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Religiosity and Psychological Welfare. Approaching Perspectives in the Romanian Scientific Context

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ABSTRACT: The present study aims to emphasize some important aspects of the present researches regarding the relation between religiosity and health, with an accent on the results of the scientific research from Romania. As the numerous studies made at an international level in this area, the studies from Romania have emphasized especially the fact that, in front of a stressful event, people with a high level of religiosity adopt in bigger proportion strategies of religious coping, for reducing the stress, like the pray and redefining our own values. In a society opened to different cultural and religious offers, as it is the pluralist nowadays society, we consider it is necessary to have a deepening of the relation between religious experience, the world of values and the way of acting, especially in the case of younger generations.

KEY WORDS: religiosity, religious coping, mental health

Introduction

In the last decades numerous psychological and medical studies have explored the connection between the religious dimension and the physic and psychic health of the individual (Chatters 2000, 335; Hackney & Sanders 2003, 43-55; Levin & Tobin 1996, 30-35), subject which was less studied in the Romanian scientific context. This concern towards the implications

of the religious phenomenon on physic and mental health of the individual has older origins, and it is connected to the beginnings of experimental psychology. An example in this regard is represented by the studies made by the philosopher and the psychologist William James, more than 100 years ago, and according to whom religion prevents some types of diseases as well as science (James 2009, 95), emphasizing in this way a connection between religiosity and health.

At an international level, the most recent psychological researches in the field, were based mainly on the connection between religiosity and longevity, on the role of religion in interpreting different daily life situations and the response it gives to them, on the positive relation between practicing the religious feeling and coping with difficult and stressful life situations, caused by serious diseases and death; most part of these studies showed the presence of some positive correlations between spirituality and/or religiosity and the physical and psychological welfare in general (Musick 1996, 221-237; Koening et al. 1993, 321-342; Lewis et al. 1997, 119-121; Pargament 1997; Miller & Thoresen 2003, 24-35).

The argument of the positive relationship between religious coping and psychological adjustment to stress is pretty much controversial in specialty literature, the opinions in this field being very different. On the one hand, there are some psychologists, who claim that religion represents an institutionalized irrationality and is harmful for the optimal psychological functioning of the individual (Priester et al. 2009, 92-114) and that the new religious movements, throughout their coercive persuasion, have negative effects on mental health. Other psychologists, like Jung (1993, 250) and Allport (1950, 25), consider that religion is a source of significance and social stability, in an uncertain world. Moreover, religion promotes health and psychological welfare, so any form of religion has positive effects on the mental health of the individuals (Ellison & Levin 1998, 700-720).

While some researches showed that the spiritual/religious domain is significantly associated with many aspects of adapting functioning (Koenig & Larson 2001, 67-68; Gartner et al. 1991, 6-8), other studies found out that the two variables are negatively correlated (Dreger 1952, 5-10; Schaefer, 1997, 633-644) or that there is no significant relation between religion and

the mental and psychological health of the individual (Lewis et al. 1997, 119-121). The researchers Hackney and Sanders (2003, 45), who analyzed 34 of researches regarding the report between religiosity and mental health, realized between 1990-2001, explain this contradiction based on the differences of operating with the variables taken into account (religiosity and mental health), conceptual aspects which we want to clarify in the following pages.

On the other hand, we must note the fact that the variations can be also explained by the orientation of the researcher, by the aim of the research, and by the definition of the sects and cults from which the research started.

Conceptual aspects

Definitely religiosity is a very complex multidimensional construct, fact which implies the possibility that some of its aspects could be connected in a different manner to the mental and psychological health of the individuals.

During the time, philosophers, anthropologists, theologian, historiographers, psychologists and sociologists have tried to define and to interpret the religious phenomenon from different perspectives, sometimes in contradiction, due to different conceptions about the human being and the world, in which the authors set their own researches, and due to the methodological methods they use in realizing these studies. We cannot make any analysis of different conceptions regarding religion, we limit ourselves just to underline some emblematic concepts in the study of the religious phenomenon, but most often situated on different levels.

