ABSTRACT

The Gods Must be Making Us Crazy:
The Effect of a Judgmental God Concept on Mental Health

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Using Wave III of the Baylor Religion Survey, this research examines the relationship between mental health and religion in a unique way. Many studies have examined church attendance as the most significant way that religion ameliorates mental health concerns. However, the sociological study of God concepts is under-examined, and may provide a more detailed picture. In a social context where denominationalism, affiliation and even social participation in religious activities are less important than they were half a century ago, God concepts may help us to understand exactly how religiosity affects behavior. God concepts represent the underlying motivations and cognitive styles that motivate people to believe and behave in certain ways. This paper finds that the effects of religion on mental health depend on the type of religion people experience. People who have a Judgmental God concept have poorer mental health, even when controlling for church attendance, prayer, and other beliefs.

The Gods Must be Making Us Crazy:
The Effect of a Judgmental God Concept on Mental Health

by

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A Thesis

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CHAPTER ONE

Religion and Mental Disorders

The days of punishment have come…
The man of the spirit is mad,
Because of your great iniquity
And great hatred.

~Hosea 9:7

Whom the Gods destroy, they first make mad.

~Greek epigram

The narratives of Old Testament prophets depict their ecstatic relationships with a wrathful, disgruntled God. According to the stories, God charged the prophets with symbolic acts that are truly bizarre: Jeremiah traversed hundreds of miles to bury a loincloth only to dig it up after it had rotted; Ezekiel prophesied to a miniature model of the siege of Jerusalem and cooking his food over cow dung for over a year; Hosea believed he was instructed to marry a prostitute; and for three years, Isaiah walked around Jerusalem naked. Surely their contemporaries thought these actions were nothing short of madness, just as modern religious eccentricities are not well received by our culture.

Yet the notion that religion *causes* psychological dysfunction is somewhat outmoded. Recent studies in the social sciences tend to recognize the benefits of religion, both organized and private, for mental well-being. Yet perhaps the former perspective has been too readily dismissed. A few decades ago, social scientists were certain that religion was detrimental because religious beliefs were pessimistic, self-abasing, and delusional, but more recent social science largely disregards the

importance of religious beliefs in favor of the importance of social effects like attendance, which has a well-documented positive effect on well-being.

However, religion is a complex combination of social behaviors, private practices, emotional commitments and cognitive foundations. God concepts are an example of the latter, a relatively stable image ingrained into one‟s neural processors (Newberg and Waldman 2009). Like the prophets, whose actions corresponded to the God they experienced, we might expect that understanding Americans‟ God concepts will shed some light on their psychological dispositions, and perhaps illuminate when religion might not be on the side of psychological health.

As mentioned, initially, especially in the 1950‟s and 60‟s, the orientation of social science and psychiatry was to equate religion with psychological maladjustment (see Koenig et al. 2001). Researchers believed that religion‟s apparent irrationality led to maladaptive behaviors and provoked negative feelings of guilt and self-condemnation (Ellis, 1962; Watters, 1992). More recently, scholars have reasoned that the positive effects of religion are due to how religious communities fend off such emotional stressors as loneliness and depression, as well as offering care and support in financial and other tangible and intangible ways (Ellison 1998). Additionally, religion may be beneficial to mental health because of its inner-focused rituals, like prayer and meditation (Ellison and Bradshaw 2010). Collins (2004) calls meditation "self-entrainment" meaning that the „dialogue‟ occurring with oneself is highly focused and full of emotional energy, which feeds back into well-being. Finally, religiosity may be beneficial to mental health because religious services often involve a variety of expressive forms, such as singing, chanting, body movements and dancing, and quiet

and collective prayer. Some researchers believe these expressions can be cathartic and elevating (eg., Idler and Kasl 1997).

Religion may also assist in coping with mental illness. Kirov et al. (1998) found that psychosis patients had a higher rate of compliance with medication. They believed that religion offered a meaning system for their difficulties and gave them greater insight into their illness. People who are mentally or physically ill may self-select into high-subjective religiosity to seek relief from their suffering, as religion can provide effective coping mechanisms in the forms of things like community support as well as a coherence of moral order (Siddle et al. 2002; Ellison 1998; Koenig et al. 2001).

Mental Health

The National Institute of Mental Health (NIMH) estimates that every year, over one quarter of the population is diagnosable with a mental disorder (Kessler, 2005). A much smaller percentage (about 6 percent) experience a serious mental illness (SMI), defined as any mental health disorder existing at any time in the previous 12 months that meets diagnostic and duration criteria laid out in the DSM-IV and that impairs functionality (Substance Abuse and Mental Health Services Administration [SAMSHSA], 1993). This population contains more women than men, more whites and interracial people than Blacks and Hispanics, and more young people aged 18- 25 than older cohorts (though this surely reflects, at least in part, the selection bias of those populations more likely to seek help). However, over their lifetime, women are not more likely than men to have a mental disorder, while Blacks are still 30% less likely to have a mental disorder in their lifetime than whites.

This study is primarily concerned with Anxiety Disorders. Anxiety Disorders are any of several disorders that are characterized by potentially debilitating concern about daily events. NIMH estimates that 40 million Americans adults are affected by an anxiety disorder every year (research performed by the umbrella organization, the National Institute of Health (NIH) 2009). As with mental disorders in general, Blacks and Hispanics are 20 and 30% less likely respectively to have anxiety disorders than Whites. Women are more likely than men by a large margin of 60%. Finally, people between the ages of 30 and 44 are slightly more likely than those cohorts on either side to experience an anxiety disorder, while people over 60 years old are about half as likely as those younger cohorts. For these reasons, controls for gender, age, and race have been included in the analysis. Other research reports demographic correlates of mental health, such as marriage and income. Married people tend to have better physical and mental health, partly because they benefit from affection and companionship, and partly because they engage in fewer risky behaviors than their non-married counterparts, such as heavy drinking (Ellison, Barrett & Moulton 2008). Income also has a strong effect on mental health, despite the old adage that "money can't buy happiness" (Newport 2007). People with lower income have greater mental health concerns. Thus, controls for marital status and income have been included in the analysis.

