Researchers have started to acknowledge the positive contribution spirituality can make to mental health. Individuals coping with cancer, heart disease, terminal illnesses as well as survivors of strife, war and mass destruction have all experienced and acknowledged ways in which spirituality and religion have contributed towards their mental health and well-being, mental illness and recovery. Quantitative and qualitative evidence suggest a positive relationship between spirituality and mental health in relation to a number of mental health problems such as depression, anxiety, schizophrenia, post traumatic stress disorder and substance abuse. The present article explores the impact that some expressions of spirituality and religion can have as part of an integrative approach to understanding mental health and well-being.

**Spirituality**

Spirituality is a way of being and experiencing that comes through the awareness of a transcendental dimension and is characterized by certain identifiable values in regard to self, others, nature, life and whatever one considers to be ultimate (Elkins, Hedstrom, Hughtes, Leaf, & Saunders, 1988). Spirituality implies that there is a deeper dimension to human life, an inner world of the soul. It is a process of “soul making,” an inner journey toward wholeness and toward God (Jones, 1985). It assumes that humans are fundamentally spiritual beings living in a spiritual, as well as physical, universe. Spirituality is about” the inner life or spirit of each of us as it relates to the unseen world of Spirit or of God. It is the name we give to the dimension of seeing and living that goes far beyond the material world to deeper truths and eternal values (Harpur, 1996). Thus it is about”the search for the sacred”(Pargament, 1997). The word spirituality itself derives from the Latin *spirare*, which means, ‘to breathe’.It includes a wide range of human experience “ traditional religions, personal mystical experience and the quest for meaning in life. There is no one, clear comprehensive definition of spirituality in the literature, therefore, nearly all the research on spirituality and health measures religious beliefs or practices.

The most fundamental concept of spirituality is that there is a transcendent dimension to life, something or someone beyond the human ego and sense experience. The experience of connection to
this larger, sacred reality is what gives our lives ultimate meaning. Thus, spirituality has to do with a
sense of connectedness and interrelatedness (Goodloe & Arreola, 1991; Whitmer & Sweeney, 1992),
and with the search for meaning and purpose in life (Chapman, 1987; Seaward, 1995). Spirituality
has been called “that which integrates everything else into meaning”. In this context, “spirituality”
becomes the vehicle through which that meaning is sought, and is found to vary with age, gender,
culture, mental health and many other factors.

Spirituality appears to be a multidimensional construct in which a few core concepts repeatedly
emerge. Sims (1994) proposed that spirituality included at least five domains viz., meaning in life,
interrelatedness, wholeness, morality, and awareness of God. LaPierre (1994) proposed that there are
six dimensions along which life can be experienced as a spiritual person: journey transcendence,
community, religion, the mystery of creation, and transformation. Spirituality has also been described
using the five concepts of transcendence, connection, ultimate meaning, inner journey and encounter
with God.

Religion

Religion derives from ‘religio’ which means ‘to bind back’. It is the search for significance
in ways related to the sacred, encompassing both the personal and social, traditional and non-
traditional forms of the religious search (Pargament, 1997). According to Matthews (1996) it is an
organized system of beliefs, practices, and symbols designed to facilitate closeness to God. However,
Testerman (1997) argued that religion is any set of beliefs and practices concerning our relationship
with the sacred. It may or may not be connected with an organized religious group. Koenig (2009)
opined that religion involves beliefs, practices, and rituals related to the sacred. It relates to the
numinous (mystical, supernatural) or God, and in Eastern religious traditions, to Ultimate Truth or
Reality. Religion may also involve beliefs about spirits, angels, or demons. Various religions usually
have specific beliefs about life after death and rules about conduct that guide life within a social
group. Religion is often organized and practiced within a community, but it can also be practiced
alone and in private.

Distinction between Spirituality and Religion

Spirituality can encapsulate a variety of activities that range from religious activities, such as
reading holy books to non-religious activities, such as painting or yoga. Spirituality is a more popular
expression today than religion, as many view the latter as divisive and associated with war, conflict,
and fanaticism. Spirituality is considered more personal, something people define for themselves that
is largely free of the rules, regulations, and responsibilities associated with religion. In fact, there is a
growing group of people categorized as spiritual-but-not-religious, who deny any connection at all
with religion and understand spirituality entirely in individualistic, secular terms. However, this
contemporary use of spirituality is different from its original meaning.

Testerman (1997) believes spirituality is an inner, personal experience, universal and without
boundaries. Religion, however, is communal, particular and defined by boundaries. It is spirituality
incarnated at the social and cultural level. Religion takes the boundless and binds it into the limitations
of language and culture, even as it may also transform culture. Religion is viewed as denominational,
external, cognitive, behavioral, ritualistic and public and the spiritual as universal, internal, affective, spontaneous and private (Richards & Bergin, 1997).

The Harvard Conference on Spirituality and Healing in 1997 raised a controversy regarding a blurred distinction existing between religion and spirituality (Zullig, Ward, & Horn 2006). A number of different understandings emerged not only to differentiate spirituality from religion, but to disparage all organized religions in favor of a free-floating, individualistic spirituality. According to Zullig et al. (2006), religion has been defined as a structured belief system with set rituals and practices, which are acquired in places of worship, while spirituality has been conceptualized as a way of being (learned anywhere), thereby establishing how individuals respond to life experiences. Further, individuals can be spiritual even without performing in any formal religious practice (Walker & Dixon, 2002), and spirituality can have different meanings to different individuals (McSherry & Cash, 2004). Furthermore, although religion may be an outward demonstration of spirituality for some, religiosity does not guarantee spirituality (Reker, 2003), thereby, highlighting the importance of making the distinction between spirituality and religiosity in measurement studies.

Koenig (2009) proposed that spirituality, if defined as good mental health and positive psychological or social traits, is found to correlate with good mental health. Thus, to avoid any methodological problem and to maintain the purity and distinctiveness of the construct, spirituality was defined in terms of religion, where religion is a multidimensional construct not limited to institutional forms of religion and using the terms religion and spirituality synonymously (for example, as RS). Various authors agree that religion and spirituality are probably, but not always interrelated and often used in an interchangeable manner (Sharma & Misra, 2010). In this article, while reviewing the studies examining the relationship between spirituality, religion and mental health, the viewpoint of Koenig has been accepted and the terms spirituality and religion are being used synonymously.

