

## Religious Belief and Its Relation to Psychological Well-being

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In recent years, psychological well-being has been the focus of intense research attention. Psychological well-being resides within the experience of the individual. It may be defined as the state of feeling healthy and happy, having satisfaction, relaxation, pleasure and peace of mind. It deals with people's feelings about everyday experiences in life activities. Such feelings may range from negative mental states or psychological strains, such as anxiety, depression, distress, frustration, emotional exhaustion, unhappiness and dissatisfaction, to a state which has been identified as positive mental health. There is now substantial literature which demonstrates positive effects of religious beliefs on psychological well-being. Psychological well-being is deeply related to the individual's religious beliefs, which offer a rich source of material to consider the relationship between various dimensions of religious involvement and other facets of psychological well-being.

**Keywords:** Religious beliefs, Psychological well-being.

An increased interest in the effects of religion on mental health and psychological well-being is apparent in psychological literature. A number of well conducted clinical and epidemiological studies have shown that the religiosity committed had much less psychological distress than the uncommitted (William, Larson, Buckler, Heckman & Pyle, 1991). Similarly, other longitudinal studies show that regular religious attendance led to much less psychological distress and depression in different spheres of life. A number of well-conducted clinical and epidemiological studies have proved that religiosity helps in the prevention of depression. Younger people also tend to experience fewer anxieties of growing up if they are religious. Those individuals who have reported higher spiritual strivings indicate greater purpose in life, better life-satisfaction and higher level of well-being. The persons with stronger religious faith have also reported higher levels of life satisfaction,

greater personal happiness and fewer negative psychosocial consequences of traumatic life events. Religiosity is positively related to a number of measures of psychological well-being. Thus, there is little doubt that religion plays an important role in many people's lives but the evidence has not been conclusive. This paper reviews the literature to find out the impact of religion on the psychological well-being of the person, concluding that the influence is largely beneficial but the overall relationship between religion and psychological well-being is in need of further improvement.

Psychologists have long been interested in studying the role of religious beliefs in psychological well-being. Within the psychology of health, an important contribution made by researchers is the significant relationship between religiosity and psychological well-being. The practice of religion has a significant effect on happiness and an overall sense of personal

well-being. It had been well-accepted that religious beliefs can shape a person's psychological perception of pain or disability as it creates a mindset that enables the person to relax and allows healing on its own. When it comes to articulating the basic structure of psychological well-being, discussions nearly always center on the distinction between positive and negative affect and life-satisfaction (Andrews & Withey, 1976; Bradburn, 1969; Bryant & Veroff, 1982; Liang, 1984, 1985). While there are some who are open to other ideas, an individual usually defends his or her religion. Such actions reflect a person's attitude and behavior, and indicate the influence of religion his way of thinking. Given the conditions and that people rely on religion for their views and understanding, researchers assume religion to produce psychological implications (Saroglou, 2003).

Within the Psychology of health, an important contribution made by researcher in psychology of religion is the significant relationship between religiosity and mental well-being. Many authors debate the issues of whether religion has beneficial or detrimental effects on the mental well-being of individuals (Bergin, 1980a, b; Ellis, 1980). A large number of studies show positive effects of religiosity on mental well-being. According to Moberg (1979) happiness is greater and psychological stress is lower for those who attend religious services regularly. Bergin's (1991) review of empirical literature on the relationship between religiosity and mental health provides evidence that average effects are generally positive, although not dramatic. His review indicates a number of correlations between religious affiliation and positive psychological functioning. Religious beliefs and practices contribute substantially to the formation of personal moral criteria and sound moral judgment. The regular practice of religion encourages such beneficial effects

on mental health, such as less depression, higher self-esteem and greater family and marital happiness.

Religiosity plays a major part in the life of an individual. It can provide hope in despair. In daily life, people report that they are able to experience deep peace even in the midst of mental distress (Underwood & Teresi, 2002), such as psychosis, prejudice, self-esteem and intelligence. There are some studies which report that religion is also associated with some indicators of poor mental health. Ellis (1980) has claimed that religiousness is accompanied by irrational thinking and emotional disturbance. While Gartner (1996) found religion is associated with some forms of psychopathology, including authoritarian, rigidity, dogmatism, suggestibility and dependence. Payne, Bergin, Bielema and Jenkins (1991) reviewed a number of studies, a search revealing several ambiguous findings. Although religiosity was positively related to number of measures of psychological well-being. However, no evidence was found for a relationship between religiosity and prevention of major clinical disorders. The authors conclude that the ambiguous findings among may be due to religion's multifaceted nature, and they call for greater specificity in how psychologists operationally define both religiosity and mental health.

