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Original Research Article

Assessment of Coping Strategies Related to Spirituality Among Persons with Disabilities in Southern India: A Cross-Sectional Study

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Abstract: ***Background:*** Disability is increasingly understood as shaped by personal, social, and environmental factors. In South India, spirituality is deeply embedded in daily life and often influences how individuals interpret suffering and adversity. People with disabilities may rely on religious coping to manage exclusion, stress, and long-term challenges. While studies elsewhere show that spirituality can be both supportive and distressing, evidence from Tamil Nadu remains limited. Understanding positive and negative religious coping can help design culturally sensitive care. This study examined religious coping strategies among persons with disabilities in Chennai using the Brief RCOPE scale. ***Methods:*** A cross-sectional study was conducted among 150 adults with permanent disabilities, selected through multistage sampling from four disability organizations in Chennai. Data were collected via face-to-face interviews in Tamil, covering sociodemographic details and the 14-item Brief RCOPE tool assessing positive and negative religious coping. Descriptive statistics summarized coping patterns, while univariate analysis explored associations with participant characteristics. ***Results:*** The mean age was 49.51 ± 19.05 years; 52% were women, and 40% had physical disabilities. Positive religious coping was predominant, with a mean score of 21.07 ± 1.62, compared to 15.63 ± 2.21 for negative coping. Most participants primarily used positive coping strategies (88.7%), while very few relied mainly on negative coping (0.7%); 10.7% used a mix. Faith-based resilience and seeking spiritual support were strongly endorsed, whereas beliefs of divine punishment were less accepted. Education level ($p = 0.032$) and duration of disability ($p = 0.030$) were significantly associated with coping patterns. ***Conclusion:*** Spiritual coping plays an important role in emotional adjustment among persons with disabilities in South India. Integrating spirituality into holistic care may enhance psychological well-being. Longitudinal studies are needed to clarify causal relationships.

Keywords: Spirituality; Disabled Persons; Coping Behavior; Religion and Medicine; Psychological Adaptation

INTRODUCTION

The worldwide conversation about disability has changed a lot in the last 30 years, moving away from just medical views to wider models that consider physical, mental, and social aspects. Instead of focusing solely on illness, these newer approaches

highlight how people live with their conditions alongside outside influences like surroundings, culture, and individual traits. One key model – the ICF by the WHO – frames disability as a dynamic outcome shaped both by health states and real-world circumstances. In line with this view, researchers now pay more attention to spiritual beliefs and religious practices as meaningful parts of self-understanding and emotional strength. Recent findings in psychology suggest inner belief systems help individuals create purpose and manage hardship, especially when dealing with ongoing challenges or lasting impairments. The APA Handbook on Psychology, Religion, and Spirituality points out that spiritual views can shape how people manage emotions, make sense of life's meaning, and also build social bonds in varied groups (1).

In public health research, faith and personal belief systems are linked to mental well-being and actions, especially in at-risk communities like people with disabilities (PWDs). Studies show these inner frameworks help shape reactions to hardship, views on pain, and ways individuals manage ongoing physical challenges. Koenig notes that religious or spiritual ideas affect lifestyle choices, bodily stress responses, connections with others, and emotional resilience under lasting pressure (2). These insights are particularly relevant for individuals with congenital or acquired impairments who face complex medical needs, limited participation, and negative societal attitudes.

Research within disability studies has begun exploring links between spiritual activities and aspects like health limitations, personal identity, and social belonging. Venkatesan highlights that people with disabilities across cultures use religious or spiritual beliefs to build strength, reduce isolation, and make sense of their condition (3). Population-based studies from Europe show continued spiritual engagement among older adults with cognitive limitations, associated with emotional balance and inner peace (4). Caregivers show similar patterns, often relying on faith-based narratives to manage long-term caregiving stress, as seen among Turkish mothers raising children with developmental disabilities (5).

