

Association between religiosity, satisfaction with life and mental health: a study of Brazilian adults

Associação entre religiosidade, satisfação com a vida e saúde mental: um estudo com adultos brasileiros

Asociación entre religiosidad, satisfacción con la vida y salud mental: un estudio con adultos brasileños

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Abstract

Introduction: Much research has been done about religiosity, and religious beliefs can play an important role in mental health and life satisfaction. **Objective:** We aim to analyze the possible association between religiosity, life satisfaction, and mental health. **Method:** Online questionnaires assessed the religiosity, satisfaction with life, and mental health of 538 Brazilian adults. We also investigated the participants' personalities and socioeconomic status with complementary measures. **Results:** We found significant correlations between organized and non-organized religiosity with satisfaction with life and mental health. Intrinsic religiosity was significantly related to life satisfaction but not mental health. **Conclusion:** People with more organized and non-organized religiosity could be more satisfied with life and have better mental health regardless of personality and socioeconomic status.

Keywords: religiosity, mental health, satisfaction with life

Resumo

Introdução: Muitas pesquisas têm sido feitas sobre religiosidade, e as crenças religiosas podem desempenhar um papel importante na saúde mental e na satisfação com a vida. **Objetivo:** Analisaremos a possível

associação entre religiosidade, satisfação com a vida e saúde mental. **Método:** Questionários online avaliaram a religiosidade, a satisfação com a vida e a saúde mental de 538 adultos brasileiros. Também investigamos a personalidade e o status socioeconômico dos participantes com medidas complementares. **Resultados:** Encontramos correlações significativas entre religiosidade organizada e não organizada com satisfação com a vida e saúde mental. A religiosidade intrínseca foi significativamente relacionada à satisfação com a vida, mas não à saúde mental. **Conclusão:** Pessoas com religiosidade mais organizada e não organizada poderiam estar mais satisfeitas com a vida e ter melhor saúde mental independente da personalidade e nível socioeconômico.

Palavras-chave: religiosidade, saúde mental, satisfação com a vida

Resumen

Introducción: se han realizado muchas investigaciones sobre la religiosidad y las creencias religiosas pueden desempeñar un papel importante en la salud mental y la satisfacción con la vida. **Objetivo:** Nuestro objetivo es analizar la posible asociación entre la religiosidad, la satisfacción con la vida y la salud mental. **Método:** Evaluamos la religiosidad, la satisfacción con la vida y la salud mental de 538 adultos brasileños. También investigamos las personalidades y el nivel socioeconómico de los participantes con medidas complementarias. **Resultados:** Encontramos correlaciones significativas entre la religiosidad organizada y no organizada con la satisfacción con la vida y la salud mental. La religiosidad intrínseca se relacionó significativamente con la satisfacción con la vida, pero no con la salud mental. **Conclusión:** Las personas con religiosidad más organizada y no organizada podrían estar más satisfechas con la vida y tener mejor salud mental independientemente de la personalidad y nivel socioeconómico.

Palabras clave: religiosidad, salud mental, satisfacción con la vida

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Introduction

Religion is understood as a universal characteristic of our species [1]. Regularly related to personal and practical knowledge of a religious group belief, religious practice engagement is seen in most people, whether individually or collectively [2].

These practices can vary according to religious beliefs. For example, some people attend church while others have dietary restrictions, holiday celebrations, believing in God, or life after death. Religiosity is relevant to many people's lives [3], and it influences even those with no religious beliefs, as seen in several contemporary social and political debates, such as gay marriage, abortion, capital punishment, and stem cell research [1]. However, the greater the level of religiosity, the more critical religious practices become to an individual.

Some studies suggest that religiosity serves a social function in which a system of beliefs stipulates moral and immoral behaviors within a group [1], with immoral behaviors being potentially harmful in the long term [4]. Belonging to a religion implies following a system of collectively accepted behaviors.

