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The mediating role of coping in the relationships between religiousness and mental health

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Summary

The aim of this study was to assess the relationships between religiousness and mental health within the mediational perspective of religious coping. The existing empirical evidence indicates that specific aspects of religiousness are associated with mental health indices. Yet, less is known about the nature of these associations and mediating mechanisms between both factors. The theory of religious coping as a mediator was employed so as to explain how religiousness is linked with mental health and what mechanisms shape the associations. The results demonstrated that religious coping can be regarded as a mediator between religiousness and mental health dimensions. Religious coping is expressed in two main forms: positive and negative that are linked to positive and negative mental health outcomes, respectively. People draw on these two religious coping methods in times of major life crises in order to make sense of trauma and loss, and to alleviate stress. The theoretical analyses showed that when religiousness contains structures of orientation and meaning, it enables individuals to attain positive functioning and well-being that reflects mental health.

religiousness / mental health / religious coping / mediational perspective

Religion plays an important role in people's lives and influences many aspects of our human existence. It is also intimately connected to mental health, including a wide variety of beliefs, emotions, and behaviours, some of which are constructive to human functioning and some dysfunctional. Some religious practices that characterise a spiritual life can be viewed as a sign of mental disturbance, while others might buffer against mental illness. The ways in which religiousness is connected with psychological functioning are thus very intricate and multifaceted. A potential factor that can help us explain those relationships is found in the form of coping with stress. While experiencing negative mental states individuals often rely on coping mechanisms and strategies that can alleviate their level of stress and pain. Many people turn to religion in order to find help and relief. The purpose of this article is to outline the ways in which religiousness interacts with mental health within the mediational perspective of religious coping.

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1. THE COMPLEXITY OF RELATIONSHIPS BETWEEN RELIGIOUSNESS AND MENTAL HEALTH

Within psychology and psychiatry there has been unceasing theoretical and empirical interest in examining positive and negative effects of religiousness on mental health. Previous research has investigated various aspects of both concepts and employed different measures of religious and mental health dimensions [1, 2]. The results of these studies have been equivocal and are difficult to integrate due to the different definitions and divergent methodologies regarding both religiousness and mental health. Providing a definite answer as to whether religious people are in better or worse mental health that others

is extremely challenging [3, 4]. Therefore, examining the positive or negative effects of religiousness on mental health requires addressing some methodological and conceptual issues that have been underlined throughout the relevant psychiatric and psychological literature.

First, it is extremely difficult to establish the direction of relationships between religiousness and mental health. Lisa Miller and Brien S. Kelly point out that researchers are often forced to analyse a narrow spectrum of religious variables and compare them with a wide range of clinical and health indicators [5]. The correlations which can be found between religious and mental health variables do not necessarily reveal the directionality of their relationship. They only point statistically to either a positive or a negative relationship. It might be that religious factors increase one's well-being or that healthier individuals are inclined to attend religious services more often. In a given situation, the cause of pathological behaviour can be twofold: religious activities can be distorted and lead to inappropriate expressions of religiousness, or the person may demonstrate mental disorder behaviour that will manifests itself in a pathological religious form. The proper explanation of these phenomena is very important, both for the overall image of religion, and establishing the objective and scientifically confirmed impact of religion on the mental and social functioning of the individual. Therefore, determining causal precedence in correlational studies is extremely difficult to establish. Longitudinal survey studies are required to reveal the direction of causality.

Second, the concept of religiousness is multidimensional and that may have multiple effects on mental health indicators. As various authors observe religion is a complex construct that comprises several dimensions of human functioning e.g., cognitive, emotional, motivational, and behavioural [6]. The effects of specific religious dimensions may thus neutralise each other, diminishing their separate influence and resulting in varied patterns of association. The method of evaluating the relationship of specific religious dimensions with mental health appears more productive than assessing global connections [7]. This approach can differentiate between different facets of religiousness and discriminate the degree to which religious variables are intertwined with mental health ones.

The analysis of results from many studies carried out by Charles D. Batson, Patricia Schoenrade, and Larry W. Ventis provides a good example of examining religion from different perspectives [8]. Drawing on the model of extrinsic, intrinsic and quest religious orientations the researchers investigated their relationships with mental health. The findings demonstrated a negative relationship between the extrinsic orientation and mental health. In the majority of studies analysed by Batson and colleagues, the extrinsic orientation was negatively associated with absence of illness, appropriate social behaviour, freedom from worry and guilt, personal competence and control, and open mindedness and flexibility. In contrast, the relationship between the intrinsic orientation and psychological well-being was positive. In the majority of studies, the intrinsic orientation positively correlated with absence of illness, appropriate social behaviour, freedom from worry and guilt, competence and control, and personal organization. The quest dimension did not show any clear relationship with various indices of mental health. Some studies pointed to positive correlations, while others demonstrated negative associations. This outcome might be due to either the scarcity of research in this area, or it may reflect no discernible associations of quest with mental health.

