

Religion and Mental Health: Theory and Research

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ABSTRACT

This article provides an overview of psychiatric and mental health research on religion. First, conceptual models of religion and of mental health used throughout this literature are described. Second, published empirical research in this field is summarized, including findings from epidemiologic, clinical, and social and behavioral investigations. Third, promising theoretical perspectives for understanding a putative religion–mental health connection are elaborated. These are based on respective behavioral, biological, psychodynamic, and transpersonal interpretations of existing research findings. Copyright © 2010 John Wiley & Sons, Ltd.

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INTRODUCTION

Recently, the idea of a “religion–health connection” (Ellison & Levin, 1998) has gained traction among clinicians, due to a growing body of research. Literature reviews (e.g. Levin & Chatters, 1998) and academic (Koenig, 1998a; Koenig, McCullough, & Larson, 2001) and popular (Levin, 2001) books have focused attention on social, behavioral, epidemiologic, and clinical research papers that total in the thousands. These studies explore the impact of religious indicators on psychiatric and mental health outcomes in population, community, and hospital samples: rates of mood disorders, such as depression and anxiety; levels of psychological distress, using numerous assessment instruments; dimensions of psychological well-being, such as life satisfaction and happiness; patterns of self-destructive behavior, including the addictions; and mental health care utilization. The weight of evidence, on average and across studies, suggests that religion, however assessed, is a generally protective factor for mental illness.

Until now, most scientific effort has been devoted to accumulating empirical evidence. Less effort has gone to stepping back and asking, “But what does this mean?” Data alone do not increase understanding of a topic without theoretical

models that help us make sense of said data. Such perspectives are akin to lenses that enable us to “see” findings that might not fit into our scientific worldviews and thus be cast aside or disparaged. Identifying perspectives to explain and interpret findings on religion and mental health is thus important and timely, especially as supportive findings have been misinterpreted – on both sides of the issue. That religion might have something to say about mental health, for good or bad, has been a sensitive and contentious issue within psychiatry, dating to Freud, as familiarity with the history of psychiatry attests.

A case in point: the 1994 revision of the American Psychiatric Association (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM), which added a new diagnostic category (V62.89) termed “religious or spiritual problem.” In earlier versions (e.g. DSM-III-R), the sole references to religion were as a sign of psychopathology – as features of cases exemplifying cognitive incoherence, catatonia, delusion, magical thinking, hallucinations, or schizotypal disorders (Larson *et al.*, 1993; Post, 1992). Once this oversight was dissected, the new construct was rolled out in the DSM-IV, defined broadly as a circumstance whereby “the focus of clinical attention is a religious or spiritual problem” (American Psychiatric Association, 1994, p. 300). Examples include loss of faith, conversion-related problems, and questioning of faith or values. This new category signifies that psychiatrists have become sensitive to the idea that certain expressions of faith, where “distorted or disrupted rather than inherently so” (Levin, 2009, p. 91), may be sources of certain kinds of psychological distress (Turner, Lukoff, Barnhouse, & Lu, 1995).

The years since have seen a sustained increase in research on religion and mental health. The time is right to step back and evaluate where we are and what we know about the relation between these two constructs. Accordingly, this paper tries to explain and interpret observed associations from behavioral, biological, psychodynamic, and transpersonal perspectives. Each perspective suggests ways to make sense of findings and each helps to place findings into a larger context that may enable a better understanding of etiology and more effective treatment.

HISTORY AND CONCEPTUAL MODELS

As religion and health research has gained acceptance in psychiatry and psychology, a misperception has arisen that such studies are a new development. Not so. Nor is this a novel topic for these fields. Scholarship on religion and psychiatric disorders dates to the nineteenth century, most famously in the writings of Freud. Less known are earlier discussions within the nascent pastoral care movement, exemplified by *Observations on the Influence of Religion upon the Health and Physical Welfare of Mankind* (Brigham, 1835), authored by a founder of the APA. The *British Medical Journal* (Review, 1905) noted, with an optimistic tone reflecting the place of religion in medical discourse of the time, “The interdependence of religion and health, which may both be regarded as inherent

birthrights of mankind, is a broad fact which is generally accepted and which is capable of easy demonstration" (p. 1047).

For many clinicians and scientists of the day, religion was highly relevant – for better or worse – as an etiologic, therapeutic, or palliative agent in psychotherapy. Whether thought to be a malign or salutary influence on mental and emotional well-being, the sphere of religiousness, faith, and sacred beliefs and experiences had been a source of exploration for decades. Whatever one's beliefs or preferences about faith or God, it at least was agreed that these things mattered.

