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Simple and Multiple Relationships between Dimensions of Religious Practicing According to Islamic Beliefs and General Health

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General health is an important and pervasive issue for all society members, including students. Concerning the presence of various factors, university is a mentally stressful period. In this respect, commitment to religious beliefs and practical attachment to them can be considered an important factor in the prevention of mental traumas and in the improvement of health. The present study aimed to investigate the relationship between dimensions of religious practicing according to Islamic beliefs (RPAIB) and students' general health. The study sample included 375 undergraduate students of Shahid Bahonar University who were selected using stratified random sampling. Tow questionnaires, including GHQ-28 and RPAIB, were administrated and analysed using Pearson correlation method and multiple regression analysis. Results showed that there was a significant relationship between GHQ and its dimensions and RPAIB and the dimensions related to it. Also, based on the results of the regression analysis, one dimension of RPAIB, i.e., commitment to conduction of religious behaviors (CCRB) could significantly predict general health. According to the results, it can be concluded that practical attachment to religious beliefs plays an important role in general health. Also, it can be considered as an effective factor for the students' health in educational and preventive interventions in educational environments.

***Keywords*:** general health (GH), dimensions of religious practicing according to Islamic beliefs (RPAIB), commitment to conduction of religious behaviors (CCRB)

Health is a state of complete physical, mental and social well-being, but not merely the absence of disease or infirmity. Literature reviews showed that spiritual beliefs, as materialized in religious practicing, are among the most important predictors of mental health. For example, in an outstanding attempt, all measures of religious commitment reported in the American Journal of Psychiatry and Archives of General Psychiatry between 1978 and 1989, were assessed and the proportions of studies that reported positive, neutral, and negative relationships between religiosity and mental health were examined (Larson et al, 1992). The meta-analysis revealed that for the majority of the measures assessed, the studies reported a positive relationship between religious commitment and general health. This is partly because faith and religious belief help curing mental disorders (Qobari Bonab, 2001). Therefore religious commitment and practicing rituals strengthens the characteristics like sacrifice, reliance upon God, patience, feeling of responsibility about ourselves and others, positive attitude about life and to have friendly emotions toward others. Accordingly, religious beliefs have remarkable effects on nearly every aspect of one's life (James, 2008; James & Wells, 2003). In addition, religious beliefs increase life satisfaction and happiness and decrease one's vulnerability to mental and physical disease when one encounters stressful events (Ellison, 2001).

Divine instructions direct human beings' nature toward perfection and divinity. If one accepts these rules and instructions, to obey them constantly and to insist to do rituals in any conditions, her/his mental capacity may increase, and consequently calmness and assurance will always be with him (Hoseini, 2006).

In religious doctrine, God's recitation and practicing religious rituals may lead to calmness and tranquillity of the soul, to life

meaningfulness for individuals, and to overcoming disappointment and despair (Faqihi, 2005). James (2008) believes that if there is anything that its possession is precious, one should spend time for it during routines. Then someone might decide that they need a daily recitation program to constantly protect the spiritual behavior and to protect higher spiritual dimensions. Literature review of the previous studies show findings that support the evidence of a positive relationship between RPAIB and general health aspects including relationship between general health (physical-mental) and Islamic beliefs (Nateqiyan, 2008); between fasting in Ramadan and a boost in the general health of nursing college students (Shafi'ie, N., Tavakoli, M., Raf'ati, F., & Kazemi, M., 2003); between doing religious beliefs and general health (Tahmasbi & Amini, 2006), and between participation of individuals in religious rituals and their general health (Moreira, Lotufo-Neto & Koeing, 2006; Levin, J., Chatters, L., & Taylor, R. J., 2005). Furthermore, higher levels of spirituality were correlated with lower levels of depression and physical symptoms (Carmody, Reed, Kristeller & Merrian, 2008). There are several aspects to religion and general health and some researchers have investigated these aspects (Allport, 1968). Allport and Ross (1967) distinguished between two religious orientations, intrinsic and extrinsic. According to this theory, for individuals with intrinsic orientation, religion is for religion, while in the model of extrinsic religion, it is emphasized on religion because of the achievements of religiousness. According to Allport, religion is a spectrum that, on one hand, has an instrumental meaning for people and on the other hand is a kind of seeking a sense of meaning that in itself is the main motivation in life and has an intrinsic value. For persons with intrinsic religious orientation, although non-religious needs are

