Original Research Article

A Cross-Sectional Study on Religiosity and Religious Coping of patients attending a psychiatry outpatient department of a Teaching Hospital in India

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ABSTRACT

Background: Religiosity is an integral component of life with a significant impact on mental health yet has been poorly studied in persons with mental illness. The study aimed to compare the level of religiosity and religious coping of patients attending Psychiatry OPD with a healthy control group and to assess the correlation of the level of religiosity and religious coping, with the level of functioning, and quality of life (QOL).
Methodology: The participants were evaluated on the religiousness measure scale, The Duke University Religion Index (DUREL), the brief religious coping scale (brief RCOPE), and World Health Organization QOL (WHOQOL)-BREF version.
Result: A total of 80 participants were recruited, which included patients with Schizophrenia (n = 19), major depressive disorder (n = 13), bipolar disorder (n = 8), obsessive-compulsive disorder (OCD) (n=10) and healthy controls (n = 30). As compared to the control group patient with schizophrenia scored significantly higher in Intrinsic Religiosity. The mean score of religious involvement among patients with schizophrenia and depression was significantly higher than in control groups. In terms of negative religious coping patients with Bipolar affective disorder (BPAD) used significantly more negative religious coping compared to, the healthy control group and patients with schizophrenia. Scores of negative RCOPE were negatively correlated with the score of global assessment of functioning (GAF) (r= -0.290; p=0.041*).
Conclusion: A higher level of religious influence, intrinsic religious practice and positive religious coping improve the level of functioning and quality of life.

Keywords: Religiosity, Spirituality, Religious Coping, Quality of Life, Schizophrenia.

(Paper received – 16th June 2023, Peer review completed – 17th July 2023, Accepted – 28th July 2023)

INTRODUCTION

Religion can be explained as an expression which involves beliefs, affiliations, practices, and rituals followed by an individual to pursue the same. In various religions, specific beliefs about life after death are followed and rules about conduct which guide life within a social group. Religion is most practiced within a community often in an organised way, but it can also be practised alone and in private [1]. We can define religion as "an organized system of beliefs, practices, rituals, and symbols designed to facilitate closeness to the sacred or transcendent [2]." Numerous terms, including orthodoxy, faith, devotion, piousness, and holiness, are frequently used as synonyms for religiosity [3]. Instead of using terms that are synonymous with religiosity, these synonyms reflect what researchers of religiosity would describe as dimensions of religiosity [3].

From different studies, religion/religiosity is understood to have many dimensions. Glock [4] described 5 dimensions as the intellectual, ideological, public, private, and experiential dimensions and considered these to be autonomous. Religiosity and spirituality are often used interchangeably in the literature. In the Indian context, these are considered part and parcel of the lives of many individuals. Spirituality is understood as a complex multidimensional concept having clear-cut boundaries than religion or religiosity. Spirituality can be defined as "one's striving for an experience of connection with oneself, connectedness with others, with nature and connectedness with the transcendent" [5].

From studies, it is found that religion and spirituality have some role in coping with illness, expression of psychopathology, self-harm behaviour, substance use pattern, help-seeking, illness models, treatment adherence, and quality of life of patients with severe mental disorders [6-9]. The data regarding of comparison of religious practices of patients with various mental disorders and the general population are of limited availability and inconsistent [10-11]. Some of the studies report lower involvement of patients of schizophrenia in religious activities when compared to the general population whereas few studies report the higher results [11-12].

A study from South India demonstrated that 58% of patients with psychotic illnesses meet a religious healer before psychiatric consultation [13]. In fact, some of the studies suggest that people often seek religious help for mental disorders as first step in the management of mental disorders. It is a cultural explanation for the illness [14]. In terms of outcome measures, religiosity and religious practices have an important impact on overall QOL of patients with schizophrenia [15]. Further, the data suggest that spirituality and religiosity domains of QOL are closely associated with coping mechanisms used by the patients [16].

Some of the researchers have also evaluated the relationship of severity of depression with religiosity and spirituality. Dew and others [17] in their study stated that, factors such as forgiveness, negative religious support, loss of faith, and negative religious coping have a significant association with the severity of depression even after controlling for variables such as social support and substance abuse [17] it is noted that loss of faith in God predicted a lower level of improvement in depression scores over 6 months during follow up, even after controlling for the severity of depression at the baseline [17].

