religions

MDPI

Brief Report

Mental Health among Italian Nichiren Buddhists: Insights from a Cross-Sectional Exploratory Study

Nicola Luigi Bragazzi *, Lorenzo Ballico and Giovanni Del Puente

Department of Neuroscience, Rehabilitation, Ophthalmology, Genetics, Maternal and Child Health (DINOGMI), Section of Psychiatry, Genoa University, 16132 Genoa, Italy; lorenzo.ballico@icloud.com (L.B.); g.delpue@unige.it (G.D.P.)

* Correspondence: robertobragazzi@gmail.com

Received: 14 February 2019; Accepted: 9 May 2019; Published: 10 May 2019

Abstract: Religiosity/spirituality is generally considered as a powerful tool for adjusting and coping with stressors, attributing purposes and meanings (either existential/philosophical, cognitive, or behavioral ones) to daily situations and contexts. While studies generally investigate these effects in Judaism and Christianity believers, there is a dearth of data concerning oriental religions. We sampled from Italian Nichiren Buddhists, the most widespread branch of Buddhism in Italy (n = 391). Participants were Buddhists on average since 5 years and self-defined moderate practitioners. Adaptive strategies exhibited higher scores than maladaptive ones. Specifically, the adaptive strategy of active coping positively correlated with self-evaluated degree of being a practicing Buddhist, as well as positive reframing and religion, while maladaptive strategies such as use of substances, venting and behavioral disengagement correlated negatively. Only the subscale of religion correlated significantly and positively with the time from which the participant had become Buddhist, while the use of emotional support correlated negatively. Most participants had a predominantly internal locus of control. External locus of control negatively correlated with time the participant became Buddhist and the self-reported degree of being a practicing Buddhist, whereas internal locus positively correlated only with the latter variable. Furthermore, Buddhist participants exhibited a low psychopathological profile when compared with the normative scores.

Keywords: buddhism; mental health; psychological well-being; locus of control; coping strategies; psychopathological profile

1. Introduction

Religiosity/spirituality is generally considered as a powerful tool for adjusting and coping with stressors, attributing purposes and meanings (either existential/philosophical, cognitive, or behavioral ones) to daily situations and contexts (Hasenkamp 2018; Hook et al. 2010; Xu 2018).

A huge body of correlational investigations has shown meaningful correlations between scoring high in religion and the use of adaptive strategies. For instance, statistically significant associations between the problem-solving coping style and religious observance/beliefs were found in a sample of 159 Israeli women undergoing infertility treatment, whereas an inverse correlation was reported for the emotional coping style (Grinstein-Cohen et al. 2017).

Similar findings were obtained in a correlational study carried out in a sample of 97 Turkish mothers of children with cancer (Bozkurt et al. 2018), as well as in culturally different populations suffering from various malignancies (Baider et al. 1999; Khodaveirdyzadeh et al. 2016; Yılmaz et al. 2017) or other chronic disorders, including chronic kidney disease (Martínez and Custódio 2014; Ottaviani et al. 2014) and Alzheimer's disease (Kaufman et al. 2007).

Religiosity/spirituality is also a way to effectively cope with job strain and burnout at workplace (Alharbi and Alshehry 2019; Bonsu and Yendork 2019; Chirico 2017; Torabi Chafjiri et al. 2017), as well as an effective tool to deal with stress among retired populations (Lowis et al. 2009).

Taken together, all this has broad, important implications in terms of general well-being and, more specifically, mental health. Generally, most studies have found a positive impact of religiosity/spirituality on perceived health-related quality of life and health (see (Bartkowski et al. 2017) for review studies). Correlational investigations have reported meaningful associations between spiritual tendencies and internal locus of control, with the latter mediating the relationship between religiosity and health and well-being (Jackson and Coursey 1988; Ryan and Francis 2012).

However, some recent studies have failed to replicate such findings (Joshi et al. 2008; Koenig 2009; Weber and Pargament 2014), therefore warranting further research. Moreover, most investigations have addressed the psychological roles and effects of Judaism and Christianity, whilst oriental religions have been less studied, despite their increasing diffusion.

