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Review Paper

Role of Religious Involvement in Good Health: A Systematic Review

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ABSTRACT

A growing body of research has suggested that religious involvement might be prominent factor to maintain physical health, mental health and well-being. The present study analyses previous studies related to religion and health in order to examine the role of religious involvement in health using systematic review method. Four hundred twenty abstracts were screened out of which 32 full articles were included after applying inclusion criteria. It was found that relationship of organizational religious practices, positive religious coping and intrinsic religiosity with health was strongly positive across all studies while relationship of importance of religion and private religious practices with health was not consistent across studies. Some indicated positive and some indicated negative impact of them on health. Thus, this paper is an attempt to focus on conducting more empirical research to find out consistent findings with regard to the relationship of religious involvement with health and well-being.

Keywords: *Physical Health, Mental Health, Well-Being, Religious Involvement*

Maintaining good health is most challenging issue in the present era. Everyone desires for success in all walks of life. This creates extreme competitive environment for them. Psychophysical problems (i.e., depression, anxiety, stress, fear, hopelessness, negative self-evaluation, obesity, diabetes, cancer, heart disease) are common outcome of this stressful environment. According to WHO, depression is one of the leading causes of disability. Suicide is the fourth leading cause of death among 15 to 29 year olds. People with severe mental health conditions die premature death in contemporary era in comparison to two-three decades ago due to preventable physical conditions. For effective functioning and to live with peace and happiness, we need to cope with psychophysical problems using constructive strategies. A growing body of studies indicated that religious involvement is conspicuous determinant factor for a better health outcomes and well-being.

Religious involvement

Larger portion of the world's population (84.40%) identified own-self as a religious person who are affiliated with a particular religion (Pew Research Center, 2017). Religion is most important part of individuals' life. Those who have faith in religious beliefs, their thinking, feeling and behaviour are directed by their religious philosophy. Oxford Dictionary defines

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religion as *"action or conduct indicating belief in, obedience to, and reverence for a god, gods, or similar superhuman power; the performance of religious rites or observances"*. In other words, it refers to the set of beliefs and practices that reflect obedience, devotion and reverence for Almighty or Supernatural Power. Majority of studies conceptualized and measured it as keeping faith in Supernatural Power, importance of religion, daily attendance in temple/mosque/church/gurudwara, extrinsic/intrinsic religiosity, positive/negative religious coping, prayer, offering namaz, fasting, reciting holy scriptures, and bathing in holy Ganges (Tan, Su, Ting, Allotey & Reidpath, 2020).

Health

Initially, it was known that proper functioning of body parts is the sign of good health however biological component is not sufficient to represent health. In 1948, World Health Organization (WHO) defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity". Comprehensively, health is balanced condition of the living organism in which the integral, harmonious performance of the vital functions tends to the preservation of the organism and the normal development of the individual. Most of the studies measured the health in terms of depression, anxiety, stress, psychological illness, level of mental and physical functioning. Studies on religion and health suggested some important factors related to religion that has contributed in coping with illness as well as in enhancing and maintaining good health. These factors are:

Religious Involvement and Healthy Behaviour

Religious people perform ritual purification before every religious practice (i.e., prayer, namaz, worship) in which they wash the body parts and keep own-selves neat and clean. In Islamic religious practice, *Wudhu* is the process of purifying different body parts, such as hands, mouth, nostrils, face and feet with water. It is very important ritual to be performed before each *namaz* (5 times in a day) which is good for personal hygiene. It has beneficial effect to protect body from dust, infection and diseases. While offering namaz, individual performs many activities such as *Qiyam* (standing), *Rukoo* (bow), and *Sajadah* (prostrate), *Tahayat* (sitting on the ground) similar to meditation and yogic practices which are beneficial for maintaining good health. It has been indicated that religious involvement is positively related with healthy behaviour (Youa, Yoob & Koha, 2019). Religious people abstain from using addictive substances (e.g., alcohol, drugs, tobacco etc).

Religious Involvement and Social Support

Religious people attend religious institutions (temple/mosque/church/gurudwara) and religious congregation that provides a chance of social interaction and bonding with other . Therefore, religious people get more social support compared to non-religious people when they face adverse and stressful situations. Social support is very effective tool to cope with unwanted situations (Smith, McCullough & Poll, 2003; Olphen, Schulz, Israel, Chatters, Klem, Parker, & Williams, 2003; Rushing, Corsentino, Hames, Sachs-Ericsson & Steffens 2012; Krause & Hayward, 2016).

