Religiosity and Psychological Well-Being

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Abstract

The aim of the current study was to explore the link between religiosity and psychological well-being in a model of Pakistani Muslims. Earlier research has acknowledged a positive relationship between the two factors. The sample (65 men and 85 women) with an age range from 18 to 60 years was chosen. Religiosity was operationalized as religious gatherings attendance, belief salience and frequency of prayer. Anxiety, loneliness and life fulfillment were chosen as dependent variables because they are important facets of psychological well-being. Reliable with previous research, correlation statistics suggested that a strong, negative relationship does indeed exist between religiosity and loneliness (r = -0.852) and between religiosity and anxiety (r = -0.511). A strong positive relationship was also found between religiosity and life satisfaction (r = 0.76) Thus, the results of this study supported the hypothesized relationship between religiosity and different facets of psychological well-being.

Keywords: Religiosity; Belief salience; Religious gatherings attendance; Life satisfaction; Psychological well-being.

Introduction

In today's fast paced world of rising political, economic, and social instability, one may find it increasingly difficult to ward off feelings of anxiety, depression or loneliness (Reinberg, 2010; Weaver, 2010). A nagging sentiment of dissatisfaction with life in general may debilitate many a mind. In such cases, individuals may turn to a variety of facets for not only therapeutic purposes but also for prevention from such ill feelings in the future. For many, this sanctuary is found primarily beneath the wings of religion.

In terms of religion a variety of different elements may be protecting scores of individuals from psychologically draining effects. Some may find their hearts at rest when bowed down in prostration to their Lord. Others, may find comfort within religious sermons where different religious books are read and recited. Still others, may find their souls at peace when they submit entirely to their Creator, with an unshakeable belief that he has full control over all that is happening in their lives.

However, there remains the possibility that such a link need not exist. It is not necessary that religion is what keeps people grounded. Many individuals may attribute their psychological health to factors that are not directly linked to religion such as hiking, reading, stitching, photography and the like (Johansson, 2008) This research therefore, focuses its attention primarily on the relationship between religiosity and psychological well being and thus attempts to unearth the true connection between the two.

Literature Review

Psychological well-being refers to positive mental health (Edwards, 2005). Research has shown that psychological well-being is a diverse multidimensional concept (MacLeod & Moore, 2000; Ryff, 1989; Wissing & Van Eeden, 2002) which develops through a combination of emotional regulation, personality characteristics; identity and life experience (Helson & Srivastava, 2001). Psychological well-being can increase with age, education, extraversion, and consciousness and decreases with neuroticism (Keyes et al., 2002).

Previous researches pertaining to the subject area of religiosity and psychological well-being, eloquently speak volumes of, and provide sound evidence to support the positive association between religiosity and psychological well being. A wide range of different researches have been carried out in this context '(Dyson, Cobb & Foreman, 1997; George, Ellison, & Larson, 2002; George, Larson, Koenig, & McCullough, 2000; Mickley, Carson, & Soecken, 1995)'. The consistent findings have been that aspects of religious involvement are associated with positive mental health outcomes (Ellison & Levin, 1998; Swinton, 2001). Evidence supporting these findings emerge from both cross sectional and longitudinal studies, as well as from studies based on both clinical and community samples (George et al., 2002; Plante & Sherman, 2001).

This relationship has extended across different populations, including samples of the young, adults, older people, general community residents, immigrants and refugees, college students, the sick, addicts, homosexuals, persons of parenthood, individuals with mental health problems and personality disorders (Yeung Wai-keung & Chan, 2007; Alvarado, et al., 1995; Baline & Croker, 1995; Braam et al., 2004; Chang et al., 1998, Donahue & Benson, 1995; Idler & Kasl, 1997; Jahangir et al., 1998; Kendler et al., 1996; Koenig, George & Titus, 2004; Levin & Taylor, 1998; Miller et al., 1997; Plante et al., 2001; Richards et al., 1997; Thearle et al., 1995).

