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Religious coping among self-harm attempters brought to emergency setting in India

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ABSTRACT

This study attempted to evaluate religious coping and its correlates among patients presenting with self-harm to an emergency setting and compared it with a healthy control group. Religious coping was assessed using brief RCOPE. Beck Hopelessness Scale, Beck Depression Inventory, Barratt Impulsivity Scale, Scale for Suicidal Ideations and Irritability Depression Anxiety scale were used to assess for hopelessness, depression, impulsiveness, suicidal ideations and irritability respectively. The study included 32 subjects with depression and 77 subjects without any psychiatric diagnosis who presented with self-harm and 50 healthy controls. Compared to healthy controls, those with self-harm irrespective of presence or absence of psychiatric diagnosis less often used positive religious coping and more often used negative religious coping. Further, among those without psychiatric diagnosis (with self harm), there was positive correlation of negative religious coping with impulsivity and hopelessness. Among those without psychiatric diagnosis with self-harm, both positive and negative religious coping correlated positively with depressive scores, severity of suicidal ideations, anxiety and irritability, but associations were stronger for negative religious coping than that for positive religious coping. The findings of the present study suggest that those who indulge in self harm have lower use of positive religious coping and higher use of negative religious coping.

1. Introduction

Suicidal behaviour is considered to have multiple risk and protective factors (Choi et al., 2013; Yur'yev et al., 2015). Religiosity is believed to have some protective role in suicide. Available data suggests that suicide rates are lower in religious countries than in secular ones (Neeleman et al., 1997). In terms of different dimensions or components of religiosity and spirituality, data suggests that suicidal gestures/suicidal attempts/suicidal ideations are negatively related with religious commitment (Koenig et al., 2014, 2001; Nock et al., 2008), religious affiliations (Nock et al., 2008; Parker et al., 2003) and high moral objection (Koenig et al., 2001; Milner et al., 2011). It is further suggested that religious affiliation/commitment/participation is associated with lower aggression (Koenig et al., 2014, 2001), impulsivity (Colucci and Martin, 2008; Nkansah-Amankra et al., 2012; Perroud et al., 2011), better social ties (Koenig et al., 2001; Nock et al., 2008), reduced alienation (Koenig et al., 2014; Nock et al., 2008) and better social support (Koenig et al., 2014; Parker et al., 2003). All these factors possibly contribute to lower suicidal behaviours.

Very few studies have evaluated the relationship of suicidal behaviour and religiosity among patients suffering from depression. These studies have evaluated religiosity in the form of religious affiliations (Sun et al., 2012), religious participation (Kleiman and Liu, 2014) in the form of attending the religious places, spiritual practices in the form of beliefs, meditation and religious coping (Rasic et al., 2009; Sun et al., 2012). Data among patients suffering from depression suggests that suicide and suicidal behaviour has negative association with religious attendance, religious worship and having religious affiliation. Studies which have compared suicide attempters and non-attempters, suggest that non-attempters have greater fear of social disapproval and greater moral objections to suicide (Kleiman and Liu, 2014;

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Nkansah-Amankra et al., 2012; Rasic et al., 2009). In terms of religious coping, data suggests that religious coping and relationship with God prevented suicidal behaviour (Wang et al., 2013). However, data also suggests that religion can have detrimental effects by inspiring guilt and fear which in turn can reduce life satisfaction. Studies have also shown higher prevalence of psychiatric disorder and suicide attempts among religious patients, which is contradictory to the general view that religion is always protective (Colucci and Martin, 2008). Based on the available literature, it can be concluded that religion influences suicidal behaviour in general population, as well as those suffering from mental disorders like depression.

Theories which evaluate the role of coping in dealing with major life stressors emphasize the active role played by the person in dealing with a stressor (Lazarus and Folkman, 1984). However, it is generally suggested that initial research on coping has not focused much on the religious dimension. Religious coping is understood as "sacred" methods used to deal with life stressors and the term "sacred" is used for '*traditional notions of God, divinity or higher powers, but also to other aspects of life that are associated with the divine or are imbued with divine-like qualities*" (Pargament, 2001; Pargament et al., 2004). Further it is suggested that religious coping has multiple functions (lowering of anxiety improving, intimacy with others, self identity, control over a situation, transformation of a person, etc), are multimodal (i.e., influences behaviour, emotions, relationships and cognition) and multivalent (i.e., have positive and negative influence) (Pargament, 2001). Further, it is suggested that religious coping expresses variously in different life situations, hence, understanding the religious coping dimension, especially of those facing major life crisis can be very useful in understanding the role of the same in dealing with the stressor (Pargament et al., 2011; Pargament, 2001). Based on the multivalent principle, religious coping is conceptualized as positive or negative religious coping (Pargament et al., 2011, 1998). Both positive and negative religious coping offer insights into the manner in which an individual attempts to deal with life stressors utilizing the faith in the sacred or transcendental.

