Religious Coping and Mental Health Outcomes: An Exploratory Study of Socioeconomically Disadvantaged Patients

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Objective: This study was designed to investigate the association between religious coping and mental health in a socioeconomically disadvantaged population.

Methods: Participants were selected as they presented for mental healthcare at a community health center for patients with little, if any, financial resources or insurance. A total of 123 patients participated in this study. Multiple regression analysis was used to identify religious coping predictors for mental health outcomes.

Results: Positive religious coping (PRC) was significantly associated with and predictive of better mental health ($P < .01$). Conversely, negative religious coping (NRC) was found to be significantly associated with poorer mental health scores ($P = .031$) with gender, income, and ethnicity controlled for in the model. The relationship between NRC and inferior mental health outcomes was more robust than the relationship between PRC and improved mental health scores.

Conclusions: This study illustrates the important association between PRC and NRC and mental health outcomes among economically disadvantaged patients. Interpretation of these findings and clinical implications are offered.

Key words: Psychiatry, mental health, religious coping, religious commitment, socioeconomically disadvantaged populations

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INTRODUCTION

It is well documented that psychiatry and religion have, at least during the past century, been at odds. Many influential writers and philosophers, including the noted Renee Descartes and his treatise on mind–body dualism, have contributed to the fracturing of the mind−body and spirit in patient care. It is beyond the scope of this document to review the relationship of psychiatry and religion historically; importantly, however, there has been a national shift in the culture of medicine, academic institutions, and philanthropic organizations toward the recognition of the importance of religious and spiritual life on health. The International Center for the Integration of Healthcare and Spirituality, for example, was founded by the late Dr David Larson, a psychiatrist and epidemiologist who focused on potentially relevant but understudied factors that might help in illness prevention, coping, and recovery. There is a measurable movement toward rerecognizing the patient as an integrated whole, with mind−body and spiritual factors affecting physical and mental health.

Multiple reviews of the empirical literature support the conclusion that the relationship between religiosity and mental health is a generally positive and salutary one.[1-7] Despite the preponderance of data on religious and spiritual factors on health and mental health outcomes generally, there is a paucity of data regarding religious coping and mental health generally and among socioeconomically disadvantaged patients more particularly.

Religious coping involves religious behaviors or cognitions that help a person cope with or adapt to difficult life situations or stress. It may involve prayer to God to change a situation or to give emotional strength, deciding to "turn a situation over" to God, reading inspirational scriptures for comfort or relief for anxiety, talking to a minister or chaplain to help work through a problem, or using any other religious thoughts or behaviors to relieve stress.[8] Further, Pargament[9] explains that religious coping can include seeking religious support, forgiveness, seeking a spiritual connection, and benevolent religious reappraisal. In studies in which patients are directly asked about how they cope with health problems or other major life stressors, they frequently mention religious beliefs and practices.[4] This is true not just for the acutely distressed (ie, "foxhole" religion) but for many dealing with the day-to-day stresses of life.[10] One of the inherent challenges in conducting research in this area currently and historically is the subjectivity of religious terms. On the surface, "religious coping" relates to other common constructs like religiousness and spirituality. Although precision in terminology is complex, the term "religious coping," in the context of this study, was based on the instrument development and work of Ken Pargament, a noted researcher in the field of religious coping.[9,11]

Existing data indicate that religious coping is a stronger predictor of mental health outcomes than general measures of religiosity or religious commitment.[9] Dr Pargament and his col-

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leagues have conducted several studies examining the role of religious coping in dealing with life stressors. They argue that individuals under stress frequently convert general religious beliefs and practices into specific coping or problem-solving behaviors.[9] Through study of the factor structure of religious coping, both positive and negative religious coping constructs have been identified as relevant to mental health outcomes.[9,11]