Further findings reveal that individuals involved in religions that encourage the internalization of a set of values are at substantially reduced risk of depression as compared to those who attend religious gatherings through obligation or duty (Margetic, 2005; McCullough & Larson, 1999). Therefore; the intention behind the attendance of religious congregations may be considered as more important here than the act itself. Often we find that individuals are forced to behave more religiously than they would choose to. In such circumstances then, the true effect of religiosity on psychological well being becomes quite hazy to understand as it is the feelings and thoughts that go behind every religious act which are expected to be linked to psychological health (or the lack of it).

Not all studies, however, have proved a positive association between religiosity and mental health outcomes. Sigmund Freud has termed religion as 'the universal obsessional neurosis of humanity' (Freud, 1959) while others too have argued that 'no correlation between religion and mental health' exists (Bergin, 1991). Other researches state that higher levels of religiosity are related to greater levels of personal distress (King & Shafer, 1992) and that religious beliefs are responsible for the development of low self esteem, depression, and even schizophrenia (Watters, 1992).

Despite such claims, a growing mass of psychological, psychiatric, medical, public health, sociological and epidemiological studies conducted during the past two decades have continued to prove the beneficial and protective effects of religious involvement (Foskett, Roberts, Mathews, Macmin, Cracknell, & Nicholls, 2004; Seybold & Hill, 2001; Weaver, Flannelly, Garbarino, Figley, & Flannelly, 2003). Furthermore, positive relations have been found specifically between some styles of religion and general well being, marital satisfaction and general psychological functioning (Gartner, 1996).

The means through which religiosity provides positive mental health outcomes have not yet been satisfactorily uncovered, however, 'factors relevant include: (1) increased social support, (2) extended psychological recourses, (3) positive health practices, and (4) a stronger sense of coherence' (George et al., 2002; Harrison et al., 2005).

Research Problem

The purpose of this study was to find the true relationship between religiosity and psychological well-being in a Pakistani Muslim society. The fact that Islam plays a major role in shaping Muslims' understanding, experience and expression during times of mental distress is well documented (Abdel-Khalek, 2007; Abu-Ras, Gheith, & Cournos, 2008; Tawfik, 2007). The holy book of the Muslims, the Quran, holds evidence to this concept in many verses. One such verse is 'for, without doubt, in the remembrance of Allah do hearts find rest' (13:28).

As of late, one may find that a multitude of researches in this subject matter have been accepted the predominantly on Western models (Pössel, Martin, Garber, Banister, Pickering, & Hautzinger, 2010; Rosmarin, David, Pirutinsky, Steven, Pargament, Kenneth, Krumrei, & Elizabeth, 2009; McCullough, 1999; Murphy, Patricia, Ciarrocchi, Joseph, Piedmont, Ralph, Cheston, Sharon, Peyrot, Mark, Fitchett & George, 2000). However, as the level of global interconnectedness continues to increase, the importance of considering samples belonging to different cultures and societies is rising rapidly.

The importance of the study thus, was to extend this topic area to Muslim, Pakistani samples and find the relationship that exists between religiosity and psychological well-being in a different culture and society in the world.

Research Hypotheses

Based on the conclusions of previous studies, it was hypothesized that (Pakistani Muslim) participants who are more religious will reveal a greater level of satisfaction with their life and would be less psychologically distressed. Therefore;

H1: The higher the level of religiosity, the lower the level of loneliness. H2: The higher the level of religiosity, the lower the level of anxiety.
H3: The higher the level of religiosity, the higher the level of life satisfaction.

Religiosity was operationalized as involvement in religious activities (religious sermons within and outside mosques), belief salience and frequency of prayer. Outcome measures included satisfaction with life, and the absence of psychological distress (anxiety, loneliness).

Methodology

This study is mainly based on a questionnaire survey. It consists of different scales that were made specifically for each variable under study. The format of the questionnaire consists only of closed ended questions so as to promote quick responses and ease of participation. 150 individuals participated in the research (65 males and 85 females) whose ages ranged from 18 to 60 years. The respondents were all either students or teachers at educational institutions.

