

Religiosity

Introduction

Religiosity refers to religious activity, dedication, and beliefs. Religious themes are often reported in the delusions and hallucinations experienced by people with schizophrenia. This table covers the available evidence on the relationship between religion and schizophrenia.

Method

We have included only systematic reviews (systematic literature search, detailed methodology with inclusion/exclusion criteria) published in full text, in English, from the year 2000 that report results separately for people with a diagnosis of schizophrenia, schizoaffective disorder, schizophreniform disorder or first episode schizophrenia. Reviews were identified by searching the databases MEDLINE, EMBASE, CINAHL, Current Contents, PsycINFO and the Cochrane library. Hand searching reference lists of identified reviews was also conducted. When multiple copies of reviews were found, only the most recent version was included.

Review reporting assessment was guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) checklist that describes a preferred way to present a meta-analysis¹. Reviews with less than 50% of items have been excluded from the library. The PRISMA flow diagram is a suggested way of providing information about studies included and excluded with reasons for exclusion. Where no flow diagram has been presented by individual reviews, but identified studies have been described in the text, reviews have been checked for this item. Note that early reviews may have been guided by less stringent reporting checklists than the PRISMA, and that some reviews may have been limited by journal guidelines.

Evidence was graded using the Grading of Recommendations Assessment, Development

and Evaluation ([GRADE](#)) Working Group approach where high quality evidence such as that gained from randomised controlled trials (RCTs) may be downgraded to moderate or low if review and study quality is limited, if there is inconsistency in results, indirect comparisons, imprecise or sparse data and high probability of reporting bias. It may also be downgraded if risks associated with the intervention or other matter under review are high. Conversely, low quality evidence such as that gained from observational studies may be upgraded if effect sizes are large or if there is a dose dependent response. We have also taken into account sample size and whether results are consistent, precise and direct with low associated risks (see end of table for an explanation of these terms)². The resulting table represents an objective summary of the available evidence, although the conclusions are solely the opinion of staff of NeuRA (Neuroscience Research Australia).

Results

We found one review that met our inclusion criteria³.

- Low quality evidence is unable to determine any consistent relationships between religion and delusions or hallucinations.

Religiosity

Gearing RE, Alonzo D, Smolak A, McHugh K, Harmon S, Baldwin S

Association of religion with delusions and hallucinations in the context of schizophrenia: Implications for engagement and adherence

Schizophrenia Research 2011; 126: 150-163

[View review abstract online](#)

Comparison	Relationship between religion and delusions and hallucinations.
Summary of evidence	Low quality evidence (unable to assess consistency or precision, unclear sample sizes) is unable to determine any consistent relationships between religion and delusions or hallucinations.
Religious influences on delusions and hallucinations	
<p>1 study reported that Protestant patients have more religious delusions than Roman Catholic patients and non-religious patients.</p> <p>1 study found that Roman Catholic patients have more religious delusions of guilt than Protestants and Muslims.</p> <p>2 studies found that Islamic patients experienced fewer religious delusions, specifically delusions of guilt and sin, than Christian patients.</p> <p>1 found that individuals from New Religious Movements scored higher on delusional measures than Hindu, Christian or non-religious patients.</p> <p>1 study found that Buddhist patients have a lower frequency of religious themed delusions than Christian patients.</p>	
Cultural influences on delusions and hallucinations	
<p>1 study found that religious delusions were more common in German patients than in Japanese patients.</p> <p>1 study found that religious delusions to be more common in Austria than in Pakistan.</p> <p>1 study found that the Kelantan Malay had a greater prevalence of religious delusions than the Penang Malay.</p> <p>1 study found that religious based auditory hallucinations were heard more clearly by patients from the United Kingdom than by patients from Saudi Arabia.</p> <p>1 study reported that religious and supernatural themes were more common in Korean patients than Korean-Chinese patients or Chinese patients.</p>	

Religion-related risk factors associated with symptoms and functioning

The majority of risk factors were associated with Christianity, followed by Islam, then ‘other’ (e.g., Rastafari, Mormonism, Christian Scientology), Judaism, Buddhism and lastly, Hinduism.

12 studies identified relationships between religious and spiritual beliefs/affiliations/activities and religious content of delusions and psychotic symptoms. Associations were also seen between religious delusions and cognitive deficits, marital and education status, and psychotic symptoms.

7 studies identified religion-related factors were associated with distressed mental health, higher rates of schizophrenia, poorer premorbid adjustment, spiritual despair, increased social isolation, increased psychotic and general symptoms, delay in treatment, and functioning less well.

3 studies identified associations between sociocultural context and delusional content.

3 studies identified associations between increased religious beliefs and reduced psychiatric treatment.

Other findings included associations between religious beliefs and suicide risk, delay in treatment, substance use, and unease of speaking with clinician about religion when psychotic symptoms reflected religious beliefs for fear of hospitalization.

Note: authors report that much of this research was methodologically weak.

Religion-related protective factors associated with symptoms and functioning

14 studies described religious beliefs, spirituality, and faith as being coping mechanisms in individuals with schizophrenia. Such beliefs provided meaning, hope, and provided a sense of control.

7 studies identified religious beliefs and affiliations were related with better prognoses, higher quality of life, better psychosocial adaptation, increased social integration, lessened psychotic and general symptoms, and aided in recovery of schizophrenia and reduced relapse.

4 studies demonstrated an association between religion and adherence to psychiatric treatment and medication.

Note: authors report that much of this research was methodologically weak

Consistency in results[‡]

Unable to assess; no measure of consistency is reported.

Precision in results[§]

Unable to assess; no measure of precision is reported.

