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The Correlation of Some Characteristics of Religious Identity with the Quality of Life of Persons with Disabilities

Povezanost posameznih značilnosti religiozne identitete s kakovostjo življenja oseb z invalidnostjo

Abstract: Research on the correlation between religious identity and the quality of life of disabled persons is relatively rare and not always yielding the same results. In this paper, attempting to clarify the image of the mentioned relationship, we examine the correlation of some characteristics of religious identity with happiness and personal well-being among persons with various disabilities. An empirical study was conducted (N=684), and the results suggest that blind persons are the most religious, while the least religious are deaf persons. A positive correlation of happiness and personal well-being was found concerning intrinsic characteristics of religiosity, while some extrinsic characteristics of religiosity (declarative belonging to a religious community and the frequency of attending religious seminars) did not show a significant correlation. Faith gives the feeling of belongingness and safety and can be a resource from which disabled persons can draw the strength to cope with a disability; however, it needs to be lived and not expressed just declaratively or ritually.

Keywords: persons with disabilities, religiosity, religious identity, happiness, personal well-being, quality of life

Povzetek: Raziskave o povezavah med religioznostjo in kakovostjo življenja oseb z invalidnostjo so razmeroma redke. Njihovi rezultati se med seboj večkrat ne ujemajo. Da bi ugotovili jasnejše stanje glede medsebojne povezanosti obeh fenomenov, smo v tem članku preverili posamezne elemente religiozne identitete z občutenjem sreče in blagostanja pri osebah z različnimi oblikami invalidnosti. Empirična raziskava je zajela 684 oseb z invalidnostjo. Rezultati kažejo, da so najbolj religiozne slepe osebe (nevideči), najmanj pa gluhe (neslišeči). Pozitivna korelacija med občutenjem sreče v življenju in osebnim blagostanjem se pri invalidnih osebah izkazuje glede na intrinzične (globoko notranje) dejav-

nike religioznosti, medtem ko na drugi strani statistično značilne pozitivne korelacije nista izkazala elementa samodeklarirane pripadnosti verski skupnosti in pogostosti izvajanja posameznih vrst verske prakse. Vera omogoča občutek pripadnosti in zanesljivosti, tako lahko za osebe z invalidnostjo pomeni vir, iz katerega črpajo moč za sobivanje z invalidnostjo. Zato morajo te osebe vero dejansko živeti, ne pa se z njo le deklarativno poistovetiti ali zgolj obiskovati verske obrede.

Ključne besede: osebe z invalidnostjo, religioznost, religiozna identiteta, sreča, osebno blagostanje, kakovost življenja

1. Introduction

Health is indeed one of the most represented topics, not only in scholarly and professional literature but also in everyday communication. As an ideal, which needs to be achieved or preserved, society invests excellent efforts in detecting the various factors contributing to health development and those causing its deterioration and inducing malfunctions, illnesses, or disabilities. The factors can be of different origin (biogenic, psychogenic, sociogenic), and it seems that a part of them are derived from the spiritual, i.e., the religious domain of the human being.

2. Religion – health – disability

We live in a time when health is often regarded as the ‚highest good' and, as Karl Gabriel would suggest, based on the teaching of Thomas Luckmann, it is becoming a kind of a »this-worldly religion« (Gabriel 2006, 218–223). This lifelong ‚jihad' for physical fitness, of a kind, reshapes the world around the body (Bauman 2005, 94–95), often making people practically obsessed with bodily topics and hunting for health. Therefore, theologian and physician Manfred Lütz is suitable in pointing out that the postmodern crisis of religion, i.e., the religious vacuum, is becoming increasingly filled with health (Gabriel 2006, 222; Gašpar and Perković 2010, 289).

Nevertheless, the relationship between religion and health is not placed solely on the level of exclusivity. The notions of health/illness and religion have had a long history of mutual relationships and have been a subject of interest of practically all religions. Primitive medicine has, in fact, entirely relied on religion (and magic); medieval monastic and scholastic medicine used the interpretation of holy scriptures for healing. In contrast, ancient Islamic medicine relied on sacred texts stipulating hygiene and diet as health prerequisites (Žuškin et al. 2012). As far as scholarly interest is concerned, several empirical studies dealt with the topic in the 19th century already; however, the positivistic oriented science often ignored

or pathologized the religious dimension of life. For example, Amariah Birgham lists the negative influences of religion on health in 1835, although pointing out some positive influences. He thus remarks that some religious rituals (circumcision, castration, flagellation, bodily scarification, joint ankylosis), religious teaching, inadequate spaces (cold, dim spaces), even the »peculiar influence of the Spirit« can harm human health (Birgham 1835, 49–76).

