Cyprus Turkish Journal of Psychiatry & Psychology Vol.7 Issue.2
Doi:10.35365/ctjpp.25.2.01

RESEARCH ARTICLE / ARAŞTIRMA YAZISI

The Relationship Between Religious Orientation and Psychological Distress Symptoms

Dini Yönelim ve Psikolojik Sıkıntı Belirtileri Arasındaki İlişkiler

Gönül Taşçıoğlu[1], Fatma Gül Cirhinlioğlu[2], Ebru Tansel[3]

Abstract:

The aim of this study is to determine the relationships between religious orientations and symptoms of psychological distress. The study was carried out with 341 adult female and 236 adult male participants residing in the TRNC. Personal Information Form, Religious Orientation Scale (ROS, Allport and Ross, 1967) and Symptom Checklist-90 (SCL-90, Derogatis, et al., 1973) were used to collect research data. The Independent sample t-test was used to compare SCL-90 scores according to the participants' intrinsic and extrinsic religious orientation. There is a statistically significant difference between the scores of the participants with low and high intrinsic orientation in the SCL-90 and in the sub-dimensions of Interpersonal Sensitivity, Anxiety, Phobic Anxiety, Paranoid Ideation and Psychoticism. Interpersonal Sensitivity, Anxiety, Phobic Anxiety, Paranoid Ideation and Psychoticism and general scores of the participants whose intrinsic orientation scores were in the last 27% (higher) were found to be significantly higher than those in the first 27% (lower). Independent sample t-test results comparing SCL-90 scores according to participants' extrinsic orientation showed that there were statistically significant differences between the scores of participants with low and high extrinsic orientation on the SCL-90 and the Interpersonal Sensitivity, Phobic Anxiety, Paranoid Ideation and Psychoticism subscales. The Interpersonal Sensitivity, Phobic Anxiety, Paranoid Ideation and Psychoticism and General symptom scores of the participants whose extrinsic orientation scores were in the last 27% (high) were found to be significantly higher than the participants whose extrinsic orientation scores were in the first 27% (low). The findings were discussed in the light of the literature.

Keywords: Religious orientation, Symptoms of psychological distress, Islam.

[1]Asst. Prof. Dr., University of Kyrenia, Department of Psychology, Kyrenia, TRN Cyprus, E-mail: gonul.tascioglu@kyrenia.edu.tr, Orcid Id: 0000-0001-7334-9586

[2]Prof. Dr., Cyprus Health and Social Sciences University, Department of Psychology, Morphou, TRN Cyprus, E-mail: fgcirhinlioglu@gmail.com, Orcid Id: 0000-0002-1140-2043

[3]Prof. Dr., Cyprus Health and Social Sciences University, Department of Psychology, Morphou, TRN Cyprus, E-mail: dr.ebrutansel@gmail.com, Orcid Id: 0000-0002-6106-5911

Address of Correpondence/Yazışma Adresi: Gönül Taşcıoğlu, University of Kyrenia, Şehit Yahya Bakır Street, Karakum 99320, Kyrenia TRNC, gonul.tascioglu@kyrenia.edu.tr

Date of Received/Geliş Tarihi: 12.11.2024, **Date of Revision/Düzeltme Tarihi:** 18.03.2025, **Date of Acceptance/Kabul Tarihi:** 18.03.2025, **Date of Online Publication/Çevirimiçi Yayın Tarihi:** 14.05.2025

Citing/Referans Gösterimi: Taşçıoğlu, G., Cirhinlioğlu, F. G. & Tansel, E. (2025). The Relationship Between Religious Orientation and Psychological Distress Symptoms. *Cyprus Turkish Journal of Psychiatry & Psychology*, 7(2), 114-122

Öz:

Bu çalışmanın amacı dini yönelimler ile psikolojik sıkıntı belirtileri arasındaki ilişkileri saptamaktır. Çalışma KKTC'de ikamet eden yetişkin 341 kadın ve 236 erkek katılımcı ile gerçekleştirilmiştir. Araştırma verilerinin toplanmasında, Kişisel Bilgi Formu, Dini Yönelim Ölçeği (The Religious Orientation Scale–ROS, Allport ve Ross, 1967) ve SCL-90 Belirti Tarama Listesi (Derogatis, vd., 1973) kullanılmıştır. Katılımcıların içsel ve dışsal dini yönelim durumlarına göre SCL-90 puanlarının karşılaştırılmasında bağımsız örneklem t testi kullanılmıştır. İçsel yönelimi düşük olan ve yüksek olan katılımcıların SCL-90 genelinden ve Kişilerarası Duyarlılık, Anksiyete, Fobik Anksiyete, Paranoid Düşünce ve Psikotizm alt boyutlarından aldıkları puanlar arasında istatistiksel olarak anlamlı düzeyde farkların olduğu saptanmıştır. İçsel yönelim puanları son %27'lik (yüksek olan) dilimde olan katılımcıların Kişilerarası Duyarlılık, Anksiyete, Fobik Anksiyete, Paranoid Düşünce ve Psikotizm ve Genel puanları ilk %27'lik (düşük olan) dilimde olan katılımcılara göre anlamlı düzeyde yüksek bulunmuştur. Katılımcıların dışsal yönelimine göre SCL-90 puanlarının karşılaştırılmasına ilişkin bağımsız örneklem t testi sonuçları dışsal yönelimi düşük ve yüksek olan katılımcıların SCL-90 genelinden ve Kişilerarası Duyarlılık, Fobik Anksiyete, Paranoid Düşünce ve Psikotizm alt boyutlarından aldıkları puanlar arasında istatistiksel olarak anlamlı düzeyde fark olduğunu göstermiştir. Dışsal yönelim puanları son %27'lik (yüksek olan) dilimde olan katılımcıların Kişilerarası Duyarlılık, Fobik Anksiyete, Paranoid Düşünce ve Psikotizm ve Genel belirti puanları ilk %27'lik (düşük olan) dilimde olan katılımcılara göre anlamlı düzeyde yüksek bulunmuştur. Bulgular literatür eşliğinde tartışılmıştır.

