Article

Hindi Adaptation of Centrality of Religiosity Scale

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Abstract: Although religiosity is part and parcel of life of most Indians, no standardized scale is available in local language which can make findings comparable with other countries'. This study aims to present the adaptations required in the Centrality of Religiosity Scale (CRS, CRSi-20) for the Indian population. Additionally, the study aimed to compare the religiosity as assessed by using CRS among healthy subjects and those with first-episode depression. CRS was translated to Hindi by following the methodology suggested by the World Health Organization. During the process of translation, the scale was adapted to suit to the sociocultural milieu of India. The adapted Hindi version of the scale was used in 80 healthy subjects and 80 patients with first-episode depression. During the process of translation, 14 out of 20 items required adaptations to suit the religious practices in India. The adaptation primarily involved elaboration on certain aspects of religious services and practices, keeping in mind the polytheistic religious beliefs in India. When the adapted Hindi version of CRS was used in both the study groups, there was no significant difference between the two groups, in terms of CRS total scores ($t = 1.12$; $p = 0.26$). In terms of various domains of CRS, a significantly higher score was observed in the depression group for the ideology domain ($t = 2.02$; $p = 0.04$ *), whereas the healthy group had a significantly higher score for the domain of public practice ($t = 2.90$; $p = 0.004$ **). Use of CRS in the Indian context requires some adaptations to suit the religious practices. There are minor differences in the religiosity of patients with depression and healthy subjects.

Keywords: religiosity; India; adaptation

1. Introduction

Religion has been defined as “an organized system of beliefs, practices, rituals, and symbols designed to facilitate closeness to the sacred or transcendent” (Koenig et al. 2012). It is an important expression of one's beliefs, and also involves affiliations, practices, and rituals based on these beliefs. These can pertain to rules about conduct in society, a higher power, as well as life and death. It is often organized and practiced within a community, but it can also be practiced alone and in private. The term religiosity is often used interchangeably with such terms as religiousness, orthodoxy, faith, belief, piousness, devotion, and holiness (Holdcroft 2006). Some of the authors consider these as various dimensions of religiosity rather than synonyms.

Glock and Stark (1965) defined five core dimensions of religion: the intellectual, the ideological, the public, the private, and the experiential dimension, while Allport and Ross (1967) identified two basic dimensions of religiosity: extrinsic and intrinsic. Huber and Huber (2012) gave the concept of the personal religious construct system as the unifying psychological entity in which the core dimensions merge. It can be defined as the superstructure in personality which consists of all the personal constructs related to the individually defined realm of religion and religiosity. A personal

religious construct is activated when the individual anticipates something with a religious meaning (Huber and Huber 2012). The five core dimensions thus act as channels through which the individuals' religious constructs are activated, based on the structure of one's system of religious beliefs in the superstructure of their personality (Huber and Huber 2012).

India is a country with many religions and many sects within each religion. Thus, the religious milieu in India is full of colors and variations. Religion is a quintessential part of the daily life of most Indians, with influence ranging from politics to individual coping and a sense of belonging. Religion also influences many aspects of life, including health. In the context of mental health, religious beliefs and practices not only influence the manifestation of psychopathology but also influence help-seeking, pathways to care, medication adherence, treatment adherence, and seeking alternative treatment (Grover et al. 2014). Despite the influence of religion on different aspects of life, the influence of religion on various aspects of health has not been evaluated thoroughly. One of the important limitations in this direction is the lack of validated instruments for the assessment of various dimensions of religiosity. The instruments which have been validated and used for the assessment of religiosity in India have only covered a single dimension of religiosity, and the relationship of the same with other aspects of behavior has not been studied. Another important limitation of the research is the lack of instruments, findings of which can be comparable to the findings from other countries.

In 2003, Huber developed a multidimensional method of measuring religiosity, known as the Centrality of Religiosity Scale (CRS) (Huber and Huber 2012). It measures five core dimensions of religion; i.e., the intellectual, the ideological, the public, the private, and the experiential dimension (Huber and Huber 2012). According to this, religiosity is understood as a personal psychological trait and it is distinguished from religion which is understood as an organized tradition-oriented social phenomenon (Huber and Huber 2012). This scale has been validated in English and other languages including German (Huber and Huber 2012), Chinese (Lee and Kuang 2020), Portuguese (in Brazil) (Esperandio et al. 2019), Greek (Fradelos et al. 2018), Polish (Zarzycka et al. 2020), Romanian (Gheorghe 2018), and Russian (Ackert et al. 2020a), etc. This scale has undergone certain adaptations taking the local beliefs and religious practices of the country into account. We also translated the scale into Hindi and evaluated its psychometric properties (Grover and Dua 2019). During the translation process, the scale was also adapted, keeping the religious practices and beliefs in the Indian context. Additionally, during translation and adaptations, the polytheism of religious practices in India was kept in mind. Against this background, this secondary analysis aims to present the adaptations required in the Centrality of Religiosity Scale (CRS) for the Indian population and additionally, to compare the religiosity as assessed by using CRS among healthy subjects and those with first-episode depression.