**Measures of Spirituality/Religion**

When measured in research, spirituality is often assessed indirectly either in terms of religion or by positive psychological, social, or character states. Spirituality is measured by its effects and associations. When spirituality is operationalized, it is religion (Testerman, 1997). Standard measures of spirituality today contain questions asking about meaning and purpose in life, connections with others, peacefulness, existential well-being, and comfort and joy. Measures of spirituality that are frequently used in research investigations are described:

**Brief Multidimensional Measure of Religiousness/Spirituality** (BMMRS; Fetzer Institute & Group, 1999) was developed to assess health-relevant domains of religiousness and spirituality for use in health outcomes research (Fetzer Institute, 1999). Initially 12 domains with independent measures for each domain were developed. In the original 1999 report on the measure, given a lack of consensus by the working group, items from the Meaning subscale were not officially included in the BMMRS (though 2 suggested items are provided on the form) (Fetzer Institute, 1999). The domains are (1) Daily Spiritual Experiences; (2) Values/Beliefs; (3) Forgiveness; (4) Private Religious Practices; (5) Religious and Spiritual Coping; (6) Religious Support; (7) Religious/Spiritual History; (8) Commitment; (9) Organizational Religiousness; (10) Religious Preference; and (11) Overall Self-Ranking. The 38-item (40 including the two suggested items) measure includes items from each
subscale that are typically comprised of one to six items scored on a Likert-type scale. Since the BMMRS was developed to assess each of the aforementioned constructs separately, subscales are scored independently, and no total sum score is available. Many of the subscales also include long forms with additional items that may be used in relevant situations (Fetzer Institute, 1999).

A Brief Multidimensional Measure of Religiousness/Spirituality (BMMRS) was also developed, comprised of key items from each of these domains (Harris, Fallot, & Berley, 2008). Based on factor analysis of the BMMRS this measure was conceptualized as measuring spiritual experiences (i.e., emotional experience of feeling connected to a higher power), religious practices (i.e., culturally-based rituals), and congregational support factors. To measure these three spiritual experiences, religious practices, and congregational support, eight scales of the Brief Multidimensional Measures of Religiousness/Spirituality (BMMRS) were used.

**BMMRS Spiritual Experiences** are measured with five subscales:

- **Daily Spiritual Experiences** measures the individual’s experience of a transcendent (i.e., God, the divine) in daily life, including the experience of interaction with a higher power (e.g., “I feel deeper peace or harmony.”). It is a 6 items subscale rated on a 6-point response format, ranging from (many times a day) to (never).

- **Meaning** measures a sense of meaning in life (i.e., “The events in my life unfold according to a divine or greater plan.”). It is a 2 items subscale rated on a 4-point response format, ranging from (strongly agree) to (strongly disagree).

- **Values/Beliefs** measures religious values and beliefs (i.e., “I feel a deep sense of responsibility for reducing pain and suffering in the world.”). It is a 2-items subscale rated on a 4-point response format, ranging from (strongly agree) to (strongly disagree).

- **Forgiveness** measures the degree of forgiveness of self, others, and belief in the forgiveness of God (e.g., “I have forgiven those who hurt me.”). It is a 3 items subscale rated on a 4-point response format, ranging from (always) to (never).

- **Religious/Spiritual Coping** measures additional religious/spiritual practices and beliefs specifically related to coping with life’s problems (e.g., “I work together with God as partners.”). Although this scale is labeled as measuring both spiritual and religious coping strategies, the factor analysis indicated it loaded on a spirituality factor. It is a 7-item subscale rated on a 4-point response format, ranging from (a great deal) to (not at all).

**BMMRS Religious Practices** are measured with two subscales:

- **Private Religious Practice** measures the frequency of privately practiced religious behaviors (e.g., “Within your religious or spiritual tradition, how often do you meditate?”). It is a 5 items subscale rated on an 8-point response format, ranging from (more than once a day) to (never).

- **Organizational Religiousness** measures involvement in a formal public religious institution (e.g., “How often do you go to religious service?”). It is a 2-item subscale rated on a 6-point response format, ranging from (more than once a week) to (never).

**BMMRS Congregational Support Scale** is measured with one subscale:
Religious Support measures the degree to which local congregations provide help, support, and comfort (e.g., “If you had a problem or were faced with a difficult situation, how much comfort would the people in your congregation be willing to give you?”). It is a 4 items subscale rated on a 4-point response format, ranging from (very often) to (never).

For all BMMRS subscales, lower scores reflect higher degrees of spiritual experience, more frequent religious practices, and greater congregational support.

Spiritual Well-being Scale (SWB; Ellison, 1983) is a 20-item construct developed to assess overall spiritual well-being conceptualized as an aggregate of religious well-being, defined as “the strength of one’s relationship with God,” and existential well-being, “a sense of satisfaction and purpose in life. Religious well-being and existential well-being are each measured using ten items. Sample items include religious well being (“I have a personally meaningful relationship with God”) and existential well-being (“I feel very fulfilled and satisfied with life”). Participants are asked to respond to items on a five-point Likert scale ranging from “strongly disagree” to “strongly agree” with higher scores representing higher levels of well-being. A measure of overall spiritual well-being can be calculated by summing both subscale scores.

Religious Coping Questionnaire (RCOPE; Pargament, Koenig, & Perez, 2000). The original Religious Coping Questionnaire is a 105-item theoretically based measure that assesses positive and negative religious coping methods with respect to five key religious functions including the following: meaning, control, comfort/spirituality, intimacy/spirituality, and life transformation. The original RCOPE comprised of 21 subscales with five items each. Participants respond to items on a four-point Likert scale with responses ranging from “not at all” to “a great deal.” A shorter version has been used in subsequent studies, namely a 36-item version with responses ranging on a 5-item Likert scale from “never” to “very often.” Three types of religious coping are assessed including self-directive, deferring, and collaborative. An even shorter 14-item version, the Brief RCOPE is available and has been used in several research studies. This version has 7-items each that assess positive (e.g., Looked for a stronger connection with God) and negative (e.g. Wondered whether God had abandoned me) religious coping.

Religious Orientation Scale (Allport & Ross, 1967) was developed to examine an individual’s intrinsic (i.e., finding motive in religion) and extrinsic (i.e., using religion for personal ends) tendencies. The Religious Orientation Scale includes a 10-item intrinsic subscale and a 10-item extrinsic subscale, intended to be examined separately. Sample items include intrinsic subscale, “My religious beliefs are what really lie behind my whole approach to life” and extrinsic subscale, “What religion offers me most is comfort when sorrows and misfortune strike”. Participants respond to items on a five-point Likert scale with responses ranging from “definitely disagree to definitely agree” (intrinsic subscale) “definitely not so” to “definitely so” (extrinsic subscale).

Systems of Belief Inventory (SBI; Holland, Kash, Passik, Gronert, Sison, Lederberg et al., 1998) was developed for use in research examining quality of life in individuals with chronic illnesses. Items included in the measure were designed to measure four constructs: (1) deriving meaning from an existential perspective; (2) frequency of religious practices or behaviors; (3) relationship to God/a Higher Power; and (4) social support derived from religious/spiritual community. Originally, 35 items were developed to measure the aforementioned domains and administered to 12 hospitalized patients.
Biopsychosocial-spiritual Models of Health

Spirituality concerns focus on the person’s relationship with transcendence. Therefore, genuinely holistic health care must address the totality of the patient’s relational existence i.e., physical, psychological, social, and spiritual. Sulmasy (2002) has developed a bio-psychosocial-spiritual model for understanding the interactions between four general domains identified in research for measuring various aspects of spirituality viz., religiosity, religious coping and support, spiritual well-being, and spiritual needs. Anandarajah (2008) has developed bio-psychosocial-spiritual models, the 3 H model (head, heart, hands) and the BMSEST model (body, mind, spirit, and environment, social, transcendent).