In India, disability remains a major public health concern shaped by economic inequality, environmental barriers, and social stigma. Studies indicate that spirituality plays a significant role in daily life and influences how people interpret loss of function, cope with stress, and respond to exclusion. Thompson et al. found that religious belief strongly affects perceptions of self-worth, control, and marginalisation among people with disabilities in India (6). Rani and Sharma also report that spirituality-based coping is common but poorly explored in Indian disability research, highlighting the need for context-specific studies (7).

Spiritual beliefs, however, do not always function positively. Evidence shows that negative religious coping can intensify stress, guilt, and emotional distress. Mancini et al. report that harmful religious interpretations are associated with poorer mental health outcomes (12). This dual nature of spirituality underscores the importance of examining both supportive and maladaptive coping strategies.

Tamil Nadu's culture is deeply rooted in spiritual traditions that shape health behaviours, emotional coping, and social support. Despite improvements in disability services, people with disabilities continue to face barriers in employment, education, and healthcare. Preliminary observations suggest frequent use of prayer, rituals, meditation, and temple visits to manage distress, yet empirical evidence from Tamil Nadu remains scarce. Without region-specific data, integrating spirituality into holistic and culturally responsive care remains challenging.

The present study therefore examines religious coping among persons with disabilities in Chennai using the Brief RCOPE, which assesses both positive and negative spiritual responses. Understanding these coping patterns and their associations with sociodemographic and disability-related factors can inform culturally appropriate mental health and rehabilitation strategies.

MATERIAL AND METHODS

Study Design and Setting

This Cross sectional study was conducted in Chennai, Tamil Nadu, focusing on persons with disabilities during the period of May-Nov 2025.

Study Population

The research included adults aged 18 or above who had a lasting disability. Participants needed to be capable of giving written informed agreement..

Sample Size and Sampling Procedure

The sample size was calculated using the formula $n = Z^2pq/d^2$. An expected disability prevalence of 8% ()was applied, with a 5% margin of error and 95% confidence, resulting in a minimum requirement of 117 participants. After adding 10% to account for non-response, the final sample size was set to 150.

Using multistage sampling technique ,Disability support organisations in Chennai were first identified and listed, from which four were randomly selected using lottery method.. Participants from each organisation were recruited by population proportion to size ,hence the target sample size was achieved.

Study Tools and Methods

Sociodemographic information included age, sex, education level, religion, disability type, and duration of disability. Religious coping was assessed using the Standard 14-item Brief RCOPE tool, comprising seven positive and seven negative coping items, rated on a four-point scale. Data were collected through interviewer-administered questionnaires in local language.Dpo/ngo heads meeting, obtained permission ,ind explanation

A meeting was conducted every week starting from may to nov on every saturdays

Ethical Considerations

Approval from the institution's review board was obtained.IEC- Written informed consent was obtained from all participants. Confidentiality was ensured, participation was voluntary, and no incentives were provided.

Statistical Analysis

Data were entered into Microsoft Excel and analysed using SPSS version 26.0. Descriptive statistics summarised participant characteristics and coping patterns. Associations were examined using Univariate analysis,chi square for categorical variable with $p < 0.05$ considered significant.

RESULTS

The research looked at information from 150 people, covering various disabilities and differing in age, gender, educational background, besides type of impairment. Instead of combining faith with struggle, most individuals used positive religious strategies - shown by high RCOPE ratings along with relatively low levels of negative reactions. When examining single variables, education level together with how long someone had a disability linked clearly to coping styles; yet additional personal traits did not show notable effects. Looking at specific items, many agreed strongly with actions reflecting spiritual support, whereas few leaned toward religious views tied to suffering or distress. In sum, those with impairments in this group mainly turned to constructive spiritual methods when facing hardship.

