



ORIGINAL RESEARCH PAPER

Psychiatry

A COMPARATIVE STUDY ASSESSING RELIGIOSITY AND PSYCHOPATHOLOGY IN NORMAL VS DEPRESSED PATIENTS

KEY WORDS: Religiosity, depression, anxiety, cases, control.

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ABSTRACT

Background: India, a country deeply rooted in religious and spiritual traditions, witness religion playing a central role in shaping individual beliefs and social behaviour. Religiosity has been shown to have both positive and negative effects on a person's mental health. Studies have shown that excess religiosity can have a negative impact and cause a lot of emotional turmoil and psychological ill effects on an individual's mind. Despite the cultural significance of religion in India, there is limited research exploring its nuanced relationship with mental health, particularly in the context of depression and anxiety. **Aims:** This study aimed to assess (a) The extent of religiosity in normal versus depressed individuals, (b) To determine the correlation between religiosity and severity of depression and (c) To evaluate the impact of demographic variables on religiosity and psychopathology. **Methodology:** A cross-sectional observational study was conducted on 1,000 individuals (500 patients diagnosed with major depressive disorder and 500 controls). Participants were assessed using the Centrality of Religiosity Scale (CRS), Hamilton Depression Rating Scale (HAM-D), and Hamilton Anxiety Rating Scale (HAM-A). Chi square test and Pearson's correlation was used for statistical analysis. **Results:** In the study, in the control group, out of 500 normal individuals, we noted that a total of 35.5% were having psychopathology out of which 22.2% of the individuals had symptoms of both depression and anxiety and 13.2% had only depressive symptoms. In the depressed group, 43% of the cases were found to be very religious (abnormal), compared to 27% in the control group which was statistically significant ($p < 0.01$). A significant association was observed between high religiosity and increased severity of both depression and anxiety ($p < 0.001$) in both the groups. Among patients with severe depression, 73.9% were very religious, while 77.2% of severely depressed controls were also very religious. Similarly, individuals with severe anxiety had higher religiosity scores, with 70.2% (cases) and 97.7% (controls) being very religious. Religiosity positively correlated with duration of illness and increasing age ($p < 0.05$). The Pearson's correlation of religiosity with age, duration of symptoms, HAM D and HAM A scores indicated a highly statistically significant relationship ($p < 0.000$). **Conclusion:** This finding concludes that, an increase in religiosity is seen with an increase in age, longer duration of symptoms, and with severe depression and anxiety symptoms. Sensitisation and awareness of our fellow psychiatrists to utilise religiosity as a simple and easy screening question to further probe for depression and anxiety in the very religious individuals.

INTRODUCTION

India is a country deeply rooted in religious traditions, with spiritual beliefs shaping societal and personal values. Religion, while often offering solace, guidance, and community, can also potentially contribute to psychological distress when it manifests in extreme or rigid forms.^[1,2,3] Oxford Dictionary defines religion as 'the belief in and worship of a superhuman controlling power, especially a personal God or gods'.^[4] Koenig H et al., in his 'Handbook on Religion' defines religion as an organized system of beliefs, practices, rituals, and symbols designed to facilitate closeness to the sacred or transcendent God, higher power, or ultimate truth/reality.^[5]

Hinduism is considered to be one of the world's oldest religions. Its exact origins are still unknown, with no known single founder or records. It is an integral part of many human lives in India and is well integrated with the cultural practices of its followers. Hinduism has certain scriptures, which are the Vedas, the Upanishads, and the Bhagavad Gita. Hinduism is also referred to as the vedic religion since the vedas are the oldest scriptures. There has been a constant evolution with Hinduism due to a continuous exchange of thoughts and beliefs with the Jain, Buddhist and Sikh religions. This interaction has also resulted in progress, reforms and rituals in the Hindu religion. The Holy book, The Bhagavad Gita, which was recited by Krishna in the epic Mahabharata, has played a very important role in understanding the concept of God, reincarnation and devotion. Historically, Hinduism sees no conflict between science and religion, as seen in the doctrines of creation, evolution, and causality. The Hindu

believes in one creator and a supreme reality which is the ground of one's divinity. This divine is called by the Upanishads as self. A self which is present in everyone and this self is in all creatures and is not different from the Ultimate Reality called God. Krishna, Rama, Buddha, Vishnu, and others were seen by Hindus as divine incarnations of God.^[6]

