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Relationship between religiousness and mental health[1]

Związek między religijnością a zdrowiem psychicznym

Abstract: The article presents considerations focused on the broadly understood relationship between religiousness/spirituality and health – primarily mental health, although issues related to physical health were also discussed. It addresses, among others, the issue of potential benefits resulting from participation in religious practices – in this context, particular emphasis was placed on the sphere of social relations and social support that can be obtained from other members of the religious community, which can be perceived as a factor that may play a key role in the process of coping with various life difficulties and the resulting stress. The final part of the article presents the potential mechanisms underlying the relationship between religiousness/spirituality and health.

Keywords: coping, health, mental health, religiousness, social relations, spirituality, stress

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Introduction

Ideas about the relationship between religiousness (religiosity) and mental health have changed over the last few centuries. During the 20th century, many mental health researchers and professionals tended to overlook the religious aspects of human life. They even tended to find them pathological or old-fashioned, predicting them to vanish with the development of mankind. However, a large body of research, consisting of hundreds of epidemiological studies performed during the last decades have shown a different picture, according to which religiousness remains an important aspect of human life and it usually has a positive association with both physical and mental health (Koenig, 2012a; see also: Hood Jr., Hill, and Spilka, 2018, pp. 461-472) – thus it should be considered as an important factor in research and clinical practice. Therefore, it should be assumed that any clinician, who truly wishes to consider the bio-psycho-social aspects of a patient, needs to assess, understand, and respect his/her religious beliefs, like any other psychosocial dimension taken into account in the treatment process. Increasing the aid providers' knowledge of the religious aspect of human beings should result in the strengthening of their capacity to honor their duty as mental health providers and/or scientists in helping people to fulfill their potential and live healthily.

In Western tradition religious methods have often been used – with good results – to treat the mentally ill – this fact supports the claim that faith and belief systems are very important constituents of psychological well-being (see: Koenig, 2012a) and could be fruitfully utilized in psychotherapy. However, their usage must be carefully evaluated. Hence, the religion-mental health connections ought to be studied with care, to increase the acceptability and efficiency and of psychiatric services in the general population. Finally, religion has a great influence on psychiatry, including symptoms, phenomenology, and outcome (see: Huguelet and Koenig, 2009). It is crucial to keep in mind that the patients have spiritual needs that should be identified and addressed, however, psychiatrists and other mental health professionals often tend to do otherwise, since they do not always feel comfortable tackling these issues. Thus adequate training aimed at the practitioners, including – first and foremost – the transfer of knowledge (concerning all the vital facets of the religiousness/spirituality-health relationship), is necessary to integrate spirituality into clinical practice. This requires the professionals in the sphere of aid and support to have at their disposal an in-depth knowledge of the cultural and religious environment, where in his/her work is being done.

Relationship between religiousness and health

The presented considerations should undoubtedly begin with the quotation of definitions, which are key from the perspective of the discussed subject matter.

According to one of the most popular definitions, „religion is a multidimensional construct that includes beliefs, behaviors, rituals, and ceremonies that may be held or practiced in private or public, however, are taken from traditions that were developed inside a community. Religion may be also defined as a system of symbols, practices, and beliefs which are organized to a) facilitate close relationship to the transcendent; b) to enhance the understanding of the relationship of a person to other people and responsibility for others living in a community (Koenig, King and Carson, 2012; see also: Nelson, 2009, p. 3-4).

It should be emphasized at this point that the results of numerous empirical analyses – including longitudinal studies – prove that religious people cope better in the face of disease and the potential difficulties and hardships resulting from it (e.g. they better endure and cope with the stress accompanying the disease, they experience positive emotions more often and they are more likely to engage in a wide variety of pro-health behaviors) (Koenig, 2012 a; Koenig, 2018, pp. 49-68; Hood Jr., Hill, and Spilka, 2018, pp. 483-499). This aspect of religiousness will be significantly extended further in the article.

The definitions of religiousness and spirituality have been a perennial source of controversy. It needs to be strongly emphasized that they are not interchangeable words, but different, though very closely connected terms (Koenig, 2018, pp. 3-9; Hood Jr., Hill and Spilka, 2009, p. 9). According to Betson and Ventisas as early as 1912, the psychologist James Leuba detected 48 distinct definitions of religion. In this article we will adopt the definitions given by Harold G. Koenig et al. (Koenig, McCullough and Larson, 2001), according to which: „Spirituality is distinguished from all other things – humanism, values, morals, and mental health – by its connection to that which is sacred, the transcendent. The transcendent is something outside and inside the self. In the Western religious traditions, we call the transcendent – God. Spirituality is what is within the organized religion, but begins before it and extends outside it; it is connected to what is mystical and supernatural. It encompasses searching for transcendence, including being between non-consideration, questioning, and then belief or non-belief. Thus, the definition of spirituality is very similar to religion and there is clearly an overlap" (Koenig, McCullough, and Larson, 2001; see also: Koenig, 2018, p. 15).

