A Meta-Analysis about Researches on Relationship between Religious Orientation and Mental Health and Depression in Iran

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ABSTRACT: Purpose of this research was to Meta – analysis about researches on relationship between religious orientation and mental health and depression in Iran. Therefore five questions were proposed about relationship between religious orientation and mental health and depression. For answering these questions, from among researches on relationship between religious orientation and mental health and depression which have been done at throughout of Iran, 10 researches which were acceptable in terms of methodology and have inclusive criteria, were selected for meta-analysis. These 10 researches contained 7 effect sizes about relationship between intrinsic religious orientation and mental health, 5 effect sizes about relationship between extrinsic religious orientation and mental health, 3 effect sizes about relationship between religious orientation and mental health, 3 effect sizes about relationship between intrinsic religious orientation and depression and 3 effect sizes about relationship between religious orientation and depression. Based on results of this meta–analysis effect size of relationship between intrinsic religious orientation and mental health was 0.272, effect size of relationship between extrinsic religious orientation and mental health was -0.135, effect size of relationship between religious orientation and mental health was 0.296, effect size of relationship between intrinsic religious orientation and depression was -0.171 and effect size of relationship between religious orientation and depression was 0.409. Results of this meta–analysis showed that effect size of rate of relationship between intrinsic religious orientation and mental health, extrinsic religious orientation and mental health, religious orientation and mental health, and intrinsic religious orientation and depression is moderate and effect size of rate of relationship between religious orientation and depression is above of moderate based on Cohen’s interpreting criteria; These results clears the important of providing ground for strengthening intrinsic religious orientation.

Key Words: religious orientation, mental health, depression, meta –analysis

INTRODUCTION

Mental health is considered as one aspect of health. According to World Health Organization (WHO), the definition of health is: the complete physical, mental and social comfort, and not merely the absence of disease or disability (Kaplan and Sadock, 2000).

"Mental health" as one components of "health" in line with "physical health" has always been in the center of attention for many scientists. Since mental health is influenced by several factors, it has changed throughout history. Now the "Bio-Psycho-Social" theory is a prominent theoretical viewpoint that its main hypothesis is interaction of biological, psychological, mental and social factors in determination of health and disease (Taylor, 1995, quotes Tabarraie, Fathi Ashtiani, and Rasoul Zade Tabatabaie, 2008). Therefore, true understanding of mental health as a biological - psychological-social phenomenon requires a correct understanding and interpretation of the related issues and that should be focused in the framework of the fundamental underlying factors and modulators. For high levels of mental health, it is required that all the levels and aspects of it be coordinated and integrated with each other (Adlyn et al, 1999, quoted from Tabarraie et al, 2008).
The brief analysis of various models of mental health and also opinions of experts, suggest that despite the efforts to achieve a comprehensive definition of the concept of mental health, and the partial success in this field, a comprehensive analysis of its nature has not yet been provided (Hobby, 2003). If the view to human being and studying various aspects of its existence and among them, its psyche and related matters such as mental health, be performed merely on the basis of empiricism, man deprives himself from the knowledge about himself and the world and stays in a limited epistemology. One of the important challenges in this field is overlooking human spiritual life and inattention toward some parts of knowledge that has come to man through revelation (Tabbarraie et al. 2008).

Accordingly, several authors (including Hobby, 2003, Esfahani, 2003, Miller and torson, 1999, quoted from Tan and Natalie, 2001) suggest that by entering divine knowledge in recognition of human existential identity and his mental-spiritual aspect and also considering factors that religion discusses for comfort and serenity, efforts to achieve a broader perspective of the concept of psyche and mental health are possible. One factor that is increasingly focused on its role in promoting mental health is religion (Tabbarraie et al 2008).

Human need to religion is as old as history. Because from the beginning of human life, man felt it necessary to have a strong support. The issue of religion has been discussed by some pioneering psychologists such as James (1929), Freud (1907) and Yung (1961-1875) and afterwards some thinkers such as Allport has tried to explain the role of religion (quotes Bahrami Ehsan and Tashk, 2005). Jung the mental analyst believed that religious concepts best explain human and psychology could not be realized except by religion. Stanley Hall (1881) who is also among the founders of Physiological Psychology has done some experimental researches in the field of religious psychology (quotes Bahrami Ehsan and Tashk, 2005).