Table 1. Sociodemographic Characteristics of Study Participants

Category	Value
Gender	
Male	64 (42.7)
Female	86 (57.3)
Religion	
Hindu	102 (68.0)
Chirstian	18 (12.0)
Muslim	20 (13.3)
Others/None	10 (6.7)
Marital Status	
Married	93 (62)
Single	33 (22)
Widowed	9 (6)
Separated	15 (10)
Education	
No Formal Education	13 (8.7)
Primary	24 (16)
Secondary	52 (34.7)
Graduate & above	61 (40.7)
Disability	
Intellectual	15 (10.0)
Multiplr	24 (16.0)
Physical	60 (40.0)
Psychosocial	19 (12.7)
Sensory (vision/hearing)	32 (21.3)

The study included participants with a wide age range, with a mean age of **49.51 ± 19.05 years**, indicating a mix of younger and older adults. The majority of participants were **female (57.3%)**, while males accounted for **42.7%**.

Most participants identified as **Hindu (68%)**, followed by Christians (12%), Muslims (13.3%), and a smaller proportion reporting other or no religious affiliation (6.7%). In terms of marital status, **62% were married**, while the rest were single (22%), widowed (6%), or separated (10%).

Educational levels varied, with **40.7% having graduate-level or higher education**, and the remainder having secondary (34.7%), primary (16%), or no formal education (8.7%).

Among the 15 participants with intellectual disabilities, specific learning disability was reported in 6 individuals, autism spectrum disorder in 5 individuals, and intellectual disability in 4 individuals.
Of the 24 participants with multiple disabilities, 18 had multiple disabilities, while 6 were acid attack survivors. Physical disabilities were the most common category (n = 60), with locomotor disability observed in 22 participants, cerebral palsy in 10, muscular dystrophy in 8, leprosy cured status in 7, Parkinson's disease in 7, and dwarfism in 6 participants.

Psychosocial disability, represented by mental illness, was identified in all 19 participants within this category. Among the 32 participants with sensory disabilities, 8 had low vision, 6 had blindness, 10had hearing impairment and 8 had speech and language disability.

Overall, the sample represents a diverse population across age, gender, religion, education, and disability categories, allowing for meaningful assessment of coping patterns across varied demographic backgrounds.

Table 2 . RCOPE Item Wise Distribution (N= 150)

RCOPE Items	Not at all	Somewhat	Quite a bit	A great deal
Looked for a stronger connection with God	0 (0.0%)	23 (15.3%)	96 (64.0%)	31 (20.7%)
Sought God's love and care	4 (2.7%)	29 (19.3%)	91 (60.7%)	26 (17.3%)
Sought help from God in letting go of my anger	0 (0.0%)	24 (16%)	93 (62%)	33 (22%)
Tried to put my plans into action together with God	1 (0.7%)	23 (22%)	87 (58%)	29 (19.3%)
Tried to see how God might be trying to strengthen me in this situation	1 (0.7%)	26 (17.3%)	91 (60.7%)	32 (21.3%)
Asked for forgiveness for my sins	2 (1.3%)	23 (15.3%)	99 (66%)	26 (17.3%)
Focused on religion to stop worrying about my problems	2 (1.3%)	27 (18%)	82 (54.7%)	39 (28%)
Wondered whether God had abandoned me	31 (20.7%)	65 (43.3%)	47 (31.3%)	7 (4.7%)
Felt punished by God for my lack of devotion	27 (18%)	60 (40%)	53 (35.3%)	10 (6.7%)
Wondered what I did for God to punish me	33 (22%)	77 (51.3%)	36 (24%)	4 (2.7%)
Questioned God's love for me	27 (18%)	78 (52%)	39 (26%)	6 (4%)
Wondered whether my church had abandoned me	27 (18%)	54 (36%)	59 (39.3%)	10 (6.7%)
Decided the devil	28	58	49	15

made this happen	(18.7%)	(38.7%)	(32.7%)	(10%)
Questioned the power of God	32 (21.3%)	61 (40.7%)	51 (34%)	6 (4%)

Analysis of individual Brief RCOPE items demonstrated a strong predominance of positive religious coping strategies among participants. For the item *"Looked for a stronger connection with God"*, a majority of respondents endorsed higher levels of engagement, with 64.0% reporting "quite a bit" and 20.7% reporting "a great deal," while none selected "not at all." Similarly, *"Sought God's love and care"* was endorsed at higher levels by most participants, with 60.7% reporting "quite a bit" and 17.3% reporting "a great deal," indicating frequent reliance on supportive faith-based beliefs.