Idol worship is very important in Hindu religion. The holy book says, once fixed on God's physical image with faith, the mind slowly turns towards God's nonphysical qualities which manifests in the worshippers' life. Gita says that idol worship plays a very important role in making the mind sensitive, powerful, and progressive.^[7]

Ancient Indian science of life in Hinduism is called Ayurveda. The purpose of Ayurveda is to tell us how our lives can be influenced, shaped, extended, and ultimately controlled without interference from sickness or old age. Desai PN et al., in 1988 reported that the classification of mental illness conforms to various Ayurvedic categories. There is a category of diseases in ayurveda - Agantu Vyadhis (diseases caused due to external causes) which makes a mention of possession spells.^[8]

In Hinduism, healthy and unhealthy religious factors influence a patient's adaptation to life situations. Healthy spirituality involves courage, love for oneself and others, as well as knowledge and open-mindedness. On the other hand, unhealthy religiosity which involves excessive fear, selfishness, self hate, hate of others, ignorance and close-mindedness, as well as more extreme symptoms such as

delusions and hallucinations of a religious nature which leads to stunted emotional and spiritual growth.^[9]

The Quran has also dealt with some specific mental disorders and behaviours. Suicide is considered to be a grave sin and has been ordained with clear, precise, and firm directives. It states, 'Do not kill yourself for God is merciful to you'.^[10] Islamic doctrine rejected the supernatural or demonic causation of mental illness and asserted that it is the product of imbalance of hormones of the body.^[11]

Confession is a common practice that takes place in a church. It is said that a confession ends the penitent's moral isolation, reducing the effects of alienation on a shamed member of society thus having a positive influence on one's mental health. Catholic teaching includes the concept of hell and the devil as well as heaven and angels. What a person associates with these beliefs and how they see themselves in relation to them shapes their thoughts.^[12]

Neuroimaging studies have shown that meditation results in an activation of the prefrontal cortex, activation of the thalamus and the inhibitory thalamic reticular nucleus and a decreased sensory input to the parietal lobe resulting in a perceived sense of unity with the environment. The neurochemical change as a result of meditative practices involves all the major neurotransmitter systems. The neurotransmitter changes contribute to the amelioration of anxiety and depressive symptomatology and in part explain the psychotogenic property of meditation.^[13]

The findings implicate several brain regions potentially associated with religion and spirituality development and behaviour, including the medial frontal cortex, orbitofrontal cortex, posterior cingulate cortex, and caudate.^[14]

Kapogiannis et al., in 2009 conducted a study in which religious people were asked to think about different kinds of statements about God, for example how involved God is emotionally, what kind of actions God might take, or what religious doctrines mean, while their brains were being scanned (fMRI). Different types of thoughts about God activated different parts of the brain. Thinking about God's moral or emotional involvement, activated the medial prefrontal cortex, this part of the brain is used when we think about morality, empathy, and making value judgments. Thinking about God's actions or intentions (agency), activated the temporoparietal junction, this region helps us understand other people's thoughts and feelings. Thinking about religious knowledge or doctrine, activated the lateral frontal lobes, these areas are involved in language and reasoning like when we analyse ideas or process complex meanings.^[15] Schjoedt et al., in 2009 used fMRI to show that highly religious individuals activate regions involved in social cognition, such as the medial prefrontal cortex and temporoparietal junction, when engaging in personal prayer.^[16]

In another study by Azari et al., in 2001, it was noted that religious experience, particularly prayer, involved the activation of the dorsolateral prefrontal cortex (DLPFC). This region is known for its role in executive function, attention, and planning, suggesting that focused religious practices may be cognitively demanding and deliberate acts rather than purely emotional responses. In contrast, meditative and contemplative states often show increased activity in the anterior cingulate cortex and decreased activity in the posterior parietal lobes, which are responsible for spatial orientation.^[17]

Miller et al., in 2014 found that individuals with high levels of personal spirituality had greater cortical thickness in regions such as the orbitofrontal cortex, and hippocampus. These areas are associated with emotional regulation, moral reasoning, and memory.^[18]

Donahue et al., in 1985 observed that intrinsic religiosity, motivated by genuine faith and internalized belief is associated with better psychological outcomes and more adaptive neural activation patterns. In contrast, extrinsic religiosity driven by social pressure or external reward may be linked to rigidity and less adaptive brain responses.^[19]

