The Relationship between Religion, Spirituality and Mental Health in Rwandan Refugees: A Cross-Sectional Study

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Abstract

Studies on coping efforts among traumatised and distressed refugees prioritise other coping mechanisms, whereas religion and spirituality are not considered. However, studies have indicated that religiosity and spiritual coping have been linked with adaptive psychological results. Recently, the relationship between religion/spirituality and mental health has been the topic of growing interest in refugee studies. A cross-sectional quantitative research study was conducted to examine the relationship between religion/spirituality and mental health. The results suggest that there is a positive correlation between religion/ spirituality and mental health. The General Health Questionnaire- 28 (GHQ-28) and Spiritual Experience Index- Revised were used to assess the relationship. The participants included older Rwandan refugees living in Lusaka, Zambia (N=267). Religion and spirituality are essential elements that should be considered in refugees' studies to enhance a comprehensive understanding of an individual, considering their needs. Mental health specialists should consider moulding coping frameworks that include religion and spirituality to improve well-being in refugees.

Introduction and Background

Religion and spirituality are components that are understudied but central dimensions of coping with adverse situations among refugees. Rwandan refugees living in Lusaka, Zambia, face several challenges that need adjustment and resilience for them to cope typically (Mwanamwambwa & Pillay, 2020). The experience of adverse challenges such as armed conflicts, migrating to new places of refuge, resettlement, and economic difficulties create psychological distress within the refugee populations (James et al., 2019; Wu et al., 2021).

Recent research has brought an increasing appreciation of the importance of religion and spirituality among refugees (Ennis, 2011; Pandya, 2018). Findings from selected studies indicate that religious and spiritual beliefs and practices have sustained many refugees in their premigration (Ennis, 2011; Khawaja et al., 2008), migration (Mwanamwambwa & Pillay, 2020) and post-migration experiences (Hassan et al., 2018). Religiosity and spirituality are a source of emotional, social and cognitive support for many refugees (Seybold & Hill, 2001). Further, spirituality and religion affect aspects of individuals' lives. Therefore, religious and spiritual engagement has been connected with improved mood and greater well-being among traumatised refugees. To some extent, spiritual belief structures affect how people view problems, causes and solutions and make meaning of distress and suffering (Pargament, 2007). Refugees, including those from Rwanda amidst challenges, seek transcendent values and practices for greater coherence in their lives.

From a holistic perspective, people's psychological well-being is inextricably intertwined with their spiritual well-being (Pargament, 1997). Thus, spirituality and religion cannot be separated from the rest of life. The aspect of meaning-making in traumatised refugees opens opportunities for refugees to excel in their physical, emotional and psychological domains. Spirituality and religion address refugees' concerns about meaning, purpose, lifestyle, and coping with upsetting life events such as loss and disappointments in life (Pargament, 2011).

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The definition of religion and spirituality

Pargament (2007) states that religion and spirituality are defined as different distinctive constructs, and there is no consensus as to which definition is correct or agreed upon. However, it is essential to point out that religiosity and spirituality have common terms that they share, such as experiences, beliefs and values (Dilmaghani, 2018; Halkitis et al., 2009). Individuals use beliefs and values to connect with the sacred (Pargamant, 1997) either within or outside an institutional context (Krumrei-Mancuso, 2018).

According to Koenig (2009), religion is defined as an organised system of beliefs, practices and rituals of a given society formed to enhance a sense of transcendence to the sacred. Pargament (1997) defines religion as a process that individuals within an established community engage in searching for ways connected to the sacred. The term 'sacred' refers to people's conceptions of God, a higher power or an absolute truth (Hogde, 2015). For Pargament (1997), there is a difference that emerges between spiritual transcendence and religiousness. Spiritual transcendence emphasises an individual search for a relationship with a greater sacredness, while religiousness gives a more social significance to experiencing the divine (Piedmont, 1999).

Many scholars have defined spirituality as a way of expression (Newman, 2004) in which an individual seeks a meaningful relationship with the self, society and the divine (Puchalski et al., 2014). Waaijman (2007) defines spirituality as a "relational process which human beings relate to God" (p.14). Here, Waaijman conceptualises spirituality in relational terms. The term relational points to an individual's relational process with anything that is considered sacred. In addition, Pargament (2013) defines spirituality as a search for the sacred. Within Pargament's definition, the word "sacred" is contextualised to include not only the notion of God but anything in the life of an individual that generates meaning. The search describes how an individual is constantly looking for meaning and purpose within their life.