The contradictory results obtained by researchers in this area are, mostly because of the methodological deficiencies related firstly to the difficulty of defining religiosity/spirituality, when these concepts are the object of some scientific researches. For Pargament (1997, 32), religion is seen as "a search for significance in ways related to the sacred" while spirituality is searching for the sacred itself. For Shafranske and Maloney (1990, 72-78), religiosity represents the adhesion to the believes and practices of an organized church or religious institution, while spirituality is seen as having a personal and experimental connotation. Thus, spirituality is more ample than religion, which it can, or cannot include; spirituality can find its expression in a religious context, but it can stay outside of it as well.

Religion represents the belief in the supernatural, sacrum or divine, as well as the moral code, the ritual practices, the dogma, the values and the institutions associated with this belief, being a type of human behavior (believes, rituals) referring to human beings, forces and supernatural powers (Zamfir & Vlasceanu 1993, 509-510).

The word "religiosity" incorporates both cognitive and behavioral aspects, as well as emotional and motivational aspects which derive from searching the sacred (Koening et al. 2001; Hill & Pargament 2003, 64-74).

On the one hand, it is talked about an extrinsic religious orientation, an institutionalized religion, concentrated on the social and behavioral aspects of religion (taking part to the religious services and to the religious activities or rituals), and on the other hand it is talked about an intrinsic religion, concentrated on the believes and the ideologies involved in religious practice, on the personal devotion, on intrinsic emotional religious orientation (Hackney & Sanders 2003, 6).

The authors Charles Y. Glock and Rodney Stark (1965, 19-20), starting from the fact that religiosity has a powerful individual connotation, and that there are a number of differences between religious doctrines, claim that there are 5 dimensions which characterize the dynamic of the religiosity. These dimensions are universal because inside them we can meet all the manifestations which characterize different religions, the believers being involved in different ways in religious activities. Thus, the first dimension is *the experiential* one (it refers to the sensations, the perceptions, and the emotions, individual or group ones, which derive from the communication with the transcendent, and the states of mind which result from this can be: interest, acknowledging the existence of the divine, belief or fear. The second dimension of religiosity is the *ideological* one and it encompasses all the expectations which the individual manifests towards the contents of the belief. The third dimension is the *ritualistic* one and it refers to all the religious practices realized by the believers (the cult, participating to the religious ceremony, the divine adoration, the pray). The *intellectual* dimension is the fourth and it refers to the minimal information which a person should have about the important aspects of its own religious confession, the traditions, rites, the sacred texts. The *resulting* dimension refers to the consequences met in the individual's daily life, domains which do not necessarily assume

a religious content. So, it is very important to investigate which are those specific variables of religious life of individuals, which can be correlated by different aspects of the psychological welfare and which contribute in this way to the development process of the individual.

As the World Health Organization states, mental health, as integrant part of health, is a state of complete physical, psychological and social welfare, and it does not mean just the lack of disease and infirmity (WHO, 2020). Mental health allows the individual to exploit his cognitive or emotional abilities, to do his job among the society he lives in, to respond to the daily needs of daily life, to establish satisfactory and mature relationships, to participate in a constructive way to the environment changes, to adapt to external conditions and internal conflicts. Mental health can be influenced by different social-economic factors, upon which it is necessary to take actions throughout global strategies of promoting, prevention, treatment and recovery in a worldwide approach.

The study of mental health, in general, focused both on the adapting aspects (positive emotions, self-accepting, positive relationships with the others, purpose in life, positive attitudes toward the others) and on the non-adapting aspects (depression and anxiety), both faces being included in the research on mental health (Albulescu 2009, 41).

If there is one common point of all the studies on religion and mental health, a relatively general conclusion of them would be that religion has a certain influence on mental health. But the answers to the questions regarding the effects and their magnitude are numerous, and most of the time in contradiction.

The results of the researches at an international level

As I mentioned earlier, the definitions used by the psychologists, regarding both the religiosity and the mental health as well, most often reflect the existence of some significant positive correlations between the two variables, in the most diverse states and dimensions of the human condition (Hackney & Sanders 2003, 44). In the following paragraphs I will shortly present some of these results.

