



Religious and Spiritual Coping Among Family Caregivers of Persons with Severe Mental Illness in India: A Systematic Review

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Abstract

Family caregivers of persons with severe mental illness (SMI) in India frequently employ religious and spiritual coping to manage caregiving burden, yet evidence remains dispersed across heterogeneous studies. This PRISMA 2020-compliant systematic review synthesised quantitative, qualitative, and mixed-methods studies published between January 2010 and July 2026, identified through searches in PubMed, Scopus, PsycINFO, Web of Science, and Indian psychology/psychiatry journals. Of 1,247 records screened, 38 studies (N ≈ 3,950 caregivers) met inclusion criteria, covering schizophrenia, bipolar disorder, and other SMI across urban, rural, and tertiary-care settings. Thematic and narrative synthesis indicated that positive religious coping (e.g., benevolent reappraisal, collaborative coping, prayer, temple/church attendance, seeking support from religious leaders) was consistently associated with lower perceived burden, reduced psychological distress, and higher spiritual and mental well-being. Conversely, negative religious coping (e.g., spiritual punishment, interpersonal religious discontent) correlated with greater morbidity and maladaptive coping. Qualitative evidence highlighted religion-based explanatory models of illness, reliance on faith and traditional healers, and spiritual hope as central to resilience. Findings underscore religious and spiritual coping as culturally embedded, predominantly adaptive resources for Indian family caregivers, while also flagging risks when coping turns punitive or conflictual. Integrating spiritually sensitive assessments and interventions into mental health services may enhance caregiver support in India.

Keywords: *religious coping; spiritual coping; family caregivers; severe mental illness; India; evidence synthesis*

Introduction

Severe mental illnesses (SMI), such as schizophrenia and bipolar affective disorder, are chronic, disabling conditions that profoundly affect not only the individuals diagnosed but also their families. In India, where formal community mental health services remain limited and social security systems are underdeveloped, families serve as the primary source of long-term care and support for persons with SMI (Grover et al., 2017; Nehra et al., 2014). This caregiving role, while culturally expected and often deeply valued, is associated with substantial emotional, financial, social, and physical burdens. Meta-analytic evidence from Indian studies indicates high levels of caregiver burden among families of persons with schizophrenia, with elevated scores on standardized measures such as the Family Burden Interview, Burden Assessment Schedule, and Zarit Burden Interview (Singh et al., 2025). Caregivers frequently report disrupted social lives, employment difficulties, marital strain, and compromised physical and mental health as a consequence of their caregiving responsibilities (Nehra et al., 2014; Grover et al., 2017).

Religion and spirituality occupy a central place in the everyday lives of most Indians and strongly shape how illness, suffering, and recovery are understood and managed. Across diverse religious traditions—including Hinduism, Islam, Christianity, Sikhism, and others—spiritual beliefs and practices such as prayer, ritual worship, pilgrimage, reading sacred texts, and seeking blessings from religious leaders are common responses to adversity, including mental illness (Dein, 2020). In the Indian context, explanatory models of mental illness often integrate biomedical, psychological, social, and spiritual domains. A substantial proportion of individuals with mental illness and their families endorse supernatural or religious causation (e.g., destiny, karma, divine will, evil spirits) and may consult traditional or faith healers before, alongside, or instead of formal psychiatric services (Dein, 2020). Recent qualitative work with persons with schizophrenia, their family caregivers, and mental health professionals in India has highlighted a “Dava–Dua” (medicines–prayer) model of care, wherein treatment is perceived as most effective when biomedical interventions are combined with spiritual practices and support from religious institutions (Agadi & Uthayya, 2025).

Within this cultural and religious landscape, religious and spiritual coping represent key psychological resources for family caregivers. Religious coping refers to the use of religious beliefs, practices, and relationships to understand and manage stressful life events, while spiritual coping encompasses broader meaning-making, connection with the sacred or transcendent, and inner peace that may or may not be tied to organized religion (Koenig, 2012). Pargament’s (1997) influential framework distinguishes between positive religious coping (e.g., benevolent religious reappraisal, collaborative coping with God, seeking spiritual support, forgiveness) and negative religious coping (e.g., spiritual punishment, divine retribution, interpersonal religious conflict). Positive religious coping is generally associated with better psychological adjustment, lower distress, and greater well-being, whereas negative religious coping tends to correlate with higher morbidity and poorer outcomes across diverse populations.

