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An investigation of the relationship between schizophrenic patients' strength of religious faith and adherence to treatment

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Introduction

Humans' complete health depends on both physical and mental health. Various factors such as heredity, experiences, environment and personal characteristics shape individuals' psychological health (Güler, 2007; Güler, 2010). Another such factor includes religious structures and characteristics. Religious faith and rituals reveal the functions and dynamics of psychological needs (Moaddel & Karabenick, 2008). Religion is an important determinant of people's lifestyles, perspectives, attitudes and behaviors. It therefore affects the behaviors that protect and improve mental health (Güler, 2010; Koenig, 2009; Köylü, 2007).

Although religion has drawn the attention of researchers in all fields throughout history, it has been neglected and unanalyzed in psychiatry for a very long time (Köylü, 2007; Mohr & Huguelet, 2004a). The fact that psychiatrists regard religious faith as an outdated issue that arises the senses of dependency and guilt has caused a conventional negative attitude in psychiatry towards religion. Hans Kung, a Danish theologian, defined religion as the final taboo of psychiatry. These negative judgments have led religion to be rarely discussed and taken into consideration in patient interviews for a very long time except as a form of psychopathology (Kung, 1986).

Recent studies emphasize that religion and spirituality should be taken into consideration in the treatment of psychiatric diseases. (Koenig, 2004; Koenig, 2009; Mohr & Huguelet, 2004a). Tepper, Rogers, Coleman, and Malony (2001) conducted a study with 406 patients who had severe mental disorders and found that > 80% of the patients were using religious faith as a coping strategy. In addition, studies have reported that high levels of religious faith are related to low levels of depression, anxiety and suicide incidence in patients with mental disorders (Koenig, 2009). Religion and spirituality accelerate schizophrenic patients' recovery, reduce pathologies and improve their coping skills (Mohr & Huguelet, 2004a). However, sometimes religion can have negative effects on patients, causing schizophrenic symptoms such as delusions, hallucinations and disorganized behavior and speech to become more severe (Greenberg & Brom, 2001; Kent & Wahass, 1996; Peters, Day, Mckenna, & Orbach, 1999). Greenberg and Brom (2001) conducted a study with Jewish patients and found that the patients hallucinated mostly at night due to their religious belief that makes them more sensitive to evil spirits and demons. The effect of religion on mental disorders differ by culture (Carone & Barone, 2001; Mohr & Huguelet, 2004a). Studies conducted with patients in psychiatry clinics show that the prevalence and characteristics of religious hallucinations show difference by culture (Rudaleviciene, Stompe, Narbekovas, Raskauskienė, & Bunevicius, 2008; Tateyama et al., 1993). Kim et al. (1993) reported that religious and supernatural hallucinations were more prevalent among Korean patients than among Chinese patients. A cultural comparative study that analyzed the auditory hallucinations of Saudi Arabia and England found that the content of the auditory hallucinations was different in these countries. While the auditory hallucinations of the patients in Saudi Arabia mostly had a religious and superstitious nature, those of the patients in England had the themes of instruction and running commentary (Kent & Wahass, 1996). Therefore, patients' religious faiths and the cultures that shape them should also be evaluated during the treatment and rehabilitation of schizophrenia. Although religion plays a central role in schizophrenic patients' lives, studies of this subject are quite inadequate, and further research should be conducted (Carone & Barone, 2001; Crossley, 1995; Koenig, 2009; Lukoff, Lu, & Turner, 1995; Mohr, Brandt, Borras, Gilliéron, & Huguelet, 2006; Neeleman & King, 1993).

Religious faith and rituals can help individuals to search for new ways of treatment, maintain treatment and adopt new health behaviors (Borras et al., 2007; Mohr & Huguelet, 2004a). Adherence to therapy is an aspect of the relationship between the advices of health professionals and the patients' behaviors. Inability to ensure this adherence causes the treatment to result in failure. Patients should adhere to and comply with treatment for it to be effective. Patients' regular use of their medications and compliance with medical advices are of prime importance for the success of treatment (Çakır, İlhem, & Yener, 2010; Çobanoğlu, Aker, & Çobanoğlu, 2003; Dilbaz, Karamustafalıoğlu, Oral, Önder, & Çetin, 2006). Despite its crucial role, adherence to treatment is a widely-observed problem among schizophrenic patients in Turkey (Alıcıkuşu, 2009; Çobanoğlu et al., 2003; Yılmaz & Okanlı, 2015). Studies of schizophrenic patients show that religion and spirituality can affect patients' attitudes towards medical treatment and contribute to

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revealing the determinants of the disease (Borras et al., 2007; Mohr & Huguelet, 2004a). This study aims to determine schizophrenic patients' strength of religious faith and its relationship with adherence to treatment.