Directness of results^{||}

Direct

Religiosity

Explanation of technical terms

* Bias has the potential to affect reviews of both RCT and observational studies. Forms of bias include; reporting bias – selective reporting of results; publication bias - trials that are not formally published tend to show less effect than published trials, further if there are statistically significant differences between groups in a trial, these trial results tend to get published before those of trials without significant differences; language bias – only including English language reports; funding bias - source of funding for the primary research with selective reporting of results within primary studies; outcome variable selection bias; database bias - including reports from some databases and not others; citation bias - preferential citation of authors. Trials can also be subject to bias when evaluators are not blind to treatment condition and selection bias of participants if trial samples are small⁴.

† Different effect measures are reported by different reviews.

Prevalence refers to how many existing cases there are at a particular point in time. Incidence refers to how many new cases there are per population in a specified time period. Incidence is usually reported as the number of new cases per 100,000 people per year. Alternatively some studies present the number of new cases that have accumulated over several years against a person-years denominator. This denominator is the sum of individual units of time that the persons in the population are at risk of becoming a case. It takes into account the size of the underlying population sample and its age structure over the duration of observation.

Reliability and validity refers to how accurate the instrument is. Sensitivity is the proportion

of actual positives that are correctly identified (100% sensitivity = correct identification of all actual positives) and specificity is the proportion of negatives that are correctly identified (100% specificity = not identifying anyone as positive if they are truly not).

Mean difference scores refer to mean differences between treatment and comparison groups after treatment (or occasionally pre to post treatment) and in a randomised trial there is an assumption that both groups are comparable on this measure prior to treatment. Standardised mean differences are divided by the pooled standard deviation (or the standard deviation of one group when groups are homogenous) which allows results from different scales to be combined and compared. Each study's mean difference is then given a weighting depending on the size of the sample and the variability in the data. Less than 0.4 represents a small effect, around 0.5 a medium effect, and over 0.8 represents a large effect⁴.

Relative risk (RR) refers to the probability of a reduction (< 1) or an increase (> 1) in a particular outcome in a treatment group, or a group exposed to a risk factor, relative to the comparison group. For example, a RR of 0.75 translates to a reduction in risk of an outcome of 25% relative to those not receiving the treatment or not exposed to the risk factor. Conversely, a RR of 1.25 translates to an increased risk of 25% relative to those not receiving treatment or not having been exposed to a risk factor. An RR of 1.00 means there is no difference between groups. A medium effect is considered if $RR > 2$ or < 0.5 and a large effect if $RR > 5$ or < 0.2 ⁵. Odds ratios (ORs) are similar to RRs, but they are based on the probability of an event occurring divided by the probability of that event not occurring. ORs and RRs are similar in size when the event is rare, such as with schizophrenia. InOR stands for logarithmic

Religiosity

OR where a lnOR of 0 shows no difference between groups. Hazard ratios (HRs) measure the effect of an explanatory variable on the hazard or risk of an event.

Correlation coefficients (eg, r) indicate the strength of association or relationship between variables. They can provide an indirect indication of prediction, but do not confirm causality due to possible and often unforeseen confounding variables. An r of 0.10 represents a weak association, 0.25 a medium association and 0.40 and over represents a strong association. Unstandardised (b) regression coefficients indicate the average change in the dependent variable associated with a 1 unit change in the independent variable, statistically controlling for the other independent variables. Standardised regression coefficients represent the change being in units of standard deviations to allow comparison across different scales.

‡ Inconsistency refers to differing estimates of effect across studies (i.e. heterogeneity or variability in results) that is not explained by subgroup analyses and therefore reduces confidence in the effect estimate. I^2 is the percentage of the variability in effect estimates that is due to heterogeneity rather than sampling error (chance) - 0% to 40%: heterogeneity might not be important, 30% to 60%: may represent moderate heterogeneity, 50% to 90%: may represent considerable heterogeneity and over this is considerable heterogeneity.

§ Imprecision refers to wide confidence intervals indicating a lack of confidence in the effect estimate. Based on GRADE recommendations, a result for continuous

data (standardised mean differences, not weighted mean differences) is considered imprecise if the upper or lower confidence limit crosses an effect size of 0.5 in either direction, and for binary and correlation data, an effect size of 0.25. GRADE also recommends downgrading the evidence when sample size is smaller than 300 (for binary data) and 400 (for continuous data), although for some topics, these criteria should be relaxed⁶.

|| Indirectness of comparison occurs when a comparison of intervention A versus B is not available but A was compared with C and B was compared with C that allows indirect comparisons of the magnitude of effect of A versus B. Indirectness of population, comparator and/or outcome can also occur when the available evidence regarding a particular population, intervention, comparator, or outcome is not available and is therefore inferred from available evidence. These inferred treatment effect sizes are of lower quality than those gained from head-to-head comparisons of A and B.

Religiosity

References

1. Moher D, Liberati A, Tetzlaff J, Altman DG, PRISMA Group (2009): Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *British Medical Journal* 151: 264-9.
2. GRADE Working Group (2004): Grading quality of evidence and strength of recommendations. *British Medical Journal* 328: 1490.
3. Gearing RE, Alonzo D, Smolak A, McHugh K, Harmon S, Baldwin S (2011): Association of religion with delusions and hallucinations in the context of schizophrenia: implications for engagement and adherence. *Schizophrenia Research* 126: 150-63.
4. Cochrane Collaboration (2008): Cochrane Handbook for Systematic Reviews of Interventions. Accessed 24/06/2011.
5. Rosenthal JA (1996): Qualitative Descriptors of Strength of Association and Effect Size. *Journal of Social Service Research* 21: 37-59.
6. GRADEpro (2008): [Computer program]. Jan Brozek, Andrew Oxman, Holger Schünemann. *Version 3.2 for Windows*.