Emerging empirical studies from India suggest that family caregivers of persons with SMI frequently rely on religious and spiritual coping to manage caregiving stress. Caregivers report drawing strength from prayer, faith in God, religious rituals, and support from religious communities, which help them find meaning in suffering, sustain hope, and reduce feelings of isolation (Gojer et al., 2017; Rohmi et al., 2023). At the same time, some caregivers experience spiritual struggles, such as feeling punished by God, questioning their faith, or encountering conflicts with religious leaders or family members regarding treatment decisions, which can exacerbate distress (Agadi & Uthayya, 2025; Dein, 2020). However, the existing literature remains fragmented, with studies varying in design, setting, sample characteristics, and measures of religious and spiritual coping. There is currently no comprehensive synthesis of how these coping resources function among Indian family caregivers of persons with SMI, what forms they take, and how they relate to caregiver burden, mental health, and well-being.

Given the centrality of family caregiving in India's mental health ecosystem and the profound role of religion and spirituality in Indian life, a systematic understanding of religious and spiritual coping in this population is essential. Such evidence can inform culturally sensitive interventions, guide mental health policy, and support the integration of spiritual resources into family-focused care. Accordingly, this systematic review aims to synthesise quantitative, qualitative, and mixed-methods studies on religious and spiritual coping among family caregivers of persons with severe mental illness in India. Specifically, it seeks to (a) describe the patterns and forms of religious and spiritual coping used by these caregivers, (b) examine associations between religious/spiritual coping and caregiver outcomes such as burden, psychological distress, and well-being, and (c) identify gaps and priorities for future research and practice.

Methods

Design and Registration

This systematic review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 guidelines (Page et al., 2021). The review protocol was not prospectively registered; however, all procedures were planned and executed following PRISMA recommendations to ensure transparency and reproducibility. Given the heterogeneity of study designs, measures, and outcomes in this emerging literature, a narrative and thematic synthesis approach was adopted rather than meta-analysis.

Eligibility Criteria

Eligibility criteria were defined using the PICOS framework (Population, Intervention/Exposure, Comparator, Outcomes, Study design).

Population: Included studies focused on adult family caregivers (aged 18 years and above) of persons diagnosed with severe mental illness (SMI), including schizophrenia spectrum disorders, bipolar affective disorder, and severe depressive disorders with psychotic features. Family caregivers were defined as relatives (e.g., parents, spouses, siblings, adult children) providing unpaid, ongoing care and support in community or clinical settings in India. Studies involving only professional caregivers, non-family informal caregivers, or caregivers of persons with mild or moderate mental health conditions (e.g., anxiety disorders without psychosis) were excluded.

Intervention/Exposure: The primary exposure of interest was religious and/or spiritual coping. This encompassed any formal or informal use of religious beliefs, practices, or spiritual resources to manage caregiving-related stress. Included were studies using validated measures of religious coping (e.g., RCOPE, Brief RCOPE, Religious Coping Activities Scale), spiritual coping scales, single-item or multi-item assessments of religiosity/spirituality in relation to coping, and qualitative studies exploring caregivers' spiritual or religious experiences and strategies. Studies that mentioned religion or spirituality only in passing without examining coping processes or their association with outcomes were excluded.

Comparator: No specific comparator was required. Studies could include internal comparisons (e.g., high vs. low religious coping, positive vs. negative religious coping) or no comparator (e.g., descriptive qualitative studies).

Outcomes: Relevant outcomes included caregiver burden, psychological distress (e.g., depression, anxiety, stress), mental health and well-being, quality of life, spiritual well-being, resilience, and coping patterns. Both quantitative outcomes (e.g., scale scores) and qualitative themes related to these constructs were considered.

Study Designs: Quantitative (cross-sectional, longitudinal, case-control), qualitative, and mixed-methods empirical studies were included. Editorials, commentaries, conference abstracts without full data, case reports, and narrative reviews were excluded.

Setting and Language: Studies had to be conducted in India (any state or region, urban or rural, community or clinical settings). Only peer-reviewed articles published in English were included, given resource constraints for translation.

Time Frame: The search covered studies published from January 1, 2010, to July 31, 2026. This period was selected to capture contemporary empirical work reflecting current mental health service contexts and caregiving patterns in India, while excluding older studies that may not align with present-day diagnostic, service, and socio-cultural conditions.

