Exploring the Impact of Spirituality on Mental Health: A Correlation Study

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Abstract- This research investigates the relationship between spirituality and mental health, examining whether spirituality or spiritual practices influence mental health conditions. Spirituality is defined as a worldview that transcends sensory and physical experiences, often involving religious or cultural practices, a connection with others and the world and the pursuit of self-improvement. It includes the recognition of a higher power and a sense of interconnectedness grounded in love and compassion. Mental health encompasses emotional, psychological and social well-being, affecting how individuals think, feel and act. It is crucial for managing stress, relationships, and making healthy choices throughout life stages. The study utilized a convenient sample of individuals aged 20-40 to assess the impact of spiritual practices on mental health. The findings indicate that while spiritual health was initially hypothesized to positively correlate with positive mental health, this was rejected. Instead, the study found a negative correlation between spiritual health and positive mental health, highlighting the complex interplay between spirituality and mental well-being.

Keywords: Spirituality, Mental health, Spiritual practices, religious beliefs, Cultural beliefs.

Spirituality involves the recognition of a feeling or sense or belief that there is something greater than myself, something more to being human than sensory experience, and that the greater whole of which we are part is cosmic or divine in nature.

Attempts at defining spirituality vacillate between the human and the divine (see Spilka, 1993, cited in Hill et al., 2000). Many people claim that ‘spirituality’ and ‘mental health’ are both multifaceted constructs that are elusive in nature (e.g., de Chavez 2005; Buck 2006; McSherry & Cash, 2004). This has not prevented people from trying to define Spirituality and mental health and their interrelationship in the form of spiritual wellbeing (SWB).

The nature of spirituality has been debated for centuries. The literature reveals the Difficulty writers have in defining the concept (Chiu et al., 2004; Diaz, 1993; Goodloe & Arreola, 1992; Seaward, 2001). Muldoon and King claim: spirituality can mean many things in popular usage, and is often understood differently by different people. While retaining a certain ambiguity, its current range of application extends from traditional institutional religion to occult practices. In General, the term appears to denote approaches to discovering, experiencing, and living out the implications of an authentic human life (1995, p.330).

Spirituality and Religion

Opinions vary on the nature of any relationship between spirituality and religion. Some people equate spirituality with religious activity, or use the words interchangeably (Piedmont, 2001; Gorsuch & Walker, 2006), whereas others believe this assumption is not valid (Banks, Poehler & Russell, 1984; Scott, 2006). Hill et al. discuss commonalities between spirituality and religion as well as differences (2000). Scott reports three polarizations between views held by behavioural scientists, differentiating spirituality and Religion (Zinnbauer, Pargament & Scott, 1999). Hill et al. (2000) argue that spirituality is subsumed by religion, but some see religion as one dimension of spirituality (Nolan & Crawford, 1997). Rather simplistically speaking,

religion focuses on ideology and rules (of faith and belief systems) (Horsburgh, 1997), whereas spirituality focuses on experience and relationships which go beyond religion (Lukoff, Lu & Turner, 1992). Koenig, McCullough and Larson (2001) include "a relationship to the sacred or transcendent" [my italics] (p.18) in their definition of spirituality. Taking this broader view, seaward asserts that spirituality involves "connection to a divine source whatever we call it" (2001, p.77). But spirituality does not have to include "God-talk" according to Jose & Taylor (1986).

What is spiritual health?

Health is something most strive to embody. From eating certain foods to exercising, along with emotional and mental self-care, the term health encompasses it all. However, there is something called spiritual health that is just as important. What is spiritual health, and how does it connect to a person's overall wellness?

Spiritual health is anything that relates to the health and wellness of a person's spirit. While spirit can be defined in many ways throughout many religions and cultures, the concept stems from something within an individual that cannot be seen in the body and is not a part of the mind. Many believe the spirit and spiritual health are the keys to balancing the physical, mental, and social aspects of the self by connecting that spirit to a god(s), the energy of the universe, or another planet/realm/dimension, to name a few.

Religion:

Spirituality and religion are often used interchangeably, but the two concepts are different. Some authors contend that spirituality involves a personal quest for meaning in life, while religion involves an organized entity with rituals and practices focusing on a higher power or God.