2. Results

2.1. Adaptations to the Hindi Version of CRSi-20

Of the 20 items of CRSi-20, 14 items were adapted keeping the Indian practices in mind. Items number 2 and 5a, *"To what extent do you believe that God or something divine exists?"* and *"How often do you experience situations in which you have the feeling that God or something divine intervenes in your life?"*, were considered not to be inclusive of the concept of polytheism and demi-gods, which is commonly practiced in India. Thus, the word *"devi-devta"*, was added in addition to the Hindi translation of God. The same was also true for items 10a, and 15, and the same adaptation was followed.

For item 10b, *"How often do you experience situations in which you have the feeling that you are touched by a divine power?"*, the words *"touch or feeling"* were considered to be insufficient to describe this experience. Hence, an additional word, *"influenced"*, was added.

In items number 3 and 8, *"How often do you take part in religious services?"*, and *"How important is to take part in religious services"*, the word *"services"* was considered not to convey the exact religious practices in the Indian context. The adapted Hindi version was made more explicit and included

a description in the form of “going to temple to pray, going to religious congregations, going on religious pilgrimages, and to religious fairs as well as performing rituals pertaining to religious activities”.

For items 4b and 9b, “How often do you meditate?” and “How important is meditation for you?”, it was considered that the word “meditate” does not convey a religious meaning in the Indian context, where the meditation can also be understood from the concept of spirituality and mindfulness which can be practiced by people who do not follow any religion or are atheists. Further, in terms of meditation, people who do not follow Hinduism also follow or practice meditation as a part of yoga. Keeping this in mind, the item was made more explicit to include “meditation, chanting, ponder over and remembrance of God”.

For item 7, “To what extent do you believe in an afterlife—e.g., immortality of the soul, resurrection of the dead or reincarnation”, for the examples, resurrection of the dead was excluded, because in the Indian context, the concept of afterlife and reincarnation are unified into one. The idea of resurrection does not fall in the realm of “afterlife” and may in fact be considered as an outcome of divine power to continue the current life.

For item 11, “How often do you keep yourself informed about religious questions through radio, television, internet, newspapers, or books?”, it was considered that in the Indian context, people use these media more to learn about religious teachings or following various religious leaders. Hence, the word “questions” was considered insufficient, and the word “topics” was added.

For item 13, “How important is it for you to be connected to a religious community?”, keeping in mind the polytheistic religious background in India along with the varying practices within one religion, the word “community” was considered inadequate to describe the religious affiliations and hence, equivalent words like society, group, cult, and conglomeration were added.

For items 14a and 14b, “How often do you pray spontaneously when inspired by daily situations?” and “How often do you try to connect to the divine spontaneously when inspired by daily situations”, the word “spontaneously” was considered to lack an appropriate equivalent Hindi word to convey the same meaning. Hence, to retain the same meaning, the words “praying without prior planning/preparation and/or over and above the usual daily religious practices” were used.

In all of the items, while translating the word “prayer”, the additional word “dua” was used keeping in mind the Muslim population.

The validity of the Hindi adapted version of the CRS was evaluated in healthy participants. The scale showed good test–retest reliability and Cronbach’s alpha was 0.95 (Grover and Dua 2019), which is much higher than that shown in the Indian sample in the original CRS (Huber et al. 2020). This possibly suggests that the Hindi adapted version has better acceptability and validity in the Indian context.

2.2. Comparison of CRSi-20 between Healthy Subjects and Those with Depression

Group I consisted of 80 participants with a diagnosis of first-episode depression and Group II consisted of 80 healthy participants. The groups did not differ statistically on any of the demographic variables (Table 1).

In the depression group, the mean age of onset for the depressive episode was 30.36 years (SD: 10.73), with the mean duration of illness of 6.1 months (SD: 7.22). The mean Beck Depression Inventory (BDI) score at the time of assessment was 33.2 (SD: 7.5), and all the participants with depression were suffering from severe depression at the time of evaluation.

