Religion and mental health: Towards a cognitive-behavioural framework

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**Purpose.** Religion is frequently ignored within the clinical domain. Yet when examined, empirical evidence indicates that specific aspects of religiosity are correlated with mental health. The established associations between religious dimensions and mental health could be mediated by cognitive-behavioural mechanisms. This paper proposes a preliminary conceptual framework in which two types of cognitive and behavioural mechanisms are described, (1) generic mental models that provide a basis for guiding appraisals of life events and (2) self-regulation of thinking processes (metacognitive control).

**Method.** A critical analysis of extant literature was employed to examine support for each of the mechanisms.

**Discussion.** Evidence supports the idea that a religious framework can serve as a generic mental model that influences appraisals and affects well-being. The benefits derived depend on the salience of the framework, level of certainty with which attributions can be accepted, and the content of the information. Evidence for the self-regulation mechanism is weaker. Although consistent with this supposition, it requires further empirical evaluation.

**Conclusion.** The relationships between religious variables and mental health may depend on cognitive-behavioural mechanisms. Developments in this area might encourage clinicians to consider further the ways in which religious variables might be utilized and assessed in therapy. However, there is a need for further efforts to incorporate religious and spiritual factors in the clinical arena.

Adams (1995) describes religion as ‘a particular form of worship, theology, ritual or creed associated with one of the five major world religions (Christianity, Judaism, Islam, Hinduism, Buddhism) or other minor religions’ (p. 202). This contrasts with spirituality,
which can be defined as ‘not a monolithic body of knowledge or practice, but a set of beliefs and practices ranging from major religions to individual spiritual paths, ancient traditions to New Age, radical/liberal to fundamental’ (p. 201). These definitions are consistent with other writers in the area. For example, West (2001) suggests that spirituality tends to involve one’s personal beliefs and practices, with religion providing an organizational structure. Within this understanding, an individual might be spiritual (e.g. believe in a higher power, such as the human spirit) without being religious (Worthington, Kursus, McCullough, & Sandage, 1996).

The current paper focuses on the literature pertaining to the domain of religiosity and specifically the relationships between aspects of religiosity and mental health. Argyle classifies religiosity, as other attitudes in social psychology, into a range of domains: cognitive; emotional and behavioural (Argyle, 2002). This paper adopts these categorizations. Although religiosity is the focus of the paper, owing to the merging of the domains, at times some literature is presented which would be characterized as spiritual subject matter.

Two mechanisms that might underlie the associations observed between religiosity and mental health are proposed, and evidence for each is explored. The paper focuses on the cognitive and behavioural domains in accordance with the proposed cognitive and behavioural mechanisms under evaluation. It is recognized that there also exists considerable literature referring to other aspects of religiosity, such as religious experience and orthodoxy, which will not be covered.

**Relationship between religiosity and mental health: An overview**

Studies have obtained mixed results concerning the association between religiosity and mental health. Evidence of the conflicting findings is summarized in Bergin’s (1983) meta-analysis in which 23% of studies found a negative relationship, 47% studies a positive relationship, and 30% studies no relationship. The multidimensional nature of religiosity provides one explanation for these mixed results. Religiosity is a complex construct that may have multiple effects on mental health. Thus, the effects of specific dimensions may counteract each other, resulting in varied patterns of association. Evaluating the relationship of specific dimensions of religiosity with mental health may therefore be more illuminating than evaluating global associations. Recent research has adopted this approach by adopting a more specific level of analysis, the origins of which derive from the work of Allport.

Allport (1954) developed a model of religiosity comprising intrinsic and extrinsic religious orientations. The extrinsic religious orientation describes individuals ‘disposed to use religion for their own ends. . . . Persons with this orientation may find religion useful in a variety of ways—to provide security and solace, sociability and distraction, status and self-justification’ (Allport & Ross, 1967, p. 434). In contrast, the intrinsic orientation describes persons who ‘find their master motive in religion. Other needs, strong as they may be, are regarded as of less ultimate significance, and they are, so far as possible, brought into harmony with the religious beliefs and prescriptions’ (p. 434).

Intrinsic and extrinsic orientations have been considered as types of belief, motivation and orientation. However, whatever their exact composition, they clearly discriminate individuals according to their cognitive content. Intrinsic religiosity is associated with perceiving death in positive terms, as an afterlife of reward and courage, and is positively associated with perceiving God as creative, gracious, blessed and kindly, and
negatively associated with perceiving God as distant, inaccessible, and impersonal (Spilka & Mullin, 1977). In contrast, extrinsic religiosity correlates with negative perceptions of death, including perceiving death as pain and loneliness and as failure, and is positively associated with viewing God as wrathful (Spilka, Stout, Minton, & Sizemore, 1977).