essential, they have less ultimate significance (Dezutter, Soenens & Hutsebaut, 2006). For these people religion unites the mental composites of the person practicing it and helps flourishing the many aspects of their personality and determinates their willfulness and they become more thoughtful and understanding with regards to life events (Allport, 1967). Studies (Karami, Roghanchi, Attari, Beshlideh & Shokri, 2006; Khodapanahi & Khaksarbeldaji, 2005; Comstock, & Partridge, 1972; Batler, 1998) showed the following results: One can say for better practicing religious beliefs, it is needed to have a strong set of essential beliefs and if, as time grows old, these beliefs are weakened, this can be a serious threat to the individual's general health. Also, Allport's viewpoint (1967) of the extrinsic orientation corresponds with this, individuals with extrinsic religious orientation have just beliefs with instrumental purposes, and to these persons religion has been seen as a means to achieve other goals and other values such as coping with life problems or improvements. Therefore, they lack a sense of mental wholeness in their personality. According to psychologists, most of the mental problems of people which are related to mental distresses and life stressors, are seen among those with a weak sense of religiosity orientation (Jafari, 2005). Some of these individuals, due to a lack of enough information about themselves and their inner processes as mentioned in the religious teachings, neglect themselves in interpersonal relationships, since they don't entitle themselves as respectful, can't establish healthy and proper relationships with others which leads to mental and physical distresses such as, depression, anxiety, migraine, hypertension etc. (Soleimanifar, 2007). The results of several studies (Maddahi, Samadzade & Keikhafarzane, 2011; Khodapanahi & Khaksarbaldaji, 2005; Fearn, Lewis & Francis, 2003; and Ross, Francis & Craig, 2005)

show that there is a significant relationship between extrinsic religious orientation and general health. Allport and Ross (1967) hold that religious orientations are important determinants of religious practices and are tools to evaluate life stressors. However, based on the literature review it seems that in most of the previous studies, both the religious beliefs and general health are considered as the whole composites, but were not studied on the level of their dimensions. Hence, according to the theoretical studies and the literature review of the important and influential role of religious beliefs in the health of individuals, and since in the college students population of our study with its unique cultural context, research in the area of commitment to religious beliefs and the general health factors of individuals is scarce; the present study aims to examine simple and multiple relationships between dimensions of religious practicing according to Islamic beliefs and general health.

Method

Participants

In this descriptive study, 375 undergraduate students were selected from Shahid Bahonar University of Kerman (N=14,648: females=8103 & males= 6545) in the 2013 academic year. The sample size was defined by means of the Cochran method (Cochran, 1950); and using stratified random sampling. To analyse data, Pearson correlation method and enter multiple regression method were used.

Materials

The General Health Questionnaire [GHQ-28] (Cochran, 1950) was employed to measure general health. The GHQ-28 is a 28-item measure. The GHQ-28 has been divided into four subscales: somatic symptoms (items 1-7); anxiety/insomnia

(items 8-14); social dysfunction (items 15-21), and severe depression (items 22-28). In the GHQ-28 the respondent is asked to compare his recent psychological state with his usual state. For each item four answer possibilities are available (1-not at all, 2-no more than usual, 3-rather more than usual, 4- much more than usual). In the study, the Likert scoring procedure (0, 1, 2, and 3) is applied and the total scale score ranges from 0 to 84. The higher the score the poorer the psychological well-being of the patient.