Anahtar Kelimeler: Dini yönelim, Psikolojik sıkıntı belirtileri, İslam.

Introduction

In the field of the psychology of religion, there are many ways in which an individual's religiosity can be measured. In the Measures of Religiosity (Hill & Hood, 1999) a classic review of religiosity measures, a total of 125 scales were listed. Religiosity studies are generally categorized into substantive and functional approaches (Hill & Pargament, 2017). Substantive approaches focus on religious *beliefs* and *practices*, while functional approaches focus on people's *motivations* for religious participation. Although defining what constitutes religious beliefs varies from theory to theory, most definitions include features such as accepting the search for holiness in life and approving a relationship with a higher power regardless of the religious group (Larson, Swyers, & McCullough, 1997). Religious beliefs also include certain characteristics attributed to God (Miller & Thoresen, 1999). For example, God can be seen as a source of punishment and fear for sinners or as a loving being who provides support and forgiveness (Pargament, Koenig, & Perez, 2000). Religious practices represent the behavioral component of religiosity. Religious practices can be represented in two sub-forms: personal and public religious practices. Personal religious practices are religious behaviors performed alone. Such practices include prayer, meditation, and exploration of religious topics. Public religious practices involve participation in an organized religious group. The concept of religious motivation is used by psychologists to describe the way a person practices or lives religious beliefs and values (Allport and Ross, 1967). Many ideas have been put forward about what motivates the behavior of believing in a religion and following a religious group and the function of religion. For example, according to Freud, God is nothing but the glorified father, and our personal relationship with God depends on our relationship with our biological father (Freud, 1913, cited in Batson, et al., 1993). Some other theorists have discussed religious motivations by basing them on the functions served by religion (Allport and Ross, 1967).

This study will focus on the functional approach, namely what motivates people to believe in Islam. The Religious Orientation Scale (ROS) developed (Allport & Ross, 1967) to assess motivation will be used as the main construct to measure the participants' religiosity**.** According to Allport, people's motivations for participating in religion vary. Allport proposed the Intrinsic/Extrinsic theory of religious orientation. Extrinsic religious orientation refers to the utilitarian mentality underlying religious behavior. A person endorses religious beliefs or engages in religious activities to help achieve other goals, such as feeling comfortable or gaining social approval. It focuses on the benefits that religion can provide for a person. Individuals with an intrinsic religious orientation, on the other hand, view religion as a primary motivation while other needs, regardless of how strong they are, are considered of less ultimate significance (Allport & Ross, 1967)**.** In other words, religion serves as an integrative framework for different aspects of an individual's life. The extrinsic-intrinsic distinction can be thought of as an individual "using" or "living" his or her own religion.

Empirical studies have shown that individuals with an intrinsic religious orientation tend to be more psychologically well-adjusted than those with an extrinsic religious orientation. A meta-analytic review of intrinsic and extrinsic religious orientation was conducted and reviewed 67 studies of intrinsic-extrinsic religious orientation distinctions published in English before 1982 (Donahue, 1985). The main findings were that intrinsic religious orientation was negatively correlated with trait anxiety and positively correlated with intrinsic locus of control and purpose in life. Extrinsic religious orientation, on the other hand, was positively related to negatively evaluated traits such as prejudice, trait anxiety, dogmatism, and fear of death. Another meta-analytic study involving 147 independent studies (N=98, 975) showed that extrinsic religious orientation was associated with higher levels of depressive symptoms (Smith et al., 2003). Studies have generally shown that there is a significant negative relationship between intrinsic religious orientation and psychological distress, and a significant positive relationship between extrinsic religious orientation and psychological distress (Aktay & Sayar, 2021; Bergin et al., 1987; Bravo et al., 2016; Kuyel et al., 2012; Sanders et al., 2015). Studies have generally

