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# RELATION OF RELIGIOUS BELIEFS WITH ANXIETY AND DEPRESSION IN FAMILIES WITH MENTAL PATIENTS

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**Abstract**

***Introduction:*** *Religious beliefs as an important factor in mental health to be considered. The aim of this study was to determine the relationship between religious beliefs and anxiety and depression in family caregivers in families with patients with mental disorders.*

***Method:*** *This study is causal - comparative. The study population consisted of families with mentally ill patients were hospitalized in psychiatric wards. The sample consisted of 152 family. Research Environment was psychiatric wards in hospitals of Ahvaz Jundishapur University of Medical Sciences. Data Collection tools were demographic Characteristics, Hospital Anxiety and Depression Scale [HADS] and religious beliefs questionnaire. Descriptive statistics were used for to describe data and for determine the relationship between qualitative variables was used of $X^2$, SPSS 22 software was used.*

***Results:*** *63.8 percent of family caregivers were male and mostly aged between 30 and 50 years.48 percent of family caregivers has symptoms of anxiety and 67.3 percent have symptoms of depression. Significant relationship was observed between anxiety and religious beliefs [P- value = 0.002]. No significant relationship was observed between depression and religious beliefs [P- value = 0.417].*

***Conclusion:*** *A religious belief is effective factor in the mental health of family caregivers and to help them be better able to take care of the patient. Whatever religious beliefs of family caregivers are stronger, their anxiety are less and the level of their mental health are more.*

**Keywords:** *Religious beliefs, anxiety, depression, Family caregivers, patients with mental disorders*

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## INTRODUCTION:

Mental disorders are of important health disorders which exert high pressure on health care services in today's societies [1]. World health organization also, expresses in its reports that there are more than 25% of world society with types of mental disorders [2]. Based on world health organization report, more than 450 million people in world suffer from a mental or behavioral disorder and of three or four people one will be with mental disorders [3]. Mental disorders are common in human societies. This disorders cause to reduce social functions of affected people and exerting high expenses on governments and support systems. Mental disorders always have been in human societies and no one in no era can claim that he or she is secure against mental disorders. [2,4]. According to statistics of mental patients in Iran, we can point to presented statistics by world health organization due to developing countries which show that one percent of society are with severe mental disorders and 10 percent are with mild mental disorder [1]. Mental disorders and drug abused disorders are common, disabling and costly disorders. Mental disorders are common disorders of societies which cause different anarchies such as disturbance in individual and society functions and create different results and complications in different fields which some of them are higher than patient's disorder and no doubt, patient family is one the fields that affected by these disorders [5].

Family is the best source for individual with severe mental disorders [6], as such more than 60 percent of clients who discharged from mental institutes return to their main family [7]. They prepare home, financial support, companionship, emotional support and also hygiene services for their patient's relatives [8]. However, one of the important stresses in family is affection of one of the family members with mental disorders which cause disorder in health dimensions or entirely their life quality [9]. In addition, from a systemic viewpoint, family is a system which functional disorder or a disease in one of the members affected on other family members, because family function as a unit which form a whole by their relations [10]. Also, health care givers understand that mental disorder and its related medications not only effect on mental patient but also effect on their families, as such generally transform their life quality [11].

Based on world health organization reports, today, of every four family, one of them are involved in caring of a mental patient. However, generally families with mental disorders have no preparation or special trainings for caring their patients. Therefore, family health may be affected by caring of patient. In addition, it can be possible to change social and pleasure family activities and also to experience depression, anxiety and psychotic signs because of caring responsibilities. Therefore, caring of a patient with mental disorder can be accompanied with adverse effects on body and mental health of caregivers [1].

Caring load of mental patients causes to create multiple results and complications on caregivers [12]. In fact, caring pressure is mental, bodily and social distresses which are exerted on caregivers because of caring of chronic patients and in the following create many problems such as: depression, anxiety and exhaustion for caregivers [13]. Steele et al study shows that 40 to 55% of patient's caregivers are under mental and spiritual pressures [14]. Existed studies show that diversity and caring role severity can cause mental disorders in patient's family caregivers [15]. Family caregivers experience and express many relational pressures and tensions in response to signs and symbols of mental disorders and follow-up and continuous care of mental patients in home, in addition to involve in grief and sorrow, absence, bereavement, anger and anxiety, feelings of shame and guilt [16]. Depression is one of the most important unwanted complications in caregivers which is very common in relation to reduce life quality and other unwanted results such as reducing function and life expectancy in these individuals [12]. Studies show that 20% of caregivers are medicated in terms of psychological disorders such as depression [3].

