RedFame

International Journal of Social Science Studies
Vol. 13, No. 4; December 2025
ISSN 2324-8033 E-ISSN 2324-8041
Published by Redfame Publishing
URL: http://ijsss.redfame.com

Spirituality, Religiousness, and Mental Health: A Literature Review of Religion's Impact in Mental Health

Keith Robert Head[1]

[1] School of Nursing and Health Sciences, Capella University, Minneapolis, USA

[1] Department of Psychology, Sociology, and Social Work, West Texas A&M University, Canyon, USA

Correspondence: Keith Robert Head, LMSW, USA. E-mail: khead4@alumni.uwo.ca

Received: August 10, 2025 Accepted: October 9, 2025 Available online: November 20, 2025

doi:10.11114/ijsss.v13i4.7882 URL: https://doi.org/10.11114/ijsss.v13i4.7882

Abstract

Religious and spiritual involvement (R/S) plays a significant role in the mental health of many Americans, yet the nature of this relationship remains complex. Current empirical evidence from systematic reviews, longitudinal studies, and clinical trials demonstrates predominantly protective effects of R/S across major psychiatric disorders, with higher religious engagement generally associated with reduced depression and substance use, enhanced resilience following trauma, and improved outcomes in several other conditions. However, the relationship proves notably bidirectional, as religious struggle, negative religious coping, and certain doctrinal beliefs can exacerbate symptoms, particularly in obsessive-compulsive disorder through scrupulosity and in depression when spiritual conflicts arise. The magnitude of protective effects remains modest, with considerable variation across populations, cultural contexts, and measurement approaches. For anxiety disorders, findings remain inconsistent, with approximately half of studies showing benefits while others report null or negative effects. Substance use disorders show the most robust inverse relationship with R/S, while eating disorders and personality disorders demonstrate limited and conflicting evidence. Understanding these complex patterns has significant implications for clinical practice, supporting the integration of spiritual assessment and religiously informed interventions into mental health care while highlighting the critical need to distinguish adaptive from maladaptive religious cognitions. Future research must address fundamental gaps including the lack of mechanistic understanding, geographic bias toward American populations, and the need for validated assessment tools that can capture the multidimensional nature of religious experience and its varied impacts on psychological well-being.

Keywords: Mental health outcomes, Mental Health Impact, Religious coping, Faith-based interventions, Psychological well-being

1. Introduction

Religious and spiritual affiliation (R/S) and practice rates in the United States are much higher than those observed in other high-income or western nations. Religious and spiritual identification among Americans remained largely stable from 2018-2024, with 45% identifying as Protestant or nondenominational Christian, 21% as Catholic, 10% as another religion, and 22% claiming no religious affiliation (Jones, 2025). Religion is a central facet of life for many Americans and has long been thought to influence mental well-being. Research examining the relationship between religiousness/ spirituality (R/S) and mental health has expanded significantly in recent years, driven by accumulating scientific evidence of meaningful connections between these domains. However, this growing body of research faces a fundamental challenge: the lack of consensus regarding how spirituality should be defined and conceptualized. Scholars have increasingly recognized the need to distinguish between spirituality and religiousness as distinct but related constructs, though definitional ambiguity continues to complicate research efforts and limit the field's theoretical coherence.

Defining “religion” and “spirituality” is important in this context. Religion typically refers to an organized system of beliefs, practices, and rituals related to the sacred or transcendent (often God in Western traditions), usually shared within a community. Spirituality is a broader, more personal concept of seeking meaning, purpose, and connection with something greater than oneself, which may or may not occur through formal religion. A person can be spiritual without being religious, and vice versa, though the two often overlap. Most empirical studies to date have combined these dimensions (often termed “R/S”) when examining health outcomes, but researchers caution that spirituality measures

must be used carefully to avoid tautology with mental health (Koenig et al., 2020). In this review, we use the term "religion" broadly to encompass both traditional religious practice and related aspects of spirituality, in line with how it appears in the literature.

Recent decades have witnessed widespread professional acknowledgment of religion and spirituality's clinical importance. Major healthcare organizations, including the American College of Physicians, the American Medical Association, the American Nurses Association, and the Joint Commission on Accreditation of Healthcare Organizations, recognize that spiritual care represents an important healthcare component warranting integration into clinical practice. Mental health organizations have shown similar recognition, with the World Psychiatric Association, American Psychological Association, American Psychiatric Association, and Royal College of Psychiatrists all maintaining dedicated religion and spirituality sections (Moreira-Almeida et al., 2014). This subject has also been systematically included in medical school curricula across the globe. The integration of spirituality into medical education has been driven by extensive research publications and mounting evidence of health-related connections, leading to thousands of published scientific articles (Koenig, 2012).

Contemporary research reveals that spirituality and religiousness correlate with multiple health outcomes spanning both physical and emotional domains (Moreira-Almeida et al., 2014). Regarding physical health, most studies demonstrate that spiritual and religious engagement associates with improved health outcomes across diverse medical conditions (Powell et al., 2003). However, mental health outcomes have commanded the greatest research attention, representing at least 80% of studies in this field and forming the primary focus of this review (Koenig, 2012).

