

Analysis of Belief, Religiousness, and Psychological Strength on Humans

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Abstract: *Clearly distinguish between religion institutionalized systems of belief and practice and spirituality individual sense of connection to something greater, often involving personal growth or existential reflection. This sets a strong conceptual foundation, especially since the terms are often used interchangeably in public discourse but have distinct implications in research. Briefly mention how psychiatry historically viewed religion, e.g., Freud's critiques versus Jung's more integrative view. This can highlight the shift in perspective from religion as pathology to potential resilience factor.*

Point out the methodological improvements in recent years (e.g., longitudinal studies, standardized scales like the Brief RCOPE or the Duke Religion Index) that have helped clarify this relationship.

Positive outcomes: lower depression/anxiety, increased meaning, better coping mechanisms.

Negative outcomes: religious guilt, scrupulosity, spiritual struggles, reinforcement of delusional thinking.

Cultural differences: how context matters religious coping might differ significantly in secular vs. religious societies..

Keywords: religion

I. INTRODUCTION

The division between religion, spirituality, and medicine began during the Enlightenment of the seventeenth and eighteenth centuries. This era marked a significant shift toward scientific reasoning, as emerging scientific communities developed empirical methods to explain human behavior and the workings of the mind. While most branches of medicine quickly embraced this scientific framework, mental health remained closely intertwined with religious and spiritual beliefs until the formal emergence of psychiatry as a distinct medical discipline in the mid-nineteenth century.

From the late nineteenth century onward, Freudian psychoanalysis significantly influenced psychiatric views on religion. Sigmund Freud conceptualized religious belief as a form of psychopathology, rooted in internal psychological conflict. He theorized that religion stemmed from the tension between instinctual desires and internalized social and moral expectations — a dynamic he framed as the interaction between the id, ego, and superego. Freud argued that belief in a monotheistic God was essentially a transference phenomenon, originating in childhood as a projection of paternal admiration. In his work *Totem and Taboo*, he proposed that religion arose from the need to resolve deep-seated guilt through a symbolic reconciliation with a divine paternal figure. In this view, religious belief functioned not as a source of healing, but as a psychological defense mechanism against unresolved inner conflict.

Freud's theories played a pivotal role in shaping early psychiatric skepticism toward religion, framing it as a developmental regression rather than a source of personal growth. However, contemporary perspectives in psychiatry increasingly recognize the complexity of this relationship, acknowledging that religious and spiritual practices can also provide meaningful support for mental health and emotional resilience. The rise of behaviorism in the early twentieth century further deepened the divide between religion and psychology. Behaviorist theorists, such as John B. Watson and later B.F. Skinner, argued that all human behavior could be explained through observable physiological processes



involving the body specifically the limbs, muscles, and glands. This perspective marked a radical departure from earlier schools of thought that considered internal motivations, beliefs, and subjective experiences.

By focusing solely on observable behavior and dismissing introspective methods, behaviorism sought to align psychology more closely with the natural sciences. This shift enabled the development of rigorous empirical research methods but came at the cost of sidelining aspects of human experience that could not be directly measured — including religious and spiritual dimensions. What had once been a shared space between religious practice and psychological healing was now fragmented. The pursuit of scientific legitimacy in psychology created a growing rift, characterized by increasing discord and mutual distrust between the fields of psychology and religion.

By the latter part of the twentieth century, attitudes toward the role of religion and spirituality in psychiatry began to shift, particularly in the United Kingdom. This change was influenced, in part, by developments across the Atlantic, where growing interest in the psychological dimensions of religion spurred a wave of new research. Increasingly, clinicians and researchers began to explore how spiritual and religious factors could be meaningfully integrated into the assessment and treatment of psychiatric disorders.

A pivotal contribution to this shift came from Allport and Ross's influential 1967 paper, *Personal Religious Orientation and Prejudice*. Rather than focusing solely on whether an individual identifies as religious, the authors emphasized the importance of understanding the nature and depth of their religious involvement. They introduced a crucial distinction between **intrinsic** and **extrinsic** religiosity. Individuals with intrinsic religiosity view their faith as a central guiding force in life a source of meaning and internal motivation. In contrast, those with extrinsic religiosity engage with religion primarily for external benefits, such as social acceptance or personal security.

Subsequent research has consistently demonstrated that intrinsic religiosity is more strongly associated with positive mental health outcomes. It has been linked to lower levels of depression and anxiety, greater resilience, and enhanced overall well-being, in contrast to the more superficial engagement often seen in extrinsic religiosity. Before engaging with the existing research, it is essential to define the terms *religion* and *spirituality*, as their ambiguous and often overlapping meanings can significantly influence how research findings are interpreted. While definitions may vary across disciplines and cultural contexts, there is general agreement on the core components of *religion*. Religion typically encompasses structured beliefs, practices, and rituals that are oriented toward the sacred.

