



RESEARCH PAPER

The Predictive Role of Religiosity and Spirituality for Life Satisfaction and Psychological Wellbeing among Hepatitis Patients

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ABSTRACT

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This study was carried out to see the predictive role of religiosity and spirituality for psychological wellbeing and life satisfaction among hepatitis patients. A total of (N=220) Hepatitis C patients ranging from 21 to 50 years using purposive sampling technique were selected from govt. and private hospitals. Muslim religiosity personality inventory MRPI translated by (Saleem, 2011), Life Satisfaction Scale (LSS) (Mahmood, 2012), and Warwick-Edinburgh Mental Well-being Scale (WEMWBS) Brown & Janmohamed, (2008) and a self constructed demographic datasheet was administered for data collection. The study design was correlational in nature, descriptive statistics, Pearson Product moment Correlation, multiple regression, t-test were performed for data analysis. Findings showed that all the variables were significantly related to each other, and religiosity and spirituality was significant predictors of Life Satisfaction and psychological wellbeing among hepatitis C patients. More over significance differences were found between religiosity and spirituality, life satisfaction, and psychological wellbeing among groups ($p < .01$).

Introduction

The psychological well being is a highly studied structure, which is focused on mental or cognitive, analytical or subjective aspects in the well-being. There are numerous attempts to conceive the construction (Marsh et al., 2019).

Psychological well-being is an extremely well researched organisation, which focuses on behavioural or emotional, empirical or subjective well-being elements. Many efforts have been made to design the building (Koopmans, 2010).

Experimental research indicates that well-being offers individuals the most and makes them emotional, supportive and ethical (Diener, 2009).

The position of revenue has been the main subject of the discussion on psychological well-being. Researchers have held the highest percentage of revenue for psychological well-being for decades: Social deprivation, hunger and GDP have been assumed to play a major role in national satisfaction (Fischer & Boer, 2011; O'Brien, 2008).

Social supports, faith, a sense of purpose, Religion and association were hypothesised "ingredients" of healing wealth, all of which were empirically correlated with short-term recovery (Laudet et al., 2006,)

Spirituality separately contributed 17 percent of the explicit variation in QOL as a whole in our intersectional analysis of recovery capital as moderating tension and increasing quality of life. Spirituality improves scope, gives hope and offers a stronger sense of control, comfort & peace. Spirituality provides motivation and strength in the form of drug rehabilitation in order to avoid the possibility to use drugs that are necessary to promote and sustain a recovery (Fetzer Institute, National Institution Aging Working Group, 1999).

Hepatitis C prevalence poses a dangerous risk for the welfare of people, households, and neighborhoods. The presence of hepatitis C is a risky threat to the health of individuals, families, and their communities. In Pakistan, surveys of targeted blood donation groups have shown a widespread incidence of hepatitis C. The general health of hepatitis C was found in Pakistan to be up to 40% for target populations of blood donors up to 40% (Abbas et al., 2008; Jiwani&Gul, 2011).

These results show that HCV patients can be scan able so that such patients are not enrolled in gastroenterological clinics due to emotional well-being or opioid dependency. These statistics cover the transition and diagnosis of this condition, the control of the patient's stigma and the strengthening of relationships and lifestyle, and the treatment of patients (Foster et al., 1992; knot et al.,2006). This crucial subject from early childhood is discussed within the research literature in the sense of increasingly possible integration of emotional well-being and therapy of patients with HCV. Health study shows that women are more vulnerable than men to fear (Walsh et al., 2004; Michael et al., 2007; Panayiotou et al., 2017).

Gender in measuring stress also varies and believes that women follow more stressful therapy approaches than men for personal health (Tamres et al., 2002). Women use several PFC tactics rather than men (such as planning, coordination, and professional coping (Nicholls et al., 2007).More recent study has now been based the spirituality of medicine as the principal health indicator (Flanagan &Jupp., 2007).

Koenig et al (2001) Tell us that very little to no research was done to compare people of distinct religious beliefs and backgrounds. To date, many of the findings

depend on US info (mainly the General Social Sample) Ferriss (2002) or the associated study in another country. The cross-border study is incomplete, with only a limited number of other cases related to religion. 90,000 individuals in 26 European countries were investigated in the European Social Survey Clark and Lelkes (2009) it was concluded that a high average religious faith improved religious and lay people's satisfaction on the land. Religion and religion are popular in social sciences as two distinct constructs (Nelson et al., 2009).

