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THE IMPACT OF RELIGIOSITY ON QUALITY OF LIFE AND PSYCHOLOGICAL SYMPTOMS IN CHRONIC MENTAL PATIENTS

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SUMMARY

Introduction: *In recent decades, there is more and more scientific research and evidence that religiosity has a positive impact on quality of life and mental health. The aim this study is to evaluate the impact of religiosity on the quality of life and psychological symptoms of chronic mental patients.*

Subjects and methods: *The test group was consisted of 100 chronic mental patients at the Clinic for Psychiatry UCH Mostar, and control group was consisted of 80 somatic patients surveyed from the Infirmary of family medicine of the Health Center Mostar. The survey was conducted by the social and demographic questionnaire, a questionnaire on the quality of life of the World Health Organization WHOQOL-BREF, the questionnaire on religiosity and self-assessment questionnaire for psychological symptoms SCL-90th.*

Results: *For the socio-demographic data we obtained results that chronic mental patients as opposed to chronic somatic patients have significantly higher percent of an average lifestyle habits. There is statistically significant difference in the place of residence, chronic mental patients live in the city as opposed to somatic who live in the countryside. On the question of religiosity we received information that the chronic mental patients in relation to chronic somatic patients significantly more attend public religious gatherings, but however, chronic somatic patients compared to chronic mental significantly more use religiosity for better financial position, social comfort. In self evaluation of psychological symptoms we received information that the chronic mental patients as opposed to chronic somatic patients had significantly more psychotic features. To test the quality of life between the two groups, we received the information that chronic mental patients have significantly better physical and mental health, social relationships and caring for the environment as opposed to chronic somatic patients.*

Conclusions: *Quality of life was significantly better in the chronic mental patients. Also, chronic mental patients significantly more attend public religious gatherings, while chronic somatic patients significantly more use religiosity for a better financial position, social comfort. Finally, chronic mental patients had a significantly more pronounced psychotic features.*

Key words: *religiosity - quality of life - psychological symptoms - mental patient*

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INTRODUCTION

Depending on the science within which it is observed, religion is perceived in different ways. Within psychology, religion is defined as a system of understanding, beliefs, behaviors, rituals and ceremonies by which individuals or communities put themselves in a relationship with God or the supernatural world and often in relationship with one another, and of which (system) religious person receives the values which govern and judge the natural world (Coric 1998). Religiosity indicates interest in religion, involvement or participation in religion. The attitude towards religion is not understood as a dichotomy religious - atheists, but as a continuum in which one end is complete religiosity, and the other end is complete lack of belief (Marinovic et al. 2000). Between these two extremes are all possible intermediate stages in which the components of religion are mixed with the components of unreligiousness. American psychologist Gregory Zilboorg, who has, in many ways, corrected Freud's unilateral binding of religiosity with neurosis, though has written: "I am skeptical with regard to the tendency... to link mental health and religious life. If someone is mentally ill, he/she can not become a successful street sweeper, nor can lead adequate religious life. On the other hand, we have a great criminals with deep religious life and neurotics with authentic holiness. For all these reasons, I am very cautious when it points out that religious life helps mental health and vice versa, and that mental health promotes the religiosity. "In addition to these general difficulties, to the quiet study of the problems, some old and new misunderstandings are the greatest obstacle (Stoiljković 1979).

When measuring different dimensions of religiosity commonly used methods are different questionnaires, one-dimensional, two-dimensional and multi-dimensional scales. As the name suggests, one-dimensional scale questionnaire examines one aspect of religiosity. An example of such a scale is a scale of attitudes towards the Church which was constructed in 1929 by Thurstone and Chave (Lavric & Flere S 2008). In the

two-dimensional concepts of religiosity the tendency of polarization of dimensions to positive and negative is manifested, or, in other words, the distinction between internalized religious value system and externally visible religious behavior behind which is not a personal religious commitment (Coric 1998).

The idea of God can fulfill more or less space in the minds of religious people. A certain "swall" of thoughts about God comes in every normal man-believer in some situations, when he/she sees the only solution in the religious response. However, the religious thought can oversize artificially, for example, by excessive fasting, solitude, persistent engagement in religious writings. Such a person considers himself very religious, but of this religiosity environment has little benefit. Everything is erased from consciousness except their own religiosity (Bergin & Jensen 1990).

