RELIGION/SPIRITUALITY AND MENTAL HEALTH

Some early social scientists acknowledged that religion could play a role in mental health. Emile Durkheim (1951) argued that the social regulation, integration, and meaning provided by religious groups could be health enhancing. Durkheim studied religion primarily in terms of its impact on the levels of suicide. William James (1902), an early psychologist, indicated that "healthy-minded religion could prevent certain forms of disease as well as science does, or even better." Sigmund Freud (1961) had decidedly negative views of religion. He viewed religion as an illusion and mass neurosis, but nonetheless indicated that religious ideas could reduce anxiety and serve as a source of consolation without which many could not endure life. Freud argued that a lack of religious belief would lead to chaos and additional mental anguish. Karl Marx (1844) is known for describing religion as the opiate of the people. However, in the very paragraph in which Karl Marx made the famous declaration, he indicated that religion was nonetheless "the heart of a heartless world and the spirit of the spiritless situation" (p. 42). It appears that even Marx conceded some potential health-enhancing effects of religion.

There is growing interest in the role that spirituality or religion can play in the mental health of the population; however, this is a generally neglected topic in studies in psychiatry. A systematic review of 2,348 studies published in the four leading psychiatric journals from 1978 to 1982 found that 2.5% of the studies included a quantified religious or spiritual variable (Larson, Pattison, Blazer, Omran, & Kaplan, 1986). Less than 1% assessed religion or spirituality with minimal standards of acceptability. Only one study had applied a state of the art approach to measuring religion or spirituality. The majority of studies measured religion with the use of religious denomination, which is not regarded as an optimal or comprehensive measure of religiousness. More recent studies continue to document the neglect of religion (Weaver et al., 1998).

Research on religion and spirituality is not without debate and controversy. It has been harshly criticized in recent years on both methodological and ethical grounds (Sloan et al., 2001). Methodologically,

many studies have been cross-sectional in design and have utilized inadequate controls for confounding variables and covariates so that the observed associations between religious involvement and health could be overestimated. In addition, failure to control for multiple comparisons could have contributed to some inconsistencies in the empirical findings. Moreover, some researchers argue that the study of religion and health raises a large ethical issue because an individual's religious beliefs and practices are private and personal and should therefore be outside of the purview of medical recommendations. According to this view, applying any findings from research on religiousness and spirituality to clinical practice could be problematic (Sloan et al., 1999). Major researchers in the area indicate that some of the recent criticisms have not been even-handed. Specifically, they point to omitted evidence; erroneous, incorrect, or misleading statements; and arguments about ethics being based on personal opinion and straw men rather than on scientific evidence (Miller & Thoresen, 2003). For example, Koenig et al. (1999) show that Sloan et al. (1999) discuss only twenty-four of the 300+ studies of religion and physical health, none of the 900 studies of religion and mental health, only seventeen of the nearly 100 studies of attendance and mortality, and none of the nine recent high-quality studies that had been identified.

One contributor to the conflict over the study of religion and health is a clash of worldviews. Researchers as a group are markedly less religious than the general population and many feel uncomfortable with the topic. Some researchers have suggested that merely studying religion and health would be an "anti-tenure factor" for a beginning scholar (Sherrill & Larson, 1994). Similarly, Rue (1985) indicated that the study of religion is academia's "most outrageous blind spot."

Research has documented that religious variables can play an important role in physical health. The strongest association exists for measures of religious attendance. A rigorous review of the empirical evidence relating religion to health concluded that the scientific evidence is strongest for the association between religious attendance

and mortality (Powell, Shahabi, & Thoresen, 2003). They indicated that there is a strong, consistent, prospective, and often graded reduction in the risk of mortality that is associated with increasing levels of religious attendance. Even after adjusting for confounders, this association exists, although the reduction approximates 25%. They also indicated that protection of religion or spirituality against cardiovascular disease is where the association is strongest, and is largely mediated through the healthy lifestyle it encourages. An example of the study of religion and health is the study by Hummer and colleagues (Hummer, Rogers, Nam, & Ellison, 1999). This national study of over 21,000 adults followed over eight years found that attendance was associated with mortality. People who never attended religious services had a 1.9 times greater risk of death than people attending more than once a week. This pattern existed for most causes of death. This study found that at age twenty, persons who attended religious services weekly or more lived on average 7 and a half years longer than those who never attended. For blacks, the difference was 13.7 years.

