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Attitudes Toward Participation in Organized Religion: Its Impact on Mental Health and Life Satisfaction

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ORIGINAL REPORT

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ABSTRACT

This is a non-experimental study that is designed to discover potential relationships between individuals' attitude towards participation in organized religion and their mental health and life satisfaction. The study contained 203 young adults taken from a convenience sample using social media, e-mail, and SMS messages. The research was conducted using a survey form composed of three instruments intended to measure attitudes toward religion, general well-being, and life satisfaction. The study's results indicated a weak positive relationship between one's attitude toward organized religion and mental health. The results also indicated a weak positive relationship between one's attitude towards organized religion and their life satisfaction.

Keywords

Mental health, Life satisfaction, Religion, Spirituality

INTRODUCTION

The role of religion is pervasive in the lives of many people. According to Salsman and Carlson (2005), 93% of Americans identify with a religious group, and over 80% of those reported that religion is *fairly* or *very important* in their lives. Religion can influence several aspects of individuals' life, including mental health. Jauncey and Strodl (2018) stated that religiosity and spirituality are associated with positive mental health outcomes in 61% of studies, along with positive outcomes in 75% of studies on individual well-being. However, they also stated that in 32% of studies, an identified mixed or no relationship with mental health existed, as well as 6% identifying adverse outcomes concerning religiosity and spirituality (Jauncey & Strodl, 2018). Religious experiences often begin at a young age, making the experience a potentially important milestone, whether positive or negative.

EARLY CHILDHOOD RELIGIOUS EXPERIENCES

Early childhood religious experiences can affect mental health in later years. Hansen (1998) found that adults' psychological functioning was affected by their early religious experiences when these experiences contained rigid expectations or fear. Individuals with a history of high levels of fear in their religious upbringing tended to either remain in the religion of their upbringing without actively participating or separate themselves entirely from the religion of their upbringing, becoming members of a different religion (Hansen, 1998). Higher engagement in the relational aspects of religion and spiritual life can be associated with decreased depression

among adolescent males and females (Paine & Sandage, 2017). These early experiences can affect differing levels of religious participation and feelings toward religious individuals and symbols. McCann et al. (2020) stated that the negative thoughts or experiences of adolescent children in the LGBTQ+ community arise from religious beliefs, attitudes from others, or cultural experience of religious beliefs. These thoughts and experiences can influence youths' self-perception in a negative way which can lead to mental health issues. O'Connor et al. (2002) stated that levels of church involvement are influenced by adult experiences more so than early religious beliefs or practices. Hansen (1998) found that participants with high levels of current religious participation displayed an association with the tendency to conform to familial expectations and display subsequent guilt, while participants with lower levels of religious participation tended to avoid items associated with the religion. However, there may be no association between individuals' histories of religious rigidity and fear with their current religious conformity or independence (Hansen, 1998).

Corona et al. (2017) determined that religion is a cultural value connected to anxiety among college students. Young adults who have integrated faith into their everyday lives and who emphasize the centrality of their relationships with God are likely to experience less overall psychological distress (Salsman & Carlson, 2005). Ultimately, early religious experiences appear to affect mental health in a variety of ways.

RELIGIOUS PARTICIPATION

Potential Benefits to Mental Health

While the relationship between mental health and religion is complex, numerous connections between religious involvement and mental health exist. Involvement in religious activities can be associated with mental health issues like depression and substance abuse (Bonelli & Koenig, 2013). The association between mental health and participation in religious activities can be positive and negative. However, Bonelli and Koenig (2013) found no association between religiosity and psychiatric disorders. Other negative issues, such as problematic coping behaviors, including drug use or risky sex, could be improved by experiences with religion and spiritual activities (McCann et al., 2020). As aforementioned, no direct association between religiosity and psychiatric disorders exists. This includes no association between religiosity and anxiety having been reported, suggesting that interventions aimed at using religion to improve anxious symptoms might not be effective (Shiah et al., 2015). However, even if using faith as a targeted therapeutic intervention for anxiety is not necessarily effective, religious communities can help provide support and practices that generate comfort and peace, particularly in times of stress (Hamblin & Gross, 2013). An important function contributing to this potential atmosphere of peace within the religious community is finding meaning, purpose, or truth.