Fisher's (2011) review of the Oxford dictionary's definitions of the word "spirit" echoes that of the creation narratives in distinguishing between mere existence and life. He states that "the general meaning underlying all the uses [of the word spirit] is that of an animating or vital Principle which gives life, transcending the material and mechanical" (p. 19). In the West, for historical and cultural reasons, the concept of spirituality has been greatly influenced by monotheistic concepts derived from Christian faith. In Christian theology, the Holy Spirit was given to humanity by God on the day of Pentecost and dwells within every person (Bash, 2004).

The Difference Between Spirituality and Religion

Somewhere, at some point, all religions started as a spiritual process. But in their eagerness to organize, they lost the fundamentals. Religion is just spirituality gone bad. Let us understand the distinction between religion and a spiritual process. The moment you say you belong to a religion; you call yourself a believer. The moment you say, "I am on a spiritual path," you call yourself a seeker. What is the difference between believing and seeking? You can seek only that which you do not know. Or in other words, the fundamentals of seeking are that you have realized that you do not know the essential nature of your own life. You do not know the source of this creation. You do not know who you are, what you are, where you came from and where you will go. You are seeking to know. When you are in a state of "I do not know," you cannot fight anyone.

The first and foremost thing in the spiritual process is to be absolutely sincere with yourself and be willing to see, "What I know, I know; what I do not know, I do not know." It does not matter who said what – whether Krishna, Jesus, Buddha or anyone else said it – maybe they are telling the truth, but with all due respect to them, you do not know – you have not experienced or seen it. Why not be sincere that you really do not know? "I do not know" is a tremendous possibility. It is the basis of knowing. Only when you see that you do not know, the possibility of knowing opens up. The moment you kill it with some kind of belief that is convenient for you, you destroy all possibilities of knowing.

Well-being:

Well-being, or wellbeing, also known as wellness, prudential value, prosperity or quality of life, is what is intrinsically valuable relative to someone. So, the well-being of a person is what is ultimately good for this person, what is in the self-interest of this person. Well-being can refer to both positive and negative well-being. In its positive sense, it is sometimes contrasted with ill-being as its opposite. The term "subjective well-being" denotes how people experience and evaluate their lives, usually measured in relation to self-reported well-being obtained through questionnaires.

Mental Health: Mental health is a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community. It is an integral component of health and well-being that underpins our individual and collective abilities to make decisions, build relationships and shape the world we live in. Mental health is a basic human right. And it is crucial to personal, community and socio-economic development.

Mental health has often been described as the absence of mental illness. However, in this paper, inspired by Keyes' dual continuum model of mental health and mental illness, mental health and mental illness will be considered as two separate yet related constructs (Keyes, 2002, 2005, 2007). Because some authors use mental illness and mental health interchangeably, mental health will hereafter be referred to as positive mental health (PMH).

PMH stems from the emerging field of positive psychology. Positive psychology is principally interested in helping individuals achieve optimal functioning in a variety of areas of life including biological, personal, relational, institutional, cultural, and global dimensions of life (Seligman & Csikszentmihalyi, 2000), Within the school of positive psychology, two philosophical traditions have long maintained opposing views on well-being; hedonism and eudaimonism.

Mental wellbeing

Mental wellbeing doesn't have one set meaning. We might use it to talk about how we feel, how well we're coping with daily life or what feels possible at the moment. Good mental wellbeing doesn't mean that you're always happy. Or that you're unaffected by your experiences. And having good wellbeing doesn't always mean that you don't have a mental health problem. You may live with a mental health problem, but have good wellbeing right now. Or you might not have a mental health problem, but be struggling with your wellbeing at the moment.

How does mental health affect physical health?