In the previous century also, some studies emphasize the negative influence of religion. Analyzing various studies, Ančić (2016, 8) finds that some of them suggest that a religious community can sometimes by its teaching impose certain beliefs that promote social deviance harmful to health, or that participation in a religious community can also contribute to the creation of social pressure, eventually leading to the consequences that harm health. Still, it is a fact that in the second half of the 20th century, various epidemiological studies also emerged, which were pointing out the positive correlation of religion and the improvement of symptoms of various physical and organic malfunctions. The latter also generally pointed to a positive relationship between religion and health in a broader sense (Ančić and Marinović Jerolimov 2011, 72; Ančić 2016, 8).

Nowadays, research often emphasizes positive correlations of spirituality and health, particularly in providing help with depressions (Platovnjak 2020). Religion reduces the risk of developing cardiovascular illnesses, high blood pressure, stroke, most cancers, and influences other domains of life quality, such as lower rates of divorces, alcoholism, drug addiction, and higher rates of life and marital satisfaction (Thoresen 1999, 294). Lee and Newberg (2005, 456) assert that prayer and meditation affect human psychological health positively (psychological tranquillity, finding the meaning of life, a more mature approach to life's hardships, reducing anxiety and depression, and higher emotional stability self-actualization, etc.). Spirituality thus offers the meaning of life by its positive effects and provides ill persons with relief in coping with illness, ageing, and death (Macuh and Raspor 2018, 647). Moreover, a negative correlation between religiosity and suicide has also been found (Nisbet et al. 2000)

Canda (2001, 110) finds that numerous studies in mental health and social work point out that spirituality contributes to developing resilience to illness among persons with disabilities. Edwards and collaborators (2016, 296) emphasize that religion provides a »positive framework for illness«, and it is increasingly pointed out that the inner world of a person, his/her attitudes towards life, his/her values, beliefs, and inspirations can provide help in coping with any of life's challenges, including illness and disability. A similar finding is presented in one of the most recent studies (Mugeere et al. 2020, 69), by which it was shown that persons living with disablement attach great importance to faith or believing in a supreme being, which empowers them to face the challenges of disablement, go further and understand the course of their lives more quickly. Kim (2020, 824) also finds that religiosity helps people face the emergence of disability. In other words, the very fact of becoming disabled undoubtedly decreases

the level of personal well-being; however, to a much greater extent non-religious, than in religious persons.

Moreover, it suggests a significant difference between the levels of happiness in religious versus non-religious individuals. Thus, spirituality and religion have become sources of strength in difficult temptations (Pate 2016, 438). It is, therefore, unsurprising that some research suggests a high percentage of persons with disabilities who are religious (around 80–85 %) and who state that faith plays an essential role in their lives (Imhoff 2017, 186). Simultaneously, studying memoirs and biographies written by persons with disabilities, Imhoff finds that even those authors who are not religious convey the need to offer some religious or theological explanation of their status.

3. Aims of the study

Research on the relations between religiosity and the characteristics of health status, psychosocial structure, and the quality of life of disabled persons is still rare, even on the global level. The existing ones do not always yield identical results, thus somewhat blurred by the nature of this relationship. Simultaneously, it is a fact that cultures, religions, and then forms of religiosity differ significantly from one setting to another. Therefore, it is plausible to presume that both their relationship to the health status can also vary significantly and that in order to have the whole mosaic of the relation between religion and health, it is necessary to have all of its pieces. This paper aims to contribute to the global knowledge on the correlation between some characteristics of religious identity and psychosocial functioning of persons with disabilities (the feeling of happiness in life and the level of personal well-being).

4. Methods

4.1 Procedure

The empirical study among persons with various disabilities was conducted in 2015/2016 in Zagreb, Croatia. By employing systematic probabilistic sampling, the study included members of several civil society organizations of persons with disabilities (Table 1), and the sample was stratified proportionally to the size of respective CSOs.

Two research approaches were employed – postal survey and the method of direct surveying. The most significant number of answers was collected by the first method, while direct surveying was employed only in the deaf and hard of hearing, and the blind and partially sighted were unable to read and fill in the questionnaire without assistance. In both cases, the respondents were informed about the aims and the purpose of the study, and the participation in the study

was voluntary and anonymous. The respondents were not obliged to sign nor to give any data that might reveal their identity. At the same time, it was explained to them that the results would be used exclusively as a set of data for statistical analysis on the group and not the individual level.