Religiosity and spirituality are 'somehow' linked. Since spirituality and religiosity are essential aspects of human life that define human experiences and values to cultivate meaning and purpose within an individual, there is a thin line between them. The only difference lies in the fact that religion alludes to beliefs and traditions that are socially constructed (Beyers, 2017). Within this understanding, religion cannot be defined away from society. It is within the community that the concept of religion finds meaning. In other words, religion is socially determined and expressed in rituals and ceremonies.

On the other hand, spirituality alludes to a personal sense of connection (Counted, 2019; Dein et al., 2010; Hawkes et al., 2020; Vieten & Lukoff, 2022). This sense of connection is expressed through beliefs and symbolism. Here, spirituality brings within an individual a sense of meaning and purpose in life.

The link between religion/spirituality and mental health

Several studies have investigated the connection between religion/spirituality and mental health, especially among people who have encountered stressful life events. Notable among them is Dein et al. (2010), who found that religious convictions influence how individuals cope with stressful life events and obtain meaning and purpose in life. Individuals who engage in religious beliefs for coping tend to manage their stress more appropriately than those who do not (Paloutzian & Park, 2014). Spirituality helps influence the mental health of distressed individuals by altering their attributions (Hechanova & Waelde, 2017). The authors, Hechanova and Waelde (2017), further state that religious beliefs form attributions about adversity and illness in different ways, and one is that spirituality shapes how people cope.

A study by Molsa et al. (2017) among older Somali refugees living in Finland found that high religiousness affects an individual's coping with trauma. Thus, indicating that religion has a buffering role. Here, an increased engagement in religious activity is associated with improved mental health. A qualitative study by

Hasan et al. (2018) among recently resettled Syrian refugees in America revealed that religion helped individuals hope for the future and created a certain level of resilience within them. Here, resilience points to the positive transformation that takes place within an individual in times of adversity. Acquaye et al. (2018) posit that resilience can be conceptualised as a coping process that individuals use to overcome adversity.

A review of different studies conducted by Koenig et al. (2001) reported a positive correlation between religiosity and some level of well-being, such as fulfilment and happiness. Individuals who had high religiosity exhibited a sense of satisfaction and happiness, thus improving their well-being. Further, in another study, Koenig (2009) posited that religion acts as a psychological and social mechanism for coping with adversity and stress and brings an individual a sense of comfort, hope and meaning. Posselt et al. (2019) highlighted that engagement in religious activities provided traumatised individuals with a sense of belonging, normality, and identity, thus creating a sense of well-being.

This paper has been conceptualised within Bronfenbrenner's (1977) ecological systems theory that stipulates that an individual's development is influenced by multiple nested layers (individual, family, community and society). Drawing from the ecological systems theory, this paper stipulates that religiosity and spirituality are coping mechanisms within the spectrum of mental health emanating from experiences encountered within their social ecology. Therefore, this study aimed to investigate the relationship between religion/spirituality and mental health in Rwandan refugees. The study hypothesised that religion and spirituality would be associated with low psychological distress.

Methods

Ethics

The Human Social Sciences Research Ethics committee at the University of KwaZulu Natal, Durban, South Africa provided ethical clearance for this study (HSS/0119/018D)

Participants

A sample of 267 Rwandan refugees living in the townships of Lusaka participated in a cross-sectional study of religion, spirituality and mental health. Participants were between the ages of 18 and 65 years (M=33.99, SD = 13.61). Female participants were (52.1%), and males were (47.9%). Religious preferences were Christian (89.9%), Muslim (8.6%), Buddhist (0.4%), and only a few individuals indicated not having any religious affiliation (0.7%). About half of the participants were single (49.8%), while 40.8% were married. Six percent were widowed, while 3% were separated or divorced. Over 69% reported that they had no financial support, and 51.7% were unemployed. Around 51.7% of the participants had children and had some formal education.

Procedure

Two-week long training sessions for research assistants fluent in English, French, Kinyarwanda and Nyanja were held. The training was conducted to familiarise the research team with research procedures, administer the questionnaire battery, and conduct interviews. To allow ethical protocols, participation in the study was voluntary. Only refugees from Rwanda or their families, aged 18-65 and living in the townships of Lusaka, were invited to participate in the study. Further, participants were allowed to participate after completing the consent forms.