According to Anandarajah (2008) while incorporating spirituality into health the model of the human being is conceptualized as being composed of body (B), mind (M), and spirit (S). Maslow’s triangle for hierarchy of needs had been earlier extended to include the pinnacle of self actualization as self transcendence. This is consistent with the inclusion of the spirit as a part of the whole person. Body, mind and spirit are closely related rather than distinct entities. Research indicates that environmental and social influences impact physical, mental and spiritual health. Spirituality as defined by Anandarajah (2008) in terms of the multidimensional 3 H model encompasses cognitive (head), experiential (heart), and behavioural (hands) aspects of the human spiritual experience. The cognitive, or existential, (head) aspects include search for meaning and purpose, and values and beliefs most important in one’s life. The experiential (heart) aspects encompass the human need for love, inner peace, resilience, and connection. Finally, the behavioural (hands) aspects pertain to the outward expression of spiritual beliefs and needs, such as life choices, behaviour toward others, rituals, and practices. These dimensions of spirituality are applicable to all human beings irrespective of culture or belief system, whether secular or religious.

Anandarajah (2008) opines that spiritual care attends to the heart needs. When the patient is in the state of distress, the intervention is needed at the heart level. The elements include compassion, presence, true listening and the encouragement of realistic hope, critical elements of spiritual whole person care. The physician patient relationship is bidirectional. Physicians using therapeutic approaches/interventions at the spirit level have the potential to heal and be healed through their clinical interactions.

While studying the world’s religions, (e.g., Jung, 1978, 1984; Smith, 2001,) two major conceptual models of a divine transcendent emerge, giving rise to two BMSEST variations—the duality model and the unity model (Anandarajan, 2008). Both models exist to some degree in all the major religions; however, the duality model predominates in western religion, and the unity model predominates in

with cancer in a structured interview format. Following the administration of the initial questions, additional items were added, resulting in a total of 54 items (SBI-54), with at least 12 items corresponding to each construct (i.e., “Religion is important in my day-to-day life”; “I follow my religion’s guidelines for prayer”; “There is purpose and meaning to life”; and “My spiritual beliefs are a source of hope”). Participants are required to respond to items on a 4-point Likert scale ranging from “none of the time” or “strongly disagree” to “all of the time” or “strongly agree.” Due to time and space constraints relevant to many research studies, the SBI-54 was shortened to create the Spiritual Belief Inventory 15-Item version (SBI-15). Results of a principal components analysis indicated that the SBI-15 provides an overall measure of spirituality/religiosity as well as subscale scores representing beliefs and social support (Holland et al., 1998).
eastern thought and the mystic traditions of many religions. In the duality model (Figure 1), God is seen as separate from human beings but able to affect us on all levels. God is seen as a father or mother, and our relationship with other people is that of brothers and sisters. Prayer and meditation are methods of communicating with and attuning oneself to God, and all healing and moral guidance ultimately come from God. A variation of this model is applicable to polytheistic religions. In the unity model (Figure 2), Maslow’s triangles are turned upside down. Here, the body is just the tip of the iceberg, and on a spiritual level, we are all one. In this model, we are part of God, as a wave is part of the ocean, and our relationship with other people is akin to limbs on the same body. Prayer and meditation are methods to connect with “God within” or the “Oneness of the universe,” and healing and ethical decisions arise from connecting with that oneness.

PT = physical therapy;
Arrow a = interactions between body and mind; Arrow b = interactions between mind and spirit; Arrow c = interactions between body and spirit; Arrow d = interactions between environmental factors and the individual; Arrow e = interactions between social factors and the individual; Arrow f = therapeutic approaches at the body level; Arrow g = therapeutic approaches at the mind level; Arrow h = therapeutic approaches at the spirit level (specialized spiritual care); Arrow i = therapeutic effects at the spirit level (general spiritual care); Arrow j = interactions between the individual and the Transcendent

Figure 1: Duality version of the BMSEST (body, mind, spirit, environment, social, and transcendent) model for whole-person care.

These BMSEST models provide insight into the various ways people view spirituality and the transcendent, paving the way for more meaningful communication between the patient and therapist. These models also emphasize that, in the clinical arena, the approaches to patient care (arrows f, g, h, i) are the same, regardless of the model variation most resonant with physician or patient. The choice of the most appropriate specific therapeutic intervention for the patient varies depending on the patient’s belief background.

In sum, the 3 H model offers a multidimensional definition of spirituality, applicable across cultures and belief systems, that provides opportunities for a common vocabulary for spirituality therapeutic options, from general spiritual care (compassion, presence, and the healing relationship), to specialized spiritual care (e.g., by clinical chaplains), to spiritual self-care. The BMSEST model provides a conceptual framework for the role of spirituality in the larger health care context, useful for patient care, education, and research. The interactions among the six BMSEST components viz., body, mind, spirit, and environment, social and transcendent have been depicted in the figures. Including spirituality in whole-person care is a way of furthering the understanding of the complexities of human health and well-being (Anandarajah, 2008).

**Spirituality Religion and Health**

Researches have implicated a role spirituality and religion in mental health and well being as well as prevention and prognosis of mental illnesses.
Spirituality Religion and Mental Health

Previous investigations indicate in general a positive role for spiritual strategies in addressing mental health problems. The Royal College of Psychiatrists identify a wide range of spiritual activities that lead to outcomes like compassion, creativity, equanimity, honesty, hope, joy, patience and perseverance that promote good mental health. Koenig (2009) has argued that religious beliefs provide a sense of meaning and purpose during difficult life circumstances that assist with psychological integration; they usually promote a positive world view that is optimistic and hopeful; they provide role models in sacred writings that facilitate acceptance of suffering; they give people a sense of indirect control over circumstances, reducing the need for personal control; and they offer a community of support, both human and divine, to help reduce isolation and loneliness. Resorting to religion is commonly seen among patients with medical and psychiatric illness (Koenig, 2009). According to Green and Elliot (2010), people who identify as religious tend to report better health and happiness, regardless of religious affiliation, religious activities, work and family, social support, or financial status. People with liberal religious beliefs tend to be healthier but less happy than people with fundamentalist beliefs. Johnstone and Yoon (2009) reported that positive spiritual experiences and willingness to forgive are related to better physical health, while negative spiritual experiences are related to worse physical and mental health for individuals with chronic disabilities. Krishna Mohan (1999) looked into the effects of spiritual experiences of 200 respondents belonging to various spiritual organizations based on Hindu Philosophy. The findings revealed that after the spiritual experiences they were generally happy, cheerful and at peace, and rarely downhearted or depressed. Majority of the respondents reported having excellent health, and were satisfied with the meaning and purpose they found in their lives.