The orientations also discriminate the degree to which religious values are applied; intrinsic religiosity is associated with ‘living a religion’, whereas extrinsic religiosity is characterized by the more limited use of religion for benefits, such as social rewards. The varied application of religiosity can be seen in the relative tendencies to making religious attributions by students in explaining experiences encountered when isolated in an immersion chamber to provide a constant sensory experience. Participants scoring highly on intrinsic religiosity tended to describe their experience in religious terms. In contrast, those scoring highly on intrinsic and extrinsic religiosity only tended to describe their experience in religious terms if prompted, and those scoring highly only on extrinsic religiosity did not explain their experience in religious terms, even if prompted. It might also be anticipated that intrinsic religiosity is associated with a higher degree of faith than extrinsic religiosity.

While Allport’s model presents an advance on global representations of religion, Batson and colleagues (Batson & Ventis, 1982; Batson, Schoenrade, & Ventis, 1993) added a third religious orientation to the model entitled ‘religion as quest’. Essentially, religion as quest refers to a number of different aspects of religiosity such as complexity, doubt, and tentativeness. Individuals scoring highly on this dimension are considered to continually question existential matters without necessarily anticipating or achieving resolution.

Batson et al. (1993) attempted to identify associations between the extrinsic, intrinsic and quest religious dimensions and various concepts of mental health. The findings of 197 studies are summarized in Table 1. The table provides little evidence to support a positive relationship between the extrinsic orientation and mental health, and suggests that, more often than not, the extrinsic orientation is negatively associated with mental-health concepts. More specifically, in the majority of studies, the extrinsic orientation is negatively associated with absence of illness, appropriate social behaviour, freedom from worry and guilt, personal competence and control, and open mindedness and flexibility. In contrast, correlations between the intrinsic orientation and psychological well-being tend to be positive. In the majority of studies, the intrinsic orientation is positively associated with absence of illness, appropriate social behaviour, freedom from worry and guilt, personal competence and control, and unification and organization. The quest dimension shows no clear relationship with the various concepts of mental health. This outcome might reflect the paucity of studies in this area, or it may be that quest has no overall association with mental health. The complexity, doubt, and tentativeness engendered in the quest approach, and because it is not being bound to religious doctrine, suggests that there will be a higher level of individuality in each person’s search. Hence, the idiosyncratic framework for understanding stressful events may contribute to the observed equivocal findings. Some individuals may find comfort in their quests, while others do not.

Intrinsic and extrinsic religiosities have also been associated with specific mental health difficulties. For example, Maltby and Day (2000), in a sample of 360 British undergraduate students, observed that depressive symptoms were positively associated with extrinsic-personal religiosity (whereby the anticipated gains include comfort, peace, well-being, and protection) and extrinsic-social religiosity (whereby the
anticipated gains include making friends and socializing). Depression symptoms were negatively related to intrinsic religiosity. Religious orientations accounted for unique variance in predicting depression symptoms. The positive association between intrinsic religiosity and shorter remission times for depression has also been demonstrated (Koenig, George, & Peterson, 1998). Similarly, anxiety has been found to be negatively associated with intrinsic religiosity and positively associated with extrinsic religiosity (Baker & Gorsuch, 1982; Bergin, Masters, & Richards, 1987; Sturgeon & Hamley, 1979, cf. Maltby & Day, 2000). However, in their study, Maltby and Day (2000) found that neither intrinsic nor extrinsic religious orientations were significantly correlated with trait anxiety in males, and only positively associated with extrinsic religiosity in females. Plante and Sharma (2001) provide a good summary of research linking these dimensions of religiosity to specific aspects of poorer mental health, including depression, anxiety, and substance misuse.

Religious behaviours are another important facet of religiosity. The religious-behaviour domain includes attendance at religious meetings, studying religious literature, individual prayer, and so forth. A number of studies have highlighted the relationship between religious behaviours and mental health. For example, Peterson and Roy (1985) cite studies that have identified positive associations between church attendance and a range of well-being measures. Furthermore, evidence suggests that the relationship between religious behaviours and mental health is independent of religious orientation. For example, church attendance is negatively associated with anxiety when other religious variables are controlled (Peterson & Roy, 1985).

Maltby, Lewis, and Day (1999) identified a possible mediating role for personal prayer in the relationship between religious orientation and mental health. Maltby et al. explored the association between six dimensions of religiosity (intrinsic; extrinsic-personal; extrinsic-social; quest; personal prayer; and church attendance) and three

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Table 1. Association of intrinsic, extrinsic, and quest religion with various concepts of mental health (reproduced with permission, from Batson et al., 1993, p. 286)