EEG research has deepened our understanding of the neurobiology of religion. For instance, during deep meditation and religious chanting, increased alpha and theta wave activity has been observed in frontal and parietal lobes—brain patterns associated with relaxation, focused attention, and altered states of consciousness. In some studies, advanced practitioners also show elevated gamma activity, linked to higher cognitive functions and conscious awareness, suggesting that religious practices can induce measurable neurophysiological changes underlying subjective experiences of transcendence and peace.^[20]

Neurotransmitters such as dopamine, serotonin, and endorphins have been implicated in the regulation of mood and reward processing during religious experience. Dopamine, for instance, plays a critical role in the anticipation of reward and has been linked to the euphoric feelings reported during worship, chanting, or spiritual ecstasy. Serotonin, which is involved in mood stabilization, is often associated with feelings of well-being and connectedness during meditation and prayer.^[21]

Religiosity has also been found to be positively linked to the treatment and prevention of depression, apart from the improvement of physical health and a faster recovery from illness.^[22] There is a dearth of studies assessing religiosity, depression and anxiety.

Aims and Objectives

1. To assess the extent of religiosity in normal versus depressed individuals.
2. To determine the correlation between religiosity and severity of depression.
3. To evaluate the impact of demographic variables on religiosity and psychopathology.

Methodology

This study was conducted in a tertiary health care centre at Navi Mumbai, after approval from the institutional Ethics committee. This is an observational comparative study written informed consent was taken from all the participants and all assessments were completed in single sitting.

Our sample consisted of 2 groups. A total of 1000 people were interviewed out of which 500 were cases and 500 control from the general population. A total of first 500 cases of major depressive disorder as per diagnosis by DSM 5 who were seeking consultation in the psychiatry outpatient department were selected for the study and the first 500 control (individuals) from the general population were selected for the study after meeting the following inclusion and exclusion criteria. The inclusion criteria being cases (patients), control (general population) in the age group of 18 to 50 years, those giving written informed consent and having at least secondary education. The patients excluded were those with past history of psychotic illnesses in case group and past history of psychiatric illness in control group (normal individuals) and, those with medical illnesses such as stroke, epilepsy, kidney, or liver disease.

A detailed psychiatric clinical interview along with a mental status examination was conducted for all 1000 persons (cases and control). In the case group, 500 patients were also evaluated for their religiosity using the Centrality of Religiosity scale. They were also evaluated for depression and anxiety using the Hamilton Depression rating scale (HAM-D) and Hamilton Anxiety rating scale (HAM-A). In the

control group, 500 individuals were evaluated for their religiosity using the Centrality of Religiosity scale. Individuals who reported symptoms of depression and anxiety were given a psychiatric diagnosis as per DSM 5. They were assessed for depression and anxiety using the Ham D and Ham A scale. The following are the scales which were administered to all 1000 persons.

Tools of Assessment-

(1) Hamilton Depression Rating Scale (HAM-D)

Hamilton depression rating scale is a clinician administered depression assessment scale, having 17 items. Each item is scored on a scale of 0–4 intended to determine the severity of depression. The total score indicates the severity of depression, where a score of 0–7 is considered normal, 8–16 indicates mild depression, 17–23 signifies moderate depression, and a score of more than 24 represents severe depression.^[23]

(2) Hamilton Anxiety Rating Scale (HAM-A)

Hamilton Anxiety Rating Scale is a clinician rating scale used to measure the severity of anxiety symptoms. The scale consists of 14 items. Each item is scored on a scale of 0–not present, 1–mild, 2–moderate, 3–severe, and 4–very severe, with a total score range of 0–56, where, 0–7 indicates no anxiety, 8–14 indicates mild anxiety, 15–23 signifies moderate anxiety, and a score of more than 24 represents severe anxiety.^[24]

(3) The Centrality of Religiosity Scale (CRS)

