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Faith conquers all? Beliefs about the role of religious factors in coping with depression among different cultural-religious groups in the UK

By

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Abstract

How effective is religious activity believed to be in coping with depression? This study assessed the perceived effectiveness of different religious activities - previously identified as important in coping – among 282 people in the UK. Mean age was 25 years, and participants were either Christian, Hindu, Jewish, Muslim, other religion, or no religion. Relative to other kinds of help for depression, religious activity was not seen as particularly helpful for depression. Religious activity was seen as less helpful by the ever-depressed than by the never-depressed, and as less helpful by women than by men. Among religious activities, faith and prayer were seen as the most helpful. Muslims believed more strongly than other groups in the efficacy of religious coping methods for depression, were most likely to say they would use religious coping behaviour, and were least likely to say they would seek social support for professional help for depression. Other differences between groups were also observed, and comparisons with qualitative material obtained in an earlier study were made. The implications of these findings for help seeking are considered.

Faith conquers all? Beliefs about the role of religious factors in coping with depression among different cultural-religious groups in the UK

This paper is about how effective different kinds of religious activity are *believed* to be, in coping with depression. We examined *perceived efficacy*, and its implications for help-seeking, in several different cultural-religious groups in the UK.

The relations between religious activity, religious orientation, and religious coping styles in relation to mental health, have been widely investigated (Batson, Scoenrade & Ventis, 1993; Pargament, Ensing, Falgout, Olsen, Reilly, Van Haitsma & Warren, 1990; Pargament, 1997; Worthington, Kurusu, McCullough & Sandage, 1996; Koenig, 1998; Loewenthal, MacLeod, Goldblatt, Lubitsh & Valentine, 2000). There is an overall positive relationship between many measures of religiosity and measures of mental health, although the effects are weak. More specific measures of religion show a range of effects, with some aspects of religiosity having zero or negative effects on mental health, while others are associated with positive effects. Pargament (1997) reviewed over 30 studies showing that religious coping was commonly used. Pargament's research team has identified varieties of religious coping, and specific conditions, associated with good and poor outcomes, developing a theoretical framework dominated by the search for significance. Regardless of whether and when religious coping actually "works", what do people *expect* of religious coping? Do they believe it to be helpful? Which forms of religious coping are believed to be helpful, and under what conditions, and by whom? Furnham (1988) has produced evidence that religious coping is sometimes believed to be helpful, and this study expands this line of questioning.

Beliefs about the efficacy of religious coping are important because they may have a stronger effect on other behaviours than any actual efficacy. If, for instance, I believe that regular sincere prayer may contain or alleviate my depression, I may delay seeking professional help, while waiting for prayer to have its hoped-for effect in lifting depression.

We first asked, how effective is religious activity believed to be, in comparison with other forms of intervention for depression. A previous interview study (Cinnirell & Loewenthal, 1999; Loewenthal & Cinnirella, 1999) suggested that

among the women interviewed, prayer was seen as relatively effective in alleviating depression, more often than medication and psychotherapy. Secondly, we asked which forms of religious activity were believed to be the most effective in coping with depression. In the Loewenthal & Cinnirella study, prayer was the most widely-supported effective religious intervention. Here we sought a more systematic, quantitative comparison between different forms of religious coping activity. Thirdly we asked whether there were between-group differences in beliefs about the efficacy of religious coping activities. In the Loewenthal & Cinnirella study, Muslims and Black Christians were particularly likely to believe in the efficacy of prayer, compared to White Christians, Jews and Hindus. Here, we sought a more systematic, quantitative comparison between groups. We also asked whether any of these beliefs were affected by personal experience of depression. Finally we looked at implications for uptake. How did beliefs in the efficacy of religious coping relate to help-seeking intentions? For example, if prayer and faith are believed to be helpful, is that associated with reduced intentions of seeking professional help for depression?

This study thus looks at the perception, by different groups of people, of the efficacy of six types of religious coping behaviour, and examines the relations between perceived efficacy and help-seeking intentions.