Based on these studies, it can be understood that there are differences in the religious and spiritual practices of patients suffering from mental disorders compared to healthy controls. However, the evidence is still preliminary on various accounts and needs more studies on this. There are very few studies in India focusing on the relation between religiosity and religious coping of patients suffering from various psychiatric illness. In many of these studies it is mainly focused on individual psychiatric illness like schizophrenia, depressive disorder, bipolar disorders etc. To our knowledge, the number of studies on relationship of the level of religiosity and religion coping with level of functioning and quality of life (QOL) is limited.

In our study population there are many groups of people who have different religious belief, practice and rituals. Considering the availability of limited research in this area, there is a need to understand the extent of religiosity, influence of religion on religious coping and QOL of the patients attending psychiatry OPD.

METHODOLOGY

Place of study: - This study was done at the outpatient services Silchar Medical College and Hospital which is a tertiary care hospital. The study was approved by the Ethics Review Committee of the Institute.

Duration of study: 6 months.

Type of study: Cross-sectional study.

Sample: 50 patients and 30 control subjects were recruited using Purposive sampling method after obtaining written informed consent.

Inclusion criteria: Patients aged above 18years of age, fulfilling the diagnostic criteria of the following diseases i.e., schizophrenia, major depressive disorder, bipolar affective disorder, and obsessive-compulsive disorders as per ICD10 criteria of Behavioural and Mental Disorder.

The healthy controls were also required to be aged between 18 and 60 years and free from any psychiatric disorder and was selected randomly among the staff of the hospital and caregivers of the patients with mental illnesses. Before recruitment, a detailed psychiatric evaluation was done to rule out any psychiatric disorder at the time of assessment or in the past. All the healthy controls were matched according to age, gender, socioeconomic status, and the religion.

Exclusion criteria: Patients with dementia and other organic brain disorders, substance-use disorders, and mental retardation, personality disorders, having major physical illnesses were excluded.

Case definition: Patients aged above 18years of age, fulfilling the diagnostic criteria of the following diseases i.e., schizophrenia, major depressive disorder, bipolar affective disorder, and obsessive-compulsive disorders as per ICD10 criteria of Behavioural and Mental Disorder.

Tools: Level of religiosity was measured by Religiousness Measure Scale [18], Duke Religion Index (DUREL) [19], and religious coping in patients was measured by the Brief Religious Coping Scale (brief RCOPE) [20]. In addition, patients were rated on global assessment of functioning (GAF) [21] scale. QOL was assessed using the World Health Organization QOL (WHOQOL)-BREF version [22].

1. **Religiousness Measure Scale** [18]: is a 17-item scale, with one item assessing religiousness, 3 items assessing religious involvement, 7 items assessing religious influence on daily life, and 6 items assessing religious hope. Another item assesses whether the person will marry a person from another religion or not. Most of the items have questions with responses on 7-point Likert scale except item 1 and 7 having Yes/No responses. Each facet score is derived by averaging the score obtained from the responses to the questions comprising that facet.
2. **Duke Religion Index (DUREL)** [19]: is a 5-item scale, with 2 items rated on 6-point scale and 3 items rated on 5-point scale. It assesses 3 major dimensions of religiosity, i.e., organizational religious activity, nonorganizational religious activity, and intrinsic religiosity. The scale has been shown to have high test–retest reliability, high internal consistency, and high convergent validity with other measures of religiosity.
3. **Brief Religious Coping Scale (Brief RCOPE)** [20]: is a 14-item scale assessing religious coping in the form of 2 overarching factors, i.e., positive, and religious coping. Positive religious coping (PRC) methods reflect a secure relationship with a transcendent force, a sense of spiritual connectedness with others, and a benevolent world view. The negative religious coping subscale (NRC) of the Brief RCOPE is characterized by indications of spiritual tension, conflict, and struggle with God and others, as shown by adverse reappraisals of God's attributes (such as feeling abandoned or punished by God), adverse reappraisals of demonic attributes (such as believing the devil is responsible for the stressor), spiritual questioning and doubting, and interpersonal religious discontent. The scale has been shown to have high internal consistency, test–retest reliability, construct validity, predictive validity, and incremental validity.
4. **WHO Quality of Life Scale Brief Version (The WHOQOL-BREF) (Hindi version)** [21]**:** is the only multilingual QOL instrument. It places emphasis on subjective evaluation of respondent's health and living conditions. Four domains of QOL are measured – physical health, psychological health, social relationship, and environment. In addition, another domain of general health is considered. The scale has 26 items scored from 1–5 with total score range of 26–130. Its psychometric properties have been found to be comparable to those of the full version (WHOQOL-100). The scale has shown good discriminant validity, concurrent validity, internal consistency, and test–retest reliability.