Further studies revealed similar associations between measures of religiousness and mental health. John Maltby and Lisa Day found that depressive symptoms were positively associated with two forms of extrinsic religiousness: personal and social [9]. The same destructive symptoms were negatively related to intrinsic religiousness. However, the results pointed to interesting differences between genders: there were no statistically significant correlations between intrinsic and extrinsic religious orientations and trait anxiety in males, but there was a positive association with extrinsic religiousness in females.

The other most common dimensions of religiousness assessed in research on religion and mental health are attendance at religious services, salience of religious identity, prayer and religious beliefs. Frequency of attendance at reli-

gious services was associated with greater psychological well-being in most studies [10, 11], although some of them revealed negative links [12, 13]. Salience of religious identity positively related to indices of psychological well-being [14]. As regards prayer the links with mental health were more complex and dependent on the type of prayer. Colloquial and meditative prayer showed positive associations with such measures of well-being as life satisfaction, existential satisfaction, and happiness. Meditative prayer turned out to be the most important predictor of religious experiences. In contrast, petitionary and ritualistic prayers, although related to some well-being measures, correlated positively with negative affect [15].

Using the Post-Critical Belief scale Beata Zarzycka and Jacek Śliwak showed that three dimensions of religiousness had significant relations with anxiety [16]. Orthodoxy (the person claims that there is only one true answer to religious questions and this answer is accepted by religious authorities) correlated negatively with suspiciousness and positively with guilt proneness in the whole sample. Among women, Historical Relativism (the person accepts the existence of God but less than orthodox individuals do) negatively correlated with suspiciousness, lack of integration, general anxiety and covert anxiety. Among men, Historical Relativism positively correlated with tension and emotional instability, general anxiety, covert anxiety and overt anxiety. External Critique (the person displays some tendency toward disbelief, yet religion usually plays a negative or ambivalent role in his/her life) was correlated with suspiciousness among men.

Overall, the results demonstrate that associations between religiousness and mental health are highly dependent upon the dimensions of the religious and health constructs being used. What matters are the person's inner approach to religion and the extent to which the individuals identify themselves as religious. Engaging in religious activities without a psychological commitment to them may reflect rather routine actions that do not entail any beneficial outcomes for one's well-being. More meaningful behaviour is required if it is to bring fruit to mental health. Furthermore, the preponderance of empirical research suggests that the associations between religion and mental health are mediated by some mechanisms [1, 5, 17]. The mechanisms most studied and recognised by psychiatrists and psychologists are: health behaviours, psychological states, coping, and social support. They may operate simultaneously and, in many cases, overlap with one another.

Third, the culture in which individuals are embedded plays a very important role in influencing how they characterise the relationships between religiousness and mental health, interpret mental symptoms, and describe their thoughts and behaviours. Existing cultural patterns and norms are vital to understanding both religious behaviours and mental schemas [18, 19]. Cultural elements e.g., specific cultural cognitions, emotions, morality, personality, and social behaviour shape religions and religious experience. They help us explain, to some extent, why religion seems to function in similar ways across cultural contexts and how religious motivations can lead to some universal consequences regarding intra-individual functioning and interpersonal relations. There is also increased recognition in clinical care and in research in psychiatry of the importance of religion and spirituality in our patients' lives as these factors may be relevant to understanding human functioning and explaining pathological symptoms [20]. Cultural differences influence forms of religious delusions, hallucinations, and the preponderance of certain types of religious rituals that can resemble particular disorders e.g., obsessive-compulsive disorder (OCD).

There is strong evidence that culture determines the interaction between religiousness and mental health and disorder. It becomes observable in specific religious activities that are closely related to personality states. The particular modes of expression and behaviour prescribed by the world's religions strongly influence the daily lives of their believers, and therefore the manifestation of the believers' symptoms must be considered within the particular schemas of each religion [1, 3]. Furthermore, Western psychiatry and psychology are predominantly a European and American phenomenon, and their findings and therapies are mostly applicable to individuals living within these cultural boundaries. In contrast, the standards of mental health found in other cultures do not necessarily have

to match Western criteria e.g., in some African communities a person would be regarded as insane if he or she did not believe that the spirits of the dead actively influence an individual's life [5]. This ambivalent situation challenges researchers to take into account different viewpoints related to religious and mental health factors.