<table>
<thead>
<tr>
<th>Conception of mental health</th>
<th>Dimension of individual religion</th>
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<tr>
<td></td>
<td>Extrinsic</td>
</tr>
<tr>
<td>Absence of illness</td>
<td>+ 1</td>
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<tr>
<td>Appropriate social behaviour</td>
<td>0 0</td>
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<tr>
<td>Freedom from worry and guilt</td>
<td>0 0</td>
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<tr>
<td>Personal competence and control</td>
<td>0 0</td>
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<tr>
<td>Self-acceptance, self-actualization</td>
<td>0 0</td>
</tr>
<tr>
<td>Unification and organization</td>
<td>0 0</td>
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<tr>
<td>Open-mindedness and flexibility</td>
<td>0 0</td>
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Note. The three columns under each dimension of religion indicate the number of reports of a positive relationship with each conception of mental health (+), the number of reports of no clear relationship (?), and the number of reports of a negative relationship (–).
mental-health indicators (depression, trait anxiety, and self-esteem) in 474 British undergraduate students. As expected, intrinsic religiosity was positively associated with measures of better mental health (higher self-esteem and lower trait anxiety), whereas both extrinsic religiosity measures were positively associated with indicators of poorer mental health (higher depression and lower self-esteem). However, when the five religious variables were regressed on the three well-being measures, only personal prayer was a consistently significant predictor.

As with religious orientation, religious behaviours are multifaceted, and so their relationship with mental health is unlikely to be simple. Prayer provides a good example of the multidimensional analysis of the associations between religious behaviours and mental health. Poloma and colleagues (Poloma & Gallup, 1991; Poloma & Pendleton, 1989, 1991) identify four categories of prayer: ritual, colloquial, petitionary, and meditative. Ritualistic prayer is described as a verbal activity that may be likened to reading or reciting a prepared script. Colloquial or conversational prayer involves a more conversational communication, often around themes of asking for forgiveness, expressing gratitude and requests for guidance. Requests to God for material things are categorized as petitionary prayers. Meditative prayer is non-verbal, requires more passivity than activity, and is seen as an interchange with God rather than a personal monologue as in the other prayer types. Meditative prayer includes spending time thinking, ‘feeling’ the presence, worshipping, adoring, and trying to listen to God speaking.

The relationship between the four prayer types and well-being has been evaluated, initially in a county-wide study (Poloma & Pendleton, 1991) and later in a Gallup national survey in the United States (Poloma & Gallup, 1991). In the initial study, 560 random telephone interviews were completed, assessing subjective ratings of quality of life and a range of demographic variables in addition to measures of prayer and religiosity. In their analysis, the type of prayer adopted was critical in determining the association with measures of well-being, including life satisfaction, existential satisfaction, religious satisfaction, and happiness. Colloquial and meditative prayers were positively associated with all measures of well-being. Meditative prayer was the most important predictor of religious experiences while praying, such as noting the existence, acknowledgement, and love of God. Religious experiences were consistently associated with measures of well-being. Although related to some well-being measures, petitionary and ritualistic prayers were not significantly associated with happiness, and they correlated positively with negative affect. Although this type of methodology produced a large sample size, it is recognized that some limitations arise. In particular, it is probable that respondents’ willingness to be truthful may be influenced by being interviewed by telephone.

To summarize, despite mixed results when considering the global association between religiosity and mental health, when the association between specific dimensions of religiosity and mental health is examined, some robust findings appear. Namely, intrinsic religious orientation, which is characterized by a more positive belief content and general applicability, is positively correlated with well-being. In contrast, extrinsic religious orientation, which is characterized by a more negative belief content and less generic applicability, is negatively associated with well-being. Within prayer types, colloquial and particularly meditative prayer types are positively associated with well-being, whereas ritual and petitionary prayers are not.

What are the possible mechanisms accounting for these relationships? Worthington et al. (1996) suggest that researchers need to determine why religion sometimes has
positive effects. They describe some of the pathways suggested to date (produce a sense of meaning, stimulate hope and optimism, give individuals a sense of control by a beneficent God, prescribe a healthier life, set positive social norms, provide a social support network, give a sense of the supernatural that provides a ‘boost’). However, it is also important to understand the negative effects. Before attempting to answer this question from a cognitive-behavioural perspective, in the next section, defence and coping explanations are briefly discussed.

Conceptual frameworks explaining the association between religiosity and well-being

Religion as a psychological defence

The notion that religion represents an inappropriate refuge of the helpless from unacceptable human impulses and uncontrollable external forces, first argued by S. Freud (1927/1961), has gained acceptance among some psychologists, social scientists, and mental health professionals. (Pargament & Park, 1995, p. 13)

Evidence that therapists tend to view religion as an inappropriate defence mechanism might be apparent in the finding that moderately religious clients tend to be viewed as having a greater psychopathology and a more pessimistic prognosis in therapy (Houts & Graham, 1986). Despite its apparent popularity as a hypothesis, there is wide-ranging evidence to dispute the position. Pargament and Park (1995), in a critique of the global position, demonstrate that although religion is often utilized in times of stress and can provide comfort, there is little evidence that it represents only a form of denial. They highlight that some religious concepts (such as sinning and hell) may well induce stress. If the predominant reason underlying religious belief is to ameliorate a fear of death, it would be expected that religious individuals should show a lower death anxiety; however, studies evaluating whether religious faith is associated with a lower death anxiety have produced conflicting results (see Ochsmann, 1984; Spilka, Hood, & Gorsuch, 1985). Perhaps most problematic in the context of this paper, the hypothesis that ‘religion is a defence’ does not predict the specific differential associations observed between aspects of religion and well-being.