Analysis has found that even the devotional customer learns more of their physicians' religiosity and the more time they have to pray for them. But many physicians had various religious and moral experiences (Oyama& Koenig, 1998; Monroe et al., 2003). This raises questions over their right to petition for the patient's welfare for religious freedom analysis has also found that harmonization and substitute drugs are most commonly used in very conservative cultures (McCurdy et al., 2003). They were spiritual or religious affairs, like faith in Heaven, look for God's aid, find salvation in worship, and prayer more than normal (Steffen et al., 2001).

Hypotheses

1. Religiosity and spirituality, life satisfaction and psychological wellbeing would be significantly correlated with each other among hepatitis C patients.
2. Life satisfaction would be predicted by religiosity and spirituality and psychological wellbeing among hepatitis C patients.
3. There would be significant difference between male and female on religiosity and spirituality, life satisfaction and psychological wellbeing among hepatitis C patients.
4. There would be significant difference between age groups (21-30 year, 31-40 year, and 41-50 year) on religiosity and spirituality, life satisfaction and psychological wellbeing among hepatitis C patients.
5. There would be significant difference between socio-economic status (lower and middle) on religiosity and spirituality, life satisfaction and psychological wellbeing among hepatitis C patients.
6. There would be significant difference between nuclear and joint family structure on religiosity and spirituality, life satisfaction and psychological wellbeing among hepatitis C patients.
7. There would be significant difference between marital status (unmarried and married) on religiosity and spirituality, life satisfaction and psychological wellbeing among hepatitis C patients.
8. There would be significant difference between mode of treatment (taking treatment from government hospital and taking treatment from private hospital) on religiosity and spirituality, life satisfaction and psychological wellbeing among hepatitis C patients.

Materials and Methods

Participants

In this research 240 Patients of hepatitis C were taken using purposive sampling technique from different private and government hospitals from different cities. Sample was comprised of both males and females. The sample was base on hospitalized patients with hepatitis with equal representation of both genders from different hospitals. Sample was further classified into males (n = 120) and females (n = 120). Cross sectional and correlational design was used in this study.

Instruments

Demographics Sheet

The demographics will be age, gender, Socio-economic status, Living style and marital status.

Religious Personality Scale of Muslim Religiosity-Personality Inventory (MRPI) (2005)

This Muslim Religiosity-Personality Inventory (MRPI) was validated and initially underwent forward and backward translation, then distributed to 215 adolescents. The questionnaires were investigated for their psychometric properties by confirmatory factor analysis (CFA) for binary and ordinal variables using lavaan package. Result: A new two-factor model with 17 items, achieved acceptable fit to the data (TLI = 0.730, CFI = 0.893, RMSEA (90%CI) = 0.059 (0.045-0.072), CIFit p-value = 0.143, SRMR = 0.056). Cronbach's alpha for ritual and mu'amalat subscale was 0.82 and 0.72 and the mean score was 35.6 (SD = 6.43) and 27.1 (SD = 4.50) respectively.

Life Satisfaction Scale (LSS) (Mahmood, 2012)

This Life Satisfaction Scale of 21-item scale designed to measure general global life satisfaction of the individual in Pakistani population. Participants rate themselves on the 21 items using a 5-point scale that ranges from 5 strongly agree to 1 strongly disagree.

Warwick-Edinburgh Mental Well-being Scale (WEMWBS) Brown & Janmohamed,. (2008)

The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) comprises 14 items that relate to an individual's state of mental well-being (thoughts and feelings) in the previous two weeks (see Appendix i). Responses are made on a 5-point scale ranging from 'none of the time' to 'all of the time'. Each item is worded positively and together they cover most, but not all, attributes of mental well-being including both hedonic and eudemonics perspectives. WEMWBS aims to measure mental well-

being itself and not the determinants of mental well-being, which include resilience, skills in relationship, conflict management and problem solving, as well as socioeconomic factors such as poverty, domestic violence, bullying, unemployment, stigma, racism and other forms of social exclusion.

Procedure

The Urdu version of all the scales will be used for research purpose. Scales and population will be finalized with the discussion of supervisor. Permission letter for the purpose of data collection will be taken from the head of the department. Main study will carry out to test the hypothesis of the study. Reliable and standardized testing tool will be used in purposed study. Scales permission will be taken from the authors. Then data will be taken from different hospitals all over the Punjab after having the required consent. All 3 scales will be given to the patients with hepatitis asking them read all the statement carefully and respond to all the items of the scales. They have to fill all these scales in the Presence of researcher.

