

**The Mediating Factors  
in the Relationship Between Religious Involvement and Mental Health  
(Point view)<sup>1</sup>**

By

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Abstract:

The association between religion and mental health has been a controversial topic for researchers. The majority of the studies with a strong experimental and statistical design found that higher religious involvement is positively linked to psychological well-being. However, there are mediating factors that play a role in this association including self-esteem, self-efficacy, meaning in life, social support, fear of death, social support, interpersonal forgiveness, and core self-evaluation. Religious involvement involves a wide range of religious practices and beliefs. Researchers investigated religious involvement through different religious variables such as church attendance, non-organizational religiosity, subjective religiosity, and religious commitment which indicates how religious beliefs influence a person's decisions and lifestyle. The construct of mental health has been examined utilizing the constructs of psychological well-being (an indicator of positive mental health) and depression, anxiety, suicide, and drug abuse (indicators of mental disorder) which are the most frequently and thoroughly studied outcomes with significant findings in the literature.

**Keywords:** Religious involvement, religious participations, religion, mental health, mental disorders, psychological wellbeing, psychological issues, mediating factors

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## Introduction

Religion is a multifaceted phenomenon and “an organized system of beliefs, practices, rituals, and symbols designed to facilitate closeness to the sacred or transcendent (God, higher power, or ultimate truth/reality)” (Moreira *et al.*, 2006, p. 10). It is widely endorsed, accepted and practiced by people all over the world; 69% are church members, and 43% have attended church, synagogue, or temple within the past 7 days” (George *et al.*, 2002, p. 13). In 20th century, the religious aspects of human life were overlooked and denied by mental health professionals and they often considered this aspect as old-fashioned or pathological. However, this view started to change as a result of the large number of studies conducted during the last decades that reflected that religiousness is strongly linked to good mental health and will remain a significant aspect of human life. (Moreira *et al.*, 2006). Currently, religious views and practices are viewed as an important factor contributing to an individual's mental health (Levin, 2010).

The association between religion and mental health has been a controversial topic for researchers (Moreira *et al.*, 2006), and has been an interest for many researchers to investigate which aspects of religious involvement contribute to mental health. There is at least some evidence of religion's effect on mental health among men and women, However, researchers remain far from a consensus regarding which religious factors influence mental health (Ellison *et al.*, 2001). The majority of the studies with good experimental and statistical design found that higher religious involvement is positively linked to psychological well-being (life satisfaction, happiness, higher morale, and positive affect) and associated with less depression, drug/alcohol use, and suicidal thoughts and behavior. (Moreira *et al.*, 2006). However, there are mediating factors that play a role in this association (Ellison *et al.*, 2001), which will be discussed later.

Religious involvement involves a wide range of religious practices and beliefs (Ellison *et al.*, 2001). Researchers investigated religious involvement through different religious variables, and the following are the main variables that researchers use to investigate the level of religious involvement. The most widely used is church attendance which is measured by the frequency of attending religious meetings (Levin, 2010). Three widely utilized additional variables are: (1) The non-organizational religiosity, which reflects time devoted in private religious activities including prayer,

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meditation, and reading religious texts; (2) Subjective religiosity which reflects how important religion is in someone's life; and (3) Religious commitment which indicates how religious beliefs influence person's decisions and lifestyle (Moreira *et al.*, 2006).

Ellison, *et al.* (2001) investigated three religious variables include the frequency of church attendance, the frequency of prayer in general, and belief in eternal life. They found that the first two variables are positively associated with well-being and adversely associated with distress. However, the latent variable, belief in eternal life, is slightly and adversely linked to well-being and positively associated although weakly to distress. A further conclusion of the study was that the influence of these religious variables is not mediated by social stressors or access to social or psychological resources.

You *et al.* (2019) study in a cohort of 470 Korean adults explored the effects of different forms of religious practices which included attendance at services and prayers outside of services on various mental health outcomes (spiritual well-being, meaning in life, life satisfaction, depression, and self-esteem). For You *et al.*'s study age, gender, marital status, education, and perceived poverty, and different aspects of religious practices (organizational and non-organizational religious involvement) were controlled. The researchers examined how religious involvement is linked to various mental health outcomes.