In considering the above methodological and conceptual points, it is apparent that a deeper and more refined model of analysis is required for understanding the complex associations of dimensions of religiousness with mental health. The coping mechanism may provide a broader framework that would enable us to comprehend those associations and embed them into the mental health context.

2. RELIGIOUS COPING AS A POTENTIAL MEDIATOR IN THE RELATIONSHIPS BETWEEN RELIGION AND MENTAL HEALTH

A very promising area of analysing the relationships between religiousness and mental health lies in the field of coping. According to Kenneth I. Pargament religiousness can be seen in three facets as: an element of coping, a contributor to coping, and a product of coping [21, 22]. At the first level religion serves as an element of coping, enabling individuals to apply their religious beliefs and activities to stressful situations. They might contain cognitive activities (e.g., finding a religious explanation in the event), behavioural activities (e.g., confessing one's sins), and passive (e.g., asking for a supernatural intervention) and collaborative responses (e.g., doing one's best and giving the rest up to God). At the second level religion is viewed as a force having the potential to shape coping processes. Religious factors can influence an individual's appraisals of events and perceived ability to cope. Through guidelines and principles that are embedded in religious teachings, religion can encourage people to behave in certain ways. At the third level religion is understood as a product of coping. This can be illustrated by the situation in which painful experiences are able to draw a person closer to God.

The underlying assumption of the ability of religion to influence the coping process lies in the observation that religion is more than a defence mechanism as it was viewed by Sigmund Freud [23]. The empirical evidence suggests that religion has been connected with several functions in coping that extend beyond anxiety reduction, including meaning making [24], personal mastery and growth [25], and the search for the sacred [26]. Religious motivation can serve a wide variety of needs for individuals. Research also indicates that religion is not generally associated with the blanket denial of the situation. Rather than inspiring denial, religion stimulates reinterpretations of negative events through the sacred lens e.g., a traumatic situation can be viewed as an opportunity for spiritual growth [23]. The encouraging force of religion is clearly evident in the religious rites that offer individuals hope and enable them to overcome grief and pain. In addition, religion is linked with both passive and active coping which refutes the accusation of passivity with regard to religious beliefs. The research conducted by Pargament demonstrated that measures of religiousness were more linked to forms of active coping than passive coping [27].

Examining the relationships between religion and coping, Pargament points out that religious coping acts as a mediator between general religious orientations and the outcomes of negative life events [22]. Although religious beliefs can at times impede the coping process, they also enable people to understand and deal with stressful situations. Religious involvement may foster more effective ways of dealing with stressful situations and conditions [2]. Consequently, more effective coping strategies can lead to improved mental health through a reduction in harmful health behaviours (e.g., less stress) and an improvement in psychological states (e.g., higher optimism and well-being).

Applying religious coping to solving existential problems Pargament initially identified three coping styles that reflect the ways in which people grapple with challenging situations [27]: (1) a deferring approach – the individual relinquishes the responsibility for problem solving to God; (2) a self-directing approach – the individual perceives God as someone who gives him or her the skills and resources required to solve problems autonomously; (3) a collaborative approach – the individual perceives God as a part-

ner who takes part in the responsibility for problem solving. The collaborative problem-solving style turned out to be more common than the deferring or self-directing styles.

Subsequent research conducted by Pargament and colleagues specified the above styles, allowing the provision of a more comprehensive array of 21 types of religious coping activities that were named "methods" [28]. The coping methods comprise a wide range of mechanisms: active, passive, and interactive strategies; emotion-focused and problem-focused approaches; and cognitive, behavioural, interpersonal, and spiritual domains. In order to measure those methods the researchers constructed the RCOPE scale that demonstrates five key religious functions: the search for meaning, the search for mastery and control, the search for comfort and closeness to God, the search for intimacy and closeness to God, and the search for a life transformation. The results obtained in many studies suggest that the RCOPE is a useful tool to assess religious and spiritual resources used in coping with a variety of major stressors [23, 28, 29].

The main question that arises in relation to religious coping is why religion is so potent and effective in dealing with daily stressful and challenging events. The answer to this question is not clear, in part because religion is a multifaceted phenomenon that serves many individual and social functions. Nevertheless, it is possible to pinpoint three main dimensions in which religion meets human needs: (1) the need for meaning, (2) the need for control, and (3) the need for relationships [30]. They are all based on the assumption that the search for meaning is of central importance to human functioning, and that religion is uniquely capable of facilitating that search.

