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Religiousness and social support as predictive factors for mental health outcomes

Dariusz Krok

Summary

The aim of this study: The study is to investigate predictive values of the religious meaning system, the centrality of religiosity and social support for mental health outcomes. Although there is some evidence about associations of religiousness and social support with mental health, insufficient data exists to explain which dimensions of religiousness and social support are related to mental health outcomes.

Material and methods: Participants were 206 people (108 women and 98 men) randomly recruited in southern parts of Poland. Their ages ranged from 18 to 78 years, with a mean age of 38.6 years (SD = 16.44). All participants filled in the four questionnaires: The Religious Meaning System Questionnaire, The Centrality of Religiosity Scale, The Berlin Social Support Scales, and The General Health Questionnaire-28.

Results: Both religiousness and social support are associated with mental health outcomes, but the character of these associations depends on particular dimensions. The religious meaning system and the centrality of religiosity showed negative links with the dimension of mental health called somatic symptoms. Actually received support was associated with better mental health, whereas need for support and protective buffering support were predictors of negative mental health outcomes.

Discussion and conclusions: The findings support the hypotheses that religiousness and social support are predictive factors for mental health outcomes, though their effects are rather moderate or weak. Both religion and social support can influence mental health by imbuing life with a sense of meaning and significance, and offering fellowship in times of stress and suffering.

religiousness / social support / mental health / religious and social predictors

INTRODUCTION

Precise analyses of social life compellingly lead to a conclusion that religion is strongly embedded in social interactions, which in turn influence mental health. Although a psychological approach to religiousness stresses a personal and subjective reference to the sacred, in all human communities religious beliefs and behaviour are formed in social experiences. There is evidently a strong effect of the surrounding society on religious beliefs and behaviour [1, 2]. A child encounters the idea of God on a basis of family environment and interactions with parents. Contacts with other people tend to shape the psychological framework in which the sacred (God, transcendent reality) is experienced. Cognitive schemas, which are made on the ground of a person's natural social experience, resonate in religious thinking and emotions.

Although there is some evidence about associations of religiousness and social support with mental health, insufficient evidence exists to explain which dimensions of religiousness and social support are related to mental health outcomes. Religiousness can be understood and defined in various ways. The current study will focus on two approaches which present religion from cognitive, motivational and behavioural

Dariusz Krok: Institute of Family Science, Opole University. **Correspondence address:** dkrok@uni.opole.pl

perspectives: the religious meaning system and the centrality of religiosity. Taken together they allow us to thoroughly examine religious thinking and behaviour, and relate them to social support and mental health.

The religious meaning system can be defined as an idiosyncratic system of concepts related to the sacred and having references to self, other people and the world [3]. The concept of the religious meaning system draws on previous theoretical approaches and empirical findings which show that meaning is at the core of human nature. The search for meaning plays a significant role in both individual and social lives [4, 5]. Religion, through its links to such psychological constructs as goals, values, and beliefs, is uniquely capable of stimulating this search and providing a deeper understanding of human motivations. For individuals for whom religion is important, religious cognitive structures form a central part of their meaning system, making an impact on their beliefs, goals, and sense of meaning in life. Drawing on religion individuals are able to derive personal meaning from their religious-oriented cognitions.

The religious meaning system contains two central dimensions which are of a cognitive and motivational character: orientation and meaningfulness [3]. The dimension of orientation assesses the extent to which religion can help individuals to comprehend their lives and the world. It is a dispositional phenomenon that uses particular religious means and seeks particular religious ends in order to obtain personally satisfactory answers to major existential questions. The dimension of meaningfulness denotes the ability of religion to empower individuals to discover purpose and meaning in their lives. The conceptualization of religiousness in terms of the religious meaning system is based on widespread observations that religion helps people in explaining and interpreting many complexities of their lives in terms of significance and purpose.