Research shows that people with a mental health problem are more likely to have a preventable physical health condition such as heart disease. This can be for a variety of reasons, including:

- Genetics–The genes that make it more likely that you will develop a mental health problem may also play a part in physical health problems
- Low motivation– Some mental health problems or medications can affect your energy or motivation to take care of yourself
- Difficulty with concentration and planning– You may find it hard to arrange or attend medical appointments if your mental health problem affects your concentration
- Lack of support to change unhealthy behaviour– Healthcare professionals may assume you're not capable of making changes, so won't offer any support to cut down on drinking or give up smoking, for example-being less likely to receive medical help health care professionals may assume your physical symptoms are part of your mental illness and not investigate them further. People with a mental illness are less likely to receive routine checks (like blood pressure, weight and cholesterol) that might detect symptoms of physical health conditions earlier. As well as this, mental health problems can come with physical symptoms. Our bodies and minds are not separate, so it's not surprising that mental ill health can affect your body. Depression can come with headaches, fatigue and digestive problems, and anxiety can create an upset stomach, for example. Other symptoms can include insomnia, restlessness and difficulty concentrating.

METHODOLOGY

Purpose: The purpose of studying the correlation between spirituality and mental health is to explore how spiritual beliefs, practices and experiences impact mental health**.**

Objectives:

- To study the impact of spirituality (such as the faith Index, the Personal piety index and the Subjective Spiritual Well-being Index) on mental health.
- To examine the relationship between spiritual practices and mental health outcomes (such as Emotional Well-being, Psychological Well-being and Social Well-being).

Hypothesis:

- Spiritual health will be positively correlated to PMH (Positive Mental Health).
- Spiritual health will be negatively correlated to PMH (Positive Mental Health).

Variables:

INDEPENDENT VARIABLE

Spirituality

DEPENDENT VARIABLE

Mental Health

Sample:

A sample is a smaller set of data that a researcher chooses or selects from a larger population using a pre-defined selection bias method. These elements are known as sample points, sampling units, or observations. Creating a sample is an efficient method of conducting research.

The type of sampling used here is Random Sampling. Simple random sampling is a type of probability sampling in which the researcher randomly selects a subset of participants from a population. Each member of the population has an equal chance of being selected. The age range was 20-40 of the population where male & female both were included. The data has been taken in Google sheet form. The form was created using the tool questions and sent to different individuals to fill it by approving an informed consent form. The total number of samples collected are-46 out of which 36.4% are male and 63.6% are female. The samples have been collected in way to check if spirituality affects mental health.

Tools & Their Administration:

Research tools refer to a wide range of resources, methods, instruments, software, or techniques that researchers use to collect, analyse, interpret, and communicate data and information during the research process. These tools are designed to facilitate and enhance various aspects of research, such as data collection, organization, analysis, visualization, collaboration, and documentation. Research tools can be both physical (e.g., laboratory equipment, survey instruments) and digital (e.g., software, online databases).

They are essential for conducting research effectively, efficiently, and rigorously across different disciplines and research domains. Examples of research tools include laboratory equipment, survey questionnaires, statistical software, data visualization tools, literature databases, collaboration platforms, and more. The choice of research tools depends on the specific research objectives, methods, and requirements of the study.

I) Spirituality Well-being Questionnaire (SWB)

The instrument is comprehen-sive because it includes individual items pertaining to social attitudes, self-percep-tions, theological orientation, religious be-liefs, opinions, experiences, preferences, affiliations, and various charitable endeavours. In developing this instrument, Moberg at- tempted to address the following require-ments for a useful measure of spiritual well- being.

The four strongest indexes or spiritual well- being are the Christian Faith Index, the Self-Satisfaction Index, the Personal Piety Index, and the Subjective Spiritual Well-Being Index. One measure of spiritual well-being could, therefore, just include the items involved in these indices. The indexes of Op-timism, Religious Cynicism, and Elitism are the weakest statistically and the author, through personal correspondence, recom-mends that these items be dropped.