Method

Participants

The questionnaire was administered to volunteers on university campuses. There were 282 participants, 186 women, 97 men, and one participant of undeclared gender. There were 130 Christians (101 Protestant and 29 Roman Catholic), 35 Jews, 33 Muslims, 18 Hindus, 15 other religions (Sikh, Buddhist and New Age), and 56 religious “nones” (None or atheist). Only 3 participants were of Black Caribbean origin, making too small a group of Black Christians for separate analysis. Most of the Muslim, Hindu and Sikh participants identified their ethnic origin as South Asian (Indian, Pakistani or Bangladeshi): 45/55 (82%). Most of the Christian, Jewish and other participants identified their ethnic origin as White: 181/227(80%). The mean age of all participants was 24.6 years. Table 1 shows the composition of the different religious groups with respect to gender, age, and level of religious practice (self-

reported frequency of prayer, religious study, and attendance at place of worship, Cronbach's alpha for this sample =.860).

TABLE 1

Those identified with the traditional religious groups were more religiously active than those belonging to other religious groups (Sikh, Buddhist, New Age), and all those belonging to religious groups were more religiously active than the religious "nones".

The Questionnaire

A 114-item questionnaire was developed on the basis of 59 semi-structured interviews reported in Cinnirella & Loewenthal (1999) and Loewenthal & Cinnirella (1999). The questionnaire was in a 7-point Likert format. Items of concern to this report were beliefs about the efficacy of different forms of help for depression (e.g. *seeing a GP, good friends, praying*), and intention of seeking different forms of help if ever suffering from depression (e.g. *see GP, seeking help from friends, praying*). Six forms of religious coping were identified from the semi-structured interview study, and included in the questionnaire. These items, in full, were: "How helpful do you consider the following methods to be for people suffering from depression?

- Faith in G-d/Trust that whatever G-d does is for the best
- Praying yourself
- Others praying for you
- Maintaining ones religious practices
- Going to see a religious leader (e.g. rabbi, priest, vicar etc.)
- Attending a place of religious worship".

Other questions asked about religious affiliation and practice, demographic and background variables, and a self-report of whether the participant had ever experienced depression. A full version of the questionnaire is obtainable from either of the first two authors.

Results

We first asked, *how effective is religious activity believed to be, in comparison with other forms of intervention for depression?* Six forms of religious coping activity were examined: faith, prayer, keeping up with religious practices, attending a place of worship, consulting religious leaders and others praying for the sufferer. Table 2 compares these with twenty other forms of coping activity.

TABLE 2

Religious coping activities were seen as relatively ineffective, compared to most forms of coping. The more effective forms of coping were felt to be social and cognitive – such as community support, and having goals to aim for. The less effective forms of coping were religious, and medical. Both orthodox and complementary medicine were seen as relatively ineffective. The perceived effectiveness of religious coping was of course lowered by the views of the "none" group. We were interested to know how those who claimed membership of a religious group saw the effectiveness of religious coping activities, compared to other coping activities. The second column of table 2 shows the perceived effectiveness of religious and other forms of coping, for the religious group members only. There are negligible differences from the rank ordering in the first column, even though in absolute terms the religious coping activities are seen as more effective when the nones are excluded from the analysis.

Secondly, we asked *which forms of religious activity were believed to be the most effective* in coping with depression. Table 2 shows that for the participants overall, faith and prayer were seen as most effective, followed by maintaining religious practice and attending religious worship, with consulting religious leaders and others praying for the sufferer as least effective. There is a similar pattern when the nones are excluded from the analysis.

Thirdly we asked whether there were *between-group differences* in beliefs about the efficacy of religious coping activities. Table 3 shows the means of the different religious groups in rating the effectiveness of the different religious coping activities.

TABLE 3

The Muslims stood out as endorsing the effectiveness of every form of religious activity more strongly than did others, with the religious nones, unsurprisingly, seeing religious coping as less effective than did others. However, the Christians thought that both prayer and others praying for the sufferer were more effective than did most other groups. The Jewish participants endorsed the effectiveness of maintaining religious practice, consulting a religious leader, and others praying for the sufferer, more strongly than did most other groups.