A religious coping model (Pargament, 1990, 1996)

Pargament (1990) describes how religion can act within the coping process outlined by Lazarus and Folkman (1984), whereby an individual conducts a primary appraisal of whether an event is potentially harmful and a secondary appraisal concerning their ability to cope. Authors such as Koenig and colleagues have observed the very high use of religious coping to manage emotional stress. In their study of a sample of 850 men aged 65 years and over experiencing illness, 20% responded to an open-ended question that religion was a primary factor in their coping, and almost the same figure (21%) indicated that religion was ‘the most important thing that keeps me going’ (Koenig et al., 1992). The nature of the religious involvement was varied. It included having trust or faith in God, praying, reading the Bible or other religious literature, listening to religious programmes on the radio or watching religious television programmes, participating in church services or other related activity, and receiving emotional support from church members or a pastor (Koenig et al., 1992). It appears from these data that religiosity can be seen as an element of coping, a contributor to coping, and a product of coping.
Pargament’s work comprises a broad consideration of the potential role of religion at each of these three levels. At the first level, religion as an element of coping, the types of religious activities subsumed in the actual process of coping are wide-ranging. A few examples include cognitive activities (such as finding a religious lesson in the event), behavioural activities such as confessing one’s sins, and passive (e.g. asking for a miracle) and collaborative responses (e.g. taking control over what one could do and giving the rest up to God). At the second level is the ability of religion to shape the coping process. For example, religion influences the likelihood of certain life events (e.g. substance misuse, extra-marital relationships) that place demands on an individual’s coping resources. Also, religious factors can influence appraisals of events and perceived ability to cope. The latter may be enhanced if the individual perceives that God is on their side. Religion can also be seen as a product of coping. This is illustrated by the observation that, at times, painful experiences can draw a person to God.

Pargament (1996) notes that although religion can at times impede the coping process, his focus is on the helpful roles of religion in understanding and dealing with stressful situations. Therefore, although he provides a wide-ranging analysis of the ways in which religion might be implicated in assisting coping, his work does not attempt to explain the differential associations between dimensions of religiosity and mental health. Rather, he suggests that religion may have different advantages and disadvantages for people depending on their situations, personal and social resources and constraints, and personal needs and preferences.

In considering these conceptual frameworks, it is apparent that the models are not easily applicable to understanding the reasons for the differential association of dimensions of religiosity with mental health. A cognitive-behavioural framework may provide a conceptualization of the differential associations identified, and a consideration of the associations from this viewpoint may help to inform how religiosity can begin to be incorporated into therapeutic practice.

**Towards a cognitive-behavioural conceptualization**

A number of cognitive-behavioural mechanisms might underlie the robust associations between dimensions of religiosity and mental health. Two basic mechanisms are: (1) that religious beliefs (schema) provide generic mental models that serve as a basis for guiding appraisals of life events and (2) they provide a basis for the self-regulation of thinking processes. Both these mechanisms might be either beneficial or unhelpful when dealing with stressful life events, depending on their content and form.

**Generic mental models (schema)**

An individual’s religious orientation is likely to be associated with the formation of religious mental models. A religious mental model can be understood as a generic belief system that contributes to appraisals, particularly those concerning stressful life events. A religious belief system may be beneficial by enabling individuals to find meanings in stressful life events that are otherwise difficult to explain. The content of the generic beliefs held would influence the content of situational stress appraisals and so affect an individual’s response. Both the content of the mental model which might influence appraisals and the certainty with which the belief system is maintained would buffer against mental-health problems. For example, if the content is such that it leads people
to blame themselves or a punishing God for negative events, the mental model would increase vulnerability to mental disturbance.

This mechanism could be evaluated on the evidence of two tenets: (1) the presence of a salient generic mental model to guide appraisals is associated with mental health and (2) the content of the generic mental model modulates its association with positive mental health.

Hypothesis 1a: The presence of a salient generic mental model to guide appraisals is associated with positive mental health.

This hypothesis is consistent with the theorizing of Peterson and Roy (1985), who proposed that religiosity provides an interpretative framework that enables the individual to make sense of their existence. They suggest that the benefits of an interpretative framework include that the meaning system contributes to an individual's perception of themselves, their significance, and the purpose of life events (McGuire, 1981). Spilka, Shaver, and Kirkpatrick (1985) and Pargament and Hahn (1986), in applying attribution theory, report that religious attributions for life events may enable individuals to maintain a sense of meaning and perceived control and predictability in the world. Recent work has begun to evaluate the type of attributions to God made and their inter-relationships with religious orientation (see Mallery, Mallery, & Gorsuch, 2000). Given that studies suggest that the cause of everyday events is likely to be only infrequently attributed to God (7%) or Satan (2%; Lupfer, Brock, & DePaola, 1992), it is probable that religious meanings are most apparent at times of stress, perhaps providing meaning at times when secular belief systems cannot; the so-called ‘God of the gaps’ hypothesis. Fewer researchers have evaluated the empirical evidence supporting the benefits of maintaining this interpretative framework.