If the total scores are employed, then the cut-off score of 28 should be used. Scores more than 28 addressing an issue of psychological concern (Taqavi, 2001). In a study titled "epidemiological study of mental disorders in urban and rural areas in Guilan (N=625)", Yaqoubi, Nasr and Mohammadi (1995) stated that reliability and validity coefficients of the Persian version of GHQ-28 were 0.88 and 0.84, respectively. They also mentioned that its internal validity was .92.

In addition, a 28-question questionnaire Religious Practicing According to Islamic Beliefs (RPAIB) was used to measure students' religious practicing. This questionnaire consists of three dimensions. Each question has five options namely "completely agree, agree, relatively agree, disagree and completely disagree". Each option has a score from 1 to 5, with completely agree being the highest and completely disagree being the lowest. Its validity was calculated to be .85 based on viewpoints of ten Clergymen and faculty members; its reliability was .93 according to factor analysis and high internal consistency with Crobach's alpha for the whole scale, .89, .88 and .80 for dimensions of Commitment to Conduction of Religious Behaviors (CCRB), Commitment to Religious Orders (CRO) and Commitment to Respects Rights and Mutual Relationships (CRRMR), respectively (Khajouei Mirzadeh,

Rahmati and Fazilat pour, 2013).

Results

The psychological outcomes were Physical Anxiety & Sleep, Social Functioning and Depression. The predictors were CCRB, CRO and SRRMR. Means, standard deviations and the sample sizes for each of the factors are presented in Table 1.

Table 1

Means, SDs and the Sample Sizes for each of the Extracted Factors

Variable	Variable	N	Mean	SD
	Physical	375	7.50	4.44
GH	Anxiety & Sleep	375	8.50	4.53
	Social	375	9.68	3.91
	Depression	375	5.05	4.94
	GH	375	30.75	14.33
RPAIB	RB	375	114.8	17.40
	CCRB	375	34.36	7.69
	CRO	375	42.95	6.69
	SRRMR	375	35.98	5.35

As shown in Table 2, there were significant correlations between RPAIB and Physical disorder, $r_{xy}(375)= -.146$, $p<.01$; CCRB, $r_{xy}(375)= -.141$, $p<.01$; CRO, $r_{xy}(375)= -.131$, $p<.05$, all the correlations (except for SRRMR) were addressing the significant relationship between the religious practicing according to Islamic beliefs and its dimensions with physical disorders aspect of general health.

Table 2

Pearson Correlation Coefficients between RPAIB and its Dimensions with GH, and its Dimensions

	RPAIB	CCRB	CRO	SRRMR
Physical Disorder	-.146**	-.141**	-.131*	-.098
	.005	.006	.011	.058
	375	375	375	375
Anxiety and Sleep Disorder	-.128*	-.135**	-.113*	-.070
	.013	.009	.029	.179
	375	375	375	375
Social Functioning Disorder	-.162**	-.143**	-.163**	-.108*
	.002	.006	.001	.037
	375	375	375	375
Depression	-.319**	-.296**	-.268**	-.253**
	.0001	.0001	.0001	.0001
	375	375	375	375
General Health	-.240**	-.227**	-.213**	-.169**
	.0001	.0001	.0001	.001
	375	375	375	375

** p≤.05 ** p≤.01 (2- tailed)*

In addition, similar pattern was observed for the Anxiety and Sleep Disorders; whereby significant correlations were observed between Anxiety and Sleep Disorders with RPAIB, $r_{xy}(375)= -.128$, $p<.05$; CCRB, $r_{xy}(375)= -.135$, $p<.01$; CRO, $r_{xy}(375)= -.131$, $p<.05$. No significant relationship was found between Anxiety and sleep disorders with SRRMR.

