ORIGINAL ARTICLE

IMPACT OF RELIGIOUS ORIENTATION ON SUICIDE BEHAVIORS AMONG PSYCHIATRIC PATIENTS

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ABSTRACT

OBJECTIVE
To investigate the predictive interaction between religious orientation (intrinsic and extrinsic) and suicidal behavior in psychiatric and non-psychiatric sample.

STUDY DESIGN
Correlational / Comparative

PLACE OF DURATION OF STUDY
The study was carried out at Institute of Clinical Psychology, University of Karachi in August, 2012.

SUBJECTS AND METHOD
Using purposive sampling technique, 50 psychiatric patients were selected from government hospital (Jinnah Postgraduate and Medical Centre, Karachi, JPMC), Karachi. Sample had five categories with ten patients from each: Mood Disorders, Anxiety Disorders, Schizophrenia, Somatoform Disorders and Others. Control group comprised of 50 participants (both males and females without psychiatric disorder). The ages ranged from 25 to 55 years (mean age = 39 years; SD = 9.44). Experimental group had patients with an education level of at least matriculation and middle; sample belonged to lower socio economic status.

RESULTS
It was found that religious orientation significantly predicted suicidal behavior in overall sample ($F = 22.84$, $p < .000$) and in the psychiatric sample as well ($F = 4.8$; $p < .033$). Extrinsic religious orientation is a better predictor of religious orientation ($F = 7.608$; $p < .008$) than intrinsic religious orientation ($F = .653$; $p < .423$) in psychiatric sample.

CONCLUSION
The findings reflect towards the effectiveness of religious interventions to treat psychiatric patients in their management of suicide behavior. Special attention should be given to the treatment of mood disorders. Adequate training is necessary to integrate spiritual knowledge, culture values and significance of religious practices into clinical practice.

KEY WORDS
Religious orientation, suicidal behavior, psychiatric patients

INTRODUCTION

Religion incorporates cognitive, emotional, motivational, and behavioral aspects. Religiosity stems from religion which is a set of beliefs, rituals, obligations, acts and symbols to enhance intimacy with the sacred (Almighty, God, supreme power) [1] .In Roget's Thesaurus, religiosity is religiousness, faith, belief, piousness, devotion, and holiness. However, these synonyms are dimensions of religiosity, rather than equivalent to religiosity[2].

Intrinsic religiosity is obeying religious guidelines for the sake of self satisfaction[3]. On the contrary, Allport and Ross interpreted extrinsic religiosity as a self-serving and utilitarian outlook on religion which enables the worshipper to gain worldly favors and appreciations from the society[4]. Various researches have highlighted that religious orientation and mental harmony seem to have a strong connection [5]. Religious association significantly predicted satisfaction with life in general [6,7].

Suicidal behaviors manifest variety of self-damaging behaviors such as suicidal thoughts, suicide attempts and suicide completions[8]. Physiological, genetic, psychological, and environmental are all the etiological factors[9]. Past researches claim that degree of religious involvement is inversely proportional to suicide rate[10]. Similarly, in an adult population from Canada, connection is manifested between increased religiosity and decreased rate of suicidal attempts [11], from Native Americans [12], from Afghan refugees [13], as well as among the adolescents from U.S [14].

In a nutshell, religiosity and mental health are two significant variables receiving attention globally. Thus, studying the interaction between religion and suicide behavior will be of elementary significance in preventing suicide and designing treatment. Individuals can be protected, prevented and cured by associating with their religious group. Hence forth, religious interventions can prove to be fruitful in the overall growth and psychological harmony in treating patients. In view of the empirical evidence, current research targets at understanding the impact religious orientation will have on an important indicator of mental disorder i.e. suicide behavior.