After documenting the sociodemographic and clinical details, patients were rated on Global Assessment of Functioning (GAF) [22] scale. Healthy controls were evaluated on the religiousness measure scale, DUREL, and RCOPE.

Statistical analysis

Data were analysed using Statistical Package for the Social Sciences version 21.0. Mean and standard deviations were calculated for the continuous variables and frequency and percentages were calculated for the categorical variables. The relationship between religiosity measures and different variables was assessed using Pearson product-moment correlations or Spearman's rank correlation analysis as per meeting the criteria of normal distribution. Comparisons of different variables were done using the Chi-square test and Fisher's exact test and ANOVA with post hoc analysis.

RESULTS

The demographic and clinical profile of the study sample is shown in [Table 1]. The study included 50 patients with severe mental disorders and 30 healthy controls. Among the patients with a severe mental disorder, 19 were diagnosed with schizophrenia, 13 were diagnosed with major depressive disorder, 8 were diagnosed with bipolar disorder, and 10 were diagnosed as obsessive-compulsive disorder. The mean age of the study groups is 34.05, with no significant difference across different groups (p= 0.653). There is slight preponderance of male participants without any significant difference across different groups. There is no significant difference in marital status among all disorder groups and there is slight preponderance of married participants in control group [n=24 (80%)] out of 50 participants of disorder group education level of 39 participants' below higher secondary level. About two-third of the patients were not on a paid job, a significant number of them (n = 14) were homemakers. 16 (84.2%) patients with schizophrenia are not in paid job. Majority no of the patients are from to families of middle socioeconomic class as per the Kuppuswamy's socioeconomic scale. There is no significant difference in religion (chi-square value = 2.892; p-value = 0.576) and type of family (chi-square value= 9.663; p-value = 0.289). Most of the participants in this study are from rural area (59.3%) and among the other groups significant portion of patients with schizophrenia are from rural area.

The GAF score for the whole study sample was 69.50 (8.517), there was no significant difference between the disorder groups.

In terms of QOL, the mean score of all domains of WHOQOL is significantly higher in control groups than all disorder groups (ANOVA F value 31.512; p-value <0.001). But there was no significant difference among different disorder groups.

Religiosity and religious coping among various groups

In terms of religiosity as assessed by DUREL there was no significant difference between the diseased groups and the healthy controls for organized religious activities and the nonorganized religious activities. However, on one of the items of intrinsic religiosity (My religious beliefs are what really lie behind my whole approach to life), patients with schizophrenia scored significantly higher than the control group.

The mean score for the religious involvement domain was 12.5 and that for religious hope and religious influence were 29.99 and 30.63 accordingly. Total religiosities score as per religious measure scale was 72.76. When the data of the different groups were compared, no significant difference were noted in various domain of religious measure scale expect religious involvement where mean of religious involvement among patient with schizophrenia and depression significantly higher than control groups.

The mean score of positive religious coping and negative religious coping subscale were 13.79 and 9.60 accordingly. Compared to the healthy controls, patients in all disorder groups scored more in total score of positive religious coping but there was no significant difference among different groups except on one of the items of positive religious coping (Tried to put my plans into action together with God.) patient with bipolar affective disorder scored significantly higher than patient with depressive disorder groups [Table 3].

