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Negative, but not positive, religious coping strategies are associated with psychological distress, independent of religiosity, in Korean adults with epilepsy

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ABSTRACT

Purpose: Religion can be important in the everyday lives of persons with epilepsy (PWE). However, there is little research on religion, as it relates to individuals with epilepsy. We determined a relationship between religious coping strategies and psychological distress in Korean adults with epilepsy who had a religious affiliation.
Methods: This cross-sectional study was conducted in outpatient clinics. Religiosity and religious coping strategies were assessed using the Duke University Religion Index (DUREL) and the Brief Religious Coping Scale (B-RCOPE). Psychological distress was measured using the Hospital Anxiety Depression Scale (HADS). Univariate and multivariate linear regression analyses were performed.
Results: A total of 88 participants were included. Positive religious coping strategies were more likely utilized than negative religious coping ($p < 001$). Religiosity was positively correlated with positive coping ($r = 0.439$, $p < 0.001$) but was not correlated with negative coping. Negative coping was significantly related to higher levels of anxiety ($\beta = 0.237$, standard error (SE) $= 0.107$, $p < 0.05$) and depressive symptoms ($\beta = 0.260$, SE $= 0.095$, $p < 0.01$), after controlling for religiosity and other confounding factors. However, positive coping was not related to anxiety and depressive symptoms. The two types of coping strategies were positively related to each other ($r = 0.304$, $p < 0.01$).
Conclusions: We found significant positive associations between negative religious coping and anxiety and depressive symptoms in PWE. Positive religious coping was not related to anxiety and depressive symptoms.

1. Introduction

The term *coping* refers to a person's conscious efforts to reduce stress [1]. Psychological coping mechanisms are commonly termed "coping strategies" or "coping skills." Perceived control is an important resource when coping with stressful situations [2]. Persons with epilepsy (PWE) can experience significant psychosocial difficulties [3,4] because of the stigmatized nature of epilepsy and the unpredictability of seizure recurrences. Such negative experiences significantly impact mental health and health-related quality of life (HRQoL) in PWE [5]. Religion may play a role in long-term adjustment to a disease, helping maintain self-esteem, giving emotional comfort and hope, and providing a sense of meaning and purpose. Therefore, religion could be a form of coping that helps PWE to deal with a wide variety of difficult life situations caused by recurrent seizures, their treatment, and disease-related social stigma [6].

Evidence relating religiosity and/or spirituality to clinical outcomes is accumulating in the medical literature [7–10]. Most studies have found positive associations between religion and patients' health and HRQoL [7]. However, studies on individual religious coping strategies among people dealing with stressful situations have yielded mixed results [10]. There has been little research about religion in the field of epilepsy. Furthermore, most studies have focused on potential relationships between religiosity and clinical aspects of epilepsy [11–15]. By contrast, little attention has been paid to the relationship between religious coping and mood and HRQoL in PWE [16].

A recent study in PWE found that patients with low religiosity were more anxious and depressed than those with high religiosity [17]. These findings were similar to those reported in other medical fields [7–9]. It is possible that these findings result from differences in religious coping strategies according to an individual's level of religiosity. Positive religious coping is characterized by a constructive reliance on faith to promote healthy adaptation (such as "solve one's problems in collaboration

Abbreviations: PWE, persons with epilepsy; B-RCOPE, Brief Religious Coping Scale; DUREL, Duke University Religion Index; HADS, Hospital Anxiety Depression Scale; HRQoL, health-related quality of life; QOLIE-31, Quality of Life in Epilepsy-31.

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with God") and may provide beneficial health effects. In contrast, negative religious coping is characterized by periods of existential turmoil and religious struggles. Thus, negative religious coping might incite consequences that prejudice individuals, such as "the belief in a punitive God" [6].

