CHAPTER ONE

RELIGION AND MENTAL HEALTH: THROUGH
THE LENS OF THE STRESS PROCESS

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Over the past two decades a burgeoning research literature has examined the relationships between religious involvement (and its close cousin, spirituality) and mental health outcomes. Although studies in this area have explored many facets of mental health, there has been significant concentration on affective outcomes. To be sure, a long tradition of theory and research in psychology has taken a dim view of the role of religion in shaping mental health. Scholars from Sigmund Freud (1928) to Albert Ellis (1962, 1983), as well as many other prominent figures, have maintained that religious belief is either an expression or a cause of emotional disturbance in many people. In sharp contrast to these critical claims, many more recent studies report that religiousness, measured in various ways, tends to be inversely associated with symptoms of depression, anxiety, or psychological distress (Koenig, Larson and McCullough 2001, Smith et al. 2003, Koenig 2009, 2011). Our chapter has four overarching objectives: (1) to review key findings from this contemporary literature; (2) to set forth the stress process perspective as one potential unifying framework for the vast body of work on religion-mental health, and to identify several conceptual models for research in this area; (3) to review the available evidence linking religious factors with the various components of the stress process model; and (4) to discuss several promising directions for future research on religion and mental health.

We should note several caveats with respect to this chapter. First, we are restricting our focus mainly to the United States, where much of the relevant research has been conducted. Further, because the United States remains primarily Judeo-Christian in culture (if not always in practice), and most studies continue to use concepts and measures that are rooted in the Judeo-Christian tradition, we shall have little to say about religion and mental health in other faith traditions. Second, in keeping with the thrust of the literature in this area, our review will
center on depression, anxiety, and generalized distress. Other mental health outcomes, ranging from substance abuse to schizophrenia to personality disorders, and many more, will necessarily be omitted from the discussion. Third, we note that a wealth of research on religion and mental health is based on clinical samples, *i.e.*, persons selected because of specific health problems or stressful conditions, and the main interest of those studies lies in the treatment and prognosis of subjects. By contrast, we focus primarily on community-dwelling or population-based samples.

*Religion and Mental Health: Reviewing the Evidence*

In recent years several researchers have attempted to review, synthesize, and take stock of the literature in this broad, multidisciplinary field, with varying degrees of success. These assessments have varied in a number of important ways: (a) they concentrated on very different slices of the literature, from divergent academic disciplines; (b) they employed divergent criteria for inclusion in the review; (c) they embraced different standards for evaluating the strengths and weaknesses of research studies and for assessing religious or spiritual effects on mental health. Thus, despite the best efforts of many talented scholars, consensus on where the field stands and how to proceed remains on the far horizon (Koenig et al. 2001, Hackney and Sanders 2003, Smith, McCullough and Poll 2003, Koenig 2009, 2011). Nevertheless, we offer several broad generalizations about the state of the field, at least with respect to community- or population-based research on religion and mental health.

First, much of the work in this area has been plagued by inadequate conceptualization and measurement of religion and related constructs (Hill and Pargament 2003, Idler et al. 2003). This problem has been exacerbated by the use of large-scale secondary data sources, which, despite their considerable virtues, often lack sophisticated items gauging health-related aspects of religiousness. Thus, many studies have relied mainly on measures of religious behaviors, most prominently the self-reported frequency of attendance at religious services, along with the frequency of prayer or meditation, as well as vague items tapping (a) religious identity, or how religious one considers oneself, and (b) religious salience, or the self-reported importance of religion in one’s daily life. Among psychologists, the study of religious