Ross (1990) provides empirical evidence for the benefits of maintaining a framework to which one is committed and accepting of its explanations. She conducted a telephone survey of 401 households and observed that in the 70.1% that responded, symptoms of depression and anxiety showed a curvilinear association with strength of religious belief. She highlights that ‘people who say they have no religion do not say it lightly; they are not indifferent. They have made a conscious choice to reject religion’ (p. 237). In essence, those with no religion as well as those deeply committed to a religion have a clear conceptual generic framework to guide decision-making. It seems that, irrespective of religious denomination, or whether or not a religious viewpoint was maintained, individuals who strongly believed in their position tended to have lower distress than those who professed a weak belief, reflecting the benefits of a salient framework. Those who are uncertain about their religious beliefs experience greater distress, as they do not hold a guiding existential framework with which to determine meaning for themselves and events.

Consideration of aversive experiences of those who cannot make sense of an event within their personal framework provides further support for the merits of a framework that can provide meaning. Wilson and Moran (1998, p. 171) describe the potential of trauma to ‘destroy faith and leave the victim in a state of spiritual disarray’. The belief system upon which one has come to depend to answer existential questions may not be able to respond adequately to the type of questions elicited by such an event, for example, ‘Why did God allow this to happen?’ and ‘If I accept that my God allowed this to happen, is He now deserving of worship?’ (Brende & McDonald, 1989;
Mahedy, 1986). Swinton (2001) has similarly described the prevalent experience of ‘meaninglessness’ of life often evident in those with depression.

Authors describing their experience of treating Vietnam veterans highlight the need to address spiritual appraisals in a proportion of individuals (Khouzam & Kissmeyer, 1997). Indeed, following reflection of their experiences working with veterans, they concluded that, for some individuals, enabling the re-development and re-confirmation of spiritual values may be a key process in their recovery (Khouzam & Kissmeyer, 1997). It seems that the re-development of a spiritual meta-framework which can make sense of experiences may be associated in some instances with recovery. Thus, there is some evidence in both clinical and non-clinical populations of the potential utility of maintaining a strong generic model consisting of the presence or absence of religious beliefs.

The idea that a religious framework may provide a general model for understanding stressful life events can explain the differential relationship of intrinsic and extrinsic religiosity with mental health. The reason may in part concern the salience and certainty given to the religious framework. For those for whom religion is salient and who are deeply committed to their religion (i.e. those scoring highly on intrinsic orientation), the explanation offered by the religion will be accepted and will provide an understanding of life events (Peterson & Roy, 1985). However, for individuals who are less committed to religion and for whom religion is less salient (i.e. those scoring highly on extrinsic orientation), religious explanations will not provide certainty or clear understanding and indeed may pose further questions. The more prevalent usage of religious schema to provide meaning among those scoring highly on intrinsic religiosity (see the previously described study by Hood, Morris, & Watson, 1990) provides a possible explanation for the association between intrinsic religiosity and mental health.

Hypothesis 1b. The concept of the beliefs comprising the mental model moderates the degree to which the generic framework is associated with positive mental health.

Several sources provide evidence consistent with the hypothesis that the content of beliefs may be relevant to mental health. For example, the evidence that intrinsic religiosity, which is characterized by positive beliefs, is more frequently associated with positive mental health, whereas extrinsic religiosity, which is characterized by more negative beliefs, is more frequently associated with negative mental health.

By examining other data on positive versus negative religious beliefs, it is possible to evaluate the assertion that content affects appraisal and emotional responses to life events. Literature evaluating the role of religiosity in coping indicates some merits of intrinsic/positive God attributions.

Bulman and Wortman (1977) evaluated the attributions of 29 victims of spinal-cord injuries and observed the most common explanations revolved around God, providing a variety of possible reasons such as teaching them a lesson or setting an example to others. Jenkins and Pargament (1988) evaluated the association of control attributions and adjustment in interviews with 62 individuals diagnosed with cancer. An example of a positive attribution of illness to God was ‘It’s a learning experience; I see God’s trying to put me in situations, help me learn about Him and myself and how I can help other people’ (p. 358). Jenkins and Pargament found that individuals who attribute control of their disease to God had higher levels of self-esteem and lower levels of observed behavioural upset. Interestingly, attributions to God were more highly related to adjustment than personal control attributions. The qualitative content of these interviews revealed an active process of exchange with God rather than passive submission to an
external force. For example, God was seen as working through their own efforts at controlling their disease, and prayer and faith acted as a means of accessing control from God. These findings support previous work that describes the positive effect of a problem-solving process involving give and take between the individual and God (Pargament et al., 1985).