CRS has been developed by Stefan Huber and has been applied in more than 100 studies in sociology of religion, psychology of religion and religious studies in 25 countries. The Centrality of Religiosity Scale (CRS) is a measure of the centrality, importance or salience of religious meanings in personality. It is a multidimensional method and it assesses the general intensities of five theoretical defined core dimensions of religiosity. The dimensions of public practice, private practice, religious experience, ideology and the intellectual dimensions can together be considered as representative for the total of religious life. This scale has been validated in English and other languages. This scale has undergone certain adaptations taking the local beliefs and religious practices of the country (India) into account. Of the 20 items of CRSi-20, 14 items were adapted keeping the Indian practices in mind. The validity of the Hindi adapted version of the CRS was evaluated in healthy participants. The scale showed good test–retest reliability and Cronbach's alpha was 0.95. Huber distinguishes between the groups of the a) highly-religious with a central position of the religious construct system in the individual, b) religious with a subordinated position of the personal religious construct system and c) non-religious with hardly any religious construct system. Thus as per CRS scoring scale- 1-2: not religious, 3: religious, 4-5: very/highly religious (abnormal).^[25]

RESULTS

In our study, as seen in Table 1, case group consisted of 500 patients who were diagnosed with major depressive disorder. In the control group, out of 500 normal individuals, we found that 177 had major depressive disorder, out of which, 111 (22.2%) individuals had symptoms of both depression and anxiety and 66 (13.2%) had only depressive symptoms. We observed that (Table 2) out of 500 patients in the case group 43% were very religious (abnormal), 20% were religious (normal) and 37% were not religious. In the control group, 27% individuals were very religious (abnormal), 21% were religious (normal) and 52% were not religious. This comparison of religiosity in case and control group was statistically significant, chi-square test ($p < 0.01$).

severe depression 73.9% were very religious (abnormal), 11.5% were religious and 14.6% were not religious. Out of 159 cases of moderate depression 41.1% were very religious, while out of 184 cases diagnosed with mild depression, 16.8 % were very religious. Similarly in the control group, out of 44 individuals who were diagnosed with severe depression, 77.2% were very religious, 13.8% were religious and only 9% were not religious. Out of 33 individuals of moderate depression 90.9% were very religious, while out of 100 cases of mild depression, 26% were very religious. This comparison of depression with religiosity was statistically highly significant, chi square test ($p < 0.0001$).

We found that (Table 4) in the case group, out of 168 patients who were diagnosed with severe anxiety, 70.2% were very religious (abnormal), 11.9% were religious and 17.9% were not religious. Out of 187 cases with moderate anxiety 29.9% were very religious, while out of 145 patients with mild anxiety 27.6% were very religious. In the control group, out of 43 individuals with severe anxiety, 97.7% were very religious and only 2.3% were religious. Out of 30 individuals with moderate anxiety, 86.7% were very religious, while out of 38 individuals diagnosed with mild anxiety, 52.6 % were very religious. This comparison of anxiety with religiosity was statistically significant, chi square test ($p < 0.001$).

In our study we compared duration of symptoms with religiosity and observed that out of 350 patients who had symptoms for more than 2 years, 46% were very religious, 21.4% were religious and 32.6% were not religious. Out of 150 patients who had symptoms for less than 2 years, 35.3% were very religious, 18% were religious and 46.7% were found to be not religious. We also observed that 104 individuals who had a symptom duration of symptoms for a period of more than 2 years, 81.7% were very religious, 12.5% were religious and 5.8% were not religious. Out of 73 individuals with symptom duration of depressive features of less than 2 years, 41.2% were very religious, 26% were religious and 32.8 % were not religious. The comparison of duration of symptoms with religiosity was statistically significant, chi square test, $p < 0.011$ (case) and $p < 0.01$ (control).

We also compared age with religiosity and observed that out of 199 patients (cases) who were under the age of 30yrs, 38.2% were very religious, 21.6% were religious and 40.2% were not religious. In the age group of 31-40yrs, out of 219 patients, 41.6% were very religious, 23.7% were religious and 34.7% were not religious. In patients above the age of 40 yrs, 57.3% were very religious, 8.5% were religious and 34.1% were not religious. The comparison between age and religiosity was found to be statistically significant, chi square test ($p < 0.011$). In the control group, in individuals with age less than 30 yrs, 19.7% of them were very religious, 24% were religious and 56.3% were not religious. In the age group, between 31-40 yrs, 29.2% individuals were very religious, 18.9% were religious and 51.9% were not religious. In the age group of more than 40 yrs, 50.8% of the individuals were very religious, 13.6% were religious and 35.6% were not religious. The comparison between age and religiosity was found to be statistically significant, chi square test ($p < 0.001$).