Spirituality tends to increase during later adulthood (Moberg, 2005), among geriatric populations, greater spirituality, but not greater religiosity, is associated with positive appraisals of health (Daalman, Perera, & Studenski, 2004). Tate and Forchheimer (2002) carried out a cross-sectional study on spirituality and life satisfaction in 136 participants from a rehabilitation setting. Spirituality significantly predicted life satisfaction for rehabilitation participants, although participants with cancer reported greater spirituality than rehabilitation participants. D’Souza, (2002) in a study of psychiatric patients found that 79% rated spirituality as very important, 82% thought their therapist should be aware of their spiritual beliefs and needs, and 67% indicated that spirituality helped them to cope with psychological pain. Religion serves as a pervasive and potentially effective method of coping for persons with mental illness (Tepper et al., 2001), warranting its integration into psychiatric and psychological practice. Intrinsically religious individuals report greater existential well-being (Genia, 1998); a greater sense of competence and control, less worry and guilt (Ventis, 1995); and positive mental health with regard to well-being (Payne, Bergin, Biclema, and Jenkins,1991) than extrinsically religious individuals.

A wide range of spiritual healing traditions emphasize the central importance of the connection of all life to spiritual or cosmic realities. In these views, healing is usually seen as restoring a condition of wholeness or harmony (Carlson & Shield, 1989). Prayer has been widely used to address health concerns by individuals with a wide array of physical and mental health diagnoses (Saydah &
Prayer is a common coping resource for individuals with chronic illness (McCaffrey, Eisenberg, Legedza, Davis, & Phillips, 2004) and has been found to be influenced by age (Wink & Dillon, 2002), gender (Coleman et al., 2006) and socioeconomic status (Arredondo, Elder, Ayala, & Campbell, 2005). Individuals using positive religious coping techniques, such as prayer, tend to have both improved perceived mental and physical health, as well as improved objectively measured health outcomes (Pargament, Koenig, Tarakeshwar, & Hahn, 2004; Wachholtz & Pargament, 2008). Rao (2005) emphasized that religion-health relationship is an important area; it needs programmatic research to understand role of religious practices such as prayer in reducing anxiety, depression and promoting a sense of well-being in the chronically ill patients in India.

Research studies suggest that spiritual activities, spiritual experiences, religious beliefs, intrinsic spirituality/religiosity, spiritual healing and positive religious coping techniques such as prayer are associated with mental health and well-being as well as improved health outcomes.

**Spirituality, Religion and Well-being**

In accordance with World Health Organization (WHO) definition, health is seen as well-being and not simply the absence of illness. Expanding the WHO definition of health, well-being is the product of a complex interplay of biological, socio-cultural, psychological, economic and spiritual factors (Sharma & Mishra, 2010). In classical Indian conditions health is conceptualized as a state of delight or a feeling of spiritual, physical and mental well-being (*prasannatmamendriyamanah*) and this conception is closer to the WHO definition of health/well-being (Dalal, 2001; Sinha, 1990). Spiritual well-being seems to be a central component of psychological health in physically healthy individuals. It has been found to offer some protection against end-of-life despair in those with chronic diseases (Mazzotti, Mazzuca, Sebastiani, Scoppola, & Marchetti, 2010). Spiritual well-being is conceptualized as a two-dimensional construct; on a vertical dimension, religious well-being describes our well-being as it relates to God or even to a transcendent dimension. However, on a horizontal dimension existential well-being considers our well-being as it relates to a sense of life purpose and life satisfaction, without any specific reference to a higher power (Ledbetter, Smith, Vosler-Hunter, & Fischer, 1991). Matheis, Tulsky, and Matheis (2006) interviewed 75 participants with spinal cord injury using the spiritual well-being scale and reported that “existential spirituality” (*i.e.*, defined as a worldview in which individuals search for purpose and meaning in their lives) was significantly related to life satisfaction, general health, and social quality of life. In contrast, “religious spirituality” (*i.e.*, defined as a relationship with a higher power) was not found to be a predictor of any outcomes in any of the models. They concluded that nonreligious beliefs (*i.e.*, existential worldview) may be more important in relating to health than religious beliefs for persons with spinal cord injury.

Studies have used measures of spirituality, mainly spiritual well-being, and usually found positive correlations with psychological well-being and other indicators of positive mental health. Out of 100 studies that examined the association between religious practices and behaviour and indicators of psychological well-being (life satisfaction, happiness, positive affect, and higher morale), 79 reported at least one significant positive correlation between these variables (Koenig, 2001). While the correlations are usually modest, they often equaled or exceeded those between well-being and other psychosocial
variables like social support, marital status, or income. This positive association has been consistently similar in samples from different countries, involving a diversity of religions, races and ages (Levin, Chatters, & Taylor, 2005). Although most studies are cross-sectional, 10 out of 12 longitudinal studies replicated this positive association (e.g., Tix & Frazier, 1997; Willits & Crider, 1998). Most of these studies showed an association between religiosity and well-being even after controlling for age, gender and socioeconomic status. Some studies have shown that the positive impact of religious involvement on well-being is more robust among the elderly, disabled, and medically ill people (e.g., Musick, 1996). This probably means that the buffering effects of religious involvement on well-being may be higher for those under stressful circumstances. Fry (2001) affirmed that religiosity was one of the most important factors associated with psychological well-being in a sample of 188 Canadian older adults following spousal loss, even after adjusting for social support, negative life events, health status and demographic variables.

Dimensions such as hope, forgiveness, or experiences of sense and meaning have been found to be substantially related to varying indicators of subjective well-being and might therefore be conceptualized as religious/spiritual dimensions without any religious/spiritual connotation. These three dimensions are not necessarily religious but bear strong relationships to both religiosity and subjective well-being. For example, forgiveness has been confirmed as an important mediator concerning the religiosity–health relationship (Lawler-Row, 2010). Most studies have also found a positive association between religiosity and other factors associated with well-being such as optimism and hope (12 out of 14 studies), self-esteem (16 out of 29 studies, but only one with a negative association), sense of meaning and purpose in life (15 out of 16 studies), internal locus of control, social support (19 out of 20) and being married or having higher marital satisfaction (35 out of 38). It has been proposed that these may be some of the mediating factors between religiousness and well-being (Salsman, Brown, Brechting, & Carlson, 2005). In a high-quality research study involving a US national sample of 1126 non-institutionalized older people, the feeling of closeness with God was related to optimism after controlling for socio-demographic variables. This optimism, in turn, had a strong influence on their self-rated health status (Krause, 2002).

According to Lysne and Wachholtz (2011) religion and spirituality are two methods of meaning making that impact a person’s ability to cope, tolerate, and accept disease and pain. The biopsychosocial-spiritual model includes the human spirit’s drive toward meaning “making along with personality, mental health, age, sex, social relationships, and reactions to stress. The authors in their review examined studies focusing on religion and spirituality’s effect upon pain in relationship to physical and mental health, spiritual practices, and the placebo response. The findings suggest that people who are self-efficacious and more religiously and spiritually open to seeking a connection to a meaningful spiritual practice and/or the transcendent are more able to tolerate pain.