We sought to determine the relationship (if any) between religious coping and anxiety and depressive symptoms in Korean adults with epilepsy, who were also affiliated with a religious organization. Our hypotheses were that positive religious coping is associated with lower levels of psychological distress, and negative religious coping is associated with higher levels of psychological distress in PWE. In a meta-analysis of 49 relevant studies that quantitatively examined the relationship between religious coping and psychological adjustment to stress [10], it was revealed that positive and negative forms of religious coping are related to positive and negative psychological adjustments to stress, respectively.

2. Material and methods

2.1. Subjects

This cross-sectional study was conducted on Korean adults living with epilepsy who attended the outpatient clinics of two university hospitals in Korea. Individuals >18 years of age, who had a religious affiliation, had been diagnosed with epilepsy and had been treated for >1 year at the time of recruitment were eligible to participate. Exclusion criteria were seizure activity within the 48 h prior to a visit, a neurologic deficit that affected daily activities, failure to answer all questions on the study questionnaires, or inability to read or understand the questionnaires. Participants who fulfilled the inclusion criteria and agreed to join the study were asked to fill out questionnaires on the day they visited the outpatient clinic. Demographic and clinical data were collected by interview and from information in patients' medical files. Written informed consent was obtained from all study participants. The study was reviewed and approved by the Institutional Review Board of the Asan Medical Center.

2.2. Assessment tools

Religious coping strategies were assessed using the Brief Religious Coping Scale (B-RCOPE) [18], which is a 14-item measure of religious coping in response to major life stressors. Positive religious coping is considered to be more spiritually-based and an expression of a secure relationship with a supportive God. Negative religious coping is believed to reflect a less-secure relationship with a God who is distant and punishing, or as a religious struggle in the search for significance. The extent to which patients engage in the seven types of positive religious coping and seven types of negative religious coping was rated on a 4-point Likert scale from 1 (never) to 4 (very often). Responses were summed to create two subscale scores with higher scores indicating a more frequent use of the coping strategy. Internal consistency was adequate for both positive (Cronbach's $\alpha = 0.833$) and negative coping (Cronbach's $\alpha = 0.757$).

Religiosity was assessed using the Korean version of the 5-item Duke University Religion Index (DUREL) [19,20], which assesses the three major dimensions of religiosity including organizational religious activity, nonorganizational religious activity, and intrinsic religiosity (or subjective religiosity). The organizational item determined the frequency of attendance at religious services. The nonorganizational item determined the frequency of private religious activities such as prayer, meditation, or Bible study. The organizational and nonorganizational items were rated on a 6-point Likert scale. The three intrinsic religiosity items determined whether the subject experienced the presence of the divine, allowed religious beliefs to guide his or her approach to life, and transported religion into other areas of life. The three intrinsic religiosity items were rated on a 5-point Likert scale. The overall DUREL score ranges from 5 to 27, with higher scores indicating greater religiosity.

Symptoms of anxiety and depression were measured using the Korean version of the Hospital Anxiety Depression Scale (HADS) [21]. The HADS consists of 14 items: 7 related to anxiety (HADS-A subscale) and seven related to depression (HADS-D subscale). Items are scored on a scale of 0 (no distress) to 3 (significant distress), generating a maximum score of 21 for each subscale. Higher scores indicate higher levels of depression or anxiety.

2.3. Measuring severity of epilepsy

As in Austin et al. [22], a composite epilepsy severity score was determined based on seizure type, seizure frequency, and number of antiepileptic drugs. Seizure type was scored 3 for generalized tonic–clonic seizures, 2 for complex partial seizures, 1 for simple partial seizures, and 0 for absence of seizures for at least 1 year. When patients had more than 1 type of seizure, the most severe seizure type was used. Seizure frequency was scored 3 for weekly or daily seizures, 2 for monthly seizures, 1 for 1–11 seizures a year, and 0 for absence of seizures for at least 1 year. The type of medication regimen was scored 3 for a regimen with 3 or more antiepileptic drugs, 2 for duotherapy, 1 for monotherapy, and 0 for no medication. The composite epilepsy severity score ranges from 0 to 9, with higher scores reflecting higher epilepsy severity.