Despite the cynical view of psychologists to the whole system of religion, from the very beginning of the formation of Applied Psychology, research on religion and mental health, often shows a positive relationship between these two variables. Since the 50s, researches have revealed the influence of religious interventions to improve the psychological suffering (Wulff, 1997). Since the 90s, following the relative failure of mental health professionals in the conventional intervention techniques and followed by several studies the results of which showed positive effects of religion on mental health, people increasingly turned to religion.

Religion on the whole has a positive effect on mental health (Ventis, 1995). Neelman, Halpern, Leon and Lewis (1997) in a cross-cultural study in 19 Western countries, which were performed on 28,085 subjects, found that as much as people have greater adherence to the religion, the degree of their tendency to commit suicide is lower. The studies also indicate the influence of religion in reducing depression and an inverse relationship between religion and depression has been observed (wulff, 1997). The study of factors such as self-esteem which cause depression also indicates the positive effect of religion on it (Bahrami Ehsan, Tamanaeifar and Bahrami, 2003).

Therefore, it is not surprising that psychologists accept "religion" as a key variable in people's lives, study it as an important source of influence on beliefs, attitudes and behavior and regard it as an integral component in psychological analysis (Tabbarraie, et al, 2008).

But with view to the history of researches on religion and mental health, it can be concluded that despite the accordance of the most performed researches about a positive relation between religion and mental health, there is disagreement about how the mechanism of the religiosity affects the mental health components (Tabbarraie, et al, 2008). Researchers and experts in various fields (psychology, sociology and medical sciences) have shown interest in this topic that how religion affects mental health (Baston, Schoenrade and Ventis, 1993, Koing and Larson, 2001). According to the opinion of some researchers, religion with influence on life style and how to resolve conflicts of values answers two fundamental questions about the purpose of life and the significance of human activities and talents (Berammer, Abrego and Shostrom, 1993, quoted from Janbozorgi, 2008) and thus, helps the integration of psychological and spiritual organization and self-regulatory of human being. Religion provides proper context to respond to the demands and ambiguous positions. Among these demands and needs it can be referred to man's problem in terms of time and eternity, socialization and staying socialized, the model of affection and separation, reward and punishment (penalty), give meaning to activities, rationality, one's place in the world, overcoming the sufferings and conflicts of life and give meaning to them (Levine, 1996, quotes Janbozorgi, 2008). Mark and smith (1996) consider major purpose of human in providing religious documents and finding meaning, control and self-esteem. Religion also presents an interpretational control sense that enhances mental health of human being. Thoresen (1999) believes that religion influences health positively through one's behavior to others and also from the way religions value relationships. On the other hand, although numerous researches have confirmed that there is relation between religion and mental health but however, the findings of these researches are not completely consistent with each other. Some researchers show a positive relation between religion and mental health, but the others don't see any meaningful relation between these two phenomena (Gartner, Larson, and Allen, 1991 and Larson et al, 1992, quotes Lahsayezadeh, Azargooin, and Moradi, 2006). Payne, Bergin, Bielema and Jenkins (1991) in a meta-analysis that has been done on religion and mental health, found that in 47% of studies there is a positive relationship between religion and mental health, in 23% there is a negative correlation and in 30% of them they
didn't observed any significant relationship. Some experts believe that Lack of consistency in the results, is due to differences in assessment of religious discussions and religious affiliations; in other words some researchers has assessed religious attitudes (Ellison, Boardman and Williams) and some others has assessed religious behavior(O'Connor and Cobb, 2003). Recent evidence suggests differences in religious attitudes are much more important in predicting mental health than differences in religious behavior (Francis, 2004).