Moreover, significant negative correlations were found between Social functioning disorder and RPAIB, $r_{xy}(375)= -.162$, $p<.01$; CCRB, $r_{xy}(375)= -.143$, $p<.01$; CRO, $r_{xy}(375)= -.163$, $p<.05$, and SRRMR, $r_{xy}(375)= -.108$, $p<.05$; all the correlations showing significant relationships between RPAIB

and its dimensions with social functioning disorder. Furthermore, significant negative correlations were found between Depression and RPAIB, r_{xy} (375)= -.319, p<.0001; CCRB, r_{xy}(375)= -.296, p<.0001; CRO, r_{xy}(375)= -.268, p<.0001, and SRRMR, r_{xy}(375)= -.253, p<.0001; all the correlations showing significant relationships between RPAIB and its dimensions with Depression. Finally, significant negative correlations were found between general health and RPAIB, r_{xy}(375)= -.240, p<.0001; CCRB, r_{xy}(375)= -.227, p<.0001; CRO, r_{xy}(375)= -.213, p<.0001, and SRRMR, r_{xy}(375)= -.169, p<.0001; all the correlations showing significant relationships between RPAIB and its dimensions with general health**.** To predict general health based on dimensions of RPAIB (CCRB, CRO and SRRMR), the multiple regression method was used. Results of Table 3 indicate that the regression model has sufficient reliability in the error level of .01.

Table 3

Regression Variance Analysis

F	Mean Squares	DF	Sum of Squares	Model
	1488.71	3	4466.13	Regression
7.80**	190.83	371	70798.55	Remained
	-	374	75264.68	Total

**P<0.01

According to the results of Table 4, among the variables entered the model, CCRB could predict negatively and significantly (p<.05, β=-.15) the variable of "general health" among students of Bahonar University; however, CRO (p>.05, β= -.08) and SRRMR (p>.05, β= -.04) were not significant

predictors of general health. In addition, R^2_{adj} showed that about 5% of the variance of general health was predicted by CCRB.

Table 4

Regression Coefficients and Summary of Regression Model Standard error of Non-Standard Coefficient

R^2_{adj}	T	Standard Coefficients	Standard error of non-Standard Coefficient	Non- Standard Coefficient	Predicting Variables
	9.59**	-	5.41	51.86	Constant
	-2.02	-.15	.13	-.27	CCRB
.05	-1.12	-.08	.16	-.18	CRO
	-.71	-.04	.17	-.12	SRRMR

**P<.01 *P<.05

Discussion

The findings resulted from the Pearson method showed a significant relationship between RPAIB and the students' general health, the more the students were practicing religious rituals according to the Islamic beliefs the higher was their general health. According to the findings, it must be noted that useful and positive effects of religion and religiosity mainly emerge in the light of the internal faith, acceding to warrant of such faith in practice and continuing the practices (Allport, 1967). Faith and belief in almighty God, along with following the religious orders according to Islamic beliefs are factors that decrease the mental symptoms. An individual with religious

beliefs is confident that the God is before him/herself. The individual admits that the God won't forget him even a moment while facing with crises. Such the person, never afraid of defeat, even when it might experience the feelings of scaring, worrying, weakness, inability, despair. These findings are in line with those studies which showed positive correlation between general health and the conduction of the religious beliefs (Alavi, 2003; Shafi'e et al, 2003; Tahmasbi & Amini, 2006). In addition, the findings are in line with Merrill & Salazar (2002), who found that people were doing rituals in church are less affected by mental disease conditions than those who were irreligious or those religious individuals who were not members of church. The findings are similar to Chapple (2007), who have reported a positive relationship between religion and general health. More specifically, the present study showed the relationship between RPAIB and physical disorders and this is in line with Nateqiyan (2008). Nateqiyan showed a negative and significant relationship between believing in Islamic beliefs and disorder in physical symptoms. The same findings are reported by Taleqani, Roghanchi & Shokri (2006), showing that the more religiously orientated were the students, the less they showed elevation in physical disorder symptoms. Moreover, Omidiyan & MollaMa'soumi (2006), showed a significant negative relationship between being religious in cognitive and behavioral dimensions and disorder in physical symptoms. Finally, Koch (2004), showed that religion plays a positive role in the physical health of those with low-income life; and also, spirituality and religion play a positive role in the physical health of individuals and even in improvement of cancerous patients (Carmody et al., 2008; Koffman et al., 2008). One explanation for such a relationship is that Islamic beliefs and physical health is indirectly lead to arrangement and cohesion in life style which

causes balance in bio-mental processes.