On-time identification of caregiving load has a determinant role in promoting their health [17]. Based on this, identification of effective and moderator factors of complications and results of experienced care load by family can have an important role in entire health of caregivers. In this regard, relationship between mental health and spirituality in recent years has been considered by psychologists. In recent years, researchers pay more attention to relationship between religious obligations of family caregivers and related results of care. Some studies show that, caregivers who have religious beliefs and functions for coping with care duties, report less care pressure, high psychology welfare and less depression than caregivers who lack religious obligations [18]. Todays, experts often believe that religion has undoubted effects on body health and other human life dimension which are the most complete orders among Divines Islam orders about body and soul hygiene and other affairs [19]. Studies show that religious and divine beliefs are considered as a factor for mental relaxation and not having religion or low religious beliefs in each divine or path is related to a high level of depression and thoughts that result to suicide [20]. Also, performed studies in all around the world show that individuals who have not religious beliefs or perform religious functions have better compatibility and mental health other than individuals who have not religious beliefs [21].

According to these cases, and by paying attention to necessity of performing studies in care load, anxiety and depression of families with mental patients and its related factors, researchers decide to perform a study by the aim of determining religious beliefs relationship with anxiety and depression in families with mental patients in order to identify effective factors on care load of families with mental disorders patients and take steps towards reduce it.

## MATERIALS AND METHODS:

Current study is a descriptive and cross-sectional epidemiologic evaluation of correlation which religious belief relationship with anxiety and depression in families with mental patients is evaluated in it. Population of this research includes all families with mental patients who were hospitalized in psychological sections of medical science university of Ahvaz Jundishapur during performing study on patients. Study samples were 152 families which were selected among study society and based on characteristics of entering to study by continuous improbable methods; in a way that all individuals who had criteria of entering to study were selected as samples from initiation of study and this job continued up to obtain final volume of sample. Entering characteristics to study include: not having mental disorders history in caregiver, caregiver should be in 18-50 age range and having enough literacy for answering to questions and removal characteristics from study include: samples who fill questionnaires incomplete. Current research environment are all subsidiary hospitals of medical science university of Jundishapur of Ahvaz include Golestan, Salamat and Sina which have psychological section. In this study in order to gather information, three questionnaires were used: demographic characteristics questionnaire, [Hospital Anxiety and Depression Scale] HADS and religious beliefs questionnaire. Demographic questionnaire include information about families, such as sex, age, marital state, education level, occupational situation, relation with patient and period of caring patient. HADS questionnaire which is used for evaluation of hospital anxiety and depression includes 7 4-choice questions for anxiety evaluation. Scores of each choice are considered from 0 to 4. Obtaining higher scores show emerging signs of anxiety and depression [20, 22]. Validity and reliability of this questionnaire in Iran, have been measured by Kavyani et al [2009] and evaluation results show that HADS scales and subscales of anxiety and depression have suitable validity, reliability and coordination [$\alpha$=0.70]. According to the results, researchers report that HADS has necessary reliability for applying in Iranian clinical population [23]. Also in Rabie SiahKali et al [1393], calculated stability factor for this tool is obtained 0.88 [20]. Religious beliefs questionnaire is designed by Agha Mohammadi et al in 1382. This questionnaire includes 29 5-choice questions with Likert spectrum [from disagree to completely agree] which for disagree, score 1 is considered and for completely agree score 5 is considered; therefore obtained score is between 29 and 145. Scores 110-145 are considered for having strong religious beliefs, scores 69-109 for having medium religious beliefs and scores 29-68 for having weak religious beliefs [24]. Validity of this questionnaire in Rabie Siahkali et al [1393] is measured through evaluation of content validity and its stability by using Kronbach Alpha coefficient. Correlation between questions are measured after a laboratory sampling by number of 34 questions which computed coefficient for this tool is obtained 0.83 which shows correlation in questionnaire questions [20].

After obtaining necessary license from medical science university of Jundishapur of Ahvaz and determining samples and coordination with concerned authorities in research environment, after presence of sample members in suitable place and communicating and reducing trial sensitivities about questionnaire and reasons for selecting them in samples, necessary explanations were presented and subjects initiate to complete questionnaires. Subjects were asked to request more explanation from researcher if encountered with ambiguity in completing questionnaires. Finally, subject's cooperation was acknowledged. All moral considerations are observed in this study and are received from moral committee of medical science university of Jundishapur of Ahvaz by moral code of IR.Ajums.REC.1395.849. In order to data analysis, at first by using descriptive statistical method including frequency distribution table, charts and central diffusion center, studied variables were described. Then quantity data normality was checked by Kolmogorov-Smirnov test. Relationship between quality variables by using $X^2$-test and relationship between quantity variables by using Pearson or Spearman correlation coefficient were evaluated. In order to compare averages, independent t-test was used and more than two averages of one-sided variance analysis or non-parametric equivalents were used. A meaningful level of tests was considered lower than 0.05 and data analysis was performed by SPSS 22 software.