A closer study of the mechanisms underlying the effects of religion on mental health and why some studies report negative effects of religion on mental or physical health, made researchers study the influence of religions (Allport, 1968). In this regard, Allport and Ross (1967) by proposing two intrinsic and extrinsic religious orientations could explain distinct religious behaviors. Based on this theory, in the model of intrinsic religion, religion is under consideration of religion itself, while in the model of extrinsic religion, it is emphasized on religion because of achievements of religiousness. According to Allport, religion is a spectrum that in one hand has an instrumental meaning for people and on the other hand is kind of seeking a sense of meaning that it itself is the main motivation in life and has an intrinsic value. Intrinsic religion has a motivational aspect per se and needs not to other stimulus. Allport and Ross (1967) believe that in extrinsic religious orientation, religion is being used for non-religious purposes (such as social support and sense of security); individuals with extrinsic religious orientation has just beliefs with instrumental purposes, and to these persons religion have been seen as a means to achieve other goals and other values such as coping with life problems or improvements. From the evolutionary aspect these people are example of the explanations that Piaget gives about ego-centeredness (Astoora, translated by Dadsetan, 1998). But in intrinsic orientation, religion is used as a dominant motivation in social life. In Allport's interpretation intrinsic orientation immerses life in motivation and meaning and inspires worship. For persons with intrinsic religious orientation, although non-religious needs are essential, they have less ultimate significance (Dezutter, Soenens and Hutsebaut, 2006). Intrinsic religion will not be organized in an instrumental manner and is not a means to control fears and gain comfort and convenience or an attempt towards idealism in sexual matters or perfection-seeking dreams. The latter issues may be in the framework of our basic needs, but religion is not a means to satisfy them, but it is a multifaceted commitment. This commitment in addition to be intellectual is fundamentally motivational. Such religion covers whatever comes through its experience and whatever that is meta-empirical is not out of its circle. This religion is a house for scientific facts and emotional realities. A person with intrinsic religious orientation is enthusiastic in commitment to oneness and ideal integration in personal life (Allport, 1968). Allport and Ross believe that religious attitudes determine how religious functions are to be used as a mechanism for evaluation and in the face of stressful events in life. This evaluation can make a relation between religious views and health. They believe that religious tendency is an independent and autonomous factor in human being's character and unites all other components of personality in a whole system (Allport and Ross, 1967).

Allport and Ross (1967) developed a scale to measure religious orientation in both intrinsic and extrinsic orientation that Later many scholars in behavioral sciences used this scale to measure religious beliefs (quoted Lahsayeazzadeh et al, 2006).

According to theoretical foundations, the question arises whether with regard to the type of religious orientation (intrinsic or extrinsic) can we gain access to a more clear explanation about the relationship between religion and mental health? In other words, according to what Allport says whether intrinsic religious orientation (the religion that one has demanded wholeheartedly, lives with it and also makes his life with such meaning and motivation) in comparison to extrinsic religious orientation (that one seeks that for comfort, convenience, position, dignity and social support) has a greater role in mental health?

In addition to the studies of Allport, numerous researches confirmed his ideas. Some researches even contrary to that of Ellis, showed that people with intrinsic religious orientation, are far more reasonable in terms of cognitive viewpoint and have more mental health (Watson, Milliron, Morris and Hood, 1994) and they have more life satisfaction ( wolf, 1997). Bemana research results (2011) showed that in the three groups of Muslim, Christian and Zoroastrian, religious orientation is associated with psychological health. Research results of Ardelt (2003) indicated that intrinsic religious orientation is positively related with welfare of the subjects and it is negatively related with fear of death and avoiding dying. In fact, intrinsic religious orientation probably provides a transcendental meaning of life and death compared to extrinsic religious orientation. The study of relation between depression and intrinsic religion is also indicative of a negative relation between these two factors, but extrinsic religion hasn't had a significant relation with depression (Bergin, 1983). Ward's research result showed that extrinsic religious orientation predicts the rate of depression and anxiety. Messay (2010) also in a research on university students found that depression is related negatively with religious orientation.

In Iran also some research has studied the relation of intrinsic and extrinsic religious orientation with psychological status such as mental health and its factors, for example Janbozorgi (2008) in a research on students found that the more intrinsic religious orientation becomes the less depression and anxiety gets and mental health increases. Research results of Gharraee, Ahmadvand, Aakbari, and Zenozian (2008),and Nouzari and Gholami (2010) also show that there is a relation between mental health and religious orientation. Aghapour and Mesri(2011) also indicated in a research that there's a relation between mental health of families.
and intrinsic and extrinsic religious orientation. Research results of Eslami, Shojaazadeh and Vakili (2001) also indicated that intrinsic religious orientation is related negatively with depression. Ehteshamzadeh, Bourna and Yousefi (2011) also found in a research that depression of persons suffering from MS is related positively with extrinsic religious orientation. Aghili and Aliniya (2012) also found in a research on students that religious orientation is related negatively with thoughts of suicide and its factors and the more intrinsic religious orientation is the less thoughts of suicide will be. On the whole, these studies have noted that persons with intrinsic religious orientation, those in whom religious beliefs are deeply rooted, in comparison to persons with extrinsic religious orientation, that regard religion as a means to achieve other things, have more mental health.