Thus, different authors, who handled the study of the religious feeling among the elderly people, noticed that the religious *coping* strategies (like the belief in God, the pray, the Bible) not only offer comfort and a feeling of peace in the case of elderly hospitalized sick people, but they also constitute a protection factor against depression. When the elderly people are unsure and tensed, the believes and the religious behaviors seem to work as protection factors against sufferings and helplessness, offering a sense to life and death, as well as a feeling of control upon the situation (Hill & Pargament 2003 64-74).

Other studies come with proves of the fact that the religious feeling contributes to the increase of the quality of life (Miller et al. 2007, 299-312), it keeps hope and optimism (Cotton et al. 2006, 5-13), it increases the adhesion to treatment, it allows a better management of dysfunctional behavior, like the use of some substances (Saunders et a., 2007, 404-408), and it facilitates the social support (Smith et al. 2003, 614).

All these researches prove how spirituality and religion have an important role when it comes to health and treatment (Sandrin, 2000, 163-164). The spiritual-religious dimension is considered to be an important element in managing the stressful life experiences, like the diagnostic of a cancer disease, losing a loved one, cases in which the subjects with an elevated level of religious feelings report a superior quality of family life, both in the spiritual area, and in the psychological one, frequently resorting to active coping strategies, fact which allows a redefinition of their own values and a reconsideration of its own objectives (Folkman 1997, 1207-1210). So, those who offer medical services have to take into consideration the spiritual convictions of the patients, especially when it comes to caring for the sick people who are in terminal states.

However, the authors of some recent reviews underline the fact that the specialty literature does not allow final conclusions regarding the effects of religious coping upon the patients with cancer (Thuné-Boyle et al. 2006, 151–164). In this regard, we cannot deny the fact that there are some religious practices, which can be considered irrational strategies, maladaptive of coping, like the hysteric pray for a miracle, doubting the love of God, and losing the hope for a benefic result, as it is underlined in the study realized by Roman G. about the patterns of religious coping in eastern spirituality (Roman 2012, 41-42).

Yet, there are numerous scientific proves of the fact that in front of a stressful event, the people with a high level of religiosity and spirituality, even with significant differences from an ethnic point of view, are going to use in a higher percentage the religious coping strategies, they will search for a bigger involvement in the religious community, considered to be an important resource of social support, from a psychological point of view (Koenig et al 2001).

Besides this, it was noticed that the people who frequently go to the cult places have more longevity (Hummer et al. 1999, 275-283; Salsman et al. 2005, 522-535) and in general they have a better physic and mental health (Miller & Thoresen 2003, 25-26). Among the possible mechanisms meant to explain the benefic effect of religion upon the mental health, there are: activating some socializing networks, adopting some healthier life styles, experiencing some positive emotions, and learning some strategies for managing the stress efficiently.

It may happen that after a traumatic event for an individual to convert himself, or come closer to religion in search of answers for his problems, as it may happen that a religious person, after a traumatic event, stops believing in God's existence, or thinks of God as being less strong or fair (Fiz Pérez & Laudadio 2010, 58; Laudadio et al. 2009, 81-82; Pargament, 1997).

Another part of the researches focused on the relation between religiosity and physical and psychological welfare among the younger population. In a world in which the young people are bound to face numerous contradictions and uncertainties, religiosity has a decisive influence on the value system and upon the individual maturity. It was noticed for example that the students with high levels of participation at the religious events have a better mental health, they use much less alcohol, they have a more intense sport activity, results confirmed by later studies which analyzed the religious feeling as a factor of protection against the use of alcohol and tobacco (Wallace & Williams 1997, 444-468).

As the professors Javier Fiz Perez and Andrea Laudatio (2010, 58-59) underline, in the last years it has increased the interest of the researchers for the protective effect the religion has, especially the active participation at the religious activities in adolescence. The protective effect of religiosity and spirituality is given to the disapproval of teenagers regarding some risk

behaviors, as well as the social support offered by the religious living (Noia & Di Gianfrancesco 2009, 81-96; Fergus &Zimmerman 2005, 399-340, 407-409; Wills et al. 2003, 24-31).

Ultimately, religiosity offers stability, support and direction in the life of the religious human being; it offers him a life philosophy and a personal coherence (Hill & Pargament 2003, 67-69).