Religiosity was measured through three variables: participation in religious services, frequency of prayer and belief salience. (1) Frequency of religious services attendance was measured through the question: 'How often do you attend religious services?'' Responses ranged from 1 (*never*) to 5 (*more than once a week*). (2) Frequency of prayer was judged through the question, 'How many obligatory prayers do you perform in a day?' Responses varied from 0 (*none*) to 5 (the maximum). Finally, (3) belief salience was measured with the question, ''In general, how important is religion to you?' Response options to this question ranged from 1 (*not at all important*) to 5 (*very important*).

Psychological well-being was measured through the Satisfaction with Life Scale. (SWLS; Diener, Emmons, Larsen, & Griffin, 1985) General life satisfaction, anxiety, and loneliness were selected as dependent variables as they reflect central elements of psychological well being. The SWLS measures general subjective well being, with five items rated on a 7-point scale (1 = *strongly disagree*, 7 = *strongly agree*). Summing these items provides a total score. The SWLS's validity is well documented (Diener et al., 1985). Diener et al. accounted high SWLS reliability ($\alpha = .87$).

The Beck Anxiety Inventory (BAI; Beck & Steer, 1993) is a 21-item scale that measures the level of self reported anxiety in adults and adolescents. Respondents were asked to specify normally how much they have been affected by each symptom. The BAI total score is the sum of the ratings of 21 anxiety symptoms, which are rated on a 4-point scale ranging from 0 (*not at all*) to 3 (*severely*), with high values indicating high levels of anxiety. The alpha coefficient used in this study was $\alpha = .87$.

The Revised UCLA Loneliness Scale (R-ULS; Russell, Peplau, & Cutrona, 1980) conceptualizes loneliness as a one-dimensional affective state. The scale consist of 20 items using a 4-point Likert scale (*never, rarely, sometimes,* and *often*), with a high score signifying greater levels of loneliness. Participants were requested to state how they usually feel. Russell et al. report that the scale has high internal consistency in college student populations ($\alpha = .94$) and correlates highly with measures of depression and anxiety. The alpha coefficient used in this study was $\alpha = .89$.

Testing the study hypotheses

The relationship between religiosity and anxiety, loneliness, and general life satisfaction was examined through correlation statistics. Through this measure, it was found that a strong relationship between several variables existed.

H1: Religiosity & Loneliness

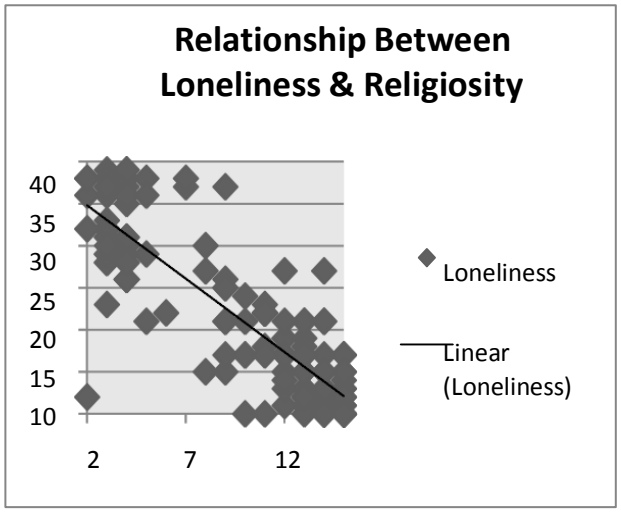
The relationship between religiosity and levels of loneliness is indeed very strong and a negative correlation exists (r = -0.853). Table 1A below indicates the correlation between loneliness and the individual variables that were used to measure religiosity. Thus belief salience is negatively correlated to loneliness (r = -0.813), as are the variables of frequency of prayer (r = -0.723) and religious gatherings' attendance (r = -0.862).

Table 1A

	Belief Salience	***Frequency of Prayer***	***Religious Gatherings' Attendance***	***Religiosity***
Loneliness	-0.81373018	-0.723461453	-0.862330832	0.852753065

Graph 1A presents this relationship in an illustrative form through which the negative relationship can easily be assessed. It appears that as levels of religiosity increase, the amount of loneliness felt by an individual decreases. Thus, proving the hypothesis that the higher the levels of religiosity, the lower will be the levels of loneliness felt.