Positive religious coping (PRC)[11] includes looking for a stronger connection with God, seeking God's love and care, seeking help from God and letting go of anger, trying to put plans into action together with God, trying to see how God might strengthen a person facing a difficult situation, asking for forgiveness, and focusing on religion to stop worrying about problems. Negative religious coping (NRC)[11] includes wondering about being abandoned by God, feeling punished by God for lack of devotion, wondering whether one is being punished by God, questioning God's love, wondering whether one's church has abandoned them, deciding the devil made the difficulty happen, and questioning the power of God. Both PRC and NRC have been related to mental health outcomes, with PRC associated with better mental health and NRC with poorer mental health outcomes.[11,12] Pargament[9] has further reported that positive religious coping patterns have been tied to benevolent outcomes, including fewer symptoms of psychological distress, reports of psychological and spiritual growth as a result of the stressor. PRC has been shown to have an ameliorative effect on psychological sequelae among patients with varied medical conditions,[12-14] with NRC being more strongly related to negative mental health.[15,16]

Socioeconomic status, whether measured by income, occupation, or education, has been shown to be a strong, consistent, and independent predictor of mental and physical health.[17] Religiousness is often inversely related to education level and income as economically disadvantaged residents, often lacking other resources to fall back on, often turn to religion to cope.[8] Considering the relationship between socioeconomic status and mental health, and because of the paucity of research on religious coping among socioeconomically disadvantaged individuals, our study set out to explore the relationship among these variables. Our hypothesis was that among our study sample, positive religious coping would have a significant association with reduced mental health distress and that negative religious coping would be alternatively associated with increased distress and poorer mental health outcomes.

METHODS

Participants

The protocol for this study was approved by the Institutional Review Board (#10-200) of the University of Texas Medical Branch. The study was explained to patients as they presented for outpatient psychotherapy at an ambulatory community medical clinic for low-income and underserved patients. There were no consequences nor incentives associated with participants participation in the study. Because the intent was to obtain a convenience sample of patients presenting for mental health services, patients were not excluded on the basis of any specific criteria.

Procedures

The design of this study was cross-sectional. Patients completed the religious coping measure brief Religious Coping Inventory (brief-RCOPE),[18] and the Short Form-36 (SF-36),[19] a measure of physical and mental health functioning.

Measures

Demographic questions. Several demographic questions were asked of the respondents, including age, gender, ethnicity, marital status, religious affiliation and educational and income levels.

The SF-36. The SF-36 is an eight-scale self-report measure designed to assess health concepts representative of basic human values that are relevant to everyone's functional status and well-being.[19-21] The SF-36 mental component scale (MCS) is a summary scale comprising five individual subscale scores (general health, vitality, social functioning, role–emotional, and mental health) and has been shown to be a useful measure in the screening for psychiatric disorders.[22] For example, using a cut-off score of 42, the MCS had a sensitivity of 74% and a specificity of 81% in detecting patients with depressive disorder.[22] The MCS scores were calculated with the use of an algorithm developed by Ware et al[23] with a linear *t*-score transformation and a mean score of 50 and standard deviation of 10. The Cronbach's alpha of the MCS is 0.90 with well-established validity.[19]

Brief-RCOPE. The brief-RCOPE[18] is a measure developed to assess an individual's positive and/or negative religious coping and consists of two seven-item subscales pertaining to positive and negative religious coping, respectively. Scores range from seven to 21 on each scale, with higher numbers indicating the greater prevalence of that particular type of coping. Cronbach's coefficient alpha for the brief-RCOPE has been estimated at 0.87 and 0.69 for both the scales.[18]

Analysis

Multiple linear regression was used to examine the extent to which positive and negative coping significantly predict SF-36 MCS scores after controlling for sociodemographic variables such as gender, ethnicity, marital status, education and income.

RESULTS

The initial sample included 143 patients. Twenty of these patients reported annual incomes greater than $20,000 and were removed from the analysis because their incomes were greater than the federal poverty level at the time the data were collected. Of the remaining 123 participants, 92 were female. Average age of subjects was 40 years (SD 11.2). Seventy-eight percent of subjects reported annual incomes less than $10,000, and the remainder reported income between $10,000 and $19,000. Seventeen percent of the subjects identified themselves as Hispanic or Latino, 55% as white or Caucasian, and 26% as black or African-American. Religious affiliation included 9% (fundamentalist Protestant), 34% (Baptist), 20% (Catholic), 6% (mainline Protestant), and 13% (unaffiliated), with 17% reporting as "other Christian." The remaining 1% included Buddhists, agnostics, or persons with no identified religious affiliation.