Study of theoretical foundations and the review of literature clarify the amount of relationship between religious orientation with mental health and depression and make the effective factors on the strength of this relationship more clear; especially because our community has a unique cultural context that can drastically affect the amount of this relationship.

According to what was discussed and with regard to the fact that as far as the authors are aware, not only in Iran but also around the globe no paper is published about meta-analysis of the amount of relationship between religious orientation and mental health and depression, this study used meta-analysis to answer this question that based on research conducted at the national level, how much is the amount of relationship between religious orientation and mental health and depression? By doing this research, an overview of the relationship between religious orientation and mental health and depression in Iran can be achieved and in case that the amount of these relationships is considerable, the possibility of planning to increase the intrinsic religious orientation of individuals in order to enhance their mental health and depression is provided.

Research Questions

How much is the quantity of relation between intrinsic religious orientation and mental health in Iran?
How much is the quantity of relation between extrinsic religious orientation and mental health in Iran?
How much is the quantity of relation between general religious orientation and mental health in Iran?
How much is the quantity of relation between intrinsic religious orientation and depression in Iran?
How much is the quantity of relation between general religious orientation and depression in Iran?

MATERIALS AND METHODS

RESEARCH METHOD

in this study considering the research purpose it is used from meta-analysis method. Meta-analysis is a statistical method for a quantitative survey and combining the results of studies that are similar but independent of each other (Sharon and Normand, 1999). Meta-analysis is analysis of analysis’ or analysis of a series of individual research results in order to combine the results (Wolf, 1986). Meta-analysis is a statistical procedure for combining the results in order to achieve a conclusion (Carr, 2002 and Kortez, 2002). Nowadays, a special position in the field of research is allocated to meta-analysis (Azkia and Tavakoli, 2006). Meta-analysis is comprised of the following components (quoted Abedi, 2004):

A comprehensive search for all the practical and applicable studies
Accurate and reliable criteria for the selection of evolvable papers and researches
To acquire the amount of effect significance of each variable
A method for combining the results of all studies and articles

In meta-analysis the fundamental principle is to calculate the effect size for separated and distinct studies and returning them to a common (general) matrix and then combine them to achieve the average of effect (Abedi, 2004). Effect size indicates the quantity or degree of the presence of a phenomenon in the society. By holding statistics such as X², t and F, the related effect size index (r) could be estimated.

According to Cohen (1988) for the r index, effect sizes of 0.1, 0.3 and 0.5, are respectively considered small, medium and large (Table 1):

<table>
<thead>
<tr>
<th>Effect size</th>
<th>R</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>0.1</td>
</tr>
<tr>
<td>Medium</td>
<td>0.3</td>
</tr>
<tr>
<td>High</td>
<td>0.5</td>
</tr>
</tbody>
</table>

| Source: Ankem (2005) |

Statistical population of the study

Statistical population of the study was masters and doctoral theses, research conducted by executive agencies and researches published in scholarly journals that have been conducted between 1380-1390 on the relation between religious orientation and mental health and depression across the country that had appropriate
sample size and in terms of the reliability and validity of the measuring instrument and method of sampling had the required criteria. Places and resources which were referred to them to gather conducted researches on the relation between religious orientation and mental health and depression were: Masters and doctoral dissertations and academic journals archived in the library of the Faculty of Education and Psychology of Isfahan University, website of Iranian Academic Documents Center1, the website of Iranian Scientific Information Database2, The website of publications Information Bank3, the website of Noor magazines database4 and Comprehensive Portal of Humanities5. Keywords used in the searching websites included: "mental health+ religious orientation", "mental health + religious beliefs ", "mental health+ intrinsic and extrinsic religion", " Mental hygiene +Religious Orientation", " Mental hygiene +religious beliefs ", "Mental hygiene + intrinsic and extrinsic religion", "religious orientation", "religious beliefs", "intrinsic and extrinsic religion" and "religion".