Were any of these beliefs affected by *personal (self-reported) experiences of depression?* None of the beliefs in the effectiveness of professional help, alternative and complementary methods, self-help or social support were related to self-reported personal experience of depression. However efficacy of the different forms of *religious* help was perceived as significantly lower by the ever-depressed (Table 4).

TABLE 4

Women thought that religious help was less effective than did men (Table 4), although other analyses (not reported here in detail) showed that men perceived other forms of help and helping as less effective than did women. No more women than men reported themselves as ever-depressed ($X^2<1$). There were no significant correlations between age and perception of the effectiveness of different forms of religious help, and there were no age differences between the ever-depressed and the never-depressed ($t<1$).

TABLE 5

Finally we asked whether *belief in the efficacy of religious coping relate to help-seeking intentions*. To deal with this, we used four additive scales derived from the questionnaire:

- overall belief in the efficacy of religious coping (six items, alpha =.934),
- intentions to use medical or mental health service professionals if suffering from depression (five items, alpha = .709),
- intentions to seek help from friends and family (social support) (three items, alpha=. 729),

- intentions to seek help from a religious leader or chaplain, a religious group, prayer, or having others praying for oneself (religious help) (four items, alpha=.910).

Table 5 shows the means of the different groups on the three intention measures (professional help, social support, religious help).

TABLE 5

The correlations between overall belief in efficacy of religious coping, and intention to seek professional help, social support and religious help were, respectively, .098 (p=.11), .140 (p=.024), and .763 (p=.000). These were all positive, and significant in the case of intentions to use social support, and religious help. The intention to use religious help was significantly lower (10.8) among the ever-depressed, than among the never-depressed (13.6; 2-tailed t=3.07, df=274, p=.002).

Discussion

How effective was religious activity believed to be in coping with depression, in comparison with other forms of intervention for depression? The main observation here is that religious coping was seen by the sample as a whole as relatively ineffective, although in absolute terms, it was seen as somewhat effective. Loewenthal & Cinnirella's (1999) sample thought that prayer was likely to be effective in helping with depression, more often than they thought that psychotherapy or medication would be effective. In the current sample, prayer was seen as relatively less effective than psychotherapy or medication. These differences may be due to differences in methodology, or possibly demography. In other respects, the pattern of findings in the previous qualitative and the present quantitative study, was very similar. The findings tie in with work on the actual use of religious coping: Pargament (1997, Appendix A) in an extensive review, has shown that religious coping is widely used, although exact proportions vary from around 20% of those studied, to over 90%. However religious coping is not used to the exclusion of other forms of coping and help-seeking.

Which forms of religious activity were believed to be the most effective in coping with depression? In the Loewenthal & Cinnirella study, prayer was the most widely-supported effective religious intervention, while the qualitative material indicated that prayer was widely believed to be effective only among those with adequate levels of religious faith. In this study, somewhat similarly, prayer and faith were seen as the most effective forms of religious coping activity. In Pargament's (1997) review, prayer and faith were the most frequently specified of the religious coping activities which peole actually used. So there might be some consistency between the perception of the effectiveness of a behaviour, and actually engaging in it.

Between-group differences in beliefs about the efficacy of religious coping activities followed a similar pattern to those observed in the Loewenthal & Cinnirella study. In that study, Muslims and Black Christians were particularly likely to believe in the efficacy of prayer, compared to White Christians, Jews and Hindus. Here, we had insufficient data on Black Christians, but Muslims stood out in seeing a higher degree of efficacy, not only in prayer, but with respect to all the other means of religious coping studied, compared to the other groups. Unsurprisingly, the nones perceived lower efficacy in these religious coping practices compared to other groups. Tentatively, this finding may be linked to the great salience attached by young Muslims in the UK to their religious identity (Jacobson, 1997), coupled with the Muslim emphasis on prayer and faith in promoting inner harmony and peace of mind (Esmail, 1996; Husain, 1998). In the same vein, Kesselring, Dodd, Lindsey & Strauss (1986) reported a striking difference between Christian-tradition Europeans (Swiss), of whom only 37% of whom thought G-d would help, and Muslim-tradition Egyptians, of whom 92% thought that G-d would help.