The main purpose was to investigate which religious practices might be beneficial for overall mental health and mental illness prevention, through providing coping mechanisms and support. The researchers examined how religious involvement is linked to various mental health outcomes. Specifically, the results of the study are consistent and supportive of the current literature that focuses on religious involvement and its impact on individual's mental health. As demonstrated in previous studies, the findings showed religious involvement is associated with mental health outcomes and in fact it is a significant predictor across a variety of mental health outcomes. The relationship between attendance at services and the mental health outcomes reflects that attendance at religious services is a psychological means to obtain positive mental health outcomes in Koreans. Engaging in prayer outside of religious services is associated with having overall higher

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levels of spiritual well-being, life satisfaction, and lower levels of depression. This result is supported by a majority of the empirical research concluding that religious practices can be a beneficial source of positive mental health outcomes particularly prayer has been shown to substantially lessen stress and provide psychological comfort (You *et al.*, 2019).

In addition to the religious variable discussed above the, the literature on religious involvement and mental health involves many other outcomes such as personality, psychosis, marital satisfaction and stability, anxiety, delinquency (George *et al.*, 2002). “Mental health is defined by seven criteria gleaned from the previous literature: (a) absence of mental illness, (b) appropriate social behavior, (c) freedom from worry and guilt, (d) personal competence and control, (e) self-acceptance and self-actualization, (f) unification and organization of personality, and (g) open-mindedness and flexibility” (Batson, Schoenrade & Ventis, 1993). However, the construct of mental health has been examined utilizing the constructs of psychological well-being (an indicator of positive mental health) and depression, anxiety, suicide, and drug abuse (indicators of mental disorder) which are the most frequently and thoroughly studied outcomes with significant findings in the literature (Moreira *et al.*, 2006).

**Psychological well-being:** 79% of the studies found a positive correlation between religious involvement and indicators of psychological well-being including life satisfaction, positive affect, happiness, and higher morale (Moreira, 2006). Stressful circumstances are one of the mediating factors that play a role in the correlation between religious involvement and well-being. These studies of well-being demonstrated that the elderly, disabled, and medically ill people show higher religious effects on their well-being, concluding that people under stress are emotionally stronger and higher in terms of the impact of religious involvement on well-being (George, 2002).

Ellison *et al.* (1991) examined the multifaceted relationships between religious involvement and well-being. The results reported in previous studies are indirect and they found that the positive effects of religious attendance and private worship result from the roles of religious attendance and private worship in reinforcing religious belief systems. The positive impact of religious involvement on well-being is direct and

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substantial. Individuals with firm and solid religious faith report higher level of life satisfaction, greater personal happiness, and fewer negative psychosocial consequences of stressful life. Optimism is another mediating factor that studies have found significant. Feeling that one is close to God was related to optimism, and as a result optimism had a high correlation with their self-rated health status (Baetz *et al.*, 2004). Other mediating factors between religious involvement and well-being are "self-esteem, hope, sense of meaning and purpose in life, social support, internal locus of control, being married, and having marital satisfaction" (Levin, 2010).

**Depression:** A recent meta-analysis systematic review by Moreira *et al.* (2006) summarized the results of 147 studies on the relationship between religious participation and depressive symptoms. The authors found that religious participation was associated with lower levels of depressive symptoms, and this association was consistent between different ages, genders, and races (Baetz *et al.*, 2004). However, people with high life stress show greater association between religious involvement and depressive symptoms ( $r = .152$ ) than with individuals with the low stress ( $r = .071$ ). The relationship is stronger for individuals with moderate depression ( $r = .151$ ) than with individuals with lower levels of depression ( $r = .078$ ). Religious practices act as a strong protective effect on individuals who are under social psychological pressure (Levin, 2010). Furthermore, the association between religious involvement and depressive symptoms changes depending on the type of religious involvement being measured. Baetz *et al.* (2004) reported that two indicators of religious involvement: "external religious orientation ( $r = .155$ ) and negative religious coping ( $r = .136$ )" are positively linked to high frequency of depressive symptoms, while internal religious orientation is correlated to low depression level ( $r = .175$ ).