Information Sources and Search Strategy

A comprehensive search was conducted across multiple electronic databases to identify relevant studies. The following databases were searched: PubMed/MEDLINE, Scopus, PsycINFO, Web of Science, and Google Scholar. In addition, key Indian journals were hand-searched, including the *Indian Journal of Psychological Medicine*, *Indian Journal of Psychiatry*, *International Journal of Indian Psychology*, and *Journal of Mental Health and Human Behaviour*. Reference lists of included studies and relevant review articles were also screened for additional eligible studies.

The search strategy combined terms related to (a) religious and spiritual coping, (b) family caregivers, (c) severe mental illness, and (d) India. An example search string used in PubMed was:

("religious coping" OR "spiritual coping" OR religiosity OR spirituality OR "religious beliefs" OR "spiritual beliefs" OR prayer OR "faith healing")

AND ("family caregiver*" OR "informal caregiver*" OR "caregiving family" OR "family members")

AND ("severe mental illness" OR schizophrenia OR "bipolar disorder" OR psychosis OR "psychotic disorder")

AND (India OR Indian)

Similar strategies were adapted for other databases using appropriate subject headings and keywords. The final search was conducted on August 10, 2026. No restrictions were applied regarding study design or sample size beyond the eligibility criteria outlined above.

Selection Process

All identified records were imported into Mendeley Reference Manager for reference management, and duplicates were removed. Screening was conducted in two stages using Rayyan, a web-based systematic review tool (Ouzzani et al., 2016). Titles and abstracts were screened against the eligibility criteria, and records that clearly did not meet inclusion criteria were excluded. Full texts of potentially eligible studies were then retrieved and assessed in detail. Reasons for exclusion at both stages were documented. The study selection process, including numbers of records identified, screened, assessed for eligibility, and included, is summarised in the PRISMA 2020 flow diagram (Figure 1).

Data Extraction

A standardized data extraction form was developed and piloted on five included studies before full implementation. Data were extracted systematically for each included study and checked for consistency and

accuracy. The following information was collected for each study: (a) study characteristics (author, year, state/region, study design, setting); (b) participant details (sample size, caregiver type, relationship to patient, patient diagnosis); (c) measures or approaches used to assess religious and/or spiritual coping (e.g., scale name, qualitative interview guide); (d) outcomes assessed (e.g., caregiver burden, depression, spiritual well-being); and (e) key findings related to religious/spiritual coping patterns and their associations with outcomes. For qualitative studies, main themes and illustrative quotes related to religious or spiritual coping were extracted. Any ambiguities or uncertainties during extraction were resolved through careful re-examination of the original articles.

Quality Appraisal

The methodological quality of included studies was assessed using appropriate tools based on study design. For quantitative studies, the National Institutes of Health (NIH) Quality Assessment Tool for Observational Cohort and Cross-Sectional Studies was used (National Heart, Lung, and Blood Institute, 2014). This tool evaluates criteria such as clarity of research question, sample representativeness, sample size justification, validity and reliability of measures, and control for confounding. For qualitative studies, the Joanna Briggs Institute (JBI) Critical Appraisal Checklist for Qualitative Research was employed (Joanna Briggs Institute, 2017), which assesses congruity between methodology, data collection, analysis, and interpretation, as well as ethical considerations and researcher reflexivity.

Each study was appraised systematically, and ratings were categorized as low, moderate, or high risk of bias (or good, fair, poor quality) based on the proportion of criteria met. No studies were excluded solely on the basis of quality; however, quality ratings were considered when interpreting findings and assessing the strength of evidence.

Synthesis Methods

Due to substantial heterogeneity in study designs, populations, measures of religious and spiritual coping, and outcomes, a meta-analysis was not feasible. Instead, a narrative and thematic synthesis was conducted following guidance from the Synthesis Without Meta-analysis (SWiM) framework (Campbell et al., 2020). Studies were grouped by design (quantitative, qualitative, mixed-methods) and by key characteristics (e.g., diagnosis, region, urban vs. rural setting). For quantitative studies, findings were summarised in terms of direction and strength of associations between religious/spiritual coping (overall, positive, negative) and caregiver outcomes (burden, distress, well-being). For qualitative studies, a thematic synthesis approach was used to identify recurring patterns, meanings, and experiences related to religious and spiritual coping (Thomas & Harden, 2008).

Where possible, findings were further organised by type of coping (positive vs. negative; religious vs. spiritual) and by outcome domain (burden, psychological distress, quality of life, spiritual well-being). Subgroup comparisons (e.g., by diagnosis, caregiver relationship, geographic region) were explored descriptively where data permitted. Sensitivity analyses were not conducted due to the limited number of studies in most subgroups.