As shown in Table 2, in terms of religiosity, the two groups did not differ on the total mean scores on the CRS. However, when the differences were evaluated for individual items, participants with depression had lower religiosity on two items. In terms of various domains of CRS, there was no significant difference between the two groups, except for in the domain of ideology and public practice. The participants with depression had significantly higher scores on the ideology domain as compared to healthy participants. On the other hand, the healthy participants scored significantly higher on the public practice domain. In terms of the total scores, the healthy participants had a higher proportion of “highly religious” subjects as compared to those in the depression group.

Table 1. Sociodemographic profiles of the study groups.

Sociodemographic Variables	Depression Group Mean (SD) [Range]/Frequency (%) N = 80	Healthy Subjects Mean (SD) [Range]/Frequency (%) N = 80	t-Test/Chi-Square Test
Age	30.77 (10.71) [16–71]	33.32 (8.47) [20–57]	1.67 (0.09)
Gender			
Male	40 (50.0)	42 (52.5)	0.10 (0.75)
Female	40 (50.0)	38 (47.5)	
Current Marital Status			
Currently married	40 (50.0)	28 (35.0)	3.68 (0.06)
Currently unmarried	40 (50.0)	52 (65.0)	
Education—Number of Years	13.47 (2.21) [10–17]	14.17 (2.32) [10–17]	1.95 (0.05)
Religion			
Hindu	47 (58.8)	47 (58.8)	0.00 (1.00)
Non-Hindu ¢	33 (41.3)	33 (41.3)	
Family Type			
Nuclear	51 (63.7)	44 (55.0)	1.27 (0.26)
Non-nuclear	29 (36.3)	36 (45.0)	

¢ Non-Hindu. Depression group: Sikh (n = 30), Muslim (n = 3). Healthy control group: Sikh (n = 28), Muslim (n = 5).

Table 2. Comparison of religiosity of healthy subjects and those with depression.

Domain	Item No.	Item	Depression Group Mean (SD)/Frequency (%) N = 80	Healthy Controls Mean (SD)/Frequency (%) N = 80	t-Test/Chi-Square Test
Intellect	1	How often do you think about religious issues?	3.44 (1.08)	3.2 (1.32)	1.2 (0.21)
Ideology	2	To what extent do you believe that God or something divine like “devi-devta” exists?	3.69 (1.13)	3.11 (1.21)	3.10 (0.002) **
Public practice	3	How often do you take part in religious services (such as going to temple to pray, going to religious congregations, going on religious pilgrimages, and to religious fairs as well as performing rituals pertaining to religious activities)?	3.36 (1.35)	3.64 (1.23)	1.34 (0.18)
Private practice	4a	How often do you pray?	4.09 (1.21)	4.01 (1.17)	0.39 (0.68)
Private practice	4b	How often do you meditate (or indulge in chanting, ponder over and indulge in remembrance of God)?	3.71 (1.54)	3.74 (1.33)	0.11 (0.91)
Experience	5a	How often do you experience situations in which you have the feeling that God or something divine such as “devi-devta” intervenes in your life?	3.08 (1.36)	2.82 (1.33)	1.17 (0.24)
Experience	5b	How often do you experience situations in which you have the feeling that you are one with all?	2.16 (1.34)	2.44 (1.29)	1.31 (0.18)
Intellect	6	How interested are you in learning more about religious topics?	2.8 (1.14)	2.93 (1.33)	0.63 (0.52)
Ideology	7	To what extent do you believe in afterlife, e.g., immortality of the soul, reincarnation?	2.85 (1.5)	2.61 (1.48)	1.00 (0.31)
Public practice	8	How important is it to take part in religious services (such as going to temple to pray, going to religious congregations, going on religious pilgrimages, and to religious fairs as well as performing rituals pertaining to religious activities)?	2.76 (1.14)	3.75 (1.04)	5.73 (<0.001) ***
Private practice	9a	How important is personal prayer for you?	3.11 (1.25)	3.9 (1)	4.39 (<0.001) ***
Private practice	9b	How important is meditation (or chanting, pondering over and indulgence in remembrance of God) for you?	3.31 (1.43)	3.16 (1.12)	0.73 (0.46)

Table 2. Cont.