2.4. Statistical analysis

Data are presented as means and standard deviations (SD) for numeric variables and numbers and percentages for nominal variables. All statistical tests were two-tailed, and $p < 0.05$ was considered significant. Positive and negative religious coping were compared using paired sample *t* test. Pearson's correlation test was used for associations among religiosity, religious coping, and psychological distress.

We determined whether there were associations of religiosity and religious coping strategies with psychological distress, including anxiety and depressive symptoms. Univariate and then multiple linear regression analyses were performed. The dependent variables were the HADS-A and HADS-D scores. The independent variables were religiosity and religious coping strategies measured by the DUREL and B-RCOPE, respectively, having significant associations ($p < 0.05$) with the HADS-A and HADS-D scores in the univariate analysis. The confounding variables were age, sex, age at seizure onset, types of antiepileptic treatment (polytherapy vs. monotherapy), and epilepsy severity composite scores. All statistical analyses were performed using the IBM SPSS Statistics, version 21.0 (IBM Corporation, Armonk, NY, USA).

3. Results

3.1. Subjects

A total of 88 participants were included in this study (Table 1), of whom 61 (69.3%) were females. The mean age was 43.0 years old (SD: 13.1), and the mean age at seizure onset was 22.8 years old (SD: 14.9). The mean DUREL score was 17.6 (SD: 6.1) (Table 2). The positive religious coping of B-RCOPE (mean: 16.0, SD: 4.7) was more likely utilized than negative religious coping (mean: 11.6, SD: 3.9) (the mean and SD of the differences 4.4 ± 5.1, $p < 0.001$). The religiosity and religious coping strategies were not related to age, gender, education, age at seizure onset, epilepsy duration, types of epilepsy and seizure, seizure frequency, types of antiepileptic treatment, and composite score of epilepsy severity (Table 3).

3.2. Correlations among religiosity, religious coping strategies, and psychological distress

Higher religiosity, measured by the DUREL, was significantly related to more positive religious coping ($r = 0.439$, $p < 0.001$) and less psychological distress, as measured by the HADS-A ($r = -0.263$, $p < 0.05$) and

Table 1
Patient characteristics (n = 88).

Female, n (%)	61 (69.3)
Age, years, mean (SD)	43.0 (13.1)
Education level, n (%)	
Middle school or below	30 (34.1)
High school	27 (30.7)
University or above	31 (35.2)
Unemployed, n (%)	22 (25.0)
Religion, n (%)	138 (61.1)
Evangelical	57 (64.8)
Catholics	15 (17.0)
Buddhist	16 (18.2)
Psychiatric comorbidities, n (%)	7 (8.0)
Age at onset, years, mean (SD)	22.8 (14.9)
Duration, years, mean (SD)	20.2 (13.6)
Epilepsy type, n (%)	
Idiopathic generalized	21 (23.9)
Symptomatic or cryptogenic partial	65 (73.9)
Undetermined	2 (2.2)
Seizure type, n (%)	
Generalized tonic–clonic	34 (38.6)
Complex partial	46 (52.3)
Simple partial	8 (9.1)
Seizure frequency, n (%)	
Seizure freedom in the last year	9 (10.2)
1–11 per year	45 (51.1)
Monthly	25 (28.4)
Weekly	9 (10.2)
Polytherapy, n (%)	62 (70.5)
Composite scores of epilepsy severity, mean (SD)	5.7 (1.7)

HADS-D ($r = -0.339$, $p < 0.01$) (Table 3). However, the level of religiosity was not associated with negative religious coping. The negative religious coping, as indicated by the B-RCOPE, was significantly related to higher HADS-A ($r = 0.275$, $p < 0.01$) and HADS-D ($r = 0.300$, $p < 0.01$) scores. In contrast, the positive religious coping was not related to the HADS-A and HADS-D scores. The two types of coping strategies were positively related to each other ($r = 0.304$, $p < 0.01$) (Table 3).