The centrality of religiosity reflects the importance or salience of religious meanings in personality. The concept was developed by Stefan Huber [6, 7] and has been applied in more than 100 studies in psychology of religion, sociology of religion, and religious studies in more than 20 countries. It is based on George Kelly's personality theory of personal constructs. His central assertion is that one's experiences and behaviors are contingent on his/her constructions of reality [8]. From a psychological point of view religious beliefs can be considered as specific ways of construing reality. Therefore, the personal system of religious constructs can be described as a superstructure in personality which consists of all personal constructs which are related to the individually defined realm of religion. Within this approach there are five core dimensions which can be perceived as modes in which personal religious constructs are activated: cognitive interest, ideology, prayer, experience and worship. Research shows that the concept of the centrality of religiosity has been a useful methodological tool to examine religious involvement in the context of personality and social behaviour [3, 7, 9].

Social support is one of the most important functions of social relationships which is strongly associated with health and illness outcomes. Social support can be characterized as the perception and actuality that a person is cared for, has assistance available from other people, and is part of a supportive social network. Generally, there are five main types of social support: emotional support (e.g. empathy, concern), esteem support (e.g. positive regard, encouraging person), tangible support (e.g., financial or direct assistance), informational (e.g. advice, feedback), and network support (e.g. welcoming, shared experience) [10]. Although social support has been linked to many benefits for both physical and mental health, it is not always beneficial. Research has revealed both harmful consequences of poor social support and protective effects of good social support in mental health [11]. The outcome thus depends on the type of social support, and personality and environmental factors which may moderate the impact of social support on mental health effects.

Both religion and social support play an important role in functioning individuals in the sphere of mental health. Examining the relationships between religiousness and mental health, Harold G. Koenig notes that approximately 80% of research on religion/spirituality and health involves studies on mental health which has stronger associations with religiousness than physical health. As regards mental health religious beliefs tend to boost positive emotions and counterbalance negative emotions,

serving as both life-enhancing factor and a coping resource [12]. The strongest positive associations were found between religiousness and the following facets of mental health: coping with adversity, well-being, hope, meaning and purpose, and positive character traits. Similarly, the strongest inverse relationships occurred between religiousness and the following indicators: depression, suicide risk, anxiety and psychoticism.

Research indicates that religious beliefs and behaviour help individuals to cope more effectively with adversity, either external adversity (e.g. problematic and challenging environmental circumstances) or internal adversity (detrimental genetic predispositions or vulnerability to mental disorders). Analysing the relationships between religion and coping, Kenneth I. Pargament and his colleagues state that religious coping acts as a mediator between general religious orientations and outcomes of negative life events [13]. 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 [14]. Overall, positive coping strategies can lead to improved mental health through a reduction in harmful health behaviours and an improvement in psychological states, whereas negative coping strategies tend to have detrimental effects on mental health outcomes.

Although most studies indicate a protective effect of religiousness on mental health, there is also evidence that some religious beliefs or behaviours can trigger or reinforce pathological expressions. Extreme religious forms (e.g. excessive rituals, disproportional accentuation of sin, delusions of persecution) may reinforce deluded beliefs and exacerbate guilt and worry, constituting psychopathological symptoms. The forms can also perpetuate mental illness by providing a structural framework in which pathological symptoms are interpreted in the way which precludes seeking treatment for the disorder [15]. In addition, some forms of religious experience may unduly resemble psychotic behaviour or hallucinations, distorting the true nature of the relationship. Therefore, we can expect associations between religiousness and mental health to have a diverse nature.

Although there has been empirical evidence that social support both influences mental health outcomes and plays a role in the relationships between religiousness and mental health [16, 17], little is known about associations between specific dimensions of religiousness, social support and mental health. With regard to connections between social support and mental health, research has unquestionably demonstrated that social support effectively reduces stress and increases positive cognitions and emotions, thus leading to enhanced well-being and better mental health consequences [18-20]. Nevertheless, existing research is rather ambiguous about differences in the relations between perceived and received social support, and mental health. It remains unclear which of them is more beneficial for mental health outcomes. Some studies indicated that perceived social support may be more helpful for mental health than actually received social support [18], but the results are rather equivocal.

According to Val Morrison and Paul Bennet [10] there are two main explanations of the relationships between social support and mental health: (1) high levels of social support provide a greater sense of belonging and self-esteem than low levels, which in turn creates a positive outlook and healthier lifestyles; (2) social support protects the person against negative effects of high stress by influencing the person's cognitive appraisal of difficult situations and modifying the person's coping response to a stressor. These mechanisms strengthen one's well-being and produce beneficial outcomes for mental health.