The current research aims at exploring the predictive interaction between religious orientation (intrinsic and extrinsic) and suicide behavior. The study hypothized the following;

1. Religious orientation will predict suicide behavior in overall sample.
2. Religious orientation will predict suicide behavior in psychiatric sample.
3. Intrinsic religious orientation will predict suicide behavior in psychiatric sample.
4. Extrinsic religious orientation will predict suicide behavior in psychiatric sample

METHOD

Participants

Purposive sampling technique helped in recruiting participants from the psychiatric department of JPMC, Karachi. There were total 100 participants with 50 in each group. Experimental group had 50 psychiatric patients, further divided in five categories with 10 patients in each i.e. Schizophrenia, Mood Disorders, Anxiety Disorders, Somatoform Disorders and Others. Control group (non-psychiatric) consisted of the family members of patients from experimental group. Ages ranged from 25 to 55 years (mean age = 39 years; SD = 9.44). Experimental group consisted of participants with a diagnosed mental disorder, minimum education till matriculation and middle or lower socio economic status. Both groups were kept constant in every other aspect such as age, gender, socioeconomic status and education in order to keep the conditions tightly controlled.

Instruments

The Age Universal Religious Orientation Scale (AUROS)[15]

It is a 5-point likert scale with 20 items ranging from a) I Strongly Disagree to e) I Strongly Agree. Either all the items can be summed up and the total score can be used to depict religious orientation or it can be broken down into its two components i.e. intrinsic and extrinsic scales and scored separately 16. The intrinsic sub-scale (r = .73) has 8 items and the extrinsic sub-scale (r = .66) has 12 items. The administration takes 10 – 15 minutes. It can be administered from children (5th grade) to the elderly.

Suicide Behaviors Questionnaire- Revised (SBQ-R)[17]

This self- administered scale takes less than 5minutes for administration. It helps in assessing previous suicidal attempts and suicide behaviors. Item 1 explores past suicide ideation and suicide attempts, item 2 assesses the frequency of past suicidal ideation, item 3 evaluates the threat of suicidal behavior and item 4 investigates self-reported suicide likelihood. Urdu translation of the scale was used. A total score on the SBQ-R can range from 3 to 18. Cronbach alpha for the SBQ-R is reported as .83.
A demographic sheet including personal characteristics, academics, occupational background, family history, and the presence of psychological and medical problems was also administered.

Procedure

Permission to use scale was taken from the authors through emails after which "Institutional Review Board Committee" of Department of Medicine of JPMC was approached for the approval of data collection from the psychiatric department (both IPD and OPD). Administration took place on an individual level to ensure comfort and adherence to ethical guidelines. Informed consent was taken. At first, demographic details were filled which was then followed by research tools administration. Participants were thanked at the end. Linear regression was applied using SPSS-20.

RESULTS

The psychiatric sample was composed of 50 patients (27 females and 23 males) and normal sample had 33 females and 17 males. There were 16 patients (32%) and 8 participants (16%) with first birth order. Experimental group had a double value for the first born in comparison with the control group. 35 patients (70%) reported to live in a joint family system and 22 of them (44%) have mentioned to earn lesser than 14, 000 rupees per month. Large families were a usual trend observed with 42 patients (84%) reporting to have more than 4 family members. 26 patients (52%) had only one earning member. Multiple visits for psychological treatment were also mentioned by the patients. 60% of them have approached for psychological help more than 3 times. 38 patients (76%) have had suicidal thoughts. Only one participant (2%) from the control group reported to have suicidal thoughts..

The results were statistically significant indicating religious orientation as a significant predictor of suicidal behavior for normal sample, R^2 =.189, F (1, 98) = 22.842, p< .000 (see Table 2) and for psychiatric sample, R^2 =.091, F (1, 48) = 4.8, p< .033. Results showed that religious orientation predicts 18% variance in suicide behavior in overall sample. It is responsible for 09 % variance in suicide behavior in psychiatric sample (see Table 3).

Intrinsic religious orientation did not predict suicide behavior, R^2 =.013, F (1, 48) = .653, p> .423 (see Table 4). Extrinsic religious orientation was found a significant predictor of suicidal behavior for psychiatric sample, R^2 =.137, F (1, 48) = 7.6, p< .008. Results showed that extrinsic religious orientation predicted 13 % variance in suicide behavior in psychiatric (see Table 5).