This review synthesizes current evidence regarding the relationship between religiousness/spirituality (R/S) and mental health, to provide an updated review, highlighting key research findings. The analysis examines common psychiatric disorders prevalent in the United States, including anxiety disorders, major depressive disorder (MDD), substance use disorders (SUDs), post-traumatic stress disorder (PTSD), attention-deficit/hyperactivity disorder (ADHD), bipolar disorder, obsessive-compulsive disorder (OCD), borderline personality disorder (BPD), schizophrenia and other psychotic disorders, and eating disorders such as anorexia and bulimia. Additionally, this review addresses the underlying mechanisms driving the R/S-mental health relationship and examines broader clinical considerations. While definitive conclusions remain premature given the field's evolving nature, this review provides essential information for understanding and navigating the complex relationship between R/S and mental health conditions.

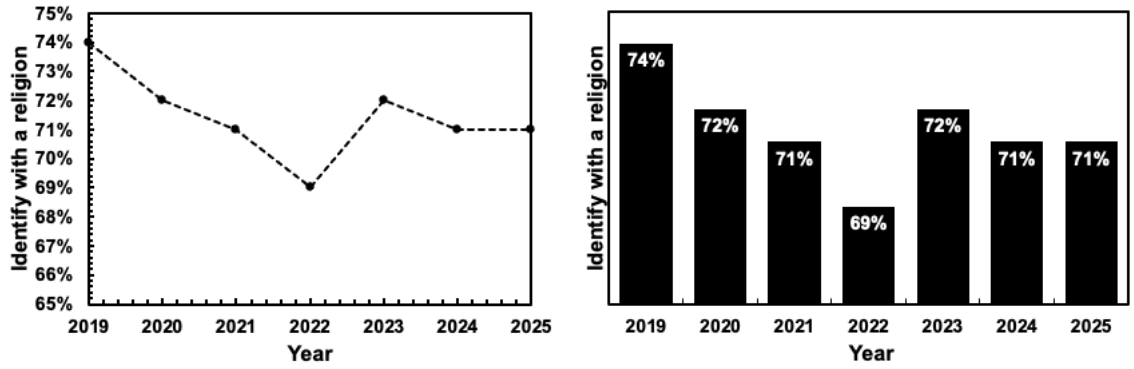

Figure 1. the trends in religious identification from 2019 to 2025, with data sourced from the Pew Research Center

2. Methodology

This narrative literature review synthesized research published between 2000 and January 2025 examining relationships between religiousness/spirituality (R/S) and mental health outcomes. Studies outside this temporal period were considered if they represented seminal works or provided data unavailable in recent literature. Comprehensive searches were conducted across PubMed/MEDLINE, PsycINFO, Web of Science, Google Scholar, and specialized resources including the Handbook of Religion and Health bibliography, using combinations of R/S terms ("religion*", "spiritual*", "faith", "religious coping") with specific mental health conditions ("depression", "anxiety", "substance use", "PTSD", "ADHD", "bipolar disorder", "OCD", "borderline personality", "eating disorder", "schizophrenia"). Inclusion criteria required peer-reviewed empirical studies examining R/S relationships with diagnosed mental health conditions or validated symptom measures, with priority given to systematic reviews, meta-analyses, longitudinal studies, and clinical trials over cross-sectional research. Given heterogeneity in R/S measurement across studies, a narrative synthesis approach was employed, categorizing findings as positive (R/S associated with better mental health), negative (R/S associated with worse outcomes), null (no significant association), or mixed effects, while distinguishing between

positive religious coping and negative religious coping/spiritual struggles when available. The review focused primarily on Western populations due to literature availability, noting methodological limitations including measurement inconsistencies and geographic constraints when interpreting findings.

3. Background

Scholarly exploration of the connection between religion, spirituality, and mental health has deep historical roots, tracing back to ancient times and spanning more than a century. The institutional separation between religion and mental health care represents a relatively recent historical development, as religious institutions were responsible for the care of the mentally ill for centuries, and the first hospitals in the West were built by religious organizations (Koenig, 2012). A major paradigm shift occurred in the late 19th century when Charcot and his pupil Freud associated religion with hysteria and neurosis, creating a divide between religion and mental health care that persisted well into the late 20th century (Dein, 2010). During much of the 20th century, mental health professionals tended to deny the religious aspects of human life and often considered this dimension as either old-fashioned or pathological, predicting that it would disappear as mankind matured and developed. The contemporary scientific renaissance in this field began with pioneers like David B. Larson, Jeffrey S. Levin, and Harold G. Koenig, who opened a new stage for systematic investigation of religion and spirituality in medicine through rigorous empirical studies (Moreira-Almeida et al., 2006). This gradual transformation in professional attitudes culminated in formal institutional recognition, including the introduction of "religious or spiritual problems" as a diagnostic category in DSM-IV in 1994, and the inclusion of religious and spiritual training requirements in psychiatric residency programs by the Accreditation Council for Graduate Medical Education (Dein, 2010). This institutional shift both reflected and facilitated a parallel transformation in empirical research. In recent decades, systematic research has painted a different picture than the earlier theoretical dismissals. An accumulating body of evidence suggests that religious involvement can have significant effects on mental health, often beneficial but sometimes detrimental, warranting careful scientific and clinical attention (Koenig et al., 2020). Reflecting this growing recognition, the World Psychiatry Association issued a position statement in 2016 advocating for the systematic inclusion of spirituality and religion in both clinical practice and professional training, emphasizing the need for more holistic and comprehensive approaches to mental health care (Moreira-Almeida et al., 2016).

