ORIGINAL ARTICLE

ASSOCIATION OF RELIGIOUS ORIENTATION WITH DEPRESSION, ANXIETY AND STRESS AMONG MALE PATIENTS WITH SUBSTANCE USE DISORDER IN PAKISTAN

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ABSTRACT

Religion has been discussed in numerous research studies with reference to its significance in mental health outcomes. It has gained its attention of researchers due to its pivotal role in the lives of human kind.

OBJECTIVES

This study aims to investigate the predictive relationship of religious orientation with mental health problems, including depression, anxiety & stress in male patients with substance use disorder (SUD).

STUDY DESIGN

Cross-sectional study.

PLACE AND DURATION OF STUDY

Study was carried out from April - July, 2018 in Karachi, Pakistan.

PARTICIPANTS AND METHODS

The sample included 200 Muslim male patients with SUD. The age ranges between 18 to 45 years (M =28.14; SD =6.55) were taken from substance use treatment and rehabilitation centres located in Karachi, Pakistan, using purposive sampling. Personal Information Form and Urdu translations of the scales, including Muslim Attitude towards Religion Scale (MARS)1 and Depression Anxiety and Stress Scale (DASS-21)2 were used to conduct this study.

RESULTS

Results revealed a significant association of religious orientation with the variables of psychological distress, i.e., depression (adj $R2=.994$, $F(4, 196)=5424.24$, $P < .01$), anxiety (adj $R2=.97$, $F(4,196)=1309.5$, $P<.01$), and stress (adj $R2=.991$, $F(4,196)=3854.25$, $P<.01$).

CONCLUSION

Religion has a significant role in the wellbeing of its believers and specifically among patients with SUD. Present findings also show that religious orientation has a noteworthy contribution to psychological distress, such as "depression", "anxiety" and "stress" in male patients with SUD. Substance use treatment practitioners may develop interventions by considering the cultural and religion aspect for better treatment outcome and to improve their wellbeing. Further, religious orientation may serve as an important variable to have better treatment outcomes, and to address mental health issues which may also improve their wellbeing.

KEYWORDS

Anxiety; Depression; Outcome Assessment, Health Care; Psychological Distress; Rehabilitation Centres; Substance-Related Disorders.

INTRODUCTION

Religion has attracted scholars from different fields, and it has a significant role in shaping the individual's life. It also has a substantial effect on mental health, and scholars in the Western world are taking an interest in studying religion.[3] This is an intricate and broader subject and it needs to be studied in a refined way to purify the mind, and to improve the way of life of its believers. Researcher[4] defined religion as "norms, values or a way of life of an individual or community for spiritual guidance for day-to-day life." It is further explained that religion instils optimistic belief in individuals, and assures them of reason for their existence in this temporary world.

In 1967, researchers[5] categorised "religious orientation" into two classes (i.e., intrinsic & extrinsic). According to authors, a person with "intrinsic religious orientation" is one who finds real inspiration in religion, and considers others' needs as less vital and meaningful. Further, it was found that a person with intrinsic religious orientation exercises religion for his/her safety/refuge, and conviviality.[6] With intrinsic religious orientation, an individual sacrifices his/her own needs and feels himself or herself close to God. Individuals with intrinsic religious orientation have higher level of wellbeing than individuals with extrinsic religious orientation.[7] These views show that both intrinsic and extrinsic religious orientation has a significant role in shaping the lives of individuals.

In the health-related concerns religious beliefs and religious orientation is considered to play a pivotal role. Researchers found the religious orientation to be positively associated with health outcomes,[8] religion and spirituality shows greater association with mental as well as physical health.[9] There is robust evidence which demonstrates that religious commitment has a significant contribution to reduce psychological distress than those who are less committed to religion. Study findings by researchers[10] found that young people committed to religious affairs have a chance to experience less anxiety.[10] This was further explained that religious beliefs create a sense of safety and establish a mental composure. It cultivates hope by creating a sense of power and control to cope with anguishes and pain and motivates the believers to live life with hope.[11] In addition to this, it is considered to be important to provide direction and meaning in life and meaning of existence.[12]