The polarities of early discourse on this subject are represented by Freud and James. In *The Future of an Illusion* (Freud, 1927/1961b) and *Civilization and Its Discontents* (Freud, 1930/1961a), Freud asserted that "religion and science are moral enemies and that every attempt at bridging the gap between them is bound to be futile" (Gay, 1989, p. xxiii). Religious practices, and belief in God, moreover, were taken by Freud as signs of obsessive neurosis, narcissistic delusion, and an infantile life outlook, and thus a dangerous threat to individual psyches and to society. They were believed to be determinative of, or indeed to reflect, an unhealthy psychological status.

James was not as pessimistic. In *The Varieties of Religious Experience* (James, 1902/1958), he identified two types of religious expression, the "religion of the sick soul" and the "religion of the healthy-minded soul." The former is a product of a damaged psyche, expressed as "positive and active anguish, a sort of psychical neuralgia wholly unknown to healthy life" (p. 126). In extremis, this includes loathing, irritation, exasperation, self-mistrust, self-despair, suspicion, anxiety, trepidation, and fear. The latter is grounded in "the tendency which looks on all things and sees that they are good" (p. 83). Healthy-minded religion is the faith of the literally healthy minded, whose psyches are implicitly hopeful, optimistic, positive, kind, and prone to happiness.

Others who followed James also saw benefit in expressions of religion – e.g. Jung (1934, 1938) and Fromm (1950) – but the psychiatric profession as a whole remained dubious. Not unanimously, but largely so, and not without reason. Unchecked manic expressions of religion have been, throughout history, sources of delusion, instability, and pathology, readily visible to clinicians who serve, essentially, as first responders for people whose religious practice has taken pathological form. Yet, until recently, there was minimal interest in testing the idea that religion lacked positive instrumentality for mental and emotional well-being. A presumption of guilt was tacit, with little impetus to validate this view. After half a century of scholarly disinterest (see Beit Hallahmi, 1989), things began to change in the 1950s and 1960s (see for example Allport, 1954/1979).

The advent of psychology's third and fourth schools encouraged critical examination of issues related to the human spirit. Humanistic and transpersonal theorists (e.g. Maslow, 1964; Tart, 1975) were influenced by yoga, Vedanta, Zen, the esoteric traditions, and various integral perspectives (see Chaudhuri, 1977;

Ghose, 1950; Wilber, 2000). While not mainstream within psychiatry and psychology, the subject of spirituality, broadly constructed as related to the quest for human potential and flourishing, became an acceptable, or at least tolerated, topic of inquiry. A broad take on spirituality was emphasized, focusing on a wider swath of experiences than the traditional usage of this concept contexted within normative religion. Rather than defined solely as a state of attainment resulting from a lifetime of religious observance and piety (a theological definition of spirituality), the new wave of psychologists explored spirituality in the context of the developmental process of attaining transcendent union with something “beyond” than the individual ego, such as the eternal source of being.

Concurrently, the putative mental health consequences of formal religious involvement became a topic for empirical study, especially within community and geriatric psychiatry and social, developmental, and health psychology. The pioneering Midtown Manhattan Study, began in the 1950s, was one of the earliest and is still among the most comprehensive and insightful epidemiologic explorations of psychiatric morbidity and its sociodemographic determinants. The study features analysis of variations in the prevalence of certain diagnoses and subsequent use of mental health services. The initial volume of findings, *Mental Health in the Metropolis* (Srole, Langner, Michael, Opler, & Rennie, 1962), is a classic text of social psychiatry and psychiatric epidemiology. The study is highlighted by a detailed analysis of the impact of religious affiliation (Srole & Langner, 1962). Investigators found that “religious origin” – Catholic, Protestant, or Jewish – is a source of significant variation in symptom formation, psychiatric impairment, patient history status, and attitude toward mental health professionals.

While investigations of physical morbidity had been ongoing for decades, prior to this study psychiatric epidemiologists showed less interest in the impact of characteristics or functions of religion on population rates of psychopathology. The Midtown Manhattan Study led to other studies, which have since snowballed. In the early 1980s, literature reviews began summarizing this work, by then consisting of about 200 empirical studies of various outcomes (e.g. Gartner, Larson, & Allen, 1981; Larson, Pattison, Blazer, Omran, & Kaplan, 1986). The verdict was consistent. According to one authoritative review, “The mental health influence of religious beliefs and practices – particularly when imbedded within a long-standing, well-integrated faith tradition – is largely a positive one” (Koenig, 1998b, p. 392).