Büssing and Koenig (2010) found that for many patients confronted with chronic diseases, spirituality/religiosity is an important resource for coping. Patients often report unmet spiritual and existential needs, and spiritual support is also associated with better quality of life. Caring for spiritual, existential and psychosocial needs is not only relevant to patients at the end of their life but also to those suffering from long-term chronic illnesses. Spiritual needs may not always be associated with
life satisfaction, but sometimes with anxiety, and can be interpreted as the patients’ longing for spiritual well-being. The needs for peace, health and social support are universal human needs and are of special importance to patients with long lasting courses of disease. They identified four core dimensions of spiritual needs, i.e., connection, peace, meaning/purpose, and transcendence, which can be attributed to underlying psychosocial, emotional, existential, and religious needs. Health care that addresses patients’ physical, emotional, social, existential and spiritual needs (referring to a biopsychosocial-spiritual model of health care) will contribute to patients’ improvement and recovery.

It is therefore concluded that spiritual and religious involvement has protective effects with respect to a wide range of well-being-related outcomes.

**Spirituality, Religion and Depression**

Given its prevalence in the population, affecting 1 in 6 people at some point in their lives, much of the research exploring the relationship between spirituality and mental health has focused on depression. Swinton (2001) argues that depression, often characterized by feelings of hopelessness, lack of meaning or purpose in life and low self-esteem is by its very nature linked with what many people understand as spirituality. He conducted a small in-depth qualitative study that involved interviewing six people who had experienced depression for at least two years. One of the central themes to arise from the research was the importance of having a meaning or purpose in life. One of the defining features of depression is a transient or stable loss of lack of meaning or purpose in the person’s life and for the participants in this study, this loss – and its associated rediscovery – were central aspects of both depression and spirituality. Many religious and spiritual traditions make the claim of offering individuals meaning and purpose amidst an otherwise confusing or depressing existence. One of the key contributions of spirituality in the lives of these individuals, therefore, may be the power it offers to restore meaning, purpose and hope to their lives. When depression leads people to struggle intellectually with their faith, ritual, prayer and worship are able to “carry a person through” their worst moments.

A number of qualitative and quantitative studies have explored the relationship between certain aspects of spirituality and depression. Hodges (2002) describes four dimensions of spirituality viz., meaning of life, intrinsic values, belief in transcendence and spiritual community and argues that each of these dimensions has an inverse linear relationship with depression. For those who find meaning or purpose in life through religion or spirituality, church attendance is often (although not always) associated with lower levels of depression and this is true for adults, children and young people (Olszewski, 1994). One way of understanding this effect is the possibility that some faith communities promote social inclusion (either passively or actively), which affects both incidence of and coping with depression. Similarly, most of the research shows that people involved in religions that encourage internalisation of a set of values are at substantially reduced risk of depression, compared to those who attend a church because of obligation or duty (McCullough, & Larson, 1999). Koenig, George and Peterson (1999) found that for every 10-point increase in a person’s intrinsic religiosity, there was a 70% increase in recovery from depressive symptoms after physical illness. Similar findings have been found amongst those who believe in a transcendent being or higher power (Seligman, 2000).
Smith, McCullough, and Poll (2003) carried out a meta-analysis of the studies conducted to explore the relationship between religiousness and depressive symptoms. The findings based on 147 independent investigations revealed that religiousness is modestly but robustly associated with lower level of depressive symptoms (effect size -0.096). The association between religiousness and depression did not vary among the different age, gender or ethnic groups. However, the studies used several types of religious measures and included people under various levels of stress. Therefore, performing the analysis of all these studies together may have decreased the strength of the association that might exist in more specific situations. The review showed that the association between religiousness and depressive symptoms is higher for people under severe life stress than for people with minimal life stress. These findings suggest that the protective effect of religiousness appears to be stronger for people under psychosocial stress.

Studies in people with serious medical illness reveal a substantial impact for religion on the prevalence and course of depression. Depressed medical inpatients aged 50 years or older with either congestive heart failure or chronic pulmonary disease were identified with depressive disorder using the Structured Clinical Interview for Depression (Koenig, 2007). The religious characteristics of these patients were compared with those of non depressed patients. Depressed patients were significantly more likely to indicate no religious affiliation, more likely to indicate spiritual but not religious, less likely to pray or read scripture, and scored lower on intrinsic religiosity. These relations remained robust after controlling for demographic, social, and physical health factors. Among the depressed patients, severity of depressive symptoms was also inversely related to religious indicators. Among these 1000 depressed patients, investigators followed 865 for 12 to 24 weeks, examining factors influencing speed of remission from depression (Koenig, 2007). The most religious patients (those who attended religious services at least weekly, prayed at least daily, read the Bible or other religious scriptures at least 3 times weekly, and scored high on intrinsic religiosity) remitted from depression more than 50% faster than other patients, controlling for multiple demographic, psychosocial, psychiatric, and physical health predictors of remission.

Nelson, Barry, Rosenfeld, Breitbart, and Galietta (2002) examined the impact of spirituality and religiosity on depressive symptom severity in a sample of terminally ill patients with cancer and AIDS. A strong negative association was observed between the FACIT Spiritual Well-Being Scale and the Hamilton Depression Rating Scale (HDRS), but no such relationship was found for religiosity, because more religious individuals had somewhat higher scores on the HDRS. Similar patterns were observed for the FACIT subscales, finding a strong negative association between the meaning and peace subscale (existential aspects of spirituality) and HDRS scores, whereas an insignificant positive, association was observed for the faith subscale (which corresponds more closely to religiosity). These results suggest that the beneficial aspects of religion may be primarily those that relate to spiritual well-being rather than to religious practices per se. Baider et al. (1999) studied spirituality beliefs in Israeli patients with cancer. Their measure of spirituality, the Spiritual Beliefs Inventory, included four subscales that measured “existential perspective on life and death,” “religious beliefs and practices,” “social support received from religious and/or spiritual community members,” and “relationship to a superior being.” Although they found several modest, statistically significant,
relationships between spiritual beliefs and measures of psychological distress and coping style, their analyses focused solely on overall spiritual beliefs, with no analysis of the different subscales. Thus, their results may reflect the confounding influence of religion and spirituality, with little separation of these two constructs.

Studies reviewed regarding the association between spirituality, religion and depression indicate that many expressions and elements of spirituality are helpful in reducing depressive symptoms and promoting well-being.

**Spirituality Religion and Anxiety**

Research has examined the relationship between spirituality and anxiety or stress. The symptoms commonly associated with anxiety can be emotional, intellectual, physical and/or social. These include feelings of shame, grief or aloneness; difficulty concentrating, inability to learn new details; increased breathing and pulse rate, difficulty sleeping and problems with eating; social apprehension, isolation or withdrawal and irritability or unusual levels of aggression. According to Swinton (2001), stress and anxiety can have spiritual symptoms, which include loss of meaning in life, obsessive religious thoughts and actions, feelings of alienation and indifference. Loss of previous spiritual belief, no sense of the future, fear of death, fear of the consequences of ‘sins’ or religiously-defined ‘bad’ behavior and/or an inability to focus on ‘God’ or to meditate. Several studies have explored the association between anxiety and spirituality amongst individuals who have chronic or life-threatening illnesses. Aukst-Margetic and Margetic (2005) reported that heart transplant patients that attended church frequently reported less anxiety and had higher self-esteem than those who attended less frequently. Boscaglia, Clarke, Jobling, and Quinn (2005) explored whether spiritual involvement, beliefs and spiritual coping mechanisms could account for any variations in anxiety among women within one year’s diagnosis of cervical cancer. They found that anxiety was more common in those who did not use positive spiritual coping mechanisms, and this was especially true for younger women and those with more advanced stages of the disease. Reduced levels of anxiety associated with spiritual activity have also been found in other populations, including medical patients in later life (Koenig, Moberg & Kvale, 1988), middle aged people with cardiac problems (Ai, Peterson, Tice, Bolling, & Koenig, 2004) and those recovering from spinal surgery (Hodges, Humphreys, & Eck, 2002). McCoubrie and Davies (2006) studied the relationship between anxiety and spirituality in eighty five patients with advanced cancer. They found a significant negative correlation between spirituality (particularly the existential aspect) and anxiety in these patients.