This study will examine five mental health disturbances: Generalized Anxiety, Social Anxiety, Paranoia, Obsession, and Compulsion. Generalized Anxiety Disorder causes individuals to experience exaggerated worry and anxiety, often without identifiable causes (i.e., the anxiety is general rather than a response to a specific

phobia). They anticipate disaster at every turn and worry constantly about finances, relationships, and other aspects of daily life. The diagnostic criteria in the DSM-IV require that a patient experience at least three of these six criteria: being restless or feeling keyed up; being easily fatigued; difficulty concentrating irritability; muscle tension; and sleep disturbance (DSM-IV 2003). Often accompanied by these and other somatic symptoms, an estimated 6% of the population is affected by it (Kroenka et al. 2009).

Social Anxiety Disorder, or Social Phobia, is identified as persistent self-consciousness in public and fear of humiliation. Such anxiety can manifest in specific situations, such as speaking in public, or in more severe cases, at almost anytime the person is around other people. Its prevalence is uncertain, with a possible range between one and 20% of the population (Moore and Gee 2002); NIHM estimates about 15 million Americans are affected.

Paranoia has colloquial connotations that range from trivial (like the admonishment, "don"t be paranoid") to severe (as when it is associated with schizophrenia). In the DSM-IV, paranoia has several diagnoses, such as Paranoid Personality Disorder, often functioning as an adjective rather than a disorder in its own right (McKenna 1997). Paranoia, in this study, is akin to overactive self-consciousness, where self-referential interpretations are made of others" behavior; for instance, a sufferer will interpret strangers" benign comments as insults directed toward them. Paranoia is the belief that the social world is threatening or deceitful (Fenigstein and Vanable 1992).

Obsessions and compulsions are distinct disturbances, though obsessions are sometimes accompanied by compulsions, such as in Obsessive Compulsive Disorder (OCD). Obsessions are thoughts or ruminations that can't be controlled, like troublesome thoughts and worries. Compulsions are rituals or behaviors that are often performed in attempts to quell obsessions. Compulsions can also manifest without obsessions, where the sufferer performs rituals simply because they feel compelled to. People with Compulsion know objectively that the rituals do not need to be performed, but they cannot emotionally control the impulse to perform them. Obsessive-Compulsive Disorder occurs in over two million American adults (NIMH).

Religion and Mental Health

Many studies use church attendance as the primary indicator of religiosity: attendance is easily measured, is regularly asked in surveys, and is an objective measure of religious behavior. As mentioned above, there are many reasons church attendance may promote good mental health. Attending religious services facilitates the making and maintaining of supportive relationships with others who share similar values and mindsets. Coreligionists can offer tangible support, in the way of goods and services, as well as intangible support, such as comfort and friendship (Ellison 1998). Recent studies have attempted to isolate the mechanisms by which attendance affects mental health by controlling for things such as friendship and extra-church support (Ellison, Boardman, Williams and Jackson 2001), certain beliefs (Ellison, Burdette and Hill 2009), inner disciplines such as prayer (Ellison and Bradshaw 2010) and emotional practices such as forgiveness and self-forgiveness (Sternthal, Williams, Musick and Buck 2010). Still, the effect of attendance at a religious service on mental health is strong. Ellison,

Burdette and Hill (2009) found that religious attendance has a robust inverse effect on feelings of anxiety, as well as a positive effect on feelings of tranquility.

The social and public demonstrations of faith are naturally quite different from private practices; the prevalence of Protestantism in North America biases us methodologically to preference typically Protestant rituals, while many religions have diverse emphases on public and private demonstrations and different senses of the importance of both. Correspondingly, Idler and Kasl (1997) examined the importance of attendance, a social or public religious behavior, with more inner-directed religious practices for elderly people with physical disability. They found that poor health is related to higher subjective religiosity, even while being negatively related to attendance, clearly because physical ailments can impede mobility along with other requirements of sharing public space with others. People who suffer from mental health disorders can experience similar barriers, both from psychosomatic symptoms and emotional and mental inhibitions that preclude attending large gatherings; health studies thus are especially well-suited for a broader measure of religiosity. The few studies that have included private religiosity in their religion measure have found mixed results. Meditation mediates the stress caused by financial strain, while prayer, conceived of as separate from meditation, had no effect on the experience of financial hardship (Bradshaw and Ellison 2010). Other studies have positively linked the effects of attendance with prayer on depression (Sternthal et al. 2010) and anxiety (Ellison and Bradshaw 2010; Bradshaw et al. 2008).

Even more rarely than studying private religious practices do studies examine the role of belief. This is probably linked to the prevalence of rational choice theory

(RTC), which emphasizes that people convert and commit to religions because of their social connections and cultural capital, and that beliefs are secondary considerations (see Stark and Bainbridge, 1989; Iannaconne 1998). Additionally, beliefs are often considered proxies for affiliations with denominations or traditions. Nonetheless, a handful of studies have been conducted to examine the relationships between beliefs and mental health. Christopher Ellison, Kevin Flannelly and their colleagues have studied afterlife beliefs in a couple of ways. Their studies find that belief in an afterlife, like attendance, has an inverse relationship to anxiety (Ellison et al. 2009; Flannelly, Ellison, Ganek and Koenig 2008) and a positive relationship to tranquility (Ellison et al. 2009), while holding a belief in human sinfulness is positively related to anxiety but unrelated to tranquility (Ellison et al. 2009). Additionally, they differentiate afterlife beliefs and test their effects on types of anxiety (Flannelly et al. 2008). Afterlife beliefs are generally negatively correlated with these mental health disturbances, although the less comforting afterlife beliefs, such as the belief that the afterlife is a pale, shadowy form of life, are positively related to mental health disturbances. Belief in an afterlife also mediates the effects of financial hardship, both objective (meaning the respondent is in a measurably more difficult financial situation than in the previous year) and subjective (meaning the respondent feels strapped for resources, even if no objective change has taken place) (Bradshaw and Ellison 2010).

Bradshaw, Ellison and Flannelly (2008) combine their tests about the effect of prayer on mental health with the belief of most interest to the present study, God concepts. The authors use eight mental disturbances from the SA-45, a well-know diagnostic tool. Most studies that look at prayer measure simply the frequency of

prayer (Levin 2004) but these researchers hypothesized that images of God affect the usefulness of prayer for people with mental health problems. Believing that one is praying to a loving, forgiving God does not mediate the effect of prayer on mental health, although such an image of God does have a direct negative effect on mental health problems. However, prayer when the respondent believes in a remote, uncaring God significantly increases poor mental health, supporting their hypothesis that prayer is only an effective coping mechanism when combined with a loving image of God. Though God concepts are a new area of interest for sociology, and are infrequently examined in studies of mental health, recent research shows that God concepts are a facet of religion worth examining. A discussion of God concepts will follow in the next chapter.