**SAMPLE AND SAMPLING METHOD**

In this meta-analysis researches have been used that qualified in terms of methodology, it means that research projects, theses and articles that have inclusive criteria have been used.

Inclusive criteria of this research were: 1- The research should have been conducted in Iran. 2- The relation between mental health and intrinsic/extrinsic religious orientation or relation between depression and intrinsic/extrinsic orientation should have been studied. 3- The study should have been conducted in frame of a correlation study or a group comparison. 4- The instrument used to measure intrinsic and extrinsic religious orientation should have been Allport's religious orientation scale, or its revised form. 5- In the research result, the effect size or statistics related to the variables of mental health and extrinsic/ intrinsic religious orientation or depression and intrinsic/ extrinsic religious orientations should have been reported.

The number of researches that had inclusive criteria were 10 that contained 7 effect size about the relation between intrinsic religious orientation and mental health, 5 effect size about the relation between extrinsic religious orientation and mental health, 3 effect size about the relation between general religious orientation and mental health, 3 effect size about the relation between intrinsic religious orientation and depression and 3 effect size about the relation between general religious orientation and depression.

**Measuring instrument**

In this meta-analysis, the following devices were used to gather information:

A) The primary sources: in this research, the studies related to research subject that had the inclusive criteria were used.

B) Content analysis checklist: this checklist has been used to extract the necessary information to calculation a meta-analysis of the content of theses, research projects and research papers that had inclusive criteria. Only studies that had proven their reliability and validity were selected for the meta-analysis.

In table 2 and 3 the characteristics of the selected studies for the meta-analysis are presented:

**The manner of performing and stages of research**

The research stages of this meta-analysis were: 1-Defining the research problem. 2-Detailed expression of the criteria for selection of researches.3-Searching for the researches conducted on the relationship of religious orientation and mental health and depression. 4 - Selection of studies for meta-analysis. 5 - Encoding the researches. 6 – Evaluation of researches. 7 - Developing research questions and hypotheses of Meta-analysis. 8 - Descriptive analysis of researches. 9- Calculating effect sizes. 10 - Describing and interpreting of effect sizes and 11-classification of meta-analysis results.

**METHOD OF DATA ANALYSIS**

Regarding to the researches about relation of religious orientation with mental health and depression that has been gathered for meta-analysis, none of them has reported the effect size, in this meta-analysis the statistics of various researches has changed to the index r by the using Hunter and Schmidt’s approach and then the calculated effect sizes were interpreted using the Cohen’s guide table for interpreting index r of effect size.

Results and Conclusions

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5 ensani
First question

how much is the quantity of relation between intrinsic religious orientation and mental health in Iran?

Table 4 shows the statistical indexes for the effect size of the relation between intrinsic religious orientation and mental health.

Table 2. the characteristics of selected studies for the meta-analysis of the relation between religious orientation and mental health