Graph 1A



Many reasons may be attributed to this relationship those who attend more religious gatherings (sermons and the like) are less likely to feel secluded and left alone. This may be because religious gatherings are a meeting place where all personal differences, big and small, are set aside and a common subject is found. This commonality may be enough to make some individuals feel as though they are not alien figures and that they have similarities with those around them. Also, many may take such gatherings as social meetings where they catch up with friends who share similar interests (i.e. religion) Also, individuals who are more interested in the existence of God and are more convinced that he truly controls the happenings of their lives (assessed through the negative correlation between loneliness and belief salience, r = -0.813), appear to feel less lonely when compared to those who give less importance to the idea of religion. It seems then, that those who have an external locus of control (pointed towards religion) are less likely to feel alone.

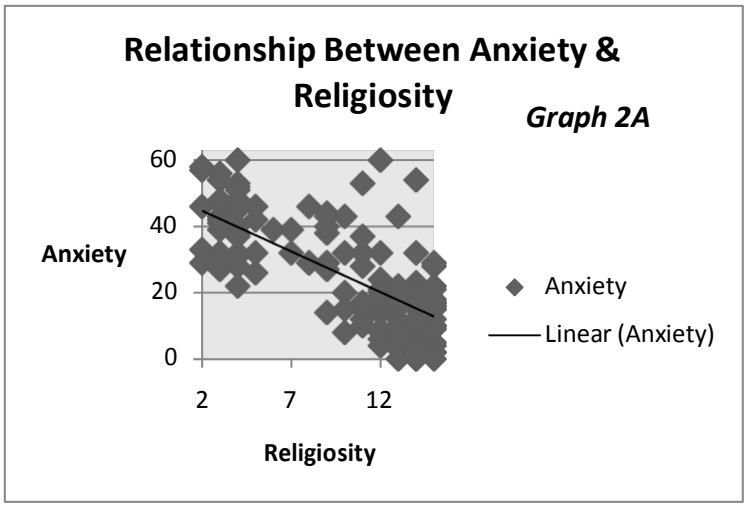
H2: Religiosity and Anxiety

Religiosity and anxiety also appeared to have a strong, negative relationship (r = -0.511). Table 2A indicates the correlation between anxiety and the individual variables that were used to measure religiosity. Thus belief salience is negatively correlated to anxiety (r = -0.516), as are the variables of frequency of prayer (r = -0.495) and religious gatherings' attendance (r = -0.418).

Table 2A

	Belief Salience	***Frequency of Prayer***	***Religious Gatherings' Attendance***	***Religiosity***
Anxiety	-0.516955954	-0.495079157	-0.418195436	- 0.511148034

Graph 2A presents this relationship in an illustrative form through which the negative relationship can easily be assessed. It appears that as levels of religiosity increase, the amount of anxiety felt by an individual also decreases. Thus, proving the hypothesis that the higher the levels of religiosity, the lower will be the levels of anxiety.



The strong negative relationship between levels of anxiety and religiosity can be attributed to many factors, the most significant being prayer. Prayers are often viewed as a better form of meditation itself, and meditation has been applauded for its calming effects. Previous research findings also indicate that "prayer/meditation can reduce stress reactions regardless of the prayer used (Maltby, Lewis, & Day, 1999; Wachholtz & Pargament, 2005) The stressor response model by Ellison and Levin (1998) assumes that stressors (e.g., chronic pain) prompt individuals to increase the frequency of prayer and so anxiety might mean that anxious people pray more often using prayer as a stress buffer". Thus, one cannot be sure whether it is prayer that calms an individual, or anxiety that leads one to praying. Such a causal relationship can not be detected within the breadth of this research.