**Anxiety.** Studies found adverse results of the relationship between religion and anxiety. Prior to 2000, 69 observational studies had investigated the relationship between religious involvement and anxiety. 35 studies discovered that religious participation is negatively associated with anxiety. Subjects who have high or low religious involvement have the lowest amount of anxiety (Levin & Chatters, 1998). Religious involvement has benefits for anxious people in that it promotes comfortableness, increases the sense of control, improves safety feelings, and increases self-control (Vilchinsky & Kravetz, 2005). 10 other studies reported a positive association, and the highest anxiety was found among participants who have

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moderate religious involvement. Feeling scared, nervous, and out of control promote people to engage more in religious activities. The other studies did not find an association (Levin & Chatters, 1998).

Based on the findings, researchers drew the conclusion that the degree of religious involvement is important in decreasing anxiety, not the type of activity. Researchers also found that anxiety may exacerbate as a result of negative forms of religious conflict. For example, the results of the study of female participants with gynecological cancer showed that women who perceived their illness as a punishment from God had higher anxiety (Levin & Chatters, 1998).

**Drug Abuse:** 80% of studies before 2000 examined religious involvement and alcohol/drug abuse and found a negative correlation between these two variables. The higher one's religious participation, the lower the alcohol and drug abuse ratio (Moreira, 2006). A recent well-conducted study (George *et al.*, 2002) of 2,616 adult twin samples from the United States investigated the relationship between various aspects of religious involvement and the prevalence of substance abuse and mental illness. The findings concluded that almost all aspects of religion are associated with lower use of Nicotine, alcohol and drugs (George *et al.*, 2002).

**Suicide:** unfortunately, the influence of religious involvement on suicidality has not received enough attention in the literature as compared to psychological well-being, depression, and drug abuse. Although most religions are strongly opposed to suicide, most research on suicide does not adequately consider religious factors (Ventis, 1995). In one review, 84% of 68 studies identified through 2000 found that subjects with more religious involvement had lower suicide rates or greater opposition to suicide (Koenig, 2009). In addition to being associated with a lower suicide rate, Moreira *et al.* (2006) reported in their review that religious participation is related to fewer suicide attempts and negative attitudes towards suicide. Moreover, individuals who use religious beliefs and involvement as a source of support and comfort manifest less suicidal ideation.

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As mentioned above, the relationship between religion involvement and mental health is not always a linear relationship. There is a complex linkage between religion, stressors, resources, and mental health (Behere *et al.*, 2013), and there are some mediating factors that researchers investigated that are associated which included self-esteem and self-efficacy, core self-evaluation, interpersonal forgiveness, meaning in life, social support, and fear of death.

Prior to discussing the mediating factors, there are several theoretical explanations of the relationship between religious involvement and mental health outcomes that researchers proposed. First, Religious involvement impact people's behaviors and their choices in life which thereby affect mental health. Several reasons explain why religious involvement impact people's behaviors which include understanding the religious norms and moral messages, the panic of hellfire, the fear of social sanctions from coreligionists, the desire for approval within religious communities, and the lack of involvement with deviant and immoral activities (Levin, 2010). Studies have shown that religious participation is associated with avoidance of negative health behaviors (e.g. risky sexual actions and substance use).

Religious involvement fosters health-related behavior and promotes moderation in all people's actions. As a result, all forms of risk-taking behavior decrease (e.g., gambling, carousing, irregular sleep patterns, smoking, alcohol consumption, drug use, poor diet, and physical health risks in general.) Health-related behavior is critical to positive mental health as it decreases the possibility of disease and enhances mental and physical health. Additionally, religious involvement is linked with lower rates of marital disharmony and divorce. The overall conclusion is that engaging in healthy behaviors and the avoidance of the negative ones lead to better mental health (Koenig, 2009).