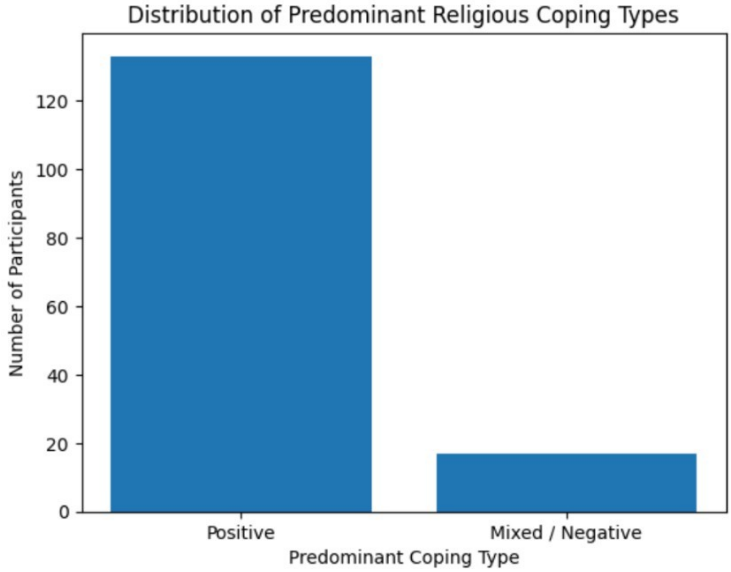
High endorsement was also observed for emotional regulation and active collaboration with faith. For *"Sought help from God in letting go of my anger"*, 62.0% selected "quite a bit" and 22.0% selected "a great deal," while no participants reported "not at all." Likewise, *"Tried to put my plans into action together with God"* showed strong engagement, with 58.0% reporting "quite a bit" and 19.3% reporting "a great deal." The item *"Tried to see how God might be trying to strengthen me in this situation"* also reflected adaptive coping, with over 80% endorsing it at "quite a bit" or "a great deal."

Religious practices related to forgiveness and cognitive distraction through faith were similarly common. For *"Asked for forgiveness for my sins"*, 66.0% selected "quite a bit" and 17.3% selected "a great deal." In addition, *"Focused on religion to stop worrying about my problems"* was endorsed at higher levels by 82.7% of participants.

In contrast, negative religious coping items were less frequently endorsed at higher levels. For *"Wondered whether God had abandoned me"*, only 4.7% reported "a great deal," while the majority selected "somewhat" (43.3%) or "not at all" (20.7%). Similarly, *"Felt punished by God for my lack of devotion"* and *"Wondered what I did for God to punish me"* showed lower endorsement at extreme levels, with most participants selecting "somewhat" or "not at all." Items reflecting doubt, such as *"Questioned God's love for me"* and *"Questioned the power of God"*, were predominantly endorsed at lower intensities, with fewer than 5% reporting "a great deal."

Overall, the frequency distribution indicates that participants predominantly relied on positive, faith-affirming coping strategies, with most endorsing constructive religious responses at higher levels. Negative religious coping tendencies were present but generally reported at lower intensities, suggesting that spiritual struggle was relatively infrequent within the study population.