identified a negative relationship between intrinsic religious orientation and anxiety, especially death anxiety, (Bergin et al., 1987; Bravo et al., 2016; Sanders et al., 2015) neuroticism (Chau et al., 1990) and depression (Sanders et al., 2015; Bravo et al., 2016). Extrinsic religious orientation was shown to have a significant positive relationship with anxiety (Bergin et al., 1987; Kuyel et al., 2012), depression (Kuyel et al., 2012), hostility (Kuyel et al., 2012) and fear of death (Kraft et al., 1987). Steffen et al. conducted an empirical study to examine the relationship between religious orientation and well-being. Intrinsic religious orientation was found to be positively related to positive effects and life satisfaction, and negatively associated with negative effects (Steffen et al., 2015). Intrinsic religious orientation has been found to be associated with self-acceptance, positive emotion, and life satisfaction (Singh & Bano, 2017; Steffen et al., 2015) and additionally to lower suicidal tendencies, hostility, paranoid thoughts, antisocial personality, avoidant personality, depressive, ADHD and somatic problems (Lew et al., 2018; Power and McKinney, 2014; Salsman and Carlson, 2005) as well as decreased participation in health-risky behaviors (Pule et al., 2019)**.** Unlike intrinsic religious orientation, having an extrinsic religious orientation is not significantly associated with well-being (Singh & Bano, 2017). Extrinsic religious orientation has been associated with multiple negative outcomes. For example, extrinsic religious orientation is negatively related to empathy (Watson et al., 1984). It is also associated with depressive symptoms (Kuyel et al., 2012; Smith et al., 2003) and has been identified as a potential contributing factor to maladaptive perfectionistic tendencies (Ashby & Huffman, 1999). Additionally, extrinsically oriented approaches to religion may be related to increased anxiety (Kuyel et al., 2012).

On the other hand, studies have generally consistently shown that there is a significant negative relationship between intrinsic religious orientation and anxiety and a significant positive relationship between extrinsic religious orientation and anxiety (Bergin et al., 1987; Kuyel et al., 2012) while the relationship between religious orientation and depression is less consistent. Although there is generally a negative relationship between intrinsic religious orientation and depression and a positive relationship between extrinsic religious orientation and depression, some studies have not found a significant difference between the depression levels of individuals with intrinsic or extrinsic religious orientations (Rosik, 1989). In other studies, it was found that while intrinsic religious orientation showed a positive relationship with depression, no significant relationship was found between extrinsic religious orientation and depression (Bergin et al., 1987; Park et al., 1990). Moreover, some studies have not consistently identified negative effects associated with extrinsic religious orientation.

In a study examining religiosity in pre-adolescents and adolescents, no significant difference was observed in psychological adjustment related to intrinsic and extrinsic religious orientation, but it was determined that better mental health was associated with religious participation, regardless of intrinsic or extrinsic religious orientation (Milevsky & Levitt, 2004). In a study examining the relationship between extrinsic religious orientation and various types of psychopathologies among university students, no significant relationship was found. The study suggested that intrinsic religiosity is not associated with low anxiety, and that intrinsic religiosity may reduce some types of anxiety and exacerbate others. For example, those with a high degree of intrinsic religious orientation may feel more comfortable with the stressors of daily life. However, they may also face greater pressure regarding their religious practices (Power & McKinney, 2014).

In this study, based on Allport's (Allport, 1966) intrinsic-extrinsic religious motivation theory, which is the most influential theory in explaining the relationship between religion and mental health, it was examined whether different religious motivations have different implications for mental health and answers were sought to the following questions.

1. Is there a significant relationship between intrinsic religious orientation and psychological symptoms?
2. Is there a significant relationship between extrinsic religious orientation and psychological symptoms?

Materials and Method

Participants

The research is a descriptive study and correlational survey model was used. The research was conducted with 341 female and 236 male participants living in the TRNC, with an average age of 39.04±11.01. Participation was voluntary and participants were retrieved via the convenience sampling method.

Procedure

The research was initiated in 2019 with the approval of the Near East University Human Research Ethics Committee with the project number NEU /SB/2019 /382. The participants were informed about the study, and verbal and written consent was obtained. In the research, the Informed Voluntary Consent Form, Personal Information Form, ROS, and SCL-90 were administered to 577 participants. Participants were informed about the purpose of the research, that their personal information would remain confidential, that no identification information would be used, and approximately how long it would take to fill out the scales (15-20 minutes). In addition, participants were informed about the process of completing the scales and that participation was voluntary. Participants filled out the scales themselves. All procedures performed in studies involving human participants were conducted in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards.

Measurements

The Personal Information Form, Religious Orientation Scale (ROS) (Allport & Ross, 1967), and SCL-90 Symptom Checklist (Derogatis et al., 1973) were used as data collection tools in the study.

Personal Information Form: The personal information form consists of questions containing demographic information such as the participants' age, gender, profession, and educational status.