Koenig (2009) put forth that religious beliefs and practices can also comfort people who are fearful or anxious, increase sense of control, enhance feelings of security, and boost self-confidence (or confidence in Divine beings). Wink and Scott (2005) conducted a longitudinal study involving 155 subjects followed for nearly 30 years, from middle age into later life. The focus of the study was to examine the impact of religious beliefs and involvement on death anxiety. The results revealed no linear relations between religiousness, fear of death, and fear of dying. Subjects with the lowest anxiety levels were those who were either high or low on religiousness. Anxiety was highest among subjects who were only moderately religious, and in particular, those who affirmed belief in an afterlife but were not involved in any religious practices. Researchers concluded that it was the
degree of religious involvement that was important in lessening death anxiety not simply belief in an afterlife. Hughes et al. (2004) found that greater religiosity was related to lower state anxiety and lower trait anxiety. Further, studies have shown that religious intervention added to secular treatments resulted in faster improvement of anxiety symptoms compared to secular interventions only. Azhar, Varma, and Dharap, (1994) examined religious patients with generalized anxiety disorder who were given religious psychotherapy in addition to supportive psychotherapy and anxiolytic drugs. Those receiving religious psychotherapy showed significantly more rapid improvement in anxiety symptoms than those who received supportive psychotherapy and drugs only.

Yoga and meditation are also associated with improvements in mental health and reductions in anxiety in the qualitative literature. Despite this, there has been little quantitative research examining the association between yoga/meditation and anxiety. Kirkwood, Rampes, Richardson, and Pilkington (2005) in a recent systematic review found eight studies that specifically explored the impact of yoga on anxiety. They concluded that although the results were encouraging, the extent of the methodological inadequacies meant that further research was necessary. Michalsen, Grossman, Acil, Langhorst, Ludtke, Esch et al., (2005) conducted a study to evaluate potential effects of Iyengar Hatha yoga on perceived stress and associated psychological outcomes in women with anxiety disorders. Women attended twice-weekly yoga classes, each lasting 90 minutes. Compared to those allocated to the waiting list control group, women who participated in the yoga-training demonstrated pronounced and significant improvements in perceived stress, state and trait anxiety, well-being, vigour, fatigue and depression. Physical well-being also increased and those subjects suffering from headache or back pain reported marked pain relief.

Research findings exploring the association of spirituality/religious activity and anxiety suggest that this relationship depends to some extent on the way in which spirituality is expressed. Increased anxiety is often found amongst those with a strict religious upbringing (Trenholm, Trent & Compton, 1998), while, those who are categorized as spiritually growth-oriented or transitional tend to have lower rates of anxiety (Reinert, & Bloomingdale, 1999).

Many investigations examining the relationship between spirituality/religion and anxiety have used measures of spirituality that do not reflect its complexity nor control for other potential mediating variables. Further research is required to understand the role spirituality can play in helping to reduce symptoms and feelings of anxiety.

SPIRITUALITY AND POST-TRAUMATIC STRESS DISORDER (PTSD)

Post-traumatic stress disorder (PTSD) is a delayed reaction to an abnormal, traumatic life experience, such as war, terrorism, a car accident, a natural disaster, or physical, sexual, emotional or psychological abuse. PTSD has been found to be associated with impaired health status (Hidalgo & Davidson, 2000). Weaver, Flannelly, Garbarino, Figley, and Flannelly (2003) reviewing articles in the Journal of Traumatic Stress concluded that religion and spirituality are highly valuable to people in times of crisis, trauma and grief. Spirituality may not so much serve as a protector against developing PTSD or poor health, but may emerge as a way of coping in those with high distress or poor health (Calhoun, Cann, Tedeschi, & McMillan, 2000; Lau & Grossman, 1997; Waysmann, Schwarzwald, & Solomon, 2001). In PTSD, the acceptance of a spiritual power may lead to a spiritual awakening
which, in turn, can assuage survivor guilt (Khouzan & Kissmeyer, 1997). It has been argued that
spiritual affirmation, whether formal-religious or personal-existential, may buffer the effect of violent
trauma and along be associated with greater well-being (Connor, Davidson, & Lee, 2003).

Hasanoviæ and Pajeviæ (2010) studied religious moral beliefs as mental health protective factors
in 152 war veterans. The aim was to determine if there is an association between level of religious
moral beliefs and severity of PTSD symptoms, depression symptoms, anxiety and severity of alcohol
misuse amongst war veterans in post-war Bosnia and Herzegovina. The findings revealed that a
higher index of religious moral beliefs enabled better control of distress, providing better mental health
stability. It enabled post traumatic conflicts typical for combatants’ survivors to be more easily
overcome. It also caused healthier reactions to external stimuli. They also found that a higher index of
religious moral beliefs of war veterans provided a healthier and more efficient mechanism of tobacco
and alcohol misuse control. The authors concluded that religious moral beliefs help in overcoming
postwar psychosocial problems and socialization of the personality, leading to the improvement in
mental health.

Shaw, Joseph, and Linley (2005) conducted a review and found eleven studies that reported links
between religion, spirituality, and trauma-based mental health problems. The review of studies revealed
three main findings. First, these studies show that religion and spirituality are usually, although not
always, beneficial to people in dealing with the aftermath of trauma. Second, they showed that
traumatic experiences can lead to a deepening of religion or spirituality. Third, that positive religious
coping, religious openness, readiness to face existential questions, religious participation, and intrinsic
religiousness are typically associated with improved post-traumatic recovery.

Ai and Park (2005) have suggested that the effects of trauma on mental health may be better
understood by taking a broader perspective that includes resilience and recovery as well as damage
and symptomatology. This view aimed to explore the positive outcomes following the experience of
trauma, such as self-discovery, renewed sense of meaning in life and increased inner strength. This
shift of including positive outcomes of trauma has led to research that identified factors that
encourage this growth to occur. Using structural equation modeling Cadell, Regehr, and Hemsworth
(2003) found that spirituality and social support were linked with post-traumatic growth. However
lack of qualitative data meant it was difficult to understand precisely the ways in which these factors
interacted.

Religious involvement, spirituality, religious coping, and social support were studied as correlates
of posttraumatic stress symptoms in sixty five African American women survivors of domestic
violence (Watlington & Murphy, 2006). Religious involvement was found to be negatively associated
with posttraumatic stress symptoms. Women who reported higher levels of spirituality reported
utilizing higher levels of religious coping strategies, and women who reported higher levels of
religious involvement reported higher levels of social support.