Gartner and colleagues[13] and further Koenig along with Larson[14] studies religion regarding different ages and socioeconomic status beyond the differences of religions and found that it has a significant impact despite different backgrounds. Mental health issues are common among patients with Substance Use Disorders. Researchers put forth that psychological distress and drug-related disorders are closely linked with each other, which creates the burden on society.[15,16] Due to stigma and fear of being labelled with addiction, people with SUD are more likely to face difficulty in availing proper services, which is again linked with their high level of distress. However, based on the review of clinical and mental health researches on faith, researcher[17] came to a conclusion that religion has a protective role and it can reduce psychological distress and improve wellbeing. Research shows that strong religious beliefs are considered to play a protective role against adverse health conditions like problems related to substance use. It has also been studied that adolescents with strong religious orientation, compared to ones with low in religious orientation, have less consumption of alcohol and other drugs.[18] Similar findings were extracted in study of adolescents who are more likely to attend religious places, like church and are less likely to use smoking compared to those who are not attending such places.[19] Recently, Khan and colleagues[20] found a significant association of meaning in life with mental health problems (i.e., stress, anxiety & depression) in SUD. Moreover, findings highlighted the importance of high religious orientation with reduction of drug usage and risky activities like sexual activities.[21] Similar findings were shown by the study of Omari and associates,[22] indicating religious affiliation and involvement to be linked with less likely engagement in unhealthy habits including alcohol and other drug use. Further the significance of religion in the areas of health was highlighted and stated that religion discourages its believer's involvement in drug use and its affiliation reduces substance use.[23] Thus, religion is considered as one of the buffering factors against mental health issues including substance use, and it protects people against the precarious environment.[24]

Researchers have found that religion helps its believers in getting rid of emotional distress.[17] Other studies explored strong religious belief and involvement most likely results in diminutions of trauma symptoms.[25]

Association of religion with mental health has been found in the western literature, and researchers have found the role of religion on well-being. In Pakistan, previously, researchers have found the significant association of mental health problems, i.e., depression, anxiety and stress with the well-being of patients with SUD,[26] with emotion regulation.[27] However, in Islamic countries such literature is limited.[28] Due to the dearth of research in this important domain, present study was planned to understand the role of religious orientation in patients with SUD in the local context. Keeping in view the literature related to significance of religious orientation in general, and in SUD in particular, current research aims to explore the predictive relationship of religious orientation, with the variable of anxiety, depression and stress in adult males with SUD in Pakistani context. Drugs not only affect the individual using them, but also affect the social fabric of individuals such as their family including children, and they are negatively affected by their loved ones' drug use.[29] Findings may also be beneficial to identify these variables as protective factors against SUD and to cope with the psychological distress. Thus incorporation of religious orientation in the practice by the professionals may help to understand the problem from different perspectives and to address the issues with such strategies where applicable.

METHOD

PARTICIPANTS

A total of 200 adult males (using poly drug) with ages between 18 to 45 years (M= 28.14, SD= 6.55) seeking treatment from four treatment and rehabilitation facilities for SUD (i.e., Al Haq Centre, Parvarish Recovery Centre & Addicare Treatment and Rehabilitation Centre) were recruited for this study. From each centre, on an average forty patients were recruited.

Inclusion/exclusion criteria

Only those patients were included who completed 21 days in rehabilitation/hospital setting. Those who were able to understand and comprehend instructions were included. Those who are not with comorbid serious mental health issues (i.e., psychosis). Further, patients with minimum age of 18 and maximum age of 45 were included.

Ethical Considerations

Researchers took every step to follow the research ethics. Confidentiality of the information was ascertained and participants' respect and dignity was maintained. Further, researchers ensured the security and flexibility of timing.

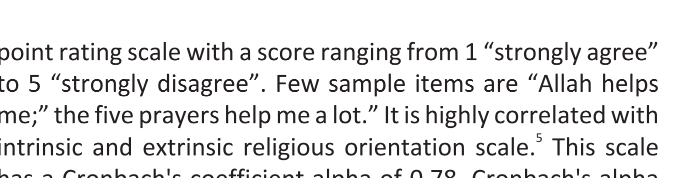
MEASURES

Socio Demographic Information Form

Personal information was obtained through sections, including the age, education and marital status. Further academic qualification, area of residence, family related information like income and earning members were also taken into consideration. Drugs related information consisted of drug of choice, drug inception, history related to interval or reversions were considered important. Moreover, a history of medical illness, drug use in family etc. was gathered.