The other findings from the present study was a negative and significant relationship between RPAIB-S and sleep disorder which means the more practical obligation they have to Islamic beliefs, the less their stress and sleep disorder will be, and this is in line with the previous studies (e.g., Jalilvand, 1997). Interestingly, this is similar to the previous studies addressing the effect of listening to the Quran recitation before surgery on decreasing the patients' stress (Tajvidi, 1997).

As a third finding, we found a negative and significant relationship between practical obligation to Islamic beliefs and disorder in social functions of the students. And this is in line with Omidiyan & MollaMa'soumi (2006), who showed a reverse and significant relationship between religious attitudes as cognitive and behavioral, and disorder in social function. Similar findings coming from Taleqani et al (2006), who showed significant relationship between religious orientation and disorder in social function of students (see also Nateqiyan, 2008).

A closer look at the findings showed that both the RPAIB as a scale or as dimensions are predicting general health. Interestingly, general health and its four dimensions were predicted significantly by Commitment to Conduction of Religious Behaviors (CCRB), and Commitment to Religious Orders (CRO). However, the pattern for Commitment to Respects Rights and Mutual Relationships (CRRMR) was different by which CRRMR only predicts social functioning disorder, depression and the general health. Physical disorder and anxiety and sleep disorder were not being predicted by CRRMR. The findings of the present study gave further support to the notion than practicing religious beliefs as measured by RPAIB and its components predicted the general health and its

components including anxiety, depression, sleep disorder, and social functioning disorder. Findings are in line with the previous research where the relationship between components of general health and practicing religious beliefs were highlighted (e.g., Jalilvand, 2004), worship and having relation with superior power was found to play the role of a preventing agent to depression (Doolittle & Farrel, 2004). In addition, the findings are in line with previous research showing that religious orientation and spirituality play a key role in depression relief of pregnant women (Mann et al., 2008), and the levels of covert and overt anxiety were significantly lower among individuals with higher levels of religious commitment than the other individuals (Azimi & Zarghami, 2004). It is important to recall that as emphasized by Newman and Pargament (1990), religion is an important predictor of hope, intimacy with others, and emotional calmness; it provides people with self-actualization opportunities, and helps to maintain the feeling of comfort, impulse control and to promote effective problem solving. In addition, commitment to religious belief has shown positive effects on general health, presumably because the individuals believe in the almighty God and practicing the religious rituals to help them when they encounter problems and will support them when they feel they are in need of confidence to a superior power (Clary, 1996).

In explaining the results of the regression analysis, it can be inferred that although there is a tendency, in the opinion and belief step, towards religious teachings in various aspects of human social and mental life including mental health and well-being, we all know that the mere presence of the belief or tendency in the step of stating and expressing beliefs or opinions does not guarantee practical attachment to these beliefs or commands. Based on psychologists' view point, Jafary (2005)

emphasizes that most mental illnesses resulted from psychological distress and life crises are found in people who are weak-kneed and weak at religious beliefs. According to Allport & Ross (1967), there are some people with external religious orientation and superficial beliefs who use religion as a means to achieve other objectives. In other words, they move towards God without leaving themselves. For this group of people, religion means external benefits and therefore they lack personal growth and cohesion of psychological elements. This is the religion which, according to Freud, ends in neuroticism. As Taleqani et al. (2006) point out, observing and practicing religious beliefs to get optimal effects requires strong underlying beliefs, and if the effect of these beliefs on the actions gets weaker over time, it can be a serious threat for people's health. Findings of this part of the study are in line with results of several studies (Maddahi et al, 2011; Khodapanahi & Khaksar Boldaji, 2005; Fearn et al, 2003; and Ross et al, 2005). Again, we know that if there is an impact on religious beliefs, it is undoubtedly in the step "practical commitment and internal attachment to them". Strictly speaking, according to Allport & Ross (1967), when people with internal religious orientation believe in something, they do their best to internalize that belief and to practice it completely. Religious tendencies in such people result in integration of psychological elements, growth and development of most of their personal traits and strength of their wills; they also make people resistant against stressful and unpleasant events and thus guarantee their health and well-being. Generally, according to Goldberg et al. (1979), an important action of religious activities and practices should be to empower individuals against stressors. Under these circumstances, people who are deeply and practically committed to their religious beliefs, evaluate themselves in accordance with