CHAPTER TWO

God Concepts

Even though almost 95% of Americans report believing in God, it is not clear what, exactly, each of them mean by „God" (Froese and Bader 2010). God-concepts are becoming recognized as an insightful contribution to the understanding of religious commitment and affiliation; some assert that "concepts of God are more complex, varied and psychologically meaningful than are the more-frequently assessed degrees of religious belief" (Hammersla, Andrews-Qualls & Frease, 1986: 424). God concepts form and maintain religious communities on the most basic level; they determine how interpersonal interactions occur and how organizational structures develop, even affecting the way churches arrange furnishings in the sanctuary. For example, after Vatican II, Catholic theologians prompted churches to move the tabernacle away from the centre in order to influence the view that Christ is in the group and not just in the Eucharistic elements. This reflects a shifting God concept, toward a God that is approachable and intimate rather than overly formal (Wolfe, 2003).

For most of us, much of what we believe about God originates in childhood (Froese and Bader 2010; Potvin 1977). God concepts might come from our parental figures, but the exact manner is up for grabs: they might be a projection of one's parents (Potvin 1977; Dickie et al. 2006), one's father (Jansen et al. 1994; Vergote et al. 1969; Freud 1927) one's mother (Dickie et al. 2006), or the same-sex parent (Vergote et al. 1969). Similarly, God concepts often reflect parental relationships. One study finds that, for college-aged children, God was nurturing to the degree that the father was nurturing

and powerful to the degree that the mother was powerful. Mothers‟ nurturance predicted God‟s qualities for sons but not for daughters (Dickie et al., 2006). Similarly, more than half of people with what Froese and Bader (2010) deem an Authoritative God image remember being spanked as a child, where only a quarter of those with a Distant God image do, demonstrating that the memory of parents as punishing or not may influence the image of God as punishing or not.

Some research contends that God concepts are reflections of the self, either as a reflection of self- esteem or self- perception (Francis et al. 2001; Potvin 1977; Benson & Spilka 1973), current life circumstances (Dickie et al. 2006), or the result of special religious training (Gorsuch 1968). Or, God concepts may originate from a combination of these sources (Gorsuch, 1968; Jansen et al., 1994; Dickie et al., 2006, Froese and Bader, 2010). In adults, self-esteem and a positive locus of control is positively related to loving God concept and negatively related to a rejecting God concept (Benson & Spilka, 1973). Variation is also accounted for by church attendance (Nelson et al. 1985; Krejci 1998; Noffke & McFadden 2001), denomination (Noffke & McFadden 2001), gender (Krejci 1998), and culture (Jansen et al. 1994; Vergote et al. 1969). Spilka et al. (1964) found that God concepts varied widely even over homogeneous groups. Froese and Bader (2010) test this wisdom by visiting a small, highly homogeneous, rural Baptist church. Its members were demographically very alike, yet they found through discussion with the researchers that they had divergent ideas of who God was. The minister was surprised to hear that not all the members agreed with him even concerning the gender of God. The ambiguity of language and its shortcomings for describing the unknown and

intangible permitted the congregants to develop diverse God concepts out of the same sermon material.

As far as the sources of God concepts go, it seems safe to conclude, as Froese and Bader (2010) do, that God concepts are reflexive, both mirroring and shaping one"s life. In *America's Four Gods* (Froese and Bader 2010) asserts that the God concepts of Americans are highly capricious, not consistently tied to religious affiliation or socio-demographics. Using the first two waves of the Baylor Religion Survey, Froese and Bader isolate four images of God embraced by the American public based on two essential features of God"s character: judgment and engagement with the world. The Authoritative God is high in both engagement and judgment and is akin to a stern parent, issuing strict edicts but also expressing concern and care. The Benevolent God is high in engagement and low in judgment; this God is loving and accepting, makes few demands, and is never punitive. The Critical God is low in engagement with the world and high in judgment of the world, a condemning, wrathful figure. Finally, the Distant God is low in both engagement and judgment and is basically irrelevant to humanity. Froese and Bader use these God concepts to assess Americans on a battery of behaviors and attitudes. They find these God concepts to be very predictive of seemingly innumerable important issues, from political outlook to views on science. The God concepts that people hold explain these attitudes more consistently than church attendance, political ideology, or denomination; God concepts tell us not how religious a person is, but how they are religious. They tell us about who people are: not only their behaviors, but also their motives and their deepest socio-emotional needs. This suggests that God-concepts have a powerful predictive capacity and are more layered than other religious determinants such

as demographic factors, affiliation, and even self-reported commitment and religious salience. Paying attention to God concepts proffers substantial understanding into the way people do religion, how religion constrains behavior, and how religion affects the self.

This research makes use of Froese and Bader‟s (2010) underlying essential features of God that determine God concepts: judgment and engagement. The purpose of this research is to examine to what extent God concepts can illuminate the role religion plays in psychological well-being, and to see how anxiety disorders are affected by the Judgmental God and Engaged God concepts.

CHAPTER THREE

Method and Measures

Data

The data used for this analysis is the third wave of the Baylor Religion Survey, collected in 2010 by the Gallup Organization. The BRS is a national representative random sample of 1714 adult American respondents. It is modeled after the General Social Survey, but is devoted to understanding religious attitudes and behaviors as well as the relationship of religion to other aspects of social life. Respondents answer questions about everything from religious affiliation to media consumption. The Baylor Religion Survey uses a series of modules to measure attitudes and behaviors concerning religion. Wave I offered modules about paranormal experiences and beliefs and moral and political attitudes. Wave II added modules about race and ethnicity, personality, questions about familial relationships and attitudes toward gender roles. Wave III, of course, includes several modules that address health issues, both physical and mental, as well as containing the items for assessing the God concepts of interest.