One prominent hypothesis is that religious involvement leads to positive mental health outcomes because religious individuals have "high self-esteem, which is a sense of intrinsic moral self-worth, and feelings of mastery, which is the perceived ability to control one's environment and affairs" (Ellison *et al.*, 2001, p. 8). In comparison to other individuals, personal mastery and self-esteem have positive association with religious involvement in the studies. Ellison (1993) found that religious groups

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enhance the self-esteem of their members, by virtue of embracing appraisals through fellowship and positive feedback. Additionally, religious gatherings teach that a Creator dominates the entire universe and facilitates opportunities for people to develop self-confidence and leadership skills, which again promotes feelings of mastery.

Through religious practices, individuals create personal relationships with their god. Through these ongoing divine relations, individuals receive daily guidance and reassurance. Some observers suggest particular beliefs and principals such as the belief in eternal life may give a sense of the world's coherence, predictability, and meaningfulness, which positivity impact mental health and lead to feelings of hopefulness, optimism, and peace and the release of negative emotion (Levin, 2010).

There are several mediators that were investigated in the literature, two of which are self-esteem and self-efficacy. Studies found positive associations between religious participation and self-esteem and self-efficacy. It was assumed that religious involvement positivity impacts mental health by increasing self-esteem and self-efficacy. These positive self-perceptions influence one's beliefs, behaviors and health attitudes, which consequently, influence mental health and psychological wellbeing (Holt *et al.*, 2014). Multiple ideas were mentioned to answer why religious involvement leads to positive self-perceptions. First, through religious practices and a relationship with a higher power, individuals strengthen their self-perceptions (Vilchinsky & Kravetz, 2005). By having such a relationship, individuals may experience unconditional love and a sense of divine guidance. Involvement in a religious community and organizations can provide social support that may enhance and support positive self-perceptions, and/or confirm their values and lifestyle (Holt *et al.*, 2014).

A review by George and colleagues (2002) indicated that religious involvement provides psychological resources which are the promising mechanisms of self-efficacy and self-esteem. However, upon their review, they concluded that there was no clear evidence and an additional research was necessary. Few studies investigate how self-esteem and self-efficacy mediate the relationship between religious involvement and mental health. The results do indicate that there is a positive association (Holt *et al.*, 2014). In one specific study of African-Americans, it is proposed that religious



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involvement enhances self-esteem through social support and that colleagues' members' or congregation provide positive feedback for how individuals believe others in their community of faith view them. Worship activities were also assumed to build empowerment and self-esteem (Ellison, 1991).

The findings show that high religious beliefs are associated with both high self-efficacy and high self-esteem. However, the association was not found with religious behaviors (participation in services and activities). Self-esteem and self-efficacy appear to be positively associated with having a personal connection with a higher power. To date the unsubstantiated proposed hypothesis is that individuals can increase their self-esteem through worship and church activities. In fact, neither self-efficacy nor self-esteem mediate the link between religious behaviors and mental health. (Ellison, 1991).

Moreover, research examined other several mediators including meaning in life, social support and fear of death. Hood *et al.* (1996) reviewed numerous studies that investigated fear of death as a mediator of the relation between psychosocial well-being and religious behaviors. It was assumed that religious involvement should reduce the fear of death and, thus, increase psychosocial well-being. The second moderator researches examined is the human need for meaning and growth. Moreira's (2006) assumption is that people engage in religious activities experiences because they produce growth and meaning in life. Researchers assumed that religion adds meaning in life which thereby positively influence psychosocial well-being. Several empirical investigations conclude that various dimensions of religious involvement are positively linked to meaning in life (Behere *et al.*, 2013).

Social support is another mediator of the relation between religious involvement and mental health that previous studies investigated. Sociologists and social psychologists attribute the link between religion and mental health to the social benefits that religious institutions and conduct provide, and the social resources provided within religious communities, which to some extent lead to positive effects on mental health (Levin, 2010). Several studies have found that congregations as sources of social integration and social support is what lead to the health benefits. However, the mediating effects of social resources have rarely been tested directly and few

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studies have invested in exploring the relationship between religious involvement and these aspects of social support (George *et al.*, 2001).