In one item of negative religious coping subscale (Wondered whether my church had abandoned me) patients among BPAD scored significantly higher than patient depression. When total score of Negative religious coping subscale were compared among groups, Patients with BPAD scored significantly higher than healthy control group and patients with schizophrenia. [Table 3]

Relationship of religiosity with other variables

When the correlation analysis was carried out for studying the relationship of age of the patients and level of education of patients with religiosity measure scale, DUREL, and religious coping, no significant correlations were seen except for significant association between age and religious hope subscale (Pearson Correlation= -0.281 p 0.012). when categorical values were compared with religiosity measure scale, DUREL, religious coping, patients who studied up to primary grade had more religious involvement than others whereas religious hope is higher in persons staying in urban area and among the students.

When different marital status of study population compared with respect Positive religious coping scale, there was significant difference in score of in few subscales, of positive religious coping scale (Sought God's

Table 1: Demographic and clinical profile of study participants						
Variable	**Whole sample (n=80)**	**Group 1 Schizophrenia (n=19)**	**Group 2 Major Depressive disorder (n=13)**	**Group 3 Bipolar affective disorder (n=8)**	**Group 4 OCD (n=10)**	**Group 5 CONTROL (n=30)**
Age						
[Mean (SD)]	34.05 (9.4)	32.37 (8.76)	35.85 (11.78)	32.88 (9.81)	31.40 (10.9)	35.53 (9.49)
18-39 years	57 (71.3)	17 (89.5)	6 (46.2)	7 (87.5)	7 (70)	20 (66.7)
40-60 years	23 (28.8)	2 (10.5)	7 (53.8)	1 (12.5)	3 (30)	10 (33.3)
Sex						
Male	44(55)	7(36.8)	4(30.8)	4(50)	9(90)	20(66.7)
female	36(45)	12(63.2)	9(69.2)	4(40)	1(10)	10(33.3)
Marital status						
Currently married	54 (67.5)	9 (47.4)	9 (69.2)	7 (87.5)	5 (50)	24 (80)
Unmarried	26 (32.5)	10 (52.6)	4 (30.8)	1 (12.5)	5 (50)	6 (20)
Education						
Illiterate	10 (12.5)	6 (31.6)	-	-	1 (10)	3 (10)
Primary	13 (16.3)	5 (26.3)	5 (38.5)	1 (12.5)	2 (20)	-
Secondary	29 (36.3)	7 (36.8)	5 (38.5)	5 (62.5)	2 (20)	10 (33.3)
Hsc	18 (22.5)	-	2 (15.4)	2 (25.0)	3 (30)	11 (36.7)
Graduate & above	10 (12.5)	1 (5.3)	1 (7.7)	-	2 (20)	6 (20)
Current employment status						
Unemployed	15 (18.8)	13 (68.4)	-	2 (25)	-	-
Housewife	21 (26.3)	3 (15.8)	7 (53.8)	3 (37.5)	1 (10)	7 (23.3)
Unskilled	15 (18.8)	1 (5.3)	2 (15.4)	2 (25)	1 (10)	9 (30)
Skilled	15 (18.8)	1 (5.3)	1 (7.7)	1 (12.5)	4 (40)	8 (26.7)
Student	14 (17.5)	1 (5.3)	3 (23.1)	-	4 (40)	6 (20)
SES (as per Kuppuswamy's SES Scale)						
Lower	11 (13.8)	9 (47.4)	-	-	2 (6.7)	2 (6.7)
Upper lower	21 (26.3)	8 (42.1)	4 (30.8)	1 (12.5)	5 (16.7)	5 (16.7)
Lower middle	24 (30)	2 (10.5)	6 (46.2)	5 (62.5)	8 (26.7)	8 (26.7)
Upper middle	23 (28.8)	-	3 (23.1)	2 (25)	14 (46.7)	14 (46.7)
Upper	1 (1.3)	-	-	-	1 (3.3)	1 (3.3)
Religion						
Hindu	40 (50)	9 (47.4)	5 (38.5)	4 (50)	8 (80)	14 (46.7)
Islam	40 (50)	10 (52.6)	8 (61.8)	4 (50)	2 (20)	16 (53.3)
Family type						
Nuclear	51 (63.8)	9 (47.4)	9 (69.2)	5 (62.5)	22 (73.3)	22 (73.3)
Joint	29 (36.3)	10 (52.6)	4 (30.8)	3 (37.5)	8 (26.7)	8 (26.7)
Locality						
Rural	46 (57.5)	13 (68.4)	8 (61.5)	3 (37.5)	5 (50)	17 (56.7)
Semiurban	9 (11.3)	3 (15.8)	3 (23.1)	1 (12.5)	2 (20)	-
Urban	25 (31.3)	3 (15.8)	2 (15.4)	4 (50)	3 (30)	13 (43.3)
GAF score	69.50 (8.517)	69.89 (9.854)	71.23 (7.833)	66.88 (8.823)	68.60 (6.835)	
WHOQOL-BREF Scores						
Physical health	22.44 (3.9)	21.84 (3.13)	20.38 (4.3)	20.75 (1.8)	18.8 (4.2)	25.3 (3.06)
Psychological health	19.56 (3.5)	17.47 (2.7)	17.15 (2.2)	18.63 (2.56)	18.2 (3.9)	22.63 (2.3)
Social relationship	9.63 (2.3)	7.79 (1.8)	17.15 (2.2)	18.63 (2.5)	8.1 (1.8)	11.8 (0.96)
Environment	26.3 (4.3)	23.89 (2.8)	23.46 (3.9)	25.13 (3.7)	24 (4.4)	30.13 (2.1)
Total score	76.85 (12.6)	68.74 (10.3)	67.31 (9.7)	72.25 (7.4)	70.1 (9.7)	89.6 (3.7)