Harris, Fallot, and Berley (2005) conducted a qualitative study to examine themes associated with
sustaining recovery among women with co-occurring disorders who had survived trauma. In semi-
structured interviews, 27 female trauma survivors described the influences they considered most
important in sustaining and hindering their recovery. Seven themes emerged from this analysis, four
of which supported recovery and three that served as obstacles. Those that supported recovery and encouraged post-traumatic growth were connection, self-awareness, a sense of purpose and meaning, and spirituality. The women in this study reported that, although caring relationships provided important supports for sustained recovery, some of these same relationships increased emotional stress and conflict and thus may impede recovery.

Research studies examining the association between spirituality, religion and PTSD need to identify the spiritual/religious coping strategies that lead to post traumatic recovery, meaning in life, human strengths and personal growth. There is a dire need for a fine-grained analysis of religion and spirituality variables. Longitudinal research designs, involving more systematic and detailed explorations of the links between spirituality, religion and post-traumatic growth would be meaningful.

**Spirituality, Religion and Schizophrenia**

Schizophrenia is seen as a severe and enduring mental illness characterized by disruption in cognition, perception and emotion. This may affect language, thought, perception, affect and a person’s sense of self. The array of symptoms can include psychotic manifestations, such as hearing internal voices or experiencing other sensations not connected to an obvious source (hallucinations) and assigning unusual significance or meaning to normal events or holding fixed false personal beliefs (delusions). No single symptom is definitive for diagnosis; rather, the diagnosis encompasses a pattern of signs and symptoms, in conjunction with impaired occupational or social functioning (American Psychiatric Association, 2000). In a review of the literature, Koenig, McCullough, and Larson, (2001) identified 16 studies that examined the relation between religion and schizophrenia. His review of 10 cross-sectional studies revealed that out of these 4 found less psychosis or psychotic tendencies among people more religiously involved; 3 found no association; and 2 studies reported mixed results. One study found religious beliefs and practices significantly more common among depressed and schizophrenic psychiatric inpatients, compared with orthopedic control subjects.

For many individuals living with schizophrenia, religion and spirituality play an important and positive role. Mohr and Huguelet (2004) reviewing literature on religious and spiritual coping amongst individuals with chronic schizophrenia concluded that “religion plays a central role in the processes of reconstructing a sense of self and recovery”. Religious coping methods have been shown to have positive effects on individuals with diagnosed schizophrenia, as well as on their families. For those individuals who share the same religious values as their family, religiosity can be a cohesive and supporting factor (Aukst-Margetic & Margetic, 2005). Studies have found that people with schizophrenia find hope, meaning and comfort in spiritual beliefs and practices (Kirkpatrick, Landeen, Woodside, & Byrne 2001, Mohr & Huguelet, 2004). Mohr, Brandt, Borras, Gilliéron, and Huguelet (2006) conducted semi-structured interviews about religious coping in a sample of outpatients with psychotic illness (primarily patients of schizophrenia). For some patients, religion instilled hope, purpose, and meaning in their lives (71%), whereas for others, it induced spiritual despair (14%). Patients also reported that religion lessened (54%) or increased (10%) psychotic and general symptoms. Religion was also reported to increase social integration (28%) or social isolation (3%). The results highlighted the clinical significance of religion in the care of patients with schizophrenia. They opined that religion is neither a strictly personal matter nor a strictly cultural one. Spirituality should be integrated into the
psychosocial dimension of care. The authors concluded that the complexity of the relationship between religion and illness requires a highly sensitive approach to each unique story.

Longitudinal studies suggest that religious activity may improve long-term prognosis in patients with psychotic disorders. A multicenter study was carried out to examine factors in the course and outcome of schizophrenia in India. A two-year and five-year follow up showed that those patients who spent more time in religious activities tended to have a better prognosis (Verghese, John, Rajkumar, Richard, Sethi, and Trivedi, 1989). Jarbin & von Knorring, (2004) followed patients with adolescent-onset psychotic disorders for 10.6 years, during which 25% of patients attempted suicide. When anxiety and depressive symptoms were controlled for, only satisfaction with religious belief was a significant protective factor. In an attempt to explore the types of alternative health care practices (Russinova, 2002) conducted a study on 157 people with schizophrenia, bipolar disorder and MDD. People with schizophrenia and MDD reported that the most common beneficial alternative health practice was spirituality/religion activity (more than one-half reported this) while for those with bipolar disorder, only meditation surpassed spirituality/religion activity.

Some patients feel that their religious or spiritual beliefs are not understood or explored within mental health services. Clinicians either ignore an individual’s spiritual life completely or treat their spiritual experiences as nothing more than manifestations of psychopathology. Swinton (2001) cautions those working in mental health services against ignoring the importance and value of an individual’s spirituality in his recovery. In a qualitative study, examining the narratives of a schizophrenic patient Swinton opined that spirituality is the form of language the patient uses to express his inner search for meaning, purpose and value. Both his normal and his delusional experiences are expressed in the language of spirituality, that is, the language which he uses to express that which is of most importance to him. Even his delusions may be more than “mere pathology” (Swinton, 2001).

Spirituality and religion are relevant in the lives of many people with schizophrenia and in many cases seem to offer valuable benefits to living with and recovering from the illness. However, the exact nature of those benefits and the mechanisms through which they operate are not fully understood or researched. Further exploration is needed in order to understand when, why and for whom certain expressions of spirituality are helpful.

**Spirituality Religion and Substance Abuse**

Substance abuse is defined as the overindulgence in and dependence on an addictive substance, especially alcohol or a narcotic drug. According to Koenig (2009) religious beliefs and practices provide guidelines for human behaviour that reduce self-destructive tendencies and pathological forms of coping. This is particularly evident from research that has examined associations between religious involvement and substance abuse. As a form of social control, most mainstream religious traditions discourage the use and abuse of substances that adversely affect the body or mind. In a review of studies published prior to 2000, Koenig et al. (2001) identified 138 studies that had examined the religion–substance abuse relation, 90% of which found significantly less substance use and abuse among the more religious. Majority of these studies had been conducted in high school/college students who were just starting to establish patterns of alcohol and drug use.
Since that review, the CASA at Columbia University reported the results of three national US surveys: the 1998 National Household Survey, CASA’s National Survey of American Attitudes on Substance Abuse, and the General Social Survey. (2001). Adults who did not consider religion very important were 50% more likely to use alcohol and cigarettes, three times more likely to binge drink, four times more likely to use illicit drugs other than marijuana, and six times more likely to use marijuana, compared with adults who strongly believed that religion is important. The same pattern was seen for religious attendance, and an even more pronounced inverse relation between religion and substance abuse was evident in teenagers. In addition, people who received both professional treatment and attended spirituality-based support programs (such as Alcoholics Anonymous or Narcotics Anonymous) were far more likely to remain sober than if they received only professional treatment. More recent studies support these findings in high risk groups for alcohol and drug use disorders such as in younger people (Sussman, Skara, & Rodriguez, 2006) and minority groups (Stone et al., 2006).