Data Analysis

In the present study initially descriptive statistics will be run to find out the descriptive characteristics like Mean, Standard deviation, Range and e.g. Moreover Pearson Product moment Correlation will be used to find out the relationship between variable. In the same way multiple regressions will be used to see the prediction. Moreover independent sample t-test and analysis of variance would be used to check the differences. All participants were informed regarding ethical consideration during data collection. Consent was taken from the participant regarding their willingness to participate in the research confidentiality of the data was maintained. Participants could leave the study any time without any penalty.

Results and Discussion

Table 1
Cronbach's alpha Reliability Analysis of Scales (N=240)

Variables	k	M	SD	α
<i>LSS</i>	21	82.44	12.83	.89
<i>WEMSBS</i>	14	52.72	8.03	.80
<i>MRPI</i>	46	177.93	16.61	.83

Table no 1 show the reliability analyses of scales which the reliability of Life Satisfaction Scale was .89 which show good reliability. Reliability of Warwick-Edinburgh Mental Well-being Scale was .80, which was also good reliability and the reliability of Muslim Religiosity Personality Inventory was .83 which was an excellent reliability.

Table 2
Demographic Characteristics of Sample of Hepatitis Patients (N=240).

Variables	<i>f</i>	%
Gender		
Male	104	43.3
Female	136	56.7
Marital Status		
Married	148	61.7
Unmarried	92	38.3
Age		
21-30	148	61.7
31-40	45	19.6
41-50	45	18.8
Social Economic Status		
Middle	76	31.7
Lower	164	68.3
Family System		
Nuclear	112	46.7
Joint	128	53.3
Hospital		
Govt. hospital	105	43.8

Table no 2 shows significant differences of frequencies and percentages among demographic characteristics in hepatitis patients.

Table 3
Inter- Correlation among Study Variables i.e. Life Satisfaction and Psychological Wellbeing and Religiosity and Spirituality in Hepatitis Patients (N=240).

Measure	1	2	3	4	5	6
<i>LS</i>	-	.76**	.77**	.99**	.82**	.76**
<i>PW</i>		-	.91**	.80**	.87**	.90**
<i>RS</i>			-	.82**	.92**	.99**
<i>RS1</i>				-	.82**	.80**
<i>RS2</i>					-	.90**
<i>RS3</i>						-

***p* < .01

Note. LS= Life Satisfaction, PW= Psychological Wellbeing, RS= Religiosity and Spirituality

Table no 3 shows there was a highly significantly positive relationship of life satisfaction with psychological well-being ($r=.76$, $**p<.01$) and with religiosity and spirituality ($r=.77$, $**p<.01$), Life satisfaction has a highly significant positive relationship with religiosity and spirituality's subscales i.e., with religiosity and spirituality 1 ($r=.99$, $**p<.01$), with religiosity and spirituality 2 ($r=.82$, $**p<.01$) and with religiosity and spirituality 3 ($r=.76$, $**p<.01$).

Furthermore, there was a highly significant positive relationship between psychological wellbeing and religiosity and spirituality ($r=.91$, $**p<.01$). Psychological wellbeing has also a significant positive relationship with religiosity and spirituality's subscales i.e., with religiosity and spirituality 1 ($r=.80$, $**p<.01$), with religiosity and spirituality 2 ($r=.87$, $**p<.01$) and with religiosity and spirituality 3 ($r=.90$, $**p<.01$). There was also a highly significant positive relationship of religiosity and spirituality with its subscales i.e., with religiosity and spirituality 1 ($r=.82$, $**p<.01$), with religiosity and spirituality 2 ($r=.92$, $**p<.01$) and with religiosity and spirituality 3 ($r=.99$, $**p<.01$).

Furthermore, religiosity and spirituality 1 has a significant positive relationship with religiosity and spirituality 2 ($r=.82$, $**p<.01$) and with religiosity and spirituality 3 ($r=.80$, $**p<.01$). And there was also a significant positive relationship between religiosity and spirituality 2 and religiosity and spirituality 3 ($r=.90$, $**p<.01$).