Many religious practices are related to an internal locus of mental and behavioral control, which, in return, could lead to healthier practices throughout life [5]. Therefore, religious beliefs and practices could lead to positive outcomes in mental health, given that religiosity provides strategies for coping with adversity and, consequently, higher positive emotions and lower stress [6].

Five hundred million people are estimated to suffer from mental health problems globally [7], a motivating fact to better understand its aspects. Religiosity has been considered one of these aspects resulting in increased research on religiosity as an aspect of mental health [6]. Depression and anxiety, the most commonly diagnosed disorders in psychiatry [8], have been intensely studied, and religiosity, one of their many factors of influence, has shown both a protective and risk effect on symptom intensity [6-9].

Usually, increased religiosity is associated with positive mental health outcomes, possibly through mechanisms such as social control, healthier lifestyles, increased social support, and better behavior control [10]. However, some studies report different findings. Researchers [11] examined 50 studies on religiosity and mental health interaction and observed that 72% reported greater mental health in those with greater religiosity, 16% reported worse mental health in those with lower religiosity, and 12% reported neutral association.

High life satisfaction is not expected in individuals with anxiety and depression once symptoms affect mood, motivation, behavior, and cognition [8]. Satisfaction with life is frequently considered a broad measure and, according to authors [12], refers to a “cognitive component of subjective well-being defined as the level of contentment one perceives when one thinks about one's life in general”. A review [13] found that 80% of studies found a positive correlation between religiosity and greater life satisfaction.

Several studies revealed ambiguous findings regarding the association between religiosity, mental health, and life satisfaction [6, 9, 14, 15]. Personality, socioeconomic condition, and mental health history can influence life satisfaction and mental health [16, 17]. Therefore, this study aims to investigate the possible association between religiosity, satisfaction with life, and mental health, controlling the influence that personality traits, history of mental health, and socioeconomic status have on those constructs.

Method

This is a cross-sectional study. We sent to a convenience sample of 538 Brazilian adults with a mean age of 27.97 ± 9.69 years an online questionnaire on a virtual platform formulated by the researchers. Criteria

for selecting the subjects were as follows: 18 years of age or older, Brazilian Portuguese as a native language, and provide free and informed consent. The sample size allowed the detection of strong correlations with a sampling power of 99%, according to an estimate made using SPSS software. The study was approved by the Ethics Committee of the Faculdade de Ciências Médicas de Minas Gerais (CAAE: 57377516.8.0000.5134). The sample descriptive statistics are shown in [Table 1](#).

Participants were asked to respond to a socioeconomic classification questionnaire [18], the Duke Religious Index (DUREL) [19], the Self Reporting Questionnaire-20 [20], and the Satisfaction with Life Scale [21]. As a control variable, personality was assessed through the Ten Item Personality Inventory [22], which evaluates the five major personality factors extroversion, emotional stability, openness, gentleness, and awareness.

As for religiosity dimensions analysis, we used the Duke Religious Index (DUREL) [19]. Organizational religiosity (ORA) is characterized by frequent meetings and social contacts with other people of the same religious congregation, such as mass attendance, worship, study groups, and prayers. Non-organizational religiosity (NORA) refers to the engagement frequency in private religious activities, such as meditation, prayer, and reading religious texts. Intrinsic religiosity (IR) refers to internalizing religious beliefs, where mystical or doctrinal religious experiences are an individual goal. Higher scores indicate high religiosity.

The variables association was analyzed through Pearson's correlation. Based on the correlation coefficients, the magnitude of the effect was calculated using the coefficient of determination (r^2). After initial analyses, we used [SPSS software](#) to calculate the partial correlations controlled for the five personality factors, mental health, and sociodemographic information. $P < 0,05$ is considered significant.

