



CRITICAL REVIEW

ARTIST
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“It’s a metaphor”: The role of religiosity in mental health

ABSTRACT

Religion plays a significant role in the lives of many, and its impact on mental health cannot be underplayed. An individual's religiosity can be measured by their involvement with institutions and behaviours associated with their religion, their attitudes and ideologies of religious faith, as well as their devotion to faith and God. All three aspects of religiosity play some role in the individual's mental health, although each has different psychological, biological, and behavioural effects. Profound positive effects on mental health have been found for religious attitudes, while negative or no effects have been found for religious behaviours. These findings can have important clinical implications.

INTRODUCTION AND HISTORY

Religion plays a major role in civilizations across the world, defining many aspects of individuality, culture, social organizations, institutions, and politics. Unsurprisingly, responses to its influence on mental health have been contentious. In the field of psychology, some prominent figures such as Sigmund Freud have considered adherence to religious practice to be a sign of neurosis—dangerous to the individual psyche and the greater community.¹ Other psychologists have argued that adherence to religion can lead to a healthier mentality that is more hopeful and optimistic.¹ The prevailing stance is that religious belief in and of itself is not indicative of an individual's mental health or well-being. This has not always been the case. In the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published in 1980, no clear diagnostic lines were drawn between zealous religious belief and delusion or mental disorder. Later versions of the DSM clarified that distortions were a result of underlying mental health conditions, shifting away from pathologizing religiosity itself.^{2,3} This shift was accompanied by a greater focus on the concept of spirituality, which refers more broadly to the quality of the individual that is attuned to self-flourishing, something that can be independent of any formal institution.²

Proper operationalizations of both “religion” and “mental health” are incredibly important in this discussion.^{4,5} The framework outlined by Hackney and Sanders helps to organize concepts under the overarching term of religion.⁴ By their account, the term ‘religiosity’ defines the extent to which an individual or group: 1)

partakes in the institutions and behaviours of religion, 2) believes in the ideologies of religious faith, and 3) devotes oneself to faith and God.⁴ Mental health is a more multifaceted concept to define. Even the World Health Organization addresses the concept in broad strokes by describing it as a state of self-realization, resilience against stress, and the ability to contribute to the community.⁶ Negative indicators of mental health, such as psychological distress (e.g. depression or anxiety) and substance addiction, are often cited alongside positive indicators such as life satisfaction and motivation.^{4,7,8} Broadly speaking, mental health outcomes can be categorized into psychological, behavioural, and biological outcomes.

EMPIRICAL FINDINGS

Psychological Outcomes

Significant effect sizes have been found for religiosity on psychological distress, life satisfaction, and self-actualization.⁴ A meta-analysis of 35 studies found that overall scores of religiosity were positively correlated with scores in life satisfaction and self-actualization ($r=0.12$ [0.11–0.13], $p<0.0001$; $r=0.24$ [0.21–0.26], $p<0.0001$), and inversely related with psychological distress ($r=0.02$ [0.01–0.03], $p<0.0001$; reverse-coded). However, these results represent overall effect sizes; individual aspects of religion had varying associations with these three outcomes. For instance, greater involvement with the institutions of religion predicted significantly higher psychological distress. Participating in religious practices and organizations was negatively associated with the individual's psychological adjustment and mental health, which may be due to incompatibility between external institutions and individual needs or desires. By contrast, high levels of personal devotion—the aspect of religion connected most closely with religious attitude and emotional attachment—most strongly predicted high self-actualization. One of the main limitations of this meta-analysis, however, was the heterogeneity in definitions of religiosity and mental health in the included studies. The authors judiciously categorized the studies' outcomes into the previous categories, but different results could have been obtained had these categories been operationalized differently. Nevertheless, this meta-analysis was conducted in the context of other previous systematic reviews and meta-analyses, and operationalizations were done appropriately and systematically.

Two competing theories have been used to explain the positive and negative effects of religiosity on mental health. The first is the theory of terror management,

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which describes the protective effects of adhering to a ‘shared cultural worldview’ and how it can provide a sense of security and greater meaning to the individual.⁹ However, this theory contrasts with some of the authors’ findings, primarily that partaking in religious institutions was positively associated with psychological distress.