Religious Involvement and Religious sense of Meaning in Life

Religious beliefs are almost similar across the religions that the life of the world is a test from Almighty for human. On the basis of good (helping, sympathizing, honesty, justice) and bad (i.e., lying, slander, deceiving, harassing) deeds done by the people in this worldly life, they will be rewarded accordingly in heaven and hell respectively after death. The worldly life, is very short as compared to the life of heaven and hell. Therefore, human being considered this life along with the emotion, for instances, sorrow, happiness, success,

failure, achievement, anger, envy, jealousy, disgust as mortal. Religious persons live their life with detached attitude with regard to the personal and social relations. These beliefs, obligations and commitment to religion, promote spiritual thoughts within the individuals and that they remain indifferent either to happiness or misery, bonding with human and natures, transformed from social animal to human being, self-control on body, mind, feeling, thoughts and behaviour and achieved state of bliss. Spiritual thoughts are reflected in their detached attitude – duty without expectation of reward. These attributes might influence positively the holistic health (Pande & Naidu, 2011; Sharma, Deborah, Harold, Koenig, Federa, Iacovielloa, Southwickde & Pietrzakde, 2017).

Religious practices

Literatures on religion and health, described two types of religious practices. First one is organizational religious practices. It is the social dimension of religion measured in terms of daily attendance in temple/mosque/church/gurudwara, participating in religious congregations and engaging in other rituals in which individuals perform religious practices with others. These getting a chance to be familiar with others. Second is private religious practice. It is the private dimension of religion in which individuals perform their religious practices (prayer, reciting holy scriptures etc.) at home in which there is no opportunity of social interaction and bonding with others. Extensive studies on religion and health indicated that organisational religious practices are playing much effective role in enhancing and maintaining good health compared to private religious practices (Yeager, Glei, Au, Lin, Sloan & Weinstein, 2006; Krause et al., 2016; Cole-Lewis, Gipson, Opperman, Arango & King, 2016).

Extrinsic/Intrinsic Religious beliefs

Gordan Allport (1967) suggested two types of religiosity; (i) extrinsic religiosity in which individuals involve in religious rituals to achieve some external goals (e.g., recognition, social approval, positive self-esteem), (ii) intrinsic religiosity in which religion and religious involvement is satisfying in itself. Person with intrinsic religious orientation live the religion and relates it with all aspect of life. Studies indicated that intrinsic religiosity is more effective for good health compared to extrinsic religiosity (Koenig, 2007; EL-Awad, Fathi, Lohaus, Petermann & Reinelt, 2022).

Rationale

Extensive researches have been done to examine the role of religious practices and beliefs in health. It has been indicated that relationship between religion and health is not uniform across the studies. Some revealed positive relation between religious involvement and health indicators while some indicated negative relation between them whereas some studies reported chaotic relations. The present study intended to deeply analyze the previous studies related to religion and health in order to draw a more comprehensive and compact picture to understand the relation between religion and health using systematic review method.

METHODS

Search strategies

PRISMA (Preferred Reporting Items for Systematic reviews and Meta-Analyses) guideline (Moher et al., 2009) was used for searching, identification, screening and to judge the eligibility of articles for systematic review. To search articles three databases (Pub Med, Psych Info and Science Direct) and other sources were used to collect articles published till 2022. For religion, four key words (e.g., religion, religiousness, religious practices, religiosity and religious faith) and for health, two key words (e.g., health, physical and

mental health) were used to explore articles (e.g., religion and health; religious practice and health; religiousness and mental health).

Inclusion criteria

Abstracts of the articles were screened to draw conclusion about the relevance. Relevant articles were located and screened for shortlisting. Empirical studies using longitudinal and cross-sectional design in which influence of religion in terms of religiousness, religious practices and religious faith on health (physical and mental) were examined, included for review. Studies in which any one variable (religion or health) was absent and those abstracts, either theoretical or qualitative in nature, of which full articles were not available were excluded to the systematic review for this paper.

RESULTS

Four hundred twenty abstracts were screened. After applying the inclusion criteria 32 full articles were included for systematic review. Review of studies focused on following aspects; (1) design of the study (2) variables used in the study (3) proposed mediator; whether supported or not (4) measures used for the variables (5) demographic detail of the sample and (6) findings of the study.

General findings

It has been found that 6 studies used longitudinal and 26 studies used cross-sectional design. These studies were conducted in Canada, America, China, Malaysia, Saudi Arabia, Palestine and Taiwan. Twelve studies conducted with the participants of 40-60 years age-group, 10 studies with people aged between 20-40, 1 study on adolescent group, 7 studies on mixed group and two studies have not mentioned age of participants.