Buddhism is based on the teachings of Buddha and relies upon the principles of self-compassion, mindfulness, faith in the rebirth and in the law of karma (an intention- and awareness-driven action/deed, which implies certain future consequences) (Şenel 2018).

According to the Italian Caritas (2011), in the Italian country there are about 160,000 Buddhists, that is to say, approximately 0.3% of the total population, with Buddhism being the third most widespread and practiced religion, after Christianity and Islam. Organized Buddhism has been present in the Italian territory since the sixties, with the establishment of the Buddhist Italian Association (Associazione Buddhista Italiana, ABI). More in detail, Nichiren Buddhists are about 75,000 (approximately half of the entire Italian Buddhist population).

Despite such rooted presence, there is a dearth of information related to the psychological impact of Buddhism, with only few studies addressing this topic. Furthermore, these studies have explored some psychological constructs (coping styles, locus of control and psychopathological profile/mental health), but not in a systematic way. As such, to fill this gap in knowledge, the present research was designed as an exploratory study aimed at systematically investigating the coping strategies, the locus of control, and the psychopathological profile in a group of Italian Nichiren Buddhists. We decided to focus on Nichiren Buddhism in that it is the most represented Buddhist group in Italy, being also a religion officially recognized by the Italian State.

Based on the foregoing scholarly literature, we hypothesize that Italian Nichiren Buddhists with more robust spiritual beliefs and more frequent religious practice will exhibit (1) adaptive coping strategies to maladaptive strategies, (2) an internal locus of control rather than an external locus of control, and (3) a low psychopathological profile.

2. Materials and Methods

Participants were recruited via snowballing sampling (that is to say, a not probabilistic, convenience sampling), partly via the Internet through social networks, in part through Italian Buddhist associations. A total of 391 Buddhist participants volunteered to take part in the study (82.9% females, 17.1% males). Mean age was 44.20 ± 12.42 years (median 45 years). Concerning the educational level, 0.5% of the participants had the elementary license, 13.3% the middle school license, 49.4% the high school license, while 29.7% were graduated and 7.2% held a master degree, a doctorate, or another post-graduate degree. Participants were Buddhists on average since 5 years (median, range 0–38 years) and self-defined moderate practitioners (median 3, on a scale from "being a practicing Buddhist for nothing" to "a lot").

All participants were informed of the purposes of our research and gave their informed, written consent to take part into this investigation. The study protocol was approved by the UNESCO Chair "Anthropology of Health—Biosphere and Healing System," University of Genoa, Italy. The study was conducted according to the 1964 Helsinki ethical guidelines and its subsequent amendments.

A battery of questionnaires (the Brief COPE of Carver, Scheier, and Weintrab of 1989 (Carver et al. 1989; Carver 1997), the Locus of Control of Behavior, LCB, of Craig, Franklin, and Andrews of 1984 (Craig et al. 1984), in the Italian version validated by Farma and Cortinovis of 2000, and the Brief Symptom Checklist, BSCL, of Derogatis and Melisaratos of 1983 (Derogatis and Melisaratos 1983)) was administered.

The Brief COPE is a 28-item self-reported questionnaire, made up of fourteen sub-scales (self-distraction, active coping, denial, substance use, use of emotional support, use of instrumental support, behavioral disengagement, venting, positive reframing, planning, humor, acceptance, religion, and self-blame). Each item is on a 4-point Likert scale, ranging from one ("not at all") to four ("a lot"). Concerning the psychometric properties, in the original study by Carver (1997), the Cronbach's alpha coefficient was in the range 0.50–0.90.

The LCB is a 17-item tool measuring the locus of control. Each item is on a 6-point Likert scale, from 0 ("strongly disagree") to 5 ("strongly agree").

The BSCL is a 53-item self-administered questionnaire aimed at evaluating psychopathological symptoms and their severity. The tool comprises nine dimensions (somatization, obsession–compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism). Each item is on a 5-point Likert scale, from 0 ("not at all") to 4 ("extremely"). Scores generated by each sub-scale can be summed up to reflect a clinically relevant global index: the Global Severity Index (GSI). The original version of the BSCL is characterized by a good internal consistency, with Cronbach's alpha coefficients ranging from 0.71 to 0.85.