Religious Orientation Scale (ROS): The ROS, developed by Allport and Ross (1967) and consisting of 20 items, is a Likert-type scale. The ROS is used to evaluate the way a person practices or lives his/her religious beliefs and values. It consists of 9 items expressing intrinsic religious orientation and 11 items expressing extrinsic religious orientation. Each of the religious orientation dimensions

reflects different motivations for being religious. While the intrinsically oriented person accepts religion as an important goal in itself, the extrinsically oriented person sees religion as a useful tool to achieve his/her goals (Allport, 1966). Various studies have reported that the Cronbach's alpha intrinsic consistency coefficients of the scale vary between .67 and .93 for the intrinsic religious orientation subscale and .76 and .85 for the extrinsic religious orientation subscale (Donahue, 1985). In the Turkish adaptation study of the ROS, two sub-dimensions were found (Cirhinlioğlu, 2006). The Cronbach's alpha intrinsic consistency coefficient of the ROS adapted to Turkish was found to be α=.87 for the Intrinsic Religious Orientation sub-dimension and α=.60 for the Extrinsic Religious Orientation sub-dimension.

Symptom Checklist-90 (SCL-90): The SCL-90 is a psychiatric symptom checklist tool based on self-assessment. The scale, consisting of 90 items, measures the general psychopathology level and the level of strain in terms of psychological symptoms. The Turkish validity and reliability study of this scale, developed by Derogatis et al. (Derogatis, 1973), was conducted by Dağ (Dağ, 1991). It consists of a total of 10 subscales that evaluate 9 different symptom clusters, one of which provides additional information. Subscales are (a) somatization (SOM), (b) anxiety (ANX), (c) depression (DEP), (d) obsessive-compulsive (O-C), (e) interpersonal sensitivity (I-S), (f) hostility (HOS), (g) paranoid ideation (PAR), (h) psychoticism (PSY), (i) phobic anxiety (PHOB) and (j) additional items. It is a Likert-type scale with each item given a score between 0-4. The increase in the Global Severity Index (GSI), which is the overall average score of the scale, indicates an increase in the distress felt by the individual about psychiatric symptoms and is the best index of the scale. In the interpretation of each subscale score and the GSI score, scores between 0.00-1.5 indicate 'normal symptom levels', scores between 1.51-2.5 indicate 'high symptom levels', and scores between 2.51-4.00 indicate 'very high symptom levels.

Statistical Analysis

Statistical analyses conducted to reveal the research findings were carried out using SPSS 24.0 software. The socio-demographic characteristics of the participants were shown with frequency analysis, and their scores from the Religious Orientation Scale and SCL-90 scales were shown with descriptive statistics. The Kolmogorov-Smirnov test, QQ plot and skewness-kurtosis values were examined, and it was determined that the data conformed to normal distribution.

Results

Table 1 shows the distribution of the socio-demographic characteristics of the individuals included in the research.

Table 1. *Sociodemographic characteristics of the participants*

	Frequency (n)	**Valid Percent (%)**
Gender		
Female	341	59.10
Male	236	40.90
Age (x±s)	39,04±11,01	
Education		
Primary	111	19.24
High school	176	30.50
University	290	50.26
Birthplace		
North Cyprus	289	50.09
Turkey	257	44.54
Other	31	5.37
Place of residence		
Village/town	128	22.18
City	410	71.06
Metropol	39	6.76

As shown in Table 1, in terms of gender, 59.10% of the participants were female and 40.90% were male. The mean of age was 39.04±11.01. 19.24% of them were primary school graduates, 30.50% were high school graduates and 50.26% were university graduates. 50.09% were born in the TRNC, and 44.54% were born in the Turkish Republic (TR). In terms of the place of residence, 22.18% lived in villages/towns, 71.06% in cities and 6.76% in the metropolis.

Descriptive statistics regarding the participants' ROS and SCL-90 scores are given in Table 2.

Table 2. *Religious Orientation Scale (ROS) and Symptom Check List 90 (SCL-90) scores of the participants.*

	n	$\bar{x}$	s	Min	Max
ROS- Intrinsic Orientation	577	33.96	9.87	11.00	55.00
ROS- Extrinsic Orientation	577	35.05	9.92	11.00	55.00
SCL90 Somatization (SOM)	577	0.93	0.83	0.00	4.00
SCL90 Obsessive- Compulsive (O-C)	577	1.04	0.81	0.00	4.00
SCL90 Interpersonal Sensitivity (I-S)	577	0.87	0.81	0.00	3.78
SCL90 Depression (DEP)	577	0.95	0.87	0.00	4.00
SCL90 Anxiety (ANX)	577	0.74	0.77	0.00	4.00
SCL90 Hostility (HOS)	577	0.82	0.83	0.00	3.67
SCL90 Phobic Anxiety (PHOB)	577	0.55	0.74	0.00	4.00
SCL90 Paranoid Ideation (PAR)	577	0.91	0.82	0.00	4.00
SCL90 Psychoticism (PSY)	577	0.62	0.75	0.00	3.60
SCL90 General Severity Index (GSI)	577	0.84	0.72	0.00	3.83

In Table 2, it was indicated that the participants scored 33.96±9.87 from the intrinsic religious orientation and 35.05±9.92 from the extrinsic religious orientation in the ROS. Participants scored 0.93±0.83 from Somatization, 1.04±0.81 from Obsessive-Compulsive Symptoms, 1.04±0.81 from Interpersonal Sensitivity, and 0.95±0.87 from Depression, 0.74±0.77 from Anxiety, 0.82±0.83 from Hostility, 0.55±0.74 from Phobic Anxiety, 0.91±0.82 from Paranoid Ideation, 0.62±0.75 from Psychoticism and 0.84±0.72 from the General Severity Index (GSI) of SCL90.