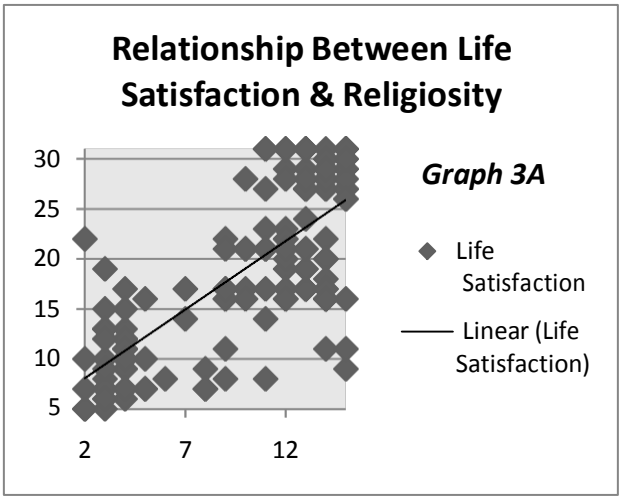
H3: Religiosity and Life Satisfaction

Finally, it was also found that a strong positive relationship exists between religiosity and life satisfaction (r = 0.76) Table 3A indicates the correlation between life satisfaction and the individual variables that were used to measure religiosity. Thus belief salience is positively correlated to life satisfaction (r = 0.705), as are the variables of frequency of prayer (r = 0.791) and religious gatherings' attendance (r = 0.619).

Table 3A

	Belief Salience	***Frequency of Prayer***	***Religious Gatherings' Attendance***	***Religiosity***
Life Satisfaction	0.705415467	0.791286471	0.61931842	0.760581167

Graph 3A may be used to view the relationship between religiosity and life satisfaction as it presents an easy to read, pictorial representation.



The strong, positive relationship between religiosity and life satisfaction may exist perhaps because individuals may feel more at peace with worldly occurrences when they attribute them to the will of God. This line of thought makes it easier be more grateful for what one has and more appreciative of his/her blessings – automatically resulting in fewer number of regrets in life and a lower level of resentment.

Thus, insufficient data was found to disprove the hypotheses.

Conclusions and Recommendations

It appears as hypothesized; a strong, positive relationship does indeed appear to exist between religiosity and life satisfaction while a strong, negative relationship exists between religiosity and psychological distress (anxiety and loneliness).

In conclusion, these findings add to a growing body of research which indicate 'the importance that religiosity has on psychological well being' (Beit-Hallahmi & Argyle, 1997; Diener, Suh, Lucas & Smith, 1999; Ellison, 1995; Emmons, Cheung & Tehrani, 1998; Koenig, 1997, 2001; Laurencelle, Abell & Schwartz, 2002; Levin & Chatters, 1998) such as 'to a reduced likelihood of depression' (Harker, 2001; Levin, Markides, & Ray, 1996; Miller & Gur, 2002) 'anxiety disorders' (Koenig, Ford, George, Blazer, & Meador, 1993) and 'addictions' (Francis, 1994; Gorsuch, 1993). The frequency of private religious activity involvement has also shown a positive association with mental health outcomes (Hel, Hays, Flint, Koenig, & Blazer, 2000; Strawbridge, Shema, Cohen, & Kaplan, 2001).

Limitations and Further Research

However, because this research is based entirely on correlation statistics, it is not possible to describe causal connections between the variables; in order to make such inferences, a prospective longitudinal design may be necessary.

Secondly, as limited aspects of religiosity were studied, an individual's true level of religiosity may have been misrepresented.

Furthermore, the sample of the study was restricted to educated students and teachers. It is important to note that in order to be more representative of the overall Pakistani Muslim population, less privileged participants should also be included.

References

Abdel-Khalek, A. (2007) Religiosity, happiness, health, and psychopathology in a probability sample of Muslim adolescents. In Mental Health, Religion & Culture 10(6). 571-583. (04029)

Abu-Ras, W., Gheith, A. and Cournos, F. (2008) The Imam's role in mental health promotion: A study of 22 mosques in New York City's Muslim community. In Journal of Muslim Mental Health 3(2). 155-176. (04590)

Alvarado, K., Temper, D. Bresler, C. & Dobson, D. (1995). The relationship of religious variables to death depression and death anxiety. Journal of Clinical Psychology, 51, 202-204.

Beck, A. T., & Steer, R. A. (1993). Beck Anxiety Inventory Manual. San Antonio, CA: The Psychological Corporation.

Beit-Hallahmi, B., & Argyle, M. (1997). The psychology of religious behaviour, belief and experience. London: Routledge.

Bergin, A. E. (1991). Values and religious issues in psychotherapy and mental health. American Psychologist, 46, 394–403.