Results

According to the results shown in [Table 2](#), organized religiosity and satisfaction with life show a weak ($r = 0.101$, $p < 0.019$) and significant correlation, indicating higher organized religiosity relates to higher satisfaction with life. Symptoms of anxiety and depression and organized religiosity correlated significantly but weakly ($r = - 0,133$, $p < 0.002$). This

result indicates that higher organized religiosity relates to greater mental health. Non-organized religiosity correlated significantly and weakly with satisfaction with life and mental health ($r = 0,135$, $p < 0,002$; $r = - 0,119$, $p < 0,006$, respectively). This result indicates that higher non-organized religiosity relates to greater life satisfaction and lower symptoms of anxiety and depression. Lastly, intrinsic religiosity correlated significantly with satisfaction with life, but it was also a weak correlation ($r = 0,143$, $p < 0,001$). Intrinsic religiosity showed no significant correlation with mental health ($r = - 0,083$, $p < 0,054$), indicating no association between these measures.

Discussion

Religiosity has been the main topic in several discussions and an issue of research interest, especially since religiosity and spirituality have been seen as significant aspects of human subjectivity [23]. Initially, this phenomenon was seen as a precursor to some pathologies, considering its mechanism of control and repression [24]. However, recent research shows that levels of satisfaction with life, well-being, happiness, and positive affect are positively correlated with religiosity [25, 26, 27, 28].

By previous research, the present study demonstrated that people involved in collective religious practices exhibit higher satisfaction with life and lower anxiety and depression symptoms, and, despite the small magnitude of this correlation, results were sustained when controlling for personality and socioeconomic status. Moreover, higher satisfaction with life and lower anxiety and depression symptoms were also seen in those with no collective religious practices but with individual religious practices, such as prayer. Further, results indicate that those with higher intrinsic religiosity manifest higher satisfaction with life, but there was no association with anxiety and depression symptoms.

Some studies report no correlation between the quality of life, mental health, and religiosity [29, 30], while others report a significant difference between such factors [31, 32]. The contrasting results might be explained by research design differences and the fact that some studies were conducted with clinical samples.

Nevertheless, a meta-analysis concluded how the differences in conceptualizing religiosity and mental health in psychology were associated with different conclusions on religiosity and mental health association [17].

Overall, the authors conclude that religiosity is positively correlated to mental health, with institutional religiosity showing the weakest correlation, ideology having a stronger correlation, and personal devotion as the religious dimension most correlated to mental health [17].

Studies with positive conclusions debate that people can use religion and religious practices to cope with stressful situations [6]. Indeed, a systematic review has shown that religiosity is related to physical and mental health, and researchers argue that religious beliefs might influence how thoughtful a person is with their health [7].

In the present study, religious practices, either organized or non-organized, are significantly correlated to life satisfaction and mental health. This finding was also reported by Bonelli and colleagues [33], who reviewed 444 studies and found that, among those with more religious and spiritual practices, 60% of subjects reported less depression and faster remission of symptoms. In contrast, only 6% of subjects reported major depression.

We expected a positive correlation between religiosity and life satisfaction. In part, high religiosity related to high life satisfaction can be explained by the beneficial relationship with mental health. Once mental health directly impacts functionality in different contexts, highly religious individuals tend to have better mental health, affecting functionality and life satisfaction [34].

Primarily, greater religious beliefs and involvement are associated with fewer stressful life events and higher life satisfaction. However, research shows that religious affiliation is highly related to life satisfaction but not private religious devotion [35]. It is suggested that religiosity alone has no impact on life satisfaction but rather on the social support and sense of belonging it provides [36]. Even so, a study found no correlation between religiosity and life satisfaction, measured by the WHOQOL-BREF scale. However, authors argue that the sample was characterized by high social fragility, possibly diminishing religiosity impact on the quality of life indices [37].