Correlations and multiple regression analyses were conducted to shed light on the determinants of the psychological constructs.

All statistical analyses were performed by means of the commercial software "Statistical Package for the Social Sciences" (SPSS for Windows, version 24.0, IBM, Armonk, NY, USA). For all analyses, figures with a p-value < 0.05 were considered statistically significant.

Raw data are available as Supplementary Materials.

3. Results

The Brief COPE questionnaire scores are reported in Table 1. Concerning internal consistency, Cronbach's alpha ranged from 0.36 to 0.87: it should be noted that some of these coefficients (for instance, the coefficient of acceptance sub-scale), are low and call up for caution when interpreting and generalizing the present results.

Table 1. Descriptive statistics of the Brief COPE questionnaire.

Coping Strategy	Mean	Standard Deviation	Cronbach's Alpha
Acceptance	6.01	1.42	0.36
Active coping	6.85	1.38	0.65
Behavioral disengagement	3.02	1.38	0.51
Denial	3.21	1.44	0.47
Humor	4.54	1.54	0.53
Planning	6.62	1.51	0.66
Positive reframing	6.61	1.45	0.65
Religion	7.00	1.53	0.87
Self-blame	5.54	1.49	0.41
Self-distraction	4.73	1.63	0.48
Substance use	2.26	0.78	0.69
Use of emotional support	4.72	1.78	0.78
Use of instrumental support	5.19	1.70	0.73
Venting	4.91	1.66	0.64

Adaptive strategies exhibited higher scores than maladaptive ones. Specifically, the adaptive strategy of active coping positively correlated with self-evaluated degree of being a practicing Buddhist

(r = 0.21, $p < 0.001$), as well as positive reframing (r = 0.22, $p < 0.001$), religion (r = 0.47, $p < 0.001$), while maladaptive strategies such as use of substances (r = −0.14, $p = 0.0057$), venting (r = −0.10, $p = 0.0421$), and behavioral disengagement (r = −0.19, $p = 0.0002$) correlated negatively. Only the subscale of religion correlated significantly and positively with the time from which the participant had become Buddhist (r = 0.16, $p = 0.0012$), while the use of emotional support correlated negatively (r = −0.12, $p = 0.0172$).

Further details are shown in Table 2.

Table 2. Correlations between the Brief COPE questionnaire scores, time (years) the participant has become Buddhist/years of religious practice and the self-evaluated grade of being a practicing Buddhist. The first value represents the correlation coefficient, the second value the *p*-value (statistical significance).

Brief COPE Sub-Scale	Age	Gender	Educational Level	Time (Years) The Participant Has Become Buddhist/Years of Religious Practice	Self-Rated Degree of Being a Practicing Buddhist
Acceptance	−0.05 0.3411	−0.03 0.5293	−0.01 0.7898	−0.09 0.0637	0.032 0.5289
Active coping	−0.01 0.8332	−0.05 0.3387	0.10 0.0421	0.08 0.1405	0.21 <0.0001
Behavioral disengagement	0.06 0.2407	−0.02 0.7436	−0.11 0.0301	−0.04 0.3927	−0.19 0.0002
Denial	0.02 0.7113	−0.08 0.1377	−0.05 0.3436	0.01 0.8094	−0.03 0.6277
Humor	−0.08 0.1132	0.05 0.3633	−0.01 0.8425	0.01 0.8741	0.03 0.5630
Planning	0.01 0.8063	0.01 0.8812	0.09 0.0814	0.01 0.7818	0.06 0.2051
Positive reframing	0.00 0.9300	−0.04 0.4844	0.00 0.9981	0.06 0.2403	0.22 <0.0001
Religion	0.13 0.0120	−0.10 0.0555	0.05 0.3606	0.16 0.0012	0.47 <0.0001
Self-blame	−0.08 0.1143	0.00 0.9922	0.03 0.5522	−0.03 0.5478	−0.09 0.0752
Self-distraction	−0.17 0.0010	−0.15 0.0028	0.02 0.6744	−0.02 0.6353	−0.04 0.3811
Substance use	−0.12 0.0226	0.14 0.0077	−0.05 0.3136	0.02 0.6644	−0.14 0.0057
Use of emotional support	−0.21 <0.0001	−0.07 0.2002	0.01 0.9200	−0.12 0.0172	−0.07 0.1726
Use of instrumental support	−0.08 0.0973	−0.06 0.2766	−0.02 0.7324	−0.06 0.2159	−0.08 0.1310
Venting	−0.06 0.2697	−0.04 0.4007	0.00 0.9970	−0.05 0.3337	−0.10 0.0421