the lofty religious figures and view their problems from superior viewpoints. This characteristic is associated with the positive impact on their health. These findings are in line with results of some research conducted by Karami et al. (2006), Khodapanahi and Khaksar Boldaji (2005), Comstock and Partridge (1972) and Batler (1998). Also, it can be said that health requires harmonious relationships with others, reformation and modification of personal and social environment and resolution of personal desires and conflicts reasonably, justly and appropriately. Thus, general health always requires an aspect of interpersonal relationships (Aghabakhshi, 2009).

Religious teachings also stress the importance of effective and productive personal rights and relations and its role in people's health. It seems that people who cannot establish constructive, stable, reasonable and balanced relationships with others are passive people who are not aware of their own human values and thus ignore themselves in their relationships due to lack of awareness of individual rights and lack of a positive image of themselves. Such people have low self-esteem and since they do not consider themselves worthy of respect they cannot have a healthy and balanced relationship with others; it leads to healthy and balanced physical and psychological ailments such as depression, anxiety, migraine, hypertension, etc. (Soleimani Far, 2006).

Suggestions

Based on the findings, parents, teachers and supervisors of student affairs, as practical models, are proposed to be pioneer in commitment to religious behavior, to internalize religion in its real meaning and to be attached to it completely. Commitment of these people to religious beliefs guarantees students' attachment and commitment to religious orders, because

students are mainly affected by their behavior rather than their spoken language. Another point is that methods of presenting and evaluating religious courses must be reviewed and modified; at present, the courses "religious knowledge" are among the courses which are studied merely to get a good mark and to supply reader's apparent benefits, but not to create and strengthen internal commitment.

Limitations

The current study has a limitation that call for a cautious interpretation of some of the results. The collected data like the similar studies that are based on the participants responses are subject to further considerations; therefore, it recommends further investigations with the larger samples from the other universities.

Conclusion

To summaries, the findings from the present study and the corroborated findings on the literature review implicate the emphasis on religion practicing as an important predictor of general health and these findings might have important implications both for the general health promotion and for the prevention programs in educational settings.

References

Alavi, H. (2003). *Study of the condition and factors related to mental health, religious behavior and attitude of university students and students of martyred fathers in Kerman city*. Kerman: Pedagogy & Education Research Cent.

Allport, G. W., & Ross, J. M. (1967). Personal religious orientation and prejudice. *Journal of Personality and Social Psychology*, *5*, 423 – 443.

Allport G. W. (1968). *The person in psychology*. Boston: Beacon Press.

Aghabakhshi, H. (2009). *Life skills.* Firth edition. Office of Social Plan and Cultural Studies of Ministry of Science. Research and Technology: Tehran.

Azimi, Z., & Zarghami, M. (2004). Investigation of religious resistance and anxiety of students of Mazandaran University of Medical Sciences, *Abstracts of articles in 2th mental health seminar*. Tehran, Tarbiat Modarres University, Iran.

Batler, M. (1998). Not just a time out: change dynamics of prayer for religious couples in conflict situations. *Family Process*, *37(4),* 451-475.

Carmody, J., Reed, G., Kristeller, J., & Merrian, P. (2008). Mind fullness, spirituality and health– related symptoms. *The United States Journal of Cardiovascular Prevention and Rehabilitation, 64(4),* 393-403.