II) Mental Health Continuum Short- Form (MHC-SF)

The MHC-LF consisted of 40 items, the MHC-SF consists of 14 items that were chosen as the most prototypical items representing the construct definition for each facet of well-being. Three items were chosen (happy, interested in life, and satisfied) to represent emotional well-being, six items (one item from each of the 6 dimensions) were chosen to represent psychological well-being, and five items (one item from each of the 5 dimensions) were chosen to represent social well-being. The response option for the short form was changed to measure the frequency with which respondents experienced each symptom of positive mental health, and thereby provided a clear standard for the assessment and a categorization of levels of positive mental health that was similar to the standard used to assess and diagnosis major depressive episode (see Keyes, 2002, 2005a, 2007). To be diagnosed with flourishing mental health, individuals must experience 'every day' or 'almost every day' at least one of the three signs of hedonic well–being and at least six of the eleven signs of positive functioning during the past month. Individuals who exhibit low levels (i.e., 'never' or 'once or twice' during the past month) on at least one measure of hedonic well–being and low levels on at least six measures of positive functioning are diagnosed with languishing mental health. Individuals who are neither flourishing nor languishing are diagnosed with moderate mental health.

Procedure:

The study aimed to investigate correlations between Spirituality and Mental Health (20-40 years). A sample of 45 individuals were randomly selected. Participants completed a the Spirituality Well-being Questionnaire (SWB) and Mental Health Continuum Short- Form (MHC-SF). Statistical analysis using SPSS and Pearson's correlation coefficient was conducted to assess correlation between Spirituality and Mental Health. Hypotheses predicted Spiritual health will be positively correlated to PMH (Positive Mental Health) and Spiritual health will be negatively correlated to PMH (Positive Mental Health).

Research Design:

The research design employed in this study is a correlational design aimed at examining the Correlation between Spirituality and Mental health among young adults aged 20-40 years.

Statistical Analysis:

The data analysis was done using Statistical Package for Social Sciences (SPSS) using Pearson's correlation coefficient.

RESULT AND DISCUSSION

Table 1 Showing Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Age	45	20	35	24.221	3.397
Gender	45	1	2	1.38	.490
TOT_SWB	45	87	208	143.38	27.226
TOT_MHC	45	11	65	38.36	14.694
Valid N	45				

In Table 1 The dataset consists of 45 participants with ages ranging from 20 to 40 years. The mean age is 24.22 years, with a standard deviation of 3.40 years, indicating a relatively young and slightly varied age group. Gender is coded as 1 for males and 2 for females, with a mean of 1.38 and a standard deviation of 0.49, suggesting a higher proportion of males in the sample.

The Total Subjective Well-Being (TOT_SWB) scores range from 87 to 208, with a mean of 143.38 and a standard deviation of 27.23, highlighting considerable variability in participants' perceptions of their well-being. The Total Mental Health Continuum (TOT_MHC) scores range from 11 to 65, with a mean of 38.36 and a standard deviation of 14.69, indicating diverse mental health statuses among the participants.

Table 2 Showing Correlation

		Age	Gender	TOT_SWB	TOT_MHC
Age	Pearson Correlation	1	-.133	.271	.176
	Sig. (2-tailed)		.382	.072	.246
	N	45	45	45	45
Gender	Pearson Correlation	-.133	1	-.118	-.142
	Sig. (2-tailed)	.382		.439	.352
	N	45	45	45	45
TOT_SWB	Pearson Correlation	.271	-.118	1	-.347*
	Sig. (2-tailed)	.072	.439		.020
	N	45	45	45	45
TOT_MHC	Pearson Correlation	.176	-.142	-.347*	1
	Sig. (2-tailed)	.246	.352	.020	
	N	45	45	45	45

*****Correlation is significant at the 0.05 level (2-tailed)

In Table 2 The correlation matrix reveals the relationships between age, gender, total subjective well-being (TOT_SWB) and total mental health continuum (TOT_MHC) among the 45 participants.

Age has a weak positive correlation with TOT_SWB ($r = .271$) and TOT_MHC ($r = .176$), although these correlations are not statistically significant ($p = .072$ and $p = .246$, respectively). This suggests a slight tendency for older participants to report higher levels of subjective well-being and mental health, but the evidence is not strong enough to draw definitive conclusions.

Gender shows a weak negative correlation with TOT_SWB ($r = -.118$) and TOT_MHC ($r = -.142$), with p-values of .439 and .352, respectively. These correlations are also not statistically significant, indicating that gender does not have a meaningful impact on subjective well-being or mental health in this sample.