Social support is an important factor in the relationships between religiousness and mental health. Religious activities, which take part in small groups and large communities, may foster stronger social networks and a greater availability of social support that may strengthen effective coping with stressors. Research proved that individuals who are more religious, or who attend church more frequently, have generally been found to have better mental health [21]. For older adults in particular, the most common source of social support outside of family members is derived from members of religious groups [22]. A sense of belonging to a religious group may provide social cohesion, the sense of

belonging to a caring group, continuity in relationships with friends and family and other support groups. Consequently, these factors can influence mental health by offering companionship in times of stress and suffering, and diminishing the impact of anxiety and other negative emotions.

The relations between religiousness and mental health also depend on other elements than social support. An important factor is a character of religiousness. Michael Argyle states that the relationship between religiousness and social support is determined by the form of religion: intrinsic religiosity correlates positively with mental health, whereas extrinsic religiosity shows negative links [23]. Research on subjective and psychological well-being revealed that the religious meaning system is associated with a higher level of life satisfaction and stronger well-being based on values and purposes, suggesting that a sense of meaning and significance embedded in internal religious structures is related to personal satisfaction and self-realization. In contrast, there was no connection between the religious meaning system and positive emotions, which are also an indicator of mental health [3]. The results are likely to imply different modes of relations between religiousness and mental health for cognitive and emotional dimensions.

The evidence from the above studies indicates that the religious meaning system, the centrality of religiosity and social support appear very promising predictors of mental health outcomes. Yet, examination of their relationships reveals that they might depend on particular dimensions of religion and social support and also vary in character. The aim of the current study is to investigate predictive values of the religious meaning system, the centrality of religiosity and social support for mental health outcomes. The study focused on the following hypotheses: (1) There will be positive associations between the religious meaning system, the centrality of religiosity and mental health outcomes; (2) Received social support will show positive associations with mental health, whereas lack of support will correlate negatively with mental health; (3) Dimensions of social support will be stronger predictors for mental health outcomes than dimensions of religiousness.

METHOD AND MATERIALS

Participants and procedure

Participants were 206 people (108 women and 98 men) randomly recruited via various organizations, universities, and religious and non-religious institutions located in southern parts of Poland. Their ages ranged from 18 to 78 years, with a mean age of 38.6 years (SD = 16.44). Participants were equally drawn from different environments to form a representative sample of the Polish population in terms of social status, gender and age. They were asked to participate in research on the role of religiousness and social attitudes in human life. The majority of participants identified themselves as Christian (91.4%), which reflects the religious specificity of Poland. Participants completed four questionnaires in their own time and then sent them back to the researcher. The study was anonymous.

Measures

All participants filled in the four questionnaires: The Religious Meaning System Questionnaire (RMS), The Centrality of Religiosity Scale (CR), The Berlin Social Support Scales (BSSS), and The General Health Questionnaire-28 (GHQ-28). All of them were Polish versions.

Religiousness. The Religious Meaning System Questionnaire (RMS) was developed by Dariusz Krok and measures religiousness in terms of a comprehensive system for understanding and evaluating people's religious experiences and behaviour [3]. It describes religiousness as a cognitive and motivational system which enables people to explain and interpret their life and the world in the categories of significance and purpose. It consists of two subscales: (1) religious orientation that evaluates to what extent religion enables individuals to comprehend their lives and the world, and (2) religious meaningfulness that assesses the extent to which religion provides opportunities for individuals to discover purpose and meaning in their lives. The overall result reflects the degree to which people consider religion to be a source of orientation and meaning. The questionnaire contains 20 items,

to which people respond according on a 7-point Likert scale.