It should be noted that in the presence of psychopathology, religion may be a part of it, contributing to the symptoms (obsessions or delusions for example) (ibidem, p. 6). It may also hinder treatment if it forbids psychotherapy or the use of medication. On the other hand, religion may turn out to be helpful in many different ways (ibidem, p. 11-12) – for example in the process of integrating the patient into society – which may most likely result in receiving social support (that plays a crucial role in the process of coping with adversities) or motivating him/her to seek treatment (promoting guilt that motivates treatment). The elements of a functional theology – present in all religions, which may promote good mental health, have been widely described in the subject literature and include such components as awareness of God, acceptance of the grace and love of God, repentance, and social responsibility, faith and trust, involvement in organized religion, fellowship, ethic, and tolerance and openness to the experiences of others.

In addition to individuals' health concepts, psychological variables and emotions have an impact on the engagement in health-related behaviors, as well. Accordingly, another relevant task of health psychology is to uncover the major psychological correlates of one's adherence to health-promoting and health-impairing lifestyles (see also: Marks, Sykes and McKinley, 2003).

In today's world, in which prevention of a great number of fatal diseases is within the human's control, desirable actions towards achieving and maintaining personal health seem to be emphasized more than ever. Kaplan argues that while secondary prevention (aimed to reduce the impact of a disease or an injury that has already occurred) has limited benefits, primary prevention (aimed at preventing diseases or injuries before they even occur), through the promotion of healthy behaviors, shows promising results in improving the health of populations, and, therefore, should be the major goal of health policies. Health psychology should serve as an inspiration for individuals to establish self-protection and, as well, to change policies and laws that improve social and environmental conditions so that they do not threaten public health (Ewart, 1991).

Health promotion efforts should not only take into account the health and illness dimensions of children, adolescents and adults possess but also should go beyond these dimensions to help individuals develop a more complete view of health, enhancing self-actualization, self-fulfillment, and quality of life. No doubts exist that such a concept can only be achieved by improving the level of development of society as a whole.

Against the background of the considerations presented above, it is necessary to emphasize that taking into account religiousness and spirituality

– their impact on the broadly understood health of an individual – in the process of both primary and secondary prevention – should be completely natural as it may lead to better coping by the sick or – from a wider perspective – by all the people in need of help, with stress and with various adversities they may encounter during their lives. In the analyzed context, particular attention should be paid to the social aspect of religiosity and spirituality – one of its aspects is membership in a religious community.

What are the potential benefits of religious practices?

Attempting to understand the impact that membership in a broader religious community (see: Nelson, 2009, pp. 396-404) (e.g. one centered around a given parish and regularly meeting and undertaking various activities in its area – for example participation in pilgrimages, masses, services and any other kinds of gatherings organized by this given community) may have on the health of an individual, requires to look at this particular issue from a general point of view – from the perspective of interpersonal relationships, including their intrapersonal correlates, as the source of the key consequence for human health, which is social support (House, Landis, and Umberson, 1988, pp. 540-545; Cohen and Wills, 1985, pp. 310-311) obtained usually by participation in such collectives, which can be easily seen as a textbook example of support groups.

For a very long time scientists studying the social area of human functioning have noted an association – significant and very difficult to overlook – between social interactions and health – generally speaking, the studies conducted so far provide empirical data, which shows that people who are more socially isolated/less socially integrated are, generally speaking, less healthy – both physically and psychologically (mentally) – and, what's more, they are simply more likely to suffer from various health problems and ultimately even to die (as social ties tend to influence health behaviors) (see: House, Landis and Umberson, 1988, p. 540; Cohen and Wills, 1985, p. 311; Galea, Tracy, Hoggatt, DiMaggio and Karpati, 2011, p. 1456, 1462), than the individuals who regularly engage in various types of social interactions (including all the specific consequences resulting from them) at their disposal. Moreover, there is a constantly growing body of research that supports the thesis, which suggests that lack of proper social relationships constitutes a major risk factor for health, competing with the effects of such well-known risk factors such as increased blood pressure, cigarette smoking, substance abuse or obesity (House, Landis and Umberson, 1988, p. 541). On the other hand, a brief overview of the recent research results in the sphere of gerontology