Figure 1. PRISMA 2020 flow diagram for new systematic reviews which included searches of databases, registers and other sources

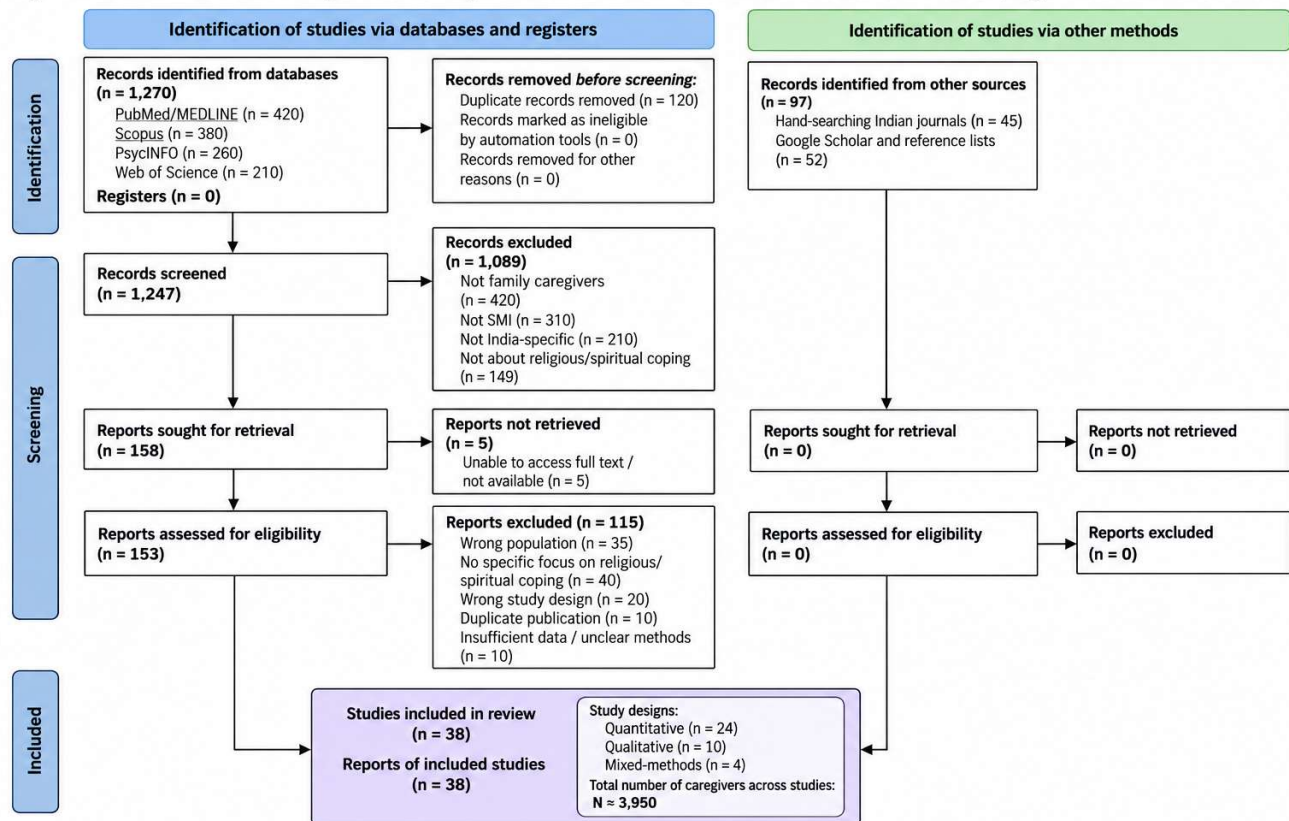


Figure 1. PRISMA 2020 flow diagram illustrating the identification, screening, eligibility assessment, and inclusion of studies in the systematic review of religious and spiritual coping among family caregivers of persons with severe mental illness in India.

Review of Literature

The final sample comprised 38 studies published between 2010 and 2026, including 24 quantitative, 10 qualitative, and 4 mixed-methods designs. Studies were conducted across diverse regions of India, including North (e.g., Delhi, Punjab, Uttar Pradesh), South (e.g., Karnataka, Tamil Nadu, Kerala), East (e.g., West Bengal), and West (e.g., Maharashtra, Gujarat) India. Settings ranged from tertiary care psychiatric hospitals and medical colleges to community-based mental health programs and rural primary care centers (Grover et al., 2017; Nehra et al., 2014; Dijkxhoorn et al., 2023).