4. Analysis of R/S and Mental Health Outcomes

4.1 Anxiety Disorders

While the relationship between R/S and anxiety disorders has received some research attention, the evidence base remains more limited and methodologically inconsistent compared to other mental health domains such as depression. Some studies report that religious involvement correlates with lower anxiety levels, while others find no effect or even higher anxiety in religious individuals. For example, a comprehensive review found 55% of high-quality studies reported less anxiety among the more religious, whereas about 10% found the opposite trend (Koenig, 2012). Likewise, a 2022 review noted that only roughly half of studies suggest a protective association of religion with anxiety, and some large longitudinal analyses show minimal or very small effects (VanderWeele & Ouyang, 2025). These discrepancies indicate that religion may provide peace and comfort for some, but in other cases or contexts it can have a negligible impact or even “afflict the comforted,” contributing to anxiety (Koenig, 2012).

Many findings highlight potential protective effects of religious faith and practices on anxiety. Frequent religious service attendance, prayer, or high intrinsic religiosity often coincide with modestly lower anxiety symptoms in general populations (Koenig, 2012). Meta-analytic evidence from longitudinal studies confirms a small but significant positive effect of overall religious/spiritual involvement on mental health and distress (Garssen et al., 2020). Systematic reviews across two editions of the Handbook of Religion and Health found that nearly half (49%) demonstrated that spirituality and religiousness reduced anxiety levels, while 40% found no relationship between the two. A smaller portion (11%) actually found that spiritual and religious practices were associated with increased anxiety (Koenig et al., 1998). Several specific studies have identified a connection between R/S and reduced anxiety levels (Sternthal et al., 2010). Proposed mechanisms include the social support and community bonds formed through religious participation, as well as coping resources like hope, meaning, and a sense of purpose that faith can provide during stress. In line with this, spiritually oriented interventions and positive religious coping (e.g. trusting in a benevolent higher power) have been associated with reductions in anxiety or stress in many populations (Aggarwal et al., 2023). The evidence does suggest that for a substantial subset of individuals, religion appears to serve as a buffer against anxiety by fostering resilience and emotional well-being (Cheng & Ying, 2023).

Conversely, several recent large-scale studies find little to no overall association between being religious and anxiety outcomes. A notable 9-year prospective cohort study (nearly 3,000 adults) reported that religious affiliation and participation had no significant impact on the prevalence or severity of anxiety disorders over time. In this population

sample, being more vs. less religiously involved did not protect against anxiety nor did it increase anxiety risk (Bos et al., 2024). This aligns with other longitudinal evidence suggesting any direct effect of religiosity on anxiety is weak or context dependent (VanderWeele & Ouyang, 2025). Indeed, systematic reviews have not rated the religion–anxiety link as consistently strong, finding that about half of studies show no reliable relationship (Balboni et al., 2022). Such null and minimal findings imply that broad religious involvement per se may often be neutral with respect to anxiety, with beneficial effects emerging mainly under specific conditions or in certain subgroups.

It is important to note that limited research also documents circumstances where religion can exacerbate and fuel anxiety symptoms. Negative religious coping, for instance, feeling punished, abandoned by God, or perceiving a crisis of faith, has been consistently linked to higher anxiety and stress (Cheng & Ying, 2023). individuals who struggle with chronic religious guilt or scrupulosity (an anxiety-driven hyper-concern with sin and morality) often experience elevated anxiety and fear. Excessively rigid or punitive belief systems may heighten worries about divine punishment or damnation, thereby intensifying anxiety rather than relieving it (Koenig, 2012). Although such negative correlations are significantly less common than protective ones, they suggest that when religion engenders conflict, doubt, or fear, it can become a source of anxiety rather than a cure.

The relationship between religion/spirituality and anxiety shows mixed and inconsistent results, with some individuals experiencing benefits through social support and positive coping while others face increased anxiety from negative religious coping or rigid beliefs. While some research suggests protective effects, the current evidence remains limited with mixed findings, highlighting the need for more comprehensive longitudinal research in this area.

4.2 Depression

The relationship between R/S and depression has been widely investigated and represents the most well-documented area within mental health research. Overall, a large body of research suggests that higher religious involvement is modestly associated with lower rates of depression, but results are not entirely consistent. For example, an exhaustive review of 444 studies found that about 61% reported significantly less depression among more religious individuals, whereas only around 6–7% found greater depression in the more religious (the rest showed no clear relationship) (Koenig, 2012; Smith et al., 2003]. Likewise, a systematic review of 152 longitudinal (prospective) studies concluded that roughly half of those studies observed a protective effect of R/S on depression over time, in other words, people with greater religiosity tended to experience a modest decrease in depressive symptoms, while about 10% of studies found higher depression or mixed outcomes among the religious (the remaining ~40% detected no significant association). Notably, the magnitude of the overall effect is small; one meta-analysis estimated the average correlation between religiosity and depressive symptoms to be only about $r = –0.10$, indicating a weak inverse relationship (Braam & Koenig, 2019). Overall, greater religious involvement tends to correlate with slightly lower depression on average, but this pattern is far from uniform across all studies and populations.