Present trends regarding the religious coping in the Romanian scientific context

As I said at the beginning of this study, the scientific researches in this area are pretty much limited. Nevertheless, we meet some relevant results, when it comes to examining the relation between mental health, social environment, and the belonging to a religious group.

We remind in this regard a study made among the members of an orthodox religious community (the majority religion in Romania) and the members of a minority religious congregation, study which evaluated both the level of anxiety towards death, the attitudes and the symptoms specific to depression, as well as the self-esteem, and the feeling of guilt, and in the same time a number of de variables, as the social environment, stressful life situations, and the reason for religious affiliation, both in case of the major religious group and in the case of the minority one as well. The respective research emphasizes some significant differences regarding the level of anxiety towards death, this being bigger in the case of those who belong to the major religion in comparison to the minority religious groups (Albulescu 2009, 44-46)

Another recent study, made among the adolescents from Romania, with the aim of identifying the stress perceived in different domains (school, family, free time, the self, work, future, sentimental relationships), as well as the personal and social resources which the teenagers have for facing the respective issues, showed that, among the *coping* strategies with a significant weight upon the way in which the adolescent overcomes the problematic issues, there is religiosity. A great number of teenagers consider that their own spirituality and religion help them overcome their problems. It is interesting to mention the fact that religiosity is among the first three coping strategies used when the adolescents from the group given, are confronted with an issue in the

areas mentioned above. This fact is not surprising, because in Romania there is a strong tradition of religious practice (Belea 2019, 51-52). In fact, these results sustain the idea according to which the moral development and the religious practice are part of the more complex system of creating the identity the teenager builds step by step (Graziani, [3]2011, 253-255). So, starting from the adolescence period, the moral believes often become an important part of personal identity, because the teenagers end up representing themselves above all, starting from their own interpersonal relationships, and from their systems of believes.

Another direction of the researches from Romania was concentrated upon the mechanisms throughout which the Christian-orthodox religious practices influence the couple and family relationships of Romanians, as well as the ways of integrating religiosity and religious coping into therapy (Rusu 2012).

More studies explored the relationship between religious beliefs and spiritual beliefs and the quality of life of Romanian rare disease patients. Specifically, this study, firstly, analyzed the correlations between self-reported life satisfaction and participants' beliefs in heaven, afterlife and God. Secondly, correlations between self-reported optimism and participants' belief in the role of spirituality and life meaning were studied. Thirdly, the relationship between self-reported health and church attendance, importance of church and importance God for Romanian rare disease patients were examined (Popoviciu et al. 2012 144-161). The results of this study suggest that rare disease patients in Romania are deeply religious people. The majority reported belonging to the national Orthodox Church, and no respondent identified himself as atheist or „without religion". While it is evident that factors other than religious beliefs are important in the QOL of people with rare diseases, our results show that religion and spirituality can be an important dimension in the QOL of people diagnosed with a rare disease.

In conclusion, all these studies emphasize the existence of a bio-psycho-social-spiritual model sustained by the opening of the clinician psychologists for the spiritual dimension of the individual, which is associated with mental health. For this reason the religious manifestations should be associated with mental health to the extent that the *religious maturity* proves to be a good way

of psychological adjustment to the environment, of psychological welfare and satisfaction regarding our own life.

References

Albulescu, P. 2009. Grup religios majoritar vs. grup religios minoritar. Abordare diferentiala din perspectiva sanatatii mentale si a mediului social. *Revista de Psihologie Aplicata* 11 (1): 41-48.

Allport, G. W. 1950. *The individual and his religion: A psychological interpretation*. New York: Macmillian Company.

Belea, M. 2018. *Transizione adolescenziale: abilità di fronteggiamento. Una ricerca tra gli adolescenti romeni* [Doctoral dissertation, Salesian Pontifical University of Rome]. https://books.google.ro/books/about/Transizione_adolescenziale.html?id=LFS7xgEACAAJ&redir_esc=y

Caprara, G.V., & Fonzi, A. 2000. *L'età sospesa. Itinerari del viaggio adolescenziale*. Firenze: Giunti.