Muslim Attitude towards Religion Scale (MARS)

The MARS1is a rating scale with 14 items. It is related to Muslim's interpretation of the applicability of the religion in life. It is about the belief of affirmative consequences of being Muslim or level of involvement in the religious practices, thus representing personal declaration to Islam. This scale is a 5-



point rating scale with a score ranging from 1 “strongly agree” to 5 “strongly disagree”. Few sample items are “Allah helps me;” the five prayers help me a lot.” It is highly correlated with intrinsic and extrinsic religious orientation scale.[5] This scale has a Cronbach's coefficient alpha of 0.78. Cronbach's alpha for the Urdu version of MARS is 558, and the test retest reliability is .9430.

Depression Anxiety and Stress Scale-Short Form (DASS-21)

This is a self-report inventory developed by Lovibond and Lovibond2 and translated by Shahzad and colleagues. This is a 21 item self-reporting tool with three sub domains including Depression, Anxiety, and Stress. It is a 4-point “Likert scale” in which “not at all” is scored as 0 and “all the time” as 3, and each subscale has 7 items., for depression sample items procedure is silent about mode of data collection are “I felt downhearted and blue”, and “I felt I wasn't worth much as a person”. Similarly, for anxiety subscale, the items are; “I was aware of dryness of my mouth” and “I experienced trembling (e.g. in the hands)”, and for stress “I found it hard to wind down”, and “I tended to over-react to situations”. The possible score ranges from 0 to 63. Higher score indicates higher levels of depression, anxiety, and stress. The Cronbach alpha for the Urdu version of DASS-21 is .94, for subscales i.e., Depression= .85, Anxiety=.90, and Stress = .84, respectively. Similarly, the test retest reliability for DASS-21 is 73, Depression = .82, Anxiety = .89, and Stress = 87, respectively.

Procedure

The study procedures and material were accepted by the Ethical Review Committee of Institute of Clinical Psychology, University of Karachi (ref. NO:ICP-1(101)/5800, dated: 11-01-2024). To recruit the sample, researchers identified the drug addiction treatment and rehabilitation centres. The authorities of those centres were contacted to get formal permission along with the research protocols for data collection. After obtaining permission, researchers approached the patients with SUD and they were briefed about the aims and objectives of the study and took informed consent from each participant in written form. After taking written informed consent from participants, researchers then approached only those who met the pre-requisite criteria; they were then briefed and guaranteed the safety of their information, data and confidentiality and privacy of participants. Data were collected through in-person interviews. After building rapport with the participants, a Personal Information Form was filled, followed by the administration of MARS and DASS-21. All the participants were thanked for their willingness to be part of the research study.

Statistical Analysis

To get the statistical picture of data, Statistical Package for Social Sciences (SPSS-V.22) was used. Descriptive statistics was applied to analyse socio-demographic information of the participants. The Multiple linear regression model was used to study the association of the variables in participants with SUD.

Table 1

Descriptive statistics of the demographic characteristics of patients receiving treatment for SUD.

	N	Min	Max	M	SD
Age	200	18	45	28.14	6.559
Education	200	0	16	8.39	4.794
Daily expenses for drug use	200	100	5000	1149	2355.97
Age onset of substance use	200	8	41	18.78	5.894
Family monthly income	200	7000	500000	88100.00	97675.65

Table 2

Multiple regression analysis for the predictive association of religious orientation and Depression in patients receiving treatment for SUD

Model	Unstandardised Coefficients		Standardised Coefficients			95.0% Confidence Interval for B				
	B	Std. Error	Beta	T	Sig	Lower Bound	Uper Bound	Adj R^2	F	Sig
(Constant)	26.40	.25		103.51	.000	25.90	26.91	.994	5424.24	.000[b]
Muslim Practice	-.29	.05	-.30	-5.58	.000	-.39	-.18			
Personal Help	.24	.04	.31	4.94	.000	.14	.34			
Muslim World View	-.52	.08	-.21	-6.07	.000	-.70	-.35			
MARS Total	-.15	.04	-.38	-3.54	.000	-.23	-.068			

a. Dependent Variable: Depression
Predictors: (Constant), Muslim practice, personal help, Muslim Worldview, MARS Total

Table 3

Multiple regression analysis for the predictive association of religious orientation and anxiety in patients receiving treatment for SUD

Model	Unstandardised Coefficients		Standardised Coefficients			95.0% Confidence Interval for B				
	B	Std. Error	B	T	Sig	Lower Bound	Uper Bound	Adj R^2	F	Sig
(Constant)	21.82	.397		54.94	.000	21.04	22.61	.97	1309.51	.000[b]
Muslim Practice	-.30	.081	-.40	-3.71	.000	-.46	-.14			
Personal Help	.28	.077	.47	3.74	.000	.13	.43			
Muslim World View	.28	.135	.15	2.10	.036	.01	.55			
MARS Total	-.49	.067	-1.59	-7.31	.000	-.62	-.36			

a. Dependent Variable: Anxiety
b. Predictors: (Constant), Muslim Practice, Personal Help, Muslim Worldview MARS Total