Many findings highlight potential protective effects of religious faith and practices on depression. Individuals who frequently attend religious services, engage in regular prayer or meditation, or who place a high intrinsic value on their faith often exhibit lower levels of depressive symptoms or a reduced risk of major depression, albeit typically by a modest degree (Koenig, 2012). For example, in a 12-year prospective study of nearly 50,000 US women, those who attended religious services at least once per week had about a 30% lower risk of developing clinical depression compared to women who never attended services (Li et al., 2016). Columbia University researchers conducted several studies of children of depressed and non-depressed parents and found that R/S reduced depression risk, especially in high-risk individuals (Miller et al., 2012). A two-decade longitudinal study also found that regular religious attendance was linked to a 43% reduction in the risk of developing mood disorders for high risk individuals (Kasen et al., 2011). These benefits come from several sources. Social support from religious communities provides help and encouragement during tough times. Religion also offers coping resources like an optimistic outlook, meaning and purpose, and comfort from believing in a caring God, all of which build resilience. Positive religious coping like trusting in a benevolent God and finding hope through faith leads to lower depression levels. Indeed, a number of clinical trials have found that incorporating patients' spiritual beliefs into therapy or using faith-based interventions can lead to significantly greater reductions in depressive symptoms compared to standard treatments or controls but varied based on condition. For example, HIV/AIDS treatment reported reduced depression, but substance abuse users did not (Bormann et al., 2006' Koenig, 2012). Religious faith can buffer against depression through comfort, hope, meaning, and support, but these protective effects vary depending on the population and circumstances.

Conversely, several recent large-scale studies find little to no overall association between general religious involvement and depression outcomes. For instance, some long-term population-based cohort studies have reported that being more religious (i.e.. service attendance) does not significantly reduce the risk of depression compared to being less religious once relevant confounding factors are taken into account. This aligns with broader longitudinal evidence suggesting that

any direct effect of religiosity on depression is often weak or highly context-dependent (Smith et al., 2003). In the 152-study review noted above, nearly as many studies showed no significant relationship as showed a benefit , suggesting that findings are mixed. Systematic reviews similarly emphasize that despite many positive findings, a considerable proportion of studies (often 30–40%) report null results, implying that generic religious involvement per se is often neutral with respect to depression (Braam & Koenig, 2019). This pattern is exemplified by longitudinal research showing that religiousness buffers against depression specifically among individuals with poor physical health, while having no protective effect among those in good health (Wink et al., 2005). In other words, Religion's impact on depression varies by person and situation, the benefits mainly appear for people under high stress or at risk for depression (like those with serious illness or family history), while healthy or younger people see little to no effect. Overall, these null and minimal findings indicate that religious involvement is not a guaranteed shield against depression in the general population, and its advantages might frequently be offset by other factors.

It is also important to recognize that religion can sometimes exacerbate or contribute to depression under certain circumstances. Notably, the aforementioned longitudinal review found that in studies specifically examining religious struggle (experiences of spiritual conflict, doubt, feeling abandoned or punished by God), a majority (around 59%) reported greater depression over time with a moderate effect size (Braam & Koenig, 2019). This suggests that when one's religious experience is fraught with anger towards God, guilt, or existential confusion, it can worsen emotional distress rather than relieve it. In such cases, religion effectively "afflicts the comforted" instead of comforting the afflicted. Although these negative correlations are less common than protective ones, they illustrate that when religious faith engenders conflict, guilt, or fear, it can become a source of psychological stress rather than solace (Koenig, 2012). Different results have also been reported in non-Western countries. A 13-year study of over 67,000 Japanese adults found that highly religious people had higher rates of major depression than non-religious people, suggesting that cultural context influences how religion affects mental health (Kobayashi et al., 2020). There have been other similar studies showing that religion can increase depression risk in different cultures and religious contexts.

Balanced against the benefits, these findings highlight that religious involvement is not universally positive for depression.

4.3 Substance Use Disorder

Successful programs including Alcoholics anonymous has driven substantial research regarding R/S and in substance use and abuse. R/S is associated with reduced risk of developing substance use disorders and may facilitate recovery from such disorders (Walton-Moss et al., 2013).

A systematic review examining the relationship between R/S and substance use found that several aspects of religiosity were associated with reduced substance use risk in over 94% of studies examined (Chitwood et al., 2008). While large studies like this have found consistent but varied positive effects, recent studies found that frequent attendance at religious services, not self-rated religious importance or affiliation was independently associated with reduced odds of alcohol, tobacco, and cannabis use disorders. Individuals who attended services regularly had significantly lower prevalence of these substance use disorders. Notably, for alcohol and tobacco, frequent religious service attendance showed stronger protective effects against substance use disorders than against substance use itself. These results suggest that active religious engagement (especially communal worship) serves as a robust protective factor against many forms of substance abuse in the general population (Livne et al., 2021). This has also been documented outside the United States, with a nationwide study of 3,007 Brazilian adults finding that higher religious attendance was associated with fewer alcohol-related problems, and self-reported religiousness was linked to reduced harmful drinking effects (Lucchetti et al., 2013).

Beyond onset, religiosity appears to slow the escalation from substance use to more severe stages of misuse. A recent analysis of U.S. adults examined how quickly users of alcohol, tobacco, or cannabis progressed from initial use to heavy use and then to a substance use disorder. After adjusting for demographic and socioeconomic factors, frequent religious service attenders showed significantly slower transitions: they were 8–15% less likely to progress from first use to heavy use of tobacco, ~9% less likely for alcohol, and up to 26% less likely for cannabis, compared to infrequent attenders. Strong personal religious belief was also linked to a reduced likelihood of escalation (for instance, highly religious cannabis users had ~16–21% lower odds of moving into heavy use). Moreover, religious engagement was associated with a lower probability of progressing from heavy use to a diagnosable substance disorder in the case of alcohol, suggesting that faith-oriented social support might help restrain use from evolving into full addiction (Hassan et al., 2023).