Table 3 provides the independent sample t test results comparing SCL-90 scores of the participants according to their intrinsic orientation status.

. **Table 3.** *Comparison of the participants' SCL-90 scores according to Intrinsic Religious Orientation*

	Intrinsic Orientation	***n***	$\bar{x}$	***s***	***T***	***p***
SOM	*Upper 27%*	*139*	*0.87*	*0.84*	*-0.842*	*0.401*
	Lower 27%	*139*	*0.95*	*0.90*		
O-C	*Upper 27%*	*139*	*0.97*	*0.83*	*-0.980*	*0.328*
	Lower 27%	*139*	*1.07*	*0.86*		
I-S	*Upper 27%*	*139*	*0.66*	*0.73*	*-3.238*	*0.001**
	Lower 27%	*139*	*0.98*	*0.89*		
DEP	*Upper 27%*	*139*	*0.84*	*0.86*	*-1.644*	*0.101*
	Lower 27%	*139*	*1.02*	*0.95*		
ANX	*Upper 27%*	*139*	*0.59*	*0.66*	*-2.441*	*0.015**
	Lower 27%	*139*	*0.81*	*0.82*		
HOS	*Upper 27%*	*139*	*0.69*	*0.79*	*-1.302*	*0.194*
	Lower 27%	*139*	*0.81*	*0.80*		
PHOB	*Upper 27%*	*139*	*0.34*	*0.59*	*-4.413*	*0.000**
	Lower 27%	*139*	*0.71*	*0.79*		
PAR	*Upper 27%*	*139*	*0.71*	*0.78*	*-2.915*	*0.004**
	Lower 27%	*139*	*1.00*	*0.87*		
PSY	*Upper 27%*	*139*	*0.42*	*0.63*	*-3.563*	*0.000**
	Lower 27%	*139*	*0.73*	*0.81*		
GSI	*Upper 27%*	*139*	*0.70*	*0.65*	*-2.524*	*0.012**
	Lower 27%	*139*	*0.92*	*0.78*		

p<0.05

As seen in Table 3, the participants in the upper 27% segment in terms of their scores from the intrinsic orientation sub-dimension of the ROS were determined to have low intrinsic orientation, and the participants in the lower 27% segment were determined to have high intrinsic orientation. It was determined that the participants whose intrinsic orientation scores were in the lower 27% (high) had significantly higher Interpersonal Sensitivity, Anxiety,

Phobic Anxiety, Paranoid Ideation, Psychoticism and Global Severity Index scores than the participants whose intrinsic orientation scores were in the upper 27% (low). In Table 4 the independent sample t test results are given for the comparison of SCL-90 scores according to the participants' extrinsic orientation status, and participants with low and high extrinsic orientation are evaluated on the basis of the ROS.

Table 4. *Comparison of the SCL-90 scores of the participants according to Extrinsic Religious Orientation.*

	Extrinsic Orientation	**N**	$\bar{x}$	**s**	**t**	**p**
SOM	Upper 27%	139	0.90	0.86	-1.124	0.262
	Lower 27%	139	1.02	0.92		
O-C	Upper 27%	139	1.00	0.83	-1.093	0.276
	Lower 27%	139	1.11	0.86		
I-S	Upper 27%	139	0.72	0.76	-2.795	0.006*
	Lower 27%	139	1.00	0.89		
DEP	Upper 27%	139	0.88	0.88	-1.583	0.115
	Lower 27%	139	1.05	0.94		
ANX	Upper 27%	139	0.67	0.72	-1.478	0.140
	Lower 27%	139	0.80	0.81		
HOS	Upper 27%	139	0.76	0.81	-0.899	0.370
	Lower 27%	139	0.85	0.82		
PHOB	Upper 27%	139	0.41	0.64	-3.317	0.001*
	Lower 27%	139	0.69	0.77		
PAR	Upper 27%	139	0.79	0.81	-2.244	0.026*
	Lower 27%	139	1.02	0.88		
PSY	Upper 27%	139	0.49	0.68	-2.424	0.016*
	Lower 27%	139	0.71	0.80		
GSI	Upper 27%	139	0.76	0.69	-2.007	0.046*
	Lower 27%	139	0.93	0.78		

p<0.05

Table 4 shows that Interpersonal Sensitivity, Phobic Anxiety, Paranoid Ideation, Psychoticism and Global Severity Index scores of the participants whose extrinsic orientation scores were in the lower 27% (high) segment were found to be significantly higher than the participants whose extrinsic orientation scores were in the upper 27% (low) segment.