Dalbert, Lipkus, Sallay, and Goch (2001) observed that belief in a just world (i.e. that self and others get what they deserve), which is associated with well-being, is also significantly correlated with religiosity. Lowenthal and colleagues found that although religiosity influenced religious-based cognitions about stressful events, this did not then impact on levels of distress, except indirectly by increasing positive affect (Lowenthal, MacLeod, Goldblatt, & Valentine, 2000). These findings are consistent with the model and suggest consideration of the pathways; in particular, the potential role of positive and negative content of religious beliefs is required.

Conversely, negative spiritual beliefs correlate positively with poorer mental health. For example, fears about ageing and death account for up to 14% of the variance in variables characteristic of hypochondriacal disorder, such as disease conviction, disease fear, and bodily preoccupation (Barsky & Wyshak, 1990). Death anxiety has been found to discriminate between hypochondriacal patients, control psychiatric out-patients and primary-care patients (Kellner, Abbot, Winslow, & Pathak, 1987). Death beliefs and superstitious beliefs were found to be significant predictors of health anxiety in samples of British Roman Catholics and Atheists (James & Wells, 2002).

Wells and Hackman (1993), in a qualitative study, identified two predominant core beliefs in health-anxious patients undergoing cognitive therapy: negative beliefs about the self and negative beliefs about the nature and consequences of death and illness. The latter included concerns about the nature of an afterlife and the will of supernatural powers, which might be very closely associated with individuals' religious beliefs. The authors provide descriptions of their assessment of two of the participants. In Case 1, the individual reported core beliefs concerning a view of himself as weak and deserving punishment. Illness and death were perceived to provide just consequences for this weakness, namely failure and eternal punishment. In Case 2, the individual held core beliefs that illness and subsequent death led to aloneness and eternal torment. The subject related these beliefs to his childhood exposure to the preaching of an extreme religious cult. Thus, a range of spiritual beliefs may be implicated in the cognitive structure of some psychological disorders. The spiritual/paranormal beliefs that people hold are probably shaped by religious doctrine and associated with intrinsic and extrinsic religiosity. Disappointingly, few studies have evaluated the relative effectiveness of therapies aimed at modifying religious schema as a means of influencing mental health.

Summary of evidence for the hypotheses underlying a generic mental model mediating the association between religiosity and health

There is evidence to support the idea that a religious framework can serve as a generic mental model that influences appraisals and affects well-being. The benefits derived are determined, in part, by the salience of the framework, level of certainty with which attributions can be accepted, and the content of information held. Evidence for this guiding system can be seen in both clinical and non-clinical studies. Further research is required to assess whether it is possible to intervene at the religious schema level to influence appraisals and well-being.
Self-regulation of thinking processes

Wells and Matthews (1994) developed the self-regulatory executive function (S-REF) model, which provides a generic model of cognitive functioning that can be used to understand the interactions between appraisals, attentional control, and beliefs in the maintenance of emotional disorder (Wells, 1997). Within this model, emotional disorder is equated with a cognitive-attentional syndrome comprising in part self-focused attention and perseverative thinking (i.e. worry/rumination), which reduces the processing of disconfirmatory information and maintains mental preoccupation with threat.

Religious beliefs and particularly religious behaviours may affect ongoing cognitive processes, including individuals’ attention to internal events. For example, some religious individuals may attend more closely to their internal cognitive processes under the assumption that thinking in certain ways is sinful and likely to be punished. In contrast, religious behaviours such as meditative prayer might provide periods of modified awareness of cognitive process and self that is beneficial for self-regulation. Moreover, worry/rumination processes that have been linked to emotional-disorder maintenance (Wells & Matthews, 1994) may be suspended during meditative prayer, thereby contributing to a greater well-being. This mechanism postulates that religious behaviours, which effect self-regulatory processes, are differentially associated with mental health.

Hypothesis 2: Religious behaviours, which contribute to self-regulation by reducing self-focus and worry, are positively associated with mental health. Conversely religiously motivated behaviours that increase these factors should be associated with negative outcomes.

The potential role of some religious beliefs in increasing self-focused attention and emotional disorder can be seen in obsessive-compulsive disorder, where researchers have speculated and begun to evaluate the significance of appraisals of intrusions (Salkovskis, 1985; Wells, 1997; Wells & Papageorgiou, 1998). Steketee, Quay, and White (1991) highlight that some religious upbringings promote the view that ‘thinking is the same as doing’, and that sexual and aggressive urges are sinful and require control. The promotion of negative religious and personal meanings and consequences of particular types of thoughts, such as intrusions, may in part explain the high prevalence of religious obsessive-compulsive disorder symptoms (Steketee et al., 1991). Aside from increasing vigilance for cognitive activity, religiosity may also promote concepts of thought control and ‘undoing’ through rituals or cognitive acts of penance. Similarly, Wells and Hackman (1993) found that some of their health-anxious patients held superstitious/religious beliefs concerning the desirability of worry about symptoms as a means of self-protection.