Table 4
Inter- Correlation among Study Variables i.e. Life Satisfaction and Psychological Wellbeing and Religiosity and Spirituality in Hepatitis Patients (N=240)

Measure	1	2	3
<i>LS</i>	-	.76**	.77**
<i>PW</i>		-	.91**
<i>RS</i>			-

$**p<.01$

Note. LS= Life Satisfaction, PW= Psychological Wellbeing, RS= Religiosity and Spirituality

Table no 4 shows there was a highly significantly positive correlation between life satisfaction and psychological well-being ($r=.76$, $**p<.01$) and a highly significant positive correlation between life satisfaction and religiosity and spirituality ($r=.77$, $**p<.01$). Furthermore, there was a highly significant positive correlation between psychological wellbeing and religiosity and spirituality ($r=.91$, $**p<.01$).

Table 5
Multiple Regression Analysis (step wise method) to see the Predictive Role of Life Satisfaction and Psychological Wellbeing to Religiosity and spirituality on Study Variables in Hepatitis Patients (N=240)

Variable	<i>B</i>	<i>SD</i>	β	<i>t</i>	<i>p</i>	ΔR^2
<i>LS</i>	.17	.041	.16	4.34	.000	.85
<i>PW</i>	.80	.039	.79	20.5	.000	

Note: $R^2 = .85$, $= **p<.001$

L.S= Life Satisfaction P.W= Psychological Wellbeing

Table no 5 shows that religiosity and spirituality was the most significant predictor of Life Satisfaction among hepatitis patients. Religiosity and spirituality

was also most significant predictor of psychological well-being .And explained .44% of the variance ($R^2 = .85$, $F(1) = 707.54$, $**p < .001$ in the model).

Table 6
Independent sample t-test of Life Satisfaction, Psychological Wellbeing and Religiosity and Spirituality on gender difference (N=240).

Variables	Male		Female		<i>t</i>	<i>P</i>	95% C.I		Cohen's <i>d</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			<i>LL</i>	<i>UL</i>	
<i>LS</i>	70.19	6.51	58.56	8.51	11.57**	.000	9.64	13.60	1.535
<i>PW</i>	67.46	10.14	56.7	8.57	8.91**	.000	8.40	13.16	1.149
<i>RS</i>	96.36	1.53	94.36	1.44	.02	.97	-.37	.38	1.346

LS= Life Satisfaction, PW= Psychological Wellbeing, RS= Religiosity and Spirituality

Table no. 6 shows that there was a significant difference on Life Satisfaction Scale

(LSS), [$t(11.57) = 11.98$, $p = .000$] among male and female hepatitis patients.

There was a significant difference on Reliability of Warwick-Edinburgh Mental Well-being Scale (WEMW), [$t(8.91) = 8.72$, $p = .000$] among male and female hepatitis patients.

There was no significant difference on Muslim Religiosity Personality Inventory (MRPI), [$t(.02) = .026$, $p = ns(.97)$] among male and female hepatitis patients.

Table 7
Independent sample t-test of Life Satisfaction, Psychological Wellbeing and Religiosity and Spirituality on marital status (N=240).

Variables	Married		Unmarried		<i>T</i>	<i>P</i>	95% C.I		Cohen's <i>d</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			<i>LL</i>	<i>UL</i>	
<i>LS</i>	64.22	10.12	62.59	8.71	1.27	.20	-.88	4.14	0.1724
<i>PW</i>	61.64	11.40	60.64	9.50	.53	.59	-2.04	3.65	0.0953
<i>RS</i>	96.33	1.47	96.41	1.50	-.41	.67	-.47	.30	0.0538

LS= Life Satisfaction, PW= Psychological Wellbeing, Religiosity and Spirituality

Table no. 6 shows that there was no significant difference on Life Satisfaction Scale (LSS), [$t(1.27) = 1.32$, $p = ns$] among married and unmarried hepatitis patients.

There was no significant difference on Reliability of Warwick-Edinburgh Mental Well-being Scale (WEMW), [$t(.53) = .55$, $p = ns$] among married and unmarried hepatitis patients.

There was no significant difference on Muslim Religiosity Personality Inventory (MRPI), [$t(-.416) = -.413$, $p = ns$] among married and unmarried hepatitis patients.

