1. Introduction

Schizophrenia is often a chronic, disabling condition, associated with impairments in multiple domains of functioning. This disorder is known for its great heterogeneity across individuals and variability within individuals over time. Numerous factors have been associated with the outcome of schizophrenia including biological, phenomenological, social and demographic aspects (American Psychiatric Association, 2000; Altamura et al., 2007). Religion, defined in a broad sense which includes both spirituality (concern with the transcendent, addressing the ultimate questions about life’s meaning) and religiousness (beliefs systems, behavioral, social and denominational characteristics) (Pargament, 1997), has seldom been considered in its potential role as a predictive factor of outcome in schizophrenia. Research on religion involving patients with schizophrenia has mainly focused on religious delusion, thus linking religion and psychopathology in this disorder (Mohr et al., 2004). However, in recent years, some studies have shown that religion was of great importance for many people with psychosis (Wahass and Kent, 1997; Corrigan et al., 2003; Mitchell and Romans, 2003; Pieper, 2004; Bellamy et al., 2007; Teuton et al., 2007; Borras, Mohr et al. 2010) and severe mental disorders (Koenig, 2009). Compared to lay methods of coping, spirituality and religiousness may offer answers to the problems of human shortenings (Pargament and Brandt, 1998). Thus, it is not surprising that many people with mental illness use religion as a coping device. Spirituality may even play a key role in the psychological recovery from severe mental disorders such as schizophrenia (Fallot, 2007).

In a cross-sectional study on spiritual/religious coping in schizophrenia, we were able to show that when religion was helpful, its importance for the patients and the extent to which they depend on it for coping with their illness correlated with fewer symptoms, better social functioning, reduced substance misuse, reduced suicide attempt rate and stronger treatment adherence. Inverse relationships were found when religion was harmful (Mohr et al., 2006). Longitudinal data providing insight into the causal relationship between outcome and religion are lacking. Few studies have investigated the relationship between religion and outcome in psychosis. In India, an increase in religious practice was predictive of better clinical and functional outcome at 2 years (Verghesel et al., 1989). Among Vietnam veterans in the USA, religiosity was a protective factor against re-hospitalization for substance abuse and psychiatric disorders at 2 years (Benda, 2002). A study by Phillips and Stein (2007) focused on how religious meaning may be given to
psycosis. The authors found that, at 1 year, a benevolent religious reappraisal of the illness was predictive of stress-related improve-
ment and psychological well-being. Conversely, judging illness as
God’s punishment, and reappraising God’s power as ineffective were
predictive of self-reported distress and personal loss (Phillips and
Stein, 2007). Similar results were reportedly obtained in other
populations. For example, in physically ill elderly patients, religious
struggle was associated with an increased risk of death during the
following two years, whereas positive religious coping was associated
with improvements in health (Pargament et al., 2004). Another
finding observed in longitudinal studies is that religiosity increased
when people had to cope with stressful events (Pargament, 1997).
This finding was also reported in individuals coping with depression
(Vaillant et al., 2008), HIV (Ironson et al., 2006) and recovery from
substance misuse (Robinson et al., 2007).

The objective of the present study is to assess the predictive value of
spirituality and religiosity in patients with schizophrenia. We
hypothesized that when religion is helpful, religious patients would
show better clinical outcome. Inversely, we hypothesized that when
religion is harmful, its importance would be predictive of a poorer
clinical outcome.

2. Method

2.1. Design

One hundred and fifteen subjects (N = 115) fulfilling DSM-IV criteria of schizophrenia
or schizo-affective disorder recruited from four public psychiatric outpatient facilities in
Geneva participated in the initial study (Mohr et al., 2006). In the initial study, patients
were randomly selected, only three patients refused to participate. All available patients
from this cohort were invited to take part in the present follow-up study. Data collection
took place from May 2006 to June 2007, three years (± 3 months) after the initial
investigation. Assessors were not involved in the patients’ care. The study was approved
by the ethics committee of the University Hospital of Geneva. Patients signed a written
detailed consent form prior to participating in the study.

2.2. Clinical measures

During the follow-up interviews, the same clinicians (SM and LB) reassessed spirituality and religiosity, symptoms and psychosocial adaptation (Positive and Negative Syndrome Scale (Kay, 1992), Clinical Global Impression (Guy, 1978) and Global Assessment of Functioning (APA, 2000)). The patients estimated their quality of life with a Visual Analogue Scale ranging from 0 (very unhappy) to 10 (very happy). The MINI (Sheehan et al., 1998) was administered to screen for current or past history of formally diagnosable psychiatric disorders, substance misuse and suicide attempts.