At the multiple regression analysis, self-reported degree of being a practicing Buddhist resulted predictor of behavioral disengagement (regression coefficient = −0.28, $p = 0.0002$), positive reframing (regression coefficient = 0.33, $p < 0.001$), religion (regression coefficient = 0.73, $p < 0.001$), and substance use (regression coefficient = −0.11, $p = 0.0101$).

Age was found to be a determinant of humor strategy (regression coefficient = −0.01, $p = 0.0451$), self-distraction (r = −0.02, $p = 0.0010$), substance use (regression coefficient = −0.01, $p = 0.0037$), and use of emotional support (regression coefficient = −0.03, $p = 0.0009$), whereas educational level predicted planning (regression coefficient = 0.38, $p = 0.0171$) and substance use (regression coefficient = −0.17,

$p = 0.0362$). Gender was a predictor of religion (regression coefficient = −0.54, $p = 0.0030$), self-distraction (r = −0.67, $p = 0.0021$), and substance use (regression coefficient = 0.28, $p = 0.0063$).

No predictors could be, instead, found for denial, self-blame, use of instrumental support and venting.

The internal locus scale was found to have a Cronbach's alpha coefficient of 0.61, whereas the external locus scale a coefficient of 0.79.

Noteworthy, 90.8% of participants had a predominantly internal locus of control (internal locus 27.01 ± 4.42 versus external locus 10.99 ± 7.68, $p < 0.001$).

External locus of control negatively correlated with time the participants became Buddhist (r = −0.11, $p = 0.0333$) and the self-reported degree of being a practicing Buddhist (r = −0.36, $p < 0.001$), whereas internal locus positively correlated only with the latter variable (r = 0.23, $p < 0.001$). At the multiple regression analysis, self-reported degree of being a practicing Buddhist resulted independent predictor of both external (regression coefficient = −2.86, $p < 0.001$) and internal (regression coefficient = 1.04, $p < 0.001$) locus of control. Interestingly, educational level was a predictor of internal locus of control (regression coefficient = 1.00, $p = 0.0288$).

For further information, the reader is referred to Table 3.

Table 3. Multiple regression analysis assessing determinants of external and internal locus of control in Italian Buddhists.

Independent Variables	B Coefficient	Standard Error	t	*p*-Value
External locus of control				
(Constant)	21.51			
Age	0.00	0.03	0.00	0.9998
Gender (male versus female)	−0.26	0.97	−0.27	0.7906
Time (years) the participant became Buddhist/years of religious practice	−0.02	0.05	−0.34	0.7336
Self-reported degree of being a practicing Buddhist	−2.86	0.40	−7.18	<0.0001
Educational level	−1.39	0.76	−1.82	0.0697
Internal locus of control				
(Constant)	23.17			
Age	0.00	0.02	−0.04	0.9679
Gender (male versus female)	−0.83	0.58	−1.42	0.1558
Time (years) the participant became Buddhist/years of religious practice	0.01	0.03	0.35	0.7250
Self-reported degree of being a practicing Buddhist	1.04	0.24	4.36	<0.0001
Educational level	1.00	0.46	2.20	0.0288

Regarding the psychopathological profile of the participants, BSCL scores are reported in detail in Table 4.

Overall Cronbach's alpha was 0.97, with coefficient ranging from 0.78 to 0.89 depending on the sub-scale.