shows that social participation is one of the key indicators of successful aging (including better general cognitive functioning, better self-rated health, and physical functioning as well as reduced risk of depression or even incidence of falls) (Douglas, Georgiou, Westbrook, 2017, pp. 455-462) – as Terrence D. Hill, Sunshine M. Rote and Christopher G. Ellison (2017, p. 952) noted, „numerous studies have shown that religious involvement—indicated by observable feelings, beliefs, activities, and experiences concerning spiritual, divine, or supernatural entities – tends to favor health and longevity in the elderly population" (see also: Koenig, 2012b). A large body of research has considered the salutary (pro-health) effects of social resources for physical and mental health (Ellison and Levin, 1998, pp. 705-706; Moreira-Almeida, Lotufo Neto and Koenig, 2007, pp. 242-250).

So how exactly social relationships and the support stemming from them can influence an individual's health? What are the possible mechanisms of acquiring such crucial benefits? There are at least a few perspectives on this matter – in this article we discuss those of them, that can be considered crucial to understanding the analyzed dependency.

The first of the mentioned perspectives is focused on stress and the accompanying coping process (Lakey and Cohen, 2000, pp. 30-36), which – for many decades now – has been a very important object of interest of psychology (Baqutayan, 2015, pp. 479-488). According to this concept, overall social support significantly reduces the effects of stressful life events on health, by serving as a sort of effective stress buffer (Cohen and Wills, 1985, pp. 348-349). This mechanism is based on either the supportive actions of others (for example giving advice, granting reassurance, or cognitive guidance – all of these actions are a part of the so-called informational support) or simply on the individual's mere belief that such kind of support is available. Therefore, we are dealing here with a division into objective and subjective support (Ellison and Levin, 1998, p. 705). All types of supportive actions – according to the stress-support matching hypothesis (Cohen and Wills, 1985, pp. 312-315) – are treated as an element enhancing the generally understood coping process, while perceptions (which – as should be noted – can be very subjective and sometimes quite far from the truth) of the support at hand, may lead to significant modifications in the appraisal process (during which the occurring events are interpreted by an individual as stressful or not stressful, on the basis of the perceived resources an individual has at his/hers disposal), causing potentially stressful and threatening situations to be seen as less dangerous to the individuals' overall well-being (Lakey and Cohen, 2000, pp. 30-31, 34-35) (due to the fact, that the person's belief

that he/she can count on the help of other people – which is equal to having the required social resources – makes it easier to cope with the awaiting adversities and is a prognosis of a positive outcome of the coping process).

Another point of view on the relationship between social support and widely understood health evolves around the concept of support as a part of more generic relationship processes (Lakey and Cohen, 2000, pp. 42-45), focusing however not on the actual help from other people received during facing hardships nor belief about the possibility of gaining support (as it was in the above-described perspective), but on the qualities of the existing relationships such as: companionship (described as a process of sharing leisure and other types of activities that are undertaken by people primarily to enjoy themselves), relationship satisfaction (defined as global and subjective evaluations of ongoing relationships), intimacy (defined as connected, bonded and close feelings people have toward each other), attachment styles (patterns taken from childhood, significantly influencing the quality and closeness of relationships established in later, also adult life) (Bowlby, 1979) or low levels of interpersonal conflict (see: Bao, Zhu, Hu, and Cui, 2016, pp. 541-545) (resulting in harmonious and positive relationships). It is hypothesized that these relationship qualities may cause beneficial health effects by elevating individuals' self-esteem (esteem support) (Cohen and Wills, 1985, p. 313) (according to the assumption that belonging to a group of people capable of creating such quality ties can contribute to feeling better about oneself – as a worthy member of such group), contributing to positive appraisals (in terms of evaluating potentially stressful situations – the process already mentioned above), and promoting active coping with various types of stressful events. So, as we can see, being a member of a religious group of any kind may play a significant role in the process of coping with stress. But what exactly is stress and how it is defined?