The most notable finding is the significant negative correlation between TOT_SWB and TOT_MHC ($r = -.347$, $p = .020$). This indicates that higher levels of subjective well-being are associated with lower levels of mental health issues. The negative relationship suggests that as

participants' subjective well-being increases, their mental health problems decrease and vice versa.

Overall, while age and gender do not show significant correlations with subjective well-being or mental health, there is a significant inverse relationship between subjective well-being and mental health status among the participants.

Table 3 Showing Group Statistics

	Gender	N	Mean	Std. Deviation	Std. Error Mean
TOT_SWB	1	28	145.86	28.104	5.311
	2	17	139.39	26.021	6.311
TOT_MHC	1	28	39.96	14.701	2.778
	2	17	35.71	14.734	3.574

In Table 3 The data presents the mean scores, standard deviations, and standard errors for total subjective well-being (TOT_SWB) and total mental health continuum (TOT_MHC) based on gender, with 28 males (coded as 1) and 17 females (coded as 2).

Males have a slightly higher mean TOT_SWB score (145.86) compared to females (139.39), though both groups exhibit similar standard deviations (28.104 for males and 26.021 for females). The standard errors (5.311 for males and 6.311 for females) indicate the precision of these mean estimates.

In terms of TOT_MHC, males also show a higher mean score (39.96) compared to females (35.71). The standard deviations are nearly identical (14.701 for males and 14.734 for females) and the standard errors (2.778 for males and 3.574 for females) again reflect similar precision in these estimates.

Overall, males in this sample report slightly higher subjective well-being and mental health scores compared to females, though the differences are not substantial. Both genders exhibit similar variability in their scores.

Table 4 Showing Independent Sample Test

		F	Sig.	t	df	One-Sided p	Two-Sided p	Mean Diff.	Std. Error Diff.	Lower	Upper
TOT_SWB	**Equal Variance assumed**	1.097	.301	.781	43	.220	.439	6.563	8.409	-10.39	23.520
	Equal Variance not assumed			.796	35.991	.216	.431	6.563	8.248	-10.16	23.292
TOT_MHC	**Equal Variance assumed**	.128	.722	.941	43	.176	.352	4.258	4.524	-4.865	13.382
	Equal Variance			.941	33.856	.177	.353	4.258	4.526	-4.942	13.459

	not assumed										

In Table 4 The independent samples t-test results compare total subjective well-being (TOT_SWB) and total mental health continuum (TOT_MHC) scores between genders.

For TOT_SWB, the F-test for equality of variances (F = 1.097, p = .301) suggests that variances are equal. The t-test assuming equal variances (t = .781, df = 43, p = .439) shows no significant difference between males and females in TOT_SWB scores. The mean difference of 6.563 (SE = 8.409) has a 95% confidence interval ranging from -10.39 to 23.520, indicating no significant gender difference.

For TOT_MHC, the F-test (F = .128, p = .722) again suggests equal variances. The t-test assuming equal variances (t = .941, df = 43, p = .352) shows no significant difference between genders in TOT_MHC scores. The mean difference of 4.258 (SE = 4.524) has a 95% confidence interval from -4.865 to 13.382, indicating no significant gender difference.

In conclusion, there are no significant differences in subjective well-being (TOT_SWB) or mental health continuum (TOT_MHC) scores between the gender groups in this sample.

Based on the results it can be interpreted that spirituality doesn't impact or effect mental health.

CONCLUSION

The analysis of the dataset reveals that age and gender do not significantly influence subjective well-being or mental health among the participants. Although there is a slight positive correlation between age and both subjective well-being and mental health, these relationships are not statistically significant. Similarly, gender shows negligible effects on both measures. The most notable finding is a significant negative correlation between subjective well-being and mental health issues, indicating that higher levels of subjective well-being are associated with fewer mental health problems. This inverse relationship suggests that improvements in subjective well-being may contribute to better mental health outcomes. However, no significant differences in subjective well-being or mental health were found between genders, highlighting that gender does not play a meaningful role in these measures within this sample. Overall, the data suggests that while subjective well-being and mental health are interrelated, factors like age and gender do not significantly impact these outcomes.

