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Positive Effects of Religiousness on Mental Health : A Review

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Abstract: *Freud and other famous mental health scholars have put forth their postulations concerning the neurotic influences of religion in mental health, many of the 20th century mental health professionals have been influenced to hold skeptical and even hostile attitudes toward religion. However, the past two decades have increasingly found more empirical evidence supporting the beneficial effects of religiousness on mental health that apparently contrasts with the postulations of Freud. Evidence in research was nonetheless mainly based on physically healthy populations.*

Keywords: *mental health scholars*

I. Introduction

Freud and other famous mental health scholars have put forth their postulations concerning the neurotic influences of religion in mental health, many of the 20th century mental health professionals have been influenced to hold skeptical and even hostile attitudes toward religion. However, the past two decades have increasingly found more empirical evidence supporting the beneficial effects of religiousness on mental health that apparently contrasts with the postulations of Freud. Evidence in research was nonetheless mainly based on physically healthy populations. Studies addressing the relationship between religiousness and mental health in physically vulnerable populations, such as the aged, ill and disabled, have been insufficient. For this reason, this paper reviews recent empirical studies published in peer-reviewed academic journals concerning these relatively neglected populations.

Religion *involve beliefs, practices and rituals related to " sacred", where the sacred is that which relates to the mystical, supernatural or god in religious traditions or to ultimate truth or reality, in Eastern tradition. Religion may also involve beliefs about the spirits , angels or demons. Religions usually have specific beliefs about the life after death and rules about conduct that guide life within the social group. Religion is often organized and practiced within a community, but it can also be practiced alone and in private.*

Spirituality *more difficult to define than religion. It more popular expression today than religion. Spirituality is considered more personal, something individuals define themselves that a largely free of the rules, regulations and responsibilities associated with religion.*

II. REVIEWS OF LITERATURE

The relationship between religion and mental health has been debated for centuries. History shows that religious organizations were often the first to offer compassionate care to the vulnerable groups, including the medically ill, the elderly and the disabled. The first hospitals for patients with mental health problems established in the fourteenth century were church-sponsored and priest-managed ***(Alexander & Selesnick, 1966***).

Towards the end of the Middle Ages, religious scientists first suggested that biological mechanisms rather than supernatural powers were responsible for mental illness ***(Kroll, 1973***).

The idea and approach of moral treatment of individuals with mental health problems actually originated from the religious people. Benefited from this approach, individuals with mental health problems were treated much like normal persons ***(Taubes, 1998***). Hence, religion had played a significant role in shaping the form of mental health care known as 'moral'.

However, the postulations of Freud and other mental health scholars concerning the neurotic influences of religion have had an enormous impact on the field of mental health in the 20th century. Freud had been skeptical, if not antagonistic toward religion. He suggested that the less religious people were more mentally healthy (***Ellis, 1980, 1988***).

Wendell Watters, another well-known psychiatrist, also stated that religious beliefs were responsible for the development of low self-esteem, depression, and even schizophrenia (***Watters, 1992***).

In fact, during much of the 20th century, mental health professionals tended to either deny the religious aspects of human life or consider religiousness as old-fashioned or pathological. They anticipated that religious issues would disappear as mankind matured and developed. Scientific and systematic research lending support to a positive relationship between religiousness and mental health emerged only in past twenty years.

These studies also showed religion is an important aspect of human life. Evidence supporting these findings emerges from both cross-sectional and longitudinal studies, as well as from studies based on both clinical and community samples (***George et al., 2002; Plante & Sherman, 2001).***

This empirical evidence apparently contrasts with the skeptical and hostile attitudes towards religion of Freud and earlier mental health scholars, which were largely formed and based on their negative experiences with religion and their encounters with the psychiatric patients ***(Meissner, 1984; Zilboorg, 1958; Koenig, 2001***)

Research pointed out that many people who were not religious previously might turn to religion for comfort (***Koenig, 2001; Koenig, & Larson, 2001).***

Past research and reviews on the religiousness-health relationship tended to have focused more on the physically healthy populations, such as adolescents and youths, family members, college students and the general public (***Koenig & Larson, 2001; Gall & Grant, 2005; Mahoney, 2005; Marks, 2005; Regnerus, 2003)***