## RESEARCH FINDINGS:

According to findings of this study, most of members of families with mental disorders patients were men [63.8] and 36.2 of them were women. Above table findings express that most of studied units [50 percent] were in 30 to 50 years old in terms of age. While, 21.1 percent of studied units that care of their patients were above 50 years old.

Most of studied units [63.8%] were married. Also, in terms of respondent and participated member relation in study about patient, results express that most of studies units [36.8%] had a relation other than father or mother or sister or brother. 34.2 percent had brother relationship with patients. [table1]

In terms of severity of families' religious beliefs and according to family members expressions, results show that most of studied units [70.4%] had strong religious beliefs. Neither of the studied units didn't evaluate themselves weak, in terms of religious belief levels [0%]. [Table 2]

Results of the study express that most of the members of families with mental disorder patients who participated in this study were healthy in terms of anxiety factors [52%]. While 22.3 percent of studied units were doubted with mental disorder in terms of anxiety sings. 25.7 percent of studied units were border in terms of anxiety signs. According to above findings, most of families with mental disorder patients which participated in this study, had depression signs [57.3%] which among them, 27% of studied units were doubted with depression disorder and 30.3 percent of studied units were border in terms of depression signs. 42.7 percent of caregivers were healthy in terms of depression signs. [Table 3]

In terms of relationship between religious beliefs, studied families and their anxiety signs, study results show that 58.9 percent of families which had strong religious beliefs were healthy in terms of anxiety signs. Most of studied units which had medium religious beliefs [44%] were boarder and abnormal in terms of anxiety signs. Chie square Statistical test between existence of anxiety signs and religious beliefs rate of studied units show a meaningful statistical relationship [p-value=0.002]. [Table 4]

In terms of relationship between religious beliefs of studied families and their depression signs, study results show that 45.8% of families which had strong religious beliefs were healthy in terms of depression signs. Also, most of studied units which had medium religious beliefs [35.6%] were healthy in terms of depression signs. 24.3 percent of studied units which had strong religious beliefs and 33.3 percent of studied units which had medium beliefs, were doubted to disorder in terms of depression signs. Chie square statistical test between depression signs and religious beliefs rate of studied units don't show meaningful statistical relationship [p-value=0.417]. [Table 5]

**Table 1: frequency distribution and percent of demographic characteristics of studied units related to respondent member of family**

| severity of beliefs and religious beliefs | Frequency | Percentage |
|---|---|---|
| Poorly | 0 | 0.0 |
| Moderate | 45 | 29.6 |
| Strong | 107 | 70.4 |
| Sum | 152 | 100 |

**Table 2: frequency distribution and percent of belief severity and religious beliefs of studied units based on responsiveness of family members**

| Variable | | Frequency | Percentage |
|---|---|---|---|
| Gender | male | 97 | 63.8 |
| | female | 55 | 26.2 |
| Sum | | 152 | 100 |
| Age | Under 30 | 44 | 28.9 |
| | 30 – 50 | 76 | 50.0 |
| | Upper 50 | 32 | 21.1 |
| Sum | | 152 | 100 |
| marital status | Single | 47 | 30.9 |
| | married | 97 | 63.9 |
| | Divorced | 4 | 2.6 |
| | Widow | 4 | 2.6 |
| Sum | | 152 | 100 |
| Relative to the patient | Mother | 13 | 8.6 |
| | Father | 13 | 8.6 |
| | Sister | 18 | 11.8 |
| | Brother | 52 | 34.2 |
| | Other | 56 | 36.8 |
| Sum | | 152 | 100 |

**Table3: frequency distribution and percent of studied units based on situation of anxiety and depression signs in family members**

| Level of symptoms | Symptoms of Anxiety | | Symptoms of depression | |
|---|---|---|---|---|
| | Frequency | percentage | Frequency | percentage |
| Healthy | 79 | 52.0 | 65 | 42.7 |
| Borderline and abnormal | 39 | 25.7 | 46 | 30.3 |
| Suspected of disorder | 34 | 22.3 | 41 | 27 |
| Sum | 152 | 100 | 152 | 100 |

**Table 4: frequency distribution and percent of studied units based on religious beliefs and anxiety signs in family**

| | | | Anxiety | | | P - value |
|---|---|---|---|---|---|---|
| | | | Healthy | Borderline and abnormal | Suspected of disorder | |
| severity of beliefs and religious beliefs | Moderate | Frequency | 16 | 20 | 9 | 0.002 |
| | | Percentage | 35.6 | 44.4 | 20.0 | |
| | Strong | Frequency | 63 | 19 | 25 | |
| | | Percentage | 58.9 | 17.8 | 23.3 | |