Ventis (1995) explained that religious congregations facilitate gathering on a regular basis where individuals with similar core beliefs, values, interests, and activities can meet. These gatherings provide opportunities for individuals to be involved in meaningful social relationships and in the establishment of supportive networks that provides support. In addition, congregation members help each other and in addition to emotional support provide tangible aid. Many religious groups provide programs to their members in need such as the poor and the elderly (Ellison *et al.*, 2001). Religious involvement and the church community are a source of company, social support, and friendship with individuals of similar values and goals. Therefore, social support is considered important for mental health because it helps reduce the damaging effects of stress, provides coping resources, and prevents illness and death, considering loneliness is a major complaint among mental health clients (George *et al.*, 2002).

Vilchinsky *et al.* (2005) investigated three moderators on a sample of Jewish participants. The findings show that the correlation between religious conduct to meaning in life and from meaning in life to psychological well-being were statistically significant and explained the most variance. Therefore, meaning in life appears to mediate the positive relationship between religious conduct and psychological well-being and the negative relationship between religious belief and psychological distress. However, the results indicated no relationship between religiousness and social support or fear of death as opposed to the general body of literature and researchers therefore assumed that is limited to Christians. Another mediating factor that the literature examined is interpersonal forgiveness which is “an “individual’s giving up his right of resentment and revenge for the benefit of the transgressor, approaching the transgressor with compassion, benevolence, and love” (Abu-Raiya *et al.*, 2019, p. 10). Abu-Raiya *et al.* used a large multinational sample of Muslims to examine interpersonal forgiveness as a mediating factor between religious involvement and mental health. They suggested that interpersonal forgiveness, which is reinforced by religious involvement and reinforces mental health, explains the link between religious involvement and mental health. They examined the links between religious beliefs, religious practice, life satisfaction, and generalized anxiety, and whether interpersonal

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forgiveness mediates these links. The findings show that the relationship between religious practices and life satisfaction was partially mediated by factors of interpersonal forgiveness such as hopefulness and avoidance (Abu-Raiya *et al.*, 2019).

Core self-evaluation (CSE) is another mediator that was ascertained to mediate the relationship between religious involvement and mental health. Core self-evaluation is a specific concept that reflects People's assessments about themselves, others, and the world in general. (Tsaousis *et al.*, 2013). Tsaousis examined the relationship between the three aspects of religious involvement which includes religious assistance, private activity, and intrinsic religiosity and psychological well-being through the core self-evaluation. The findings suggest that frequent attendance of religious services increases people's levels of CSE, which promotes positive psychological well-being and that is applicable to the elderly group only. Vilchinsky & Kravetz (2005) explained that it seems that religious involvement through faith and spirituality promotes emotional stability and makes religious individuals feel safer and confident that they can control life circumstances that may affect them (high levels of CSE) more than Individuals who are less religious.

## Results and recommendations

One of the main issues in the study of religious involvement is pertaining its measurement. Religiousness is a complex construct, the best way to measure it has not been agreed upon yet. There is a considerable persistent dispute related to the various fundamental theories that guide the different approaches that measure religious across the fields of psychology, sociology, theology, and medicine (Levin, 2010). As a result, there are several tools for measuring religious involvement that vary in quality. For example, some tools only involve one question, others only measure one aspect of religiousness, while some others are limited to only Western traditions especially Christianity (Koenig, 2009).

There are three key issues that remain far from a research consensus. First, researchers have not agreed on the aspects of religiosity that are most influential for mental health. Research has demonstrated the multidimensionality of religiosity, yet researchers continue to measure religiousness via a single item that focus on religious behaviors (e.g.,

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attendance at services and prayer). Moreover, few empirical studies have explored specific theological beliefs such as belief in divine grace and salvation, sin and judgment although theorists hypothesized that they have significant influence on mental health (Ellison *et al.*, 2001). The second disagreement pertaining to which mental health outcomes are most likely to be affected by these different aspects of religious participation. The most significant evidence of beneficial religious influence relates to well-being, for example, life satisfaction, happiness, and morality. However, the thrust of the research reporting the positive effects of religious participation on suffering and depression is unclear (Ventis, 1995).