RAPH 1 . Distribution of Positive and Negative Religious Coping Scores



The distribution of religious coping scores shows that participants predominantly relied on positive forms of religious coping. The mean positive coping score was high at 21.07 ± 1.62, with a median of 21 (IQR 20–22), indicating that most individuals consistently engaged in constructive and spiritually supportive coping behaviors. In contrast, negative religious coping scores were lower, with a mean of 15.63 ± 2.21 and a median of 15 (IQR 14–17), suggesting that maladaptive or distress-related religious responses were less commonly used. The composite score (PRC–NRC)

further demonstrated a positive balance, with a mean of 6.00 ± 2.77, reflecting a clear dominance of positive coping over negative coping strategies among participants. Overall, the majority 88.7% were categorized as predominantly using positive coping, while only 0.7% showed predominantly negative coping patterns and 10.7% exhibited mixed or neutral coping. These findings imply that religious coping in this population is largely adaptive, with most individuals turning to religion as a source of strength, meaning, and emotional support.

Table 4. Comparison of Positive vs Negative Coping (Univariate Analysis)

Variables	Coping		p value
	Positive (n=133) n (%)	Negative (n=17) n (%)	
Age (in years) (Mean±SD)	49.52 ± 19.2	49.41 ± 18.11	0.982
Gender			
Female	53 (39.85)	11 (64.71)	0.051
Male	80 (60.15)	6 (35.29)	
Education			
Schooling	83 (62.41)	6 (35.29)	0.032
Graduate	50 (37.59)	11 (64.71)	
Disability			
Non-Physical Disability	80 (60.15)	10 (58.82)	0.916
Physical Disability	53 (39.85)	7 (41.18)	
Duration of Disability			
<1 years	28 (21.05)	4 (23.53)	0.030
1-5	73 (54.89)	4 (23.53)	
5-10	18 (13.53)	6 (35.29)	
>10	14 (10.53)	3 (17.65)	
Marital Status			
Single/Windowed/Separated	52 (39.1)	5 (29.41)	0.438
Married	81 (60.9)	12 (70.59)	
Employment			
Unemployed	83 (62.41)	10 (58.82)	0.774
Employed	50 (37.59)	7 (41.18)	
Religion			
Christian/Muslim/Others	42 (31.58)	6 (35.29)	0.786
Hindu	91 (68.42)	11 (64.71)	
Frequent Practice			
Daily/Weekly/Monthly	96 (72.18)	11 (64.71)	0.572
Rarely/Never	37 (27.82)	6 (35.29)	

The univariate analysis explored how different demographic and disability-related factors were associated with coping styles. **Age** showed no difference between groups (p = 0.982), indicating that coping patterns were similar across the lifespan.

A near-significant association was observed for **gender** (p = 0.051), with a higher proportion of females displaying negative or mixed coping patterns, suggesting a potential trend that may warrant further exploration.

Education showed a statistically significant difference (p = 0.032). Individuals with schooling were more likely to demonstrate positive coping compared to graduates, indicating stronger engagement with adaptive coping strategies among those with foundation-level education.

Duration of disability was also significantly associated with coping (p = 0.030). Participants living with disability

for **1–5 years** showed a higher proportion of positive coping compared to those with disability for less than one year, suggesting that coping ability may strengthen over time.

Other variables including **disability type, marital status, employment status, religion, and frequency of religious practice** did not show significant differences between coping groups ($p > 0.05$), suggesting that positive coping was generally consistent across these categories.

DISCUSSION

The current cross-sectional analysis of 150 individuals with disabilities in Chennai shows mostly constructive spiritual responses. About 88.7% (n = 133) used mainly helpful strategies, whereas only 0.7% (n = 1) depended on harmful ones; meanwhile, 10.7% (n = 16) displayed both or neither approach clearly. Average positive religious coping stood at 21.07 ± 1.62 – much above the average negative score of 15.63 ± 2.21. When subtracting NRC from PRC, the resulting difference reached 6.00 ± 2.77, suggesting a strong tilt toward beneficial methods. Looking item by item, people frequently agreed with statements like "Searched for God's support" (mean = 2.93), "Asked divine aid to release anger" (3.06), and "Turned to God when anxious" (3.05). In contrast, beliefs such as "Believed I was being punished by God" scored lower (2.07); similarly low was "Doubted God's concern for me" (2.35). Results link educational level ($p = 0.032$) and duration of disability ($p = 0.030$) to these patterns, though age ($p = 0.982$), type of impairment ($p = 0.916$), and other background traits did not show notable connections.