The World Health Organization (WHO) defines quality of life as an individual's perception of his position in life in the context of the culture of life and value systems in which he lives, and in relation to the goals, expectations, standards and environmental problems (Cummins 2000). One of the more comprehensive definition is given by Felce and Perry who define the quality of life as an overall general well-being, which includes the objective factors and subjective evaluation of physical, material, social and emotional well-being, including personal development and purposeful activity, and all observed through personal evaluation system of the individual (Felce & Perry 1993). Subjective quality of life includes seven domains: material well-being, emotional well-being, health, productivity, intimacy, safety and community. The objective component includes culturally relevant measures of objective welfare (Cummins 1998). An international team of researchers and scientists "International Well-Being Group" represents the view that quality of life is multidimensional and that it is consisted of: living standards, health, productivity, the possibility of achieving close contact, security, belonging to a community and a sense of security in the future (Diener et al. 1995). An objective approach to the study of quality of life is based on a set of assumptions about what constitutes a good life, and is focused on the identification of external conditions that would improve the quality of life. This approach uses a variety of events, environmental and demographic factors as indicators of quality of life (Oliver et al. 1995). The differences in quality of life due to some demographic variables, such as gender, age, education, marital status, culture and the like can be seen, but the results of these studies are mostly inconsistent. Most studies showed no gender differences in the subjective quality of life, while some other studies established negative correlation between age and quality of life (Lučev & Tadinac 2012). As for marital status, studies show that, generally, people in marriage or in common law marriage have a higher personal quality of life than singles. Similarly, more educated are more satisfied with their lives than those of lower education. As far as cultural differences are concerned, although individuals live in different circumstances, the average level of life satisfaction of the world population varies only about 20% (Mihaljevic et al. 2012).

Research of quality of life of mentally ill, mainly schizophrenics, have appeared at the beginning of the 90's. In determining the quality of life of schizophrenic patients the absence or intensity of present psychiatric symptoms and side effects of drugs plays an important role (Sansome et al. 1990). The conclusion of these first results was that chronically ill psychiatric patients have a lower quality of life compared to the general population (WHO 1998). Schizophrenic patients have a reduced quality of life for many reasons. First, there are reduced personal resources to meet their own needs (reduced number of cognitive and social skills, sensitivity to stress and external criticism), that lead them, more or less directly, to social isolation and make them subjects of social stigmatization. In fact, if patients accept labeling, they usually receive social benefits and thus the help of professionals (Neeleman & Persaud 1995).

Measurements of the quality of life of psychiatric patients are used for different purposes. In the first place it is the assessment of the success of treatment and prevention of diseases. It also examines the satisfaction of treatment, so the research of quality of life is very often related to assess their treatment (Martin & Allan 2007). According to available literature, the quality of life of chronic mental patients is not well enough understood, especially in our region, but the purpose of this study was to complete this issue, point out problems and lay the foundation for further research and improvement of the quality of life of psychiatric patients in Mostar. The aim of this paper is to examine the impact of religiosity on the quality of life and psychological symptoms of chronic mental patients.

SUBJECTS AND METHODS

Subjects

The study included 180 subjects. The test group was consisted of 100 chronic mental patients at the Clinic for Psychiatry of the UCH Mostar, while the control group was consisted of 80 chronic somatic patients at the Infirmary of Family Medicine of the Health Center Mostar. Both groups included subjects of both sexes aged 25-65 years.

The study included subjects that met the following criteria:

- The test group included chronic patients with a confirmed diagnosis of chronic mental illness (schizophrenia, schizoaffective disorder and bipolar affective disorder), who were hospitalized at the Clinic for Psychiatry of UCH Mostar or were interviewed during regular psychiatric controls.

- The control group included chronic patients, with a confirmed diagnosis of chronic somatic diseases (cardiovascular, gastrointestinal, rheumatic, immunological, endocrine, pulmonary and renal).
- Chronic patients younger than 25 and older than 65 and patients, who along with a primary diagnosis of chronic mental illness, have a diagnosis of chronic somatic disease, and if, together with a primary diagnosis of chronic somatic disease have a diagnosis of chronic mental illness, were excluded from the research.

Methods

For the realization of the goals the following instruments were used:

- Personally developed socio-demographic questionnaire, made for this study. The questionnaire contained questions about gender, age, place of residence, the standard of living and satisfaction with his mother, father and friends.
- Questionnaire of religiosity (Duke University Religion Index). The scale consists of five items that capture the three dimensions of religiosity that are more related to health outcomes: Organizational religious activity (Ora participation in religious meetings, such as the mass and church services), non-religious organization activity (NORA - attend private religious activities, such as prayers) and intrinsic religiosity (IR search internalization and full experience of faith as the main goal of the individual). In analyzing the results of DUREL, the results for all three dimensions (ORA, Nora and IR) should be analyzed separately, and their results should not be added to the overall score (Koenig 1998).
- SCL-90 (Symptom Check List 90) self assessment questionnaire assessing ie. Extent nine personality dimensions: somatization, obsessive-compulsive reactions, interpersonal sensitivity, depression, anxiety, phobic anxiety, hostility, paranoid ideation, psychoticism (Derogatis & Savitz 2000).
- Questionnaire quality of life of the World Health Organization WHOQOL-BREF is a short form questionnaire WHOQOL-100. Selected 24 items from the original questionnaire, one from each of the 24 items that describe the quality of life, and has been selected by one particle to the quality of life in general and for general health. The questionnaire in its entirety contains 26 items. As a result of the questionnaire WHOQOL-BREF gets the profile of the quality of life that is based on a model that explains the quality of life through four areas: physical health, mental health, social relationships and environment. The results were obtained by combining 24 items questionnaire. The result in each area is expressed as the average response to the particles is described. Particle overall quality of life and general health are considered private. Answers for each item are given on a scale Likert of 1-5, where 1 denotes at least match and 5 indicates the highest agreement with particle (Skevington et al. 2004).

Table 1. The differences between the groups with respect to socio-demographic dana

	Group of subjects					
	Chronic mental		Chronic somatic		χ^2	p
	N	%	N	%		
Gender					0.140	0.708
Men	62	62.6	47	58.8		
Women	37	37.4	33	41.2		
Education					7.097	0.214
Complete or incomplete primary school education	11	11.1	4	5.0		
Vocational schools	6	6.1	10	12.5		
High School	57	57.6	51	63.7		
College	13	13.1	11	13.8		
Faculty	11	11.1	4	5.0		
Do not know	1	1.0	0	0.0		
Standard					15.858	0.003*
Significantly higher than the average	0	0.0	2	2.5		
Slightly higher than the average	13	13.1	7	8.8		
Average	59	59.6	65	81.2		
Slightly lower than the average	19	19.2	5	6.2		
Significantly lower than the average	5	5.1	0	0.0		
I can not evaluate	3	3.0	1	1.2		
Place of residence					39.535	<0.001
Village	31	31.3	26	32.5		
City	65	65.7	25	31.2		

Table 2. Religiosity in relation to the type of subjects

	Group of subjects				t	p
	Chronic mental		Chronic somatic			
	$\bar{X}$	SD	$\bar{X}$	SD		
ORA	3.36	1.60	2.61	1.45	3.252	0.001
NORA	2.73	2.00	2.69	1.25	0.162	0.871
IR	6.66	4.06	7.58	1.97	1.981	0.049

Statistical data processing

Results for categorical variables were expressed as frequency and percentage, for parametric variables as mean and standard deviation. To test the differences between categorical variables chi-square test and the parametric variables were used, and Student t-test for independent samples. The level of significance of $p<0.05$ was taken as statistically significant.

Table 3. The differences between the groups in relation to the self-assessment of mental symptoms

	Group of subjects				t	p
	Chronic mental		Chronic somatic			
	$\bar{X}$	SD	$\bar{X}$	SD		
Somatization	1.75	0.47	1.03	0.90	0.861	0.390
Obsessive compulsive symptoms	0.65	0.55	0.61	0.46	0.474	0.636
Interpersonal vulnerability	0.85	0.62	2.16	0.75	1.327	0.186
Depression	0.93	0.67	2.14	0.45	1.274	0.204
Anxiety	0.88	0.74	0.81	0.75	0.640	0.523
Aggressiveness	0.91	0.78	0.81	0.63	0.964	0.336
Phobias	0.72	0.71	1.13	0.46	1.577	0.117
Paranoia	0.62	0.61	0.61	0.73	0.038	0.970
Psychotic features	0.70	0.59	0.49	0.43	2.778	0.006
Non-specific symptoms	0.75	0.66	0.90	0.64	0.816	0.416

Table 4. Quality of life in relation to the type of subjects

	Group of subjects				t	p
	Chronic mental		Chronic somatic			
	$\bar{X}$	SD	$\bar{X}$	SD		
Physical health	14.44	2.85	13.06	1.88	3.877	<0.001
Mental health	13.60	2.91	12.71	2.03	2.418	0.017
Social relations	13.35	3.45	11.02	2.04	5.615	<0.001
Environment	13.36	2.96	12.56	1.15	2.486	0.014
Bref total	12.79	3.65	12.73	3.20	0.121	0.904

For statistical analysis software system SPSS for Windows (version 17.0, SPSS Inc., Chicago, Illinois, USA) and Microsoft Excel (versions 11.0., Microsoft Corporation, Redmond, WA, USA) were used.