According to one of the most popular definitions of stress, formulated by Richard S. Lazarus and Susan Folkman as a result of their work on the transactional concept of stress (one of the leading theories in the analyzed area), stress is the relationship (transaction) between a given person and his/hers environment, which is assessed (perceived) by this person as burdening or exceeding his/hers resources and threatening the broadly understood well-being: physical, mental and social (Lazarus and Folkman, 1984, p. 18). In other words, stressful situations are the ones in which the person perceives that it is important to respond to the stressor, but an appropriate response is not immediately available. Stress is a process that for many years has been a point of interest in the field of health, psychiatry, psychology, and many

other spheres of science, and remains the subject of extensive empirical research, aimed primarily at learning about its different conditions, symptoms, various negative consequences and – what seems to be a crucial part of these actions – ways of preventing and counteracting it. It seems that people living in the reality of the 21st century, extremely dynamic and rich in many stimuli, have become – even more than ever – exposed to various types of situations that can generate stress (often very intensive), i.e. various types of stressful life events (Schwarzer and Luszczynska 2012, pp. 29-56).

By and large, all sorts of stressful events are thought to influence the pathogenesis of physical disease in general, by causing negative affective states (such as feelings of anxiety or depression), which in turn make a direct impact on biological processes or behavioral patterns that influence and significantly increase the risk of disease. Exposure to chronic stress (which, according to the works of Hans Selye – a pioneer in the field of stress studies who coined the General Adaptation System theory – leads to exhaustion, which can even cause death) is considered the most harmful because it is very likely to result in long-term or even permanent changes in the emotional, physiological, and behavioral responses that influence susceptibility to and course of a given disease (Selye, 1951).

This includes stressful events that persist over an extended duration or brief focal events that continue to be experienced as overwhelming long after their direct influence on the individual has ended (Cohen, Janicki-Deverts and Miller, 2007, p. 1685). Among the many negative consequences that stress has on generally understood health, we can distinguish: increased risk of depression, cardiovascular disease, upper respiratory tract infections, asthma, herpes viral infections, autoimmune diseases, wound healing, increased risk of acute infectious respiratory illness (Cohen, Tyrrell, Smith, 1991, pp. 610-611), increased risk of coronary heart disease and cerebrovascular disease, hypertension, heightened risk of both Alzheimer's disease and dementia or impairment of the endocrine system (Koenig, 2012a). There is also a large body of evidence that suggests that stress and depression result in an impairment of the immune system (Segerstrom, Miller, 2004), and might promote the initiation and development of some types of cancer (Reiche, Odebracht Vargas Nunes and Kaminami Morimoto, 2004, p. 624). Furthermore, there are also studies in the field of cellular aging, which provide evidence that psychological stress is significantly associated with higher oxidative stress, lower telomerase activity, and shorter telomere length, which are known determinants of cell senescence and longevity (Epel et. al., 2004).

Therefore, regarding the information presented above, the main aim of these considerations is to show that religiousness/spirituality can play an extremely important role in the process of counteracting and coping with stress, defined as „efforts, both action-oriented and intrapsychic, to manage (that is master, tolerate, reduce, minimize) environmental and internal demands, and conflicts among them, which tax or exceeds person's responses" (Lazarus and Launier, 1978, p. 288) – as one of the stress moderators (i. e. factors influencing the assessment made by an individual and the process of interpretation of stressors experienced by him/her), preventing the development of distress as a result of various stressors (Zimbardo, Johnson and McCann, 2010, p. 167). As Harold G. Koenig noted, „the use of religion to cope with emotional, social, and physical distress is one of the most important functions that religion serves, and from an evolutionary perspective, may be one reason contributing to the development, flourishing, and persistence of religious groups over time, along with their ability to enhance cooperation and cohesion within groups" (Koenig, 2018, p. 49).

According to H. G. Koenig, religious coping can be defined as using the various religious beliefs and/or practices in the process of dealing with negative life experiences and trying to make sense of them (by giving them a deeper meaning). As he notes "in Western religious traditions, this may include behaviors such as praying during emotionally trying times; reading religious writings for inspiration and guidance; attending religious services to be uplifted by singing and worshiping together with others; seeking support from members of one's congregation; and/or giving support to others for religious reasons" (ibidem, p. 51). It should also be emphasized that religious coping includes both behaviors and beliefs – it may involve cognitive processes – including beliefs concerning a better life after death (after all the pain and suffering is gone), or beliefs in the existence of loving and caring God who is in control of everything and has a purpose for the world and each individual living in it, and has the power to transform adversities, hardships, and many other difficult circumstances in a way, those good effects are still possible to obtain from them (Krumrei and Rosmarin, 2012, pp. 245-246).