3.3. Associations of religiosity and negative religious coping with psychological distress

Univariate linear regression analyses showed that HADS-A and HADS-D scores were negatively related to the DUREL whereas they were positively related to the B-RCOPE negative coping scores (Table 4). On the multiple linear regression with controlling for confounding variables, both the DUREL and the B-RCOPE negative coping scores remained significant as independent factors associated with HADS-D (Table 4). This model explained 28.6% of the variance in the HADS-D. In contrast, associations of HADS-A with the B-RCOPE negative coping scores, but not with the DUREL scores, remained significant after controlling for confounding variables. This model explained 20.1% of the variance in the HADS-A.

Table 2
Religiosity, religious coping, and health outcomes in patients with epilepsy (n = 88).

DUREL, total scores, mean (SD)	17.6 (6.1)
Organizational	4.1 (1.8)
Nonorganizational	3.0 (1.8)
Intrinsic	10.6 (3.5)
B-RCOPE, positive coping, mean (SD)	16.0 (4.7)
B-RCOPE, negative coping, mean (SD)	11.6 (3.9)
HADS-A subscale, mean (SD)	6.8 (3.9)
HADS-A scores ≥8, n (%)	36 (40.9)
HADS-D subscale, mean (SD)	7.2 (3.7)
HADS-D scores ≥8, n (%)	40 (45.5)

B-RCOPE, Brief Religious Coping Scale; DUREL, Duke University Religion Index; HADS-A, Hospital Anxiety Depression Scale-Anxiety subscale; HADS-D, Hospital Anxiety Depression Scale-Depression subscale; SD, standard deviation.
The range of possible scores of the measures: the DUREL total scores: 5–27, Organizational and Nonorganizational subscales of the DUREL: 1–6, Intrinsic subscale of the DUREL: 3–15, positive and negative B-RCOPE: 7–28, and the HADS-A and HADS-D: 0–21.

Table 3
Correlations with religiosity, religious coping, and health outcomes in patients with epilepsy (n = 88).

	DUREL	Positive B-RCOPE	Negative B-RCOPE	HADS-A	HADS-D
DUREL	–	0.439***	−0.106	−0.263*	−0.339**
Positive B-RCOPE	0.439***	–	0.304**	0.055	0.004
Negative B-RCOPE	−0.106	0.304**	–	0.275**	0.300**
Age, years	0.186	0.038	−0.032	−0.259*	−0.138
Age at seizure onset, years	0.155	0.123	−0.014	−0.284**	−0.311**
Epilepsy duration, years	−0.010	−0.198	−0.082	0.015	0.221
Composite score of epilepsy severity	−0.027	−0.095	0.030	0.017	0.210*

B-RCOPE, Brief Religious Coping Scale; DUREL, Duke University Religion Index; HADS-A, Hospital Anxiety Depression Scale-Anxiety subscale; HADS-D, Hospital Anxiety Depression Scale-Depression subscale.
* p value <0.05.
** p value <0.01.
*** p value <0.001.

4. Discussion

In the present study, negative religious coping was positively correlated with both depressive and anxiety symptoms in PWE. Such associations remained significant after controlling for confounding variables. Our study failed to demonstrate a relationship between positive religious coping and psychological distress levels. Our findings agreed with previous studies, indicating the significant association between negative religious coping and psychological distress on a wide range of medical conditions [23–26]. In a study of 170 patients with end-stage renal disease, for example, negative religious coping measured by the B-RCOPE was correlated with symptoms of depression and anxiety [23]. These associations remained significant following multivariate adjustment for clinical and sociodemographic data. A recent Brazilian study on family caregivers of pediatric patients with cancer also showed that depressive symptoms were positively associated with negative religious coping, but not with positive coping [25]. Furthermore, a longitudinal study identified negative religious coping strategies as a predictor of mortality among medically ill elderly patients [27].