This often involves in beliefs in a living and caring God, private religious activities, reading religious scriptures for direction and encouragement, or looking for support from pastors or members of faith community. In fact, many studies commonly reported that religiousness was powerful resources of hope, meaning and purpose in life, comfort and solace. These protective and beneficial effects are particularly strong in people with illness and disability ***(Ehman et al., 1999; King, 2000; Koenig et al., 1998; Koenig et al., 2004; Mueller et al., 2001).***

III. FINDING AND RESULT

Recent research revealed that people become more religious when they are getting older. In comparison with young people, older people think that religion is more important for them, especially for those who are toward the end of life (***Koenig et al., 2004; Moreira-Almeida, 2006).*** There exist different explanations as to why older persons are apparently more religious than younger people, such as for psychological compensation after retirement. Whichever explanations are more salient in depicting the relationship, religious involvement is obviously a critical factor for older people to cope better and have better social and psychological adjustments while facing the debilitating process of aging. Undoubtedly, there have been increasing empirical evidence in gerontological, medical, social psychological and psychiatric literature that support the positive effects of religiousness on mental health in the older population ***(Ayele et al., 1999; Braam et al., 2004; Strawbridge et al, 2001***),especially the positive relationship between religiousness and depression in old ages.

Another recent and more salient longitudinal study of aged residents in Amsterdam by ***Braam et al. (2004)*** also reported an inverse relationship between religious involvement and depression. The findings reveal that religiousness, in terms of church attendance and religious importance, was inversely related to depression in a representative sample of 1840 community-dwelling older people. The relationship remained significant even after adjusting for physical health, self-perceptions, social integration, urbanization, and level of alcohol use. Over the 6-year period, depressive symptoms were significantly lower or reduced in frequency for those who attended church more frequently, compared to those elderly participants who had less church attendance or never attended church. Controlling for possible confounding variables did not change this relationship.

Bienenfeld et al. (1997) surveyed a group of retired Catholic sisters, examining the contributions of psychosocial factors and religiousness to life satisfaction, psychological distress, and depression. As a result, they found that sense of mastery, social support, physical functioning, and religious commitment were important factors contributing to life

satisfaction in the older population. The finding supported that elderly religiousness was conducive to mediating the psychological impact of impaired functional status.

Being ill, especially for those with severe and chronic illnesses, is a life-threatening experience that taxes on a person's psychological and social resources and coping capacity. Religiousness could help a patient to withstand psychological, physical and social impacts resulted from these adverse experiences (***Mueller et al., 2001; Pargament et al., 2004).***

Similarly, ***Maetal. (1998***) examined the effect of religious activity on depressive symptoms among community-dwelling elderly persons with cancer. In this two-wave longitudinal study, measures of religiousness in the form of service attendance, religious devotion, and watching or listening to religious programs were adopted. The findings indicated that religious activity was related to lower levels of depressive symptoms in participants with cancer. However, the effects of religious activity on alleviating depressive symptoms were stronger among Blacks than Whites in the study.

Positive Mental Health

Thereby a state of Wellbeing reflects Emotional Wellbeing (minimization of negative emotions and the maximization of positive emotions through the realization of ones abilities to coping with life stressors), Psychological Wellbeing (optimal functioning and meaning in one's life), and finally Social Wellbeing (optimal functioning and meaning in one's social life) ***(Lamers, 2012).***

There is a growing body of evidence indicating that spiritual practices are associated with better health and wellbeing for many reasons, including:

Prayer may elicit the relaxation response, along with feelings of hope, gratitude, and compassion—all of which have a positive effect on overall wellbeing. There are several types of prayer, many of which are rooted in the belief that there is a higher power that has some level of influence over your life. This belief can provide a sense of comfort and support in difficult times—a recent study found that clinically depressed adults who believed their prayers were heard by a concerned presence responded much better to treatment than those who did not believe.

Yoga is a centuries-old spiritual practice that aims to create a sense of union within the practitioner through physical postures, ethical behaviors and breath expansion. The systematic practice of Yoga has been found to reduce inflammation and stress, decrease depression and anxiety, lower blood pressure, and increase feelings of wellbeing.