In this study no statistically significant association was found between gender, marital status, substance use, medical comorbidities, pre-morbid personality and religiosity.

The Pearson's correlation of religiosity with age, duration of symptoms, HAM D and HAM A scores (Table 5) indicated a highly statistically significant relationship ($p < 0.000$). This finding concludes that, an increase in religiosity is seen with increasing age, longer duration of symptoms, severe depression and anxiety symptoms (HAM D and HAM A scores).

We noted that (Table 3) in the case group, out of 157 cases of

TABLE 1

DEPRESSION AND ANXIETY IN CASE AND CONTROL

	CASES	CONTROL
NORMAL INDIVIDUALS	-	323 (64.6%)
DEPRESSION + ANXIETY	-	111 (22.2%)
DEPRESSION	500 (100%)	66 (13.2%)
TOTAL	500 (100%)	500 (100%)

TABLE 2

COMPARISON OF RELIGIOSITY (CRS SCORE) IN CASE AND CONTROL GROUP

		GROUP				Total	Chi-square value	p- value
		CASES (n=500)		CONTROL (n=500)				
CRS SCORE	Not religious	184	37%	260	52%	444	29.906	0.01*
	Religious	102	20%	103	21%	205		
	Very religious	214	43%	137	27%	351		

(p < 0.01* = statistically significant)

TABLE 3

COMPARISON OF DEPRESSION (HAM D SCORE) WITH RELIGIOSITY (CRS SCORE) IN CASE AND CONTROL GROUP

CASE

		CRS SCORE				Total	Chi-square value	p-value
		NOT RELIGIOUS (n=184)	RELIGIOUS (n=102)	VERY RELIGIOUS (n=214)				
HAM D	Mild	114	62.0%	39	21.2%	31	16.8%	184
	Moderate	47	29.6%	45	28.3%	67	42.1%	159
	Severe	23	14.6%	18	11.5%	116	73.9%	157

CONTROL

		CRS SCORE				Total	Chi-square value	p-value
		NOT RELIGIOUS (n=260)	RELIGIOUS (n=103)	VERY RELIGIOUS (n=137)				
HAM D	Normal	221	68.4%	65	20.1%	37	11.5%	323
	Mild	37	37.0%	37	37.0%	26	26.0%	100
	Moderate	2	6.1%	1	3.0%	30	90.9%	33
	Severe	4	9.0%	6	13.8%	34	77.2%	44

(p < 0.0001**= statistically highly significant)

TABLE 4

COMPARISON OF ANXIETY (HAM A SCORE) WITH RELIGIOSITY (CRS SCORE) IN CASE AND CONTROL GROUP

CASE

		CRS SCORE				Total	Chi-square value	p-value
		NOT RELIGIOUS (n=184)	RELIGIOUS (n=102)	VERY RELIGIOUS (n=214)				
HAM A	Mild	74	51.0%	31	21.4%	40	27.6%	145
	Moderate	80	42.8%	51	27.3%	56	29.9%	187
	Severe	30	17.9%	20	11.9%	118	70.2%	168

CONTROL

		CRS SCORE				Total	Chi-square value	p-value
		NOT RELIGIOUS (n=260)	RELIGIOUS (n=103)	VERY RELIGIOUS (n=137)				
HAM A	Normal	250	64.3%	90	23.1%	49	12.6%	389
	Mild	7	18.4%	11	28.9%	20	52.6%	38
	Moderate	3	10.0%	1	3.3%	26	86.7%	30
	Severe	0	0.0%	1	2.3%	42	97.7%	43

(p < 0.001* = statistically significant)

TABLE 5

CO RELATION BETWEEN RELIGIOSITY, DEPRESSION, ANXIETY, AGE AND DURATION OF SYMPTOMS

CASES

		AGE	SYMPTOM DURATION	HAM D	HAM A
Religiosity (CRS score)	Pearson Correlation	0.16	0.136	0.464	0.338
	p-value	0	0.002	0	0
	N	500	500	500	500

CONTROL

		AGE	SYMPTOM DURATION	HAM D	HAM A
Religiosity CRS score	Pearson Correlation	0.2	0.476	0.609	0.581
	p-value	0	0	0	0
	N	500	130	500	500

p value < 0.05 = statistically significant

DISCUSSION

Our study assessed the extent of religiosity in the Indian population. We have evaluated 500 patients of depression and 500 individuals, control (from the population). The degree of religiosity, psychopathology and demographic data were assessed in both these groups. We have found only one study in India by Gupta S et al., in 2011 assessing religiosity in depressed patients only. There have been no published studies till date assessing religiosity , depression and anxiety using the Centrality of Religiosity Scale. There has been no research done taking all these aspects into consideration, thus making comparison of our data with other studies difficult.