A greater sense of purpose or meaning contributes to lower anxiety and perceived stress levels, which may contribute to improved mental health. The idea of meaning bridges the concepts of religiosity and mental health together (Shiah et al., 2015). Creating or discovering meaning can help individuals find purpose in the why and how religion can be important in their lives and their mental health. The presence of meaning and the ability to love God and others can lead to greater satisfaction in life and reduce levels of anxiety and depression (Jauncey & Strodl, 2018). Additionally, Paine and Sandage (2017) found that involvement in religious activity decreased symptoms of depression in graduate students within the helping professions (counselors, psychiatrists, social workers, nurses, etc.). Participating in religious activities can help them focus on a higher meaning or purpose in life, reducing their anxiety and depression levels. However, when individuals have strong beliefs about Biblical texts holding truths that require reflection, a stronger relationship between their psychological distress and their doubts about their faith exist (Kezdy et al., 2011). This conflation again highlights the complexities in the relationship between mental health and religion and demonstrates that some individuals will attach to a given religious belief system and find peace when others find doubt. Clinicians can aid individuals in understanding how they perceive meaning and utilizing meaning as a coping mechanism for mental health problems. Extending beyond what religion offers, meaning can be created in other aspects of life (Shiah et al., 2015). When used as a coping mechanism, spiritual coping can help support healthy living, promote better mental health, motivate positive changes, and increase self-esteem (McCann et al., 2020). Religiosity can create meaning and be highly beneficial but also create a problematic relationship with spirituality, contributing to negative mental health.

Potential Problems for Mental Health

Relational processes surrounding spirituality (doubt, abandonment, disappointment) can harm an individual's mental health. When spiritual beliefs are held firmly, a stronger relationship between religious doubts and negative mental health exists (Kezdy et al., 2011). Firmly held religious beliefs can create rigid dichotomies, which can cause high levels of distress if individuals' beliefs are questioned. Rigidly held religious beliefs commonly emanate from Biblical interpretations. For instance, Biblical interpretations based on symbolic religious context over literal religious context can potentially reduce adverse mental health (Kezdy et al., 2011). Other strict religious beliefs that contribute to poor mental health include attending a more conservative church or rejecting the beliefs of faith communities but still attending services. Strict adherence to these beliefs are associated with higher levels of general anxiety disorder symptoms (Hamblin & Gross, 2013). In addition to external problems, internally, how individuals perceive themselves and their willingness to engage in positive health behaviors (seeking out therapeutic help, mindfulness), can be influenced by negative experiences with religious institutions (McCann et al., 2020). Mental health problems stemming from spiritual issues do not arise solely from rigid or literal understandings, but more broadly can come from individuals' relationships with their deities. Relational

spirituality can be defined as intertwining spirituality with personal relationships and relying on spirituality to guide and transform intimate relationships between individuals.

Relational spirituality is a more significant predictor of depressive symptoms over involvement in religious institutions. Furthermore, a strong association between depression and relational, spiritual struggle exists (Paine & Sandage, 2017). Paine and Sandage (2017) also found that excessive preoccupation with abandonment, punishment, and self-status with the divine is conducive to a higher likelihood of depressive symptoms. Disappointment in God is a more reliable indicator in predicting depression than one's involvement in religious institutions (Paine & Sandage, 2017).

Considering the research presented, religion can influence several aspects of individuals' lives, including their mental health. While early religious experiences may influence mental health, a strong correlation between the two does not exist. The relationship between mental health and religion is complex and has numerous connections between religious involvement and mental health. This association between mental health and an individual's participation in religious activities can be positive and negative; however, based on the research, no correlation is found between religiosity and psychiatric disorders. Despite the lack of a correlation between psychiatric disorders and religiosity, evidence suggests that religious communities can still help provide support and practices that generate comfort and peace, particularly in times of stress. An important function contributing to this potential atmosphere of peace within the religious community is finding meaning, purpose, or truth.

PURPOSE OF STUDY

The purpose of this study was to determine if attitudes toward participation in organized religion had an effect on the mental health and life satisfaction of young adults.

HYPOTHESES

Attitudes toward participation in organized religion are related to mental health in young adults. Attitudes toward participation in organized religion are related to life satisfaction in young adults.