Table 1
Descriptive Statistics of Age for Entire Sample

variables	Psychiatric Sample (*n* = 50)		Normal Sample (*n* = 50)		Total Sample (*n* = 100)	
AGE	*M*	*SD*	*M*	*SD*	*M*	*SD*
	34.1	9.06	38.08	9.49	36.09	9.44

Table 2
Linear Regression of Religious Orientation (RO) and Suicide Behavior in Overall Sample

Predictor	R	R^2	F	Sig
RO	.43	.18	22.84	.000***

Predictor: (Constant), Religious Orientation
Dependent variable: Suicide Behavior

Table 3
Linear Regression of Religious Orientation (RO) and Suicide Behavior in Psychiatric Sample

Predictor	R	R^2	F	Sig
RO	.302	.091	4.8	.003

Table 4
Linear Regression of Intrinsic Religious Orientation (IRO) and Suicide Behavior in Psychiatric sample

Predictor	R	R^2	F	Sig
RO	.116	.013	.653	.423

Table 5
Linear Regression of Extrinsic Religious Orientation (ERO) and Suicide Behavior in Psychiatric sample

Predictor	R	R^2	F	Sig
RO	.37	.137	7.6	.008

Predictor: (Constant), Extrinsic Religious Orientation
Dependent variable: Suicide Behavior

DISCUSSION

Results showed that religious orientation saved suicidal ideation. Parallel with findings of the current study, negative correlation was observed between suicidal behaviors and religious orientation[18]. Various reasons can be attributed for the findings. Data was collected from Karachi, Pakistan where significance of religion and stigma against suicide are deep rooted. Religion connects with the Supreme Being, is a belief practiced from early childhood till the end of life and continues to strengthen with the social pressure. Quran opposes self mutilating behavior by stating 'And do not kill yourself or one another (Quran 4: 29)'. Thus, Muslims hold the fear of hell if involved in suicidal acts. Religion also promotes catharsis and meditation which soothes emotionally, thus preventing from suicidal act [19]. Religious practices give birth to the sense of community bond and support, resulting in the decline in suicide [20]. Research shows that countries with huge numbers of Muslims tend to have lower suicide rates[21]. Similar findings were reported from the studies conducted in the US [22] and Turkey[23]. The results of a study demonstrated that Muslim students who practiced their religion perceived their life meaningful[24].

Participating in both public religion and private worshipping reduces depressive symptoms[25]. Believers with an intrinsic view of religion give value to the rituals and like to serve others, thus find lesser opportunities to ventilate their stress. Conversely, extrinsic religious orientation helps to achieve incentives like social support [3,4]. Praise reinforces such individuals to interact more with their surroundings. Stack[26] posited that decline in the church attendance (extrinsic religious orientation) leads to the higher rate of suicidal behavior. Moreover supporting the present research, Robins and Fiske[27] posited that involvement in public religious practices such as church attendance were associated with lower levels of suicidal ideation and attempts, whereas private religious practices (intrinsic) such as prayer were not.

LIMITATIONS

Few of the shortcoming of the study were: data collection should be only from OPD or IPD to avoid bias responses due to the difference in the severity of the mental disorder; including participants from middle and lower socio economic status targets psychologically vulnerable individuals; studying family members as a normal sample could give rise to genetic proneness of the disease; gender biasness may have hampered the findings to an extent, and larger sample size should have been used for generalization.

CONCLUSION

In a nutshell, the findings reflect towards the effectiveness of practicing religion publicly. Suicidal behaviors are also controlled with extrinsic religious practices rather than intrinsic. Understanding the findings will help the practitioners in devising interventions to deal with psychiatric patients in their treatment of suicide behavior. Special attention should be given in the treatment of mood disorders. Adequate training is necessary to integrate spiritual knowledge, culture values and significance of religious practices into clinical practice.

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