[all scores in N(%) format and continuous variables in Mean (SD) format]

Table 2: Religiosity as assessed by duke university religion index (DUREL) and religiousness measure scale using ANOVA test							
Variable	**Group I Schizophrenia (n = 19)**	**Group II Depression (n=13)**	**Group III Bipolar disorder (n=8)**	**Group IV OCD (n =10)**	**Group V Controls (n=30)**	**ANOVA**	**Post-hoc**
	Mean (SD)	**Mean (SD)**	**Mean (SD)**	**Mean (SD)**	**Mean (SD)**	**F-value (p-value)**	
DUREL							
Organized religious activities							
How often do you attend a church / temple / mosque, etc or other religious meetings	3.37 (1.257)	3.92 (1.32)	3.5 (0.75)	3.80 (0.789)	3.90 (1.45)	0.675 (0.612)	II>V>IV>III>I
Nonorganized religious activities							
How often do you spend time in private religious activities, such as prayer, meditation, or Bible study?	2.68 (0.749)	2.92 (0.954)	2.50 (1.069)	2.70 (0.823)	2.67 (0.124)	0.262 (0.901)	II>IV>I>V>III
Intrinsic religiosity							
In my life, I experience the presence of the Divine (i.e., God)	3.74 (1.195)	3.15 (0.987)	3.38 (1.061)	3.60 (0.1)	3.53 (0.937)	0.680 (0.608)	I>IV>V>III>II
My religious beliefs are what really lie behind my whole approach to life	3.89 (1.595)	3.77 (1.235)	3.00 (1.69)	3.00 (0.816)	2.73 (1.015)	3.564 (0.010)*	I>II>III=IV>V; I>V*
I try hard to carry my religion over into all other dealings in life	3.16 (1.167)	3.00 (0.816)	2.88 (1.126)	2.70 (0.823)	2.73 (0.828)	0.729 (0.575)	I>II>III>V>IV
Intrinsic religiosity total	10.79 (1.96)	9.92 (1.801)	9.25 (1.581)	9.30 (1.252)	9.13 (1.795)	2.898 (0.027)*	I>II>IV>III>V I>V*
Religiousness measure scale							
Religious involvement	12.84 (1.259)	12.69 (1.377)	12.75 (1.035)	12.30 (1.059)	11.27 (1.721)	4.778 (0.002)*	I>III>II>IV>V; I>V*; III>V*
Religious influence	31.47 (2.836)	31.23 (3.086)	29.13 (3.357)	30.10 (2.923)	30.40 (3.549)	0.979 (0424)	I>II>V>IV>III
Religious hope subscale	29.26 (1.821)	29.62 (2.219)	30.75 (1.832)	30.10 (1.449)	30.37 (2.895)	0.968 (0.430)	III>V>IV>II>I
Total religiosity scores	73.58 (3.610)	73.54 (5.125)	72.63 (3.335)	72.5 (3.472)	72.03 (4.657)	0.512 (0.727)	I>II>III>IV>V