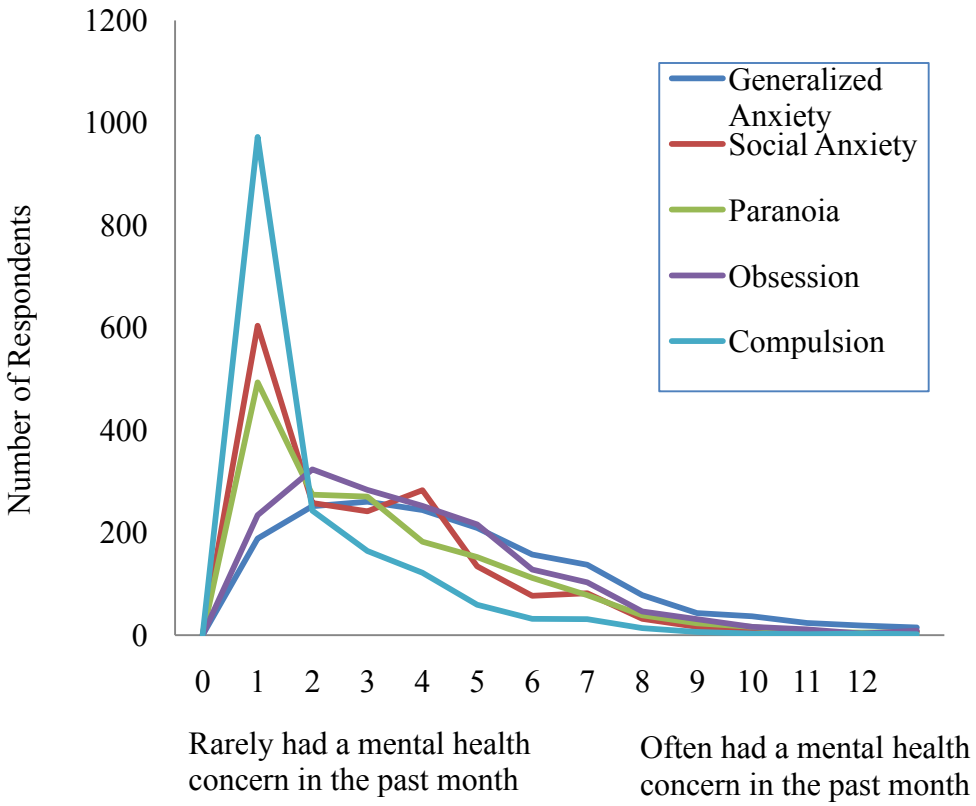
Since this project attempts to illuminate cognitive processes using sociological data, the Baylor Religion Survey is a good fit for this paper. The BRS offers in-depth questions about perceptions of God‟s attributes and abilities, which get at the properties cognitively assigned to God in mental schemas. Additionally, the Baylor Religion Survey offers the broadest range of religious demographic variables available, allowing us to control for a variety of religious attributes and produce a robust measure of religiosity, which has been rarely accomplished in other research of this sort.

Dependent Variables: Mental Health Items

The mental health module is a part of a larger theme of physical and mental health, including perceptions of health, trust in medicine, and faith healing. This study is concerned with 15 items that ask about mental health concerns, specifically anxiety-related disorders.

The questions were developed from several existing scales to measure the five types of anxiety-related disorders discussed above. The respondent chose a response (never, rarely, sometimes, often or very often) to the question asking how often they had experienced each disturbance over the past month. The items were then reorganized into their indices for measuring each of the five mental health disturbances: Generalized Anxiety, Social Anxiety, Paranoia, Obsession, and Compulsion. Since mental health disturbances are, almost by definition, rare, the distribution is quite skewed, showing that most people have few or infrequent concerns about their mental health. Figure 1 shows the distribution of the mental health disorders according to the Baylor Religion Survey.

Three questions addressing feeling anxious without specific causes (i.e. "worried too much about different things") measure Generalized Anxiety disorder, and are taken from Kroenka et al."s (2009) development of a 7-item and its condensed 2-item questionnaire. The resulting index has an alpha of .842 and has values ranging from 5-15. The three questions measuring Social Anxiety are taken from a 21-item scale developed as a diagnostic tool (Moore and Gee 2002) and ask about fearing others" judgment (i.e., "became anxious doing things because other people were



Note: Source is Baylor Religion Survey, Wave III

Figure 1: Frequency Distributions of Mental Health Disorders

watching"). Its alpha score is .824. To measure paranoia, the survey uses questions adapted from Fenigstein and Vanable"s (1992) questionnaire for assessing paranoia and self-consciousness (i.e., "felt like you were being watched or talked about by others"), and has an alpha of .765. Questions for Obsession (i.e., "been plagued by thoughts or images that you can"t get out of your mind") and Compulsion (i.e., "repeated actions that realistically did not need to be repeated") were taken from 35-item self-rated scale used primarily to assess the severity of OCD (Kaplan 1994), and are measured as separate concepts, with alphas of .760 and .765 respectively. Table 1 shows the

descriptive statistics of each of the scales. All five scales were then transformed into natural logs to correct the skewed distributions.

Table 1
Descriptive Statistics for Anxiety Disorder Scales

Variable	Mean	SD	Range	Alpha
General Anxiety	3.5	2.66	5 to 15	0.842
Social Anxiety	2.04	2.24	5 to 15	0.824
Paranoia	2.31	2.32	5 to 15	0.765
Obsession	2.87	2.3	5 to 15	0.760
Compulsion	1.13	1.72	5 to 15	0.765

Note: Source is Baylor Religion Survey, Wave III

As a caution, it is prudent to remember that these scales, like the God concept assessment and most other indices created by quantitative methods, are constructions. While survey questions will never perfectly measure intangible concepts, the fact that serious consequences follow those who are diagnosed with mental disorders merits some concern.[1] Additionally, this survey is administered differently than the scales used as diagnostic tools from which the mental health items are adapted. Test subjects for those scales were often clinical patients, persons already diagnosed with a particular disorder, or college students. Such respondents have, at least, some familiarity with clinical counseling and diagnoses, and presumably a fair amount of faith in