It can be assumed that one of the main factors that make religiousness/spirituality so important in coping with stress is the already mentioned social support, which, according to Aaron Antonovsky's salutogenic concept, is one of the so-called generalized resistance resources (GRRs) (Idan, Eriksson and Al.-Yagon, 2017, pp. 57-58), defined as the characteristics of an individual, group, environment and culture that are distinguished by a functional feature that enables them to avoid stressors and improve the process of coping with

requirements in such a way that they prevent tension from turning into a state of stress; by helping to combat stressors, they are conducive to health protection and recovery processes (Antonovsky, 1987, p. 19). What seems to be the most important, it's that among generalized resistance resources we can also find: a) commitment and cohesion with one's cultural root's (which can also be applied to religiousness/spirituality, as in many Christian countries religion has intertwined with culture for centuries) (Beyers, 2017), b) ritualistic activities, c) religion and philosophy (providing a stable set of answers to various life's perplexities) (Idan, Eriksson and Al-Yagon, 2017, p. 57). It, therefore, seems that by co-creating several GRRs, religiousness/spirituality should significantly support the course of the process of coping with stress, providing the individual with extremely helpful resources necessary in the process of facing various difficulties and adversities -including illness and other health-related problems. (Ringdal, 1996, pp. 193-211). It should be emphasized that a high level of religiousness/spirituality can positively affect both individuals coping with stress (giving the individual inner strength and equipping him/her with beliefs that enable him to make the necessary re-evaluations), as well as – which seems completely obvious in the context of the information provided so far on the importance of social support – it can provide an individual with a wide social base, consisting of fellow believers, priests, etc., which may prove invaluable support in the process of fighting the disease and the stress it generates, as well as in the process of recovery – a large body of research proves that „religious beliefs help patients make sense of their medical conditions and may enable them to better integrate health changes into their lives. Religious practices can help to relax, distract, and counteract the effects of loneliness and isolation that are so prevalent" (Koenig, George and Titus, 2004, p. 559).

The mechanism of the relationship between religiousness-spirituality and health – both mental and physical

At the very beginning of this part of the presented considerations, it is worth emphasizing that scientific research aimed at establishing the relationship between religiousness/spirituality and human health initially focused predominantly on the aspect of mental health. Over time, however, the problem of the influence of religiousness on physical health has become more and more often discussed, especially in the context of palliative care and chronic diseases, in particular cardiovascular diseases and cancer. It was important for initial research in this specific area to define religiousness and spirituality as factors significantly affecting the quality of life (Koenig,

2018, pp. 3-19). Later studies have provided proof that spiritual well-being is closely related to managing disease and disorders, both physical and mental (Żołnierz i Sak, 2017, p. 108).

Religion gives a person resources to cope with stress by providing positive emotions and sense of purpose and that in turn results in a lower likelihood of stress and stress-related mental health problems. According to the salutogenic orientation in clinical psychology, the sense of meaningfulness (the sense of purpose), which is one of the three components of the sense of coherence as described by Aaron Antonovsky (1987; 1996), is related to the belief in an individual that the difficulties and hardships faced in everyday life are worth the cognitive and emotional commitment and effort. Individuals with a high sense of meaningfulness look for meaning and significance in the challenges posed by life events, and their discovery strengthens their motivation to make the effort necessary to solve the problems they face and deal with them effectively. So, if a person believes that all the things that happen to him/her are a part of God's plan, they will be much more willing to cope and remain healthy – both physically and mentally.

So what kind of mechanisms may come into play in the case of the relationship between religiousness/spirituality and health – both mental and physical? There are at least a few possible mechanisms by which religiousness/spirituality may enhance mental and social health – below some of the most important ones are mentioned (Koenig, 2018, pp. 52-54):

1. First of all, about the data concerning stress and the process of coping, religion provides significant resources extremely useful in the process of coping with stress – they may increase the frequency of positive emotions and – at the same time – reduce the likelihood that stress will result in various emotional disorders such as depression, anxiety disorder or substance abuse. Religious coping resources include powerful cognitions (strongly held beliefs) that enable the believers to find the meaning of difficult life circumstances and provide them with a sense of purpose (Koenig, 2012 a, p. 7). Religions provide a worldview in which a potential transcendental force exists (God, Jehovah, Allah, etc.), and this force is a source of hope, love and care, responding to the needs of individuals (Koenig, 2018, p. 49). These cognitions regarding a transcendental force are linked to convictions regarding a sense of control (e.g., a belief in God's control over events and the possibility of using prayer to convince God to influence the course of life). Religious beliefs provide satisfying answers to existential questions (to which science and medicine have no answer), such as „where did we come from", „why are we here," „where are we going",