In recent psychological and psychiatric studies on religion, there has been an increasing interest in examining religion in terms of meaning. Probably the most popular definition of religion describes it as "a search for meaning in ways related to the sacred" [22, p. 32]. Religion is essential to the global meaning systems of many people, because it provides individuals with an integrated set of beliefs, goals and meanings which can be used in explaining intricacies of the world and in dealing with personal situations and problems. Recent research has repeatedly shown that religion is a powerful source of meaning in life [24, 26, 31]. Despite the fact that the relationship between religion and meaning is intimate and complex many people find in religious beliefs a sense of purpose, understanding and psychological support.

The results obtained by Dariusz Krok revealed that religion conceptualised as the religious meaning system enables individuals to comprehend their lives and the world and to discover purpose and meaning in their lives [32]. It allows us to assess religion as a central factor in the life purposes of many people, taking into account their ultimate motivation and goals for living. The religious meaning system was associated with higher levels of subjective and psychological well-being, and their relationships were mediated by such psychosocial factors as a sense of coherence, meaning in life, and social support. It implies that meaning plays a mediational role in the relationship of religion with mental health.

Religion can offer a sense of control over life's countless uncertainties that is extremely important when coping with stressful and challenging situations. When threatened with harm or pain, individuals often tend to control and even predict the outcomes of the events that affect them. This inclination is deeply rooted in cognitive mechanisms directed at constructing personal mastery in one's life [33]. Religious activities such as prayer and rituals can strengthen a person's feeling of mastery which in turn enhances a sense of self-control and control of one's world. When people face uncertainty and helplessness that limit their sense of control and mastery, religious beliefs may provide a subjective sense of control to enable individuals regain their willpower and strength [30]. Therefore, religion as a coping strategy imbues life with significance as it facilitates people's efforts to interpret their experiences in terms of existential meaning.

The last function of religion linked to meaning is the need for relationships. Roy F. Baumeister and Mark R. Leary emphasise that people have a basic psychological need to feel closely connected to others, and that caring, affectionate bonds from close relationships are a major part of human behaviour [34]. They use the term "need to belong" to illustrate the observable fact that human beings are fundamentally and pervasively

motivated to engage in social relationships and have a strong desire to form and maintain enduring interpersonal attachments. Connections and interactions are indispensable throughout one's entire life. Through its services and ceremonies religion can connect individuals to each other and their groups. Religious beliefs provide norms and standards that socialise members into community, and concurrently suppress destructive and undesirable behaviour. There is strong empirical data demonstrating that social support offered by church communities is beneficial to people's well-being and mental health, although at times it can have adverse effects [2, 30, 35]. People experience religious influences through their interpretations and motivations of daily events, and religious behaviours can either strengthen social cohesion (altruism, interpersonal approval) or reinforce divisions (prejudice).

The evidence presented in this section supports the idea that a religious framework can be a mediator in the relationships between religion and mental health. Religious coping strategies influence appraisals and affect different dimensions of mental health. The effects are determined, in part, by a sense of meaning and significance which is strongly embedded in internal religious structures. Further analysis is required to assess the extent to which religious coping can increase people's well-being and consequently their mental health.

3. THE ROLE OF RELIGIOUS COPING IN INCREASING WELL-BEING

Religion hardly precludes stress and suffering as they are "inscribed in the equation of life". Yet, religiousness may help individuals buffer stress and increase their level of well-being. A religious belief system enables individuals to find meanings in stressful and traumatic life events that are otherwise difficult, if not impossible, to explain e.g. death, terminal illness, unexpected accident. The beneficial role of religion appears mainly in times of stress which is rather logical given the fact that studies suggest that the cause of everyday events is likely to be only infrequently attributed to the religious realm [7]. The religious interpretative framework that is based on the meaning system empowers people to make sense of their stressful life events.

According to Pargament, religious coping methods can be grouped into two main categories: positive and negative [22, 23]. These were established on a basis of higher order factor analyses that considered similarities and differences between their content and effects. The efficacy of religious coping can be examined by applying those methods to the outcomes of stressful situations. The positive and negative methods of religious coping can be measured by using the Brief RCOPE scale that is a shorter form of the RCOPE. Confirmatory factor analyses of the Brief RCOPE indicated that the two-factor solution (two distinctive methods) provided a reasonable fit for the data. The scale is divided into two subscales, each consisting of seven items, which identify clusters of positive and negative religious coping methods.