Thus the practice of religion has a significant effect on happiness and overall sense of personal well-being. There are always a positive associations between religion and mental well-being which eventually enhances general psychological functioning.

There are various types of religious practices, such as prayer, yoga and meditation, which have a significant effect on psychological well-being and over all functioning of the body.

### **Prayer**

Prayer has been used as a self-enhancing intervention for centuries. It is inherently a religious affair and activity. Further, a prayer can be general or specific for oneself, for others or for all; to a specific deity or may be offered more generally (Sharma & Sharma, 2006). Richards and Bergin (1997) have cited preliminary evidence suggesting that different forms of prayer may have differential associations with effective coping with over all well-being and life satisfaction. In a study, Poloma & Pendleton (1991) suggested that colloquial prayers were associated with higher levels of well-being and life satisfaction.

### **Meditation**

Meditation is also a part of religious practice, which is used as a way of reducing the physiological and psychological stress. Meditation may have a number of health benefits, (Domino, 1977; Solberg, Berglund, Engen, Ekeberg & Loeb, 1996), by decreasing anxiety, depression, irritability, and moodiness, and improving learning ability, memory, self-actualization, feelings of vitality and rejuvenation, and emotional stability (Astin, 1997; Astin, Berman, Bausell, Lee, Hochberg & Forsy, 2003; Bitner, Hillman, Victor & Walsh, 2003; Solberg et al., 1996; Walton, Pugh, Gelderloos & Macrae, 1995). There are various kinds of meditative practices e.g. zen, transactional meditation, mindfulness etc. These meditative practices may benefit and provide acute and chronic support for patients with hypertension, psoriasis, irritable bowel disease, anxiety, and depression (Barrows & Jacobs, 2002; Carlson, Ursuliak, Goodey, Angen & Specca, 2001; Castillo-Richmond, Schneider, Alexander, Cook & Myers, 2000; Kabat-Zinn, Massion, Kristeller, Peterson & Fletcher, 1992,1998; Kaplan, Goldenberg & Galvin-Nadeau, 1993; Keefer & Blanchard, 2002; King, Carr & D' Cruz, 2002; Manocha, Marks,

Kenchinton, Peters & Salome, 2002; Reibel, Greeson, Brainard & Rosenzweig, 2001; Williams, Kolar, Reger & Pearson, 2001). Regarding the important form of meditation i.e., TM a large number studies have been done. Schneider, Staggers, Alexander, Sheppard, Rainforth, kondwani (1995) conducted a study in which subjects were randomized to three months of transactional meditation (TM) versus muscle relaxation versus life style education classes. At the end of three-month follow-up subjects randomized to TM had significantly reduced systolic and diastolic blood pressure as compared to the others two. Again Schneider, Nidich, Salerno, Sharma, Robinson, Nidich, Alexander (1998) found that the TM practitioners were found to have lower levels of serum lipid peroxides. Similarly, Infante, Reran, Martinez, Roldan, Poyatos (1998) found that TM practitioners had lower levels of Adrenocorticotrophic hormone. In this way TM has been considered as an important tool in the practice of meditation.

### **Yoga**

Unlike meditation, Yoga has also been used worldwide for enhancing the well-being of individuals. Yoga is probably the best known Hindu philosophical system in the world. Yoga develops the physical, mental, intellectual, emotional and spiritual components, thus building up a well- round organic personality. Yoga may be associated with acute and long-term decrease in blood pressure (Murugesan, Govindarajulu & Bera, 2000; Sundar, Agrawal, Singh, Bhattacharya, Udupa & Vaish, 1984) and may benefit patients with asthma, hypertension, heart failure, mood disorders, and diabetes (Jain, Uppal, Bhatnagar & Talukdar, 1993; Malhotra, Singh, Singh, Gupta & Sharma, 2002; Malhotra, Singh, Tandon, Madhu, Prasad & Sharma, 2002; Manocha et al., 2002; Van Montfrans, Karemaker, Wieling & Dunning, 1990). In this system the self control and self mortification are supreme.