2.3. Assessment of spirituality and religiosity

At baseline, the patients’ spirituality and religiosity were assessed with a semi-
structured interview (Mohr et al., 2007). We retained a modern version of spirituality and religiosity, i.e. spirituality is limited to the area of the sacred and/or the
transcendent, but may occur outside an established religious tradition (Koenig, 2008).
For patients with psychosis, for whom religion can also be mixed with their
psychopathology, the most appropriate evaluation method is the clinical interview, which allows for the clinician to adapt his language to the beliefs of each individual. Open questions were based on previous questionnaires for religion and religious coping
in health research (Koenig et al., 1997; Fetzer Institute 1999; Pargament et al., 2000).
This interview was designed to explore the patients’ spiritual and religious history, spiritual beliefs, private and communal religious practices; the importance of religion in their lives, in their coping with their illness and its consequences; its interaction with the psychiatric treatment. This interview allowed for the clinician to grasp the patients’ spiritual and religious worldview, the range and intensity of their religious practices
(individual and collective) and how they resort to it (or not) to cope with their illness.
In addition to the structured interview, we used a Visual Analogue Scale to obtain self-
report measures on the salience of those various dimensions was measured by a Visual Analogue Scale ranging from 0 (of no importance) to 10 (essential). To make responses
more precise, especially for patients who presented deficits in abstraction, five
anchored points were provided. The duration of the interview was about 30 minutes.
In addition to this quantitative estimate, a qualitative content analysis of all
interview transcripts was conducted independently by the two clinicians (SM and LB)
to obtain a comprehensive view of religious coping strategies. Qualitative analysis
categorized patients into three sub-groups: 1—helpful use of religion for coping with
existential and symptomatic issues (i.e. religion provided patients with a positive sense
of self or a spiritual sense of their illness that helped them accept it and mobilize their
spiritual resources to cope), 2—harmful use of religion (i.e. religion contributed to a
negative sense of self, in terms of despair and suffering or a spiritual sense of the illness
including fear, anger, or guilt) and 3—no use of religion (i.e. patients without spiritual
beliefs or religious practices or if their religion was not mobilized to cope with their
illness in any way). A high inter-rater reliability was obtained (kappa = 0.86).

2.4. Statistical analyses

Baseline clinical and demographic characteristics between subject with helpful and harmful
use of religion to cope with existential and symptomatic issues were compared using a
linear logistic regression adjusted for age and gender for categorical and
continuous variables respectively.

Predictors of drop-out from the 3 years follow-up were assessed using Cox
proportional hazard regression adjusted for age and gender.

Linear mixed models (Rabe-Hesketh and Skrondal, 2005; Uher et al., 2009) with
fixed effect of treatment year and a random effect of individual, fitted with maximum
likelihood with additional fixed effects of linear and quadratic functions of time, age,
gender, and baseline severity of each individual scales was used to analyze if helpful vs.
harmful use of religion was a predictor of treatment response for continuous scales.
Treatment response was evaluated using the following scales: PANSs negative, positive,
general symptoms and total score, and the Global Assessment functioning. The results
of regression models are presented as standardized regression coefficients (β) with
95% confidence intervals which can be interpreted as effect size.

For ordinal outcome (the subjective quality of life, the clinical global impression and
the global evaluation of clinical and functional status), prediction of positive and negative
changes by the type of religious use (helpful vs. harmful) during the 3 years follow-up was
analyzed using generalized linear latent and mixed model (glmm) in STATA with
adaptive quadrature to obtain maximum likelihood estimates for the individual random-
intercept and slope model. As for the Linear mixed models, to relax the assumption of
conditional independence in the responses of the same person, we included a subject-
specific random-intercept. The analyses assumed a binomial error distribution. Helpful vs.
harmful use of religion was included as fixed factors adjusted for age and gender.

In a second sensitivity analysis, the subjective importance of religion in daily life, to
give meaning to life (SIRE), to cope with symptoms (SIRS), the frequency of communal
religious activities and the support from the religious community were also
investigated as potential predictors of response inside the two groups (harmful vs.
helpful use of religion).

3. Results

3.1. Attrition

Twenty-three (20%) patients out of the 115 dropped-out at follow-
up. One patient committed suicide, four were unattainable and the
others refused the follow-up on the grounds that they were not
interested in the topic. Of the 23 drop-outs, five patients had a harmful
use of religion, 12 had a helpful use, and six showed no religious
interests. In the follow-up group: harmful (N = 13), helpful (N = 76)
and no religious interests (N = 3). This difference in helpful vs.
harmful religion was significant (p = 0.01) and being a subject
showing no religious concern was a predictive factor of drop-out
with a hazard ratio (HR) of 4.72 (95% CI: from 1.70 to 13.07; p = 0.003). After adjusting for age and gender, better education and
not having made a suicide attempt were both predictors of drop-out
(HR = 3.24, 95% CI: from 1.27 to 8.25; p = 0.014 and HR = 0.36, 95% CI: from 0.13 to 0.97, p = 0.044). In a multivariate models and after
adjusting for age and gender, better education and having no religious
concern were the two remaining predictors of drop-out (HR = 3.61, 95% CI: from 1.39 to 9.34, p = 0.008 and HR = 3.55, 95% CI: from 1.24
to 10.17, p = 0.018 respectively). No other baseline demographic or
clinical characteristics were associated with drop-out.

3.2. Baseline religious, clinical and demographic characteristics

The majority of the patients were Christians (63%); 10% came from
other traditional religions (Judaism, Islam and Buddhism), 12% from
minority religious movements and 15% had no religious affiliation.
One-third of patients participated in religious activities with other
people at least once a month, 14% occasionally and 52% never.
Two thirds reported daily or weekly individual religious practices;
and only 21% never. Nearly half of the patients (46%) reported that religion
was the most important element in their lives. For most measures,
between half and three-quarters of the patients rated religion as
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