Coinciding with religious attendance Research indicates that the community religious environment can additionally shape substance use outcomes. A multilevel study of over 34,000 U.S. adults found that individuals living in states with higher proportions of Evangelical Protestants actually had elevated odds of alcohol use disorder, whereas those in states

with greater membership in historically Black Protestant churches had a significantly lower risk of alcohol disorder. These contextual effects persisted even after controlling for each person's own religiosity and socioeconomic factors (Ransome et al., 2019). In other words, beyond personal beliefs, residing in a highly religious "moral community" was linked to reduced alcohol abuse, while certain regional religious concentrations (like evangelical-heavy areas) correlated with higher alcohol use disorder rates. Such findings imply that the broader religious milieu, norms, networks, and support systems in one's environment, also independently influence substance use behavior in the U.S. adult population.

In summary, substantial evidence demonstrates an inverse relationship between R/S and substance use disorders, with higher religious involvement consistently associated with lower rates of substance use and abuse. While research has focused primarily on alcohol, similar protective effects have been documented for other substances.

4.4 Post-Traumatic Stress Disorder

Several studies have examined the role of R/S in post-traumatic stress disorder, generally reporting beneficial effects on PTSD symptoms and recovery. Studies suggest that religious coping can significantly influence short term PTSD outcomes after disasters. For example, among Mississippi residents who survived Hurricane Katrina, those who engaged in positive religious coping (e.g. seeking spiritual support) tended to report fewer PTSD symptoms, whereas negative religious coping (e.g. feeling punished by God) was linked to worse psychological outcomes (Wortmann et al., 2011). Religious faith may also foster resilience over the long term. In a large study of over 10,000 U.S. adults, intrinsic religiosity (personal religious commitment) and positive religious coping significantly moderated the impact of childhood trauma on later mental health. In that sample, individuals with high intrinsic religious devotion and healthy coping (along with traits like forgiveness and gratitude) experienced less adverse effect from early traumatic stress on their adult psychological well-being (Reinert et al., 2015). This has also been documented outside the US with a study of 1,091 Spanish participants finding that religiousness correlated with post-traumatic growth during the COVID-19 pandemic (Prieto-Ursúa & Jódar, 2020). These findings imply that drawing comfort and meaning from faith can buffer trauma-related stress and that private religious faith can be protective factors in trauma recovery.

Research in U.S. military veterans similarly indicates a protective effect of religion on PTSD. A 7-year nationally representative study found that veterans who frequently attended religious services had a significantly lower risk of developing new-onset PTSD (Rubenstein et al., 2021). Likewise, in a PTSD treatment program for combat veterans, those entering with higher levels of spiritual involvement, such as frequent spiritual practices, church attendance, and positive religious coping, showed greater improvement in PTSD symptoms by discharge. However, not all religious influences are beneficial; spiritual struggle or maladaptive religious responses can exacerbate post-traumatic distress. Among veterans, those who endorsed more negative religious coping at treatment entry (e.g. spiritual struggles) had significantly poorer PTSD outcomes following therapy (Currier et al., 2015).

Therefore, overall, R/S may provide protective effects against post-traumatic stress and enhance psychological resilience and growth following adverse events. However, R/S may also result in negative outcomes in certain circumstances, particularly with those struggling with religion. Since most studies focus on veteran populations, additional research examining general populations is needed.

4.5 Attention-Deficit/Hyperactivity Disorder

Some limited studies have assessed the relationship between R/S and Attention-Deficit/Hyperactivity Disorder. These studies specifically found that R/S affects management of the condition rather than its prevention. For example, a 2022 study of 806 Israeli adults found that higher religiosity was linked to fewer ADHD symptoms/diagnoses and to better psychosocial outcomes. Religious participants with ADHD reported significantly less antisocial behavior and emotional distress than their non-religious counterparts, and religiosity appeared to buffer (moderate) the usual negative effects of ADHD on these outcomes (Novis-Deutsch et al., 2021). Similarly, an international 2025 study of 578 adults with both ADHD and substance use disorder found that greater religiousness was associated with lower ADHD symptom severity. Notably, this ADHD–religiosity link was not fully explained by self-control differences, hinting that religious engagement itself may benefit ADHD symptoms in this group (Begeman et al., 2025). Interestingly, evidence from U.S. community samples indicates that individuals with ADHD are less likely to be religiously active (Dew et al., 2020).

Thus, while limited research indicates that higher levels of R/S may help reduce certain adverse effects of ADHD, additional studies are necessary to substantiate these findings.

4.6 Bipolar Disorder

Religious themes are common in bipolar disorder (BD), particularly during manic episodes. While this connection is primarily understood through religious delusions and hyper-religiosity that can occur during mania, research examining religion's actual impact on the course and management of bipolar disorder remains limited. The most robust finding

across available research suggests that private religious activities like prayer and meditation demonstrate complex, sometimes contradictory associations with bipolar symptoms. A scoping review of 416 articles found that Individuals with BD frequently report R/S beliefs as important in their lives, often more so than general psychiatric populations. The majority of studies showed that positive religious coping (e.g., prayer, trust in God, spiritual meaning-making) was associated with beneficial outcomes, such as higher quality of life, increased social support, greater treatment adherence, and reduced suicidality. Conversely, negative religious coping (e.g. spiritual struggle) correlated with higher depressive and manic symptoms, worse functioning, and increased distress. Some studies found that spirituality facilitated recovery by helping individuals find purpose, sustain hope, and frame their experience of illness (Jackson et al., 2022).