### ***Intrinsic and extrinsic religiosity and psychological well-being***

Gorsuch (1988) has argued that one area of research that has given an insight into the relationship between religion and mental health is the distinction of individuals who display intrinsic and extrinsic orientation towards religion (Allport, 1966; Allport & Ross, 1967). Gorsuch again argued that this distinction between two different orientations to religion has been most useful to research on relationship between religiosity and psychological well-being. Individuals having an intrinsic orientation to religion have been described as living their religious beliefs, the influence of which is evident in every aspect of life (Allport, 1966). On the other hand, those who demonstrate an extrinsic orientation to religion have been described as using religion to provide participation in powerful in-group (Genia & Shaw, 1991); protection, consolation, and social status (Allport & Ross, 1967); religious participation (Fleck, 1981); an ego defense (Kahoe & Meadow, 1981).

Intrinsic religiosity has been related to several positive outcomes including better self-reported health, decreased anger, hostility and social isolation along with increased self-esteem (Donahue, 1985; Masters & Bergin, 1992; McIntosh & Spilka, 1990; Maltby & Day, 2000; Laurencelle, Abell & Schwartz, 2002; Acklin, Brown & Mauger, 1983). On the other hand, extrinsic orientation has been related to neutral and negative health indexes such as depression, anxiety, identity diffusion, irrational thought, and failure to volunteer to help (Baston, Olesen & Weeks, 1989; Swanson & Byrd, 1998; Bergin, Masters & Richards, 1987; Markstrom-Adams & Smith, 1996). The persons having intrinsic orientation have a greater sense of responsibility and greater internal control are more self-motivated and do better in their studies. By contrast, persons having extrinsic orientation are

more likely to be dogmatic, authoritarian, and less responsible, have less internal control, be less self-directed, and do less well in their studies (Wiebe & Fleck, 1980). Religious orientations can offer not only a sense of ultimate destinations in living, but also viable pathways for reaching these destinations, such as the effort to sustain themselves and their spirituality in stressful situations. Those with stronger religious frameworks may have greater access to a wide array of religious coping methods (e.g., spiritual support, meditation, religious appraisals) which may have been linked to better mental and physical health (Pargament, 1997).

In this way these two orientations lead to two very different sets of psychological effects. On one hand intrinsic practice is God oriented and based on beliefs which transcend the person's own existence where as on other hand extrinsic practice is also self-oriented and characterized by outward observance not internalized as a guide to behavior or attitude.

**Belief system and cognitive framework:** Beliefs and cognitive processes influence how people deal with stress while suffering from life problems. Religious beliefs can provide support through different ways e.g., enhancing acceptance, endurance and resilience (Argyle & Beit-Hallahmi, 1975). They generate peace and self-confidence, purpose, forgiveness to the individual's own failures, self-giving and positive self-image. Many patients use religion to cope with medical and non-medical problems. The study of religious coping has emerged as a promising research field. Positive religious coping has been associated with good health outcomes and negative religious coping with the opposite. Religious patients tend to use more positive than negative religious coping. Positive religious coping involves behaviors such as trying to find a lesson from God in the stressful event, doing what one can do and leave the rest in God's hand, seeking

support from clergy/church members, thinking about how one's life is part of larger spiritual force, looking to religion for assistance to find a new direction for living when the old one may no longer be viable and attempting to provide spiritual support and comfort to others. Negative religious coping includes passive waiting for God to control the situation, redefining the stressor as a punishment from God, or as act of the devil and, questioning God's love (Tepper, Rogers, Coleman & Malony, 2001; Pargament, Koenig, Tarakeshwar & Hahn, 2001; Pargament et al., 2004). Similarly, religious practices can help to maintain mental health and prevent mental diseases. They help to cope with anxiety, fears, frustrations, anger, anomie, inferiority feelings, despondency and isolation (Scheff, 1979; Schumaker, 1992). The most commonly studied religious practice is meditation (Benson, 1975).

There are many qualities like faith, hope, forgiveness and use of social support which have a noticeable effect on psychological well-being:

**Faith:** A person's most deeply held beliefs strongly influence his or her health. Some researchers believe that faith increases the body's resistance to stress (Efficace & Marrone, 2002). In another study Myers & Diener (1995) reported that people who have a meaningful religious faith are more likely to experience a sustained level of happiness.