All the scales correlated significantly and negatively with the time from which they had become Buddhists (with the exception of the somatic and obsession–compulsion subscales), while all, without exception, were significantly and negatively associated with the self-evaluation of being a practicing Buddhist. Finally, GSI correlated significantly and negatively with the number of years (r = −0.16, $p = 0.0014$) and with the self-evaluation of being a practicing Buddhist (r = −0.30, $p < 0.001$). Further details are shown in Table 5.

Table 4. Descriptive statistics of the Brief Symptom Checklist (BSCL) questionnaire.

BSCL Sub-Scale	Mean	Standard Deviation	Cronbach's Alpha
Anxiety	7.13	5.90	0.88
Depression	6.51	5.90	0.89
Hostility	4.64	4.17	0.83
Interpersonal sensitivity	4.47	4.08	0.85
Obsession-compulsion	7.51	5.66	0.86
Paranoid ideation	5.26	4.70	0.83
Phobic anxiety	2.39	3.52	0.78
Psychoticism	4.17	4.37	0.81
Somatization	6.45	6.33	0.87
Global Severity Index	0.99	0.77	0.97

Table 5. Correlations between the Brief Symptom Checklist (BSCL) questionnaire scores, time (years) the participant has become Buddhist and the self-evaluation grade of being a practicing Buddhist. The first value represents the correlation coefficient, the second value the *p*-value (statistical significance).

BSCL Sub-Scale	Age	Gender	Educational Level	Time (Years) the Participant Has Become Buddhist/Years of Religious Practice	Self-Rated Degree of Being a Practicing Buddhist
Anxiety	−0.21 <0.0001	−0.05 0.3498	−0.06 0.2544	−0.15 0.0025	−0.24 <0.0001
Depression	−0.16 0.0017	0.00 0.9517	−0.04 0.3947	−0.14 0.0076	−0.30 <0.0001
Hostility	−0.17 0.0007	−0.02 0.7199	−0.02 0.7062	−0.11 0.0266	−0.25 <0.0001
Interpersonal sensitivity	−0.25 <0.0001	−0.03 0.6053	−0.01 0.8272	−0.18 0.0003	−0.24 <0.0001
Obsession-compulsion	−0.16 0.0015	−0.03 0.6279	−0.05 0.3188	−0.08 0.1256	−0.29 <0.0001
Paranoid ideation	−0.22 <0.0001	−0.05 0.3137	−0.05 0.3247	−0.19 0.0002	−0.26 <0.0001
Phobic anxiety	−0.16 0.0012	−0.05 0.2978	−0.01 0.9150	−0.16 0.0015	−0.23 <0.0001
Psychoticism	−0.26 <0.0001	0.01 0.7797	0.00 0.9516	−0.17 0.0005	−0.28 <0.0001
Somatization	−0.10 0.0448	−0.12 0.0155	−0.12 0.0173	−0.08 0.1358	−0.17 0.0007
Global Severity Index	−0.22 <0.0001	−0.05 0.3568	−0.06 0.2125	−0.16 0.0014	−0.30 <0.0001

At the multiple regression analysis, GSI score resulted predicted by age (regression coefficient = −0.01, $p = 0.0026$) and self-reported degree of being a practicing Buddhist (regression coefficient = −0.20, $p < 0.001$) (Table 6).

Table 6. Multiple regression analysis assessing determinants of external and internal locus of control in Italian Buddhists.

Independent Variables	B Coefficient	Standard Error	T	*p*-Value
(Constant)	2.22			
Age	−0.01	0.00	−3.03	0.0026
Gender (male versus female)	−0.05	0.10	−0.52	0.6014
Time (years) the participant became Buddhist/years of religious practice	0.00	0.00	−0.37	0.7152
Self-reported degree of being a practicing Buddhist	−0.20	0.04	−5.06	<0.0001
Educational level	−0.13	0.08	−1.73	0.0854

4. Discussion

Buddhism is characterized by the faith in the principle of karma and self-mediation. In our study, we found a major use of adaptive coping strategies, a prominently internal locus of control, and a low psychopathological profile. Karma could explain the prevalence of internality of the locus of control, being a non-fatalistic conception of the world and emphasizing the freewill (Ozer 2010). Meditation practice and self-awareness could contribute to the low psychopathological profile (Xu 2018).