"what is our purpose". The answers they provide apply to life here and now and the afterlife, resulting in decreased existential anxiety. These beliefs also help to normalize loss and change, as well as to provide role models, for example, persons suffering from the same or similar problems (often illustrated in religious scriptures), who can cope with them or endure them. Religious beliefs can, therefore, influence the appraisals of the negative events in life so that they seem less distressing for an individual. For people with medical illness, these beliefs are particularly useful because they are not lost or impaired due to becoming physically disabled – unlike many other coping resources that are dependent on the health and being able to move or speak (hobbies, relationships, and jobs/finances) (Koenig, 2012, p. 7). In this specific context, a mention should be made of the concept of religious coping, which – according to H. G. Koenig is „a gateway to many of the mental and physical health benefits" (Koenig, 2018, p. 50) that religion can provide. It should also be mentioned that there is a very important distinction between two types of this particular type of coping – positive and negative. The first one – positive religious coping – has been associated with good health outcomes, and the second one – negative religious coping – has been linked with the opposite. Studies show that religious patients tend to use more positive than negative religious coping. Positive religious coping involves such behaviors as trying to find a lesson from God in the stressful event (trying to find a meaning of what is happening), doing what one can do in a particular situation, and leaving the rest in God's hands (trusting in his guidance), seeking support from clergy and church community members (looking for the already mentioned social support within the religious community), thinking about how one's life is part of a larger spiritual force, looking to religion for assistance to find a new direction for a living when the old one may no longer be viable and possible to continue, and attempting to provide spiritual support and comfort to others. On the other hand, negative religious coping includes passive waiting for God to take control of the situation (a feature characteristic for people with an external locus of control), redefining the stressor as a punishment from God or as an act of the devil and, as a result, questioning God's love. What's more, it is also necessary to stress that public and private religious practices can help in maintaining mental health and prevent mental diseases – they prove to be very useful in the process of coping with such affective states as anxiety, fears, frustration, anger, inferiority feelings or isolation. It is worth noting that the most commonly studied religious practice is contemplation (meditation). It

has been reported that it can produce personality changes, reduce tension and anxiety, diminish self-blame, stabilize emotional ups and downs, and improve self-knowledge. Improvement in generally understood dealing with panic attacks, generalized anxiety disorder, depression, insomnia, drug use, stress, chronic pain, and other health problems have also been reported. Studies have shown that this technique turns out to be satisfactory effective, similar to other religious practices, such as personal prayer, confession, forgiveness, exorcism, liturgy, blessings, and altered states of consciousness (Moreira-Almeida, Lotufo Neto and Koenig, 2007, p. 247).

2. Secondly, as H. G. Koenig notices, Western Christianity, like most religions, has rules and regulations (doctrines) about how to live ones' life and how to treat other members within a particular social group. When individuals act according to those rules and regulations, it reduces the likelihood of stressful life events, which leads to reducing positive emotions and increasing the negative ones. Religion may help for example in stressful life circumstances such as financial stress, incarceration, experiences of the disease, relationships, and family problems. Western Christianity discourages behaviors such as the use of drugs and excessive amounts of alcohol that increase the risk of engaging in maladaptive behaviors (crime, risky sex) that are associated with negative mental health consequences (Koenig, 2012a, p. 50).

3. Lastly, Western Christianity strongly emphasizes the love of others, compassion, and altruistic acts as well as encourages meeting with each other during various social events placed in the widely understood religious context. As it was already mentioned, these kinds of pro-social behaviors have many desirable consequences that buffer stress and lead to gaining social support, especially when it is needed during difficult times abundant in adversities and hardships. Since religion encourages helping other people and emphasizes a focus outside of the self, engagement in other types of helping – pro-social activities may increase positive emotions and serve as a factor distracting the person from his/her problems. Importantly, Western Christianity promotes values and behaviors such as forgiveness, gratitude, honesty, dependability, patience, which foster positive social relationships. Daily conduct in harmony with these virtues may also directly increase positive emotions and neutralize the negative ones (Koenig, 2012a, p. 7-8). Therefore, religious beliefs influence the quality and amount of social engagement, as well as give guidelines for decisions affecting people with whom an individual is bonded (family, co-workers, friends) who may be a source of social support when a traumatic event happens in life (Koenig, 2018, p. 50).