With regard to clinical detail of the participants, 4 studies conducted on participants with physical disease (e.g., cancer, HIV, kidney disease), 6 studies on depression diagnosed participants, 2 studies on childhood abused participants, 1 on immigrants, one on military veteran and remaining were conducted on normal participants.

Regarding the measurement of religion, most of the studies conceptualized in terms of religious practices (private and organizational), religious service attendance, importance and belief in religion, affiliation and commitment toward religion. To measure the religion, 4 studies used BMMRS (The Brief Multidimensional Measure of Religiousness/Spirituality: Fetzer Institute, 2003), 2 studies Muslim Religiosity Scale (Koenig et al. 2014), 4 studies Duke University Religion Index (DUREL; Koenig & Büssing, 2010), 21 studies used self-constructed items of religiousness and some other scales have been used.

Regarding the measurement of health, most of the studies conceptualized in terms of depression, anxiety, stress and general health including physical and mental health. To measure the health, following measures have been used: Depression, Anxiety and Stress Scale - 21 Items (DASS-21, Henry & Crawford, 2005), Self-Rated Health (SRH, Wannamethee & Shaper, 1991; Singh-Manoux et al., 2008; Idler & Benyamini, 1997), Centre for Epidemiological Studies Depression Scale (CES-D, Radloff, 1977), Structured Clinical Interview for DSM-IV (SCIDI/NP, Version 2.0) (First et al., 1996), Hamilton Depression Rating Scale (HDRS: Hamilton, 1967), Montgomery Asberg Depression Rating Scale, or MADRS (Montgomery and Asberg, 1979), General Health Questionnaire (GHQ, Goldberg, 1972) and Reynolds Adolescent Depression Scale: Short Form (RADS-2:SF; Reynolds 1987). Review of studies informed that 20 studies (62.5%) used depression, 4

(12.5%) stress and anxiety, 10 (31.25%) mental health, 5 (15.6%) physical health/problem, 5 (15.6%) suicidal ideation and 1 (3%) positive-negative affect as health/mental health.

It was demonstrated that relationship between religion and health varies across different indicators of religiousness. There are 4 indicators of religion have been used across the studies (i.e., organisational/private religious practice, importance of religion, positive/ negative religious coping and intrinsic/extrinsic religiosity).

It indicated that religious practice (e.g., praying, offering namaz, reciting holy books and other rituals) are playing important role in enhancing and maintaining good health as well as in coping and recovering from bad health. It also indicated that 22 studies have focused on organisational religious practice as indicator of religion and all studies reported positive impact of organisational/institutional religious practice on health while private religious practice negatively associated with health in 4 studies and positively associated with health in 2 studies. It was found that importance of religion is negatively associated with health in 5 studies and positively associated with health in 3 studies.

Review of studies indicated that 2 studies have used extrinsic/intrinsic religiosity as indicator of religion and both reported that intrinsic religiosity has positive impact on health while extrinsic religiosity has no impact on health. It indicated that 2 studies used religious coping as religiousness and both studies showed that positive religious coping is positively related with health while negative religious coping had negative impact on health. It was found that in 7 studies social support has been used as mediator between religion and health in which 5 studies revealed that religion affect the health via social support only while 2 studies demonstrated that it has affected the health directly and indirectly both.