These findings align with the framework proposed by Pargament and colleagues, where the Brief RCOPE distinguishes positive from negative religious coping across diverse populations (16). In the present study, positive coping demonstrated a narrower spread (SD = 1.62) compared to negative coping (SD = 2.21), suggesting greater consistency in constructive spiritual responses. The relatively low endorsement of negative items supports the tool's validity and indicates participants were able to differentiate supportive religious beliefs from those associated with spiritual struggle.

The predominance of PRC mirrors Koenig's observations among medically ill older adults, where religious coping was associated with improved mood and perceived health (17). Although participants here resided in community settings rather than hospitals, their mean age of 49.51 ± 19.05 places many within middle or later adulthood, a stage where Koenig noted stronger links between faith-based coping and emotional wellbeing (17). Elevated PRC scores in this study may therefore indicate similar adaptive benefits, though longitudinal data would be needed to confirm this relationship.

Cultural context likely influenced these outcomes. Balasundaram's work on Hindu interpretations of disability suggests that concepts such as karma and endurance may encourage acceptance and meaning-making rather than hopelessness (18). In this sample, where 68% identified as Hindu, faith-based growth items such as "Noticing ways God could be helping me grow stronger" (mean = 3.03) received strong endorsement. At the same time, moderate agreement with doubt-related items such as "Questioning if God left me behind" (mean = 2.31) suggests the coexistence of reassurance and uncertainty, aligning with Balasundaram's observation that Hindu coping often accommodates both peace and questioning (18).

The Tamil Brief RCOPE was interviewer-administered, consistent with Mohanraj et al.'s emphasis on cultural and linguistic adaptation when studying southern Indian populations (19). Response patterns indicated good comprehension and contextual relevance. Education level showed a significant association with coping style, with participants having basic education demonstrating higher PRC compared to degree holders. As noted by Mohanraj and colleagues, educational attainment can shape how individuals interpret distress, with higher education sometimes linked to more critical or secular responses to hardship (19).

Idler et al.'s conceptualisation of spirituality as distinct from formal religious participation helps explain the absence of association between coping patterns and service attendance ($p = 0.572$) (20). Responses emphasising forgiveness, emotional regulation, and closeness to God suggest that internalised spiritual meaning was more influential than outward religious practices in managing stress among participants.

Although NRC was uncommon, its presence aligns with Grover and Chakrabarti's findings that religious coping can have both supportive and distressing dimensions (22). Low yet non-zero NRC scores, particularly on items related to punishment or abandonment, indicate that spiritual conflict existed for a subset of participants.

Overall, the findings suggest that positive religious coping functions as a culturally embedded mechanism for emotional adjustment among persons with disabilities in southern India, while negative coping remains limited but relevant.

LIMITATIONS

This study had few limitations. Data were self-reported and may reflect social desirability, especially in a religious context. Although Brief RCOPE

performed well, it may not capture informal or indigenous spiritual practices common in Tamil Nadu. The sample was limited to individuals associated with DPOs and NGOs in Chennai, restricting generalisability.As most participants identified as Hindu (68%), with smaller representations from Christian, Muslim, and other or non-religious groups, the findings may reflect faith-specific coping patterns and may not be fully generalisable across all religious communities.

CONCLUSION

This study demonstrates that persons with disabilities in southern India predominantly use positive religious coping strategies, with nearly 89% relying on constructive faith-based methods. Associations with education level and duration of disability suggest coping strategies evolve with experience and context, while consistency across other sociodemographic variables indicates widespread reliance on spiritual resources. These findings underscore the importance of integrating culturally sensitive spiritual elements into rehabilitation, mental health care, and community support services. Since this a minority and vulnerable group a longitudinal research is needed to clarify psychological outcomes and causal pathways. Overall, this study contributes region-specific evidence to the growing literature on spirituality and disability.

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