Conclusion

It seems that the evidence for the close and relatively strong relationship between religiosity-spirituality and broadly understood health – both mental and physical, presented in this article should be a sufficient impulse not only for this relationship to be further explored (alongside with gradually expanding the knowledge that underlies it) but also to start using the dependencies specific to it in practice, daily, inter alia, by specialists in the field of human health. The reality of the 21st century is full of numerous adversities that can lead to stress – also in its chronic form, which makes people search for remedial methods that would increase the effectiveness of preventive measures – both primary and secondary – justified by all means. Perhaps religiousness and spirituality, together with the sense of community connected with it, may turn out to be factors that, by strengthening the generalized resistance resources of a person (directly or indirectly), will play a key role in the generally understood process of coping.

References:

Antonovsky, A. (1987). *Unraveling the Mystery of Health – How people manage stress and stay well*. San Francisco: Josey Bass.

Anotnovsky, A. (1996). The salutogenic model as a theory to guide health promotion. *Health Promotion International, vol. 11, 1.*

Bao, Y. S., Zhu, F. W., Hu, Y., Cui, N. (2016). The Research of Interpersonal Conflict and Solution Strategies. *Psychology, 7*, 541-545. http://dx.doi.org/10.4236/psych.2016.74055

Baqutayan, S. M. S. (2015). Stress and Coping Mechanisms: A Historical Overview. *Mediterranean Journal of Social Sciences, vol. 6, 2*, 479-488.

Beyers, J. (2017). Religion and culture: Revisiting a close relative', *HTS Teologiese Studies/Theological Studies, 73(1)*, a3864. https://doi. org/10.4102/hts.v73i1.3864.

Bowlby, J. (1979). *The making and breaking of affectional bonds*. London: Tavistock.

Cohen, S., Wills, T. A. (1985). Stress, Social Support, and the Buffering Hypothesis. *Psychological Bulletin, vol. 98, 2*, 310-357.

Cohen, S., Janicki-Deverts, D., Miller, G. E. (2007). Psychological Stress and Disease, *The Journal of American Medical Association, vol. 298, 14*, p. 1685-1687.

Cohen, S., Kessler, R. C., Gordon, U.L., (1995). Strategies for measuring stress in studies of psychiatric and physical disorder, in: S. Cohen,

R. C. Kessler, U. L. Gordon (eds.), *Measuring Stress: A Guide for Health and Social Scientists* (3-26). New York: Oxford University Press.

Cohen, S., Tyrrell, D. A. J., Smith A. P. (1991). Psychological stress and susceptibility to the common cold, *The New England Journal of Medicine, 325*, 606-612, doi: 10.1056/NEJM199108293250903.

Denaro, M., Tomasello, L., Rusii, E. G. (2014). Cancer and stress: What's matter? from epidemiology: the psychologist and oncologist point of view, *Journal of Cancer Therapeutics & Research, 3*, 1-4, doi: 10.7243/2049-7962-3-6.

Douglas, H., Georgiou, A., Westbrook, J. (2017). Social participation as an indicator of successful aging: an overview of concepts and their associations with health. *Australian Health Review, 41*, 455-462.

Ellison, H. G., Levin, J. S. (1998). The Religion-Health Connection: Evidence, Theory, and Future Directions. *Health Education and Behavior vol. 25, 6*, 700-720.

Epel, E. S., Blackburn E. H., Lin J., Dhabhar F. S., Adler N. E., Morrow J. D., Cawthon R. M. (2004). Accelerated telomere shortening in response to life stress, *Proceedings of The National Academy of Sciences of the United States of America, vol. 101, 49*, retrieved from: https://pubmed.ncbi.nlm.nih.gov/15574496/, doi: 10.1073/pnas.0407162101.

Ewart, C. K. (1991). Social action theory for a public health psychology. *American Psychologist, 46 (9)*, 931-946.

Galea, S., Tracy, M., Hoggatt, K. J., DiMaggio, Ch., Karpati, A. (2011), Estimated Deaths Attributable to Social Factors in the United States. *American Journal of Public Health, vol. 101, 8*, 1456-1465.

Hill, T. D., Rote, S. M., Ellison, Ch. G. (2017). Religious Participation and Biological Functioning in Mexico, *Journal of Aging and Health, vol. 29, 6*, 951-972.

Hood Jr., R. W., Hill, P. C., Spilka, B. (2018). *The Psychology of Religion. An Empirical Approach. Fifth Edition*. New York – London: The Guilford Press.

House, J. S., Landis, K. R., Umberson, D. (1988). Social Relationships and Health, *Science New Series, Vol. 241, 4865*, (Jul. 29, 1988), 540-545

Huguelet, P., Koenig, H. G. (2009). *Religion and Spirituality in Psychiatry*. New York: Cambridge University Press.