Figure 1. PRISMA flow chart of search strategies and inclusion criteria

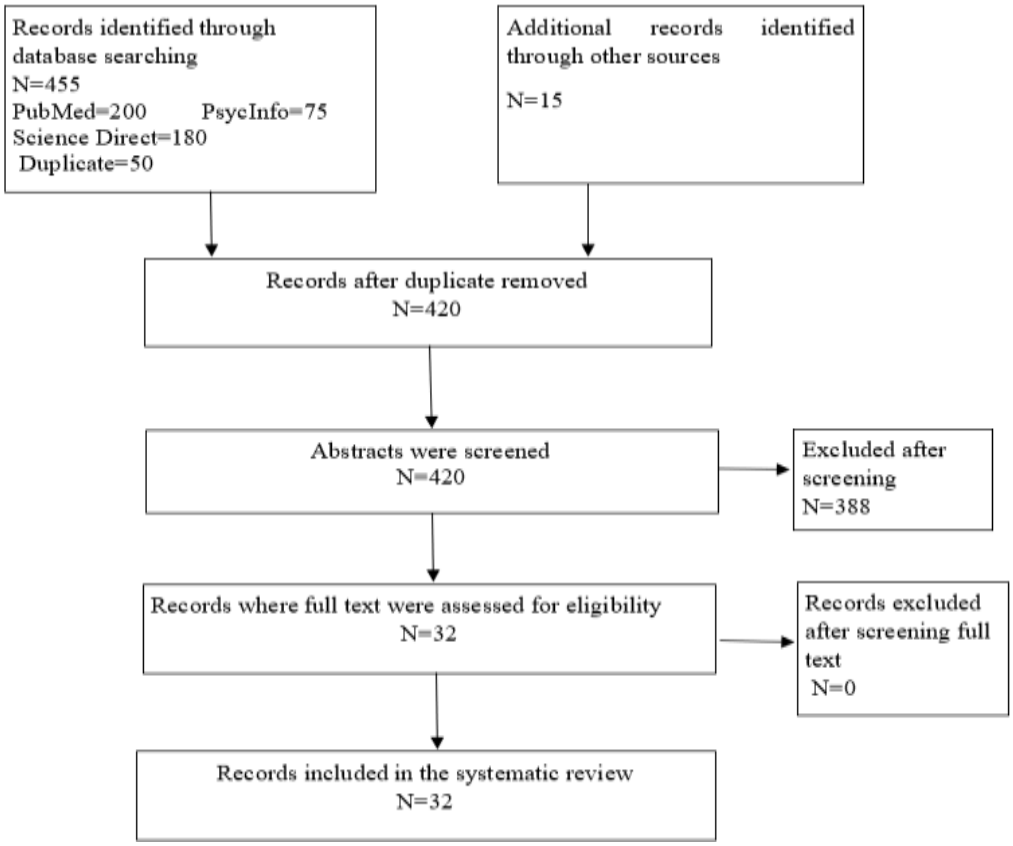

Table 2: Summary of the reviewed articles

Authors	Sample	Measure of religion	Measure of health	Mediators	Findings
Tan, Su, Ting, Allotey and Reidpath (2020)	N=7068 participants (4418 Malays, 2080 Chinese and 570 Indians) aged >55 years	Self-constructed items of religious importance and belief in a Higher Power	DASS-21 (Henry & Crawford, 2005), the short form of the Depression, Anxiety, and Stress Scale (DASS) (Lovibond, 1998).	None	Religious importance was positively and significantly correlated with depression, anxiety and stress scores among Chinese and Indians. Among Malays, religious importance was negatively and significantly correlated with anxiety. Belief in a higher power was negatively and significantly correlated with depression, anxiety, and stress in all ethnic groups, except anxiety among Chinese.
Dilmaghani (2017)	Canadian Community Health Survey (N = 20,868)	Self-rated importance of religion	self-rated mental health; (2) self-rated ability to deal with day-to-day demands of life; (3) self-rated ability to handle unexpected and difficult problems in life.	None	In strong religious and secular groups, frequency of individuals who reported excellent health were equal and greater compared to moderate religious group
Julianna and Koronczai (2021)	N=523 (women=62%), age=18-28 years	The Brief Multidimensional Measure of Religiousness/Spirituality (BMMRS: Fetzer Institute/National Institute on Aging Working Group, 1999)	CES-D scale (Radloff, 1977) for depression and WBI-5 for Well-being	None	Moderate positive relation between religion/spirituality and depression in women and weak relation in men
Jung (2017)	American adults (N= 1,635)	Self-constructed items of religious involvement	Mental health in terms of	None	Religious salience and spirituality were

Authors	Sample	Measure of religion	Measure of health	Mediators	Findings
		measured by religious attendance, religious salience and spirituality	Positive and negative affect (Huppert, 2009)		found effective to control the harmful effect of childhood abuse on positive affect but not on negative affect.
Al Zaben, Khalifa, Sehlo, Al Shohaib, Binzaqr, Badreg, Alsaadi and Koenig (2015)	310 patients (age=18-85 years) with chronic kidney disease from dialysis	Muslim Religiosity Scale (Koenig et al. 2014).	Global Assessment of Functioning (GAF) scale, Structured Clinical Interview for DSM-IV (SCID-I/NP, version 2.0) and measure of physical functioning	None	Religious involvement was significantly positively correlated with better physical and psychological functioning.
Al Ahwal, Al Zaben, Sehlo, Khalifa, and Koenig (2016)	70 patients with colorectal cancer, age ranged from 18 to 85 years	Muslim Religiosity Scale (Koenig et al. 2014).	For depression Structured Clinical Interview of DSM-IV (SCID-I/NP, version 2.0) and Hamilton Depression Rating Scale (HDRS)	None	religiosity was inversely related to depressive symptoms and suicidal ideation after controlling for financial status and social factors.
Sternthal, Williams, Musickc and Buck (2012)	Adults (n=3103) with age of 18 years and above	Self-constructed items of service attendance, Private religious activity, Importance of spirituality and religious saliency.	American Psychiatric Association's Diagnostic & Statistical Manual of Mental Disorders-III (DSM-III)	Congregational support, purpose in one's life and self-forgiveness	religiously involved Black Americans and Hispanic Americans did not experience greater mental health benefits than their White counterparts. For White Americans alone, service attendance was inversely related to depressive symptoms, anxiety symptoms, and major depressive disorder. Religious