India is a diverse country which is the birthplace of several religions like Hinduism, Buddhism, Sikhism and Jainism; and is home to people of various religious dominations. Religious observations seem to be an important part of the Indian society. Though several studies from India have attempted to find out characteristics of self-harm attempters, none have attempted to assess the religious coping among them. One study evaluated the relationship of suicidal behaviour and religiosity in patients of depression and reported that patients with high religiosity reported lower suicidal intent and fewer attempts than those with low religiosity (Gupta et al., 2011).

Understanding the use of religious coping among patients with psychiatric disorders is of interest as this can help in identifying adaptive and maladaptive religious coping coloured through the lens of psychopathology (Dein, 2010; Nurasikin et al., 2013). Further, many self-harm attempts in India are often triggered by interpersonal issues in the absence of psychiatric disorders (Das et al., 2008; Kattimani et al., 2015), assessing the coping of self-harm attempters without a clinically diagnosable psychiatric disorder can also help in understanding the factors which are protective or contribute to the self-harming behaviour.

Accordingly this study attempted to evaluate religious coping among patients presenting with self-harm to an emergency setting and compare it with a healthy control group. The secondary aims of the study were to: (1) compare the religious coping among patients with depressive disorder presenting with self-harm attempt and those presenting with self-harm attempt but not satisfying any psychiatric diagnosis; (2) to evaluate the correlates of religious coping among those presenting with self-harm attempt.

2. Methods

2.1. Setting and participants

The study was approved by the Institute Ethics Committee and the patients were recruited after obtaining written informed consent. Besides obtaining assent from the patients, informed consent for patients aged less than 18 years was obtained from their legal guardians. The data collection lasted from March 2013 to Dec 2013.

This study was conducted at the emergency department of a tertiary-care central government-funded teaching hospital in north India. The emergency department of the hospital provides round-the-clock care through a team of medical and surgical personnel to both referred and non-referred patients.

A resident from the department of psychiatry initially attends to the patients requiring care for mental health issues in the emergency department under the supervision of a senior resident and a consultant psychiatrist. The resident is present throughout the day (i.e., from 8:00 AM to 8.00 PM) and is on call for the remaining duration (i.e., from 8:00 PM to 8.00 AM). The patient is initially evaluated by the junior resident under the supervision of a senior resident, who takes a detail history from the patient and the accompanying close relatives. Depending on the requirement, patients are investigated further. The patient is reviewed by the consultant and on the basis of all the available information in terms of history, findings of physical examination and investigations a psychiatric diagnosis is made and treatment plan is formulated. All the diagnoses are made on the basis of International Classification of Diseases, 10th revision (ICD-10). All the patients presenting to the medical emergency outpatient services with self-harm are referred for psychiatric evaluation after initial physical stabilization.

To be included in the study, the participants were required to have come to/brought to emergency after an attempt of self-harm by any means, were medically stable to cooperate for an interview with the psychiatrist and able to complete the required questionnaires and provided informed consent to participate in the study. Those who refused informed consent, who were too sick to be evaluated prior to being shifted out of emergency, were excluded. Similarly those who were very sick throughout their stay in the emergency were not included. Those with psychiatric disorder (including personality disorders), other than depressive disorders (i.e., depressive episode, recurrent depressive episode, and dysthymia) were excluded.

The present study included patients brought to the emergency department with recent self-harm behaviour. Based on the presence or absence of a depressive disorder, the study sample was divided into two groups, i.e., those with depressive disorders (Group-1) and those without any psychiatric disorder (Group-2). A control group included healthy volunteers recruited among the caregivers of patients and hospital staff. The healthy controls were evaluated by a psychiatrist to rule out any axis-I psychiatric diagnosis, except for tobacco dependence and any history of self-harming behaviour (Group-3).

2.2. Procedure

All the patients attending the emergency outpatient services after an attempt of self-harm were eligible for the study. After medical stabilization, patient/caregivers were approached for participation in the study and those who provided written informed consent were included. Based on the presence or absence of a depressive disorder and lack of any axis-I psychiatric diagnosis as per the ICD-10, the study sample was divided into Group-1 and Group-2. Patients of both the study groups were