RELIGION AND MENTAL HEALTH

Research has also looked at the association between religion and mental health. A critical review of seventeen studies that assess the association of religion to general indices of anxiety concluded that church attendance and other religious variables are related to decreased anxiety in several populations (Shreve-Neiger & Edelstein, 2004). Some studies find that those who lived their religion (intrinsic religiousness) have less anxiety than those who use their religion (extrinsic religiousness). However, under some conditions, religion may be associated with elevated anxiety. Catholic women, for example, tended to have higher levels of anxiety than others. Sudden religious converts have been shown to have higher anxiety in some studies, and extrinsic religious persons also show anxiety in some studies.

A meta analysis of 147 studies has also examined the association between religiousness and depressive symptoms (Smith, McCullough,

& Poll, 2003). It concluded that high levels of religious involvement were associated with fewer symptoms of depression. This association was robust, but modest in size. The association was stronger for studies of persons under stress. This review also found that an extrinsic religious orientation and negative religious coping were associated with elevated symptoms of depression.

Reviews have also been conducted on the association between religion and substance use. A review of fifty-four studies of religion and drug use found that 87% showed that religious involvement predicted a lower risk of drug abuse (Johnson, 2002). Similarly, 94% of ninety-seven studies that looked at religion and alcohol use found that religious participation was associated with a reduced tendency to initiate alcohol use or have problems with alcohol, if used. These findings exist in both retrospective and prospective studies of children, adolescents, and adults.

Research also shows that religion is associated with reduced risk of delinquency (Johnson, 2002). These studies have found a lower risk of multiple delinquent behaviors, including criminal behavior associated with religious involvement. Similarly, religious involvement has been associated with preventing delinquent behavior in high-risk urban youth. It has also been related to increased pro-social behavior in adolescents that emphasize concern for the welfare of others. In some of these studies, the effect of religious involvement is evident only at the level of the group and not at the level of the individual (Stark, 1985). That is, it is not individual religious behavior that appears to be most important, but whether the individual is in a context of other religious people.

RELIGION/SPIRITUALITY AND MENTAL HEALTH: PATHWAYS

Several mechanisms have been identified by which religion might be associated with health (Williams & Sternthal, 2007). First, religious participation can discourage negative health behaviors such as tobacco,

alcohol, drugs, and risky sexual practices. Second, by encouraging moderation in all things and reducing risk-taking behavior, religious involvement can reduce exposure to stress. Third, religious institutions can provide support, intimacy, a sense of connectedness, and belonging. Fourth, religious organizations and clergy engage in a range of activities that can promote physical and mental health. Other mechanisms by which religion can affect health include the effects of religious beliefs and values in providing systems of meaning that can enable individuals to interpret and re-interpret stress. Religious beliefs can also provide feelings of strength to cope with adversity. And finally, religious institutions can also adversely affect health by generating stress, time demands, role conflicts, social conflicts, and criticism.

HEALTH PRACTICES

There is striking evidence of the role of religion in enhancing healthy behaviors. A national study of high school seniors, persons in both public and private schools, found that religious high school seniors were less likely than their non-religious peers to carry a weapon such as a gun or knife to school, to get into fights or hurt someone, to drive after drinking, to ride with a driver who had been drinking, to smoke cigarettes, and to engage in binge drinking or use marijuana (Wallace & Forman, 1998). Similarly, religious seniors were more likely to wear seatbelts; eat breakfast, green vegetables, and fruit; get regular exercise; and sleep at least seven hours per night. Similarly, in the Alameda County Study an association was documented over time with levels of religious behavior (Strawbridge, Shema, Cohen, & Kaplan, 2001). This study examined the association of frequency of attendance in 1965 with improvements or changes with healthy behaviors by 1994. Adjusted for age, sex, education, and self-rated health, there were improved healthy behaviors among persons who attended religious services weekly. They were more likely over this time period to quit smoking, to start physical activity, to stop being depressed, to get and stay married, to increase social relationships, and to stop heavy drinking. There was no

association between religion and starting medical checkups. Religious individuals were also more likely to continue to not smoke, not be depressed, not get divorced or separate, keep up personal relationships, and maintain medical checkups. There was no significant association between frequency of attendance and continuing physical activity or continuing to not drink heavily.