These early efforts at quantifying the impact of religious identity, belief, and practice on mental health were not the whole of the religion–mental health discussion. In 1980, the National Institute of Mental Health (NIMH) published *Religion and Mental Health* (Summerlin, 1980), an annotated bibliography of 1836 entries – journal articles, chapters, books, reports, other media. Approximately 1500 of these had appeared just since 1970. Empirical research studies, clearly, were just one expression of a more widespread intellectual and professional engagement of this subject.

Since then, findings have accumulated from large research programs, such as by Koenig and colleagues at Duke University (see Koenig, 1999). Yet this subject remains provocative due to issues related to conceptualizing religion and to theoretical perspectives that underlie a religion–mental health connection. While study designs and analyses are increasingly sophisticated, the field as a whole has been less successful in making sense of results. For example, statistically significant findings implicating religious membership, church attendance, belief in God, and so on in rates of psychiatric symptoms or well-being do not tell us about a salutary influence of spirituality, no matter how much some wish it were so. Spirituality remains underinvestigated, not just in studies of mental health but in all domains of religious research.

To understand how faith impacts on something as personal as psychological status, thoughtful investigation of spirituality would be more fruitful than continued enumeration of discrete religious behaviors. Features and correlates of the trajectory of inner evolverment toward perceived union with the transcendent – a decent functional definition of the spiritual process – seem to tap dimensions of life experience more germane to the struggle to maintain intrapsychic equilibrium than counts of participation in congregational events. But this is a hypothesis, not a conclusion. Researchers, generally speaking, have shown little enthusiasm for addressing issues not easily amenable to conventional approaches to religious assessment (see Levin, 2003).

In studies of physical and mental health, the most common religious measures are single-item questions on affiliation and attendance at worship services. Such questions (ostensibly) emphasize something observable and quantifiable. For the most part, investigators have avoided assessment of attitudes, beliefs, states, or experiences. Very little is thus known about their impact on outcomes of interest, such as rates of mental health or psychological well-being.

Likewise, most studies focus on dimensions of well-being: life satisfaction, congruence, happiness, positive affect, depressed mood – constructs for which validated indices are available. Fewer studies explore religion's impact on psychiatric diagnoses, except for attention to its etiologic or preventive role in clinical depression and anxiety disorders and to some addictive behaviors. Most of these studies use single-item measures or unidimensional indices.

While findings are often interpreted as relating to richly nuanced and multidimensional spirituality–mental health connections, this is not true. Most findings are results of analyses of one-off measures of public and private religious behavior, mostly in relation to single-item measures or unidimensional indices of self-reports of general or domain-specific well-being. Moreover, these are mostly prevalence (cross-sectional) studies of religion as a correlate of distress/well-being in general populations; they do not examine religion as a therapeutic agent for existing pathology. These are thus not studies of healing but of prevention. Further, existing studies have been conducted mostly within populations of US Christians of one denomination or another. To be clear, this is not problematic, in and of itself; this is a thriving area of study at the forefront of several

fields, including religious gerontology, health psychology, and medical sociology. But it is important to underscore these points, as this work is often tacitly believed to imply a presumably global and therapeutic impact of spirituality on mental health, something it does not address. There is reason to believe that religion or spirituality may function in this way, but the wealth of findings accruing on religion and health have little to say about such an effect.

RESEARCH FINDINGS

Empirical investigations of religion and mental health include epidemiologic studies involving population-based national or community samples, clinical studies of psychiatric outpatients or inpatients, and social and behavioral research on psychological distress and well-being. Due to a wealth of published work over the past two decades, this review is selective rather than comprehensive. Many good reviews are available, and interested readers are directed to them for greater detail (e.g. Levin & Chatters, 1998; Koenig *et al.*, 2001).

Early systematic reviews of studies of religion in psychiatry journals identified a paradox: research on the impact of religion was not uncommon (139 published analyses just between 1978 and 1989), but conceptual and theoretical engagement was lacking (see Larson *et al.*, 1986; Larson *et al.*, 1992). In 78 percent of studies no hypothesis was tested, in 64 percent no adequate statistical analysis was conducted, and only superficial measures were typically used (e.g. broad categories of affiliation). Findings were largely positive – indicative of a generally salutary effect of religious identity or practice – but what they implied was unclear. The subject was still touchy for academics; the unspoken “R word,” as one paper described it (Larson, Sherrill, & Lyons, 1994).

