and prevent healthy growth. For example, religious concerns are common among people with obsessive-compulsive disorders and even people in nonclinical samples, including fears of sin, fears of God, and viewing the moral status of thoughts to be equal to that of actions. Vivid examples can be seen when individual cases are examined: the rigid fundamentalist; the obsessive-compulsive who attends church daily and prays 10 or 20 times per day; the psychotic patient who believes he is God, Jesus, or the devil; and the severely depressed person who is overwhelmed with guilt, believing that she has committed the unpardonable sin. This does not necessarily mean that religion promotes mental ill health, since ill people often turn to religion for comfort.

## 7. TRAINING COUNSELORS AND CONSULTANTS

Training programs in both psychiatry and psychology are beginning to emphasize the need for mental health professionals to address religious or spiritual issues as part of routine mental health care. This is now a requirement for accreditation of psychiatric residency programs by the American College for Graduate Medical Education (1994), which has mandated that training programs include didactic training in the “presentation of the biological, psychological, sociocultural, economic, ethnic, gender, religious/spiritual, sexual orientation and family factors that significantly influence physical and psychological development in infancy, childhood, adolescence, and adulthood” (pp. 11–12). Training programs in psychology are also required to ensure that the curriculum “includes exposure to theoretical and empirical knowledge bases relevant to the role of cultural and individual diversity,” and religion is included in the definition of cultural and individual diversity.

As a result of increased training and exposure to research on the relationship between religion and health, there appears to be more widespread integration of religion into clinical practice, with therapists now utilizing patients’ religious beliefs and social connections within the faith community to facilitate healing and recovery. Not only is the area of pastoral counseling growing rapidly but also there are indications that

secular therapists are beginning to address spiritual issues when treating patients. Unfortunately, systematic research documenting when, where, and how frequent such integration is taking place has not been done.

## 8. CONCLUSION

Religion and mental health appear to be related—either for better or for worse. Clinicians need to be aware of the research that has been done in this area and understand how to both sensibly and sensitively apply this knowledge to clinical practice.

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## See Also the Following Articles

Coping ■ Well-Being

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