Table 8
Independent sample t-test of Life Satisfaction, Psychological Wellbeing and Religiosity and Spirituality on family structure (N=240)

Variables	Nucl		Joint		<i>t</i>	<i>p</i>	95%		<i>Cohen's d</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			<i>LL</i>	<i>UL</i>	
<i>LS</i>	64.91	9.08	62.46	9.95	1.98*	.04	.012	4.88	0.257
<i>PW</i>	62.66	10.71	60.19	10.59	1.79*	.04	-.24	-5.18	0.231
<i>RS</i>	98.53	1.62	96.20	1.33	1.78*	.05	.013	3.26	10.578

LS= Life Satisfaction, PW= Psychological Wellbeing, Religiosity and Spirituality

Table no. 6 shows that there was a significant difference on Life Satisfaction Scale (LSS), [$t(1.98) = 1.99, p=.04$] among nuclear and joint family hepatitis patients.

There was a significant difference on Reliability of Warwick-Edinburgh Mental Well-being Scale (WEMW), [$t(1.795) = 1.794, p=.05$] among nuclear family and joint family hepatitis patients.

There was a significant difference on Muslim Religiosity Personality Inventory (MRPI), [$t(1.78) = 1.76, p=.05$] among nuclear and joint family hepatitis patients.

Table 9
Independent sample t-test of Life Satisfaction, Psychological Wellbeing and Religiosity and Spirituality on socio economic status (N=240)

Variables	Midd		Lower		<i>t</i>	<i>p</i>	95%		<i>Cohen's d</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			<i>LL</i>	<i>UL</i>	
<i>LS</i>	67.13	8.10	61.96	9.84	3.98**	.000	2.61	7.71	0.575
<i>PW</i>	64.64	10.45	59.82	10.49	3.31**	.001	1.95	7.68	0.460
<i>RS</i>	92.52	1.72	92.28	1.35	1.16	.24	-.16	.64	0.155

LS= Life Satisfaction, PW= Psychological Wellbeing, Religiosity and Spirituality

Table no. 9 shows that there was a significant difference on Life Satisfaction Scale (LSS), [$t(3.98) = 4.27, p=.001$] among middle and lower class hepatitis patients.

There was a significant difference on Reliability of Warwick-Edinburgh Mental Well-being Scale (WEMW), [$t(3.31) = 3.318, p=.001$] among middle and lower class hepatitis patients.

There was no significant difference on Muslim Religiosity Personality Inventory(MRPI), [$t(1.16) = 1.06, p= ns$] among middle and lower class hepatitis patients.

Table 10
Independent sample t-test of Life Satisfaction, Psychological Well Being and Religiosity and Spirituality on Hospital (N=240)

Variables	Gov		Private		<i>T</i>	<i>p</i>	95%		<i>Cohen's d</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			<i>LL</i>	<i>UL</i>	

<i>LS</i>	65.51	7.72	62.11	10.66	2.75**	.006	.96	5.82	0.210
<i>PW</i>	63.71	9.30	59.51	11.37	3.07**	.005	1.50	6.89	0.404
<i>RS</i>	96.41	1.65	96.31	1.24	.52	.61	-.28	.48	0.068

LS= Life Satisfaction, PW= Psychological Wellbeing, Religiosity and Spirituality

Table no. 10 shows that there was a significant difference on Life Satisfaction Scale (LSS), [t (2.75) = 2.85, p=.01] among government and private hospital hepatitis patients.

There was a significant difference on Reliability of Warwick-Edinburgh Mental Well-being Scale (WEMW), [t (3.07) = 3.14, p= .01] among government and private hospital hepatitis patients.

There was no significant difference on Muslim Religiosity Personality Inventory(MRPI), [t (.52) = .50, p= ns] among government and private hospital hepatitis patients.

Table 11
Post Hoc Analysis for Age on Study Variable among Hepatitis (N= 240)

Variables	95% C.I		MD(I-J)	ED	P	LL	UL
	Age(I)	Age (J)					
SL	21-30	31-40	.016	.242	.94	-.461	.494
		41-50	-.495	.246*	.04	-.981	-.009
	31-40	21-30	-.011	.242	.94	-.494	-.009
		41-50	-.511	.302	.09	-1.10	.083
	41-50	21-30	.495	.246*	.04	.008	.981
		31-40	.511	.302	.09	-.083	1.10
PW	21-30	31-40	-.220	.248	.37	-.710	.269
		41-50	-.798	.252**	.002	-1.29	-.29
	31-40	21-30	.220	.248	.37	-.269	.720
		41-50	-.572	.309	.06	-1.18	-.037
	41-50	21-30	.793	.252**	.002	.295	1.29
		31-40	.572	.309	.06	-.037	1.18
RS	21-30	31-40	-.096	.255	.70	-.600	.407
		41-50	-.643	.260*	.01	-1.15	-.131
	31-40	21-30	-.096	.255	.70	-.407	.600
		41-50	-.547	.318	.08	-1.17	.080
	41-50	21-30	.643	.340*	.01	.131	1.15
		31-40	.547	.318	.08	-.080	1.17