Domain	Item No.	Item	Depression Group Mean (SD)/Frequency (%) N = 80	Healthy Controls Mean (SD)/Frequency (%) N = 80	t-Test/Chi-Square Test
Experience	10a	How often do you experience situations in which you have the feeling that God or something divine like “devi-devta” wants to communicate or reveal something to you?	2.13 (1.22)	2.34 (1.31)	1.06 (0.28)
Experience	10b	How often do you experience situations in which you have the feeling that you are touched or influenced by a divine power?	1.96 (1.11)	2.3 (1.06)	1.96 (0.05)
Intellect	11	How often do you keep yourself informed about religious questions or topics through radio/TV?	2.5 (1.27)	3.39 (1)	4.90 (<0.001) ***
Ideology	12	In your opinion, how probable is it that a higher power really exists?	3.07 (1.39)	2.85 (1.38)	1.02 (0.30)
Public practice	13	How important is it for you to be connected to a religious community or society, group, cult, or conglomeration?	2.93 (1.28)	3.03 (1.3)	0.49 (0.62)
Private practice	14a	How often do you pray spontaneously when inspired by daily situations or pray without prior planning/preparation and/or over and above the usual daily religious practices?	3.18 (1.17)	3.72 (1.1)	3.06 (0.003) **
Private practice	14b	How often do you try to connect to the divine spontaneously when inspired by daily situations or without prior planning/preparation and/or over and above the usual daily religious practices?	2.5 (1.17)	3.46 (1.25)	5.02 (<0.001) ***
Experience	15	How often do you experience situations in which you have the feeling that God or something divine <i>such as</i> “devi-devta” is present?	2.56 (1.28)	2.66 (1.38)	0.47 (0.63)
		Intellect	8.74 (2.64)	9.51 (2.72)	1.82 (0.06)
		Ideology	9.61 (3.07)	8.58 (3.39)	2.02 (0.04) *
		Public practice	9.05 (2.96)	10.41 (2.97)	2.90 (0.004) **
		Private practice	11.14 (2.9)	12.0 (2.62)	1.97 (0.05)
		Experience	8.08 (3.08)	8.3 (3.1)	0.45 (0.64)
		Total	46.56 (11.61)	48.8 (13.51)	1.12 (0.26)
		Mean	3.1 (0.77)	3.25 (0.9)	1.12 (0.26)
		Level of religiosity			
		Not religious	6	6	
		Religious	64	53	4.93 (0.085)
		Highly religious	10	21	

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$.

3. Discussion

Religion in India is a complex concept considering the diversity of various religions, polytheistic views, as well the assimilation of religious practices into the sociocultural norms. Hence, any instrument which is to be used in the Indian context to assess religiosity needs to take these facts into consideration. Keeping these facts in mind, in the present study, CRS was adapted in the Indian context. However, the adaptation was done in such a way that the items did not lose the meaning of the original scale and, hence, the findings drawn by using the adapted scale remain comparable to studies based on CRS from other parts of the world. The adaptations took into account various aspects of practicing religiosity in India. It is expected that the availability of this adapted scale will further research in this area. When the CRSi-7 was used in the Indian context, without adaptation, the mean item score was 3.88 (SD 0.62) and was considered to be higher than the international average. In contrast, in the adapted version used in the present study, the mean item score ranged from 3.1 (for the healthy subjects) to 3.25 for the participants with depression. When we compare the mean score of the adapted versions with findings from other international studies, the mean item scores in the Indian context are still higher compared to those reported in studies from one country ([Ackert et al. 2020a](#)), but comparable to studies reported from two countries ([Lee and Kuang 2020](#); [Fradelos et al. 2018](#)) and lower than those reported in studies from three countries ([Esperandio et al. 2019](#); [Zarzycka et al. 2020](#); [Ackert et al. 2020b](#)).

In the present study, we also compared participants with and without depression to understand the impact of mental illness (depression) on religiosity. It was observed that the participants in both groups did not differ significantly in terms of mean scores for most of the items and three out of the five dimensions. However, significant differences were observed in the dimensions of ideology and public practice between the two groups. These findings possibly suggest that going through an experience of depression influences faith in God, as indicated by the ideology domain. It is also possible that the participants had higher faith in God to start with, which makes them more vulnerable to depression. It is also possible that higher ideology may contribute to the severity of depression in the form of experiencing ideas of guilt or sin.

In India, public practice is a part of the daily routine of many individuals. Going to religious gatherings and religious places such as temples and “gurudwaras” are often the morning ritual. The negative impact of depression on public practices may be understood from the perspective of all the participants suffering from severe depression at the time of assessment for the study. People with severe depression may be experiencing psychomotor retardation, which possibly influences going out for religious activities. It is also possible that participants with depression may have lower participation in the public practices, which makes them more vulnerable to depression, as participation in public religious practices often provides social support by virtue of affiliation and a sense of belonging, which may act as a protective factor against depression.