<table>
<thead>
<tr>
<th>Variable</th>
<th>Study of the relation between intrinsic religious orientation and mental health in Kashan</th>
<th>Relation between religious orientation and mental health in the family</th>
<th>Study of the relation between religious orientation and mental health of immigrants based on the model of Allport and Ross, sample from Ghasre Shirin</th>
<th>Study of the relation of religious orientation and practical commitment to Islamic beliefs and students' mental health</th>
<th>Religious orientation and the rate of depression among the elderly</th>
<th>The role of intrinsic/extrinsic religious beliefs in general health of the elderly and the rate of depression among the elderly</th>
<th>The role of religious beliefs in general health of the elderly Members of retirees in Rasht, Gilan University of Medical Sciences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent variable</td>
<td>1031 People over 18 years</td>
<td>600 Woman over 18 years</td>
<td>200 immigrants</td>
<td>210 Students</td>
<td>230 The Elderly in Social Welfare and public venues</td>
<td>73 The elderly in the elderly Members of retirees in Rasht, Gilan University of Medical Sciences</td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td>Study of the relation between mental health and intrinsic/extrinsic religious orientation in Kashan</td>
<td>Family</td>
<td>Study of the relation between religious orientation and mental health of immigrants based on the model of Allport and Ross, sample from Ghasre Shirin</td>
<td>Students</td>
<td>Research in medicine (4)</td>
<td>Members of retirees in Rasht, Gilan University of Medical Sciences</td>
<td></td>
</tr>
<tr>
<td>Researchers</td>
<td>Gharaei Ahmadvand, Akbari Dehaghi and Zenouzian</td>
<td>Aghapour and Mesri</td>
<td>Lahsaei Zadeh, Azaragoon and Moradi</td>
<td>Nozari and Gholami</td>
<td>Bahrami and Ramezani Farani</td>
<td>John Bozorgi</td>
<td></td>
</tr>
<tr>
<td>Year of study</td>
<td>1987</td>
<td>1980</td>
<td>1985</td>
<td>1388</td>
<td>1384</td>
<td>1388</td>
<td></td>
</tr>
<tr>
<td>statistical method</td>
<td>Modern psychological research (Psychology of Tabriz University) 3 (10)</td>
<td>Journal of Quran and Medicine, First Year, issue 1</td>
<td>Social Sciences (Faculty of Literature and Human Sciences, Mashhad), (2)3</td>
<td>Two quarterly of Islamic Studies and Psychology, No 7</td>
<td>Rehabilitation, 6 (1 serial 20)</td>
<td>Research in medicine (4)31</td>
<td></td>
</tr>
<tr>
<td>Rate of significance</td>
<td>r=0.132 P=0.01 r=0.132</td>
<td>r=0.69 P=0.001</td>
<td>r=0.79 P=0.001</td>
<td>r=0.44 P=0.001</td>
<td>r=0.291 P=0.001</td>
<td>r=0.319 P=0.0001 r=0.319</td>
<td></td>
</tr>
<tr>
<td>Significance level</td>
<td>P&lt;0.01</td>
<td>P&lt;0.001</td>
<td>P&lt;0.001</td>
<td>P&lt;0.072 R=0.117</td>
<td>P&lt;0.02</td>
<td>P&lt;0.02</td>
<td></td>
</tr>
</tbody>
</table>

Note 1: in Table the modulus of effect sizes have been reported.

Note 2: in researches that the relation between intrinsic/extrinsic religious orientation and mental health has been studied separately, at first the effect size of the relation between intrinsic religious orientation and mental health has been reported.
Table 3. characteristics of selected researches for meta-analysis of the relation between religious orientation and depression

<table>
<thead>
<tr>
<th>Row</th>
<th>Independent variable</th>
<th>Title</th>
<th>Sample size</th>
<th>Subjects</th>
<th>Year of study</th>
<th>Researchers</th>
<th>Sources</th>
<th>Type of statistics</th>
<th>Rate of statistics</th>
<th>Significance</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Intrinsic/extrinsic religious orientation</td>
<td>The study of relation between mental health and intrinsic/extrinsic religion in Kashan</td>
<td>1031</td>
<td>People over 18 years</td>
<td>1387</td>
<td>Charaeae, Ahmadvand, Akbari Dehaghi and Zenouzian Nozari and Gholami</td>
<td>Modern psychological research</td>
<td>r</td>
<td>0.152</td>
<td>P=0.01</td>
<td>r= 0.152</td>
</tr>
<tr>
<td>4</td>
<td>Study of the relation between religious orientation and practical commitment to Islamic beliefs with students' mental health</td>
<td>340</td>
<td>Students</td>
<td>1389</td>
<td>Nozari and Gholami</td>
<td>Two Quarterly of Islamic studies and psychology, no 7</td>
<td>r</td>
<td>0.177</td>
<td>P= 0.001</td>
<td>r= 0.177</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Study of the relation of religious orientation and irrational beliefs with depression in patients with MS</td>
<td>120</td>
<td>1380</td>
<td>120</td>
<td>Ehteshamzadeh, Borna and Yousefi</td>
<td>New findings in psychology, 6 (20)</td>
<td>r</td>
<td>0.325</td>
<td>P= 0.001</td>
<td>r= 0.325</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>The role of intrinsic and extrinsic religious beliefs in mental health and rate of depression in the elderly</td>
<td>230</td>
<td>The Elderly</td>
<td>1384</td>
<td>Bahrami and Ramezani Farani</td>
<td>Rehabilitation, 6(1 serial 20))</td>
<td>r</td>
<td>0.276</td>
<td>P= 0.001</td>
<td>r= 0.276</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Religious orientation and mental health</td>
<td>138</td>
<td>Students</td>
<td>1386</td>
<td>John Bozorgi</td>
<td>Research in medicine, (4) 31</td>
<td>r</td>
<td>0.375</td>
<td>P= 0.0001</td>
<td>r= 0.375</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Investigating the rate of depression and its relation with individual's attitude towards being religious in medicine students in Gorgan University of Medical Sciences in the year 1378-79</td>
<td>73</td>
<td>The elderly in Pensoiners Center</td>
<td>1381</td>
<td>Eslami, Shojaee zadeh and Vakili</td>
<td>Medicine and refinement, 43</td>
<td>r</td>
<td>0.58</td>
<td>P&lt; 0.05</td>
<td>r= 0.58</td>
<td></td>
</tr>
</tbody>
</table>