4.2 Instruments

Religiosity is a rather intimate, multidimensional, and complex phenomenon that is very hard to measure (Marinić 2014; Klarin and Krasicki 2020). Nevertheless, it is possible to grasp some of its outlines by analyzing various characteristics of religious identity. This was attempted to be achieved by exploring a total of five questions/variables – belongingness to a particular religious community and acceptance of the teaching; level of religiosity; helpfulness of faith in life, illness and accepting one's status; attendance of healing and spiritual renewal seminars; level of conviction that faith could heal a person. It was for this study that we constructed some of these questions, while the remaining scales were taken and modified from the study „Vjera i moral u Hrvatskoj" [Faith and Morals in Croatia] (Valković et al. 1998).

Happiness, i.e., the affective component of subjective well-being, is measured by the instrument constructed by Fordyce (1988). In it, the respondents are asked to assess their usual mood (happiness) on an 11-degree scale (0-extremely unhappy, 10-extremely happy).

To analyze specific and individual domains of subjective well-being, we employed the modified International Well-being Index – IWI (Cummins et al. 2003) in our study. Initially, the questionnaire consists of the personal and national index; however, in this study, we analyzed only seven items of the personal well-being index: life standard, health, life achievement, relations with family and friends, the feeling of physical safety, the acceptance within the community and the feeling of safety regarding the future. We also asked the participants to assess their satisfaction with the mentioned aspects of life on a scale of 11 degrees (0-extremely unsatisfied, 10-extremely satisfied).

Additionally, we used the information on the socio-demographic characteristics of the participants and the data on the distinctive characteristics of their health status.

4.3 Achieved sample

Altogether, a total of 1630 persons with disabilities were contacted to participate in the study. A total of 42 % of them accepted and accurately filled in the questionnaires. Thus, the final number of respondents was 684 persons with various types of disabilities. Due to the specificity of particular types of disablement, and to better overview the comparisons and table presentations of the results, the sample was first divided into persons with physical and those with sensory disabilities. The sub-sample of persons suffering from physical disabilities was then divided into the easier moveable (those who can walk without assistance or with

the help of medical aid or another person) and those hard of moving (who can move in a wheelchair or are completely immovable). The sub-sample of persons with sensory disabilities was divided into those with impaired hearing and impaired vision. The structure of the achieved sample divided as explained is presented in Table 1.

		Physical disability		Sensory disability		Total
		Easier movable	Hard of moving or immovable	Deaf and hard of hearing	Blind and partially sighted	
Zagreb Muscular Dystrophy Society	N	43	49	0	0	92
	%	46.74	53.26	0	0	
Association of persons with cerebral palsy and polio Zagreb	N	44	45	0	0	89
	%	49.44	50.56	0	0	
Multiple Sclerosis Society of Zagreb	N	95	34	0	0	129
	%	73.64	26.36	0	0	
Zagreb Association of the Physically Disabled	N	85	27	0	0	112
	%	75.89	24.11	0	0	
Association of the Deaf and Hard of Hearing of the City of Zagreb	N	0	0	103	0	103
	%	0	0	100	0	
Spinal Injuries Zagreb	N	6	44	0	0	50
	%	12	88	0	0	
Zagreb Association of Blind Persons	N	0	0	0	109	109
	%	0	0	0	100	
Total	N	273	199	103	109	684

Table 1: *Achieved sample according to types of disabilities.*

In the context of sociodemographic characteristics, the sample was comprised of 56.14 % of women, and 43.86 % of men, respectively. The average age of the respondents was 50.99 (SD=16.292), and they were dispersed in all legal age groups (age range 18–98).

From the aspect of characteristics related to disability, 29.5 % of persons were born with a disability, 24 % became disabled by the age of 20, and all the remaining became persons with disabilities in somewhat later periods of life. Almost 70 % of the respondents have the highest officially assessed degree of disability. It is often a consequence of a severe illness (60 %), while the remaining part is a consequence of traffic accident, occupational injury, war injury, or some other cause.