Meditative prayer may function in a similar manner to other meditative procedures that are thought to reduce self-focused attention, enhance mental control, and free individuals from preservative symptoms of stress such as worry and rumination (cf. Wells & Matthews, 1994). Consistent with this, the work of Poloma and colleagues, as described in the overview of the literature, found that prayer types likely to be associated with increased rumination preservation (petitionary and ritualistic) are correlated with negative affect, whereas prayer types associated with a meditative and more conversational approach are associated with well-being (Poloma & Gallup, 1991; Poloma & Pendleton, 1991).

Much evidence supports the benefits of meditative procedures. Alexander,
Robinson, Orme-Johnson, Schneider, and Walton (1994) found that mindfulness meditation resulted in reduced overall psychological symptoms, increased perceived control, and acceptance. These meditative practices, although often not highlighted, tend to originate in eastern religions; for example, mindfulness meditation (Kabat-Zinn, 1994; Teasedale, Segal, & Williams, 1995) is part of Buddhist practice that promotes the development of detached awareness. Only a small number of studies have evaluated the benefit of meditative prayer procedures that explicitly include a religious component.

Carlson, Bacasetta, and Simanton (1988) assessed the effectiveness of devotional meditation in a between-groups comparison. The three groups each comprised 12 Christian undergraduates. Two treatment groups received either devotional meditation or progressive relaxation training, and a third control group received no treatment. The authors defined devotional meditation as ‘a period of (a) quiet reading and reflecting on a passage of Scripture emphasizing God’s care and concern and (b) praying about development of Christian virtues using prepared liturgical materials’ (p. 363). The dependent variables included a range of physiological measures (four EMG sites, heart rate, and skin temperature) and psychometric measures of psychological distress. Findings indicated that devotional meditation was associated with significantly greater reductions in anger, anxiety, and muscle tension compared with progressive relaxation.

Summary of evidence for the hypotheses underlying self-regulatory processes mediating the association between religiosity and health

It would seem that there is some evidence that contemplative prayer may enhance mental health. However, the studies have tended to be somewhat inadequate methodologically. There is more evidence to support the role of meditative procedures such as mindfulness meditation, but these are not necessarily embedded within a clear religious framework. Thus, it would appear that further research is required to evaluate the effects of religious behaviours on self-regulatory processes.

If religious factors are involved in psychological well-being, it is possible that including religious factors in treatment may enhance change and improve psychological resilience. There is some emerging evidence from a small number of treatment studies that including religious factors in cognitive behavioural treatments for depression may be helpful.

Including religious factors in cognitive behavioural therapy

The studies conducted have not attempted to address religious beliefs and behaviours directly; rather, they aim to increase the power of the active ingredients of therapy, such as the therapeutic relationship, and enhance the acceptability of therapy, by increasing its concordance with the client’s own language and belief structures. To date, they do not provide a clear indication of effectiveness for clinical usage due to their equivocal findings, limited sample sizes, using a single therapist identified as Christian, or sample characteristics.

Propst (1996) describes two studies that she conducted in this area (Propst, 1980; Propst, Ostrom, Watkin, Dean, & Mashburn, 1992). In the initial study, she found that for religious patients, a cognitive-behavioural therapy-related religious-imagery treatment and religious placebo (group discussions of religious issues) showed a more positive effect than a cognitive-behavioural-related non-religious-imagery treatment. The more recent of the two studies evaluated the efficacy of including a religious component in a
cognitive-behavioural treatment for depression in Christian patients. The religious component included a religious rationale for procedures, religious arguments to counter irrational thoughts and religious-imagery procedures. The comparison groups comprised a waiting list control, pastoral counselling, and cognitive-behavioural therapy. The two cognitive behavioural treatment groups were split according to whether the therapist was religious or not. Findings indicated that the treatment groups performed approximately equally well overall on the Beck Depression Inventory and the Hamilton Rating Scale. Any more consistent differences observed were largely due to a superior performance of non-religious therapists in the religious cognitive-behavioural treatment compared with the cognitive-behavioural condition without a religious component. This would suggest that non-religious therapists may be able to improve the effectiveness of their therapy by including the differing world view of the client (Worthington et al., 1996).

Pecheur and Edwards (1984) similarly adapted a cognitive-behavioural treatment model by integrating biblical teachings into the rationale, homework assignments and basis for challenging thoughts and assumptions. Both treatment groups (cognitive-behavioural treatment and religious cognitive-behavioural treatment) comprised seven subjects, and the sessions were conducted with an explicitly Christian therapist. They observed a trend towards a greater reduction in depression levels in Christian clients receiving the religious therapy, although the effect was not statistically significant. Thus, further research is required to assess the benefits of including a religious component to established psychological treatments.