**Table 5: frequency distribution and percent of studied units based on religious beliefs and depression signs in family**

| | | | Depression | | | P - value |
|---|---|---|---|---|---|---|
| | | | Healthy | Borderline and abnormal | Suspected of disorder | |
| severity of beliefs and religious beliefs | Moderate | Frequency | 16 | 14 | 15 | 0.417 |
| | | Percentage | 35.6 | 31.1 | 33.3 | |
| | Strong | Frequency | 49 | 32 | 26 | |
| | | Percentage | 45.6 | 29.9 | 24.3 | |

## DISCUSSION:

Obtained results show that most of studied families express that they have strong religious beliefs and none of the studied units had weak religious beliefs. Religious beliefs are accounted as an important factor for obtaining mental relaxation [20]. Linkage and relation that exist between human mind and his beliefs and the role that divine plays in mental health as a collection of trainings and beliefs is undeniable. Divine and religion beliefs relax human being, guarantee individual safety, strengthen moral, affection and spiritual vacuity and create a strong base for human against problems and life deprivations [25]. In Swang et al study on individuals who care of mental disorders patients, results show that often, families turn to spiritual support which show religious beliefs importance [26] and in Siahkali study it was determined that 86.6 percent of studied individual which were of families of hospitalized patients in special section, had medium to high religious beliefs, which are aligned with results of the study.

Also, results show half of studied families and participated in study were suffered from anxiety signs or had boarder signs and abnormal or were doubted by anxiety disorders. Also, results show that most of caregivers in families showed depression signs. Results of this study show that high percent of families who care of patients with mental disorders experience anxiety and depression signs which can be worrying and put family in problems during performing their duties. Emotional reactions of caregivers of patients with mental disorders play an important role in compatibility with disease and giving care for patient. Studies show that families experience high level of anxiety while reception and hospitalization of their patient in hospital which can cause problems in in their compatibility and supplying patient needs [20]. Mental pressure in families with mental disorder patient will put tension on family members specially caregivers and create special reactions in them which sometimes are compatible and sometimes are incompatible. In Kaberal et al study in 2014 by title of evaluation of anxiety, stress and depression in mental disorder patient's companions, study results show that women caregivers have high rate of anxiety, depression and stress [27] and in Rudrigo et al by title of care pressure and depression signs in main caregivers of schizophrenic and moral disorder patients in 2013, it was determined that 37.5 percent of caregivers had depression signs [28] and also Garcia et al study by title of "anxiety and depression in caregivers of patients with Alzheimer" showed that high percent of caregivers show high levels of anxiety and depression. Also, in Hynz et al in 2015 by title of mental signs in caregivers of acute patients, depression prevalence was reported among caregivers 75.5% [29] which these results were aligned with current study. According to experienced mental pressures by families and individuals who care of mental patients, it is important and vital that should be paid attention in mental health organization of country.

Study results show that there is a reverse relationship between severity of religious beliefs and rate of anxiety of family caregivers of mental disorder patient; it means the stronger is religious beliefs severity, studied units numbers which are healthy in terms of anxiety signs, increase. Then it can be concluded that religious beliefs have a direct role in reducing anxiety in families with mental disorder patient. With regard to relations between religious beliefs and depression signs, study results show that in spite of the fact that some percent of individual which are healthy in terms of depression signs, have stronger religious beliefs, but statistical test results express that there is no relationship between religious beliefs and depression signs. Then it can be concluded that in this study didn't find a meaningful statistical relationship between religious beliefs and depression signs. In Alesis et al study in 2013 it was showed that anxiety and depression signs in caregivers who had high spirituality were lower [30]. Rabi'a Siahkali et al study show that there is a relationship between religious beliefs and anxiety and depression of families with hospitalized patients in special sections [20], which are aligned with current study in anxiety dimension and are not aligned with current study in depression dimension. Being religious is one of the effective factors in mental health and prepare the field for transcendental and reassurance experience and prepare a suitable bed for forming healthy life style. As, the important index for mental relaxation of human is existence or nonexistence of anxiety which is the main core of mental disorders, it can be concluded that it is determined in this study that there is a relationship between religious beliefs and mental health in anxiety signs and the stronger religious belief studied units had, their anxiety was lower.

Limitation of this study is that the effect of spiritual situation and individual and mental characteristics of studied units during completing questionnaires which were out of discretion of researchers.

## CONCLUSIONS:

Families with mental disorder patients always face with challenges and multiple bodily, mentally, social and family, especially anxiety and depression. Religious beliefs are strong factors in supplying mental health of caregivers who care of their mental patients and help them to care of their patient better. The stronger are religious beliefs, their anxiety rate is lower and mental health level is higher.

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