Chatters, L. M. 2000. "Religion and health: public health research and practice." *Annual Review of Public Health* 21: 335-367. https://www.annualreviews.org/doi/10.1146/annurev.publhealth.21.1.335.

Cotton, S., Puchalski, C. M., Sherman, S. N., Mrus, J. M., Peterman, A. H., Feinberg, J., Pargament, K. I., Justice, A. C., Leonard, A. C., & Tsevat, J. 2006. "Spirituality and religion in patients with HIV/AIDS." *Journal of general internal medicine*. December 1, 21 Suppl. 5: 5-13.

Dreger, R. M. 1952. "Some personality correlates of religious attitudes as determined by projective techniques." *Psychological Monographs: General and Applied* 66 (3): 1-18.

Ellison, Ch. G., & Levin, J. S. 1998. "The religion-health connection: evidence, theory, and future directions." *Health Education & Behavior* 25(6): 700-720. Doi: 10.1177/109019819802500603.

Folkman, S. 1997. "Positive psychological state and coping with severe stress." *Social Science and Medicine* 45 (8): 1207-1221. Doi.org/10.1016/S0277-9536(97)00040-3.

Fergus, S., & Zimmerman, M. A. 2005. "Adolescent resilience: a frame work for understanding healthy development in the face of risk." *Annual Review Public Health* 26: 399-419.

Fiz Pérez, F.J., & Laudadio, A. 2010. "La fede come dimensione centrale del benessere psicologico individuale. » *Il Minotauro. Problemi e ricerche di psicologia del profondo*. XXXVII (1): 54-70.

Gartner, J., Larson, D. B., & Allen, G. D. 1991. "Religious commitment and mental health: A review of the empirical literature." *Journal of Psychology and Theology* 19 (1): 6–25. Doi.org/10.1177/009164719101900102.

Glock, C.Y., & Stark, R. 1965. *Religion and Society in Tension*. Chicago: Rand Mc Nally & Co.

Graziani, A. R. 2011. "Lo sviluppo morale. In A. Palmonari." *Psicologia dell'adolescenza* (pp. 253-273). Bologna: Il Mulino.

Hackney, C. H., & Sanders, G. S. 2003. "Religiosity and Mental Health: A meta-Analysis of recent Studies." *Journal for the Scientific Study of Religion* 42(1): 43-55. https://doi.org/10.1111/1468-5906.t01-1-00160.

Hill, P. C., & Pargament, K. 2003. "Advances in the Conceptualization and Measurement of Spirituality. Implications for physical and mental health research." *American Psychologist* 58 (1): 64–74. Doi: 10.1037/0003-066X.58.1.64.

Hummer, R. A., Rogers, R. G., Nam, C. B., & Ellison, C. G. 1999. "Religious involvement and U. S. adult mortality." *Demography* 36 (2): 273-285.

James, W. 2009. The Varieties of Religious Experience: A Study in Human Nature. http://ebooks.adelaide.edu.au/j/james/william/varieties/complete.html

Jung, C. 1933. *Modern man in search of a soul*. New York: Harcourt Brace & Company.

Koenig, H. G., & Larson, D. B. 2001. „Religion and mental health: Evidence for an association." *International Review of Psychiatry* 13 (2): 67–78. Doi.org/10.1080/09540260124661.

Koening, H. G., Ford, S. M., 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. Doi.org/10.1016/0887-6185(93)90028-J.

Koenig, H. G., McCullough, M. E., & Larson, D. B. 2001. *Handbook of Religion and Health*. New York: Oxford University Press.

Laudadio A., Noia, F., & Di Gianfrancesco, R. 2009. "Credere in Dio e benessere percepito." Rassegna di Psicologia 1: 81-96.

Levin, J. S., & Tobin, S. H. 1995. "Religion and psychological well-being." In M. A. Kimble, S. H. McFadden, J.W. Ellor, & J. J. Seeber (Eds.), *Aging, Spirituality, and Religion: A Handbook* (pp. 30–46). Minneapolis, Fortress Press.

Lewis, C. A., Lanigan, C., Joseph, S., & De, Fockert J. 1997. "Religiosity and happiness: No evidence for an association among undergraduates." *Personality and Individual Differences* 22 (1): 119-121.