Note 1: in the table, the modulus of effect sizes has been reported.

Note 2: in researches that the relation of intrinsic/extrinsic religious orientation with depression has been studied distinctly, at first the effect size of the relation between intrinsic religious orientation and depression has been reported.

Table 4. the statistical indexes for the effect size of the relation between intrinsic religious orientation and mental health

<table>
<thead>
<tr>
<th>Statistical indexes Independent study of dependent variable</th>
<th>Number of studies (n)</th>
<th>Average of effect size (r)</th>
<th>Standard deviation of effect size (SDr)</th>
<th>Standard error of effect size (SEr)</th>
<th>z</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrinsic Religious orientation</td>
<td>Mental health</td>
<td>7</td>
<td>0.272</td>
<td>0.281</td>
<td>0.0050</td>
</tr>
</tbody>
</table>

According to Table 4, the best estimate of the effect of the independent variable (intrinsic religious orientation) on the dependent variable (mental health) is equal to 0.272 that based on the Cohen's table of interpretation of effect size it is evaluated as the average. Hence, it could be said that according to the results of this meta-analysis, mental health has an average relation with intrinsic religious orientation.

Table 5. statistical indexes for the effect size of the relationship between extrinsic religious orientation and mental health

<table>
<thead>
<tr>
<th>Statistical indexes Independent study of dependent variable</th>
<th>Number of studies (n)</th>
<th>Average of effect size (r)</th>
<th>Standard deviation of effect size (SDr)</th>
<th>Standard error of effect size (SEr)</th>
<th>z</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extrinsic Religious orientation</td>
<td>Mental health</td>
<td>5</td>
<td>-0.135</td>
<td>0.425</td>
<td>0.0083</td>
</tr>
</tbody>
</table>

According to Table 5, the best estimate of the effect of the independent variable (extrinsic religious orientation) on the dependent variable (mental health) is equal to -0.135 that based on the Cohen's table of
interpretation of effect size it is evaluated as the average. Hence, it could be said that according to the results of this meta-analysis, mental health has an average negative relation with extrinsic religious orientation.

The third question: how much is the relation between general religious orientation and mental health in Iran?

Table 6 shows the statistical indexes for the effect size of the relation between general religious orientation and mental health.

**The second question**

how much is quantity of relationship between extrinsic religious orientation and mental health in Iran?

Table 5 shows the statistical indexes for the effect size of the relationship between extrinsic religious orientation and mental health.

<table>
<thead>
<tr>
<th>Statistical indexes</th>
<th>Number of studies (n)</th>
<th>average of effect size (r)</th>
<th>Standard deviation of effect size (SD_r)</th>
<th>Standard error of effect size (SE_r)</th>
<th>z</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extrinsic Religious orientation Mental health</td>
<td>3</td>
<td>0.296</td>
<td>0.017</td>
<td>0.0008</td>
<td>370</td>
</tr>
</tbody>
</table>

According to Table 6, the best estimate of the impact of the independent variable (general religious orientation) on the dependent variable (mental health) is equal to 0.296 that based on the Cohen's table of interpretation of effect size it is evaluated as the average. Hence, it could be said that according to the results of this meta-analysis, mental health has an average relation with general religious orientation.

The fourth question: according to the performed researches how much is the relation between intrinsic religious orientation and depression in Iran?

Table 7 shows the statistical indexes for the effect size of the relation between intrinsic religious orientation and depression.