Our results show no significant correlation between intrinsic religiosity and the mental health scale score (SRQ-20) but show a significant correlation between organized religiosity. This effect may be due to the predominance of the young age group, justifying a cultural effect of less incentive to

religiosity and, therefore, less internalization of religious beliefs. Not only, but the correlation with organized religiosity could also demonstrate the effect of social support involved in religious organizations and not the religiousness factor itself. Religiosity itself is not enough to protect the individual from mental illness, as shown by Lotufo Neto's [38] studies with 207 religious ministers, in which 47% of the evaluated ministers showed some anxiety and depression.

Religions have different practices and beliefs that might relate differently to mental health and life satisfaction. Nevertheless, our study did not specify religions such as Catholicism, Judaism, and Islam. Researchers have already investigated the influence of religious affiliation, salience, and practice on depressive symptom levels in a non-clinical sample of Christians, Muslims, atheists, and agnostics. They found no significant differences in depressive symptoms between affiliations [39]. Those findings suggest that affiliation is not significantly related to depressive symptoms or treatment preferences [39].

A similar result was seen in a recent study, in which atheists showed the best outcomes in physical and mental health and, among theists, those religious affiliates had better outcomes, independently of the religion they were affiliated with [40]. Those results suggest that an optimal supportive context of religious beliefs might be defined not by specific religious affiliation but by participation in a religious congregation.

Generally, the social and medical sciences literature points to the importance of religious aspects in mental health. Regarding psychopathology, religious content is more than expected and can be part of and contribute to obsessions and delusions to formulate rigid, inflexible beliefs and magical thoughts.

In some individuals, the social pressure of religion to follow its rigorous practices can influence feelings of guilt and sadness. To the same extent, it can motivate the patient to seek treatment and support improvement, giving meaning to life. Therefore, it is essential to know religiosity and its functioning in the life of each subject and the general population, treating it as a construct that constitutes the human condition. Thus, the area needs investment, using a rigorous methodology and a larger population sample.

Conclusion

People with higher levels of organized religiosity have better mental health and life satisfaction. People with more non-organized religiosity also have better mental health and higher levels of life satisfaction. People with intrinsic religiosity have more satisfaction with life but not better levels of mental health.

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↑ **Table 1.** Participants description

Age	M±SD	27.97±9.62
Sex	Male	29%
	Female	71%
Socioeconomic Classification ¹	A	22%
	B1	18%
	B2	36%
	C1	17%
	C2	6%
	D-E	1%
Occupation	Does not study or work	5%
	Studying	35%
	Working	27%
	Studying and working	33%
Religion	Atheist / agnostic	23%
	Catholic	39%
	Spiritism	8%
	Evangelical	22%
	Buddhist	2%
	African Matrix Religions	2%
	Others	4%
History of Mental Disorder	No	78%
	Yes	22%
Symptoms of depression/anxiety ²	No	74%
	Yes	26%
Big Five Openness	M±SD	3.99±1.84
Big Five Extraversion	M±SD	1.42±1.66
Big Five Neuroticism	M±SD	4.01±1.70
Big Five Agreeableness	M±SD	5.62±1.91
Big Five Conscientiousness	M±SD	4.08±1.88

¹ Classification according to the Economic classification criteria Brazil.² Classification according to the Self Reporting Questionnaire-20.



↑ **Table 2.** Correlation between Satisfaction with life, Religiosity (Duke Religion Index), and symptoms of anxiety and depression (SRQ-20)

		Organized Religiosity			
		r	p	r ²	r ² (cov)
Satisfaction with Life		0.101	0.019*	1%	<1%
Mental health (SRQ-20)		-0.133	0.002*	2%	2%
		Non-Organized Religiosity			
		r	p	r ²	r ² (cov)
Satisfaction with Life		0.135	0.002*	2%	2%
Mental health (SRQ-20)		-0.119	0.006*	1%	1%
		Intrinsic Religiosity			
		r	p	r ²	r ² (cov)
Satisfaction with Life		0.143	0.001*	2%	2%
Mental health (SRQ-20)		-0.083	0.054	<1%	<1%

*p<0.05. Cov: effect size controlled by sociodemographic data and personality