RELIGIOUS SERVICE ATTENDANCE AS THERAPY?

Research by Ezra Griffith and colleagues (Griffith, English, & Mayfield, 1980; Griffith & Mathewson, 1981; Griffith, Young, & Smith, 1984) has also documented the potential therapeutic benefits of at least some religious services. In a study of church services in New Haven, Connecticut, these researchers documented that there were several therapeutic aspects of groups that are present within the liturgy or ritual of these services. These include providing the installation of hope, group cohesiveness, altruism, social learning, and universality. These researchers argued that several major rituals could be therapeutic. For example, testimony can provide an opportunity to talk about offenders, what to do when offended, identify with the oppressed, and provide validation for the experiences described. Other rituals within the church services also provide security, renewal, installation of hope, positive sensations (feeling good, happy, and light), and reduction of tension and catharsis. Other researchers have noted that several aspects of religious services are distinctive in the provision of opportunities to articulate and manage personal and collective suffering (Gilkes, 1980). The expression of emotion and active congregational participation can promote "collective catharsis" in ways that can facilitate the reduction of tension and the release of emotional distress.

De Sousa (2005) has summarized research on the role that songs and music can play in enabling individuals to allay anxiety. Music has been shown to relax patients in critical care units and other contexts. Music has been used to alleviate grief and sadness and to combat bouts of sadness. Music therapy has also been shown to modify the behavior

of children with autism and other developmental disorders and reduce agitation in patients with dementia. De Sousa (2005) argues that music can instill joy and hope and help people maintain or regain inner peace.

RELIGIOUS INSTITUTIONS: HEALTHY OR UNHEALTHY ENVIRONMENTS?

Limited research evidence also indicates that religious congregations have psychosocial environments that can vary in their health enhancing potential. Ken Pargament and colleagues (1993) studied 352 church members in thirteen congregations and found that congregational attributes were related to psychosocial well-being. There were multiple aspects of congregations examined. They included the clergy, weekly services, education programs, facilities, policies, and social programs. Leaders and members were ranked on dimensions of congregational climate (Pargament, Silverman, Johnson, Echemendia, & Snyder, 1983). Pargament and his colleagues used a congregational climate scale that rates congregations on ten different dimensions. They were openness to change, stability, social concern, autonomy, level of activity, order/clarity, sense of community, intrinsic religious orientation, extrinsic religious orientation, and expressiveness.

These researchers found that the environments of churches varied. Small black Protestant congregations had greater expressiveness, social concern, and extrinsic climate scores. Small white Protestant congregations had higher levels of a sense of community and expressiveness, but, unlike black ones, lower levels of stability and social concern. Large white Catholic parishes had lower expressiveness and sense of community scores, but a higher activity score. Importantly, the well-being of members was related to the psychosocial environment of their congregation. For example, members who perceive more autonomy in their congregations reported higher levels of self-esteem and life satisfaction. Climate may be reciprocally determined and could reflect the role of member preferences. For example, expressiveness was negatively related to well-being in some congregations, but positively

related in others. This illustrates the importance of paying attention to organizational aspects of religious spiritual environments and assessing their consequences for health.

THE CLERGY: A BRIDGE OR BARRIER TO TREATMENT?

The National Comorbidity Study (NCS) documented that clergy play a major role in the treatment of mental illness in the United States (Wang, Berglund, & Kessler, 2003). This study of 8,098 individuals from a nationally representative population study in the United States found that among individuals who sought treatment for mental disorders 25% contacted the clergy, 16% contacted psychiatrists, and 16.7% contacted general medical doctors. Nearly one quarter of those seeking help from clergy had the most seriously impairing mental disorders. The majority of persons who sought help from the clergy sought help from the clergy only. Another national study found that the clergy play an important role in helping individuals cope with serious personal crises (Neighbors, Musick, & Williams, 1998). This study found that women were more likely than men to seek help from ministers and that people with economic problems were less likely than those with death and bereavement problems to seek help from clergy. Across problem types, persons who sought help from the clergy first were less likely to seek help from other professionals. Among persons seeking help from only one source, those who use the clergy were more satisfied with the support received.

