

Review Article

**Religion and mental health:
A critical appraisal of the literature**

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Abstract. *Religiosity and spirituality have been long investigated for their positive or negative effects on mental health, with mixed results. The author examines different associations and study methodologies, and describes criticism of the findings. Then, religious coping is explored and recent research on the inclusion of religious elements within therapeutic practices are reported. Finally, psychopathological aspects of some religious experiences are described.*

Keywords: Religion, religiosity, spirituality, mysticism, mental health, religious coping, religious psychotherapy.

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INTRODUCTION In the past twenty years there has been increasing attention given to the relationships between various dimensions of religiosity and mental health. By now several thousand studies (epidemiological involving population based or community samples and clinical involving psychiatric outpatients/inpatients and social and behavioural research) have been conducted demonstrating positive associations between the two (Koenig *et al*, 2012). On balance, those who are more religious in terms of 'being' and 'doing' have better indices of mental health (Levin, 2010). The vast majority have been cross sectional and have focused on religious attendance and beliefs among North American Christians. There has been far less work examining ritual, prayer and other aspects of being religious (e.g., Dein & Littlewood, 2007; Dein, 2010).

Being religious results in more hope and optimism and life satisfaction (Koenig, 2009), less depression and faster remission of depression (Koenig, 2007; Smith *et al*, 2003), lower rates of suicide (Van Praag, 2009), reduced prevalence of drug and alcohol abuse (Cook *et al*, 1997) and reduced delinquency (Johnson *et al*, 2000). Findings in relation to anxiety are mixed. Although some studies demonstrate reduced anxiety rates, others indicate that anxiety levels are heightened in the more religious (Koenig *et al*, 2012; Shreve-Neiger & Edelstein, 2004). Work on schizophrenia is still embryonic, recent studies however in Switzerland suggest that religious individuals with psychotic illnesses frequently deploy prayer and Bible reading to help them cope with their voices and higher levels of religiosity may increase medication compliance (Mohr *et al*, 2006; Mohr *et al*, 2011). Rates of religious delusions in schizophrenia in the UK remain high (Siddle *et al*, 2002).

Although the predominant focus of the extant literature on religion and mental health is on Christianity, there has been recent work on Islam (Abu-Rayyah *et al*, 2009), Judaism (Rosmarin *et al*, 2009) and Hinduism (Tarakeshwar *et al*, 2003a; 2003b) suggesting that those who are religious have better indices of mental health. Furthermore these studies suggest that religious beliefs impact differentially on mental health according to the faith group of subjects. Cohen and colleagues (2006)

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have proposed that the relevance of different facets of religiousness to mental health is not arbitrary but relates to doctrine-specific values and culture.

EXPLAINING THE ASSOCIATION A myriad of factors have been proposed to account for positive correlations between religion and mental health. These include positive cognitive appraisals, hope and optimism, increased social networks resulting in greater emotional support, healthy lifestyles (diet, less alcohol and drugs, less antisocial behaviour), immunological and endocrine changes, and supportive relationships with God (Dein, 2006). Private or group prayer or worship may give rise to salutary emotions – gratitude, humility, grace, forgiveness, love – with preventive or therapeutic benefit (Levin, 2010). More altruism and gratitude in the religious have been cited as mediating factors in the links between religion and mental health (Schwartz, 2003). This is not to ignore the fact that at times religion may negatively impact on health, through inducing guilt and dependency and in extreme cases may precipitate suicide (e.g., in extreme cultic groups expecting the end of the world, see Dein & Littlewood, 2005, on apocalyptic suicide).

CRITICISMS OF THE FINDINGS There have been a number of criticisms of the above findings. First studies have generally deployed one off measures of public and private religious behaviour using single item measures. Second, there may be selection biases in recruiting subjects. Third, more work needs to be done on the non-religious and their mental health associations, including atheism and agnosticism (Hwang *et al*, 2009). Some people are spiritual – connected to a higher power from which they derive meaning – although not belonging to and participating in institutionalised religion. The similarities and differences between religion and spirituality warrants further research. Spirituality and religion may impact upon mental health in different ways. In a recent UK study (King *et al*, 2013), people who had a spiritual understanding of life in the absence of a religious framework were vulnerable to mental disorder. Fourth, measurement scales are not usually culturally validated; they should take account of cultural factors on levels of beliefs and practices (Milstein *et al*, 2010). Fifth, measurement scales need to be more theologically sensitive (Dein *et al*, 2012).

Finally, as Sloan notes (Sloan *et al*, 1999; Sloan, 2006), many studies on religion and health fail to make an adjustment for the greater likelihood of finding a statistically significant result when conducting multiple statistical tests. For instance, they cite a double-blind study of intercessory prayer (Byrd, 1988) where patients in a Coronary-Care Unit (CCU) were assigned randomly either to standard care or to daily intercessory prayer ministered by three to seven born-again Christians. 29 outcome variables were measured, and on six the prayer group had fewer newly diagnosed ailments. However, the six significant outcomes were not independent: the prayer group had fewer cases of newly diagnosed heart failure and of newly prescribed diuretics and fewer cases of newly diagnosed pneumonia and of newly prescribed antibiotics. There was no control for multiple comparisons, a fact recognised by the author. To address this issue, “multivariate” analysis was conducted but the results were not presented, except for a *p* value for overall model.