Authors	Sample	Measure of religion	Measure of health	Mediators	Findings
					saliency was consistently associated with worse mental health for Hispanic Americans only. However, both meaning and forgiveness conferred mental health benefits for all three groups.
Krause and Hayward (2014)	N=1154, age=50 years and above	Self-constructed item of church attendance. A single item was used to assess how often study participants attend worship services	Self-rated health	Spiritual support, Practical wisdom and Hope	It was found that religious involvement was directly related to better health as well as mediated by spiritual support, practical wisdom and hope.
Yeager, Glei, Au, Lin, Sloan and Weinstein (2006)	N=2462 persons aged 50–66	Self-constructed items of religious affiliation, religious attendance, beliefs, and private religious practices	self-reported measures of overall health status, mobility limitations, depressive symptoms (CES-D Scale), and cognitive function; clinical measures of systolic and diastolic blood pressure, serum interleukin-6, and 12-h urinary cortisol; and 4-year mortality	None	Results showed positive associations of religious attendance with physical and psychological health outcomes. In all cases, private religious practices and stronger beliefs are associated with worse health. However, this relation disappeared after control of prior health.
Olphen, Schulz, Israel, Chatters, Klem, Parker, and Williams (2003)	N=700 households with age ranged 18 years and above	Organizational, nonorganizational and subjective religious involvement	Single item self-rated general health, CES-D Scale, (Radolf, 1977)	Social support	Results reported that religious involvement contributes in positive health directly as well as through social

Authors	Sample	Measure of religion	Measure of health	Mediators	Findings
					support
Ahrenfeldt, Möller, Ranberg, Vitved, Jacobsen and Hvidt (2017)	N=9707, Mean age=62.6 years	Self-rated items of Praying, taking part in a religious organization and religious education,	The Global Activity Limitation Index (GALI, Jagger, Gillies, Cambois, Van Oyen, Nusselder and Robine, 2010), single item self-rated health Self-rated long-term health and Euro-depression (EURO-D) 12-item scale	None	Restful religiousness (praying, taking part in a religious organization and being religiously educated), which is associated with good health. Crisis religiousness (praying without other religious activities), which is associated with poor health.
Cole-Lewis, Gipson, Opperman, Arango, King (2016)	161 youth, 106 females and 55 males, mean age = 13.5 years	The Brief Multidimensional Measure of Religiousness/Spirituality (BMMRS: Fetzer Institute/National Institute on Aging Working Group 1999)	The Reynolds Adolescent Depression Scale: Short Form (RADS-2:SF; Reynolds 1987); Suicidal Ideation Questionnaire-Junior (SIQ-JR; Reynolds 1987)	None	Results showed that private religious practice and religious support were associated with lower levels of depressive symptoms; private religious practice and organisational religiousness were associated with less suicidal ideation.
Mahamid and Bdier (2021)	400 Palestinian adults, involving 172 males and 228 females with age ranged 20-59 years.	Positive religious coping was assessed by the IPRC subscale of the Psychological Measure of Islamic Religiousness (Abu-Raiya et al. 2008)	Depressive symptoms were measured by a 10-item version of the Center for Epidemiological Studies Depression Scale (Andresen et al. 1994);	None	Findings revealed a statistically significant negative correlation of positive religious coping with depressive symptoms and perceived stress. Further analysis revealed that positive religious coping