Chapple, E. P. (2007). Mental health and religion a guide for service providers. *The American Journal of Academy of Religion, 75(4),* 875-895.

Clary, R. A. (1996). Religion and psychology save ideals and beliefs. *A. P. A. Monitor, 27(18),* P. 47.

Cochran, W. G. (1950). The comparison of percentages in matched samples. *Biometrika Journal, 37,* 256-266.

Comstock, G. W., & Partridge, K. B. (1972). Church attendance and health. *Journal of Chronic Diseases, 25,* 665-672.

Cronbach, L. (1970). Coefficient alpha and the internal structure of tests. *Psychometrica, 16,* 197-334.

Doolittle, B. R., & Farrel, M. (2004). The association between spirituality and depression in an urban clinic. *Journal of Clinical Psychology, 6(3),* 114-118.

Dezutter, J., Soenens, B., & Hutsebaut, D. (2006). Religiosity and mental health: A further exploration of the relative

importance of religious behaviors versus religious attitudes. *Personality and Individual Differences*, *40*, 807-818.

Ellison, C. G. (2001). Introduction to symposium: 'religion, health, and well- being'. *The American Journal of the Scientific Study of Religion*, *37(4),* 692- 694.

Faqihi, A. (2005*). Mental health in science and religion*. Qom: Green Life.

Fearn, M., Lewis, C. A., & Francis, L. J. (2003). Religion and personality among religious studies students: A replication, *Psychological Report*s, *93*, 819-822.

Goldberg, D. P., & Hillier, V. F. (1979). A scaled version of the general health questionnaire. *Psychological Medicine*, *9*, 139-145.

Hoseini, A. (2006). *Mental health principals* (primary study of mental health, Psychotherapy and programming in Islam ideology). Mashhad: Astan Guds Razavi.

Jafari, A. (2005). The relationship between religious orientation (internal-external) and stress preventive methods among students of Abhar Islamic Azad University. *Journal of Behavioral Sciences, 1(1),* 91-114.

Jalilvand, M. A. (2004). Investigation of relation between mental health and obeying on religious beliefs in students. *Second national seminar of students' mental health*. Tehran, Tarbiat Modarres University, Iran.

Jalilvand, M. A. (1997). The relationship between praying and stress among students of Tehran high schools. *Teaching & pedagogy research center*, Tehran research assembly of teaching & rearing.

James, A., & Wells, A. (2003). Religion and mental health: Toward a cognitive-behavioral framework. *The British Journal of Health Psychology*, *8*, 359-376.

James, W. (2008). *Religion psychology*. (Translated by Masoud Azarbayjani). Qom: Research Institute for Islamic Studies of Hawzeh & University.

Karami, J., Roghanchi, M., Attari, Y., Beshlide, K., & Shokri, M. (2006). Studying simple and multiple relationships between dimensions of religious orientation and mental health among students of Kermanshah Razi University. *Journal of Educational Science & Psychology*, *13(3)*, 31-52.

Khajouei Mirzadeh, A., Rahmati, A., & Fazilat pour, M. (2013). Validation and factorial structure of the scale for religious practicing according to Islamic beliefs- RPAIB. *International Journal of Psychology*, *7 (1)*, 75-86.

Khodapanahi, M. K., & Khaksarbaldaji, M. A. (2005). Relationship between religious orientation and psychological adjustment in students. *Journal of Psychology, 9 (35),* 310-320.

Koch, J. R. (2004). 'Is religion a health resource for the poor? *The American journal of Social Science*, 45(3), 497-503.

Koffman, J. M., Edmonds, P., Speck, P., & Higginson, I. J. (2008). I know he controls cancer: The meanings of religion among black Caribbean and with British patients with advanced cancer'. *The New England Journal of Science and Medicine, 67(5),* 780-789.