RELIGIOUS COPING Global measures of religious involvement may reflect dispositional religiousness rather than how people draw from religion during crises. Rather than belief or attendance, some researchers underscore the role of religious coping in the wake of adverse life events. Pargament (2010) argues for two sorts of coping, positive religious coping and negative religious coping. Positive religious coping (e.g., benevolent religious appraisals, religious forgiveness, etc.) reflects a secure relationship with God and is associated with improved mental health. In contrast, negative

religious coping (e.g. reappraisals of God's powers, feeling abandoned or punished by God, etc.) reflects a tenuous relationship with God and is associated with worse mental well-being. There is recent interest in the mental health implications of theodicy – the attempt to reconcile an omnipotent, omniscient, all loving God with evil and suffering in the world (Dein *et al*, 2013).

RELIGIOUS EXPERIENCE Although popularised in William James classic, the *Varieties of Religious Experience*, religious experience has received comparatively less research than attendance, beliefs and coping on account of its subjective nature. Three areas however have received some attention – mysticism, conversion and religious hallucinations.

Religious conversion has generally been associated with positive mental health experiences. James 1902/1958 identified two types of religious expression, the “religion of the sick soul” and the “religion of the healthy-minded soul”. The former derives from a damaged psyche, expressed as “positive and active anguish, a sort of psychical neuralgia wholly unknown to healthy life” (p. 126). In extremis, this includes loathing, irritation, exasperation, self-mistrust, self-despair, suspicion, anxiety, trepidation, and fear. The latter is grounded in “the tendency which looks on all things and sees that they are good” (p. 83). James noted that sick souled individuals were prone to undergo conversion experiences in an attempt to heal their psyches.

Although religious conversion often may occur during a period of emotional upheaval or psychological stress, this is not always the case. In perhaps the largest study of religious conversion to date, Heinrich (1977) interviewed 152 generally healthy persons recently converted to Catholicism, compared to 158 controls. The most important factors involved in bringing on conversion were discussions with friends, relatives, or religious professionals, not stressful circumstances.

In terms of **mysticism**, there are close phenomenological parallels between mystical and psychotic states including delusions, hallucinations and social withdrawal. The outcomes however are different for the two phenomena (Brett, 2003). While mystical experiences usually positively impacts on mental health, psychosis is generally a negative experience (Jackson & Fulford, 1997). These authors differentiate between the two experiences. The spiritual experience is generally: directed towards others, short lived, intellectually vivid, there are doubts regarding it, the insight of the internal origin of the experience is preserved, it is controlled, does not lead to loss of contact with reality, it is emotionally neutral or positive (brings satisfaction), brings awareness as to its incomprehensibility by others, flaws in intentional actions do not occur, it does not negatively affect life, its content is acceptable by the cultural reference group of the individual and promotes personal growth. In contrast, the psychotic experience is generally: directed towards the person himself, is long-lived, experienced physically, there is a certainty about it, a lack of insight regarding its internal origin, drives the individual to be submerged in it, suffering a loss of contact with reality, it is emotionally negative (causing suffering), a lack of consciousness of the incomprehensibility by others, creates flaws in intentional actions, deteriorates quality of life, its content is strange to the cultural reference group of the individual and a general loss occurs in their personal life (see also Menezes & Moreira-Almeida, 2009).

In terms of **religious hallucinations**, there is some work on hearing God's voice among Pentecostal Christians in London. 40 members of an English Pentecostal group completed a questionnaire on prayer: 25 reported an answering voice from God, 15 of them hearing Him aloud. The latter groups were interviewed and characteristics of phenomenology and context elicited. The voice of God cannot be held to be ipso facto pathological and many reported its utility in situations of doubt or difficulty (Dein & Littlewood, 2007).

RELIGIOUS PSYCHOTHERAPY Finally, there is some work examining the incorporation of religious activities such as prayer, Bible reading and ritual into CBT. Some evidence suggests that Christian-based CBT is more effective among Christian patients with depression and anxiety than traditional non-religious CBT. Future work in this area should concentrate on which therapies are efficacious for which patients and which therapists should be conducting them (Propst *et al*, 1992). Pargament (2007) in *Spiritually Integrated Psychotherapy* provides a comprehensive overview of the inclusion of spirituality into psychotherapy and provides a number of illustrative clinical scenarios as to how this can be done.

CONCLUSION In conclusion, there is by now a wealth of literature examining relationships between religion and mental health. This literature comprises mostly prevalence (cross-sectional) studies of religion as a correlate of distress/well-being in general populations; they do not examine religion as a therapeutic agent for existing pathology. In summary, religious involvement, broadly defined, exhibits a salutary and primary-preventive function in relation to psychological distress and outcomes related to mental health and well-being (Levin, 2010). On average, this finding is statistically significant, replicated, and modest in magnitude. It is however important to note that we cannot surmise from the existing data that religious involvement results in healing. Future work in this area needs to elaborate on these findings and to look at factors accounting for these associations and most importantly needs to be sensitive to cultural and theological issues in their assessment.

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