Idan, O., Eriksson, M., Al.-Yagon, M., (2017). The Salutogenic Model: The Role of Generalized Resistance Resources, in: M. B. Mittelmark, S. Sagy, M. Eriksson, G. F. Bauer, J. M. Pelikan, B. Lindstrom, G. A. Espnes (eds.), *The Handbook of Salutogenesis*, Springer, 57-69.

Koenig H. G. (2012a). Religion, Spirituality, and Health: The Research and Clinical Implications, *ISRN Psychiatry, 12*, doi: 10.5402/2012/278730.

Koenig, H. G. (2012b). The Complex Association Between Religious Activities and Functional Limitations in Older Adults, *The Gerontologist, vol. 52, 5*, 678-685.

Koenig, H. G., George, L. K., Titus, P. (2004). Religion, Spirituality, and Health in Medically Ill Hospitalized Older Patients, *Journal of the American Geriatrics Society, 52*, 554-562.

Koenig, H. G., King, D. E., Carson, V. B. (2012). *Handbook of Religion and Health. 2nd edition*. New York, NY, USA: Oxford University Press.

Koenig, H. G., McCullough, M. E., Larson, D. B. (2001). *Handbook of Religion and Health. 1st edition*. New York, NY, USA: Oxford University Press.

Koenig, H. G. (2018). *Religion and Mental Health. Research and Clinical Applications*. London: Academic Press.

Krumrei, E. J., Rosmarin, D. H. (2012). Process of Religious and Spiritual Coping, in: J. D. Aten, K. A. O'Grady, E. L. Worthington Jr. (eds.), *The Psychology of Religion and Spirituality for Clinicians. Using Research in Your Practice* (245-273). London: Routledge/Taylor & Francis Group.

Lakey, B., Cohen, S. (2000). Social Support Theory and Measurement, in: S. Cohen, L. G. Underwood, B. H. Gottlieb (eds.), *Social Support Measurement and Intervention: A Guide for Health and Social Scientists* (29-52). New York: Oxford University Press.

Lazarus, R. S., Launier, R. (1978). Stress-related transactions between person and environment, in: L. Pervin, M. Lewis (eds.), *Perspectives in Interactional Psychology*, (287-327). New York: Plenum.

Lazarus, R. S., Folkman, S. (1984). *Stress, appraisal, and coping*. New York: Springer, p. 18.

Marks, D. F., Sykes, C. M., McKinley, J. M. (2003). Health Psychology: Overview and Professional Issues, in: A. M. Nezu, Ch. M. Nezu, P. A. Geller (eds.), *Handbook of Psychology. Volume 9. Health Psychology* (5-23). New Jersey: John Wiley & Sons.

Moreira-Almeida, A., Lotufo Neto, F., Koenig, H. G. (2006). Religiousness and mental health: A review. *Brazilian Journal of Psychiatry, vol. 28, 3*, 242-250.

Nelson, J. M. (2009). *Psychology, Religion, and Spirituality*, New York: Springer.

Reiche, E. M. V., Odebracht Vargas Nunes, S., Kaminami Morimoto, H. (2004). Stress, depression, the immune system, and cancer, *The Lancet Oncology, 5*.

Ringdal, G. I. (1996). Religiosity, Quality of Life, and Survival in Cancer Patients, *Social Indicators Research, vol. 38, 2*, 193-211.

Schwarzer, R., Luszczynska, A. (2012). Stressful Life Events, in: I. B. Weiner, A. M. Nezu, Ch. M. Nezu, P. A. Geller (eds.), *Handbook of Psychology, Second edition, vol. 9 – Health Psychology* (29-56). New Jersey: John Wiley and Sons.

Segerstrom, S. C., Miller, G. E. (2004). Psychological Stress and the Human Immune System: A Meta-Analytic Study of 30 Years of Inquiry, *Psychological Bulletin, 130(4)*, 601-630. https://doi.org/10.1037/0033-2909.130.4.601

Selye, H. (1951). The General Adaptation Syndrome, *Annual Review of Medicine, 2*, 327-342.

Zimbardo, P. G., Johnson, R. L., McCann, V. (2010). *Psychologia. Kluczowe koncepcje. Tom 5. Człowiek i jego środowisko*, [*Psychology. Key concepts. A Man an his enviroment*]. Warszawa: Wydawnictwo Naukowe PWN.

Żołnierz, J., Sak, J. (2017). Współczesne badania nad wpływem religijności na zdrowie człowieka (Modern research on religious influence on human health), *Journal of Education, Health and Sport, vol. 7, 4*, p. 100-112.