The *sacred* is understood here as that which pertains to the numinous — encompassing mystical or supernatural elements — or to a divine entity such as God. In many Eastern religious traditions, the sacred may instead be framed in terms of an *Ultimate Reality* or *Ultimate Truth*. Additionally, religious systems may include beliefs about spiritual beings such as angels, demons, or other supernatural forces. Establishing a clear and inclusive definition of religion is critical for evaluating its impact on mental health, as interpretations can vary widely based on cultural background, religious tradition, and individual worldview. In contrast to religion, *spirituality* is more challenging to define. In contemporary discourse, it has become a more widely embraced term than *religion*, which many people associate with dogma, institutional authority, conflict, and even fanaticism. Spirituality, by comparison, is often viewed as deeply personal — something individuals define for themselves, independent of the rules, rituals, and organizational structures traditionally tied to religion. This has given rise to a growing demographic often referred to as *spiritual but not religious* (SBNR). Individuals in this category may reject formal religious affiliation altogether, choosing instead to understand spirituality through secular, individualistic, or eclectic frameworks. For many, spirituality centers on personal meaning, connectedness, inner peace, or ethical living — without reference to a divine being or sacred tradition.

However, this modern, individualized understanding of spirituality differs significantly from its historical origins. According to Philip Sheldrake, professor of applied theology at the University of Durham, the term *spiritual* originates from the Latin *spiritualism*, which in turn is derived from the Greek *pneumatikos* — a term found in the letters of Paul to the Romans and Corinthians. Traditionally, a spiritual person was seen as someone indwelt by the Spirit of God, often associated with clergy or those deeply embedded in religious life. Throughout most of Western history, the concepts of *spiritual* and *spirituality* were closely tied to religious frameworks. For instance, during the Second Vatican Council, the term *spirituality* came to replace earlier theological categories such as *ascetical theology* and *mystical theology*. Even in classical Greek thought, where the term distinguished humans from the non-rational elements of creation, it retained a metaphysical — and often religious — connotation.



Changing Attitudes to Spirituality and Religion within Psychiatry, 1960–2010

From the 1960s through the early 2000s, the relationship between psychiatry and religion underwent a gradual but significant transformation. During the early part of this period, religion and spirituality were largely viewed with suspicion within mainstream psychiatry. Influenced by Freudian psychoanalysis and the rise of behaviorism, many mental health professionals perceived religious belief as a regressive or pathological phenomenon, rooted in internal conflict, unresolved trauma, or cognitive distortion.

However, by the late 20th century, this outlook began to shift. In part, this change was influenced by sociocultural developments, including the rise of the humanistic and existential schools of psychology, which emphasized meaning, values, and personal growth — areas often overlapping with spiritual concerns. In addition, increasing globalization and multicultural awareness prompted greater sensitivity to the role of religion and spirituality in mental health, especially among patients from diverse cultural and religious backgrounds.

A pivotal moment came with the publication of Allport and Ross's (1967) study distinguishing between *intrinsic* and *extrinsic* religious orientations, which laid the groundwork for a more nuanced understanding of how religion functions psychologically. Their findings — and subsequent research — suggested that intrinsic religiosity, wherein individuals internalize their faith as a core source of meaning and purpose, was often associated with positive mental health outcomes. This contrasted sharply with extrinsic religiosity, which appeared more closely tied to social conformity or utilitarian goals, and was less consistently associated with mental well-being.

The 1980s and 1990s saw a growing body of empirical research investigating the effects of religious and spiritual practices on mental health, particularly in areas such as depression, anxiety, substance use, and coping with chronic illness. Organizations such as the American Psychiatric Association (APA) began to show greater openness to discussing the clinical relevance of spirituality, and by the early 2000s, major psychiatric journals were publishing research on spiritual assessment and spiritually integrated therapies.

In the UK, similar changes began to take root, influenced in part by transatlantic trends. By the 1990s and into the 2000s, the British psychiatric community started to re-evaluate its largely secular stance. Efforts were made to incorporate spiritual assessments into clinical practice, and there was growing interest in understanding how spiritual and religious beliefs could serve as both resources and risk factors in psychiatric care.

While tensions and skepticism remained in some quarters, by 2010, the inclusion of religion and spirituality in psychiatric discourse had become more normalized. The conversation had moved beyond viewing religion as either purely pathological or purely protective, toward a more balanced and contextual understanding of its role in psychological functioning and human flourishing.