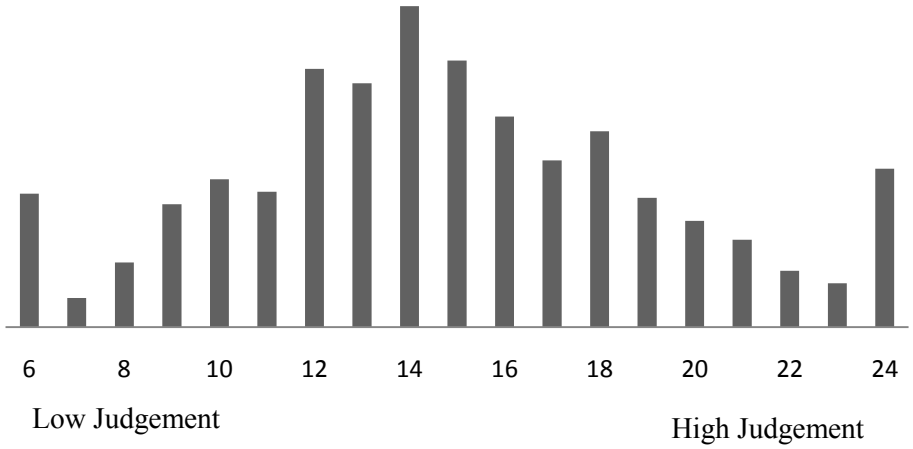
[1] Szasz (1974) cautions us against the scientism of psychotherapy, which he believes is a medical metaphor, rather than a medical field. For instance, Obsessive-Compulsive Disorder is not subject to exact diagnostic criteria in the same way that tuberculosis, heart attacks, or broken bones are. Mental health concerns are not imaginary, but the diagnostic categories, Szasz argues, are not scientific. The act of measuring mental disorders reifies them in a way that is not completely true to life (like many concepts in the social world). Authors Kutchins and Kirk (1997) add that part of the DSM‟s power is its connection to insurance coverage; the medicalization of psychiatry helps people get the assistance they need, but it also creates mental disorders that carry the authority of medical disorders, and can become highly constraining in social life (for instance, current and future employers can see your psychiatric history).

psychotherapy, which may not be as true for the general population. Their familiarity with the system means they may anticipate less stigmatization associated with these disorders. On the other hand, these groups are more likely to be primed with the meanings of the disorders and their symptoms, and so may be able to answer more "accurately" knowing the diagnostic criteria for a given disorder. Although it is not clear how these factors may affect the responses, it is worth noting that these questions are not typically administered to a random sample. Nonetheless, the survey showed variation, and the respondents had some identifiable concerns about their psychological well-being. We can safely attribute their concerns to these five areas of mental health disorders.

Independent Variables: God Concepts

The God concept measures were constructed based on Froese and Bader's (2010) book *America's Four Gods*. Using the Baylor Religion Survey, Froese and Bader construct two scales from several survey items asking respondents what God is like. One scale is a measure of God's judgment, while the other is a measure of God's engagement. *America's Four Gods* then splits both of the scales at their means and interacts them so that there are four resulting God concepts in combinations of high and low judgment and high and low engagement. Because judgment and engagement are the two core components by which Americans formulate their God concepts, and also for conceptual clarity, this analysis uses simply the Judgmental God scale and the Engaged God scale. Figure 2 shows the frequency distribution of the Judgmental God concept. We can see that most Americans prefer to think of God as only somewhat judging. The distribution of opinions about God's judgment are almost normally

distributed, though skewed slightly to the left. Most people seem to believe that God does judge, but few people think of God as either very judgmental or not judgmental at all.

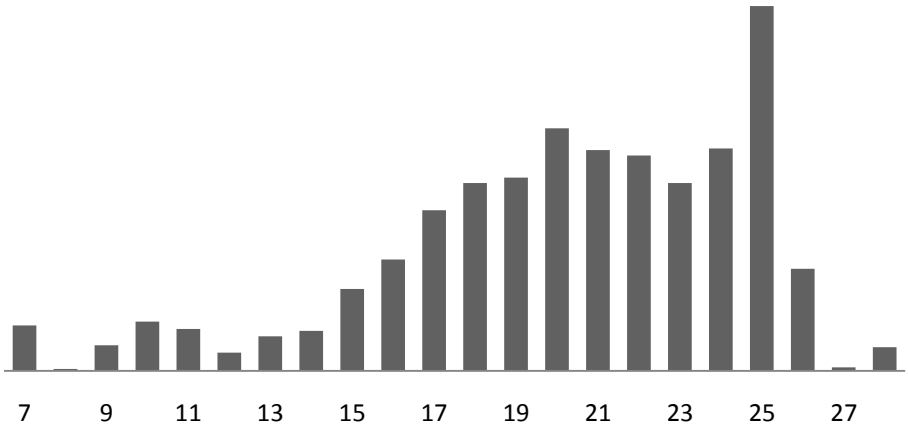


Note: Source is Baylor Religion Survey, Wave III

Figure 2: Distribution of Judgmental God Concept

On the other hand, Figure 3 shows us that most Americans are disposed to think of a pretty highly engaged God, and few think of God as being only slightly engaged. Notice that the median response is quite high, around 25, where the highest response on the scale is 28. Belief in an Engaged God is skewed toward thinking of God as very engaged.

The six items used for the Judgmental God measure from the second wave of the BRS were replicated on Wave III. Respondents were asked to report their agreement the following statements about God: angered by human sin; angered by my sin; critical; wrathful; punishing; and severe. Again, each item used a Likert scale of strongly agree



Note: Source is Baylor Religion Survey, Wave III

Figure 3: Distribution of Engaged God Concept

wrathful; punishing; and severe. Again, each item used a Likert scale of strongly agree to strongly disagree, so the Judgmental God scale runs from 6- 24 and its alpha is .883.

Six items are used to create the Engaged God scale in the first two waves, but not all of the items used for the Engaged God measure were replicated on Wave III of the Baylor Religion Survey. The repeated items ask respondents agreement that God is directly involved in the world; directly involved in my affairs; concerned with the well-being of the world; and concerned with my personal well-being. In addition to these items, I added three other items that ask the degree of agreement that the respondent has a warm relationship with God, feels that God is generally responsive, and feels that God seems impersonal (the last item was reverse coded so that God‟s impersonality is low). All of the items have Likert scale responses from strongly agree to strongly disagree. The resulting Engaged God scale run from 7- 28 and has a Cronbach‟s alpha of .813. Table 2 shows the descriptive statistics of the Engaged God and Judgmental God scales.

Table 2
Descriptive Statistics of God Concept Scales

Variable	Mean	SD	Range	Alpha
Engaged God	20.18	4.44	7 to 28	0.813
Judgmental God	14.79	4.51	6 to 24	0.883

Note: Source is Baylor Religion Survey, Wave III

Religion Variables

In their meta-analysis of studies on religion and mental health, Hackney and Sanders (2003) note that inconsistent measurement of religion largely accounts for the ambiguous results of the relationship between religion and mental health. This study provides an extremely robust measure of religion, including social and private practices of religion as well as belief measures. Additionally, it is my contention that the God concept measures used in this analysis assess some underlying religio-cognitive types that surpass other measures of religiosity in accuracy and predictive power.