The present study was limited by its small sample size and it was cross-sectional. Hence, the findings for the depression group must be interpreted in the light of cross-sectional assessment and cause–effect association must not be interpreted. Future longitudinal studies should evaluate subjects on multiple occasions to understand to the effect of religiosity on depression.

4. Materials and Methods

This cross-sectional study was conducted at a tertiary-care multispecialty teaching hospital after obtaining approval from the ethics committee of the institute, and all the participants were recruited after obtaining written consent. The study included 2 groups of participants; Group I consisted of participants with first-episode depression while Group II included healthy participants, who were free from depression and were matched with Group I for age, gender, and level of education.

The study participants were recruited by purposive sampling. To be included in the study, the participants of Group I were required to be diagnosed with a major depressive episode as diagnosed by Mini International Neuropsychiatric Interview (MINI)–PLUS ([Sheehan et al. 1998](#)), aged 16–75 years, able to read Hindi/English, and provide written informed consent. Patients with

primary psychotic illness (non-affective), bipolar affective disorder, organic brain syndrome, intellectual disability, those suffering from a terminal medical illness like cancer, unwilling to participate in the study, or medically not fit to participate were excluded. Participants in Group II did not meet any psychiatric disorder as per the MINI-PLUS.

Participants in both groups were assessed on the Centrality of Religiosity Scale (Huber and Huber 2012). Participants with depression were also evaluated on the Beck Depression Inventory (BDI) (Beck et al. 1961) to rate the severity of depression.

One paper discussing the validation of Hindi CRS has already been published (Grover and Dua 2019) and some of the data of CRS of subjects with depression included in the present study sample has also been published (Dua et al. 2016). However, the validation paper did not include the information about the exact adaptations required in the Hindi version of CRS, and the depression paper did not present an item-wise comparison of CRS between patients with depression and the healthy controls. For this paper, the demographic profile of both groups was matched.

The Centrality of Religiosity Scale (CRS) (Huber and Huber 2012) is a measure of the centrality, importance, or salience of religious meanings in personality. It measures the general intensities of five theoretically defined core dimensions of religiosity. The dimensions of public practice, private practice, religious experience, ideology, and intellectual dimensions can together be considered as representative for the total of religious life. From a psychological perspective, the five core dimensions are seen as channels or modes in which personal religious constructs are shaped and activated. The activation of religious constructs in personality can be regarded as a valid measure of the degree of religiosity of an individual. In the original description of the CRS scale (Huber and Huber 2012), the authors had provided norms for the Indian population. According to this, the mean of the 7-item version of the CRS (CRSi-7) is 3.88.

As part of the validation study, the CRS-i20 version was translated to Hindi by 3 health-care professionals (one psychiatrist, one clinical psychologist, and one social worker) with proficiency in both Hindi and English following the World Health Organization standard methodology of translation and back-translation. The three Hindi translations were initially reviewed by a panel of experts (two psychiatrists and one clinical psychologist) who were not a part of the initial translation process, for accuracy and semantics. Each item was evaluated to confirm that it retained the original meaning. The version closest to the original scale was retained. In case the experts considered that none of the translations conveyed the original meaning, the item was modified/translated to achieve the same. The experts also focused on the need for adaptation of certain items in the Indian context where the majority of the people follow Hinduism, Sikhism, and Islamic religions. Wherever required, examples were provided to make the items more explicit.

Based on the above modifications, a pre-final version of the scale was designed. This was given to 10 health care professionals and 10 laypersons for evaluating the simplicity of the language and cultural appropriateness. Further modifications were made based on the inputs provided and a final Hindi version of the CRSi-20 was prepared. This was back-translated to English by another set of bilingual health-care professionals and the same was matched to the original English version CRS. In case there were any discrepancies between the original English version and the back-translated version, modifications were made to retain the original meaning while maintaining cultural appropriateness to arrive at the final Hindi adapted version of CRS.

Data were analyzed by using SPSS-14. Continuous data were evaluated in the form of mean and standard deviations and the categorical data were analyzed in the form of frequency and percentages. Comparisons were made by unpaired *t*-test and the Chi-square test.

5. Conclusions

The present study shows that CRS requires adaptation in the Indian context. The present study also suggests that people with depression differ from healthy controls on certain aspects of religiosity.

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