5. Results

Based on our five variables, we first analyzed the characteristics of the religious identity of persons with disabilities.[1]

Our first variable (on the declarative belongingness to a religious community and acceptance of the religious community's teaching) showed that more than two-thirds of the respondents were members of some religious community, albeit a part of them accepted all that their religious community was teaching, while the other did not (37.96 compared to 31.71 %). The number of believers, but do not belong to any religious community is 13.41 %, while a little above 10% points out that they are not believers. (Table 2)

		Physical disability		Sensory disability		Total
		Easier movable	Hard of moving or immovable	Deaf and hard of hearing	Blind and partially sighted	
I believe and accept all that my religious community teaches	N	118	61	24	46w	249
	%	44.53	31.61	25.00	45.10	37.96
I believe but do not accept all that my religious community teaches	N	81	73	21	33	208
	%	30.57	37.82	21.88	32.35	31.71
I believe in God or a higher force but do not belong to any religious community	N	28	28	21	11	88
	%	10.57	14.51	21.88	10.78	13.41
I do not believe in God, nor a higher force	N	25	19	18	8	70
	%	9.43	9.84	18.75	7.84	10.67
I am looking for answers	N	13	12	12	4	41
	%	4.91	6.22	12.50	3.92	6.25
Total	%	100	100	100	100	100

Table 2: *Belongingness to a religious community.*

We observe the distribution of the answers classified across our groups: the highest percentage of those who believe and accept all that their religious community teaches in the group of the blind (45.10 %) and more accessible movable persons with a physical disability (44.53 %). On the other side, the highest number

[1] A part of the results from Tables 2–6 are also presented in the final group overview of all the results obtained after the completion of the empirical study (See: Marinić and Rihtar 2016, 70,132-133). Nevertheless, these results were weighted according to the sizes of corresponding CSOs and, unlike the results presented hereinafter, included only descriptive overviews (percentages and means), without concrete frequencies and more detailed statistical analyses ($\chi 2$ test, variance analysis, t-test and Pearson correlation).

of convinced atheists is deaf and hard of hearing – as many as 18.75 %, while this percentage is below 10 % in other groups. Therefore, it is clear that the χ2 test revealed a statistically significant difference among the groups in the answers to this question ($\chi^2 = 38.223$; p=0.000).

On an 11-degree scale, we tested the respondents' religiosity's innate sense, regardless of formal (non)belonging to a religious community. The average answer on the scale ranging from 0 (not religious at all) to 10 (extremely religious), which is 5.66, points to a generally moderate level of religiosity. Nevertheless, by observing the results according to the groups of respondents with different disabilities, significant differences in mean values of the answers are also visible. Notably, it has been revealed that deaf and hard of hearing persons were the least religious (M=4.31), while the most religious were blind and partially sighted persons (M=6.37). The variance analysis points to the statistical significance of these differences (F=6.965; p=0.000).

	N	Minimum	Maximum	Mean	Std. Deviation
Easier movable	242	0	10	5.84	3.177
Hard of moving or immovable	169	0	10	5.66	3.279
Deaf and hard of hearing	81	0	10	4.31	2.764
Blind and partially sighted	94	0	10	6.37	2.958
Total	586	0	10	5.66	3.167

Table 3: *Level of religiosity.*

The level of religiosity was tested with the respondents' sex, and it was found that women were reporting a significantly higher level of religiosity (M=6.11) than men (M=5.17). The t-test analysis confirmed the finding (t=-3.569; p=0.000).

The same measure of religiosity was correlated to the respondents' age. Unlike the previous analysis, we did not find a significant correlation here (r=0.042; p=0.326), i.e., there were no large deviations and regularities in expressing the level of religiosity of respondents grouped according to age.

In the context of the severity/degree of disability correlated with this variable, it was detected that there was no statistically significant correlation (r=0.028; p=0.503). Both the respondents with a less severe degree of disability and those with a more severe degree reported a similar level of religiosity.

In the subsequent analysis, we asked the respondents directly to what extent they found faith helping them cope with the disability. The results of the answer to the question »If you are a believer, can you assess how much your faith helps you in your life, illness and accepting your status?«, displayed in Table 4, indicate that around 42 % of the respondents see their faith as helpful in coping with their state. However, a fourth of them unambiguously point out not having this type of help.