There has been considerable interest in exactly what the clergy do for persons seeking help. A study of ministers in the greater New Haven area in Connecticut provides some information (Young, Griffith, & Williams, 2003). This study found that clergy on average spend 6.2 hours per week in counseling. One third indicated that they spent less time than they wanted to and more than half indicated that they had a regular schedule for counseling sessions, with a weekly schedule being the most common. In this study most of the counseling reported by clergy was short term. Two thirds reported that the duration of their

typical counseling session was three months or less. Forty percent of the clergy reported that they had seen people with severe mental illness, and two thirds reported that they had dealt with substance abuse in their congregation. Two thirds of the clergy also counseled suicidal persons, and over 60% had counseled persons they considered dangerous.

RELIGION, SOCIAL SUPPORT, AND COPING WITH STRESS

The life stress paradigm is an important perspective in assessing a potential way in which religion can affect health. Research shows that exposure to psychosocial stressors is a strong predictor of the onset and the course of some mental health problems. Social resources can improve health and reduce stress in at least three ways. Social ties can directly improve health by meeting basic needs for affection, social contact, and security. Supportive social ties can also reduce social conflict and tensions, thereby reducing stress. Social ties can also buffer the negative effect of stress on health. That is, in the face of stress, social ties can reduce at least some of the negative consequences of stress on health.

Research has found that religious institutions can serve as important sources of social support (Taylor & Chatters, 1988). Taylor and Chatters (1988) report that congregation-based friendship networks can serve as a type of extended family. Another study found that church-related friends are strongly related to life satisfaction for elderly blacks and account for the advantage and subjective well-being for older blacks (Ortega, Crutchfield, & Rushing, 1983). Religious support has also been shown to provide important benefits to both blacks and whites (Ferraro & Koch, 1994). An example of a buffering effect is a study conducted in New Haven, Connecticut, of 720 adults (Williams, Larson, Buckler, Heckmann, & Pyle, 1991). This study found that attendance at religious services did not directly reduce psychological distress. However, when followed for two years, religious attendance reduced the negative effects of the stressors (28 undesirable life events and 16 health problems) on mental health.

RELIGIOUS COPING AND MENTAL HEALTH: BELIEFS MATTER

There has also been considerable interest in the ways in which religious coping can be a resource that has health consequences. Tix and Frazier (1998) studied religious coping among patients dealing with kidney transplant surgery. They found that religious coping (for example, seeking God's help in dealing with the situation, trusting God to handle the situation, and trying to find a lesson from God in the situation) was associated with higher life satisfaction and less psychological distress both cross-sectionally and when the patients were followed prospectively. Particular religious belief systems may also create expectations and anxieties that can have consequences for mental health. The role of specific religious beliefs has been understudied in the research on religion and mental health. A study of 1,139 adults in the Detroit metropolitan area found that the belief in eternal life was positively associated with psychological well-being (Ellison, Boardman, Williams, & Jackson, 2001). This study also found a buffering effect for belief in eternal life. Belief in eternal life reduced the negative effect of some stressors (such as chronic health problems and financial problems) on psychological well-being and reduced the negative effects of work-related stress on psychological distress.

The work of Ken Pargament has also highlighted the role of positive and negative religious coping. For example, a study of 296 members of two churches coping with the Oklahoma City bombing assessed both positive religious coping and negative religious coping (Pargament, Smith, Koenig, & Perez, 1998). Negative religious coping included items like wondering whether God had abandoned them, feeling that God was punishing the victims of the bombing for their sins and lack of spirituality, and questioning whether God really exists. Pargament found that positive religious coping was associated with growth and recovery over time while negative coping was strongly predictive of symptoms of post-traumatic stress disorder (PTSD) and higher levels of callousness and insensitivity to the distress of others.