Studies have also been conducted comparing rational emotive therapy with a Christian version of the therapy. In contrast to the previous studies, Christian rational-emotive therapy not only aims to use a religious component to strengthen the client’s faith but also utilizes prayer as part of the therapy procedure, and the bible is adopted rather than human reason as a source of ultimate truth (Johnson, 1993). Johnson and Ridley (1992), in a study of 10 Christian clients with mild depression receiving six 50-min sessions over 3 weeks by a Christian therapist, found that both rational-emotive therapy and a Christian version of rational-emotive therapy were effective in terms of demonstrated improvements in depression and negative automatic thoughts. However, only the Christian version resulted in reduced irrational ideas. The similar beneficial effects have been replicated with a larger sample size ($N = 32$; Johnson, DeVries, Ridley, Pettorini, & Peterson, 1994).

Further research is required, which sensitively and with respect for people’s religious backgrounds addresses the actual religious beliefs and behaviours which people maintain and conduct that may contribute to their mental-health difficulties. There are early indications that although this approach may be perceived as useful, altering practice may prove difficult. Holden, Watts, and Brookshire (1991) evaluated the perceptions of 95 counsellors and clergy to addressing religious beliefs in therapy. Respondents, having read a description of a depressed client presenting religious beliefs (that her depression was evidence that God wanted her to suffer and that if God did not prevent her attempts at suicide, perhaps God did not wish her to live), completed a questionnaire. The responses indicated that they perceived that the religious beliefs were erroneous, that challenging these beliefs would be beneficial, and that they had a right to do this, but counsellors were less confident about their ability to challenge such beliefs. The study achieved only a 35% response rate and so has limited external validity, but it would seem that further consideration is required to enable clinicians to begin to incorporate religious factors further into therapy.
Looking to the future

The mental-health field has begun to consider the role of religiosity in clinical practice. However, the role of religiosity in mental health deserves further careful evaluation utilizing models that avoid the limitations of previous research (see Spilka & McIntosh, 1997). Religious schema can affect mental health in a similar manner to other schemas concerning the self and one’s environment, yet their existence has been largely ignored. Without an improved understanding of the interrelationships between religious schema and mental health, clinicians are unlikely to incorporate further spiritual dimensions into clinical practice.

To date, the majority of research on religion and psychopathology has been conducted on American Protestant populations (Gorsuch, 1988). The findings of this research may not extend to European populations, as there are already some indications that American and British religiosity show some epidemiological differences. British populations report a less prevalent belief in God (USA 94%, UK 70%; Gallup & Castelli, 1989; Gallup Poll International, 1984; cf. Brown, 1987) and less frequent use of prayer (America 88%, Gallup & Jones, 1989; British 50%, Gallup Survey, 1990, cf. Poloma & Gallup, 1991). Additional research is needed to assess the role of religiosity in mental health in British populations and within different religious denominations (e.g. Park, Cohen, & Herb, 1990). Religious denominations that promote excessive self-regulation, negative appraisals of one’s own thoughts and impulses, and excessive self-control may not provide the general interpretative framework or self-regulation strategies that can contribute to positive mental-health outcomes.

Further, changes in training are required to ensure that progress within the academic field is matched by further consideration of religious factors in the clinical domain. The current lack of attention paid to religiosity in mental-health practice is detrimental, since clinicians may overlook the potential influence of these variables in mental-health problems. In addition, service users may be diagnosed, feel misunderstood, and are more likely to receive culturally insensitive interventions. Psychologists’ concern should be focused on understanding people’s problems in view of their faith and not necessarily just supporting their religious commitment (Chirban, 2001). Understanding the role of religious factors in mental-health difficulties may enhance the effectiveness of interventions. Further research is needed to evaluate how religiosity can be used in therapy to enhance cognitive restructuring, to increase individual’s resilience, and to reduce vulnerability to mental-health problems.

Those involved in training are beginning to consider how religion and the wider domain of spirituality might be incorporated more into training (see West, 2001) and clinical work (see Chirban, 2001; Lovingier, 1996). Encouragingly, there is evidence that interest in the area is now growing. Dunn and Baker (2002) observed that the average annual citation rate for PsycLIT/PsycINFO for ‘religious beliefs and mental health’ was just three in 1980–1984, almost 14 in 1995–1999, but rose to 28 in 2000. In light of some of the writings in the area, this will be a very complex task.

The opinions of those such as Rowe (2001), who proposes that religious beliefs may not be developed in a logical fashion but rather may be accepted on the basis of meanings which appeal to us, and our identity, should not be ignored. Smail has similarly suggested as psychologists trying to say something in public about the causes and cures of human distress, we have to stick to the effable [that which we can put into words to have a common understanding], even though the effable never tells the whole story. (2001, p. 49)
Moreover, in their comprehensive review of the literature, Worthington et al. (1996) cited evidence of how difficult it may be to include the religious dimension, finding a preference for counsellors who do not directly challenge a Christian client’s religious values (McCullough & Worthington, 1995; Morrow, Worthington, & McCullough, 1993). It is therefore a considerable challenge for the profession to encourage and move forward consideration of just how the important and significant religious influences can be sensitively addressed in therapy.

References


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