The theory of self-determination presents an alternative perspective.¹⁰ This theory supports the finding that personal devotion or investment in religion—so long as it is accompanied by healthy internalization of values, beliefs, and motivation—can provide benefits to an individual’s self-esteem, self-determination, and mental health.

The theory of self-determination is in line with another study that investigated the differential effects of religious behaviour and religious attitude on the mental health of an individual. This study administered a questionnaire to 472 participants to assess their religious involvement, religious orientation, and social-cognitive approaches to religion.¹¹ It was found that the two domains involving the attitudinal aspects of religion—religious orientation and social-cognitive approaches to religion—were significantly and positively correlated to outcomes of well-being. However, religious involvement, which is primarily associated with the behavioural aspects of religion, was not at all associated with psychological well-being.

Behavioural and Biological Outcomes

Despite the evidence suggesting a

negative correlation between religious behaviour and psychological well-being, religious involvement can promote healthy behaviours such as tobacco and alcohol avoidance, as well as reduce antisocial behaviours.¹ Furthermore, because religion can be a means of establishing community, social, and emotional supports, it can promote healthy behaviours that are not directly religious. Notably, some of the psychological outcomes, such as those of self-actualization and self-motivation, can also be found in non-religious and non-spiritual people. These outcomes may be results of improved self-control and self-regulation, and not religious belief specifically.¹²

More recent research tries to connect behaviour with neurobiology, often with the motive of finding new methods of therapy. Unfortunately, literature that assesses correlates of religiosity and neural structure and function is scant. Very little is known about the exact neural foundations of religiosity, and past research has focused primarily on unusual religious experiences resulting from abnormalities in limbic and temporal areas of the brain.^{14,15} It is unwise to generalize these findings to all religious thought, given that they are likely exceptions to the vast majority of religious thoughts and experiences, which are not pathological.

One recent fMRI study examined particular regions of the brain that were activated when patients thought about certain religious statements.¹⁵ The findings showed that statements reflecting God’s perceived emotion activated areas involved in higher-order emotional regulation, while statements regarding ‘God’s love’ activated an area involved in positive emotional states and suppression of sadness. The authors suggested



that activation of this positive emotion area may explain the inverse relationship between positive conceptualizations of God and the incidence of depressive symptoms. However, it is unclear if those thoughts exclusively result in activation of positive emotion areas, or if any thought associated with positive emotion, such as one of a loved one or family member, activates such areas. Regardless, it is evident that religious or spiritual attitudes may orient the individual towards better mental health outcomes. More research needs to be done to ascertain the exclusive effects of religiosity on neural functioning.

CLINICAL IMPLICATIONS

In their paper, Baetz and Toews highlight how current research on religion, spirituality, and mental health can inform clinical practice.⁷ They discuss practical means of incorporating ‘psychospiritual interventions’ into patient treatment by referring to common spiritual issues such as forgiveness, gratitude, and altruism. These concepts are common in most major religions and for a good reason: researchers have discovered that “positive acts and emotions have a profound effect on health,” which is a theory central to positive psychology.⁷

Data from the 2001–2003 National Surveys on Drug Use and Health were used to identify subgroups with moderate and serious mental or emotional distress.¹⁶ This outcome was related to frequency of religious service attendance and strength and influence of religious belief. Evidence was found of a positive relationship between religious service attendance and use of outpatient mental

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health care. Furthermore, a negative relationship was found between the perceived importance of religious beliefs and use of outpatient mental health care. The data suggest that religious behaviours provide a greater facilitative effect in the usage of mental health services than religious attitude. This finding demonstrates that although religion need not be at the core of mental health care, religious institutions and organizations can provide the scaffolding for mental health care service delivery. This sort of mental health service would be most helpful for patients who are already involved with a religion, or who have a desire to become involved.

CONCLUSION

Involvement with religious practices and institutions can help facilitate mental well-being, although it is more so the individual’s orientation toward self-determination and flourishing that has the greater positive impact. To some, religious doctrines and practices act as symbols or metaphors that help them grapple with the difficulties of life. This does not downplay the significance of religious institutions and frameworks; further research may be able to identify the core therapeutic aspects of religion that can be translated to other forms of mental health therapy.