For instance, a cross-sectional analysis of 168 patients with bipolar disorder revealed that both religiousness and positive religious coping strategies correlated with improved mental health and well-being, while negative coping approaches were linked to poorer mental health outcomes (Stroppa et al., 2018). In contrast, international studies focused on Japan and Austria show a different pattern, with spiritual well-being demonstrating greater relevance to resilience in bipolar disorder compared to religiosity (Mizuno et al., 2017). However, Brazilian research demonstrated that both positive religious coping and intrinsic religiousness were predictors of improved well-being in longitudinal studies, while negative coping was associated with increased manic symptoms (Stroppa & Moreira-Almeida, 2013).

Overall, limited research indicates that increased religiosity and spirituality are associated with improved outcomes in bipolar disorder, though negative religious coping correlates with higher depressive and manic symptoms, worse functioning, and increased distress. However, this is not universal, with more religious countries like the United States and Brazil demonstrating positive correlations between religious practices and bipolar disorder outcomes. In contrast, research from other regions such as Japan and Austria shows spiritual well-being, rather than religiosity, as the more relevant factor outcomes with bipolar disorder. However, frequently noted is the need for clinicians to assess R/S content thoughtfully to distinguish between helpful belief systems and symptoms of mania or delusion. However, additional studies are necessary to substantiate these findings.

4.7 Obsessive-Compulsive Disorder

Despite Religion being one the most common themes in obsessive–compulsive disorder (OCD), very limited research has explored the connection between R/S and OCD. Clinical studies have found that in some samples up to 90% of OCD patients experience religious obsessions. Religious faith alone is not considered a direct trigger for OCD; instead, the important factors appear to be the specific nature of one's beliefs and the cognitive interpretation of intrusive thoughts. (Moroń et al., 2022). In fact, some clinical observations show that while devout OCD sufferers all report strong faith, the severity of their OCD relates more to specific religious doubts and rituals (e.g. repetitive prayer) than to general spirituality.

In general, higher religiosity is associated with greater OCD-like symptoms in the general population. For instance, a cross-cultural study comparing Christian students in Canada and Muslim students in Turkey found that religiosity had a specific relationship with obsessional (OCD) symptoms, but not with general anxiety or depression. In that study, highly religious students reported more obsessive thoughts, and the highly devout Muslim group even had significantly more compulsive rituals than their equally devout Christian counterparts (Inozu et al., 2012). Other research likewise confirms a positive link between intensity of religious faith and scrupulosity (religious OCD symptoms) across different groups (Moroń et al., 2022). A recent machine learning study reinforces this, finding religiosity as a significant predictor of OCD severity and suggests that the religion-OCD relationship may be more nuanced than previously understood (Zaboski et al., 2024).

Researchers have identified cognitive mechanisms by which religiosity can exacerbate OCD symptoms. Highly devout individuals often feel a heightened sense of personal guilt and responsibility over unwanted thoughts, coupled with beliefs that one must strictly control “immoral” thoughts (Inozu et al., 2012). This mirrors the OCD-related distortion known as thought–action fusion (TAF), the belief that having a blasphemous or sinful thought is nearly equivalent to carrying out a sin. Experimental findings show that religious teachings can indeed fuel TAF: one study found that among Christians, greater religiosity predicted stronger moral TAF beliefs, which in turn mediated the link between religiosity and obsessive-compulsive symptoms. In that experiment, devout participants reacted to induced intrusive thoughts with more guilt and an urge to suppress the thought, reflecting how religious doctrine about “sinful” thoughts can transform normal intrusions into distressing obsessions Importantly, authors note that religion per se isn’t pathological, rather, doctrines emphasizing the sinfulness of thoughts or absolute purity create a cognitive vulnerability that can intensify OCD symptoms (Williams et al., 2013). Consistent with this, fostering the opposite traits (e.g. self-compassion and mindfulness) is associated with fewer religious obsessions, since a non-judgmental attitude helps reduce TAF and intolerance of uncertainty that drive scrupulosity (Moroń et al., 2022). In contrast, studies conducted outside the US have found religious attendance to be either unrelated or inversely related to OCD, while religious

coping showed no such associations. (Himle et al., 2012).

Hence, the evidence suggests that being religious doesn't inherently produce or worsen OCD; instead, certain doctrinal beliefs and their cognitive interpretation amplify the disorder. While these results are still emerging, current research in this domain is remarkably limited, with the need for additional studies.

