**The Importance of Cognitions in Measuring Spirituality and Religion: The Case for Personal Theological Beliefs**

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### Introduction

Early research on religion and health consisted simply of health surveys “in which religion … made only rare ‘guest appearances’” (Levin & Schiller, 1987, p. 13), in the form of participants’ religious affiliation or denomination. A review of nearly 250 health surveys between 1837 and 1984 revealed that the overwhelming majority of them were confined to comparisons of morbidity and mortality rates across religious denominations (Levin & Markides, 1986).

In the 1960’s health researchers began to ask survey participants how often they attended religious services (Levin & Vanderpold, 1987), a measure that became widely known as “church attendance.” While Levin and Vanderpold (1987) identified only 27 studies for inclusion in their review of church attendance and health, a recent search of Medline found over 230 articles using the term “church attendance.”

Subjective, self-assessments of one’s own religiousness also have become common in health research, as functional religious measures, especially religious coping. (Hall et al., 2008)

Hall et al.’s review of religious measures in health research suggests that existing measures of religious beliefs are complex and difficult to interpret. This is unfortunate since a meta-analysis of Hackney and Sanders (2003) provides limited evidence that beliefs may exert greater influence on mental health than other aspects of religion, such as organized religious activities (church attendance, etc.) or personal devotion (private prayer, personal devotion, etc.).

Though only a handful of the studies Hackney and Sanders examined involved beliefs, their findings raise two important questions: First, what is the association between religious beliefs and mental health? And second, to what extent have researchers examined this relationship? We will explore both of these questions, starting with the latter.

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### Common Religious Measures

Table 1 shows the most commonly used measures of religion in research on the three mental-health outcomes. These were organizational religious activities, subjective religion, and religious affiliation. Religious beliefs were measured fairly rarely. Table 2 shows that religious beliefs were examined even less frequently in research on physical health outcomes.

**Table 1. Percent of Studies Using Each Type of Religious Measure by Mental Health Outcome Studied**

<table>
<thead>
<tr>
<th>Religious Measure</th>
<th>Organization</th>
<th>Subjective</th>
<th>Reincarnation</th>
<th>Peace &amp; Tranquility</th>
<th>Union with God</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety (N = 108)</td>
<td>51.9</td>
<td>32.0</td>
<td>30.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression (N = 122)</td>
<td>36.1</td>
<td>33.6</td>
<td>33.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well-Being (N = 80)</td>
<td>19.4</td>
<td>34.4</td>
<td>25.0</td>
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</tr>
</tbody>
</table>

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### Religious Beliefs & Psychiatric Symptoms: Recent Findings

The five figures that follow, which are based on findings from a national survey, reveal some interesting associations between beliefs and psychiatric symptoms. The first two figures show that certain beliefs about life-after-death are related to higher, and some to lower, levels of symptoms.

**Table 2. Percent of Studies Using Each Type of Religious Measure by Physical Health Outcome Studied**

<table>
<thead>
<tr>
<th>Religious Measure</th>
<th>Heart Disease</th>
<th>Cerebrovascular Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression (N = 44)</td>
<td>4.7</td>
<td>21.0</td>
</tr>
<tr>
<td>Anxiety (N = 35)</td>
<td>4.7</td>
<td>12.0</td>
</tr>
<tr>
<td>Well-Being (N = 19)</td>
<td>4.7</td>
<td>3.0</td>
</tr>
</tbody>
</table>

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### Religious Beliefs & Psychiatric Symptoms: Recent Findings

The final figure shows how different beliefs may interact with one another in relation to psychiatric symptomatology.

**Conclusions**

Relatively few studies have examined the association between religious beliefs and mental health and even fewer have looked at religious beliefs and physical health. As we have shown here, some beliefs have stronger associations with psychiatric symptoms than others and some have no association at all.

We think it is important to study beliefs for at least two reasons. The first is that religions are first and foremost, systems of theological beliefs, as well as practices. The second reason is we think beliefs provide a plausible causal mechanism by which religion can directly influence brain function and physical and mental health.

We also think it is vitally important to study psychiatric symptoms, instead of more subjective measures of health, because psychiatric symptoms provide a window into primitive structures and functions of the brain.

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### References


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### Handbook of Religion & Health

Data from the Handbook of Religion and Health were used to determine the frequency with which different religious variables were used in research on three kinds of physical and mental health outcomes. The three mental health outcomes (psychological well-being, depression, and anxiety) and the three physical health outcomes (heart disease, hypertension, and cerebrovascular disease) with the greatest number of studies were selected for analysis.

We used 10 of the Handbook categories to form the six categories shown in Tables 1 and 2: (1) Religious Beliefs; (2) Subjective Religion; (3) Religious Affiliation; (4) Religious Coping; and (5) Religious Activities.

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### Criticisms of Religious Measures

“Although knowing that a person belongs to a specific religious denomination imparts something about the nature of one’s beliefs, it does not provide information about the strength of those beliefs or one’s adherence to the practices of that faith” (Flannelly et al., p. 1284).

Yet religious affiliation is still widely used in research on religion and health. Hall et al. question the use of organizational religious activities, or “church attendance” in such research because it “may simply function as a proxy for more ‘secular’ pathways of healthy living.” (Hall et al., 2008, p. 141). Flannelly et al. (2004) discuss a number of studies that undermine the reliability of “church attendance.”

In the next two figures shows that certain beliefs about God have significant relationships with psychiatric symptomology, while others have less, or no association.

**Table 3. Level of Belief and Three Beliefs about God**

<table>
<thead>
<tr>
<th>Level of Belief</th>
<th>Association Between Paranoid Ideation and Three Beliefs about God</th>
<th>Association Between Social Anxiety and Three Beliefs about God</th>
<th>Association Between Depression and Three Beliefs about God</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
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### Handbook of Religion & Health

For a complete list of references, see the Handbook of Religion and Health.