Over the past 20 years, empirical study has expanded greatly, highlighted by large funded research programs. The first edition of his *Handbook of Religion and Health* (Koenig *et al.*, 2001) summarized hundreds of studies analyzing effects of dimensions of religion on depression, suicide, anxiety disorders, schizophrenia and other psychoses, alcohol and drug use, delinquency, features of personality, and other outcomes. The weight of evidence was positive: over half of the studies in these categories point to a statistically significant protective effect. Nevertheless, besides Koenig’s own work and that of several of his colleagues and collaborators, most studies are one-off analyses from small samples of convenience.

Medical sociologists, health psychologists, and gerontologists have done a more sophisticated job at identifying impacts of religious life on mental health indicators. Studies of dimensions of psychological distress and well-being, many of them large-scale probability surveys, consistently find a protective effect of religious participation (see Levin & Chatters, 1998). Within the gerontological literature, especially, features of institutional religious involvement (e.g. attendance at worship services) and non-institutional involvement (e.g. private prayer,

embeddedness in religious support networks) have been associated with positive mental health outcomes and high scores on scales and indices assessing psychosocial constructs such as self-esteem, mastery (self-efficacy), optimism, hope, and dimensions of well-being. This overall finding has been replicated across age cohorts, in both sexes, and regardless of social class, race or ethnicity, religious affiliation, and specific diagnosis or outcome measure (see Levin, 1997). Much of the literature focuses on symptoms of mood disorders, such as depression or anxiety, and many studies have found a health-promoting effect of religion on overall and domain-specific life satisfaction, happiness, and positive affect. Sophisticated systematic reviews and meta-analyses (e.g. Smith, McCullough, & Poll, 2003) provide depthful critiques of conceptual, theoretical, and methodological issues and offer guidance for the next generation of research.

To summarize, religious involvement, broadly defined, exhibits a salutary and primary-preventive function in relation to psychological distress and outcomes related to mental health and well-being. Findings are consistent, and a protective effect of religiousness seems to be especially salient among older adults. But it is important not to overinterpret this overall result.

The present author (Levin, 1996) has identified common misinterpretations of the larger religion–health literature; the same points are applicable to mental health. For example, results are often taken to mean that religious involvement promotes healing. It may, but, as noted, studies do not address that topic; they focus almost exclusively on primary prevention. Nor do findings mean that religious people do not become ill; of course they do. When examining population rates of morbidity, however, there is a modest advantage, on average, attributable to religious practice. Nor do findings tell us much about spirituality. While that would be a fine research topic, studies mostly look at the impact of affiliation with and participation in established religions. Studies also do not provide evidence for or against a healing power of prayer. Nor do they suggest that religiousness or faith (or spirituality) is the most important factor in health. As a public health scientist, the present author finds this latter claim especially unfortunate. These factors may measurably impact on morbidity, both physical and mental, but tobacco use and socioeconomic disparities, for example, far outweigh a religious effect. Finally, and this goes without saying, studies of religion using epidemiologic or social or behavioral research methods cannot tell us anything about the possibility of a “supernatural” influence on health or the human body or mind. If folks are looking to scientific research (on health, of all things) to validate the existence or motives of God, then they are looking in the wrong place.

So what can we conclude for certain? Simply this: there is considerable evidence that one’s religious life has something significant to say about one’s mental health. This includes both the “being” and “doing” aspects of religion – our religious identity and how we believe or feel or act as a consequence. This does not mean that religious people do not become ill – one of the usual

misconceptions of this work, noted earlier – just that higher categories of response to questions about religious participation are associated with lower rates of symptoms or pathology or with higher scores on well-being measures. No more, no less. The take-home point is simply that religion merits a place at the table with those factors known to impact the risk or odds of subsequent psychiatric morbidity in adult populations. This, we can say, is the “what” of a religion–mental health relationship. But what about the “how” or “why”?

THEORETICAL PERSPECTIVES

To explain these findings, we must rely on interpretive grids – theoretical perspectives, in the language of social science. These are respective lenses by which empirical observations are made sense of in light of existing or proposed scientific mechanisms and clinical observations. Within psychiatry, psychology, and the mental health field, generally, such lenses are many. We are all familiar with the famous four forces or schools of modern psychology: behaviorism, psychodynamics, humanism, and transpersonalism. But these do not exhaust the ways that the human psyche and patterns of behavior, and their antecedents, are understood to influence health by behavioral and social scientists. For purposes of this discussion, several broad meta-categories of potential explanations for religion–mental health associations are examined.