In addition to socio-demographic controls, several religion controls are used. First, I control for attendance, since it has a persistent effect on mental health. This item asks respondents to select whether they attend never, less than once a year, once or twice a year, several times a year, once a month, 2-3 times a month, about weekly, weekly or several times a week. Concerning prayer, the BRS asks, "About how often do spend time alone praying outside of religious services?" There are six response options ranging from never to several times a day. I also control for meditation, using an item that asks whether the respondent meditates (yes = 1). One item, often highly predictive of behavior and attitudes, asks respondents to assess the degree to which they

believe the Bible is literally true. The categories are: "The Bible is an ancient book of history and legends," "the Bible contains some human error," "the Bible is perfectly true, but it should not be taken literally, word-for-word. We must interpret its meaning," and "the Bible means exactly what it says. It should be taken literally, word-for-word, on all subjects." Finally, religious tradition is used as a control to offset the effects of denominational affiliation. The control is a modified version of RELTRAD, developed by Steensland et. al (2000). This analysis uses a series of dummy variables for Black Protestant, Evangelical Protestant, Mainline Protestant, Catholic, Jewish, other religion and no affiliation based on the responses to religious affiliation. Regressions are run using evangelical as the reference group.

I also included controls that have shown to be relevant in other literature on this subject. Ellison et al. (2009) showed that beliefs were important in predicting mental health. They included belief in an afterlife and sin beliefs, or belief in human sinfulness. As will be shown below, the Judgmental God concept in some ways measures a sin belief, so no additional measure will be used. The BRS does ask whether what type of afterlife the respondent believes will occur; however, the variation was not considered to be broad enough. Thus, the variable is transformed into a dummy variable, where belief in the afterlife is coded as 1 and not belief in the afterlife as 0.

Demographic Controls

A standard set of socio-demographic controls, as well as controls used in other mental health analyses, are used in this analysis. Education is measured using highest level of education completed, from 8th grade or less through postgraduate work or degree. Income asks respondents to locate themselves in an income category from

$10000 or less, through $35001 - $50000, to $150001 or more. Other controls included in this analysis are gender (female = 1), race (white = 1), age (in years), and marital status (married = 1, all other categories = 0). Additionally, I have also controlled for number of children as family size can be (a) an indicator of socioeconomic status and (b) understood as a stressor that may contribute to mental health concerns (i.e., Ellison et. al 2008). The range is from 0-8 and 8 or more children.

Finally, I have controlled for physical health, which is known to have a high correlation with mental health (i.e., Eldridge, Dawber & Gray 2011). The BRS asks, "Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?" with the response options of never, 1-10 days, 11-20 days, 21- 29 days, and all 30 days. Since the mental health scales runs with poor mental health being high, this variable was left as is, such that poor physical health (i.e., health concerns) are high.

Method

The analyses are conducted by a series of Ordinary Least Squares (OLS) regressions. There are five regression models, one for each of the mental health disorders. Because the dependent variables are log-transformed, the coefficients are interpreted as elasticities.

CHAPTER FOUR

Results

This analysis supports some previous findings on the correlates of mental disorder. As was expected, poor physical health is shown to be a strong, consistent predictor of poor mental health. Every additional 10 days that a person says their physical health is not good leads to a 15% increase (in Social Anxiety) to an 18% increase (in Obsession) in having mental health concerns. Females are significantly more likely to have Generalized Anxiety Disorder, just as is reported by the NIMH. Similarly, whites are quite a bit more likely than non-whites to have Social Anxiety and Obsession. As expected, in four of five models, being married significantly reduces mental health concerns. Married people are anywhere from 16% less likely to have Generalized Anxiety Disorder to 26% less likely to have Social Anxiety Disorder than non-married (that is, single, divorced, separated, widowed and co-habiting) people, confirming some of the wisdom in the literature about the health benefits of marriage. Finally, although income has no effect, education has a significant negative effect on mental health concerns. Because income and education are most often related, perhaps education is serving as a proxy for socio-economic status, rendering the income variable insignificant. In this analysis, more highly educated people are less likely to have mental health concerns, with each additional year of education decreasing the mental health concerns by 6- 8%, depending on the disorder.

Table 3
Effect of a Judging God Concept on Mental Health

Variables	Generalized Anxiety		Social Anxiety		Paranoia		Obsession		Compulsion	
	b	stB	b	stB	b	stB	b	stB	b	stB
DEMOGRAPHICS										
Female	.183*	-.073	-.017	-.005	0.025	0.008	0.079	0.031	-.130	.0.41
White	0.158	-.046	.543***	0.12	0.037	0.008	.343***	0.097	-.010	.023
Age	-.007**	-.082	-.009**	-.087	-.003	-.031	-.007**	-.082	-.005	-0.052
Education	-.022	-.031	-.060*	-.062	-.079**	-.085	-.059*	-.079	-.084**	-.093
Income	-.039	-.059	-.050	-.056	-.046	-.054	.002	.003	-.039	.047
Married	-.161*	-.062	-.264*	-.077	-.243*	-.074	-178*	-.067	-.140	-0.043
Children	0.035	0.03	-.022	-.015	-.005	-.003	0.059	0.053	0.017	0.013
Physical Health	.179***	0.15	.150***	0.095	.147***	0.097	.180***	0.147	.149***	0.101
RELIGION VARIABLES										
RELTRAD										
Black Protestant	0.149	0.02	0.293	0.026	-.008	-.001	.129	-.015	0.21	0.019
Mainline Protestant	0.129	0.05	0.138	0.036	0.121	0.033	.252**	0.085	0.076	0.021
Catholic	-.069	-.024	0.012	0.003	.094	-.026	0.022	0.011	-.018	-.005
Other Religion	0.033	0.01	0.027	0.004	0.013	0.002	-.015	-.003	-.100	.017
No Affiliation	-.198	-.040	-.350	-.052	-.412*	0.064	0.041	0.008	.129	.020
Attendance	-.031*	-.073	-.004	-.006	-.078***	-.141	-.025	-.057	-.047*	-.089
Biblical Literalism	-.011	-.011	-.046	-.035	-.009	-.007	-.035	-.034	-.083[a]	-.067

(Table continues)