In our study, our case group comprised of depressed patients as per inclusion criteria. In the control group we observed that 64.6% of the individuals demonstrated no symptoms, while 35.4% of the control group demonstrated symptoms of depression and anxiety.

In the case group 43% were very religious (abnormal), whereas in the control group 27% were very religious (abnormal). This comparison of religiosity in case and control group was statistically significant.

In the case group, 73.9% of the cases with severe depression were very religious (abnormal), 41.1% of cases with moderate depression were very religious and 16.8% of cases with mild depression were very religious. Similarly in the control group, 77.2% of the cases with severe depression were very religious (abnormal), 90.9% of cases with moderate depression were very religious and 26% of cases with mild depression were very religious. This comparison of depression with religiosity was statistically highly significant.

In the case group, 70.2% of the cases with severe anxiety were very religious (abnormal), 29.9% of cases with moderate anxiety were very religious and 27.6% of cases with mild anxiety were very religious. Similarly in the control group, 97.7% of the cases with severe anxiety were very religious (abnormal), 86.7% of cases with moderate anxiety were very religious and 52.6% of cases with mild anxiety were very religious. This comparison of anxiety with religiosity was statistically highly significant.

In our study we also compared duration of symptoms with religiosity and observed that out of 350 patients (case) who had symptoms for more than 2 years, 46% were very religious. Out of 150 patients who had symptoms for less than 2 years, 35.3% were very religious. We also observed that 104 individuals (control) who had a symptom duration of symptoms for a period of more than 2 years, 81.7% were very religious. Out of 73 individuals with symptom duration of depressive features of less than 2 years, 41.2% were very religious. The comparison of duration of symptoms with religiosity is statistically significant.

We also compared age with religiosity and observed that out of 199 patients (cases) who were under the age of 30yrs, 38.2% were very religious(abnormal). In the age group of 31-40yrs, out of 219 patients, 41.6% were very religious. In patients above the age of 40 yrs, out of 82 cases 57.3% were very religious. The comparison between age and religiosity was found to be statistically significant. In the control group, in individuals with age less than 30 yrs, 19.7% of them were very religious. In the age group, between 31-40 yrs, 29.2% individuals were very religious. In the age group of more than 40 yrs, 50.8% of the individuals were very religious. The comparison between age and religiosity was found to be statistically significant.

In this study no statistically significant association was found between gender, marital status, substance use, medical comorbidities, pre-morbid personality and religiosity.

The Pearson's correlation of religiosity with age, duration of symptoms, HAM D and HAM A scores indicated a highly statistically significant relationship ($p < 0.000$). This finding concludes that, an increase in religiosity is seen with an increasing age, longer duration of symptoms, and with severe depression and anxiety symptoms.

In 2011 a study by Gupta S et al., in Chandigarh, India, compared the psychopathology between depressed patients with low religiosity and those with high religiosity and found that depressed patients with higher religiosity was associated with significantly lower levels of hopelessness and suicidal intent. The study found that the incorporation of religious

elements in the treatment of the depressed is likely to have a useful positive impact.^[26]

Literature search till date did not reveal any studies assessing religiosity in depressed vs normal individuals, thereby unable to compare our results with others.

We found many studies conducted by non-mental health professionals using self validated questionnaires to assess religiosity, therefore they have not been cited here.

Conclusion

Our study duly confirms that religiosity increases with an increase in age, and with an increase in depressive and anxiety symptoms and those with a longer duration of symptoms. This is an eye opener considering India is a land with a rich cultural heritage and vast diversity! We need to create an awareness and sensitise our fellow psychiatrists the necessity to utilise religiosity as a simple and easy screening question to probe further for depression and anxiety symptoms in the very religious individuals.

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