Table 4

Multiple regression analysis of the predictive association of religious orientation and stress in patients receiving treatment for SUD

Model	Unstandardised Coefficients		Standardised Coefficients			95.0% Confidence Interval for B				
	B	Std. Error	B	T	Sig	Lower Bound	Uper Bound	Adj R^2 Square	F	Sig
(Constant)	25.003	.25		96.65	.000	24.49	25.51	.991	3854.25	.000b
Muslim Practice	-.14	.05	-.17	-2.65	.009	-.24	-.03			
Personal Help	.20	.05	.31	4.18	.000	.11	.30			
Muslim World View	-.62	.08	-.30	-7.13	.000	-.80	-.45			
MARS Total	-.19	.04	-.57	-4.50	.000	-.28	-.11			

Dependent Variable: Stress

b. Predictors: (Constant), Muslim Practice, Personal Help, Muslim Worldview MARS Total

DISCUSSION

The findings of the study show a negative predictive association of religious orientation and depression in patients with SUD (adj $R2=.994$, $F (4, 196) =5424.24$, $p < .01$), anxiety (adj $R2=.97$, $F (4,196) =1309.5$, $p < .01$(, and stress (adj$R2=.991$, $F (4,196) =3854.25$, $p< .01$). These findings are supported by other studies which emphasise religion to have significant preventive factors, which plays a buffering effect against depression in people using drugs or substance.[32] It is further explained that the existence of religious beliefs is one of the integral factors to get social support and consequently a person enjoys an enhanced mental health and wellbeing.[24] In connection to these findings, previous literature also shows that religious involvement and attendance at religious places is one correlate of low levels of anxiety.[33] This could give them a sense of relief when they approach their creature to help them resolve their issues.

A strong belief in faith or a religion is a source of hope and which reduces the risk of distress. Such associations are explained by Tataro and associates34 by describing the relationship between prayer and forgiveness and a low level of reactivity to cortisol. Spirituality and religiosity were considered to be a fundamental aspect in relapse prevention of substance use disorders35. In substance use problems, people usually cannot accept it as an illness. Rather, it is considered an issue of character and for which the sufferer is always blamed and hence these issues are tabooed and stigmatised. In such circumstances, getting help and support for the issues from such a society is very challenging. Therefore, in cultures like Pakistan, religious belief and practices are the major coping mechanisms against such issues. It is largely because Identifications help from a superpower in very demanding circumstances and a belief that high powers other than themselves can direct and create order in their life inculcate confidence and safety.[36] The focus of several studies on religious belief and spirituality signifies the protective role of religion in treatment and relapse prevention.[37] Rugs Summing up the findings of previous studies which found that religious orientation is highly associated with both physical and mental wellbeing among people9. These findings are a valuable addition to the literature in the local context to be used to enhance treatment outcomes and improve the wellbeing of patients with SUD. It should be noted that practising could be one of important domains in people's life but practising religion with understanding is significant, incorporating its guidelines that has been established for its followers, and applying its essence in daily practices.

As far as the limitations of present research are concerned, there are few things which need to be improved in future research. For generalisability of the findings, a large size of sample is recommended. Representation of both male and female population is highly recommended for future research by including samples from different religious backgrounds and comparing it to see its influence on wellbeing. Utilisation of qualitative research design can give more accurate and comprehensible findings in the future research.

CONCLUSION

The present study determined the impact of religious orientation on mental health issues, including “depression, anxiety and stress” among patients receiving treatment for their issues related to SUD. The results highlight the importance of religious orientation in the psychological and mental wellbeing of an individual with SUD. It is a fact that people around the globe more or less inclined themselves towards their religious beliefs to help themselves cope with unavoidable and demanding circumstances of life; therefore, incorporation of this important aspect of life has remarkable advantages in the improvement of psychological health. For most people, religion embedded in itself several solutions to the problems and inculcated hope to fight with them, resulting in lower levels of mental health problems.

Thus, while designing and implementing interventions in local context, clinicians should design individualised treatment plans and add this variable if it plays a role in their positive treatment outcome and wellbeing.

CONFLICT OF INTEREST

The authors declare that they have no conflict of interests.

DISCLOSURE
None

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