*p<.05, **p<0.1, ***p<.001

Note: LS= Life Satisfaction, PW= Psychological Wellbeing, RS= Religiosity and Spirituality

Within group differences were further explored by using post hoc test in table no 11. The Results showed significant differences in the model between life satisfaction, psychological wellbeing and religiosity and spirituality in the term of age among hepatitis patients.

Discussion

The first hypothesis of the present study was that there would be significant relationship between religiosity and spirituality, life satisfaction and psychological wellbeing among hepatitis patients. It was checked by using the independent sample t-test. The results indicate significant relationship of religiosity and spirituality, life satisfaction and psychological wellbeing among hepatitis patients. The value Pearson correlation analysis shows $R^2 = .85$. Some studies confirm role of religiosity and spirituality in psychological wellbeing (Nelson-Becker, 2005). Subject also reported that their religious and spiritual belief helps them to (Amadi et al., 2016). It is significant that spirituality has significant positive relationship with religiosity and psychological wellbeing (Mann et al., 2010).

The second hypothesis of the present study was that Life satisfaction would be predicted by religiosity and spirituality and psychological wellbeing among hepatitis C patients. It was checked by using multiple regression analysis and the results have shown that that religiosity and spirituality was the most significant predictor of Life Satisfaction among hepatitis patients. Religiosity and spirituality was also most significant predictor of psychological well-being. And explained .44% of the variance ($R^2 = .85$, $F(1) = 707.54$, $**p < .001$ in the model. Previous studies in literature have also found through analysis of multiple regressions that religiosity and spirituality was significantly positive relationship with psychological wellbeing (Anson et al., 1990; Coke, 1992; Bryant & Rakowski, 1992; Levin et al., 1995). Furthermore with sticking to (Ellison & Gay, 1990; Levin et al., 1995) there older studies indicate that spirituality and religiosity are also important for life satisfaction in positively. Other studies (Neighbors et al., 1983; Black, 1999) also supports that religiosity and spirituality also impact positively to create life satisfaction and believes that life satisfaction enhanced by religiosity and spirituality believes values.

The third hypothesis of the study was regarding the gender difference on religiosity and spirituality, life satisfaction and psychological wellbeing among hepatitis C patients. That there was a significant difference on Life Satisfaction Scale among male and female hepatitis patients. There was a significant difference on Reliability of Warwick-Edinburgh Mental Well-being Scale (WEMW), [$t(8.91) = 8.72$, $p = .000$] among male and female hepatitis patients. There are studies where women are more prone to psychological problems as compare to men in this study there is 34 percent of population in Pakistan who confront different type of psychological issues in their life this is said by annual report of Human Rights Commission (Kundi, 2011). There are other researches who supports that women are shown higher prevalence of spirituality as compare to men. (Knox et al., 1998; Reker, 1999). Studies suggested that to some extent men and women are similar on mechanisms of

psychological characteristics (Hyde, 2014). Donahue (1985) said that women are more into religiosity as compare to men.

The 4th hypothesis focused on difference of age groups (21-30 year, 31-40 year, and 41-50 year) on religiosity and spirituality, life satisfaction and psychological wellbeing among hepatitis C patients. Within group differences were further explored by using post hoc test. The Results showed significant differences in the model between life satisfaction, psychological wellbeing and religiosity and spirituality in the term of age among hepatitis patients. There is a significant relationship of age and religiosity, spirituality, life satisfaction and psychological wellbeing studies also supported the relationship of these variables (Stone et al., 2010).

It is purposed by previous researches that life satisfaction and psychological wellbeing change with age in different times in life of an individual (Campel et al., 1976). According to Baltes & Mayer (1999) health status and social contact of a person change rapidly in a person life by aging older and these all social contacts which got limited or decreased with the time in old age affect person mental and physical health and leads to worse life satisfaction.

On the other hand, different theories said that life satisfaction increased when person age got increased (Carstensen, 1995).

The fifth hypothesis of the present study was that There would be significant difference between socio-economic status (lower and middle) on religiosity and spirituality, life satisfaction and psychological wellbeing among hepatitis C patients.