The Centrality of Religiosity Scale (CR) was developed by Stefan Huber and is a measure of the centrality, importance or salience of religious meanings in personality [6, 7]. It consists of five dimensions: (1) cognitive interest – it reflects the intensity of one's thinking about religious matters, (2) ideology – it represents the probability of God's existence and religious doctrines, (3) prayer – it assesses the frequency of prayer in one's life, (4) experience – it describes the strength of spiritual contact with God, and (5) worship – it reflects the frequency of church service attendance [6]. The scale contains 15 items, which are assessed on a 7-point Likert scale. It has good psychometric properties. The scale was adopted by Beata Zarzycka [24].

The Berlin Social Support Scales were developed by Ute Schulz and Ralf Schwarzer in order to measure domains of social support [25]. The method contains five subscales: perceived available support, need for support, support seeking, actually received support, and protective buffering support. The subscales measure both cognitive and behavioral aspects of social support. The scale consists of 38 items. People rate their agreement with the statements on a 4-point scale. Possible endorsements are: strongly disagree (1), somewhat disagree (2), somewhat agree (3) and strongly agree (4). It has good psychometric properties. The scale was adopted by Aleksandra Łuszczyńska [26].

The General Health Questionnaire (GHQ-28) was developed by David Goldberg as a screening tool to detect those likely to have or to be at risk of developing psychiatric disorders [27]. The questionnaire focuses on two major groups of problems: inability to carry out one's normal "healthy" functions and the appearance of new distressing symptoms. It examines mental disturbances in normal functioning. The questionnaire contains 28 items evaluated on a 4-point response scale: "less than usual", "no more than usual", "rather more than usual", "much more than usual". GHQ-28 consists of four scales: somatic symptoms, anxiety and insomnia, social dysfunction and severe depression. It allows for mental health assessment on the four dimensions. The questionnaire was adopted by Zofia Makowska and Dorota Merecz [27].

RESULTS

In the first step of statistical analyses possible gender differences for all the scales measuring religiousness, social support and mental health were assessed by using t-tests (Table 1 – *next page*).

Women were found to score higher on the centrality of religiosity and four dimensions: ideology, prayer, experience, and worship. There were no differences between women and men in cognitive-oriented dimensions, i.e. the religious meaning system and cognitive interest. As regards social support women obtained higher scores on all but protective buffering support scales. In the domain of mental health the only statistical result was for anxiety and insomnia with women scoring higher.

In order to examine relations between religion and mental health correlations were computed among the religious meaning system, the centrality of religiosity and mental health (Table 2 – *next page*).

The results revealed that most associations between religion and mental health were found for the somatic symptoms dimension. In the domain of the religious meaning system the total score and religious orientation were negatively related to somatic symptoms. As regards the associations between the centrality of religiosity and mental health significant correlations were found among cognitive interest, prayer, experience, the total score and somatic symptoms. All of them were of a negative character. Prayer also negatively correlated with anxiety and insomnia.

In the next step, correlations between social support and mental health dimensions were computed (Table 3 – *page 69*).

Need for support was positively related to somatic symptoms, and anxiety and insomnia. Support seeking positively correlated only with somatic symptoms. More associations were found for actually received support and protective buffering support, but they were of different characters. Actually received support was negatively correlated with social dysfunction, severe depression and the total score of mental health, whereas protective buffering support showed positive associations with anxiety and insomnia, social dysfunction and the total score.

Table 1. Student's t-test results between women and men for the religious meaning system (RMS), the centrality of religiosity (CR), social support (BSSS) and mental health (GHQ-28)

		Woman		Man		t-test	
		M	*SD*	*M*	*SD*	*t*	*p*<
RMS	Religious orientation	3.82	1.29	3.59	1.38	-1.27	0.206
	Religious meaningfulness	4.76	1.25	4.49	1.35	-1.48	0.140
	Total score	4.29	1.24	4.04	1.31	-1.43	0.155
CR	Cognitive interest	2.57	0.77	2.56	1.02	-0.08	0.936
	Ideology	3.96	1.07	3.54	1.18	-2.65	0.009
	Prayer	3.56	1.16	2.96	1.31	-3.51	0.001
	Experience	2.69	0.99	2.23	1.03	-3.24	0.001
	Worship	3.40	1.14	2.89	1.24	-3.06	0.003
	Total score	3.25	0.89	2.83	1.00	-3.13	0.002
BSSS	Perceived available support	3.38	0.56	3.00	0.62	-4.57	0.000
	Need for support	3.09	0.62	2.68	0.70	-4.52	0.000
	Support seeking	3.04	0.61	2.54	0.65	-5.76	0.000
	Actually received support	3.42	0.55	3.21	0.58	-2.65	0.009
	Protective buffering support	2.31	0.60	2.46	0.62	1.68	0.094
GHQ-28	Somatic symptoms	1.04	0.54	0.95	0.50	-1.30	0.196
	Anxiety and insomnia	1.10	0.72	0.88	0.52	-2.53	0.012
	Social dysfunction	1.06	0.35	1.05	0.34	-0.15	0.880
	Severe depression	0.36	0.59	0.36	0.43	-0.01	0.994
	Total score	0.88	0.42	0.81	0.34	-1.37	0.174