Larson, D. B., Sherrill, K. A., Lyons, J. S., Craigie, F. C. Jr., Thielman, S. B., Greenwold, M. A., & Larson, S. S. (1992). Associations between dimensions of religious commitment and mental health. *The American Journal of Psychiatry and Archives of General Psychiatry*: 1978-1989. Apr; 149(4), 557-9.

Levin, J., Chatters, L., & Taylor, R. J. (2005). Religion health in African Americans: implications for physicians. *The*

American Journal of the National Medical Association, 97(2), 237-249.

Maddahi, M. A., Samadzade, M., & Keikhafarzane, M. M. (2011). Studying the relationship between religious orientation and psychological wellbeing of students. *Journal of Educational Psychology, 2 (1),* 53-63.

Mann, J. R., Mckeom, R. E., Bacon, J., Vesselinor, R., & Bush, F. (2008). Religiosity, spirituality, & antenatal anxiety in southern U.S. women. *Archives of Women's Mental Health, (11),* 19-26.

Merrill, R. M., & Salazar, R. D. (2002). Relationship between church attendance and mental health among Mormons and non-Mormons in Utah. *The London Journal of Mental Health, Religion and Culture, 5(1),* 17-33.

Moreira, A. A., LotufoNeto, F., & Koeing, H. G. (2006). Religiousness and mental health. (Special Article*). The Brazil Journal of Revistabrasileria De Psiquiatria, 28(3),* 242-250.

Nateqiyan, S. (2008). Study the relationship between believe in Islamic beliefs and general health among B.Sc. Payam Noor University Students of Karaj City. *Abstracts of articles in 4th mental health seminar*, 22th& 23th of May 2008, Shiraz University.

Newman, J. S., & Pargament, K. I. (1990*).* The role of religion in problem solving process. *Review of Religion, 31*, 390-403.

Omidiyan, M., & Molla Ma'soumi, E. (2006). Study the simple- and multi-relationship between being religious, native and marital status and mental health of Yazd University female students. *Abstract of articles in 3rd seminar of students' mental health*, 24th& 25th of May 2006. Tehran University.

Qobari Bonab, B. (2001). A study about common domain of religion and psychology. *Journal of Social Science (Human Science Methodology),* University and Theological School. 7th year, *29*, 97 -108.

Ross, Ch. F. J., Francis, L. J., & Craig, Ch. L. (2005). Dogmatism, religion, and psychological type. *Pastoral Psychology*, *53*, 483-497.

Shafi'ie, N., Tavakoli, M., Raf'ati, F., & Kazemi, M. (2003). Effect of fasting in Ramadan month on mental health of Jiroft Nursing college students. *Rafsanjan Journal of Medical Sciences University*. Kerman: Medical Sciences University.

Soleimani far, S. (2006). *Study the charactristics of young people from qoran viewpoint. Psychological, hadith and sience*. Farhang Maktoub Publication: Tehran.

Tahmasbi, S., & Amini, M. (2006). Relationship between mental health and doing religious beliefs among Tehran rehabilitation & welfare university students. *Abstracts of articles in 3rd seminar of students' mental health*, 24th& 25th of May 2006. Tehran University.

Tajvidi, M. (1997). *Study the effect range of Holy Quran sound on patients' stress before surgery in chosen hospitals of Tehran*. M. A. Thesis. Tehran.

Taleqani, N., Roghanchi, M., & Shokri, M. (2006). Relationship between religious orientation and mental health of Razi University students. *Abstracts of articles in 3rd seminar of students' mental health*, 24th& 25th of May 2006. Tehran University.

Taqavi, M. R. (2001). Credit validity of the general health questionnaire. *Journal of Psychology,*4(4), 38-398.

Yaqoubi, N., Nasr, M., & Shahmohammadi, D. (1995). Epidemiological study of mental disorders in urban and

rural areas in Somee Sara (Guilan). *Iranian Journal of Clinical Psychology and Psychiatry*, *4*, 55-65.

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