love and care 1.96 (SD 0.672) vs 1.81 (SD 0.895) t= 0.784 (0.024). Asked forgiveness for my sins 1.91 (0.591) vs 1.81 (0.849) t-value=0.539 (0.018). Focused on religion to stop worrying about my problems 1.94 (0.677) vs 1.92 (0.545) t value 0.115 (0.036).) and total score of religious measure scale (72.07 (3.618) vs 74.19(5.020) t value -1.929 (0.029) among married and unmarried persons.

There was significant positive relationship found between GAF and some subscale of religious coping and religiosity like in scores of positive RCOPE [0.285*(0.045], DUREL Intrinsic religiosity [0.303*(0.032] and religious influences [0.295* (0.037)]. Scores of negative RCOPE was negatively correlated with score of GAF. There was also no significant relationship found between all domains of WHOQOL-BREF score and score of religious coping and religiosity Except for religious involvement as shown in table no 4.

Table 3: Religious Coping Strategies Utilized by Patients as per Brief Religious Coping Scale

Variable	Group-I Schizophrenia (n = 19)	Group-II depression (n=13)	Group-III Bipolar disorder (n=8)	Group IV OCD (n=10)	Group-V Controls (n=30)	ANOVA	Post-hoc
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	F-value (p-value)	
Negative religious coping							
Wondered whether God had abandoned me	1.16 (0.688)	1.46 (0.66)	1.63 (0.744)	1.5 (0.527)	1.3 (0.596)	1.089 (0.368)	III>IV>II>V>I
Felt punished by God for my lack of devotion	1.37 (0.684)	1.77 (0.439)	1.88 (0.354)	1.3 (0.675)	1.4 (0.724)	1.871 (0.124)	III>II>V>I>IV
Wondered what I did for God to punish me	1.26 (0.653)	1.46 (0.66)	1.5 (0.756)	1.5 (0.527)	1.37 (0.718)	0.33 (0.857)	IV=III>II>V>I
Questioned God's love for me	1.26 (0.562)	1.46 (0.66)	1.75 (0.463)	1.1 (0.738)	1.43 (0.728)	1.323 (0.269)	III>II>V>I>IV
Wondered whether my church had abandoned me	1.16 (0.688)	1.15 (0.689)	2 (0.535)	1.2 (0.632)	1.57 (0.679)	3.398 (0.013)*	III>V>IV>I>II III>I*; III>II*
Decided the devil made this happen	1.21 (0.631)	1.15 (0.801)	1.75 (0.463)	1.2 (0.789)	1.4 (0.77)	1.149 (0.34)	III>V>I>IV>II
Questioned the power of God	1.32 (0.749)	1.23 (0.599)	1.63 (0.744)	1.5 (0.527)	1.27 (0.868)	0.542 (0.705)	III>IV>I>V>II
TOTAL	8.74 (1.910)	9.69 (1.974)	11.88 (0.991)	9.4 (1.578)	9.57 (2.192)	3.742 (0.008)*	III>II>V>IV>I III>I* III>V*
Positive Religious Coping Subscale Items							
Looked for a stronger connection with God	2.16 (0.688)	2 (0.913)	2.13 (0.354)	1.8 (0.632)	1.73 (0.640)	1.442 (0.228)	I>III>II>IV>V
Sought God's love and care.	1.95 (0.705)	1.85 (0.899)	1.88 (0.641)	2.5 (0.527)	1.73 (0.740)	2.119 (0.087)	IV>I>III>II>V
Sought help from God in letting go of my anger.	2.32 (0.82)	1.85 (0.801)	2.38 (0.518)	2.2 (0.632)	1.87 (0.776)	1.732 (0.152)	III>I>IV>V>II
Tried to put my plans into action together with God.	2 (0.816)	1.77 (0.832)	2.75 (0.463)	2.4 (0.699)	2.13 (0.629)	2.893 (0.028)*	III>IV>V>I>II III>II*
Tried to see how God might be trying to strengthen me in this situation.	1.74 (0.653)	1.92 (0.862)	2 (0.756)	2.1 (0.994)	2.07 (0.521)	0.759 (0.555)	IV>V>III>II>I
Asked forgiveness for my sins.	1.84 (0.834)	2.08 (0.641)	1.88 (0.641)	1.6 (0.843)	1.9 (0.548)	0.702 (0.593)	II>V>III>I>IV
Focused on religion to stop worrying about my problems.	2.05 (0.78)	2.15 (0.555)	2.13 (0.641)	1.4 (0.843)	1.9 (0.607)	2.206 (0.076)	II>III>I>V>IV
TOTAL	14.11 (1.629)	13.62 (2.694)	15.13 (1.356)	14.00 (2.357)	13.23 (1.832)	1.670 (0.166)	III>I>IV>II>V