Religious Perspectives on Mental Health, 1960–2010

From 1960 to 2010, religious perspectives on mental health evolved significantly, reflecting broader societal changes and growing engagement with psychological discourse. During the early part of this period, many religious traditions maintained a cautious or even skeptical stance toward psychiatry and psychology. Mental illness was sometimes interpreted through theological lenses as the result of moral failing, spiritual weakness, demonic influence, or divine punishment rather than as a condition requiring clinical intervention. This contributed to the stigma surrounding mental health issues within some religious communities and often discouraged individuals from seeking professional help. However, beginning in the 1970s and accelerating in the decades that followed, many religious groups began to re-examine these assumptions. Influenced by developments in pastoral theology, the integration of psychology into seminary education, and interfaith dialogue with mental health professionals, new frameworks emerged that sought to reconcile faith-based worldviews with psychological understanding.

In Christianity, particularly within mainline Protestant and Roman Catholic traditions, there was a growing emphasis on the pastoral care model, which framed mental suffering as part of the broader human condition rather than solely as a spiritual failure. The Second Vatican Council (1962–1965) played a key role in shifting Catholic attitudes toward greater openness and engagement with modern science, including psychology. Similarly, pastoral counseling movements in the United States and the UK developed programs that combined spiritual guidance with psychological support. Evangelical and Pentecostal communities, while slower to engage with psychiatric frameworks, also began to



shift during this period. While some continued to emphasize prayer, deliverance, and spiritual warfare as primary responses to mental distress, others increasingly acknowledged the legitimacy of mental illness and supported dual approaches that combined faith with professional counseling or medication.

In Jewish communities, mental health was often framed through a holistic lens, grounded in the ethical and communal imperatives of Jewish law and tradition. Rabbinical authorities and communal organizations began to recognize the importance of addressing mental health as a matter of justice and compassion, and partnered with mental health professionals to provide support services. Islamic perspectives on mental health during this period were also evolving. Classical Islamic scholarship had historically included detailed discussions of psychological well-being, and from the 1980s onward, a renewed interest in Islamic psychology emerged. This movement sought to reclaim traditional understandings of the soul and healing while integrating them with contemporary psychiatric practice. Muslim communities in both Western and non-Western contexts increasingly emphasized culturally and religiously sensitive approaches to mental health care. Across traditions, the late 1990s and early 2000s witnessed the rise of faith-based mental health initiatives, interfaith collaborations, and the development of spiritually integrated therapies. Religious leaders began to speak more openly about mental illness, working to reduce stigma and promote mental wellness as a vital component of spiritual life. By 2010, many religious communities had made significant strides in understanding and addressing mental health, moving from a posture of suspicion to one of engagement. While challenges remained — particularly regarding stigma, access to care, and theological tensions — the period marked an important shift toward dialogue, integration, and compassionate support.

The Scientific and Medical Network

Established in 1973, the Scientific and Medical Network (SMN) emerged as a response to the perceived limitations of reductionist scientific paradigms, particularly in areas related to consciousness, spirituality, and holistic health. The Network consists of professionals across disciplines who seek to bridge the gap between empirical science and spiritual insight, promoting an integrative worldview that includes subjective experience, ethical reflection, and metaphysical inquiry. The SMN has played an influential role in expanding the conversation around mental health, particularly in relation to spirituality and consciousness studies. Its conferences, publications, and discussion forums provide a platform for examining topics such as near-death experiences, meditation, transpersonal psychology, and the spiritual dimensions of healing subjects that often lie outside conventional psychiatric frameworks. By encouraging open inquiry into questions traditionally marginalized by mainstream science, the Network has contributed to a more inclusive understanding of mental well-being — one that recognizes the potential relevance of spiritual experience in both personal transformation and clinical practice. In doing so, the SMN aligns with a broader movement that seeks to re-integrate science with meaning, purpose, and values concerns central to both religious traditions and holistic approaches to mental health.

Spirituality and Psychiatry in Other Faiths

While Christianity, Islam, and Judaism have historically received significant attention in the dialogue between spirituality and psychiatry, other religious traditions have also developed unique frameworks for understanding mental health, mental suffering, and healing. These perspectives provide valuable insights into the intersections of spirituality and psychiatry, often highlighting culturally specific beliefs and practices that contribute to both individual and collective well-being.

Hinduism and Psychiatry

In Hinduism, mental health is viewed through the lens of the mind (*manas*) and the soul (*atman*), with a focus on maintaining harmony between these aspects of the self. The concepts of *dharma* (righteous living), *karma* (action and its consequences), and *moksha* (liberation) form the spiritual foundation for addressing mental distress. The practice of meditation, particularly forms like *yoga* and *pranayama* (breathing exercises), plays a crucial role in alleviating psychological suffering by promoting mindfulness, self-awareness, and emotional regulation.