Behavioral Explanations

The religious impulse is expressed through myriad behaviors, emotions, motivations, beliefs, attitudes, thoughts, values, experiences, and relationships. Independently of religion, we have long known that our behaviors, emotions, and social relationships are significant health determinants. Physical and mental health – self-rated and objectively diagnosed – and rates of psychiatric morbidity are known to vary by categories of behavioral and psychosocial variables, including stress, social support, life-style behaviors, and health-related cognitions and affects.

Researchers have proposed many possible mediators of observed religion–mental health associations, drawing on various functions and domains of the psyche. Collectively, these help us understand how the practice of faith or a spiritual path may impact psychological health. Commitment to a religious belief system may benefit mental health by promoting healthy behaviors conducive to wellness (e.g. avoidance of tobacco, alcohol, drugs, antisocial behavior). Fellowship with likeminded congregants embeds one in formal or informal social networks that facilitate receipt of tangible and emotional support. Private or group prayer or worship may produce salutary emotions – gratitude, humility, grace, forgiveness, love – with preventive or therapeutic benefit. Religious beliefs (about God, human existence, the purpose of life, life after death, free will, the

nature of evil, human obligations) may be consonant with beliefs that foster preventive health care practices. Faith, or religious certainty, may engender positive expectations that instill hope and optimism capable of preventing or ameliorating distress. In sum, psychological mediation of a religion–mental health link is plausible and consistent with research on correlates and determinants of health and healing (Levin, 2009).

Biological Explanations

Some theories of psychological mediation of a religion–mental health association posit “hard-wired” connections among brain, behavior, affect, and immunity. These connections are not unique here; research on psychoneuroimmunology dates back 40 years (see Ader, 2007). But consideration of neurocognitive and neuroendocrine pathways, for example, accounting for positive findings in this field is a hopeful development for investigators seeking naturalistic explanations for religious effects. In light of evidence of religious motivations (e.g. intrinsic religiosity) associated with psychophysiological markers such as absorption (e.g. Levin, Wickramasekera, & Hirshberg, 1998), and of “spiritual” centers in the brain (e.g. Beauregard & O’Leary, 2007; Newberg, D’Aquili, & Rause, 2001), neurophysiological mediation of religious effects on mental health is biologically plausible. A conference on psychoneuroimmunology and religion (Koenig & Cohen, 2002) suggested that collaboration among neuroscientists, psychiatrists, and psychiatric epidemiologists should become a cutting edge for this field.

The complexity of interrelationships between religion and etiologic agents of or risk factors for psychopathology is exemplified in a model proposed for antecedents of major depression (Koenig, Blazer, & Hocking, 1995). A maze of hypothesized and validated pathways connects myriad factors (e.g. health behaviors, alcohol and drug use, medications, physical illness, chronic pain, disability, genes, personality, brain disease, comorbid psychiatric illness, stressful events, aging changes, cognitive appraisal, coping behavior, social support, economic resources, history of depression) with each other and with diagnosis of an affective disorder. For most of these factors, research has identified religious correlates or determinants. This model underscores the complexity of an etiologic role for characteristics or functions of religiousness – intimately connected with other accepted etiologic or risk factors for this diagnosis.

Psychodynamic Explanations

In an early review, a dozen explanations for religion–health associations were proposed (Levin & Vanderpool, 1989). Among these were the psychodynamics of belief systems and the psychodynamics of religious rites. By the first of these, the authors referred to the tendency of religious beliefs to “give rise to psychodynamics engendering greater peacefulness, self-confidence,

and a sense of purpose, or, alternatively, guilt, depression, and self-doubt” (p. 73). These outcomes may be symbiotic with certain personality styles (e.g. Type A) or with theological perspectives such as Calvinism (determinism) or Arminianism (free will). The second referred to “public and private rituals [that] serve to ease dread and anxiety, reduce personal and group tension and aggressiveness, allay fears, and moderate loneliness, depression, anomie, and/or feelings of entrapment and inferiority” (p. 74). These rites enable people to “dramatize or act out their beliefs in settings conducive to or charged with emotion – provide avenues of escape, purification, catharsis, and empowerment. These positive affects may serve as sorts of psychic beta-blockers or emotional placebos” (p. 74).