RESULTS

According to data from the first chart, statistically significant difference was seen for the standard question of life and place of residence or chronic mental patients significantly more live an average lifestyle in relation to chronic somatic and chronic mental patients significantly more live in the city in relation in comparison to the chronic somatic who live more in cities, but it is not statistically important fact (Table 1, 2).

The results showed that chronic mental patients in relation to somatic, significantly more often attend public religious gatherings (prayer groups, Bible study groups), but however chronic somatic patients compared to chronic mental, significantly more use religiosity for a better financial position, social comfort (Table 3).

In the self assessment of psychological symptoms we received information that the chronic mental patients as opposed to chronic somatic patients had significantly more psychotic features (Table 4).

To test the quality of life between the two groups we gained the information that chronic mental patients have significantly better physical and mental health, social relationships and caring for the environment as opposed to chronic somatic patients.

DISCUSSION

In this study, our goal was to examine the influence of religion on the quality of life of chronic mental patients and compare the quality of life of chronic somatic patients because such or similar survey was never conducted in the Federation of Bosnia and Herzegovina.

The research conducted at the psychiatric clinic in Tuzla showed that at high religious respondents factors such as internal conflicts, frustration, fear, anxiety, psychological trauma, injury-esteem, mental imbalance

of homeostasis occurre in a lesser extent, and that the negative psychological energy is neutralized through healthier and more efficient way. This ensures adequate assessment of the situation in which the subject is afflicted, more rational allocation and utilization of psychic energy, faster socialization, greater resistance to frustration, more effective overcoming of conflicts, greater satisfaction, more pronounced tendency towards higher goals. Highly religious are less anxious, less depressed, and less aggressive and are in lesser extent suspectible to deviant behavioral patterns (Larson et al. 1997). There are also significant evidence linking the spiritual life with mental health. Some meta-analysis indicated a figure of 80% studies that have found a positive connection of spirituality / religiosity with mental health (Gallup 1996).

According to the results of this research, it is evident that the chronic mental patients in relation to chronic somatic patients significantly more attend public religious gatherings (prayer groups, Bible study groups), but it is interesting information that chronic somatic patients compared to chronic mental significantly more use religiosity for better financial position, social comfort. This is to be expected regarding the fact that the function of religion is assisting with daily treatment of depressive states, is overcoming difficult situations and life crises, is controlling pathological thinking and behavior, is helping people disappointed in the life to come to sense, but also leads to the successful socialization and culture of man. A statistically significant correlation was shown between religiosity and males and females, and it was found that the male subjects compared to female significantly more perform religious activities in private life, such as prayer, scripture study, watching religious television programs, listening to religious radio.

Chronic mental patients as opposed to chronic somatic patients had significantly more psychotic features, which is not surprising. Chronic mental patients who include schizophrenic patients, who are the patients with the most common psychotic disorder, are characterized by hallucinations and delusions (Mihaljevic 2014).

The Quality of Life of mentally ill, mainly schizophrenics, have appeared at the beginning of the 90s of the last century. The conclusion of these first research was that chronically ill psychiatric patients have a lower quality of life compared to the general population (Helgeson 1993). Based on current literature the following characteristics of the quality of life of schizophrenic patients are identified: quality of life of schizophrenic patients is worse than the quality of life of the general population; young people, women and married people, as well as less educated schizophrenic patients have a better quality of life; quality of life of schizophrenic patients declines with the duration of disease and the number of hospitalizations; better quality of life show those schizophrenic patients who are on a combined psychotherapy and psychopharamacologic treatment and patients involved in programs to support the community (Lauer 1993).

Our results showed an interesting twist, ie. We got the information that chronic mental patients have significantly better physical and mental health, social relationships and caring for the environment as opposed to somatic diseases.

CONCLUSIONS

Chronic mental patients attend public religious gatherings more than chronic somatic, but chronic somatic patients compared to chronic mental patients use religiosity more often for personal gain. Chronic mental patients have better physical and mental health, social relationships and caring for the environment as opposed to chronic somatic patients, chronic mental patients have more psychotic features.

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Contribution of individual authors:

Martina Šimunović: Participated in the design of the study, literature searches and analyses and interpretation of data;
Stanija Tokmakčija: Participated in selection of the patients;
Marko Pavlović: Literature searches, analyses and interpretation of data, writing the manuscript;
Romana Babić: Interpretation of data, writing the manuscript;
Marina Vasilj: Patient's data analiyses;
Marko Martinac: Statistical analyses;
Ivan Vasilj: Design of the study, interpretation of data;
Dragan Babić: Participated in the design of study, selection of the patients, questionnare distribution and took part in interpretation and formatting data.

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