Due to the lack of studies and information concerning the relationship between coping strategies, locus of control, psychopathological profile, and Buddhism, it is difficult to compare our results with the literature. However, our results seem to be in line with the few existing studies.

For instance, Grepmair and collaborators (Grepmair et al. 2007) have explored the effect of Zen meditation in a group of 124 inpatients, treated for 9 weeks by 18 psychotherapists in training, randomly allocated to two groups (practicing Zen meditation versus not performing any form of meditation). Authors found that the former group reported greater symptom reduction on the GSI and eight sub-scales of the Symptom Checklist-90-Revised or SCL-90-R (namely, somatization, insecurity in social contact, obsessiveness, anxiety, anger/hostility, phobic anxiety, paranoid thinking, and psychoticism). Shaku and coworkers (Shaku et al. 2014) have performed an investigation in Rinzai Zen monasteries, recruiting 198 monks. Stratifying according to the length of training, authors found that somatization, anxiety, social dysfunction, and depression scores resulted significantly lower (i.e., better). Kasai and coauthors (Kasai et al. 2017) have compared 97 Myanmar participants practicing meditation (specifically, Vipassana contemplation) versus 81 Myanmar nurses without any experience with contemplation. Meditation was found to mitigate depressive mood, anger, hostility, and fatigue, whereas it significantly increased vigor. These positive effects, however, could be noted only after practicing meditation for more than one year. Finally, Rana and colleagues (Rana et al. 2015), comparing 320 participants practicing different religious creeds (78 Buddhists, 77 Catholics, 89 Protestants, and 79 Muslims), found that Buddhists exhibited lower scores for obsession–compulsion, hostility, paranoid ideation, and overall psychopathological symptom severity.

Specifically in Italy, Buddhism has been generally overlooked. Giannini and collaborators (Giannini et al. 2018) recruited a sample of 184 participants (60 Soka Gakkai Buddhists, 62 non-practicing Roman Catholic Church believers, and 62 atheists). Authors found that Buddhists had higher optimism than both Catholics and Atheists, higher self-efficacy and self-esteem than Catholics and higher perceived social support than Atheists. Furthermore, they were more extraverted than the other groups, and less tough-minded than Catholics. Authors concluded that religion per se does not provide believers with particularly effective psychological resources: it is, instead, religious practice that exerts a positive impact on mental health and well-being.

Our manuscript has some strengths, including its novelty. However, it suffers from some shortcomings, such as the study design (cross-sectional study), which, being a static snapshot, does not enable to capture the dynamic relationship between coping strategies, locus of control,

psychopathological profile, and religiosity/spirituality. Another limitation is the non-randomized recruiting sampling adopted in the investigation. A further drawback is given by some low Cronbach's alpha coefficients, which call for caution in interpreting the present results.

5. Conclusions

In the present study, we found that Italian Nichiren Buddhists made use of adaptive coping strategies and had a predominant internal locus of control. Furthermore, the participants showed a rather low psychopathological profile. However, because of the limitations mentioned above (non-probabilistic sampling, cross-sectional study design and some low Cronbach's alpha coefficients), further longitudinal and randomized design studies, with larger samples, are necessary to replicate our results in a statistically more robust manner.

Supplementary Materials: The following are available online at http://www.mdpi.com/2077-1444/10/5/316/s1.

Author Contributions: Conceptualization, N.L.B.; methodology, N.L.B.; software, N.L.B.; validation, N.L.B.; formal analysis, N.L.B.; investigation, N.L.B. and L.B.; resources, N.L.B.; data curation, N.L.B.; writing—original draft preparation, N.L.B.; writing—review and editing, N.L.B.; visualization, N.L.B.; supervision, G.D.P.; project administration, N.L.B.; funding acquisition, N.L.B.

Funding: This research received no external funding.

Conflicts of Interest: The authors declare no conflict of interest.