Authors	Sample	Measure of religion	Measure of health	Mediators	Findings
			Perceived stress was tested by the perceived stress scale (PSS), developed by Cohen et al. (1983)		was statistically significant to explain variance in depressive symptoms.
Jarvis, Kirmayer, Weinfeld and Lasry (2005)	N= 1485, mean age=44.5 years	Religious involvement was measured with three items: 1) declared religion; 2) frequency of attendance at religious meetings; and 3) frequency of religious rituals performed at home.	Psychological distress was assessed with the 12-item version of the General Health Questionnaire (GHQ, Goldberg, 1972; Goldberg & Hillier, 1979; McDowell & Newell, 1987)	None	Religious involvement was negatively associated with psychological distress in females, Protestants, Catholics, Filipinos, and Afro-Caribbeans; but not for males, Buddhists or Jews. Religious practice at home was not associated with level of distress for any group.
Rushing, Corsentino, Hames, Sachs-Ericsson and Steffens (2012)	N=248 depressed patients with age of 59 years and older	Self-developed items of public religious activity, religious importance, private religious practices and private religious media involvement	For current suicidal ideation, suicidal thoughts item (Item 10) from the Montgomery–Asberg Depression Rating Scale (MADRS; Montgomery & Asberg, 1979)	Duke Social Support Index (Koenig et al., 1993)	Religious involvement was negatively correlated with suicidal ideation and partially mediated by social support.
Baetz,Griffin, Bowen Koenig and Marcoux (2004)	N=70,884 respondents older than 15 years	Self-developed items of worship service attendance, importance (salience) of spiritual values or faith and self-perception of spirituality/ religiousness	The Composite International Diagnostic Interview (Beaudet, 1996; Statistics Canada, 1998) for depressive symptoms.	None	frequent worship service attendees had significantly fewer depressive symptoms. In contrast, those who stated spiritual values or faith were important or perceived themselves to be

Authors	Sample	Measure of religion	Measure of health	Mediators	Findings
					spiritual/religious had higher levels of depressive symptoms.
Nicholson, Rose and Bobak (2010)	18,129 men and 21,205 women, aged 15 years and above obtained from European Social Survey	Religious involvement (frequency of attendance at religious services; frequency of private prayer; self-assessment as a religious person)	self-rated health (SRH, Wannameth ee & Shaper, 1991; Singh-Manoux et al., 2008; Idler & Benyamini, 1997)	None	Frequency of attendance at religious services was associated with better health in both men and women while private prayer was negatively associated with better health.
EL-Awad, Fathi, Lohaus, Petermann and Reinelt (2022)	135 adolescent s, mean age = 18.25 years, refugees (n_1) = 75, immigrants (n_2) = 60.	The Duke University Religion Index (DUREL; Koenig & Büssing, 2010)	The Hopkins Symptom Checklist – 37A (HSCL-37A; Bean et al., 2007)	None	Stronger religiosity (intrinsic) was associated with better mental health in refugee and immigrants.
Rosmarina, Pirutinskyb, Appelb, Kaplanb and Pelcovitzd (2018)	N= 372 Jews, age range=18 to 83 years	Jewish religious involvement (e.g., Pirutinsky & Rosmarin, 2018a; Pirutinsky & Rosmarin, 2018b) and Duke Religion Index (Koenig, Parkerson, & Meador, 1997)	Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983)	None	Religious/spiritua l factor contributed to decrease anxiety and depression in childhood sexual abused people.
Ferraro and Kim (2014)	longitudina l data from a representat ive survey of adults 57-85 years obtained from National Social Life, Health, and Aging Project (NSHAP).	Self-developed items of religious affiliation, religious attendance, and clergy confidant.	C-reactive protein (CRP) concentratio n	None	religious attendance was not related to CRP among the White respondents, attendance was associated with lower CRP and change in CRP over time among the Black respondents that is useful in reducing the prevalence of hypertension and cardiovascular disease.

Authors	Sample	Measure of religion	Measure of health	Mediators	Findings
Sharma, Marin, Koenig, Feder, Iacovielloa, Southwick and Pietrzak (2017)	3151 U.S. military veterans with age range of 60-79 years.	The Duke University Religion Index (DUREL) (Koenig and Büssing, 2010)	For depression Patient Health Questionnaire-2 (PHQ-2), for anxiety Generalized Anxiety Disorder-2 (GAD-2) and PTSD Checklist (Weathers et al., 2013)	None	High religiosity/spirituality (R/S) was associated with decreased risk for lifetime posttraumatic stress disorder, major depressive disorder (MDD), and alcohol use disorder while Moderate R/S was associated with decreased risk for lifetime MDD, current suicidal ideation and alcohol use.
Koenig, (2007)	N=1000 depressed patients, age=50 years and older	Self-constructed items of religious activities; Hoge Intrinsic Religiosity scale (Hoge, 1972).	Depression by Structured Clinical Interview for DSM-IV (SCIDI/ NP, Version 2.0) (First et al., 1996)	Social support by Duke Social Support Index (DSSI)	the combination of frequent religious attendance, prayer, Bible study, and high intrinsic religiosity, predicted a 53% increase in speed of remission after controls. Patients highly religious by multiple indicators, particularly those involved in community religious activities, remit faster from depression.
Bosworth, Park, McQuoid, Hays and Steffens (2003)	Elderly patients (N=114) with depression enrolled and receiving ongoing care in a NIMH-sponsored Clinical Mental	Two questions regarding attendance at religious services and other religious activities at places of worship (Koenig et al., 1997); positive and negative religious coping by Brief RCOPE (Fetzer Institute/National	Montgomery Asberg Depression Rating Scale, or MADRS (Montgomery and Asberg, 1979)	Social support by Duke Social Support Index (DSSI)	higher levels of pubic religious practice and positive religious coping was significantly related to lower MADRS score after adjusting for such covariates as demographic, social support and clinical factors. Higher