Table 2. Correlations among the religious meaning system, the centrality of religiosity and mental health

	Religious meaning system	Centrality of religiosity							
Mental health	RO	RM	Total	CI	I	P	E	W	Total
Somatic symptoms	-0.18*	-0.11	-0.15*	-0.20**	0.06	-0.14*	-0.20**	0.09	-0.17*
Anxiety and insomnia	0.07	0.03	0.05	0.07	-0.09	-0.16*	-0.12	-0.08	-0.11
Social dysfunction	-0.05	-0.09	-0.07	0.01	-0.11	0.01	-0.03	-0.08	-0.05
Severe depression	-0.02	-0.08	-0.05	0.02	-0.05	0.05	-0.01	-0.02	-0.01
Total score	-0.06	-0.00	-0.03	-0.09	-0.02	-0.13	-0.12	0.02	-0.09

***p<0.001; **p<0.01; *p<0.05

Symbols: RO – religious orientation, RM– religious meaningfulness, CI – cognitive interest, I – ideology, P – prayer, E – experience, W – worship

Table 3. Correlations between social support and mental health.

Mental health	Social support				
	PAS	NS	SS	ARS	PBS
Somatic symptoms	0.07	0.15*	0.15*	-0.11	0.12
Anxiety and insomnia	0.04	0.16*	0.09	-0.13	0.19**
Social dysfunction	-0.10	-0.02	0.01	-0.16*	0.16*
Severe depression	-0.05	0.06	0.04	-0.36***	0.12
Total score	-0.01	0.12	0.09	-0.24***	0.20**

***p<0.001; **p<0.01; *p<0.05

Symbols: PAS – perceived available support, NS – need for support, SS – support seeking, ARS – actually received support, PBS – protective buffering support.

Table 4. Stepwise regression statistics for mental health on religious meaning system, centrality of religiosity and social support.

	β	t	p
Somatic symptoms: R = 0.34; R2 = 0.12; F(4, 201) = 4.43; p<0.001			
Cognitive interest	-0.17	-1.97	0.049
Need for support	0.18	2.49	0.014
Actually received support	-0.18	-2.41	0.017
Experience	-0.19	-1.98	0.048
Anxiety and insomnia: R = 0.39; R2 = 0.16; F(4, 201) = 5.22; p<0.001			
Protective buffering support	0.18	2.67	0.008
Prayer	-0.29	-2.45	0.015
Actually received support	-0.20	-2.78	0.006
Need for support	0.20	2.68	0.008
Social dysfunction: R = 0.29; R2 = 0.09; F(2, 203) = 3.12; p<0.01			
Actually received support	-0.15	-2.10	0.037
Ideology	-0.23	-2.05	0.042
Severe depression: R = 0.46; R2 = 0.21; F(2, 203) = 11.15; p<0.001			
Actually received support	-0.45	-6.72	0.000
Need for support	0.23	3.31	0.001
Total score: R = 0.42; R2 = 0.17; F(3, 202) = 7.11; p<0.001			
Actually received support	-0.32	-4.51	0.000
Need for support	0.21	2.86	0.005
Protective buffering support	0.15	2.32	0.021

Table 5. Hierarchical regression analysis of mental health on religious meaning system, centrality of religiosity and social support (total scores)

	Change R^2	β	F
Mental health			
Step 1	0.02	-0.12	2.21
Religious meaning system		0.16	
Centrality of religiosity			
Step 2	0.16		5.33***
Religious meaning system		-0.12	
Centrality of religiosity		0.17	
Perceived available support		0.5	
Need for support		0.18	
Support seeking		0.02	
Actually received support		-0.32***	
Protective buffering support		0.17**	

In order to examine the relative contribution of religion and social support to mental health, a stepwise regression analysis was conducted (Table 4). The predictors were the religious and social support dimensions. The dependent variables were, separately, the dimensions of mental health.