PROCESS TO ACCOMPLISH

SAMPLE

The participants in this study were a convenience sample of 203 young adults (15-30 years old). The demographic information obtained from the participants in this study were sex, ethnicity, location of home, and highest level of education. Of those 203 participants, 22% were male, 78% were female, and less than one percent were unidentified. There were 88% Caucasian participants, and the other 12% were African-American, Native-American, Latino/Hispanic, or two or more ethnicities. There were 99% participants whose home country was located in North or Central America, and the other 1% participants were in South America or Europe. Of the 203 participants, 46% of the participants had completed a bachelor's degree, 31% had completed a master's degree, 14% had completed high school, and less than 1% had completed some high school, trade school, a doctorate, or preferred not to answer.

INSTRUMENTATION

The instrument used in this study was the Mental Health Survey. The survey included three different scales: Riverside Life Satisfaction Scale (Margolis et al., 2019), Edinburgh Mental Well-Being Scale (Tennant et al., 2007), and Religiosity Scale (Stanovich, 1989). Each survey section listed instructions on the scale to complete each question.

For the Riverside Life Satisfaction Scale portion of the survey, statements were presented and rated on a 7-point Likert scale: 1 = Strongly disagree, 2 = Moderately disagree, 3 = Slightly disagree, 4 = Neither agree nor disagree, 5 = Slightly agree, 6 = Moderately agree, and 7 = Strongly agree (Margolis et al., 2019). The construct validity of this scale correlated with other well-being measures (Margolis et al., 2019). The internal consistency was tested using McDonald's coefficient omega of 0.93 (Margolis et al., 2019). The test-retest indicated a high correlation over 2 weeks with (r = .90, 95% CI = [.87, .92]) (Margolis et al., 2019).

For the Edinburgh Mental Well-Being portion of the survey, responses for the 14 items were scored on a 5-point scale: *none of the time, rarely, some of the time, often,* and *all of the time*, with a minimum score of 14 and maximum score of 70 (Tennant et al., 2007). The internal consistency of Cronbach's alpha was 0.89. Also, the test-retest reliability at 1 week was 0.83 for the sample, which indicated high reliability (Tennant et al., 2007). The content validity was good for this instrument (Tennant et al., 2007).

The Religiosity Scale portion of the instrument consisted of four items rated on a 6-point scale: *more than once a week, once a week, a couple of times a month, a couple of times a year, hardly ever, never* and *extremely strong, very strong, strong, moderately strong, somewhat weak, nonexistent*); a 7-point scale; and a 5-point scale (*extremely important, very important, somewhat important, not very important, completely unimportant*). All the statements were scored so that higher numbers indicated stronger religious commitment (Stanovich, 1989). The scale's validity is unknown; however, internal consistency reliability indicated that the four items were moderately correlated with each other (Stanovich, 1989). Item 1 correlated with the other three items of .52, .37, and .56, and Item 2 displayed a correlation of .48 and .70 with Items 3 and 4, while the latter two items displayed a correlation of .53 (Stanovich, 1989).

The survey also comprised demographic information. The five demographic questions were multiple choice including sex, age,

ethnicity, home country, and education level. A copy of the Mental Health Survey is included as an Appendix.

PROCEDURE

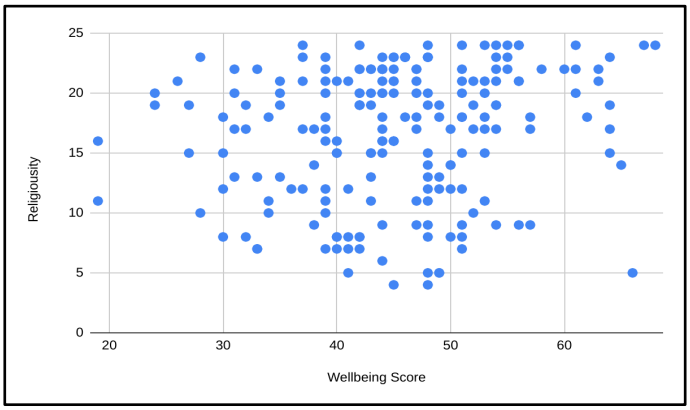
Once the Internal Review Board (IRB) approved this nonexperimental study, the survey link to a Google form was posted on Facebook. The link was also shared digitally via text message with friends. Clear instructions were given to all participants, informing them that they were not compelled to answer any questions and that they were free to withdraw from the study at any time. If they chose to participate, they were providing their informed consent. After a period of time, the survey was closed, and the data was collected and scored by the researchers. To analyze the data and test the hypotheses, a Pearson Correlation Coefficient was used to examine the strength of the linear relationship between participants' attitudes toward participation in organized religion with mental health and life satisfaction. Both hypotheses were tested using an alpha level of 0.05.