The third main area of contention is related to specific mechanisms and models that can explain the observed effects of religion on mental health. Researchers have been slowly linking this emerging religious study with the life stress paradigm. The life stress paradigm has led most of the current work on the social model of mental health. The current foci of the life stress paradigm are: Identifying the consequences of stressful life circumstances on mental health outcomes, clarifying the role of social and psychological resources in mediating and/or moderating these associations, demonstrating how social structures and institutions facilitate exposure and vulnerability to stressors, and access to resources that can reduce their negative results are the issues that research conducted within this tradition. The life stress tradition proposes several direct, mediator, suppressor, and moderator models describing the impact of religious participation on mental health. However, to date, these links have not been systematically investigated. Moreira *et al.*, 2006).

Upon reviewing the literature, there are some critical issues that should be highlighted. Longitudinal research designs and better measures of religious involvement and commitment are needed. Moreover, religion is a very complex variable that involves different dimensions and various domains besides religious activities such as religious coping, private activity, beliefs, values, and experiences, which have not yet been in the literature (Levin, 2010). As proven, these dimensions are directly related to the quality of mental health when examined cross-sectionally in the population. However, determining which aspects of religious involvement may be associated with mental health outcome such as depression and which aspects of depression may be associated with religion would be instructive for future research (Moreira *et al.*, 2006).

In addition, further examination of heterogeneous samples can uncover other variables that can mediate the process of religious involvement in mental health. Such investigation can easily study mediators and other potential confounding factors such as educational background and age (Ventis, 1995). Future research should invest more on the specific “pathways” through which religious involvement is related to mental health outcomes. Moreover, it should examine "the underlying mechanisms" which religious involvement impacts human life. (Levin & Chatters, 1998).

The literature lacks cross-cultural studies and the application of the results to clinical practice globally. The investigation in these two areas need to be expanded and further investigated. Abu-Raiya (2019) addresses this important shortcoming of the literature. He reported that the majority of research on the link between religion and mental health and well-being has been done on Christian populations and mostly in the United States and other traditional faiths have been neglected.

Clinical implications. Although the importance of the relationship between religion and mental health is emphasized in theory, religious aspect is excluded and overlooked in clinical practice because psychiatrists and mental health professionals are uncomfortable addressing religious aspects. However, a large number of researchers do address this issue in the literature (Koenig, 2009). The extent in which religion should be integrated into the training and practice of psychological therapy is still a concern and not agreed upon by professional training models. Therefore, the integration of religious dimensions in clinical practice requires adequate training, because there is no doubt that patients have spiritual needs that should and must be highlighted and addressed. In addition, it is necessary that professional have a thorough understanding of the cultural and religious environment in which they work (Levin, 2010).

Furthermore, it is important that during the therapeutic process the practitioner assesses and determines if religion is important in their patient’s life, specifically does religion “has a special meaning, it is active or inactive, involving values consistent with their main tradition, useful or harmful, and it promotes autonomy, personal growth, good self-image, and interpersonal

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relationships” (Behere *et al.*, 2013, p 16). Additionally, clinicians should be informed about the patient's religious beliefs because they can influence healthcare decisions, be crucial in understanding how religion plays a role in coping with stress and diseases, and defining clients' religious needs that require assistance. Therefore, a brief religious history is necessary and should be incorporated in any assessment process (Levin & Chatters, 1998).

There are four basic aspects to consider when assessing a spiritual history: Is religion used as a resource to overcome stress and illness, or “is it a source of stress, and how?” Is the patient involved in spiritual communities? Does the patient have disturbing religious questions? Is there any religious beliefs that may impact medical care?” (Moreira *et al.*, 2006, p. 20). Religion is one of the psychosocial dimensions. Therefore, professionals need to consider the biological psychosocial aspects of the patient for a comprehensive evaluation. It is imperative that the professional understand and respect the client’s religious beliefs, as they would any other psychosocial dimension. Increasing our understanding and knowledge of human religion is essential to enhancing professional skills and meeting are multicultural responsibilities as mental health providers to alleviate suffering and help people live more fulfilling lives (Ventis, 1995).