For sure, “psychodynamic” covers a lot of ground. Different schools and philosophies posit different theories of religion and faith and disagree as to the polarity of their impact on psychological health. Freud’s (1927/1961b) antipathy to the “peculiar value of religious ideas” (p. 18) is well known, but his take no longer predominates in the field. Jung’s (1938) perspective on the reciprocal influence of religious dogma and the symbolism of the unconscious is also influential, but his references to mystical, gnostic, and occult sources are less pertinent to normative religion. In *Psychoanalysis and Religion*, Fromm (1950, p. 9) appealed for a middle ground:

If I undertake to discuss the problem of religion and psychoanalysis afresh ... it is because I want to show that to set up alternatives of either irreconcilable opposition or identity of interest is fallacious; a thorough and dispassionate discussion can demonstrate that the relation between religion and psychoanalysis is too complex to be forced into either one of these simple and convenient attitudes.

Transpersonal Explanations

The advent of psychology’s third and fourth schools introduced many concepts into the lingua franca of psychotherapists. Foremost are the transcendent experience and the idea of the transpersonal. The latter refers to states “beyond” the personal and egoic, oriented toward development of human potential, including attributes and functions of higher consciousness (see Vaughan, 1984). Transpersonal therapy emphasizes “self-determination, self-actualization, self-realization, and self-transcendence” (Vaughan, 1984, p. 25). Therapists acknowledge higher states of consciousness, neither normal waking nor dreaming states, whose experience may be a rich source of growth. These may be infused with spiritual symbolism and serve as gateways to “divine” experiences, such as transcendence. Accounts of mystics point to subtypes: a “green” type of transcendent experience “characterized as transitory and involving a profound experience of pleasure, oftentimes described as ecstatic” and a “mature” type “characterized as long lasting... a more enduring serenity and equanimity” (Levin & Steele, 2005, pp. 89–90). An example of the former might be Maslow’s peak experiences; the latter, the yogic attainment of *samādhi*.

The significance here is found in psychophysiological correlates of transcendence and markers of other transpersonal experiences. Health- and mood-related sequelae of spiritually motivated pursuits engendering such experiences – e.g. meditation, prayer – point to a potentially therapeutic instrumentality. While better mental health may not be an objective of the quest for transcendence, the large research literature on psychophysiology, consciousness, and spirituality (see Murphy & Donovan, 1999) suggests a valuable interpretive framework with interesting tie-ins to the behavioral, biological, and psychodynamic explanation broached earlier.

CONCLUSION

To summarize, empirical evidence supports a generally protective effect of religious involvement for mental illness and psychological distress. Like all epidemiologic findings, there are exceptions: e.g. individuals whose religious ideations and practices contribute to, or reflect, pathology. But, on average, this finding is statistically significant, replicated, and modest in magnitude. It is not solely a function of the assessments used for religion or mental health or of characteristics of the populations studied. Existing theoretical perspectives provide a reasonable basis for making sense of this association, which is coherent with behavioral, biological, psychodynamic, and transpersonal understandings of determinants of mental and emotional well-being. While much remains to be learned, scholarship has come a long way in the past 30 years.

One marker of the growing acceptance of this field is the annual Oskar Pfister Award, given by the APA since 1983 in recognition of outstanding career contributions to religion and psychiatry through research, publications, and clinical practice. Named for a pioneering psychoanalyst and protégé of Freud, Pfister Award laureates include some of the most influential and highly regarded figures in psychiatry, including Jerome Frank, Viktor Frankl, Robert Jay Lifton, Oliver Sacks, Robert Coles, Don Browning, and Paul Ricoeur.

For researchers, the mainstreaming of this subject presents an opportunity for substantive, programmatic contributions – in contrast to the one-off approach of so many papers to date. A field that is sufficiently established for the APA to sanction a major career award no longer needs atheoretical “exploratory” research. The envelope can begin to be pushed. Perhaps someday we will look back and wonder how we ever presumed that well-being is unrelated to the workings of the spirit. Just as the relation of mind and body was rejected by biomedicine until the weight of evidence made such a connection tacit, so, too, may the role of spirit become acknowledged fact. If so, not just our research stands to benefit. Our clients and patients will benefit from more directed attention to dimensions of the self that may be sources of both distress and adjustment but that which, until recently, have been overlooked in our professional discourse.

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