Authors	Sample	Measure of religion	Measure of health	Mediators	Findings
	Health Clinical Research Center (MHCRC) at Duke University Medical Center.	Institute on Aging, 1999; Paragament et al., 2000).			levels of private religious practice was not significantly related to lower levels of depression. Higher levels of negative religious coping were also significant related to higher MADRS scores.
Rasic, Belik, Elias, Katz, Enns, Sareen and Swampy Cree Suicide Prevention Team (2009)	Nationally representative sample of Canadian Community Health Survey Cycle 1.2 (CCHS 1.2) (N=36,984, response rate 77%) of individuals aged 15 years and older	Self-constructed items of self-perception as spiritual and religious practices.	Self-constructed items of suicidal behaviour.	Social Support Scale (Sherbourne and Stewart, 1991).	Identifying oneself as spiritual was associated with decreased odds of suicide attempt but it was mediated by social support, not directly. Similarly religious attendance was associated with decreased odds of suicidal ideation but it was mediated by social support, not directly. Religious attendance was associated with decreased odds of suicide attempt and remained significant after adjusting for social supports.
You, Yoo and Koh (2019)	N=470 Korean adults with age ranged 17-55 years	religious involvement scale (Levin, Taylor, & Chatters, 1995); Brief Multidimensional measure of Religiousness/Spirituality (Masters et al., 2009)	Spiritual well-being scale. The spiritual well-being scale was developed by Paloutzian and Ellison (1982; Paloutzian, Bufford, & Wildman, 2012;	None	It was found that religious practices (church attendance and prayer) was positively associated with spiritual well-being, life satisfaction, self-esteem and negatively associated with depression.

Authors	Sample	Measure of religion	Measure of health	Mediators	Findings
			Paloutzian & Ellison, 1991); The Brief Multidimensional Life Satisfaction Scale, developed by Huebner, Suldo, Valois, Drane, and Zullig (2004); The Center for Epidemiology Studies Depression Scale (Radloff, 1977).		
Jansen, Motley and Hovey (2009)	N=430 college students, mean age=19.66 years, age range= 18–47 years, female=285 (66%)	self-report of religious influence on their lives (how much influence does religion have on your life?), self-reported level of religiosity (how religious are you?), and rate of church attendance (how often do you attend church?).	Beck Anxiety Inventory (BAI; Beck, 1990), and the Beck Depression Inventory (BDI; Beck, 1987)	None	Self-reported religious influence and self-reported religiosity were significantly related to depression but not anxiety. Religious service attendance was negatively correlated with both anxiety and depression.
Kasen, Wickramaratne,Gameroff and Weissman (2012)	Offspring of depressed (n=126) and non-depressed parents (n=59) with mean age 30 years	Self-reported questions of service attendance and personal beliefs regarding religious/spiritual importance	Schedule for Affective Disorders and Schizophrenia – Lifetime Version (SADS-L; Mannuzza et al. 1986)	None	Increased attendance was associated with significantly reduced mood disorder and any psychiatric disorder in all offspring.
Koenig (2007)	Patients (age=50 years and above) of congestive heart failure and chronic pulmonary	Religious characteristics were examined in terms of religious affiliation, spiritual–religious self-categorizations, public and private	Hamilton Depression Rating Scale (HDRS)	Duke Social Support Index (DSSI)	Patients with major depression were less involved in religious practices compared to patients with minor depression.