4.8 Borderline Personality Disorder

The relationship between R/S and Borderline Personality Disorder (BPD) has limited investigation. However, recent evidence reinforces the notion that religiosity can have a protective role against certain BPD symptoms and correlates inversely with both symptom severity and diagnosis. A U.S. study of medical outpatients revealed an inverse relationship between R/S and BPD, with patients exhibiting more severe borderline features reporting significantly lower levels of R/S well-being (Sansone et al., 2011). This is correlated with prior studies finding that significant correlations with BPD diagnosis and lack of R/S (Snyder et al., 1985). Interestingly, individuals high in BPD symptoms while not more involved in organized religious activities, exhibit significantly greater religious quest orientation, a tendency to search for spiritual meaning and grapple with religious questions (Hosack, 2019). Thus, lower spirituality scores correlate with BPD symptoms but do not necessarily reflect the impact of R/S on BPD symptomatology. However, outside the U.S. studies have found greater R/S and frequent participation in religious activities correlated with fewer BPD traits in young adults. those scoring high on religiosity had significantly less chronic anger, mood instability, feelings of emptiness, and self-harm behaviors (Hafizi et al., 2014).

Recent evidence reinforces the notion that religiosity can have a protective role in BPD. A study of 419 internal medicine outpatients at Wright State University revealed statistically significant inverse relationships between religion/spirituality measures and borderline personality symptomatology. Participants exhibiting BPD symptoms demonstrated consistently lower scores across multiple dimensions of religious and spiritual well-being compared to those without such symptoms (Sansone et al., 2011). A 2020 community study in Brazil also found that various domains of R/S well-being were inversely related to borderline personality traits. In other words, participants with more pronounced BPD traits tended to score lower on positive spiritual well-being measures, and overall religiosity was associated with less personality pathology (Carvalho et al., 2020). Collectively, these outcomes imply that engagement in religious faith or community might buffer against some of the emotional turbulence and self-destructive tendencies characteristic of BPD.

Despite the severe limitations in available research, the existing studies demonstrate remarkably consistent inverse relationships between R/S involvement and BPD symptoms or associated behaviors.

4.9 Eating Disorders

The connection between R/S and eating disorders has received far less attention than other areas where R/S intersects with mental health. A recent systematic review of 22 studies found that people with strong, positive religious beliefs tended to have fewer issues with disordered eating and body image. However, those with uncertain or conflicted faith experienced the opposite effect, showing worse outcomes in these areas (Akrawi et al., 2015). Studies outside the U.S have found similar associations, with an Italian study finding that women with clinically diagnosed eating disorders scored lower on intrinsic religiosity (sincere personal faith) and higher on extrinsic religiosity (outward or utilitarian religiosity) compared to healthy controls, implying that genuine faith may be linked to lower risk of eating pathology (Castellini et al., 2014). Recent research also suggests how this works: a 2022 study found that more religious people had higher self-esteem, which was linked to fewer symptoms of orthorexia (obsessive healthy eating) (Sfeir et al., 2022). These findings support the idea that spiritual well-being and internal faith can bolster factors (like self-worth and body satisfaction) that guard against eating disorder behaviors. However, not all studies support this finding. The same systematic review by Akrawi et al. reviewed 15 studies with conflicting results: six found religiosity increased disordered eating, four found it decreased it, two showed mixed effects, and three found no relationship (Akrawi et al., 2015).

However, emerging evidence indicates that R/S relationship with eating disorders may differ by gender, and this warrants further research. One 2022 study of nearly 750 adults found that religious men exhibited more disordered eating behaviors (e.g. higher levels of bingeing, purging, and food restriction) than non-religious men, whereas religiosity made little difference in women’s disordered eating levels (Beaulieu & Best, 2022). By contrast, a large U.S. longitudinal cohort study found adolescent girls who frequently attended religious services showed higher body satisfaction, which served as a protective factor that lasted from their teenage years into young adulthood. For boys, however, the study found no significant long-term connections between religious attendance and body image. (Baltaci et al., 2024). Therefore, R/S has mixed effects on eating disorder symptom severity, with outcomes depending on how R/S relates to and interacts with symptoms, indicating a need for additional research.

5. Discussion

Understanding how religion and spirituality shape mental health is critical for effective treatment planning. These factors influence symptom expression, coping strategies, and help-seeking behaviors. Integrating this understanding into clinical standards and policies supports more comprehensive, culturally responsive care.

5.1 Religious Influence versus Community Influence

A critical challenge in interpreting the relationship between R/S and mental health outcomes lies in differentiating the effects of religious belief itself from the social and communal aspects of religious participation. The protective effects observed across multiple mental health conditions, particularly depression and substance use disorders, may stem primarily from the robust social support networks, sense of belonging, and community accountability that religious involvement provides rather than from spiritual beliefs per se. This interpretation is supported by findings that frequent religious service attendance often shows stronger associations with positive mental health outcomes than private religious practices or self-rated religious importance alone, as demonstrated in the substance use disorder literature where communal worship showed more robust protective effects than personal faith measures. However, the evidence for intrinsic religiosity and private religious activities like prayer and meditation also showing benefits, albeit sometimes weaker ones, suggests that the spiritual dimension contributes independently to mental health outcomes beyond mere social connectivity. The bifurcation between positive and negative religious coping further complicates this picture, as spiritual struggles and feelings of divine abandonment consistently correlate with worse mental health outcomes regardless of community involvement, indicating that the quality and nature of one's religious experience matters as much as, if not more than, the quantity of religious participation.