Variables	Generalized Anxiety		Social Anxiety		Paranoia		Obsession		Compulsion	
	b	stB	b	stB	b	stB	b	stB	b	stB
Prayer	-.010	-.015	-.026	-.028	-.012	-.014	-.000	-.000	-.016	-.018
Meditation	-.035	-.012	-.069	-.018	0.018	0.005	-.047	.016	-.031	-.009
Belief in Afterlife	-.060	-.017	0.039	0.008	-.090	-.020	-.069	-.019	-.080	-.018
Engaged God	-.012	-.043	-.013	-.034	-.018	-.050	-.010	.-036	0.001	0.003
Judgmental God	0.008	0.03	.033*	0.09	.050***	0.14	.022*	0.076	.038**	0.109
R-square	0.069		0.058		0.084		0.072		0.069	
	N = 1303		N = 1301		N = 1302		N = 1302		N = 1302	

Note: Source is Baylor Religion Survey, Wave III. All regressions are run on the natural log transformations of the dependent variables.
a. Coefficient approaches significance ($p = .058$)
* significant at .05 ** significant at .01 ***significant at .001

The table also displays the sporadic effects of religion predictors when God concepts, or more specifically, the Judgmental God concept, is in the model. Where attendance at religious services was a robust predictor in previous studies, attendance has moderate effects in just two of the five models, and is a strong effect in Paranoia. For General Anxiety, each increase in attendance results in a 3.1% decrease in mental health concerns. For Paranoia and Compulsion, mental health concerns decrease by 7.8% and 4.7% respectively. Attendance has no effect on Social Anxiety or Obsession. Affiliation, too, has almost no effects, except that Mainline Protestants are 25% more likely than Evangelicals to have an Obsessive disorder, and people who do not affiliate with any religion are 41% less likely than Evangelicals to be paranoid. Private religious disciplines like prayer and meditation have no effect on mental health concerns; similarly, the belief items (belief in an afterlife and Biblical literalism) have no effect, except that Biblical literalism approaches significance for Compulsion (with each increase in literal belief in the Bible"s text, Compulsion decreases by 8.1%).

While the literature has shown us that religion variables tend to increase mental health, this analysis shows us the nuances of religiosity when God concepts are considered. Believing in a Judgmental God significantly increases the likelihood of reporting mental health concerns. While, surprisingly, the Engaged God concept has no apparent effect on mental health, Judgmental God is significant in all but one model, the Generalized Anxiety model.

Despite its respectable alpha score, the Generalized Anxiety scale is conceptually less clear than the other scales. When one of the items ("How often have you felt nervous, anxious or on edge?") is removed, Judgmental God is again

significant, as can be seen in Table 4. The frequency distribution of this question is somewhat different than all of the other items; it has a greater number of respondents who answer very often and often (about 6% versus 1-3% in all the other items), indicating that it appeals more broadly to respondents as "normal" behavior or feeling and may not address mental health in the same manner as the other items. Feeling anxious or nervous, even over the course of a month, can be a very normal response to a time-conditional stressor, such as end-of-the-semester exams, beginning a new job, or preparing for an important event. The other items both in Generalized Anxiety and each of the other scales refer to behaviors that do not signal adaptive or appropriate coping, so they more accurately measure mental health disorders.

In the regression for the modified Generalized Anxiety scale, Judgmental God is the only religion variable that is significant. Being female, having a low income, and having poor physical health also increase the likelihood of having this kind of mental health concern. In this model, with every increase in belief in God's judgment, Generalized Anxiety increases by about 2.5%.

Having a Judgmental God concept is a consistent predictor of having mental health concerns, more than other religion variables and even more than many demographic variables. Belief in a Judgmental God has a significant, positive relationship with Social Anxiety, Paranoia, Obsession and Compulsion. Each increase of belief in how judgmental God is increases Social Anxiety by 3.3%. For Paranoia, the increase is 5%. Obsession increases by 2.2% with each increase in God's judgment, and Compulsion increases by 3.8%. Remarkably, Judgmental God is also the strongest effect in the Compulsion model, and is about as strong as the top effects in both Social

Anxiety and Paranoia (the strongest effects in those being physical health and attendance respectively).

Table 4
Effect of Judgmental God on Generalized Anxiety (Modified Scale)

Variables	b	stB
Female	0.245**	0.083
White	0.121	0.029
Age	-.001	-.019
Education	-.054	-.064
Income	-.061*	-.075
Married	-.061	-.052
Children	0.058	0.045
Physical Health	.166***	0.116
RELTRAD		
Black Protestant	0.052	0.005
Mainline Protestant	0.077	0.022
Catholic	-.099	-.028
Other Religion	0.002	0
No Affiliation	-.024	.032
Attendance	-.035	-.068
Biblical Literalism	-.024	-.020
Prayer	-.001	-.001
Meditation	-.101	-.029
Belief in Afterlife	-.0136	-.032
Engaged God	-.029	-.086
Judgemental God	0.026*	0.079
R-square	0.067	

Note: Source is Baylor Religion Survey, Wave III

The field of psychiatry and mental health has been increasingly medicalized in the past several decades, beginning with the introduction of the Diagnostic and Statistical Manual of Mental Disorders (DSM) several decades ago (Kutchins and Kirk 1997). We therefore expect mental disorders to be explained largely by psychological and physiological factors, which are not assessed in this model. That said, the Judgmental God concept along with other primarily social variables, explain a surprising amount of the variation.

CHAPTER FIVE

Discussion

It is probably a fair conjecture that the prophets of the Old Testament experienced a Judgmental God, and perhaps they had what we might think of as maladjustment to the social world. Though not quite as extreme, this analysis finds that people with a Judgmental God concept have some experience of mental health disruptions. In other words, those earlier social scientists who predicted that religion would produce mental disturbance were right- sometimes. Religion *can* disturb mental health but it can also promote it. What this analysis shows us is that measuring the type of religion, through something fundamental like the cognitive construct of God concepts, is absolutely crucial to understanding how religion works in the social, emotional, and psychological lives of believers.