Discussion

Literature has generally shown a significant positive relationship between extrinsic religious orientation and psychological distress (Bergin et al., 1986; Bravo et al., 2015; Kuyel et al., 2012; Sanders et al., 2015). However, the literature generally shows a significant negative relationship between intrinsic religious orientation and psychological distress (Bergin et al., 1986; Bravo et al., 2015; Kuyel et al., 2012; Sanders et al., 2015).

The study findings show that there is a positive relationship between religious orientation and the Interpersonal Sensitivity, Phobic Anxiety, Paranoid Ideation, Psychoticism and GSI score averages, regardless of whether the religious orientation is intrinsic or extrinsic. On the other hand, anxiety level has a significant positive relationship with only intrinsic orientation.

The relationship between religion and mental health and well-being has been the focus of numerous empirical studies for more than three decades. Studies have found a significant positive relationship between many forms of religious experience and physical and mental health. Religiosity can affect psychological well-being both directly and indirectly. There are various mechanisms that explain the observed positive relationship between religiosity and psychological well-being. These mechanisms are the function of religion to establish social relationships, strengthen social participation and provide social support, using religion as a coping strategy and beneficial health practices recommended by religion (Aziz, 2024). Religious participation effect health and well-being by providing individuals with the opportunity to engage with other people. Establishing close relationships with others can serve as a buffer against the effects of stressful life events on mental and physical health (Gülpak & Babayiğit, 2024). Considering the results of this study, it is thought that having an intrinsic religious orientation is not effective in reducing individuals' feelings of psychological distress in the TRNC culture and religious tradition. This may be explained by referring to the classical understanding of religion which basically identified four functions of all religions: social cohesion, order, stability and preventing radical change (Durkheim, 1912). According to this view, any social structural change would influence these functions.

For example, a war that society went through would break cohesion, order, the stability of that society and trigger radical changes. So, trust in religion would get loosened or weakened and finally individuals create some borders between their lives and their religion. Individuals living in TRNC have been exposed through its long history to many social and political problems such as war between north and south sides of Cyprus, many other difficulties in establishing and ruling an independent state and welfare-based economy, getting recognized of this state by international community and so on. From this it can be followed that the religion may have lost its traditional meaning and functions in TRNC and play less effective role in individual's lives.

According to the study findings, when intrinsic religious orientation increases, anxiety level increases; however, this relationship is not seen in extrinsic religious orientation. There are different results in the literature on the relationship between anxiety and religious orientation. While some studies have found that intrinsic orientation reduces anxiety, others have not found such a relationship or even determined that it is in the opposite direction. This may be because while religious orientation reduces some forms of anxiety, it may also increase anxiety in other areas. In particular, people with a high intrinsic religious orientation may put pressure on themselves to practice religion and live a life consistent with their beliefs.

On the other hand, many theorists and researchers have tried to understand the relationship between religiosity and coping (Hackney & Sanders, 2003; Maltby & Day, 2003) and suggested that religion provides people with a tool for coping with stressful situations that arise from traumatic events. They claimed that it can alleviate the effects of events and stress. Accordingly, having faith is a coping strategy that can help alleviate the negative effects of negative life events (fatal diseases, disability, etc.). For example, when parents see themselves as chosen by God to raise their children born with developmental disabilities (because they have the ability to do this task), it helps the parents to reinterpret this situation in a positive framework without denying its negative impact. Thus, individuals with strong religious beliefs feel the impact of traumatic life events less. For example, it has been observed that elderly patients who use religious coping at a higher level are less likely to show cognitive symptoms of depression (helplessness, distress, demoralization) than patients who use moderate or lower levels of religious coping (Koenig et al., 1995). Caregivers who made a positive religious evaluation of their situation (believing that the situation was part of God's plans) achieved more positive results than caregivers who evaluated their situation negatively (a punishment from God, injustice, etc.) (Mickley, 1998). The results obtained in this study suggest that negative religious coping methods may have been used more frequently among the study participants instead of positive religious coping methods. In other words, individuals who tend to use positive religious coping styles believe that God has a reason for their actions and that the pain and trouble they experience has a meaning. In contrast, individuals who tend to engage in negative religious coping styles are more likely to believe that God has abandoned them or that the trouble and pain they experience is a form of punishment for their sinful behavior.

In addition, the positive relationship observed between intrinsic and extrinsic religious orientation and Interpersonal Sensitivity, Phobic Anxiety, Paranoid Ideation, Psychoticism and GSI can be explained by the participants' turning to religion to cope with psychological distress. It was shown that experiencing a psychotic illness can lead to increased religious beliefs (Kirov et al., 1998). Belief is often used when coping with illness. It was reported that 76.7% of patients receiving inpatient treatment with a diagnosis of psychotic disorder benefited from religious practices to face the disease (Serfaty & Strous, 2021).

In sum, researchers and theorists have put forward many explanations and theoretical models about how religiosity or participation in religious activities has a positive impact on mental and physical health. According to one of these explanations, religion positively affects adaptation and health by strengthening social bonds, making it easier to access social support, increasing coping resources, and providing a cognitive schema or interpretive framework. In this study, it is considered that in the sample group, religion did not fulfil its function of providing social support and relationship opportunities that provide emotional, cognitive and material benefits.