5.2 Proposed Mechanisms

Despite extensive research documenting associations between R/S and mental health outcomes, the underlying mechanisms remain poorly understood and largely theoretical. Koenig and colleagues have proposed that R/S may operate through human virtues such as forgiveness, altruism, and gratefulness, though empirical evidence directly testing these mediational pathways remains limited. The review identified only one clearly documented mechanism: thought-action fusion in OCD, where experimental studies demonstrated that religious teachings about sinful thoughts can transform normal intrusions into distressing obsessions through the belief that thinking something immoral is equivalent to committing the act (Koenig, 2012). Other frequently proposed pathways, including social support effects, health behavior changes, adherence to therapy, and coping resources, have been suggested but not systematically tested as mediators in the R/S-mental health relationship. The absence of well-established mechanisms after decades of research represents a critical gap in the field, as understanding how R/S influences mental health is essential for developing targeted interventions and identifying which patients might benefit from spiritually integrated treatments versus those who might be harmed.

5.3 Clinical Implications

The substantial evidence linking R/S to mental health outcomes, whether beneficial or harmful, necessitates fundamental changes in how mental health professionals' approach clinical assessment and treatment planning. The finding that patients desire their spiritual needs to be addressed while few mental health providers broach these topics represents a significant gap in person-centered care that may compromise treatment engagement and efficacy (Moreira-Almeida et al., 2014) Mental health professionals should routinely incorporate spiritual history-taking into comprehensive assessments, not as an afterthought but as a core component comparable to social or medical history, using validated instruments to evaluate both positive religious coping resources and potential religious struggles or conflicts (Moreira-Almeida et al., 2016) For conditions where religiosity shows protective effects, clinicians should consider how to leverage existing religious resources and communities as adjuncts to treatment, collaborating with chaplains or religious leaders while maintaining appropriate professional boundaries. Conversely, for presentations involving religious scrupulosity in OCD or spiritual struggles exacerbating depression, clinicians need competence in differentiating adaptive from maladaptive religious cognitions and the skills to address religious content therapeutically without invalidating patients' faith. The evidence supporting religious and spiritually integrated psychotherapies for certain conditions (Bormann et al., 2006; Koenig, 2012) suggests that training programs should equip clinicians with basic competencies in this area, moving beyond cultural competence to include spiritual literacy and the ability to work within patients' religious frameworks when clinically indicated.

5.4 Limitations

While this review offers a broad synthesis of literature on religiousness, spirituality, and mental health, several limitations should be acknowledged. The narrative approach lacks the rigor of systematic reviews, allowing for potential bias in study selection and interpretation. Most reviewed studies included were correlational, preventing

determination of whether religiosity causes mental health changes or vice versa. The inconsistent measurement of religiosity across studies, some measuring attendance, others measuring belief intensity, and still others measuring spiritual experiences, makes it impossible to identify consistently which aspects of R/S matter. Research quality varied dramatically, from large longitudinal cohorts to small convenience samples, yet all were weighted equally in the synthesis. Geographic bias toward American populations dominates the literature, with minimal representation from Africa, South America, or Asia where religious contexts differ substantially. For several disorders, conclusions rest on fewer than five studies, hardly sufficient for drawing meaningful patterns. The review also cannot address the critical question of individual differences: why does religion help some people while harming others with the same condition? and psychological symptoms over time. Addressing these gaps through rigorous, culturally inclusive, and methodologically consistent research will be critical for investigating the impact of religion on these conditions and informing evidence-based clinical practice.

6. Conclusion

The extensive body of research examining religiousness and spirituality in relation to mental health reveals a nuanced landscape where faith can serve as both a protective factor and, in certain circumstances, a source of psychological distress. While the preponderance of evidence suggests that religious involvement correlates with modestly improved outcomes across several psychiatric conditions, particularly depression and substance use disorders, these benefits are neither universal nor uniformly distributed across populations, disorders, or cultural contexts. The protective effects appear strongest when religious engagement provides robust social support, positive coping resources, and meaningful frameworks for understanding suffering, yet the same religious systems can exacerbate symptoms when they engender guilt, spiritual struggle, or maladaptive thought patterns such as the thought-action fusion observed in religious obsessive-compulsive presentations. The field's progress remains hampered by fundamental challenges including inconsistent measurement of religiosity across studies, limited understanding of underlying mechanisms beyond correlational associations, geographic bias toward American populations, and insufficient research for several disorders. "Moving forward, the mental health field must recognize that R/S is both therapeutic and potentially harmful, and develop assessment tools and interventions that harness religious resources while addressing spiritual struggles. Clinicians require training to competently integrate spiritual dimensions into treatment without imposing or invalidating patients' beliefs, while researchers must pursue methodologically rigorous investigations that can disentangle the effects of religious belief from community support, examine cross-cultural variations, and identify which aspects of religiosity matter most for which individuals under which circumstances. Only through such comprehensive approaches can the complex relationship between faith and mental health be fully understood and appropriately addressed in clinical practice.

Acknowledgements

We greatly appreciate the valuable contributions of all researchers whose studies were included in this review. We would also like to thank each author who conducted the original investigations that informed this work.

Authors' contributions

Mr. Keith Robert Head was responsible for the literature review design, literature search and selection, synthesis and analysis of the reviewed studies, manuscript drafting, and manuscript revision. All authors read and approved the final manuscript.

Funding

Not applicable.

Competing interests

Not applicable.

Informed consent

Not applicable.

Ethics approval

The Publication Ethics Committee of the Redfame Publishing.

The journal's policies adhere to the Core Practices established by the Committee on Publication Ethics (COPE).

Provenance and peer review

Not commissioned; externally double-blind peer reviewed.

Data availability statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

Data sharing statement

No additional data are available.

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