Sample sizes varied considerably, from small qualitative studies with 15–30 caregivers to larger cross-sectional surveys with 200–300 participants. The total pooled sample across all studies was approximately 3,950 family caregivers. The majority of studies focused on caregivers of persons with schizophrenia ($n = 22$), followed by bipolar disorder ($n = 10$), and a smaller number including mixed SMI diagnoses such as severe depressive disorder with psychosis or schizoaffective disorder ($n = 6$) (Jaraddi et al., 2021; Thara et al., 2019). Caregivers were predominantly parents (especially mothers), followed by spouses and siblings, reflecting the typical family structure of caregiving in India (Grover et al., 2014).

Measures of religious and spiritual coping varied widely. Quantitative studies employed instruments such as the Brief RCOPE, Religious Coping Activities Scale, Spiritual Well-Being Scale, and custom-developed items assessing frequency of prayer, temple/church/mosque attendance, and faith-based practices (Gojer et al., 2017; Cattaneo et al., 2021; John et al., 2025). Qualitative studies used semi-structured interviews and focus group discussions to explore caregivers' spiritual experiences, explanatory models of illness, and coping narratives (Dijkxhoorn et al., 2023; Iseselo et al., 2016).

Patterns of Religious and Spiritual Coping

Across the included studies, religious and spiritual coping emerged as a pervasive and culturally embedded strategy among family caregivers. The vast majority of caregivers reported engaging in some form of religious or spiritual practice to manage caregiving-related stress (Gojer et al., 2017; Rohmi et al., 2023). Common practices included daily prayer, visiting religious places (temples, mosques, churches, dargahs), performing rituals (e.g., puja, aarti, fasting), reading sacred texts (e.g., Gita, Quran, Bible), and seeking blessings from religious leaders or elders (Dein, 2020; Agadi & Uthayya, 2025).

Positive religious coping was consistently more prevalent than negative religious coping. Caregivers frequently described using benevolent religious reappraisal, interpreting the illness as part of divine will, karma, or a test of faith that could foster spiritual growth (Agadi & Uthayya, 2025). Collaborative coping — working together with God or a higher power to manage difficulties — was also commonly reported, particularly among caregivers who described feeling strengthened by their faith (Gojer et al., 2017; Rohmi et al., 2023). Seeking spiritual support from religious communities, prayer groups, or faith-based organisations was another adaptive strategy highlighted in several studies, particularly in urban settings where such networks were more accessible (Dijkxhoorn et al., 2023; Thara et al., 2019).

Negative religious coping, though less frequently endorsed, was present in a notable minority of caregivers. Manifestations included feelings of spiritual punishment (e.g., believing the illness was a result of past sins or divine retribution), interpersonal religious conflict (e.g., disagreements with family members or religious leaders about treatment decisions), and spiritual discontent (e.g., feeling abandoned or angry with God) (Agadi & Uthayya, 2025). These forms of coping were more commonly reported in qualitative studies,

where caregivers described internal struggles and existential distress alongside their faith-based practices (Dijkxhoorn et al., 2023; Dein, 2020).

Associations With Caregiver Burden and Psychological Distress

A consistent finding across quantitative studies was the inverse association between positive religious coping and caregiver burden. Caregivers who reported higher levels of positive religious coping tended to score lower on measures of family burden, perceived stress, and role overload (Gojer et al., 2017; Nehra et al., 2014). For example, several studies using the Brief RCOPE found that benevolent religious reappraisal and collaborative coping were significant negative predictors of burden scores, even after controlling for patient symptom severity and caregiver demographics (Cattaneo et al., 2021; Grover et al., 2017).

Similarly, positive religious coping was associated with lower levels of psychological distress, including depression, anxiety, and stress. Caregivers who engaged in regular prayer, religious attendance, or spiritual practices reported better emotional adjustment and lower scores on instruments such as the Depression Anxiety Stress Scales (DASS-21) and General Health Questionnaire (GHQ-12) (Gojer et al., 2017; Rohmi et al., 2023). Spiritual well-being, often measured using the Spiritual Well-Being Scale, mediated the relationship between religious coping and mental health outcomes in several studies, suggesting that faith-based practices contribute to psychological resilience through enhanced meaning, purpose, and inner peace (Agadi & Uthayya, 2025).