Study Limitations

Despite the importance of studying, it also has some limitations. In the study, a relational screening model was employed, which does not give an idea about the direction of the relationship between religious orientation and psychological stress. The average SCL-90 subscale and GSI scores of the study group ranged between 0.34-1.10. Subscale scores below 1.5 are considered normal. The psychopathology level of the research group is low. In future studies, participants may be recruited from a psychiatric patient group, which may provide more sensitive results.

Conclusion

In this study, it was determined that as the severity of Interpersonal Sensitivity, Phobic Anxiety, Paranoid ideation, Psychoticism and GSI increased, both intrinsic and extrinsic religious orientation increased. While the level of anxiety increased with intrinsic religious orientation, it was not associated with extrinsic religious orientation. Additionally, unlike the literature, it was found that having an intrinsic religious orientation was not associated with a decrease in psychological distress, on the contrary, having a high intrinsic religious orientation was associated with an increase in some symptoms and general psychological distress. This different result was thought to be related to the cultural characteristics of the sample. The results of the study suggested that having an intrinsic religious orientation in the TRNC culture and religious tradition is not effective in reducing psychological distress.

Declarations

Ethics Committee Approval

The research was initiated in 2019 with the approval of the Near East University Human Research Ethics Committee with the project number NEU /SB/2019 /382.

Consent for Publication

Not applicable.

Availability of Data and Materials

Not applicable.

Competing Interests

The author declares that there is no competing interest in this manuscript.

Funding
Not applicable.

Authors' Contributions
Gönül Taşçıoğlu, Fatma Gül Cirhinlioğlu and Ebru Tansel contributed greatly to the writing of the method and discussion sections of the article and the abstract. They also contributed to the overall writing and control of the article and to the analysis and interpretation of the research data. Likewise, the authors contributed to the writing of the introduction and discussion section of the article and data collection. All authors read and approved the final version of the manuscript.

References

Aktay, M., & Sayar, G. H. (2021). Psikiyatrik bozuklukların psikososyal yönü. *Kıbrıs Türk Psikiyatri ve Psikoloji Dergisi*, *3*(1), 48-55.

Allport, G. W. (1966). The religious context of prejudice. *Journal for the Scientific Study of Religion*, *5*(3), 447-457.

Allport, G. W., & Ross, J. M. (1967). Personal religious orientation and prejudice. *Journal of Personality and Social Psychology*, *5*(4), 432.

Ashby, J. S., & Huffman, J. (1999). Religious orientation and multidimensional perfectionism: Relationships and implications. *Counseling and Values*, *43*(3), 178-188.

Aziz, R. (2024). Teachers' Mental Health: a Mixed-Method Study on Spirituality, Well-Being, and Distress in the Workplace. *Cyprus Turkish Journal of Psychiatry & Psychology*, 6(3): 232-239

Batson, C. D., Schoenrade, P. A., & Ventis, W. L. (1993). *Religion and the Individual. A Social Psychological Perspective.* New York: Oxford University Press.

Bergin, A. E., Masters, K. S., & Richards, P. S. (1987). Religiousness and mental health reconsidered: A study of an intrinsically religious sample. *Journal of Counseling Psychology*, *34*(2), 197.

Bravo, A. J., Pearson, M. R., & Stevens, L. E. (2016). Making religiosity person-centered: A latent profile analysis of religiosity and psychological health outcomes. *Personality and Individual Differences*, *88*, 160-169.

Chau, L. L., Johnson, R. C., Bowers, J. K., Darvill, T. J., & Danko, G. P. (1990). Intrinsic and extrinsic religiosity as related to conscience, adjustment, and altruism. *Personality and Individual Differences*, *11*(4), 397-400.

Cirhinlioğlu, F. G. (2006). *The relationships among shame proneness, religious orientations, self-construals, psychological well-being within a university student group* (Doctoral dissertation). Hacettepe University, Institute of Social Sciences, Ankara.

Dag, I. (1991). Symptom check list (SCL-90-R): A reliability and validity study. *Türk Psikiyatri Dergisi, 2*(1), 5-12.

Derogatis, L. R., Lipman, R. S., & Covi, L. (1973). SCL-90: An outpatient psychiatric rating scale - Preliminary report. *Psychopharmacol Bull*, *9*(1), 13-28.

Donahue, M. J. (1985). Intrinsic and extrinsic religiousness: Review and meta-analysis. *Journal of Personality and Social Psychology*, *48*(2), 400.

Durkheim, Emile, Translated by Joseph Swain (1912). *The Elementary Forms of the religious life*. London: George Allen & Unwin Ltd.

Gülpak, D. & Babayiğit, A. (2024). Self-Change and Self-Efficacy in the Romantic Relationships, *European Archives of Social Sciences*, 1(1): 39-45

Hackney, C. H., & Sanders, G. S. (2003). Religiosity and mental health: A meta–analysis of recent studies. *Journal for the Scientific Study of Religion*, *42*(1), 43-55.