IV. CONCLUSION

Through this review and analysis of the related literature, it is hoped to illustrate that religious involvement would result in a set of religious resources, such as spiritual, cognitive, psychological and social resources, which will mutually interact and reinforce one another through the 'chain reaction'. Through this process of mutual interaction and reinforcement, religiousness is considered hypothetically to contribute to mental health in believers. Though these theoretical explanations are at best hypothesis to be tested at the present stage, something more concrete is that most religious resources are thought to be beneficial in human mental health. Nevertheless, there is much room for researchers to conduct research to find out a clearer picture about mediational mechanisms linking the relationship between religious involvement and mental relationship. Theoretical concepts suggested in this paper may be or may not be one of the mediational relationships between religiousness and mental health.

REFERENCES

[1]. Ayele, H. et al. (1999). Religious activities improve life satisfaction for some physicians and older patients. Journal of American Geriatric Sociology, 47, 454-455.

[2]. Alexander, F. G. & Selesnick, S. T. (1966). The history of psychiatry: An evolution of psychiatric thought and practice from prehistoric times to the present. New York: New American Library.

[3]. Braam A. W. et al. (1997). Religious involvement and depression in older Dutch citizens. Social Psychiatry Epidemiology, 32, 284-291.

[4]. Braam, A. W. et al. (2004). Religious involvement and 6-year course of depressive symptoms in older Dutch Citizens: Results from the longitudinal aging study Amsterdam. Journal of Aging and Health, 16(4), 467-489.

[5]. Bienenfeld, D., Koenig, H. G. & Larson, D. B. & Sherrill, K. A. (1997). Psychosocial predictors of mental health in a population of elderly women - Test of an explanatory model. American Journal of Geriatric Psychiatry, 5 (1), 43-53.
[6]. Ellis, A. (1980). Psychotherapy and atheistic values: A response to A. E. Bergin's 'Psychotherapy and religious values'. Journal of Consulting and Clinical Psychology, 48, 635-639.
[7]. Ellis, A. (1988). Is religiosity pathological? Free Inquiry, 18, 27-32.
[8]. Ehman, J., Ott, B. et al. (1999). Do patients want physicians to inquire about their spiritual or religious beliefs if they become gravely ill? Archive of Internal Medicine, 159, 1803-1806.
[9]. Gall, T. L. & Grant, K. (2005). Spiritual disposition and understanding illness. Pastoral Psychology, 53(6), 515-533.
[10]. George, L. K. et al. (2002). Explaining the relationships between religious involvement and health. Psychological inquiry, 13(3), 190-200
[11]. Kroll, J. (1973). A reappraisal of psychiatry in the middle ages. Archrivals of General Psychiatry, 29, 276-283.
[12]. Koenig, H. G. & Larson, D. B. (2001). Religion and mental health: Evidence for an association. International Review of Psychiatry, 13, 67-79.
[13]. Koenig, H. G., Larson, D. B. & Larson, S. S. (2001). Religion and coping with serious illness. The Annals of Pharmacotherapy, 35, 352-359.
[14]. King, D. E. (2000). Faith, spirituality and medicine: Toward the making of the healing practitioner. Binghamton, NY: Haowth Press.
[15]. Koenig, H. G. (1998). Religious attitudes and practices of hospitalized medically ill older adults. International Journal of Geriatric Psychiatry, 13 (4), 213-224.
[16]. Koenig, H. G. (2001). Religion and medicine II: Religion, mental health, and related behaviors. International Journal of Psychiatry in Medicine, 31(1), 97-109.
[17]. Koenig, H. G., Larson, D. B. & Larson, S. S. (2001). Religion and coping with serious illness. The Annals of Pharmacotherapy, 35, 352-359
[18]. Ma, M. et al. (1998). Religious activity and depression among community-dwelling elderly persons with cancer: The moderating effect of race. Journal of Gerontology Series B-Psychological Sciences and Social Sciences, 53 (4): S218-S227.
[19]. Meissner, W. W. (1984). Psychoanalysis in religious experience. New Heaven, CT: Yale University Press.
[20]. Mahoney, A. (2005). Religion and conflicts in marital and parent-child relationships. Journal of Social Issues, 61(4), 689-706