Religiousness and spirituality are known to be a protective factor for substance use. The protective effect of religiousness has been demonstrated against drinking alcohol, cigarette smoking, and/or opiates consumption (Menagi, Harrell, & June, 2008; Piko & Fitzpatrick, 2004; Klein, Elifson, & Sterk, 2006). A 6-month longitudinal survey of 123 patients with alcohol use disorders demonstrated increases in spirituality was associated with decreased heavy drinking (Robinson, Cranford, Webb, & Brower, 2007). Stone et al. (2006) found that traditional spiritual activities had a significantly positive effect on alcohol cessation. Gonzales et al. (2007) reported that patients’ spiritual resources are usually excluded from tobacco dependence treatment. They proposed that smokers, especially heavier smokers, may be receptive to using spiritual resources in a quit attempt and role of spirituality in tobacco dependence treatment requires more systematic investigations and program development.

Spirituality is one of the essential foundations for the remediation of an addictive disease (DiLorenzo, Johnson, & Bussey, 2001). Miller (1998) opined that spirituality was an important factor in recovery from addiction, but surprisingly little research had explored the relationships between these two phenomena. Many drug users, treatment providers, and faith leaders believe that spirituality/religion is critical to success in recovery. Prior studies have documented a relationship between spirituality/religion and health, but there is no systematic account of the magnitude, direction, and stability of associations between various dimensions of spirituality/religion and health outcomes, including drug use outcomes. Similarly, studies of faith-based health services are mixed and inconclusive, in part because outcomes have not been examined in relation to particular spirituality/religion dimensions (Longshore, Anglin, & Conner, 2009). Empirical studies have shown an inverse relationship to exist between religious involvement and drug use, suggesting that spiritual and religious involvement may act as a protective mechanism against developing addictions (Miller, 1998; Benson, 1992). Possible protective mechanisms may include avoidance of drugs; social support advocating abstinence or moderation; time-occupying activities that are incompatible with drug use; the promotion of pro-social values by the religious affiliation that includes leading a drug free life.

Conner, Anglin, Annon, and Longshore, (2009) studied the effect of religiosity and spirituality on drug treatment outcomes. The participants in the study comprised of 315 individuals dependent on
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heroin, seeking narcotic replacement therapy (NRT). Results revealed that spirituality was an important predictor of reductions in drug use while in treatment and at the follow-up interview. Increases in spirituality scores over time were predictive of reductions in drug use over time, indicating that finding methods for increasing spirituality during drug treatment could improve long-term drug treatment outcomes. According to Brown, Tonigan, Pavlik, Kosten, and Volk (2011) spirituality of the individual in a faith-based recovery program may be a component of their successful recovery through increased confidence to resist substance abuse. A greater understanding of self-efficacy and other potential mechanisms of spiritual recovery may lead to improved outcomes (Morgenstern, Bux, Labouvie, Blanchard, & Morgan, 2002). Individuals with high self-efficacy being more confident in their ability to cope with high-risk situations may better resist the temptation to use alcohol and thereby maintain sobriety (Greenfield et al., 2000).

While religious influences on substance abuse appear to be generally positive, this is not always the case. Studies show that when people from religious traditions that promote complete abstinence start using alcohol or drugs, substance use can become severe and recalcitrant. These people may completely withdraw from religious involvement, resulting in social isolation and worsening mental health owing to feelings of guilt and shame (Musick, Blazer, & Hays, 2000).

Longitudinal studies need to be conducted to investigate and understand how spiritual practices, spiritual and religious involvement may provide support to individuals recovering from substance abuse disorders.

CONCLUSIONS

Spirituality is a universal phenomenon characteristic of human wholeness (Cavendish et al., 2001). Spirituality as a concept evades simplistic definition, categorization or measurement and yet it affects the social, emotional, psychological and intellectual dimensions of our lives. The terms spirituality and religion are more frequently described than defined. Spirituality and religion are often used interchangeably although they are arguably different. In identifying spirituality as an important component of human development, Crawford and Rossiter (1996) caution against defining the spiritual (a) in religious terms (b) excluding any reference to religion or (c) something so broad that it includes every possible aspect of life. Koenig (2009) has suggested that spirituality be defined in terms of religion where religion is a multidimensional construct not limited to institutional forms of religion and using the terms interchangeably. In the present article the review presented is in line with Koenig’s viewpoint.

Researchers generally consider spirituality/religion to be a multidimensional concept in that it consists of multiple domains. In agreement with the earlier recommendations (Idler et al., 2003) it is suggested that research investigations use a wide set of domains of spirituality/religion, as these may be differentially linked to the way spirituality/religion affects individual health and well-being.

Spirituality, if defined in terms of good mental health and positive psychological or social traits has been found to correlate with mental health and well being (Koenig, 2009). Studies have indicated in general the positive role of religious beliefs, religious activities and religious experiences in promoting mental health and psychological well-being. The bio-psychosocial-spiritual model also seeks to discover the role religious and spiritual belief systems play in the appraisal process, the development of hope,
optimism, self efficacy, and the ability to tolerate and accept disease and pain. Resorting to spirituality and religion is commonly seen among patients with psychiatric illness. A number of qualitative and quantitative studies have identified that many expressions and elements of spirituality are helpful in reducing depressive symptoms. Some studies have suggested that this beneficial effect is linked to spiritual well-being rather than religious practices per se. Intrinsic religiosity has been found to lead to a greater sense of competence and control and less feelings of worry and guilt. Researchers examining the relationship between spirituality, religion and anxiety suggest that religious involvement and spirituality may help to reduce symptoms and feelings of anxiety. This relationship depends to some extent on the way in which spirituality is expressed. Research studies have looked at the association between spirituality, religion and PTSD. A high index of religious moral beliefs seem to provide help in overcoming post war psychosocial problems leading to improvement in mental health. Positive religious coping, religious involvement and intrinsic religiousness are associated with improved post traumatic recovery. Studies show that spirituality and religion are important in the lives of many people with schizophrenia and offer valuable benefits to living with and recovering from illness. Spirituality and religiousness are known to be protective factors for substance use. Spiritual and religious involvement may provide support to individuals recovering from substance abuse disorders.

Considering that spirituality/religion has associations with mental health, it should be considered in research and clinical practice. Research studies must take into cognizance the socio-cultural context in which the relationship between spirituality, religion and mental health emerge and recognize the short comings of some studies. It is proposed that quantitative, qualitative and longitudinal studies will be useful in understanding the complex relationship between spirituality, religion and mental health. A comprehensive research effort is needed to determine the efficacy of spiritual/religious beliefs, experiences, practices on persons from different spiritual and religious backgrounds. The health psychologist or clinician who truly wishes to consider the bio-psychosocial-spiritual aspects of a patient needs to assess, understand, and respect his/her religious beliefs, like any other psychosocial dimension. Increasing our knowledge of the religious aspect of human beings will increase our capacity as health psychologists and mental health providers in relieving suffering and helping people to live more meaningful and fulfilling lives.

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Spirituality, Religion and Mental Health