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

Chang, B. Noonan, A. & Tennstedt, S. (1998). The role of religion/spirituality in coping with caregiving for disabled persons. Gerontologist, 38, 463-470. de St Aubin, E. (1999). Personal ideology: The intersection of personality and religious beliefs. Journal of Personality, 67, 1105–1139.

Donahue, M. J. & Benson, P. L. (1995). Religion and the well-being of adolescents. Journal of Social Issues, 51, 145-160.

Diener, E., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The Satisfaction with Life Scale. Journal of Personality Assessment, 49, 71–75.

Diener, E., Suh, E. M., Lucas, R. E., & Smith, H. L. (1999). Subjective well-being: Three decades of progress. Psychological Bulletin, 125, 276–302.

Dyson, J., Cobb, M., & Foreman, D. (1997). The meaning of spirituality: A literature review. Journal of Advanced Nursing, 26, 1183–1188.

Edwards, S.D.(2005). A psychology of breathing methods. Internation Journal of Mental Health Promotion, 7 (4), 28-34.

Ellison, C. G. (1995). Race, religious involvement, and depressive symptomatology in a southeastern US community. Social Science and Medicine, 40, 1561–1572.

Ellison, C.G., & Levin, J.S. (1998). The religion-health connection: Evidence, theory, and future directions. Health Education and Behaviour, 25, 700 – 720.

Emmons, R. A., Cheung, C., & Tehrani, K. (1998). Assessing spirituality through personal goals: Implications for research on religion and subjective well-being. Social Indicators Research, 45, 391–422.

Foskett, J., A. Roberts, R. Mathews, L. Macmin, P. Cracknell, and V. Nicholls, 2004, From research to practice: The first tentative steps: Mental Health, Religion & Culture, v. 7, no. 1, p. 41-58.

Francis, L. J. (1994). Denominational identity, church attendance, and drinking behavior among adults in England. Journal of Alcohol and Drug Education, 39, 27–33.

Freud, S., 1959, Civilisation and its discontents: London, Hogarth

Gartner, J., 1996, Religious commitment, mental health and prosocial behaviour: a review of the empirical literature, in EP Shafranske ed., Religion and the clinical practice of psychology: Washington DC, APA, p. 187-214.

George, L. K., Ellison, C. G., & Larson, D. B. (2002). Explaining the relationships between religious involvement and health. Psychological Inquiry, 13, 190–200.

George, L. K., Larson, D. B., Koenig, H. G., & McCullough, M. E. (2000). Spirituality and health: What we know, what we need to know. Journal of Social and Clinical Psychology, 19, 102–116.

Gorsuch, R. L. (1993). Religious aspects of substance abuse and recovery. Journal of Social

Issues, 25, 65–83.

Harker, K. (2001). Immigrant generation, assimilation, and adolescent psychological well-being. Social Forces, 79, 969–1004.

Harrison, M. O., Edwards, C. L., Koenig, H. G., Bosworth, H. B., Decastro, L., & Wood, M. (2005). Religiosity/spirituality and pain in patients with sickle cell disease. The Journal of Nervous and Mental Disease, 4, 250–257.

Helm, H., Hays, J. C., Flint, E., Koenig, H. G., & Blazer, D. G. (2000). Effects of private religious activity on mortality of elderly disabled and nondisabled adults. Journal of Gerontology, 55A, M400–M405. 2011

Helson, S. & Srivastava, S.(2001) Three paths of adult development: conservers, seekers, and achievers. Journal of Personality and Social Psychology, 80, 995, 1010.

Idler, E. L. & Kasl, S. V. (1997). Religion among disabled and non-disabled elderly persons: II. Attendance at religious services as a predictor of the course of disability. Journal of Gerontology Series B-Psychological Sciences and Social Sciences, 52B, S306-S316.

Jahangir, F., ur Rehman, H. & Jan, T. (1998). Degree of religiosity and vulnerability to suicide attempt/ plan in depressive patients among Afghan refugees. International Journal of the Psychology of Religion, 8, 265-269.

Johansson, C. (2008) ‘‘What Keeps You Grounded?’’ Davis Network PT.