RESULTS

A Pearson Correlation Coefficient was used to examine the strength of the linear relationship between participants' attitudes toward participation in organized religion with mental health (Table 1). The hypothesis was tested using an alpha level of 0.05. A weak positive relationship was found r (201) = 0.16, P < .01; the null hypothesis was rejected.

Table 1

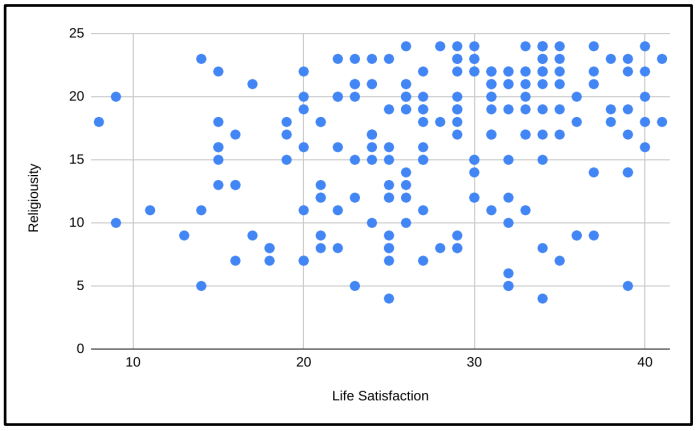
Religiosity and Wellbeing



A Pearson Correlation Coefficient was used to examine the strength of the linear relationship between participants' attitudes toward participation in organized religion with life satisfaction (Table 2). The hypothesis was tested using an alpha level of 0.05. For this relationship, a weak positive relationship was found, r (201) = 0.28, P < .0001; the null hypothesis was rejected.

Table 2

Religiosity and Life Satisfaction



DISCUSSION

FINDINGS

This study's results indicated that a connection between participant's attitudes towards organized religion and their mental health existed, although a weak one. Similarly, a weak connection was also found between participants' attitudes toward organized religion and their life satisfaction. These findings were corroborated by Paine and Sandage's (2017) findings that involvement in religious activity decreased symptoms of depression in graduate students and in Hamblin and Gross's (2013) findings that religious communities can help provide support and create peace in times of stress. Other research noted conflicting information about the possible effects of this relationship. This conflict could be due to more specification in what constitutes mental health, differing religious faiths, or inclusion of variables outside of the ones used in this study.

LIMITATIONS

There were several limitations found in this study. The sample size was relatively small and could limit the generalizability of the results. Also, the sample was a convenience sample so the participants were limited by the accessibility of the researchers. The means of distributing the survey were limited by access to social media and other forms of technology. Using a Google survey limited access to individuals with a Google account. Another limiting factor of this study was the demographics of the participants, which were primarily Christian, White, American, and female. The results found are not an accurate representation of the population. Additionally, the survey's self-reporting nature indicated that the authenticity of the responses may not be completely reliable, especially considering a religious institution hosted the survey.

IMPLICATIONS

From the results of this study, relationships do exist between how one views organized religion and internal regulation, framed in this study as mental health and life satisfaction. While the findings may be relatively minor, there is more research that can be completed on this topic. This subject, where participants expressed interest and passion with many wanting more information and results, implies the importance of this topic. Due to the existing relationship discovered, incorporating faith into treatment for mental health or the pursuit of life satisfaction could be helpful for many individuals.

FUTURE RESEARCH

Future research needs to be conducted on religion and the relationship with mental health and life satisfaction, preferably with a larger, more diverse sample of participants. A larger and more diverse sample would help more accurately represent the overall population. Another consideration for future research would be to use more specific variables to produce more specific results. Some specific areas to address might be the construction of meaning, locus of control, perceived rigidity, and flexibility of religion. These facets would narrow and provide more specificity within mental health, life satisfaction, and religion. Additional research in these areas may help minimize the extreme responses.