In contrast, negative religious coping was positively associated with caregiver burden and psychological morbidity. Caregivers endorsing spiritual punishment or divine retribution reported higher burden, greater depressive symptoms, and lower quality of life (Agadi & Uthayya, 2025). Qualitative studies provided nuanced insights into these associations, describing how spiritual struggles could exacerbate feelings of guilt, shame, and hopelessness, particularly when caregivers perceived the illness as a moral failing or karmic consequence (Dein, 2020; Dijkxhoorn et al., 2023).

Qualitative Themes: Meaning-Making, Hope, and Resilience

Qualitative studies offered rich descriptions of how religious and spiritual coping functioned in the daily lives of caregivers. A dominant theme was meaning-making: caregivers frequently framed their caregiving role within spiritual or religious narratives, viewing it as a moral duty, a form of seva (selfless service), or an opportunity for spiritual purification (Agadi & Uthayya, 2025). This reframing helped caregivers find purpose in suffering and sustain their commitment over the long term (Thara et al., 2019; Dijkxhoorn et al., 2023).

Hope was another central theme. Many caregivers expressed faith that recovery or improvement was possible through a combination of medical treatment and divine grace (Dein, 2020; Agadi & Uthayya, 2025).

Religious rituals and prayers were often performed with the specific intention of seeking healing, protection, or relief for the person with SMI (Rohmi et al., 2023). This hope, even in the face of chronic illness and limited functional recovery, served as a protective factor against despair and burnout (Gojer et al., 2017).

Resilience emerged as a key outcome of adaptive religious coping. Caregivers described drawing strength from their faith during crises, such as relapses, hospitalisations, or aggressive episodes (Thara et al., 2019; Iseselo et al., 2016). Social support from religious communities — including practical assistance, emotional encouragement, and shared prayer — further bolstered resilience (Dijkxhoorn et al., 2023). However, some caregivers also described tensions between spiritual and biomedical explanatory models, particularly when family members or religious leaders discouraged psychiatric treatment in favour of faith healing alone (Dein, 2020). These conflicts sometimes delayed help-seeking or created additional stress for caregivers navigating multiple belief systems (Agadi & Uthayya, 2025).

Variations by Diagnosis, Region, and Caregiver Characteristics

Several studies explored variations in religious and spiritual coping across subgroups. Caregivers of persons with schizophrenia tended to report higher reliance on religious coping compared to caregivers of persons with bipolar disorder, possibly due to the more chronic and disabling nature of schizophrenia (Jaraddi et al., 2021). Rural caregivers often described more traditional and ritualistic forms of coping, including consultation with faith healers and participation in community religious festivals, whereas urban caregivers were more likely to engage in individualised practices such as personal prayer or meditation (Dein, 2020).

Gender differences were noted in a few studies, with female caregivers (particularly mothers and wives) reporting higher levels of both positive and negative religious coping compared to male caregivers (Hegde et al. 2019; Nehra et al., 2014). This may reflect gendered patterns of religiosity and emotional expression in the Indian context. Caregiver education and socioeconomic status also influenced coping patterns, with more educated caregivers tending to integrate biomedical and spiritual explanations, whereas those with lower education sometimes relied more exclusively on religious or supernatural interpretations (Grover et al., 2017; Agadi & Uthayya, 2025).

Limitations Across Included Studies

Despite the consistent findings, several limitations were evident across the included studies. Most quantitative studies were cross-sectional, precluding causal inferences about the direction of relationships between religious coping and caregiver outcomes (Gojer et al., 2017; Cattaneo et al., 2021). Sample sizes were often small and drawn from single tertiary care centers, limiting generalizability to community or rural populations (Nehra et al., 2014; Thara et al., 2019). Measures of religious coping varied widely, with some

studies using validated scales and others relying on ad hoc items, complicating comparisons (Rohmi et al., 2023).

Qualitative studies, while rich in detail, were often limited to specific religious or regional contexts, and few explored negative religious coping or spiritual struggles in depth (Dijkxhoorn et al., 2023; Dein, 2020). Mixed-methods studies were rare, and no longitudinal studies tracked changes in religious coping over the caregiving trajectory (Agadi & Uthayya, 2025). These gaps highlight the need for more rigorous, diverse, and longitudinal research to better understand the dynamic role of religion and spirituality in caregiving for SMI in India.