Kendler, K. S. Gardner, C. O. & Prescott, C. A. (1996). Religion, psychopathology, and substance use and abuse: A multimeasure, genetic-epidemiologic study. American Journal of Psychiatry, 154, 322-329.

Keyes, C.L.M., Schmotkin, D. & Ryff, C.D.(2002). Optimizing well-being: the empirical encounter of two traditions. Journal of Personality & Social Psychology, 87, 1007 – 1022.

King, M., & Schafer, W. E. (1992). Religiosity and perceived stress: A community survey. Sociological Analysis, 53, 37–47.

Koenig, H. G. (1997). Is religion good for your health; effects of religion on mental and physical health. New York: Hawoth.

Koenig, H. G. (2001). Religion and medicine II: Religion, mental health, and related behaviors. International Journal of Psychiatry in Medicine, 3, 97–109.

Koenig, H. G., Ford, S., George, L. K., Blazer, D. G., & Meador, K. G. (1993). Religion and anxiety disorder: An examination and comparison of associations in young, middle-aged and elderly adults. Journal of Anxiety Disorders, 7, 321–342.

Koenig, H. G., George, L. K. & Titus, P. (2004). Religion, spirituality, and health in medically ill hospitalized older patients. Journal of the American Geriatrics Society, 52 (4): 554-562.

Laurencelle, R. M., Abell, S. C., & Schwartz, D. J. (2002). The relation between intrinsic religious faith and psychological well-being. The International Journal for the Psychology of Religion, 12, 109–123.

Levin, J., & Taylor, R. (1998). Panel religious involvement and well-being in African Americans: Contemporaneous and longitudinal effects. Journal for the Scientific Study of Religion, 37, 695-709. 2011

Levin, J. S., & Chatters, L. M. (1998). Research on religion and mental health: An overview of empirical findings and theoretical issues. In H. G. Koenig (Ed.), Handbook of religion and mental health (pp. 33–50). San Diego, CA: Academic Press.

Levin, J. S., Markides, K. S., & Ray, L. A. (1996). Religious attendance and psychological well- being in Mexican Americans: A panel analysis of three generations data. The Gerontologist, 36, 454–463.

MacLeod, A.K., & Moore, R. (2000). Positive thinking revisited: positive cognitions, well-being and mental health. Clinical Psychology and Psychotherapy, 7, 1-10.

Maltby, J., Lewis, C.A., & Day, L. (1999). Religious orientation and psychological well-being: The role of frequency of personal prayer. British Journal of Health Psychology, 4, 363 – 378.

Margetic, B. (2005), Religiosity and health outcomes: review of literature: Coll.Antropol., v. 29, no. 1, p. 365-371

McCullagh, P. (1980). Regression models for ordinal data. Journal of the Royal Statistical Society, 42, 109–142.

McCullough, M. et al. (2000). Religious involvement and mortality. Health Psychology, 19, 211-222.

McCullough, M.E., (1999) Research on Religion-Accommodative Counseling : Review and

Meta-Analysis. Journal of Counseling Psychology, 46(1), 92-98

McCullough, M. E., and D. B. Larson (1999). Religion and depression: a review of the literature: Twin.Res., v. 2, no. 2, p. 126-136.

Mickley, J. R., Carson, V., & Soecken, K. L. (1995). Religion and adult mental health: The state of the science in nursing. Issues in Mental Health Nursing, 16, 345–360.

Miller, L. et al. (1997). Religiosity and depression: Ten-year follow-up of depressed mothers and offspring. Journal of the American Academy of Child and Adolescent Psychiatry, 36, 1416-1425.

Miller, L., & Gur, M. (2002). Religiosity, depression, and physical maturation in adolescent girls. Journal of the American Academy of Child and Adolescent Psychiatry, 41, 206–214.

Murphy, Patricia E., Ciarrocchi, Joseph W., Piedmont, Ralph L., Cheston, Sharon, Peyrot, Mark, Fitchett & George (2000). The Relation of Religious Belief and Practices, Depression, and Hopelessness in Persons with Clinical Depression. Journal of Consulting and Clinical Psychology, 68, 6.