Table 4: Correlation between GAF, WHOQOL-BREF score and religiosity measures, duke religion index, and religious coping

	GAF	WHOQOL-BREF score				
		Physical health	Psychological health	Social relationship	Environment	Total QOL score
Positive-RCOPE	0.285* (0.045)	-0.258* (0.021)	-0.041 (0.717)	-0.181 (0.103)	0.39 (0.728)	-0.152 (0.178)
Negative-RCOPE	-0.290* (0.041)	-0.142 (0.209)	-0.070 (0.536)	-0.075 (0.508)	0.107 (0.343)	0.040 (0.723)
DUREL Organised	0.112 (0.439)	0.017 (0.881)	-0.007 (0.948)	0.087 (0.442)	0.034 (0.763)	-0.014 (0.903)
DUREL Non-organised	0.134 (0.353)	0.032 (0.779)	-0.028 (0.808)	-0.024 (0.829)	-0.198 (0.078)	-0.066 (0.559)
DUREL intrinsic	0.303* (0.032)	-0.114 (0.315)	-0.119 (0.294)	-0.056 (0.622)	-0.023 (0.839)	-0.026 (0.816)
Religious influence	0.295* (0.037)	-0.196 (0.081)	-0.013 (0.907)	-0.79 (0.484)	-0.041 (0.718)	-0.018 (0.875)
Religious involvement	0.034 (0.815)	-0.383* (0.00)	-0.223* (0.047)	-0.374* (0.001)	-0.243* (0.030)	-0.330* (0.003)
Religious hope	-0.070 (0.63)	0.083 (0.466)	0.126 (0.266)	0.022 (0.846)	0.227* (0.043)	0.179 (0.112)

DISCUSSION

The present study attempted to study the level of religiosity and religious coping among patients with various mental disorders attending Psychiatry OPD and healthy controls. It is hoped that understanding the importance of religion for the patients and its influence on outcome variables such as residual psychopathology and QOL can help the clinicians in better organization of services as per the needs of the patients, improve the outcome of patients and developing a holistic approach to treatment.

For this study, 50 patients with various mental disorders who were clinically stable were assessed for religiosity on 2 standardized scales, i.e., the religiosity measure scale and DUREL. Religious coping was assessed using brief RCOPE. The demographic profiles were found to be like previous studies. [23-25].

In terms of religiosity as assessed on the DUREL, there was no significant difference between the diseased groups and the healthy controls for organized religious activities and the nonorganized religious activities. However, on one of the items of intrinsic religiosity (My religious beliefs are what really lie behind my whole approach to life), patients with schizophrenia scored significantly higher than the control group. No significant difference was seen among the four disorder groups. Few previous studies on religious coping reported similar findings [26]. From the above findings, it can be said that the present study partially supports previous studies. When religious practices of the patient with various mental disorders and healthy populations were assessed using different scales, the findings were inconclusive, with some reporting higher. [23] and in a few studies, it was found lower involvement in religious activity among patients with schizophrenia compared to the healthy population [27]. Our findings suggest a higher influence of religious beliefs on the overall approach to life. When the data of the different groups were compared using the Religiousness measure scale, no significant differences were noted among different groups in various domains of the religious measure scale except religious involvement mean of religious involvement among patients with schizophrenia and depression was significantly higher than control groups. As there are inconsistencies in the available literature, our findings must be considered preliminary and must be replicated in future studies.