Psychiatric issues are sometimes understood in Hinduism as a result of an imbalance in the energies or forces that govern the body and mind. Traditional treatments often include spiritual practices like prayer, devotion to deities, and consultation with spiritual healers. Modern psychiatrists in India and other Hindu-majority countries increasingly recognize the value of integrating these spiritual practices with conventional mental health treatments, offering holistic approaches to care.

Buddhism and Psychiatry

Buddhism presents a unique approach to mental health, focusing on the alleviation of suffering (*dukkha*) through the understanding of the impermanent and interconnected nature of all things. Buddhist teachings on mindfulness and meditation, particularly the practices of *vipassana* (insight meditation) and *metta* (loving-kindness meditation), have been widely integrated into therapeutic practices such as *mindfulness-based cognitive therapy* (MBCT). In the Buddhist worldview, mental distress is often seen as a consequence of attachment, desire, and ignorance, which lead to negative emotions such as anger, fear, and sadness. Psychiatric issues are viewed as arising from a lack of mental clarity and an inability to cope with the natural impermanence of life. Buddhist-inspired approaches to mental health emphasize mindfulness as a way to cultivate awareness of the present moment, reduce emotional reactivity, and develop compassion toward oneself and others. Many Buddhist practitioners in Asia and the West have found that the integration of Buddhist principles with psychological therapies can enhance mental well-being, particularly in addressing anxiety, depression, and trauma.

Indigenous Spiritualities and Psychiatry

Indigenous spiritual traditions around the world often approach mental health within a holistic framework that emphasizes the interconnectedness of body, mind, spirit, and community. In many Indigenous cultures, mental health is seen as inseparable from one's relationship with nature, ancestors, and the spiritual world. For example, in many Native American communities, mental suffering is believed to result from imbalances between an individual and their community or environment. Healing practices may include ceremonies, rituals, or the use of sacred plants under the guidance of a spiritual leader or healer. These practices are often embedded in community life and emphasize collective well-being. Similarly, in many African traditional religions, mental health is viewed in terms of the balance between the physical and spiritual realms. Spiritual healers or shamans are often called upon to diagnose and treat mental health conditions, with an emphasis on restoring balance between the individual and the spiritual forces that influence their lives.

In recent years, there has been a growing recognition of the importance of these spiritual practices in mental health treatment, particularly in postcolonial contexts where Western psychiatric models may not fully address the cultural and spiritual needs of Indigenous populations.

Sikhism and Psychiatry

In Sikhism, mental health is viewed through the lens of *seva* (selfless service), *simran* (remembrance of God), and *sangat* (community). Mental suffering is often seen as the result of ego-driven desires, attachments, and a disconnect from one's true spiritual nature. Meditation on the divine name (Naam) and living a life of service are central practices aimed at alleviating mental distress. Psychiatric issues are approached with a focus on spiritual growth, ethical living, and community support. Sikhism emphasizes the importance of maintaining mental balance through a harmonious relationship with God, others, and oneself. In contemporary settings, mental health professionals in Sikh communities often integrate these spiritual practices with more conventional psychiatric treatments, offering a compassionate and community-oriented approach to mental health care.

Shintoism and Psychiatry

In Shintoism, mental health is understood in the context of *kami* (spiritual beings) and the natural world. Shinto emphasizes purity, harmony with nature, and the importance of rituals to maintain balance and health. Mental distress is sometimes believed to arise from a disruption in one's connection with the natural world or the spiritual forces that



govern life. While modern psychiatric care in Japan has become increasingly aligned with Western medical practices, many individuals still seek spiritual guidance through Shinto priests or participate in rituals designed to purify and restore balance to the spirit. In some cases, psychiatric care is complemented by Shinto practices, highlighting the ongoing relevance of spirituality in the healing process.

II. CONCLUSION

The integration of spirituality and psychiatry within these diverse faith traditions reflects a broader understanding of mental health that transcends the purely medical model. Across religious and spiritual frameworks, mental suffering is not seen solely as a biological or psychological issue, but as a complex interplay of the body, mind, spirit, and community. In the 21st century, there is increasing recognition of the need to incorporate spiritual practices and beliefs into psychiatric care, particularly for individuals whose religious or spiritual identity plays a central role in their worldview. This integrated approach offers a holistic model for addressing mental health that respects cultural and religious diversity while promoting well-being on multiple levels.

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