Materials and method

Type of study

This study used a descriptive and correlational research design.

Population and sample of the study

The study population consisted of patients who were referred to the psychiatry polyclinic of a psychiatric hospital in Eastern Anatolia between December 2015 and May 2016 and were diagnosed with schizophrenia according to the DSM-V diagnosis criteria. The study sample consisted of 109 patients in this population who met the inclusion criteria, which were: being diagnosed with schizophrenia, being in remission (treatment completed, signs of an active period, insight developed), no physical or neurological disorders that would hinder filling out the study forms, being older than 18 and no diagnosis of a comorbid psychiatric disorder.

Outcomes and measurements

Instruments

A personal information form, the Santa Clara Strength of Religious Faith Questionnaire and the Morisky Adherence Scale were used for data collection.

Personal information form

This form with 10 questions was prepared by the researcher to determine the demographic and socio-economic characteristics of the participants. It included question about: age, gender, marital status, educational status, residence, people with whom the patients share living space, employment status, monthly income, other family members diagnosed with schizophrenia and the duration of the illness.

The Santa Clara strength of religious faith questionnaire

This scale was developed by Plante and Boccaccini (1997) and tested by Akin, Turan, and Altundağ (2015) for validity and reliability in Turkish. It includes 10 items. These items are scored using a four point Likert-type scale where 1 means strongly disagree, 2 means disagree, 3 means agree, and 4 means strongly agree. Higher scores indicate stronger religious faith (Akin et al., 2015). The Cronbach's alpha internal consistency coefficient of this scale was found to be 0.93 in this study.

The Morisky adherence scale

This scale was developed by Morısky, Green, and Levıne (1986) and tested by Yılmaz (2004) for validity and reliability in Turkish. The scale includes 4 yes/no questions about adherence to medication. Answering no to all questions indicates high adherence to medication, answering yes to one or two questions indicates moderate adherence to medication, and answering yes to three or four questions indicates low adherence to medication (Yılmaz, 2004). The Cronbach's alpha internal consistency coefficient of the Morisky Adherence Scale was found to be 0.75 in this study.

Data assessment

SPSS (Statistical Package for Social Sciences) for Windows 18.0 was used for statistical analysis of the data. Descriptive statistical data (numbers, means, standard deviations and percentage distributions) were used for data analysis. Pearson's correlation was used to analyze relationships between the scales. The results were interpreted using a confidence interval of 95% and a threshold for significance of $p < 0.05$. Cronbach's alpha was used to assess the internal consistency of the scales.

Ethical considerations

The study protocol was approved by the Ethics Committee of Atatürk University in accordance with the Declaration of Helsinki. Before the study, written approval was received from the hospital where the study was conducted, and an informed consent form was obtained from each patient. The participants were informed about the aim and methods of the study and the time they would be asked to allocate for participation. It was explained to the patients that the data obtained by this study would be kept confidential; that their participation in this study posed no risk to them; that they could leave the study whenever they wanted; and that participation in the study was entirely voluntary. The three questionnaires were completed by each participant in one session that lasted 15–20 min.

Results

In all, 109 patients (93 male and 16 female) participated in this study. Their mean age was 40.22 ± 10.14 years. Of the participants, 78.9% were single, and 55.0% had completed primary school. Of them, 82.6% were unemployed, and 45.9% had very low incomes (Table 1).

The patients' mean strength of religious faith score was found to be 31.36 ± 7.22. This result indicates that the patients had strong religious faith (Table 2).

Of the patients, 29.3% were adherent to treatment, 35.8% were

Table 1
The distribution of Sociodemographic and disease-related characteristics of patients (n = 109).

Characteristics	Number	Percentage
Sex		
Male	93	85.3
Female	16	14.7
Educational level		
Illiterate	4	3.7
Literate	11	10.1
Elementary school	60	55.0
High school	29	26.6
University	5	4.6
Residence		
City	82	75.2
District-town	12	11.0
Village	15	13.8
Marital status		
Married	23	21.1
Single	86	78.9
Living (alone or with someone else)		
Family	84	77.1
Alone	11	10.1
Others (relatives etc.)	14	12.8
Working status		
Not working	90	82.6
Working	13	11.9
Retired	6	5.5
Total monthly income		
< 400 Turkish lira	50	45.9
400–1000 Turkish lira	36	33.0
1000–1500 Turkish lira	23	21.1
Disorder onset age		
0–5 year	7	6.4
6–10 year	14	12.8
11 year and ↑	88	80.8
The presence of family member diagnosed with schizophrenia		
No	47	43.1
Yes	62	55.9
Age	X ± SS	
	40.22 ± 10.14	