Although positive religious coping was not found to be associated with psychological distress, it is possible that positive coping is an independent correlate of aspects of HRQoL. Ramirez et al. [23] found that, in patients receiving hemodialysis, positive religious coping was associated with better overall HRQoL, even though it was not associated with psychological distress. On the contrary, negative religious coping was associated with worse overall HRQoL. Recently, Lin et al. [28] investigated the relationships between religiosity, religious coping, medication adherence, and HRQoL in Iranian patients with epilepsy, using the DUREL, the B-RCOPE, and the Quality of Life in Epilepsy-31 (QOLIE-31). Similar to Ramirez et al. [23], they found that both positive and negative religious coping directly correlated with medication adherence and HRQoL, indicating that religious coping may be determinants of medication adherence and HRQoL in PWE [28]. Tedrus et al. [16] also investigated a relationship between religious coping and HRQoL in 110 Brazilian PWE, using the 87-item Spiritual/Religious Coping Scale and the QOLIE-31 [16]. They found a negative correlation between the negative/positive religious coping ratio and the overall QOLIE-31 score, although individual negative or positive religious coping was not related to HRQoL.

In the present study, religiosity was positively related to positive religious coping, as expected; but, it was not related to the degree of negative religious coping in PWE. This finding was contrary to the

Table 4
Linear regression analyses showing associations of religiosity and negative religious coping with anxiety, depressive symptoms, and well-being sense in patients with epilepsy (n = 88).

	HADS-A				HADS-D			
	Univariate		Multiple[a]		Univariate		Multiple[a]	
	β	SE	β	SE	β	SE	β	SE
DUREL, total scores	−0.171*	0.067	−0.129	0.069	−0.207**	0.062	−0.149*	0.061
Negative B-RCOPE	0.270*	0.106	0.237*	0.107	0.255*	0.100	0.260**	0.095

B-RCOPE, Brief Religious Coping Scale; DUREL, Duke University Religion Index; HADS-A, Hospital Anxiety Depression Scale-Anxiety subscale; HADS-D, Hospital Anxiety Depression Scale-Depression subscale; SE, standard error.
[a] Adjusted by age, sex, age at seizure onset, polytherapy, and composite scores of epilepsy severity.
* p value <0.05.
** p value <0.01.

results of Lin et al. [28], showing that religiosity was inversely correlated with negative religious coping but not with positive religious coping in PWE. The reasons for this discrepancy are unclear. However, the conflicting results may be attributable to study sample characteristics. For example, epilepsy duration was much longer in our study sample (mean: 20.2 years) compared with Lin et al.'s (mean: 6.7 years) [28]. The level of education was also different. Lin et al.'s participants had an average of 8.9 years of education [28] whereas about two-thirds of our participants had 12 years or more of education.

Certain limitations should be noted when interpreting the results of our present study. First, our analyses reflect relationships at a single time point, and therefore, they do not provide evidence for causal or temporal relationships. Second, over 80% of our participants had Christian, largely evangelical, religious affiliations. Therefore, these results could not be generalized to individuals of other religious denominations. It is unclear whether the effects of religious beliefs of Christians are similar to those of believers in other religions (e.g., Buddhists and Muslim). Third, there was no information about the treatment of antiepileptic drugs that could have significant influence on patient depression secondary to side effects. In addition, brain lesions, lesion location, and laterality may affect cognition and coping behaviors, particularly if the lesion involves the frontal or mesial temporal lobes, or other limbic structures. Such information was not provided in this study.

5. Conclusions

Our study found significant positive associations between negative religious coping and anxiety and depressive symptoms, independent of the levels of religiosity, in PWE. Positive religious coping was not related to anxiety and depressive symptoms. A randomized controlled interventional study is needed for determining the effects of religious coping on mental health.

Declaration of interest

None.

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