Results shows that there was a significant difference on Life Satisfaction Scale (LSS), [t (3.98) = 4.27, p=.001] among middle and lower class hepatitis patients. There was a significant difference on Reliability of Warwick-Edinburgh Mental Well-being Scale (WEMW), [t (3.31) = 3.318, p= .001] among middle and lower class hepatitis patients. There was no significant difference on Muslim Religiosity Personality Inventory (MRPI), [t (1.16) = 1.06, p= ns] among middle and lower class hepatitis patients. Researchers purposed that high level of income decreased participation of religious and spiritual and low level of income increased participation of religiosity and spirituality (Huza, 2020). Other studies also depicts that low income leads to an individual to decreased life satisfaction and worse the health of a person (Carstensen, 1995).

The sixth hypothesis was that there would be significant difference between nuclear and joint family structure on religiosity and spirituality, life satisfaction and psychological wellbeing among hepatitis C patients. Results shows that there was a significant difference on Life Satisfaction Scale (LSS), [t (1.98) = 1.99, p=.04] among nuclear and joint family hepatitis patients. There was a significant difference on Reliability of Warwick-Edinburgh Mental Well-being Scale (WEMW), [t (1.795) = 1.794, p= .05] among nuclear family and joint family hepatitis patients. There was a

significant difference on Muslim Religiosity Personality Inventory(MRPI), [t (1.78) = 1.76, p=.05] among nuclear and joint family hepatitis patients.

According to Luong (2010) the elderly families have significant relationship with psychological wellbeing than younger adult families; religious families are biggest and main support for elderly as they have religious and spiritual oriented nurture in psychological wellbeing. Krause (2013) said that elderly families have more strengthen orientation towards spirituality.

The seventh hypothesis of study was that there would be significant difference between marital status (unmarried and married) on religiosity and spirituality, life satisfaction and psychological wellbeing among hepatitis C patients. Markides (1983) find out that religiosity predict higher level of life satisfaction in marital status. Married person have higher level of life satisfaction and mental or physical health. Mirowsky and Green and Elliott (2010) suggest that marital status have higher level of mental health. Married individual have increased level of marital satisfaction which is interlinked with higher level of psychological wellbeing (Ellison et al. 1989; Ellison, 2010).

The last hypothesis was that there would be significant difference between mode of treatment (taking treatment from government hospital and taking treatment from private hospital) on religiosity and spirituality, life satisfaction and psychological wellbeing among hepatitis C patients. Table no. 10 shows that there was a significant difference on Life Satisfaction Scale (LSS), [t (2.75) = 2.85, p=.01] among government and private hospital hepatitis patients. There was a significant difference on Reliability of psychological wellbeing [t (3.07) = 3.14, p= .01] among government and private hospital hepatitis patients. There was no significant difference on Muslim Religiosity Personality Inventory (MRPI), [t (.52) = .50, p= ns] among government and private hospital hepatitis patients.

Conclusion

Main objectives of the study were to examine the relationship between religiosity and spirituality, life satisfaction and psychological wellbeing and to check the role of religiosity and spirituality as a predictor of life satisfaction and subjective wellbeing among hepatitis patients. Moreover the study also intended to see the effect of demographic variables (gender, age, socio-economic status) on study variables among (religiosity and spirituality, life satisfaction and psychological wellbeing) hepatitis C patients. By the extensive researches it was assumed that there was a significant relationship among spirituality and religiosity, life satisfaction and psychological wellbeing. It was a purposive study and the sample size was two hundred and forty which consist one hundred and twenty males and one hundred and twenty females. The age range of the sample between 21 to 50 which further divided into three parts. The data were collected from the hospital of Faisalabad, Lahore and Pakpattan. For personal information a demographic sheet was prepared. The sample has to fill three urdu translated scales named as Religious Personality

Scale of Muslim Religiosity-Personality Inventory (MRPI) (2005), Life Satisfaction Scale (LSS) (Mahmood, 2012) and Warwick-Edinburgh Mental Well-being Scale (WEMWBS) Brown & Janmohamed, (2008). Statistical Package for social Sciences version 22 (SPSS-22) was used for statistical analysis. The results showed that the reliability values of all the scales are significant. The results also showed that there is a positive significant relationship among all the variables, and that religion and spirituality were significant predictors of life satisfaction and subjective wellbeing among hepatitis patients.

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