Discussion

This systematic review synthesises evidence from 38 studies ($N \approx 3,950$ caregivers) on religious and spiritual coping among family caregivers of persons with severe mental illness (SMI) in India. The findings converge on three core messages: religious and spiritual coping are ubiquitous and culturally embedded; positive forms of coping are generally adaptive and linked to lower burden and distress; and negative or conflicted forms of coping, though less common, are meaningfully associated with poorer outcomes. Beyond summarising patterns, this discussion situates these findings within broader theoretical, clinical, and policy debates, and outlines concrete directions for future research.

The predominance of positive religious coping—benevolent reappraisal, collaborative coping, prayer, ritual participation, and seeking support from religious networks—aligns with Pargament's (1997) framework and international evidence showing that faith-based resources often function as protective factors in high-stress caregiving contexts (Koenig, 2012). In the Indian context, however, these coping processes are not merely individual psychological strategies; they are deeply relational and embedded in family, community, and religious institutions. Caregivers' narratives of *seva* (selfless service), *karma*, and divine will reflect a moral-spiritual economy in which caregiving is imbued with purpose beyond the biomedical frame (Agadi & Uthayya, 2025). This helps explain why spiritual well-being frequently mediates the relationship between religious coping and mental health outcomes in the included studies.

The association between negative religious coping and heightened burden and distress underscores an important nuance: religion and spirituality are not uniformly beneficial. Spiritual struggles—feelings of punishment, abandonment, or conflict with religious authorities—mirror findings from Western and other non-Western contexts where religious coping can become maladaptive under conditions of chronic strain, stigma, or conflicting explanatory models (Dein, 2020). In India, such struggles may be compounded by tensions between faith healing and psychiatric treatment, particularly when religious leaders or family members discourage medication in favour of ritual or prayer alone (Dein, 2020; Agadi & Uthayya, 2025).

This highlights the need to move beyond a simplistic "religion as resource" narrative and attend to the conditions under which spiritual coping becomes a source of conflict or distress.

This review extends existing theory in several ways. First, it contextualises Pargament's (1997) positive–negative coping dichotomy within a collectivist, spiritually pluralistic society where religious coping is often a family-level, not just individual-level, phenomenon. Many caregivers described coping practices that were jointly performed with other family members or religious communities, suggesting that the unit of analysis for religious coping in India may need to expand beyond the individual to include dyadic or family-level spiritual processes.

Second, the findings reinforce and elaborate the "*Dava–Dua*" (medicines–prayer) model emerging from recent qualitative work in India (Agadi & Uthayya, 2025). Rather than positioning biomedical and spiritual approaches as competing, many caregivers and families navigate both simultaneously, integrating psychiatric treatment with prayer, ritual, and faith-based support. This integrative stance challenges dominant secular frameworks in global mental health that often marginalise or pathologise religious help-seeking. Instead, it points toward a culturally consonant model of care in which spiritual resources are acknowledged, assessed, and, where adaptive, incorporated into psychosocial interventions.

Third, the review highlights the role of religious institutions as informal mental health resources. Temples, mosques, churches, and dargahs often function as spaces of solace, social support, and meaning-making, particularly in contexts where formal mental health services are scarce or stigmatised (Dein, 2020). This suggests that mental health policy in India could benefit from strategic engagement with religious leaders and institutions, not as substitutes for psychiatric care, but as complementary partners in reducing stigma, promoting help-seeking, and supporting caregivers.

The clinical implications of these findings are clear. Mental health professionals working with families of persons with SMI in India should routinely assess religious and spiritual coping as part of standard psychosocial evaluation. Simple, culturally adapted questions about prayer practices, religious attendance, spiritual beliefs about illness, and experiences of spiritual struggle can open pathways for collaborative care planning (Koenig, 2012). For caregivers endorsing positive religious coping, clinicians can reinforce these strengths by integrating them into psychoeducation, family interventions, and relapse prevention plans. For example, prayer or meditation routines can be incorporated into daily stress-management strategies, and religious leaders can be invited to participate in family sessions where appropriate.

For caregivers experiencing negative religious coping or spiritual struggles, clinicians should adopt a non-judgmental, exploratory stance. Spiritual struggles may signal underlying guilt, shame, or existential distress that warrants targeted psychological support, such as meaning-centred therapy, acceptance and commitment therapy, or spiritually integrated counselling. Importantly, clinicians should avoid dismissing

religious beliefs as irrational or superstitious; instead, they can work with families to reconcile spiritual and biomedical explanatory models in ways that support treatment adherence and reduce conflict (Dein, 2020; Agadi & Uthayya, 2025).