In religious coping, there was no significant difference between patient groups and healthy control groups in terms of the mean score of different items of Positive RCOPE. Our finding suggests that patient with bipolar affective disorder uses more positive religious coping than patient with depressive disorder groups in one of the items of positive religious coping (Tried to put my plans into action together with God.) In terms of the use of negative religious coping, in the present study patients with mental disorders more frequently used negative religious coping compared to healthy controls. Among the different groups of patients with a mental disorder, those who are suffering from Bipolar affective disorder use more negative religious coping than other groups. In few previous studies on religious coping had a similar finding [27-28]. Another study, which evaluated the use of negative religious coping of patients presenting with self-harm to the emergency, also reported a higher frequency of negative religious coping among patients with self-harm, irrespective of the presence or absence of axis-I psychiatric disorder [29]. Accordingly, it can be said that the findings of the present study are supported by the existing literature. In different studies on schizophrenia, it was found that higher use of negative religious coping was associated with higher residual positive and negative symptoms, which suggests that higher use of negative religious coping can be adverse for residual psychopathology. A previous study done has shown that patients with depression who uses more negative religious coping are associated with higher severity of suicidal ideation [30]. Based on the findings of the present study, we can hypothesize negative religious coping has an adverse impact on the residual psychopathology of the patient which can lead to treatment failure so, it can be recommended that clinicians managing patients with various psychiatric disorders should always evaluate the religious coping of the patients and should encourage them to use more adaptive coping and to avoid the use of negative religious coping.

A study from Germany, reported that diagnosis, education, gender, duration of illness, and self-evaluation of current mental health status had no significant statistical impact on the importance of religion [31]. The findings of the present study also suggest that sociodemographic variables such as gender, education, and duration of illness have no relationship with different aspects of religiosity and religious coping.

The findings of the present study suggest that religious influence, intrinsic religious practices, and the use of positive religious coping are associated with better QOL. This finding is in concordance with previous studies which suggests that religion is associated with better QOL [32-33] and regard to the relationship between religion and psychosocial adaptation [34] and better recovery [35-37]. Accordingly, it can be said that encouraging the patients to participate in public and private religious activities can reduce the level of residual psychopathology and improve the QOL of patients.

In making future government policy in prevention and creating awareness of mental illness should consider religion as one of the stakeholders as religious practice and religious coping might help in overall improvement of quality of life of patients suffering from mental illness. For all these purpose we should focus on more scientific research on the impact of religiosity and religious coping on quality of life and prevention of various mental illness.

Limitations:

The present study has certain limitations in the form of a small sample size, purposive sampling, and cross-sectional assessment. This study was limited to the patients attending the Psychiatry outpatient service of a tertiary hospital. Hence the result cannot be generalised to the other patient population. The assessment of the religious practices of the patients may not be a complete reflection of their premorbid practices, with the possibility of being coloured by the whole experience of illness. So detailed evaluation from attendants/caregivers regarding patients' premorbid religious practices may be required. The study involved a cross-sectional evaluation and did not include patients with comorbidities. It is important to understand that this was an exploratory study, and hence, the results must be considered preliminary, needing further validation. Future studies must attempt to overcome these limitations.

CONCLUSION

To conclude, the present study suggests that compared to healthy controls, patients with severe mental disorders have higher religious involvement and positive religious coping. Patient with schizophrenia has higher intrinsic religious practices than healthy control and patient with the bipolar affective disorder have higher negative religious coping than others. The present study also suggests a higher level of religious influence, intrinsic religious practices and positive religious coping improve the level of functioning and quality of life.

Keeping these things in mind, we can opine that clinicians should be more approachable with regard to religiosity among patients. In the holistic care of the patients, clinicians should enquire about the religiosity and spirituality, religious and spiritual practices, and religious and spiritual needs of the patients. They should encourage the patients to use positive religious coping strategies and guide the patients to decrease the use of negative religious coping.

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Acknowledgements – Nil
Conflict of Interest – Nil
Funding – Nil