Of course, we cannot tell the causality of the relationships from cross-sectional survey results. We don't know whether such anxiety disorders lead to belief in a judging God or if belief in a judging God leads to anxiety, though we do know that God concepts tend to be formed in early childhood (i.e., Dickie et al. 2006; Potvin 1977) where anxiety disorders are often diagnosed in adolescence and early adulthood (NIMH). On the other hand, Durkheim (1912/1995) would have us believe that God is the sum of the social environment we worship in. In *The Elementary Forms of Religious Life,* Durkheim (1912/ 1995) proposes that societies lift up an image of themselves, their energy and accomplishments, and reify that image as God; God is the embodiment of the collective effervescence. Thus, from a Durkheimian view, people

who have known a social world that is untrustworthy, critical and fear-inducing may produce a similar image of God.

Regardless, believers who experience God as condemning, angry and severe probably see the world that way, empathizing with their god"s perspective. A world deserving of such criticism, and a God who is ready to judge, is understandably a source of anxiety. A person who believes that God is critical and punishing may fear that even her own actions will bring her shame, as Social Anxiety Disorder sufferers do. Along the same lines, believing in a God who sees sin in every human might solicit the expectation that people are untrustworthy, deceitful, or malicious: the symptoms of paranoia. Obsessions, or uncontrollable ruminations, might stem from the notion that one"s mind is corrupted, or from persistent concerns about God"s imminent wrath and punishment. We can understand Compulsivity from the standpoint that God"s perpetual displeasure at sin demands correction, which might lead to the compulsion to perform rituals in the "right" way. Finally, even though only the partial index of Generalized Anxiety showed a significant relationship with Judgmental God, we can anticipate how belief in a Judgmental God might instill a sense of nervousness and uncertainty, inducing anxiety that has no obvious origin. Indeed, it almost appears that belief in a Judgmental God is synonymous with an anxious disposition.

Unexpectedly, in none of the models does the Engaged God concept have an effect on mental health. People who believe in an Engaged God believe that God is active in the world, involved in and concerned with their lives. This belief seems like it would lend itself to greater optimism and, referring again to Collins" (2004) idea of the energy-generating inner dialogue with a perceived other, greater self-solidarity; these

traits are surely conducive to good mental health. On the other hand, perhaps the Engaged God concept simultaneously empowers the believer in certain ways while enervating her in others; sometimes God‟s ways are mysterious and believers must resign themselves to the divine will. An Engaged God, after all, is as likely to correct worldly wrongs as well as reward worldly goods, so the believer may not gain any consolation for anxiety regarding the social world. Thus, a Judgmental God concept augments mental health concerns while an Engaged God concept has no effect.

Another reason for the differential results is that a Judgmental God concept implies consequences; God is displeased with the state of things and is motivated (i.e., critical, punishing, wrathful) to judge. The unpleasant anticipation of such action is not present with an Engaged God concept, as those items do not imply consequences for specific actions, but merely premise that God is "concerned with" and "directly involved in" the world and our lives, and that he is not impersonal, but responsive and warm. A person who finds God to be warm may also believe God to be punishing when appropriate, like a loving parent who administers discipline; both of these characteristics fall within the Engaged God concept. The Judgmental God, however, is one to be feared.

Additionally, it is plausible that believers get what they need in terms of warmth, support and interaction from their church community, such that the Engaged God concept adds little in terms of easing mental health concerns. It simply appears that, as far as mental health is concerned, believing in an Engaged God does not ameliorate the effects of believing in a Judgmental God.

An important speculation from this analysis is that the effect of church attendance, as well as other religious rituals, is dependent upon the kind of God concept a believer experiences. A likely explanation for the benefit of mental health at religious services is that religion provides a coherent worldview and a method for organizing discrete experiences into a cohesive whole, much like Peter Berger describes in *The Sacred Canopy* (1967). For Berger, religion provides a plausibility structure, or a moral order, that protects people from experiencing a chaotic, anomic world. Sharing that plausibility structure with others is what maintains and reifies it. This is the very definition of a religious gathering: a "plausibility community" continually reified by bodily copresence and group rituals, and supported by the symbols of sacred texts and private rituals. The stability offered by a plausibility structure is not something easily measured by quantitative analysis, but is perhaps what is being picked up with a question on frequency of attendance. Naturally, the type of moral order varies according to the type of religion an individual experiences, which is why attendance itself is not a consistent predictor in this analysis. Instead, moral orders depend on God concepts, as the character and mythology of God is the organizing principle for a religious plausibility structure. God concepts underlie basic religious orientation; when we have insight into how a believer understands God, we have insight into their experience of the world and all the attitudes and behaviors that go along with it, including psychological health. God concepts, the cognitive structures and images of a divine being, clearly matter for psychological dispositions.

There are still questions left unanswered concerning God concepts and mental health. Froese and Bader (2010) tell us that God concepts are not consistently tied to

denominations, so we need to discover how God concepts are formed in a community, perhaps at the congregational level. A God concept may be a conglomeration of individuals‟ God concepts, which comes to represent that community; it is that God concept that creates a plausibility structure for that community, and in that sense God concepts are highly personal, or highly interpersonal. This will help to describe more about attendance at a specific church and how that affects mental health. Also intriguing, and much more difficult to assess, is why certain rituals and practices are less effective at mitigating mental health disturbances. Why do meditation and prayer not consistently contribute to well-being? Quantitative or longitudinal analyses would be useful for this sort of study so that researchers can control for religious coping versus what we might be termed preventative religious practices; that is, praying and meditation as a part of a healthy spiritual lifestyle rather than a response to distress. Finally, research on God concepts and mental health could be fruitfully combined with studies on well-being, many of which have been conducted using religion variables. This could illuminate the role of an Engaged God, which may have a greater effect on well-being, life satisfaction or contentment, or feeling a sense of meaning in life.

In conclusion, religion is neither bad nor good for mental health in an absolute sense. Rather, we must understand *what type* of religion a believer experiences to know whether it is beneficial or detrimental. While assessing the religious acts and attitudes is certainly helpful in explaining some of the mechanisms of maintaining good mental health, it is not the whole picture. We need to know, in addition, why believers hold the attitudes they do, and how they process the activities they participate in. A person who attends church frequently and meets there a loving, involved God is reinforced with a

very different cognitive structure than the person who meets a judging, angry God. Someone who believes that abortion is wrong because a loving God is filled with sorrow for the loss of any potential human‟s life is worlds away from someone who believes abortion is wrong because it is murder and the product of the infinite sinfulness of the human race, and these distinctions do not fall out across denominational or political lines. In short, we must know how the beliefs and rituals associated with religion fit into the believer‟s moral order, based on the God concept they maintain, to evaluate religion‟s effects on mental health.

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