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# Diagnostic Differences in Religious Coping Among the Persistently Mentally Ill

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Note: This paper represents a summary of a longer article currently under review.

# Diagnostic Differences in Religious Coping

## Among the Persistently Mentally Ill

Recent research suggests a high prevalence and salience of religious coping among individuals with mental illness (Rogers et. al., in press). There remains, however, an impoverished understanding of the factors differentiating those who do and do not select various types of religious coping and who have varying perceptions of its helpfulness. Considering the potential impact of diagnostic differences on individuals' threat perception and selection of coping resources, it may be that individuals' psychiatric diagnoses can serve as one of the variables differentiating the degree and type of religious coping used to cope with mental illness.

Lazarus' (1966, 1999) cognitive appraisal coping model conceives of coping responses as dependent, in part, upon the interaction of environmental demands with the personal resources available to the individual. In the case of individuals with diverse forms of persistent mental illness, the nature of the environmental stressor and the resources available could be unique depending on the qualitative nature or degree of impairment produced by the presenting psychopathology associated with different diagnoses. These differences could lead to differing appraisals of the threat and, therefore, different coping responses. Consistent with this theoretical background, there exists a body of literature on nonreligious coping that suggests diagnostic differences in how individuals cope with stressors or difficulties (e.g., Billings, Cronkite, Moos, 1983; Middelboe & Mortensen, 1997; Vollrath & Angst, 1993). But the degree to which these findings generalize to religious coping is unclear.

This study sought to explore whether or not diagnostic differences existed regarding: a) the total number of religious coping strategies used; b) the use of specific religious coping strategies; c) the length of time across one's life religious coping had been used; and, d) the

perceived helpfulness of religious coping.

## Methodology

### *Participants*

A convenience sample of 415 individuals suffering from persistent mental illness participated in this study. They attended one of 13 Los Angeles County Mental Health facilities. Of these, 244 (59%) were men and 171 (41%) were women. Collectively they reported a mean age of 40.97 (*SD* =10.68 ) and received a mean Global Assessment of Functioning (GAF) score of 38.16 (*SD* = 8.37). They averaged 18.84 (*SD* = 12.46) years of mental illness, their average number of total lifetime hospitalizations for mental illness was 5.63 (*SD* = 9.09), and 93% professed taking medications daily.

Their Axis I Disorders from the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994) were distributed such that 149 (36%) were diagnosed with some type of Schizophrenia, 80 (19%) with some form of Depressive disorder, 69 (17%) with Schizoaffective Disorder, 58 (14%) with some type of Bipolar Disorder, and the remaining 59 (14%) with disparate psychotic, mood, or anxiety disorders. All participants were treated in accordance with the standards and ethical principles established by the American Psychological Association (American Psychological Association, 1992).

### *Measures and Procedure*

Diagnoses were procured from participants' County case files and then sorted into five qualitatively distinct groups. These groups included Schizoaffective Disorder, any form of Schizophrenia, any type of Depression, various forms of Bipolar Disorder, and an Other category that included disparate disorders that were not highly prevalent in the current sample. The Other category, however, was excluded from analyses so as to create a more homogeneously discrete

set of diagnostic variables leaving a final sample of 356 for this study.

To assess religious coping, the participants completed a 48-item demographic survey and were interviewed on an adapted version of Koenig's (1994) Religious Coping Index (RCI), which measured the perceived helpfulness of religious coping along a 10-point Likert scale. The demographic survey included items that assessed the total number of years participants used religious coping and the specific religious strategies that were used for the purposes of coping.

Subsequent to the project's approval by the Los Angeles County Human Subjects' Review Committee, contact was made with 23 directors of County mental health facilities and board and care units. A schedule was then established with the 13 directors who approved the implementation of the project such that interviewers who were trained in each measure could administer the project to clients in their treatment groups or site meetings over a period of several weeks.

## Results

There were significant differences in the use of religious coping among those with different diagnoses of mental illness. Although there were no diagnostic differences in the type or total number of religious coping strategies that were used, differences between diagnoses were found in terms of the number of years participants used religion to cope $F(3, 352) = 3.23$, $p <. 05$ and the perceived helpfulness of religion in coping with difficulties $F(3, 352) = 3.5$, $p < .05$. Specifically, those who received diagnoses of schizophrenia ($M = 17.45$; $SD = 17.54$), schizoaffective disorder ($M = 18.5$; $SD = 17.98$), and bipolar disorder ($M = 17.29$; $SD = 19.63$) used religious coping for a significantly greater number of years than those diagnosed with depressive disorders ($M = 10.78$; $SD = 16.00$). Those who were diagnosed with schizophrenia ($M = 7.03$; $SD = 3.05$) or schizoaffective disorder ($M = 6.84$; $SD = 3.02$) also perceived religious

coping to be significantly more helpful than those diagnosed with depression ($M = 5.62$; $SD = 3.61$). These diagnostic differences persisted independent of gender, age, ethnicity, and the number of years participants had suffered from mental illness.

## Discussion

These results suggest that religious forms of coping may be a more salient, enduring, and meaningful style of coping for those with certain types of diagnoses of mental illness, particularly those with schizophrenia, schizoaffective, and bipolar disorders. Compared with those who had depressive disorders, these individuals seem to be more likely to not only tap into and use religious coping for a greater period of time, but to also perceive it as more effective in combating their daily frustrations and difficulties. This is consistent with coping theory (Lazarus, 1999) that suggests that the varying environmental threats and personal resources associated with disparate diagnoses may lead to differing types of threat perception and resultant coping responses. Whereas previous research has demonstrated that diagnostic differences occur in non-religious forms of coping, like problem-solving or cognitive avoidance, this study extends these findings to religious sources of coping.

These results seem to suggest that religion may be a significant coping strategy for those with mental illness, particularly those with schizophrenia and schizoaffective conditions. Considering our finding that there were no diagnostic differences in the actual type of religious coping that was utilized, clients may use a diversity of religious strategies regardless of diagnosis. Accordingly, mental health professionals may need to make religious coping less foreign to our research, assessment, and treatment with this population. As religion is not always used in adaptive ways, however, we may need to be more explicit in considering how religion is used by clients, whether it is adaptive or non-adaptive, and whether it is combating

symptomotology or being co-opted by it to exacerbate clients' difficulties. This may require, however, that clinicians receive better training for competency in religious issues, as well as active participation in continuing education opportunities that are aimed at exploring the potential role of religion in the lives of those with mental illness.

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