In the first regression equation, the combined predictors accounted for a significant portion of variance (12%) in somatic symptoms ($F = 4.43$; $p<0.001$). Examination of the beta weights revealed that need for support predicted higher levels of somatic symptoms, whereas cognitive interest, actually received support and experience predicted lower levels. In the regression equation for anxiety and insomnia, the combined predictors accounted for 16% of variations ($F = 5.22$; $p<0.001$). The results of beta weights indicated that protective buffering support and need for support predicted higher levels of anxiety and insomnia, whereas prayer and actually received support predicted lower levels. Two predictors: actually received support and ideology accounted for 9% of variations ($F = 3.12$; $p<0.01$) for social dysfunction. The predicted level of social dysfunction will be higher when actually received support and ideology are lower. In the regression equation for severe depression, two predictors accounted for 21% of variations ($F = 11.15$; $p<0.001$). Actually received support predicted lower levels of depression, whereas need for support predicted higher levels. Finally, the combined predictors accounted for a significant portion of variance (17%) in the total score ($F = 7.11$; $p<0.001$). The results of beta weights indicate that actually received support predicted lower levels of mental health problems, whereas need for support and protective buffering support predicted higher levels.

DISCUSSION

The article aimed to evaluate the predictive value of religiousness and social support for mental health outcomes. Religiousness was assessed in forms of the religious meaning system and the centrality of religiosity. This methodological approach provided deeper insights that complement previous research investigating relations of religiousness and social support with mental health outcomes. The results obtained in the current study suggest that both religiousness and social support are associated with mental health outcomes, but the character of these associations depends on particular dimensions.

Both the religious meaning system and the centrality of religiosity showed negative links with

the dimension of mental health called somatic symptoms which reflects personal experiences of physical problems that may be caused by psychological factors. Although statistically significant, the associations between religiousness and mental health were rather weak. Among the religious dimensions which had the strongest associations with somatic symptoms were religious orientation, cognitive interest, prayer, and experience. Individuals, who treat religion as an orienting force in their lives, pray more and have religious experiences, are less exposed to somatization and negative somatic feelings. The findings partially confirm the first hypothesis positing associations between the religious meaning system, the centrality of religiosity and mental health outcomes.

However, our research points out that the associations between religiousness and mental health are rather weak. It corresponds with previous findings suggesting that religion is only one of the many factors affecting mental health and is often unable to outweigh the negative impact of personal and environmental causes [12, 29]. The relationships between religiousness and mental health outcomes are often mediated by other factors, e.g. existential beliefs, health behaviours, psychological states, coping methods, social support. The positive impact of religious involvement on mental health is more robust among people under stressful circumstances and those who are in difficult conditions (e.g. the elderly, disable, and ill) [30]. In addition, our research group consisted of a representative sample of the Polish population who was not necessarily in challenging and problematic health situations. All these elements may explain the weak associations between religiousness and mental health found in our study.

Religion appears to have some effect on mental health mainly on a basis of meaning, values and personal significance [4, 14, 31]. Religious beliefs and behaviour can satisfy personal needs for meaning and provide a sense of coherence on a basis of three main criteria: (1) religious beliefs, such as the existence of God, the possibility of afterlife, and moral values, give individuals a deeper life philosophy through which they can interpret, evaluate, and respond to their experiences and encounters, (2) religion can provide ultimate motivation and primary goals for living as well as prescriptions and guidelines for achieving those goals; (3) religion has a unique capacity to imbue human life with a sense of meaning in life which is noticeably visible in critical situations, e.g. death of a beloved person or one's serious illness [32]. For religious-oriented individuals religious constructs have a noticeable influence on their experience and behaviour, because the constructs enable them to explain the complexity of the world and find meaning to existential questions. The constructs are activated when a person approaches an object that has a religious meaning.