The positive religious coping method depicts secure relationships with God, a sense of spiritual connectedness with others, and a belief that life has a greater benevolent meaning. The method reflects spiritual support, collaborative religious coping, and benevolent religious reframing. In general, positive religious coping concentrates on accepting God as a partner who could help in stressful situations and active attempts to find strength, support and guidance in crises. The negative religious coping method represents insecure relationships with God and strains between individuals, signs of spiritual tension, conflict and struggle with God and others, as manifested by negative reappraisals of God's powers (i.e. feeling abandoned or punished by God), demonic reappraisals (i.e. feeling the devil is involved in the stressor), spiritual questioning and doubting, and interpersonal religious discontent [27, 36]. In general, negative religious coping expresses the attitude of perceiving God as one who punishes and spiritual discontent in difficult situations.

Through these two coping methods religion provides people with comprehensive and cohesive structures of meaning that enable them to cope with challenging events. The results of studies conducted by Pargament and other researchers revealed that religious coping can be helpful or harmful, depending upon the particular type of religious coping strategy employed

[28, 29]. The positive and negative religious coping methods turned out to show different connections to measures of mental health.

The results of a large meta-analysis (49 relevant studies with a total of 105 effect sizes) conducted by Gene G. Ano and Erin B. Vasconcelles demonstrated that positive and negative forms of religious coping are related to positive and negative psychological adjustment to stress, respectively [36]. The authors decided to examine four types of relationships between religious coping and mental health: positive religious coping with positive psychological adjustment, positive religious coping with negative psychological adjustment, negative religious coping with positive psychological adjustment, and negative religious coping with negative psychological adjustment.

The findings indicated that a moderate positive relationship exists between positive religious coping strategies and positive outcomes to stressful events. Individuals who applied positive religious coping strategies such as benevolent religious reappraisals, collaborative religious coping, and seeking spiritual support tended to experience more stress-related growth, spiritual growth, and positive affect. They were also characterised by higher self-esteem. This result may suggest that positive religious coping facilitates adaptive functions, especially in times of challenging events [21]. Positive religious coping was also inversely related to negative psychological adjustment. That is, individuals who used positive religious coping strategies displayed less depression, anxiety, and distress. Thus, religious coping can serve adaptive functions in terms of decreasing the level of negative mental health states.

Rather surprisingly, negative religious coping was not inversely related to positive psychological adjustment. That is, individuals who used those negative strategies were not characterised by lower self-esteem, less purpose in life, or lower spiritual growth. One explanation for this finding is that negative religious coping is balanced by using positive religious strategies which in turn prevent individuals from experiencing too many negative outcomes. This interpretation is consistent with another study suggesting that personality dispositions interact with religious coping and that using negative religious coping may be balanced by positive dispositions [37]. Finally, negative religious coping strategies were positively associated with negative psychological adjustment to stress. In other words, individuals who reported using negative forms of religious coping experienced more depression, anxiety, and distress. This finding was confirmed by the relationship of negative religious coping to psychological distress among early adolescents [38].

Further research examining the nature of religious coping revealed that individuals enter the coping process with orienting and meaning systems that influence the specific ways in which they interpret and handle stressful events. Facing challenging situations, individuals draw on religious coping methods as a part of their general orienting and meaning systems, which in turn influence their abilities to cope with adversity and life stress [24, 31]. It is especially discernable in coping with major stress situations e.g., among patients diagnosed with cancer [39] or people who experienced traumatic events [40]. The orienting and meaning systems appear to influence the types of coping strategies that are used in specific situations. The stronger and more constructive are the orienting and meaning systems that individuals employ, the more positive are the health outcomes that can be attained.

CONCLUSIONS

To summarise, the article indicates that religiousness can either improve the mental states of troubled persons or it can exacerbate situational stress. It is a consequence of the many religious and spiritual references with which people surround themselves, constructing a specific sacred context that makes an impact on major life events. Although the associations between religiousness and mental health appear to be very complex and multifaceted, the current findings show that they are highly dependent upon the religious and health constructs employed in the research. Religious coping can function as a mediator between general religious orientations and mental health dimensions. It has two main forms: positive and negative that are linked to positive and negative mental health outcomes,

respectively. The effects of religious coping methods on mental health are determined, at least partially, by the structures of orientation and meaning that are strongly embedded in internal religious schemas. While facing challenging and stressful situations individuals heavily rely upon them in order to buffer stress and increase subjective well-being.

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