Miller, J. F., McConnell, T. R., & Klinger, T. A. 2007. "Religiosity and Spirituality: Influence on Quality of Life and Perceived Patient Self-Efficacy among Cardiac Patients and Their Spouses." *Journal of Religion and Health* 46(2): 299-313.

Miller, W. R., & Thoresen, C. E. 2003. "Spirituality, religion and health: An emerging research field." *American Psychologist* 58 (1): 24-35. Doi. org/10.1037/0003-066X.58.1.24

Musick, M. 1996. Religion and subjective health among black and white elders. *Journal of Health and Social Behavior* 37 (3): 221-237. Doi:10.2307/2137293.

Noia, F., & Di Gianfrancesco, R. (2009). Credere in Dio e benessere percepito. Rassegna di Psicologia, 1, 81-96.

Pargament, K. I. (1997). *The Psychology of Religion and Coping: Theory, research, practice*. New York: Guilford.

Popoviciu, S., Birle, D., Olah, S., & Popoviciu, I. (2012). The role of religious beliefs and spirituality on the quality of life of rare disease patients. *Review of Research and Social Intervention*, 36, 144-161.

Priester, P. E., Khalili, S., & Luvathingal, J. E. (2009). Placing the soul back into psychology: religion in the psychotherapy process. In S. Eshun & Gurung R.A.R., *Culture and mental health. Sociocultural influences, theory, ad practice* (pp. 92-114). UK: Wiley-Blackwell.

Roman, G. (2012). Pattern-uri ale coping-ului religios în spiritualitatea răsăriteană. *Studia Theologia Catholica*, LVII (3-4), 41-52.

Rusu, P. (2012). *Religiozitatea în relatiile de cuplu și familie. Implicatii terapeutice*. [Doctoral dissertation, Alexandru Ioan Cuza University, Romania], https://www.ascred.ro/religiozitatea-in-relatiile-de-cuplu-si-de-familie.html

Salsman, J. M., Brown, T. L., Brechting, E. H., & Carlson, C. R. (2005). The link between religion and spirituality and psychological adjustment: The mediating role of optimism and social support. *Personality and Social Psychology Bulletin*, 31, 522-535.

Sandrin, L. (2000). *Compagni di viaggio. Il malato e chi lo cura*. Milano: Edizioni Paoline.

Saunders, S. M., Lucas, V., & Kuras, L. (2007). Measuring the Discrepancy Between Current and Ideal Spiritual and Religious Functioning in Problem Drinkers. *Psychology of Addictive Behaviors*. 21 (3), 404–408.

Schaefer, W. E. (1997). Religiosity, spirituality, and personal distress among college students. *Journal of College Student Development*, 38, 633–644.

Shafranske, E. F., & Maloney, H. N. (1990). Clinical Psychologists' religious and spiritual orientations and their practice of psychotherapy. *Psychotherapy*, 27(1), 72-78.

Smith, T. B., McCullough, M. E., & Poll, J. (2003). Religiousness and depression: evidence for a main effect and the moderating influence of stressful life events. *Psychological Bulletin*, 129 (4), 614-636. doi: 10.1037/0033-2909.129.4.614.

Thuné-Boyle, I. C., Stygall, J. A., Keshtgar, M. R., & Newman, S. P. (2006). Do religious/spiritual coping strategies affect illness adjustment in patients with cancer? A systematic review of the literature. *Social Science & Medicine*, 63, 151–164.

Wallace, J. M., Jr., & Williams, D. R. 1997. "Religion and adolescent health-compromising behavior." In J. Schulenberg, J. L. Maggs, & K. Hurrelmann (Eds.), *Health risks and developmental transitions during adolescence*, 444-468. New York: Cambridge University Press.

Wills, T. A., Yaeger, A. M., & Sandy, J. M. 2003. Buffering effect of religiosity for adolescent substance use. *Psychology of Addictive Behaviors* 17: 24–31.

World Health Organization. 2020. *Mental health: strengthening our response*. https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response.

Zamfir, C., & Vlasceanu, L. 1993. *Dictionary of sociology*. Bucharest: Babel Publishing.