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APPENDIX

Mental Health Survey

Please answer the following questions to the best of your ability. You are not compelled to answer these questions. You are free to withdraw from the survey at any time.
Please rate your agreement with each of the statements below, using the 7-point scale provided. 1. Strongly disagree 2. Moderately disagree 3. Slightly disagree 4. Neither agree nor disagree 5. Slightly agree 6. Moderately agree 7. Strongly agree

1. I like how my life is going.
2. If I could live my life over, I would change many things.
3. I am content with my life.
4. Those around me seem to be living better lives than my own.
5. I am satisfied with where I am in life right now.
6. I want to change the path my life is on.

Below are some statements about feelings and thoughts. Please select the number that best
describes your experience over the last 2 weeks. 1. None of the time 2. Rarely 3. Some of the time 4. Often 5. All of the time

7. I've been feeling optimistic about the future.
8. I've been feeling useful.
9. I've been feeling relaxed.
10. I've been feeling interested in other people.
11. I've had energy to spare.
12. I've been dealing with problems well.
13. I've been thinking clearly.
14. I've been feeling good about myself.
15. I've been feeling close to other people.
16. I've been feeling confident.
17. I've been able to make up my own mind about things.
18. I've been feeling loved.
19. I've been interested in new things.
20. I've been feeling cheerful.

In this part of the questionnaire, please select the number of the response that is most appropriate. 1. Never 2. Hardly ever 3. A couple of times a year 4. A couple of times a month 5. Once a week 6. More than once a week

21. I attend religious services.

In this part of the questionnaire, please select the number of the response that is most appropriate. 1.Nonexistent 2. Somewhat weak 3. Moderately strong 4. Strong 5. Very strong 6. Extremely strong

22. I consider my religious beliefs to be_____

In this part of the questionnaire, please select the number of the response that is most appropriate. 1. I am certain that God does not exist 2. I think that there probably is not a God 3. I am not sure whether God exists or not 4. I think that there probably is a God 5. I am pretty sure that God exists 6. I am certain that God exists

23. My feelings concerning the existence of God are _____

In this part of the questionnaire, please select the number of the response that is most appropriate. 1. Completely unimportant 2. Not very Important 3. Somewhat unimportant 4. Somewhat important 5. Very important 6. Extremely important

24. How important is religion in your everyday life?
25. What is your sex?

A. Male, B. Female

26. What is your age?

A. 0 - 15 years old, B. 15 - 30 years old, C. 30 - 45 years old, D. 45+

27. Please specify your ethnicity

A. Caucasian, B. African-American, C. Latino or Hispanic, D. Asian, E. Native American, F. Native Hawaiian or Pacific Islander, G. Two or More, H. Other/Unknown

28. Where is your home located?

A. North America/Central America, B. South America, C. Europe, D. Africa, E. Asia, F. Australia, G. Caribbean Islands, H. Pacific Islands, I. Other: _____

29. What is the highest degree or level of education you have completed?

A. Some High School, B. High School, C. Bachelor's Degree, D. Master's Degree, E. Doctorate Degree or higher, F. Trade School, G. Prefer not to say

ABOUT THE AUTHORS

Kayla Riley is a recent graduate of Harding University. She completed her EdS and MS degrees in Clinical Mental Health Counseling. She is now a Licensed Associate Counselor (LAC) in Arkansas. She currently works at Harding University in the Mental Health and Wellness Department. While continuing her work at the University, Kayla is also searching for a counseling job that would be a good fit for her. Kayla is married to Jonathan Riley, who was the co-author on this article. They have been married for 6 1/2 years. They have 2 cute cats at home to keep them company. Kayla loves reading, writing, and listening to music.

Jonathan Riley is a recent graduate of Harding University. He completed his EdS and MS degrees in Clinical Mental Health Counseling. Jon is currently undergoing the licensing process for Arkansas to become a Licensed Associate Counselor (LAC). Jon works at Capstone Treatment Center in Judsonia, AR as a therapist. He wants to focus his counseling work on addiction and trauma. Jon is married to Kayla Riley, who co-authored this article with him. Jon loves consuming film, music, and books.