References

Alharbi, Homood, and Abdualrahman Alshehry. 2019. Perceived stress and coping strategies among ICU nurses in government tertiary hospitals in Saudi Arabia: A cross-sectional study. *Annals of Saudi Medicine* 39: 48–55. [CrossRef] [PubMed]

Baider, Lee, Simcha M. Russak, Shlomit Perry, Kathryn Kash, Melissa Gronert, Bernard Fox, Jimmie Holland, and Atara Kaplan-Denour. 1999. The role of religious and spiritual beliefs in coping with malignant melanoma: An Israeli sample. *Psychooncology* 8: 27–35. [CrossRef]

Bartkowski, John P., Gabriel A. Acevedo, and Harriet Van Loggerenberg. 2017. Prayer, Meditation, and Anxiety: Durkheim Revisited. *Religions* 8: 191. [CrossRef]

Bonsu, Akosua Serwaah, and Joana Salifu Yendork. 2019. Community-Based Mental Health Care: Stigma and Coping Strategies Among Professionals and Family Caregivers in the Eastern Region of Ghana. *Issues in Mental Health Nursing* 3: 1–8. [CrossRef]

Bozkurt, Gülçin, Sevil İnal, Leman Yantiri, and Özgür Alparslan. 2018. Relationship Between Coping Strategies, Religious Attitude, and Optimism of Mothers of Children with Cancer. *Journal of Transcultural Nursing*. [CrossRef]

Caritas. 2011. Dossier Immigrazioni. Available online: http://www.caritasitaliana.it/materiali/Pubblicazioni/libri_2011/dossier_immigrazione2011/scheda_religioni.pdf (accessed on 9 May 2019).

Carver, Charles S. 1997. You want to measure coping but your protocol's too long: Consider the brief COPE. *International Journal of Behavioral Medicine* 4: 92–100. [CrossRef]

Carver, Charles S., Michael F. Scheier, and Jagdish K. Weintraub. 1989. Assessing coping strategies: A theoretically based approach. *Journal of Personality and Social Psychology* 56: 2267–83. [CrossRef]

Craig, Ashley R., John A. Franklin, and Gavin Andrews. 1984. A scale to measure locus of control of behaviour. *British Journal of Medical Psychology* 57, Pt 2: 173–80. [CrossRef]

Chirico, Francesco. 2017. Religious Belief and Mental Health in Lay and Consecrated Italian Teachers. *Journal of Religion and Health* 56: 839–51. [CrossRef]

Derogatis, Leonard R., and Nick Melisaratos. 1983. The Brief Symptom Inventory: An introductory report. *Psychological Medicine* 13: 595–605. [CrossRef]

Giannini, Marco, Yura Loscalzo, Daniela Beraldi, and Alessio Gori. 2018. Psychological Resources, Personality Traits and Buddhism: A Study of Italian Young Adults. *Journal of Religion and Health* 57: 2416–30. [CrossRef]

Grepmair, Ludwig, Ferdinand Mitterlehner, Thomas Loew, Egon Bachler, Wolfhardt Rother, and Marius Nickel. 2007. Promoting mindfulness in psychotherapists in training influences the treatment results of their patients: A randomized, double-blind, controlled study. *Psychotherapy and Psychosomatics* 76: 332–38. [CrossRef]

Grinstein-Cohen, Orli, Anne Katz, and Orly Sarid. 2017. Religiosity: Its Impact on Coping Styles Among Women Undergoing Fertility Treatment. *Journal of Religion and Health* 56: 1032–41. [CrossRef]

Hasenkamp, Wendy. 2018. Fruits of the Buddhism-science dialogue in contemplative research. *Current Opinion in Psychology* 28: 126–132. [CrossRef]

Hook, Joshua N., Everett L. Junior Worthington, Don E. Davis, David J. Jennings 2nd, Aubrey L. Gartner, and Jan P. Hook. 2010. Empirically supported religious and spiritual therapies. *Journal of Clinical Psychology* 66: 46–72. [CrossRef]

Jackson, Laurence E., and Robert D. Coursey. 1988. The Relationship of God Control and Internal Locus of Control to Intrinsic Religious Motivation, Coping and Purpose in Life. *Journal for the Scientific Study of Religion* 27: 399–410. [CrossRef]

Joshi, Shobhna, Shilpa Kumari, and Madhu Jain. 2008. Religious belief and its relation to psychological well-being. *Journal of the Indian Academy of Applied Psychology* 34: 345–54.