SUGGESTIONS AND LIMITATIONS:

- The present research has focused on the age group of 20-40. So further research can be done on the below and above age group population for more in-depth findings.
- Research can be done on atheist to know whether Spirituality correlates their positive mental health.
- Research can be done on the Monks to know how Spiritual belief correlates to their positive mental health.
- Lack of availability of proper tools for assessing spirituality.
- The tools used here in the research is in English so it leads to a language issue among people.
- The sample used for this research are theist (believe in god) so the result of this research may not be applicable to atheist.

REFERENCES

1. Bradburn, N. M. (1969). The structure of psychological well-being. Chicago:Aldine. Cantrell, H. (1965). The pattern of human concerns. New Brunswick, NJ: Rutgers University Press.
2. Gallagher, M. W., Lopez, S. J., & Preacher, K. J. (2009). The hierarchical structure of well-being. Journal of Personality, 77, 1025-1049.
3. Keyes, C. L. M. (1998). Social well–being. Social Psychology Quarterly, 61, 121–140.
4. Keyes, C. L. M. (2002). The mental health continuum: From languishing to flourishing in
5. Life. Journal of Health and Social Behavior, 43, 207-222.
6. Lamer, S.M.A., Westerhof, G.J., Bohlmeijer, E.T., ten Klooster, P.M., & Keyes, C.L.M. (2010). Evaluating the psychometric properties of the Mental Health Continuum-Short Form (MHC-SF). Journal of Clinical Psychology, 67, 99-110.
7. Treitschke, C., & Keyes, C. L. M. (2006). [Multidimensional well-being and social Desirability]. Unpublished data.
8. Treitschke, C., & Keyes, C. L. M. (2009). The structure of Keyes' model of mental health and the role of personal growth initiative as a parsimonious predictor. Journal of counselling Psychology, 56, 321−329.
9. Riff, C. D. (1989). Happiness is everything, or is it? Explorations on the meaning of Psychological well–being. Journal of Personality and Social Psychology, 57, 1069–1081.
10. Riff, C. D. & Keyes, C. L. M. (1995). The structure of psychological well–being Revisited. Journal of Personality and Social Psychology, 69, 719–727.
11. Westeros, G. J., & Keyes, C. L. M. (2010). Mental illness and mental health: The two continua model across the lifespan. Journal of Adult Development, 17, 110–119.
12. Alonso, J., Codony, M., Kovess, V., Angermeyer, M.C., Katz, S.J., Haro, J.M., De Girolamo, G., De Graaf, R., Demyttenaere, K., Vilagut, G., Almansa, J., Lepine, J.P., & Brugha, T.S. (2007). Population Level of unmet need for mental healthcare in Europe. British Journal of Psychiatry, 190, 299–306.
13. Andrade, C., Shah, N., Tharyan, P., Reddy, M.S., Thirunavukarasu, M., Kallivayalil, R.A., … Mohandas, E. (2012). Position statement & Guidelines on unmodified electroconvulsive Therapy. Indian Journal of Psychiatry, 54, 119–133.
14. Antony, J.T. (2000). A decade with the Mental Health Act, 1987. Indian Journal of Psychiatry, 42, 347–355. **Antony, J.T. (2014). The mental health care bill 2013: A
15. Disaster in the offing? Indian Journal of Psychiatry, 56(1), 3–7. Doi: 10.4103/0019 5545.124707
16. Arboleda-Flórez, J. (2001). Stigmatization and human Rights violations. World Health Organization, Mental Health: A Call for Action by World Health Ministers. Geneva, WHO: 57-70.

17. Bartlett, P. (2010). Thinking about the rest of the world: Mental health & rights outside the ‘first world’. In B. McSherry, & P. Weller (Eds.), Rethinking rights-based mental health laws (pp. 397–418).
18. Oxford and Portland, Oregon: Hart Publishing. Baxter, A.J., Patton, G., Scott, K.M., Degenhardt, L., &Whiteford, H.A. (2013). Global Epidemiology Of Mental Disorders: What Are We Missing? Plos One, 8(6): e65514.