We noticed an interesting contrast with our qualitative material. Some Muslims had said that they thought that consulting a religious leader was not a favoured strategy in Islam. Depression was best conquered by religious faith. Religious leaders were described as an intermediary between the individual and G-d, more favoured in other religions than in Islam. In the quantitative data in the present study, Muslims thought that consulting a religious leader might be more effective, compared to members of other groups. This apparent conflict between the qualitative and quantitative material can be resolved by noting that the relative disapproval of consulting a religious leader is relative to other methods of coping with depression.

As in our earlier study, Christians contrasted with other groups in believing in the relative efficacy of knowing that others are praying for the sufferer. This study confirmed this group difference, although Jews and Muslims are also relatively enthusiastic about the value of knowing that others are praying for the sufferer. But this is only a relative effect. Even the Christians, Jews and Muslims do not have a very high level of belief in the efficacy of this compared to their belief in the efficacy of other methods of religious coping.

A striking effect was that the ever-depressed believed less strongly in the effectiveness of religious coping than the never-depressed, and were less likely to say they would use it if depressed. Why was this? One possibility is that there was a confounding religious group affiliation and proportion of ever-depressed: there were 48% ever-depressed in the Christian groups, and 35% in the other groups. If the Christians had lower beliefs than other groups in the efficacy of religious coping, then this might give a spurious effect of experience of depression on belief in the efficacy of religious coping. But the Christians did not have generally lower beliefs than other groups in the efficacy of religious coping. So we cannot say that the ever-depressed were relatively sceptical about the efficacy of religious coping, because of the over-representation of Christians among the ever-depressed. Similarly, other confounded factors can probably be ruled out: There were as many men as women among the ever-depressed, and the ever-depressed were no older than the never-depressed. Another possibility is that the ever-depressed were disillusioned and disappointed with religious coping. We did not ask participants whether they had tried religious coping, and with what result, so we cannot be confident about this disillusionment hypothesis. A further problem with the disillusionment hypothesis is that there are several studies suggesting that religious coping activity (e.g. prayer) is associated with better mental health outcomes (Jahangir, Rehman & Jan, 1998; Pargament & Brand, 1998; Maltby, Lewis & Day, 2000; Loewenthal, MacLeod, Goldblatt, Lubitsh & Valentine, 2000). There have been frequent suggestions that cognitive factors are important in mediating between coping behaviours and outcomes (Pargament, 1996, 1997; Loewenthal, MacLeod, Goldblatt, Lubitsh & Valentine, 2000). For example Pargament reported that belief in divine punishment was associated with poor outcomes, and such a belief could be more likely among the ever-depressed, and could help to explain the poor view taken by the ever-depressed on the helpfulness of

religious coping. It is likely that cognitive factors will be important in exploring the But without further data we cannot advance on the disillusionment hypothesis.

Men saw religious coping as relatively more effective than did women. There is some evidence to suggest that men are less willing and less likely to use professional help for depression (Potts, Burnam & Wells, 1991), perhaps because of stigma. In the present study professional, medical and other "secular" forms of help were perceived as less effective by men than by women. There is virtually no evidence on gender differences in the use of and preferences for religious coping, and this finding, that men think it more effective than do women, is of great interest. It is possible that religious coping is seen as less stigmatising than professional help, and this may help to account for men's relatively favourable view of the effectiveness of religious coping.

