

Religion and Mental Health: Current Findings

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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 have been conducted demonstrating positive associations between the two (Koenig, King and Carson 2012). On balance those who are more religious have better indices of mental health. 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 and Littlewood 2007, Dein 2010). On balance being religious results in more hope and optimism and life satisfaction (Koenig 2009), less depression and faster remission of depression (Koenig 2007, Smith, McCullough and Poll 2003), lower rates of suicide (Van Praag 2009), reduced prevalence of drug and alcohol abuse (Cook, Goddard and Westall 1997) and reduced delinquency (Johnson, Larson and McCullough 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, King and Carson 2012, Shrieve Neiger and 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. 2007). 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 raiyah and Khalil 2009), Judaism (Rosmarin et al. 2009) and Hinduism (Tarakeshwar, Pargament and Mahoney 2003) 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.

Several explanations have been proposed to account for positive correlations between religion and mental health. These include positive cognitive appraisals, increased social support, healthy lifestyles (diet, less alcohol and drugs) and supportive relationships with God (Dein 2006). 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, Dein and Littlewood 2005).

There have been a number of criticisms of the above findings (Sloan, Bagiella and Powell 1999). First there may be selection biases in recruiting subjects. Second, more work needs to be done on the non-religious and their mental health associations, including atheism and agnosticism (Hwang, Hamer and Cragun 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. Third, we need to take account of cultural factors on levels of beliefs and practices (Milstein, Maniere and Yali 2010). Finally, measurement scales need to be more theologically sensitive (Dein, Cook and Koenig 2012).

Global measures of religious involvement may reflect dispositional religiousness rather than how people draw from religion during crises. Rather than belief or attendance, other researchers underscore the role of religious coping in the wake of adverse life events. Ken 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, Swinton and Abbas, in press).

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. There are close phenomenological parallels between mystical and psychotic states although the outcomes are different (Brett 2002). While mystical experiences usually positively impacts on mental health, psychosis is generally a negative experience (Jackson and Fulford 1997). Finally there is some work on hearing God's voice among Pentecostal Christians in London. Forty 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 and Littlewood 2007).

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.

In conclusion, there is by now a wealth of literature examining the relationship between religion and mental health. Although on balance it appears that being religious improves mental health, future work in this area needs 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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