Kasai, Yuichi, Toshihiko Sakakibara, Thein Aung Kyaw, Wai Soe, Zaw-min Han, and Maung Mg Htwe. 2017. Psychological effects of meditation at a Buddhist monastery in Myanmar. *Journal of Mental Health* 26: 4–7. [CrossRef]

Kaufman, Yakir, David Anaki, Malcolm Binns, and Morris Freedman. 2007. Cognitive decline in Alzheimer disease: Impact of spirituality, religiosity, and QOL. *Neurology* 68: 1509–14. [CrossRef]

Khodaveirdyzadeh, Roghieh, Rabee Rahimi, Azad Rahmani, Akram Ghahramanian, Naser Kodayari, and Jamal Eivazi. 2016. Spiritual/Religious Coping Strategies and their Relationship with Illness Adjustment among Iranian Breast Cancer Patients. *Asian Pacific Journal of Cancer Prevention* 17: 4095–99.

Koenig, Harold G. 2009. Research on religion, spirituality and mental health: A review. *Canadian Journal of Psychiatry* 54: 283–91. [CrossRef]

Lowis, Michael J., Anthony C. Edwards, and Mary Burton. 2009. Coping with retirement: Well-being, health, and religion. *Journal of Psychology* 143: 427–48. [CrossRef]

Martínez, Beatriz Bertolaccini, and Rodrigo Pereira Custódio. 2014. Relationship between mental health and spiritual wellbeing among hemodialysis patients: A correlation study. *Sao Paulo Medical Journal* 132: 23–27. [CrossRef]

Ottaviani, Ana Carolina, Érica Nestor Souza, Natália de Camargo Drago, Marisa Silvana Zazzetta de Mendiondo, Sofia Cristina Iost Pavarini, and Fabiana de Souza Orlandi. 2014. Hope and spirituality among patients with chronic kidney disease undergoing hemodialysis: A correlational study. *Revista Latino-Americana de Enfermagem* 22: 248–54. [CrossRef]

Ozer, Simon. 2010. The Understanding of Karma and Etiology in Buddhist Ladakh in Relation to the Theory of Locus of Control. *Ladakh Studies* 26: 6–13.

Rana, Madiha, Majeed Rana, Philipp Y. Herzberg, and Christin Krause C. 2015. Religious Confession and Symptom Severity: A Prospective Comparative Study. *Journal of Religion and Health* 54: 2142–54. [CrossRef]

Ryan, Matthew E., and Andrews J.P. Francis. 2012. Locus of control beliefs mediate the relationship between religious functioning and psychological health. *Journal of Religion and Health* 51: 774–85. [CrossRef]

Şenel, Engin. 2018. Dharmic Religions and Health: A Holistic Analysis of Global Health Literature Related to Hinduism, Buddhism, Sikhism and Jainism. *Journal of Religion and Health*, 1–11. [CrossRef]

Shaku, Fumio, Tsutsumi Madoka, Goto Hideyoshi, and Denise Saint Arnoult. 2014. Measuring the effects of Zen training on quality of life and mental health among Japanese monk trainees: A cross-sectional study. *Journal of Alternative and Complementary Medicine* 20: 406–10. [CrossRef]

Torabi Chafjiri, Razieh, Nasrin Navabi, Abbas Shamsalinia, and Fatemeh Ghaffari. 2017. The relationship between the spiritual attitude of the family caregivers of older patients with stroke and their burden. *Clinical Interventions in Aging* 12: 453–58. [CrossRef]

Weber, Samuel R., and Kenneth I. Pargament. 2014. The role of religion and spirituality in mental health. *Current Opinion in Psychiatry* 27: 358–63. [CrossRef]

Xu, Jianbin. 2018. Buddhism-as-a-meaning-system for coping with late-life stress: A conceptual framework. *Aging and Mental Health* 22: 100–8. [CrossRef]

Yılmaz, Karabulutlu Elanur, Süheyla Yaralı, and Seda Karaman. 2017. Evaluation of Distress and Religious Coping Among Cancer Patients in Turkey. *Journal of Religion and Health*. [CrossRef]