At the policy level, these findings support the integration of spiritual competence into mental health training curricula for psychiatrists, psychologists, social workers, and community health workers. India's National Mental Health Programme and District Mental Health Programme could benefit from guidelines on engaging with religious institutions and leaders as part of community-based mental health initiatives. Such guidelines should emphasise collaboration without compromising evidence-based care, ensuring that faith healing complements rather than replaces psychiatric treatment.

Strengths and Limitations

This review has several strengths. It is the first systematic synthesis of religious and spiritual coping among family caregivers of persons with SMI in India, covering a 16-year period (2010–2026) and including quantitative, qualitative, and mixed-methods studies. The use of PRISMA 2020 guidelines enhances transparency and reproducibility. The inclusion of diverse regions, settings, and diagnostic groups improves the generalisability of findings within the Indian context.

However, several limitations must be acknowledged. Most included studies were cross-sectional, precluding causal inferences about the direction of relationships between religious coping and caregiver outcomes. Sample sizes were often small and drawn from single tertiary care centers, limiting generalisability to community or rural populations. Measures of religious coping varied widely, with some studies using validated scales (e.g., Brief RCOPE) and others relying on ad hoc items, complicating comparisons. Qualitative studies, while rich in detail, were often limited to specific religious or regional contexts, and few explored negative religious coping or spiritual struggles in depth. No longitudinal studies tracked changes in religious coping over the caregiving trajectory, and mixed-methods studies were rare.

Directions for Future Research

Future research should prioritise longitudinal designs to examine how religious and spiritual coping evolve over the caregiving trajectory, particularly during key transitions such as diagnosis, relapse, hospitalisation, and bereavement. Intervention studies are needed to test the efficacy of spiritually integrated family interventions that build on positive coping while addressing spiritual struggles. Such interventions could be delivered in collaboration with religious institutions, leveraging existing community networks to reach underserved populations.

More diverse samples are needed, including caregivers from different religious traditions (Hindu, Muslim, Christian, Sikh, Buddhist, tribal faiths), rural and tribal areas, and marginalized groups (e.g., LGBTQ+ caregivers, single-parent households). Cross-cultural comparisons within India and with other low- and middle-income countries could illuminate how religious coping functions in different socio-cultural contexts. Finally, the development and validation of culturally specific measures of religious and spiritual coping for Indian caregiver populations would enhance measurement precision and comparability across studies.

Conclusion

This systematic review demonstrates that religious and spiritual coping are integral to how family caregivers of persons with severe mental illness in India understand, endure, and respond to caregiving stress. Positive forms of coping—prayer, ritual participation, benevolent religious reappraisal, and support from religious communities—are consistently associated with lower caregiver burden, reduced psychological distress, and greater spiritual and mental well-being. At the same time, negative religious coping and spiritual struggles, though less common, are meaningfully linked to poorer outcomes and warrant clinical attention.

These findings underscore the need for mental health services in India to move beyond secular, biomedical-only frameworks and adopt culturally responsive approaches that acknowledge and engage with caregivers' spiritual resources. Routine assessment of religious and spiritual coping, collaboration with religious leaders and institutions, and integration of adaptive spiritual practices into psychosocial interventions can enhance the acceptability and effectiveness of family-focused care. Equally important is the identification and support of caregivers experiencing spiritual conflict or distress, ensuring that faith-based resources do not become sources of additional burden.

Future research must address critical gaps, including the need for longitudinal studies, diverse and representative samples, culturally validated measures, and intervention trials that test spiritually integrated models of caregiver support. By bridging empirical evidence with culturally grounded practice, mental health professionals and policymakers can harness the protective potential of religious and spiritual coping while mitigating its risks, ultimately improving outcomes for both caregivers and persons with severe mental illness in India.

Conflict of Interest

The authors declare that they have no conflict of interest related to this study, its findings, or its publication.

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Use of Generative AI Statement

Generative artificial intelligence was used during the preparation of this manuscript solely for language-related assistance, including grammar correction, language refinement, editing for clarity, and improvement of academic phrasing. GPT-5.6 Luna (OpenAI) was used for these language-support functions. The authors retained full responsibility for the study design, literature selection, interpretation of findings, scientific content, accuracy of the manuscript, and final decisions regarding the submitted text. Generative AI was not used to generate, fabricate, or independently determine study findings, data, references, or conclusions.

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