Instruments

A questionnaire consisting of a demographic section, the Spiritual Experience Index- Revised (SEI-R) and the General Health Questionnaire-28 (GHQ-28) was administered to each study participant. The response rate stood at 98.9% and took an average of 45-60 minutes to complete.

SEI-R

The SEI-R was used to measure religiosity and spirituality among participants. Genia (1997) designed the SEI-R as a 23-item scale to assess overall responses to spiritual experience. The scale yields two subscales, spiritual support and spiritual openness. The SEI-R scale groups items into two subscales: Spiritual Support (SS) and Spiritual Openness (SO). The Spiritual Support (SS) has 13 items that assess individuals' support from practising their faith. In addition, the SS measures issues related to consciousness of God, faith, worship and spiritual wellness and the Spiritual Openness (SO) has ten items. Items 1,3,7, and 10 on the SO are reverse scored. The SO articulates matters about an element of openness and receptivity that an individual exhibits to other spiritual and religious dimensions (Genia, 1997). The items are rated on a Likert scale ranging from 1 (strongly disagree) to 6 (strongly agree). According to Eyer et al. (2017), the SEI-R scale reported good construct validity and internal consistency (Spiritual Support $\alpha = .95$, Spiritual Openness $\alpha = .79$, and the overall SEI-R had $\alpha = .89$).

GHQ-28

The GHQ-28 is a self-administered scale designed to detect recent psychological disorders (Goldberg & Hillier, 1979). The GHQ-28 classifies psychological symptoms into four parts: somatisation; anxiety and insomnia; social dysfunction; and severe depression. The four domains consist of seven items. The items are scored based on a 4-point Likert scale. Scholars have reported different scoring methods for the GHQ-28. A binary score method of assigning 0 to the first and second response choices and a score of 1 to the third and fourth response choices. A score of ≥ 5 indicates the probable case of psychological distress, whereby higher scores on the GHQ-28 subscales indicate poorer functioning (Goldberg & Williams, 1988). The internal consistency for the whole scale in this study was $\alpha = .95$. The Cronbach's alpha for the GHQ-28 subscales were: somatic (.87), anxiety and insomnia (.89), social dysfunction (.88), and severe depression (.89). These values surpass the usual cut-off of .70 by Fornell Lacker (Al Mansoori et al., 2020). These are signs of measurement scale appropriateness.

Analysis and Results

The study data was collected and captured using the Statistical Package for Social Sciences, version 25 (IBM SPSS 25).

We conducted bivariate analyses to access associations between the demographic variables and spirituality scores and the GHQ-28 scores using independent samples t-tests, one-way ANOVAs, and Pearson's correlations where appropriate. Results are shown in Table 1. Descriptive statistics and correlation statistics between the GHQ (total score and subscale scores) and the two spiritual subscales, spiritual Support (SS) and spiritual openness (SO), are provided in Table 2, including their respective Cronbach's alpha coefficients.

We produced a two-way frequency distribution of the SS and SO items, with rated items being dichotomised as "high" and "low". Concerning spiritual openness and spiritual support of each participant, they were

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divided into four subgroups: high spiritual openness and high spiritual support (growth-oriented), high spiritual openness and low spiritual Support (spiritual seekers), low spiritual openness and high spiritual Support (dogmatic believers), low spiritual openness and low spiritual Support (spiritually underdeveloped). Results are shown in Table 3.

GHQ-28 scores were grouped into low and high symptoms. A predictive model of psychological distress (using the four GHQ-28 subscales as dependent variables) on spirituality (using the two spirituality subscales) was developed using binary logistic regression analysis. We controlled for the demographic factors, including age, number of children, marital status, education, gender, employment status, and whether or not the respondent received financial support. Results are shown in Table 4.

Table 1: Descriptive statistics of demographics and spirituality scales and their relationship with psychological distress