Authors	Sample	Measure of religion	Measure of health	Mediators	Findings
	disease (CHF/CPD) with major depression (n=411) and minor depression (n=585)	religious activities, and religiosity.			
Ironson, Stuetzle and Fletcher (2006)	N=100 HIV positive Participants with mean age=38 years (L)	Self-rated items of self-perceptions as religious/spiritual and religious service attendance	Depression by Beck Depression Inventory (Beck, 1961), hopelessness by the Beck Hopelessness Scale (Beck, 1974), optimism by a composite of the Life Orientation Test (LOT; Scheier and Carver, 1985)	EnrichedSocial Support Instrument (ESSI; Mitchell et al, 2003)	Increased religiousness/spirituality resulted in slower disease (HIV) progression as well as decreased depression and hopelessness.
Kodzi, Gyimah, Emina, and Ezeh (2010)	N=2606 (66% men) age=50 years and above	Self-rated religious commitment and religious participation	Self-rated health	None	Frequency of religious attendance was negatively associated with health, while the number of close friends, social support, and frequency of community participation were positively and independently related to self-reported health.
Dew, Daniel, Goldston and Koenig (2008)	N=117 Adolescents, with age ranged of 12-18 years, girls (n)=53	Brief multidimensional measure of religiousness/spirituality (BMMRS; Fetzer Institute, 2003)	Depression Inventory (BDI; Steer and Beck, 1988)	None	Religious practices (private and organizational) and positive religious coping related to lower depression while negative religious coping related to higher depression.

Authors	Sample	Measure of religion	Measure of health	Mediators	Findings
Baetz and Bowen (2010)	N=183 patients of depression (65% female), with a mean age of 40 years	The Brief RCOPE (Pargament, Smith, Koenig, & Perez, 1998) to assess the religious coping. The Duke Religion Index (DRI; Koenig, Parkerson, & Meador, 1997) to assess religious involvement	The Beck Scale for Suicidal Ideation (BSI; Beck, Brown, & Steer, 1997; Beck, Steer, & Ranieri, 1988). Affective Lability Scale-Short Form (ALS; Oliver & Simons, 2004).	None	Suicidal ideation was positively correlated with negative religious coping and negatively correlated with positive religious coping.

DISCUSSION

The present study was intended to analyse the relationship between religion and health by using systematic review. Total 32 studies were selected for systematic review. Results informed that studies regarding religion and health, were conducted on different age-group, gender, and normal/patient groups. Majority of studies used religious practices to examine the relationship between religion and depression. It was found that organisational religious practices, intrinsic religiosity and positive religious coping had strong positive impact on health indicators (e.g., depression, anxiety, stress, suicidal ideation, mental health and physical health) compared to private religious practices and religious importance. Previous studies also reported same findings (Koenig & Larson, 2001, Smith, McCullough & Poll, 2003; Jawaid, 2014; AbdAleati, Zaharim, & Mydin, 2014; Rosmarin & Loenig, 2020). Positive impact of religion on health can be explained by several mediating factors such as social support, healthy behaviour, positive explanation of adverse situation, meaning of life. Studies (Dulin, 2005; Krause, 2008a; Baruth, Wilcox, Hooker, Hussey, & Blair, 2013) have demonstrated that religious persons provide an opportunity of social interaction and close relation with others resulted in getting social support during stressful situation. Social support is prominent factor for coping with stressful situation. Religious involvement is also related with healthy behaviour. For performing religious practices (prayer, namaz, reciting holy scripture), individuals keep themselves purify (i.e., Bathing, Wudhu) before every religious practices (e.g., namaz). Thus, religious involvement promotes healthy and hygienic behaviour and protects from viral and bacterial infections. Religious involvement enlightens the individuals to behave with others in a civilized way that is essential for the welfare of humanity as well as nature. It can be concluded that religious involvement is beneficial for good psychological as well as physical health and well-being. It promotes healthy behaviour, enhances social support, and flourish spiritual thoughts that contributed in good health of the individuals. Hence, this paper highlights the positive side of religion, religiosity and religious beliefs for health, however, the negative side indicates that it may be a source of conflict, war and violence. It depends upon the individuals' approach to the religion either for promoting brighter aspects or for provoking darker aspects.

CONCLUSION

Results of present study indicated that relationship between religion and health varies due to different aspects of religion. It was found that organizational religious practices, intrinsic

religiosity and positive religious coping are playing important role in positive mental health as compared to private religious practices and religious importance. Majority of studies have used correlational method. Therefore, causal relation can not be inferred between religion and health. Studies on religion and health have less focus on possible mediating factors (only seven studies have used social support as mediating factors). Using of some more mediating factors (e.g., locus of control and attribution style) could be useful for creation of more comprehensive and compact picture to understand the underlying mechanism of relation between religion and health.

Limitation

Longitudinal and experimental studies are more valid to infer causal relation between studied variables. In this systematic review little studies on religion and health have been identified in which longitudinal design have been used. Further review required to focus on longitudinal studies. Every religion has some unique pattern of religious practices and beliefs. Further studies with qualitative method could be more effective to study deeply regarding the latent factors of a religion responsible for influencing the health of their follower.

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Conflict of Interest

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