Finally we turn to implications for uptake. How did beliefs in the efficacy of religious coping relate to help-seeking intentions? There were significant positive associations between belief in the efficacy of religious intervention, and the intention to seek social support and to use religious coping, if and when suffering from depression. The intention to seek professional help was not closely related to belief in the efficacy of religious help, though the relationship was positive. We might have expected inverse relationships, in the light of the view that is advanced in some religious traditions, that the believer needs only to trust in G-d, and has no need of human help (Loewenthal, 2000). Thus Mitchell & Baker (2000) suggested that fundamentalist Christians see the secular mental health services as lacking understanding, as insensitive to spiritual issues, and less likely to deliver real help. We might therefore also have expected that those who believed that they might be helped by religious coping, would be less likely to intend to turn to professionals, friends and family should they become depressed themselves. In fact the pattern of results suggests a possibly active style of coping, involving both religious coping activity, plus the use of social support resources, and not debarring the possible use of medical and other professional help. Comparably, Sorgaard, Sorensen, Sandager & Ingebrigtsen (1996) noted that people who sought help from clergy were not dissatisfied with secular mental health services as such, but were more open to help-seeking generally.

Conclusions

So, does faith conquer all? In our earlier qualitative study, it appeared that prayer and faith conquered other interventions, in being seen as likely to help with with depression. However our comparisons in that study were with professional interventions (medication and psychotherapy), which also fared rather poorly in the present study compared to religious interventions. In this study, social and cognitive and cognitive coping resources were seen as more effective than purely religious resources.

How did the groups differ? Muslims were relatively more enthusiastic about the efficacy of religious coping, and the religious nones least enthusiastic. Christians and Jews were also relatively enthusiastic about some forms of religious coping compared to other groups. Such effects may be important in the future planning of mental health service provision, since the inclusion of a question on religion is likely in future UK censuses.

Experience of depression did go with lowered belief in the efficacy of religious coping, and this might have been the result of disillusion.

How did belief in the efficacy of religious coping relate to help-seeking intentions? Those who thought the religious coping was effective were more likely to seek social support, and (to a weaker extent) professional help, suggesting the possibility of an active coping style. This study therefore gave no support for the view that religious coping activities are seen as an alternative to other forms of coping with psychological distress and illness. The study does highlight the importance of investigating religious factors in the planning of mental health service provision. Finally, the finding that men were relatively enthusiastic about religious help may prove to be an important issue.

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Table 1: Composition of the different religious groups with respect to gender, age and level of religious practice

	Christian	Hindu	Jewish	Muslim	Other	None
N	130	18	35	33	15	56
Gender	66% women (86F,44M)	71% women (12F,5M)	80% women (28F, 7M)	45% women (15F,18M)	73% women (11F,4M)	61% women (34F,19M)
Age (years)	23.2	20.5	36.5	22.4	20.0	24.3
Religious Practice (2-10)	6.1	6.5	6.4	7.0	4.7	2.4

Table 2: Perceived effectiveness of religious and other forms of coping, for all participants (n=282)

	Rank order/Mean ratings (1-7) by all participants (n=282)	Rank order/Mean ratings by religious group members (n=226)	Rank order/Mean ratings by the religious "nones" (n=56)
Good friends	1 (5.63)	1 (5.62)	2 ((5.63)
Knowing people care and value	2 (5.61)	2 (5.61)	1 (5.64)
Finding goals	3 (5.46.)	3 (5.53)	6 (5.13)
Recreational activities	4 (5.42)	4 (5.45)	4 (5.27)
Belief in self	5 (5.32)	5 (5.31)	3 (5.38)
Working through problems with friends or family	6 (5.27)	7 (5.27)	5 (5.25)
Meeting people	7 (5.22)	6 (5.30)	11 (4.87)
Encouragement or inspiration from other sufferers	8 (5.06)	8 (5.12)	14 (4.81)
Coming to terms with the situation	9 (5.05)	9 (5.07)	8 (4.98)
Counsellor	10 (5.02)	10 (5.07)	12 (4.83)
Holiday or change of scene	11 (4.98)	11 (5.06)	13 (4.82)
Psychiatrist	12 (4.97)	13 (4.95)	7 (5.06)
Psychologist	13 (4.97)	12 (4.97)	10 (4.94)
Psychotherapist	14 (4.78)	15 (4.74)	9 (4.98)
More financial or other help	15 (4.78)	14 (4.83)	15 (4.54)
Medication	16 (4.20)	20 (4.18)	16 (4.28)
Social worker	17 (4.20)	19 (4.19)	17 (4.24)