Psychological distress (GHQ-28)					
Variables	n (%)	M	SD	Statistic (r,t or F)	P-value
Age (18-65); M = 33.99; SD = 13.61	–	–	–	r = .491	<.001
Number of children (0-11); M=1.84; SD = 2.24	–	–	–	r = .408	<.001
Gender				t = .189	.851
Male	128 (47.9)	62.91	17.79		
Female	139 (52.1)	62.47	20.02		
Employment status				t = 5.058	<.001
working	129 (48.3)	68.50	19.21		
Not working	138 (51.7)	57.23	17.05		
Financial Support				t = -1.927	.055
Yes	81 (30.3)	59.31	19.51		
No	186 (69.7)	64.15	18.56		
Marital status				F = 22.144	<.001
Married/living together	110 (41.2)	69.03	20.19		
Separated/Widowed	24 (9.0)	73.00	20.71		
Single	133 (49.8)	55.56	14.43		
Education				F = 4.803	.003
Primary	58 (21.7)	69.38	18.71		
Secondary	107 (40.1)	62.37	18.56		
College	50 (18.7)	62.54	20.60		
University	52 (19.5)	55.96	16.14		
Spiritual Support				t = 1.888	.060
High	141 (52.8)	64.7	19.9		
Low	126 (47.2)	60.4	17.6		
Spiritual openness				t = -0.219	.827
High	143 (53.6)	62.4	19.8		
Low	124 (46.4)	62.9	17.9		

M denotes the mean.

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Most of the participants were female (52.3%), not employed (51.7%), had no financial support (69.7%), single (49.8%), and had only a secondary school education (40.1%); age ranged from 18 to 65 years with mean 33.99 (SD= 13.61).

Table 2: Frequency distribution of the Spirituality scores and its subdomains

Component	n (%)
Growth Oriented	75 (28.1)
Spiritual Seekers	68 (25.5)
Dogmatic Believers	66 (24.7)
Spiritually Underdeveloped	58 (21.7)

As shown in Table 2, the majority of the participants were growth-oriented (28.1%), followed by spiritual seekers (25.5%), dogmatic believers (24.7%), and spiritually underdeveloped (21.7%).

Results indicated that spiritual support (t = 1.888, P = .060), employment (t = 5.058, P = <.001), having financial support (t = -1.927, P = .055), marital status (F = 22.144, P = <.001), and education (F = 4.803, P = .003) significantly have an effect on psychological distress symptoms of the GHQ-28. Higher ages (r = .491, P = < .001), higher number of children (r = .408, P = < .001), were significantly associated with higher psychological distress symptoms.

Using Cronbach's alpha, reliability coefficients for the SO and SS subscales were .719 and .614, respectively. For the mental health indicator, the GHQ scale had a Cronbach's alpha coefficient of 0.957, respectively, with coefficients of subscales ranging from 0.879 – 0.898.

Table 3: Mental health scores and their sub-domains and their relationship with the spirituality scores

	GHQ-Somatic	GHQ-Anxiety	GHQ- Social dysfunction	GHQ- Severe depression	GHQ	SO	SS
GHQ_Somatic	1	.797**	.715**	.617**	.892**	-0.01	.201**
GHQ_Anxiety		1	.717**	.629**	.902**	-0.112	0.102
GHQ_Social dysfunction			1	.657**	.875**	-0.034	0.048
GHQ_Severe depression				1	.833**	0.025	.148*
GHQ					1	-0.039	.144*
SO						1	.150*
SS							1
Mean	16.1	16.61	15.9	14.07	62.68	38.42	71.91
stdev	5.29	5.78	4.97	5.61	18.95	5.39	6.77
Alpha	0.879	0.897	0.888	0.898	0.957	0.719	0.614

*p <.01. ** p <.001

Table 4: Demographics – Adjusted association of mental health and spirituality

				95% C.I. for Odds Ratio		
		Odds Ratio	P-value	Lower	Upper	R^2
Somatic	SS	0.614	.121	0.331	1.137	0.310
	SO	0.74	.356	0.39	1.403	
Anxiety	SS	0.955	.878	0.534	1.71	0.205
	SO	0.805	.451	0.458	1.415	
Social dysfunction	SS	0.837	.611	0.422	1.66	0.346
	SO	0.732	.353	0.378	1.415	
Severe depression	SS	0.912	.792	0.459	1.813	0.314
	SO	1.097	.797	0.54	2.228	

GHQ total scores ranged from (M = 62.68, SD = 18.95, 30–101). Among the GHQ subscales, the highest mean scores were observed for anxiety (M = 16.61, SD = 5.78, 7–28), followed by somatic symptoms (M = 16.10, SD = 5.29, 7–27), social dysfunction (M = 15.90, SD = 4.97, 7–28), and severe depression (M = 14.07, SD = 5.61, 7–27). Among the spirituality dimensions, the mean spiritual openness score was lower (M = 38.42, SD = 5.39, 24–51) than the spiritual support mean score (M = 71.91, SD = 6.77, 23–78).