**Hopes:** Is a positive attitude that a person assumes in the face of difficulty. Without hope many people become depressed and are more prone to illness. The existing research and theoretical literatures on hope identity relationships as being key ingredients in promoting hopefulness (e.g., Farran, Herth & Popovich, 1995; Dufault & Martocchio, 1985; Byrne et al., 1994; Frank, 1968).

**Forgiveness:** Is a practice that is encouraged by many spiritual and religious traditions. Forgiveness is a release of hostility and resentment from past hurts. In a study Worthington (1997) found that Unforgiving persons have increased anxiety, symptoms, increased paranoia, increased narcissism, increased frequency of psychosomatic complications, increased incidence of heart disease and less resistance to physical illness and act of forgiveness can result in less anxiety and depression, better health outcomes, increased coping with stress, and increased closeness to God and others. Pargament (1998) had also demonstrated the similar results that people who are unable to forgive themselves or others also have an increased incidence of depression and callousness towards others.

**Love and Social Support:** A close network of family and friends that lend help and emotional support has been found to offer protection against many diseases. Researchers believe that people who experience love and support tend to resist unhealthy behaviors and feel less stressed. Social support can influence health by facilitating adherence to health promotion programs, offering fellowships in times of stress, suffering and sorrow, diminishing the impact of anxiety and other emotions and anomie. Social supports reduce physiological strain (e.g. anxiety, high blood pressure) as well as psychological stress (e.g. role, ambiguity), and provide a buffer against strains caused by psychological stress (Pinnaeau, 1976). Similarly Boyce (1981) find individuals indicate a greater impact of high level of life stress when social supports are low as opposed to high.

It can be concluded that psychological well-being seems to include a variety of mental states and the practice of religion has a significant effect on happiness and overall sense of personal well-being.

### Present and Future Challenges

Although many studies have demonstrated positive effects of religious beliefs on psychological well-being a small number has demonstrated either negative or neutral effect. There are many reasons for this. An understanding of their challenges is crucial for designing appropriate studies and interpreting the results. These challenges are follows:

1. Religion is often exchanged with the term spirituality. Investigators have struggled to agree on formal definitions of these two, which are often mistakenly used synonymously (Powell, Shahabi & Thoresen, 2003; Tanyi, 2002).

2. Designing studies with sufficient numbers of subjects and adequate controls can be problematic. So investigators may have trouble monitoring and ensuring that subjects comply with study requirements. Inadvertent non-compliance can easily occur, as patients are influenced by visitors or their environment (Lee et al., 2005).

3. There are many possible measures of religiousness, which bring out many different dimensions. Patients who score high on one dimension may not necessarily score high on others. Thus, there is always a need for clear and exact measures used to avoid making claims about measures that are not used (Lee et al., 2005).

4. Religion should be measured by accurate and valid means. Even well-validated instruments are susceptible to a number of potential biases (Lee et al., 2005).

5. The direction of causality is not always clear. If an association is noted in a study, it is not always clear which side is the cause. In some cases, poor health can prevent or discourage patients from participating in religious and spiritual activities. In other cases, serious health problems may motivate patients to attend religious activities (Lee et al., 2005).

### Conclusion

There is a on going interest in the relationship between psychological well-being and religiosity. Based on the studies cited, this paper confirms the positive link between religious beliefs and psychological well-being. Although less in number but some psychologists have viewed religion as a cause of psychopathology. Hence, the exploration of its psychopathological implications should also be pursued and research should adopt different approaches to make the relationship between religious beliefs and mental health valid. The claim of such relationship cannot be fully verified because there are many mental health problems that do not yet seem to be linked with religious beliefs e.g. phobia, eating disorders, autism, dementia etc., should be explored and linked specifically with religious beliefs. There is already some literature available on the positive relationship between religious beliefs and mental health, the evidences are not conclusive. More researches should be conducted with methodologically sound and reliable measures. As religion brings many things (e.g., social and emotional support, motivation, health care resources) it also promotes healthy life styles. Religious and spiritual activities may serve as adjunct therapy in many disease and addiction treatment programs. Future studies should also be conducted on specific religious/spiritual interventions, which may prove beneficial for individuals in particular and society in general.

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