Stronger links were found between social support and mental health. Actually received support from other people was associated with better mental health in terms of lower levels of social dysfunction and severe depression, whereas experiences of need for support and protective buffering support were predictors of negative mental health outcomes. The findings confirm the second hypothesis which assumed that received social support would show positive associations with mental health, whereas lack of support would have negative links. They extend previous research on relationships between social support and mental health by providing evidence that it is actually received support that offers most beneficial effects for mental health.

According to the existing data social support has been reliably related to physical and mental health outcomes [19, 33]. However, it is the actually provided support from others that is primarily responsible for individuals' perceptions of support and strengthening their mental health abilities. This observation views social support primarily as an environmental transaction that can be accessed by the individual in social interactions. The underlying assumption is that social support is interpersonal in nature. Facing challenging situations, individuals tend to seek support that is seen as a source of help and comfort. When support is provided, it eases psychological tensions and enhances well-being.

The comparison of predictive values of religiousness and social support showed that dimensions of social support are stronger predictors for mental health outcomes than dimensions of religiousness. Actually received support and need for support were stronger predictors than religious experience or prayer. Examina-

tion of the beta weights revealed that actually received support predicted better mental health outcomes, whereas need for support predicted worse mental health. It enables us to confirm the third hypothesis that assumed this pattern of relations.

This finding is thought-provoking as it puts forward two important suggestions. First, religiousness is strongly embedded in social interactions. Religions exist as an organized and integrated set of beliefs, behaviours, and norms related to the sacred (God, transcendence) and focused on important values and goals. From a functionalist perspective, religion creates many opportunities for social interactions and the formation of groups. It provides social support and social networking, offering a place to encounter other people who hold similar values and social norms. Being a social phenomenon religion can foster group cohesion and integration, as well as generate community divisions and conflicts [34, 35]. Furthermore, religion is a universal cultural phenomenon found in all social groups. It can bring order and organization through shared familiar symbols and patterns of behaviour. Second, the impact of religiousness on mental health occurs on a basis of social support. Religious factors do not operate in vacuum, but are strongly rooted in social situations and conditions. This interpretation is in accordance with views presented by Doug Oman and Carl E. Thoresen who claim that religious involvement fosters larger and stronger social networks and a greater availability of social support, a well-established salutary factor that may protect health in part by fostering effective coping with stressors [16].

Many events that occur around individuals are very difficult to fully understand (e.g. death, illness, natural disasters). Nevertheless, people strive to unfold the causes of these events and place them in their general cognitive structures. By providing answers to some existential questions, religion is an orienting system which reflects a frame of reference of oneself and the world that is used in seeking satisfactory explanations. Religious beliefs can provide support and influence the ways in which people deal with stress, suffering and life problems. It will help individuals to retain mental health even in challenging and stressful circumstances.

There are several limitations that should be mentioned in relation to this study. First, religiousness and social support were measured as general constructs without any specific references to particular events that could affect one's mental health (i.e. illness, traumatic events). Applying these measures to people whose mental health has been disturbed by such negative events would reveal closer associations between religion, social support and mental health outcomes. Second, our study was correlational in nature. Although this procedure has been most popular in recent research the use of longitudinal or experimental research methods could provide more accurate insights regarding causal relations between the examined factors.

In conclusion, despite their limitations the findings are important in the context of studies examining relations between religion, social support and mental health. They support the hypotheses that religiousness and social support are predictive factors for mental health outcomes, though their effects are rather moderate or weak. Both religion and social support can influence mental health by imbuing life with a sense of meaning and significance, offering fellowship in times of stress and suffering, and diminishing the impact of negative emotions. It does not necessarily mean that religion is a universal panaceum for every mental health problem as it can also lead to detrimental effects. The conceptual approach to religion which describes it in the category of a meaning system is particularly promising as it offers deeper insights into the cognitive and motivational processes underlying religious behaviour.

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