Pearson's correlation coefficient showed a significant positive relationship between the total score of mental health and spiritual support ($r = .144$; $p < 0.05$). Moreover, there were significant positive correlations between spiritual support and the following mental health subdomains: Somatic symptoms ($r = .201$; $p < 0.01$) and severe depression ($r = .148$; $p < 0.05$). There were no significant correlations between spiritual openness and mental health indicators (Table 3).

The binary logistic regression analysis predicting each of the four domains of psychological distress, controlling for demographic variables of age, the number of children, employment status, financial support, marital status, and education, showed no significant association for any spiritualty subscales. The models explained 31%, 20.5%, 34.6%, and 31.4% of the variation in somatic symptoms, anxiety, social dysfunction and severe depression, respectively.

Discussion

This study investigated whether religiosity and spirituality measured as spiritual support and spiritual openness, respectively, are associated with mental health outcomes. We found a significant, positive correlation between spiritual support and the overall score of psychological distress, as well as two of its dimensions, including somatic symptoms and severe depression. Our results imply that higher levels of spiritual support were associated with worse mental health outcomes on somatic symptoms and severe depression and the total score of psychological distress. However, there is a lack of significant association between psychological distress and the dimensions of spirituality (SS and SO) when adjusting for socio-demographic variables. This result may be due to the limited sample size. These results, which will be explored, further advance our understanding of how spirituality and religiousness affect mental health.

This study is the first cross-sectional design that examined the associations between religiosity/spirituality and mental health outcomes within the Rwandan refugees in Zambia. Religious freedom has made many scholars embark on studies of the relationship between Religiosity/spirituality and mental health (Peres etal., 2017; Goncalves, 2017; Panzini et al., 2017; Anderson & Nunnelley, 2016; McFarland, 2009; Hodapp & Zwingmann, 2019), and this study is no exception. The major limitation of this study is the utilisation of a cross-sectional design, in which the causality cannot be explored. In other words, the association between mental health and spirituality does not necessarily indicate a causal relation.

Individuals who have spiritual experiences and religious beliefs can cope with stress and psychological problems, and resilience is much stronger (Jafari et al., 2010; Vitorino et al., 2018). Spiritual well-being has a protective effect and acts against psychological distress, and causes gains in healthy psychological life and supportive behaviours (Garssen et al., 2021; Pillay et al., 2016; Milner et al., 2020). Our results, which suggest that higher levels of spiritual support were associated with worse mental health outcomes, is different from the popular opinion and previous findings. As evidenced by earlier studies (Exline et al., 2014; Vitorino et al., 2018), the most probable reason is that both spirituality and religiosity, not only either of them, are related to better mental health outcomes. Individuals with a higher prevalence of spiritual experiences but who do not profess an organised religion may have a certain predisposition to mental disorders (Exline et al., 2014).

There are many contrasting findings on this topic from previous studies. King et al. (2013) investigated the association between religiosity/spirituality and psychiatric symptoms among 7,403 individuals. They found that individuals with higher spirituality and lower religiosity were likely to suffer from mental disorders, such as anxiety disorder, phobia and neurotic disorders. Likewise, a study by Leurent et al. (2013) evaluated 8,318 people from seven countries and found that individuals who were spiritual but not religious were more likely to develop depression. However, some studies have found the opposite. Hechanova & Waelde (2017) found that participants who had higher levels of spirituality did not significantly present depressive symptoms and anxiety when compared with religious persons; this is because spirituality alters the attributions of distressed people.

Conclusion

Our study provides vital information to clinical work and humanitarian organisations that deal with refugees. Rwandese refugees and other refugees found in Sub Saharan Africa emanate from countries and backgrounds, where the notion of religiosity and spirituality are constructed into their culture. Therefore, mental health specialists and other professionals should consider addressing religious and spiritual beliefs when working with refugees. Religiosity and spirituality are concepts that build a significant worldview for many refugees. Thus mental health practitioners should integrate into their clinical setups assessments that are inclusive of the refugees' faith and religious beliefs. Clinical work that considers the refugees' religious beliefs and spirituality enhance wellness, thus adhering to ethical issues and rights needed by marginalised and traumatised populations.

The role of religion and spirituality in enhancing resilience in refugees cannot be overemphasised. Future scholarly work on refugees and mental health should provide research that informs policy that will ensure and promote refugee integration into society. Considering religion and spirituality as a source for resilience and coping among refugees' research will only enhance their sense of well-being and safety.

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