Faith in G-d	18 (4.13)	16 (4.43)	22 (2.79)
Praying	19 (4.08)	17 (4.38)	23 (2.73)
Religious practice	20 (4.01)	18 (4.28)	20 (2.87)
General practitioner	21 (3.89)	24 (3.85)	19 (4.06)
Alternative medicine	22 (3.88)	25 (3.83)	18 (4.14)
Attending religious worship	23 (3.87)	21 (4.11)	21 (2.81)
Consulting a religious leader	24 (3.81)	22 (4.06)	24 (2.73)
Others praying	25 (3.56)	23 (3.87)	26 (2.23)
Alternative advisor e.g. astrologer	26 (2.19)	26 (2.16)	25 (2.33)

Table 3: Mean ratings of the effectiveness of different religious coping activities by different religious groups

	Christian	Hindu	Jewish	Muslim	Other	None
Faith	4.3	3.8	4.2	5.4*	3.9	2.8~
Prayer	4.4*	4.1	3.9	5.5*	3.1	2.7~
Religious practice	4.1	4.2	4.7*	5.0*	3.4	2.9~
Attending worship	4.0*	4.1	4.0	5.0*	3.8	2.8~
Religious leader	4.1	3.6	4.2*	4.6*	2.9	2.7~
Others praying	4.2*	3.1	3.38*	4.1*	2.6	2.2~

Notes: Multiple range tests (Least Significant Differences) showed the following significant differences between means, all at p<.05, where * denotes higher, and ~ denotes lower:

Faith: Muslims higher than all others; nones lower than all except other religions.

Prayer: Muslims higher than all others; Christians higher than nones and other religions; Nones lower than all except other religions.

Maintaining ones religious practice: Jews and Muslims higher than Christians, other religions and nones; Nones lower than all except other religions.

Attending a place of worship: Muslims higher than all others except Jews; Christians higher than nones and other religions; Nones lower than all except other religions.

Consulting a religious leader: Christians, Jews and Muslims higher than nones and other religions.

Knowing that others are praying for one: Christians higher than all except Muslims; Muslims higher than nones and other religions; Jews higher than nones. Nones lower than all except other religions.

Table 4: Means of the ever-depressed and the never-depressed, and of men and of women, for belief in the efficacy of different forms of religious help. (In each case the two groups had similar variances. Two-tailed t values are reported, with 278 d.f.)

	Ever-Depressed (n=116)	Never-Depressed (n=168)	t	p	Men (n=96)	Women (n=184)	t	P
Faith	3.7	4.4	3.1	.002	4.5	3.9	2.3	.021
Prayer	3.7	4.3	2.9	.005	4.4	3.9	1.9	.057
Religious Practice	3.6	4.3	3.2	.002	4.2	3.9	1.2	NS
Attending Worship	3.5	4.3	3.2	.002	4.2	3.7	2.4	.017
Religious leader	3.3	4.3	4.0	.000	4.2	3.6	2.3	.022
Others praying	3.2	3.8	2.1	.033	3.8	3.5	1.2	NS

<u>Table 5: Means of the different groups on intentions to use professional help, social support, and religious help if depressed</u>.

	Christian	Hindu	Jewish	Muslim	Other	None
Professional help	17.4	16.2	18.9*	14.9	16.9	15.8
Social support	17.0	15.2	17.0	14.5*	16.6	16.2
Religious help	14.6*	12.5	13.7	15.4*	9.8	5.4~

<u>Notes</u>: Multiple range tests (Least Significant Differences) showed the following significant differences between means, all at $p<.05$, where * denotes higher, and ~ denotes lower:

Professional help: Jewish higher than Muslims and nones.

Social support: Muslims lower than Christians and Jews.

Religious help: Christians and Muslims higher than nones and other religions; nones lower than all other groups.