<table>
<thead>
<tr>
<th>Statistical indexes</th>
<th>Number of studies (n)</th>
<th>Average of effect size (r)</th>
<th>Standard deviation of effect size (SD_r)</th>
<th>Standard error of effect size (SE_r)</th>
<th>z</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrinsic Religious orientation depression</td>
<td>3</td>
<td>-0.171</td>
<td>0.090</td>
<td>0.0023</td>
<td>74.347</td>
</tr>
</tbody>
</table>

According to Table 7, the best estimate of the impact of the independent variable (intrinsic religious orientation) on the dependent variable (depression) is equal to 0.171 that based on the Cohen's table of interpretation of effect size it is evaluated as the average. Hence, it could be said that according to the results of this meta-analysis, depression has an average relation with intrinsic religious orientation.

The fifth question: according to the performed researches how much is the relation between general religious orientation and depression in Iran?

Table 8 shows the statistical indexes for the effect size of the relation between general religious orientation and depression.

<table>
<thead>
<tr>
<th>Statistical indexes</th>
<th>Number of studies (n)</th>
<th>average of effect size (r)</th>
<th>Standard deviation of effect size (SD_r)</th>
<th>Standard error of effect size (SE_r)</th>
<th>z</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrinsic Religious orientation depression</td>
<td>3</td>
<td>0.409</td>
<td>0.102</td>
<td>0.0042</td>
<td>97.38</td>
</tr>
</tbody>
</table>

According to Table 8, the best estimate of the impact of the independent variable (general religious orientation) on the dependent variable (depression) is equal to 0.409 that based on the Cohen's table of interpretation of effect size it is evaluated as over average. Hence, it could be said that according to the results of this meta-analysis, depression has an over average relation with general religious orientation.
DISCUSSION AND CONCLUSION

The results of this meta-analysis showed that according to Cohen's criteria for interpreting, the amount of effects related to the relationship between intrinsic religious orientation and mental health, relation between extrinsic religious orientation and mental health, relation between overall religious orientation and mental health and relation between intrinsic religious orientation and depression is moderate and the effect amount of the relationship between overall religious orientation and depression is well above average.

As far as the authors know, no meta-analysis about the subject of this study has been performed so far, that the results of meta-analysis could be compared with that. It seems that in spite of different ideas about possible mechanisms connecting faith and health, these two factors are related positively.

Various theories and models are presented to explain the psychological structures of religion and how religion effects on mental health. One of the most famous and respected theories among them is Allport's theory of religious orientation. Allport believed that it is only the intrinsic religious orientation that ensures mental health (Janbozorgi, 2008). He states with regard to the classification of intrinsic and extrinsic religious orientation, this question can be answered that whether some religious beliefs are more remedial and more preventive than other stimulus?

His premise is that extrinsic religion is less remedial and preventive than intrinsic religion. For many people, religion is a boring habit, ritualistic, merely cultural and solely used in traditional ceremonies and for the comfort of family and individuals and issues like these. For some others it gives them post and dignity and strengthens their self-esteem and advances their purposes, by which they overcome their friends, influence on others and achieve power. In this regard, sometimes religion is a defense against reality. Those who have extrinsic religion turn to God but do not turn away from themselves. That is why their religion doesn't become a shield for their ego-centeredness. This is that religion which in view of Freud leads to neurosis (mental irritation). Here religion acts as a protection against anxiety. From motivational viewpoint, this religion is not motivating but serves other motivations such as the need for security, the need for authority and the need for self-esteem (Allport, 1968).

Allport and Ross (1967) in discussion of the character of human found that man's whole life depends on his faith. It means that the person who has a more intrinsic religion, has more mental health, but the more he uses religion in order to promote his welfare and social needs and don’t notice its principles, he has less mental health. With the rise of religious orientation (intrinsic) and religious faith in people, the self-control process increases in people and it prevents the influence of external conditions or demographic and environmental pressures. As a result, the person is less affected by poor conditions and can keep his mental health (Tabarraie, et al, 2008).

Yet research on the relationship between religious orientation and mental health and depression requires further enrichment. For example, it seems that religious orientation affects the amount of the effectiveness of psychological interventions on individuals. If religious orientation and mental health are likely to shows a positive relation with each other, probably it is possible to help religious clients by measuring this concept. The study of religious orientation with the valid and reliable Iranian device is less noticed. The concept of religious orientation based on the used device, seems different and does not cover any specific religion.

Generally, relationship between religion and mental health seems to meet complex and multi-dimensional considerations and the existent theories in this field should be gradually expanded.

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