Oxman, T. E., Freeman, D. H., & Manheimer, E. D. (1995). Lack of social participation or religious strength and comfort as risk factors for death after cardiac surgery in the elderly. Psychosomatic Medicine, 57, 5–15. 2011

Plante, T. G. & Sherman, C. (2001). Research on faith and health: New Approach to old questions. In T. G. Plante & C. Sherman (Eds.), Faith and Health: Psychological Perspectives. New York: The Guilford Press.

Pössel, P., Martin, N. C., Garber, J., Banister, A. W., Pickering, N. K., & Hautzinger, M. (2010). Bidirectional Relations of Religious Orientation and Depressive Symptoms in

Adolescents: A Short-Term Longitudinal Study. Psychology of Religion and Spirituality. Advance online publication.

Radloff, L. (1977). The CES-D scale: A new self-report depression scale for research in the general population. Applied Psychological Measurement, 1, 381–401.

Reinberg, S. (2010). Depression hits 9% of adults, worst in South, CDC reports. USA Today online magazine.

Richards, P. et al. (1997). Spiritual issues and interventions in treatment of patients with eating disorders. Eating disorders: The Journal of Treatment and Prevention, 5, 261-279.

Rosmarin, David H., Pirutinsky, Steven, Pargament, Kenneth I., Krumrei, & Elizabeth J. (2009) Are religious beliefs relevant to mental health among Jews? Psychology of Religion and Spirituality, Vol. 1, Issue 3.

Russell, D. W., Peplau, L. A., & Cutrona, C. E. (1980). The revised UCLA Loneliness Scale: Concurrent and discriminant validity evidence. Journal of Personality and Social Psychology, 39, 472–480.

Ryff, C.D. (1989). Beyond Ponce de Leon and life satisfaction: new directions in quest of successful aging. International Journal of Behavioural Development, 12, 35 – 55.

Salway, D. & Ashman, A. F. (1998). Disability, religion and health: A literature review in search of the spiritual dimensions of disability. Disability and Society, 13, 429-439.

Seybold, K. S., and P. C. Hill, 2001, The Role of Religion and Spirituality in Mental and

Physical Health: Current Directions in Psychological Science, v. 10, no. 1, p. 21-24.

Strawbridge, W. J., Shema, S. J., Cohen, R. D., & Kaplan, G. A. (2001). Religious attendance increases survival by improving and maintaining good health behaviors, mental health and social relationships. Annual Behavioral Medicine, 23, 68–74.

Swinton, J. (2001). Spirituality and mental health care: Rediscovering a ‘‘forgotten’’ dimension. London: Jessica Kingsley.

Tawfik, L. (2007) The preventive and healing wonders of ablution. Islamic World: 4.(03912) 2011

Thearle, M. J. et al.(1995). Church attendance, religious affiliation and parental responses to sudden infant death, neonatal death and stillbirth. Omega, 31, 51-58.

Wachholtz, A.B., & Pargament, K.I. (2005). Is spirituality a critical ingredient of meditation? Comparing the effects of spiritual mediation, secular meditation, and relaxation on spiritual, psychological, cardiac, and pain outcomes. Journal of Behavioural Medicine, 28, 369 – 384.

Watters, W. (1992). Deadly doctrine: Health, illness, and Christian God-talk. Buffalo. New

York: Prometheus Books.

Weaver, A. J., L. T. Flannelly, J. Garbarino, C. R. Figley, and K. J. Flannelly, 2003, A systematic review of research on religion and spirituality in the Journal of Traumatic Stress : 1990-1999: Mental Health, Religion & Culture, v. 6, no. 3, p. 215-228.

Weaver, R. (2010) Feeling Lonely With So Many People: New Research Suggests a Loneliness Problem. EmpowHer Mental Health Online Magazine.

Wissing, M.P. & Van Eeden, C.(2002) Empirical clarification of the nature of psychological well-being. South African Journal of Psychology, 32, 32 – 44.

Yeung, W. J & Chan Y. (2007). The positive effects of religiousness on mental health in physically vulnerable populations: A review on recent empirical studies and related theories. International Journal of Psychosocial Rehabilitation. 11 (2), 37-52.