Hill, P. C., & Hood, R. W. (Eds.). (1999). *Measures of religiosity* (pp. 119-158). Birmingham, AL: Religious Education Press.

Hill, P. C., & Pargament, K. I. (2017). Measurement tools and issues in the psychology of religion and spirituality. In R. Finke & C. D. Bader (Eds.), *Faithful measures: New methods in the measurement of religion* (pp. 48–77). New York University Press.

Kirov, G., Kemp, R., Kirov, K., & David, A. S. (1998). Religious faith after psychotic illness. *Psychopathology*, *31*(5), 234-245.

Koenig, H. G., Cohen, H. J., Blazer, D. G., Kudler, H. S., Krishnan, K. R. R., & Sibert, T. E. (1995). Religious coping and cognitive symptoms of depression in elderly medical patients. *Psychosomatics*, *36*(4), 369-375.

Kraft, W. A., Litwin, W. J., & Barber, S. E. (1987). Religious orientation and assertiveness: Relationship to death anxiety. *Journal of Social Psychology*, *127*(1), 93-95.

Kuyel, N., Cesur, S., & Ellison, C. G. (2012). Religious orientation and mental health: A study with Turkish university students. *Psychological Reports*, *110*(2), 535-546.

Larson, D. B., Swyers, J. P., & McCullough, M. E. (1997). *Scientific research on sprituality and health: A Consensus Report.* Rockwille, MD: National Institute for Healthcare Research.

Lew, B., Huen, J., Yuan, L., Stack, S., Maniam, T., Yip, P., ... & Jia, C. X. (2018). Religious orientation and its relationship to suicidality: A study in one of the least religious countries. *Religions*, *9*(1), 15.

Maltby, J., & Day, L. (2003). Religious orientation, religious coping and appraisals of stress: Assessing primary appraisal factors in the relationship between religiosity and psychological well-being. *Personality and Individual Differences*, *34*(7), 1209-1224.

Mickley, J. R., Pargament, K. I., Brant, C. R., & Hipp, K. M. (1998). God and the search for meaning among hospice caregivers. *The Hospice Journal*, *13*(4), 1-17.

Milevsky, A., & Levitt, M. J. (2004). Intrinsic and extrinsic religiosity in preadolescence and adolescence: Effect on psychological adjustment. *Mental Health, Religion & Culture*, *7*(4), 307-321.

Miller, W. R., & Thoresen, C. E. (1999). Spirituality and Health. In W. R. Miller (Ed.), *Integrating Sprituality into Treatment: Resources for Practitioners*. Washington, DC: American Psychological Association.

Pargament, K. I., Koenig, H. G., & Pererz, L. M. (2000). The many methods of religious coping: Development and initial validation of the RCOPE. *Journal of Clinical Psychology*, 56, 519-543.

Park, C., Cohen, L. H., & Herb, L. (1990). Intrinsic religiousness and religious coping as life stress moderators for Catholics versus Protestants. *Journal of Personality and Social Psychology*, *59*(3), 562.

Power, L., & McKinney, C. (2014). The effects of religiosity on psychopathology in emerging adults: Intrinsic versus extrinsic religiosity. *Journal of Religion and Health*, *53*, 1529-1538.

Pule, H. M., Mashegoane, S., & Makhubela, M. S. (2019). Intrinsic religiosity and health risk behaviours among black university students in Limpopo, South Africa. *Journal of Religion and Health*, *58*, 937-948.

Rosik, C. H. (1989). The impact of religious orientation in conjugal bereavement among older adults. *The International Journal of Aging and Human Development, 28*(4), 251-260.

Sanders, P. W., Allen, G. K., Fischer, L., Richards, P. S., Morgan, D. T., & Potts, R. W. (2015). Intrinsic religiousness and spirituality as predictors of mental health and positive psychological functioning in Latter-day Saint adolescents and young adults. *Journal of Religion and Health, 54*, 871-887.

Serfaty, D. R., & Strous, R. D. (2021). Role of religion in psychotic illness in the Israeli ultra-orthodox Jewish population: Patient beliefs and expectations. *The Journal of Nervous and Mental Disease, 209(*2), 100-105.

Siegel, K., Anderman, S. J., & Schrimshaw, E. W. (2001). Religion and coping with health-related stress. *Psychology and Health, 16*(6), 631-653.

Singh, P., & Bano, S. (2017). Effect of Intrinsic-Extrinsic Religiosity on the Psychological Well-being of Adolescents. *Journal of Psychosocial Research, 12*(1).

Smith, T. B., McCullough, M. E., & Poll, J. (2003). Religiousness and depression: Evidence for a main effect and the moderating influence of stressful life events. *Psychological Bulletin, 129*(4), 614.

Steffen, P. R., Clayton, S., & Swinyard, W. (2015). Religious orientation and life aspirations. *Journal of Religion and Health, 54*, 470-479.

Watson, P. J., Hood Jr, R. W., Morris, R. J., & Hall, J. R. (1984). Empathy, religious orientation, and social desirability. *The Journal of Psychology, 117*(2), 211-216.