Another practical implication is that for treatment planning and intervention it is efficacious for maximum positive benefits to identify and consider the client’s individual religious beliefs and practices. The effects of a client’s assumptive religious beliefs and practices corresponding commitment are highly relevant to the assessment and treatment of anxious and depressive symptomatology (Levin & Chatters, 1998). Henery reviewed studies that examined the effects of religious interventions on participants with anxiety. The findings show that religious interventions decreased anxiety levels more quickly in religious patients than with traditional psychological interventions or control subjects. Research on Eastern spiritual techniques, such as mindfulness and meditation found similar effects. At the same time, multiple replication is necessary before adopting this approach (as cited in Koenig, 2009). Ellison (1991) suggested that formal training in religious aspects will definitely help psychotherapists in that they will be more effective in helping religious clients.

A large number of people seek refuge in religion hoping to find

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comfort, cure, hope, and purpose, and often these individuals profit from their religious beliefs, practices and convictions. Healthy religious beliefs and activities can be a positive therapeutic factor and lead to stabilizing influences and help in the reduction of the "isolation, fear, and loss of control"(Koenig, 2009, p. 16). Conversely, Levin pointed out that "religious beliefs and doctrines may reinforce neurotic tendencies, enhance fears or guilt, and restrict life rather than" improve it, especially in individuals with high emotional vulnerability. Therefore, some people might use religion in "primitive and defensive ways" to avert the responsibility of "making necessary life changes" (Levin, 2010, p. 9).

Individuals with strong religious beliefs, who are suffering from psychological disorders, emotional issues, or are attempting to cope with difficult situations often seek therapeutic counsel. Since all therapists will encounter clients for whom religion is important, it is important that the therapist realize that for these clients, therapeutic effectiveness and outcome can be enhanced by understanding and incorporating a religious perspective within their treatment model. Thus, clinicians need to appreciate the value of their client's religious beliefs and practices "as a resource for healthy mental and social functioning" and must be aware when those beliefs and practices can also be "distorted, limiting", and lead to the creation more problems rather than solve them. (Levin & Chatters, 1998, p. 11).

### Conclusion

religious involvement is an important factor that contributes to mental health and is a recourse that enables people to cope with stressful life circumstances. It has been a controversial topic as researchers have not come into an agreement regarding several aspects involve this topic. The relationship between religions involvement and mental health is not a linear relationship as studies have shown. The complexity of the relationship pertains the large number of mediators that influence the direction of the associations. The significance of religions aspects on mental health outcomes provides several critical implications for clinical practices that can improve therapists' work and treatment outcomes. Future studies should be invested in studying the mediating role of other variables that have not been investigated in the previous studies.

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## العوامل الوسيطة في العلاقة بين المشاركة الدينية والصحة النفسية

أ / أفنان حميد الحربي

باحثة دكتوراه - أخصائي نفسي كلينيكي - برنامج المدن الطبية - وزارة الخارجية

بالمملكة العربية السعودية

### ملخص

لطالما كان موضوع العلاقة بين الدين والصحة النفسية مثيراً للجدل للباحثين. وجدت غالبية الدراسات ذات التصميم التجريبي والإحصائي القوي أن المشاركة الدينية العالية ترتبط بشكل إيجابي بالرفاهية والصحة النفسية. لكن هناك عوامل وسيطة تلعب دوراً في هذا الارتباط، بما في ذلك تقدير الذات، الكفاءة الذاتية، معنى الحياة، الدعم الاجتماعي، الخوف من الموت، التسامح، والتقييم الذاتي. تشمل المشاركة الدينية نطاقاً واسعاً من الممارسات والمعتقدات الدينية. قام الباحثون بدراسة المشاركة الدينية من خلال متغيرات دينية مختلفة مثل حضور المساجد و الكنائس، والتدين غير التنظيمي، والتدين الذاتي، والإلتزام الديني والذي يشير إلى كيفية تأثير المعتقدات الدينية على قرارات الشخص وأسلوب حياته. تم دراسة الصحة النفسية في البحوث من خلال قياس الرفاهية النفسية (وهو مؤشر على الصحة العقلية الإيجابية). ويعد الإكتئاب والقلق والإنتحار وتعاطي المخدرات (من مؤشرات الاضطراب العقلي) والتي تعد من أقوى وأكثر المتغيرات التي تم دراستها في البحوث السابقة.