		Physical disability		Sensory disability		Total
		Easier movable	Hard of moving or immovable	Deaf and hard of hearing	Blind and partially sighted	
I am not a believer	N	35	29	28	13	105
	%	13.06	15.03	27.45	12.26	15.70
It does not help me at all	N	21	24	13	10	68
	%	7.84	12.44	12.75	9.43	10.16
It both helps me and does not help	N	84	60	38	30	212
	%	31.34	31.09	37.25	28.30	31.69
It helps me	N	74	37	22	34	167
	%	27.61	19.17	21.57	32.08	24.96
It helps me a lot	N	54	43	1	19	117
	%	20.15	22.28	0.98	17.92	17.49
Total	%	100	100	100	100	100

Table 4: *Helpfulness of faith in coping with challenges due to disability.*

Once again, it has been shown that in the deaf and hard of the hearing group, there was the highest percentage of those reporting not being believers or not feeling such help – around 40 % in total. Moreover, only one respondent from that group stated that faith was of great help to him. On the other side, if we add the answers »It helps me« and »It helps me a lot«, we see that the highest percentage (a little below 50 %) is in the group of the blind and partially sighted and in the group of the more straightforward movable persons with a physical disability. The χ^2 test points to the statistically significant difference in the groups' answers (χ^2=41.053; p=0.000).

Since the respondents are persons with severe and permanent health problems, i.e., disabilities, we thought it would be interesting to ask them whether they attended healing and spiritual renewal seminars. Table 5 provides evidence that two-thirds of the respondents have never attended these types of worship, while only 17.21 % of them have been to such events multiple times.

Keeping in mind that most often, there are no sign language interpreters present at worship, the most significant number of the respondents who have never been to a seminar or spiritual renewal is from the group of deaf and hard of hearing persons (over 91 %). The most frequent attendees of this type of spiritual gatherings are the hard of moving or the completely immovable (23.32 %). The χ^2 test again revealed a statistically significant difference in the groups' answers (χ^2=34.974; p=0.000).

		Physical disability		Sensory disability		Total
		Easier movable	Hard of moving or immovable	Deaf and hard of hearing	Blind and partially sighted	
Never	N	174	115	94	70	453
	%	64.44	59.59	91.26	64.81	67.21
Once	N	49	33	5	18	105
	%	18.15	17.10	4.85	16.67	15.58
Multiple times	N	47	45	4	20	116
	%	17.41	23.32	3.88	18.52	17.21
Total	%	100	100	100	100	100

Table 5: *Attendance of healing and spiritual renewal seminars.*

Finally, we asked them if they believed that strong faith in God could heal a person, regardless of the illness he/she was suffering from. A third of the respondents thought that was impossible, and once again, it was shown that it mainly was the deaf and hard of hearing who had such an opinion (53.4 % of them).

We also tested the statistical significance of the differences in the groups' answers, and it was confirmed (χ^2=32.614; p=0.000).

		Physical disability		Sensory disability		Total
		Easier movable	Hard of moving or immovable	Deaf and hard of hearing	Blind and partially sighted	
No	N	75	63	55	27	220
	%	27.78	33.16	53.40	25.00	32.79
Both yes and no	N	86	58	28	36	208
	%	31.85	30.53	27.18	33.33	31.00
Yes	N	75	40	9	27	151
	%	27.78	21.05	8.74	25.00	22.50
I do not know	N	34	29	11	18	92
	%	12.59	15.26	10.68	16.67	13.71
Total	%	100	100	100	100	100

Table 6: *Can strong faith heal a person.*

In the following analyses, we used all the mentioned variables of religiosity as independent variables in assessing the correlation with some domains of life of persons with disabilities. Since the analysis was conducted by employing the method of Pearson correlation, we adjusted some questions so that the scale of answers would be adequate. In the first question, regarding belonging to a religious

community, we excluded the answer »I am looking for answers«. Further on, in the question regarding whether strong faith could heal a person, we excluded the answer »I do not know«. Finally, in the direct question on how helpful faith was in life, illness, and accepting one's health conditions, we merged the answers »I am not a believer« and »It does not help me at all« in one answer. The questions were correlated with the level of happiness in life and the IWI Personal Well-being Index.

It is clear from Table 7 that the very fact of declarative belonging to a religious community and accepting its teaching is not in correlation with any of the analyzed variables. In other words, those who belong to a religious community and accept declaratively all that a particular community teaches are equally happy, and their well-being index does not differ significantly.

In the following question, in which the intrinsic dimension of religiosity was assessed, i.e., the level of personal religiosity, there were significant correlations with all the analyzed characteristics of disabled persons' lives. The persons express a higher level of religiosity while reporting higher levels of happiness and personal well-being.

The same was repeated in the direct question of how helpful faith was in their lives, illness, and accept their status. All the analyzed domains are positively correlated with this question, i.e., the more they think that faith helps them in life, the more satisfied they are with these domains.

The frequency of attending healing and spiritual renewal seminars is not related to happiness and personal well-being, while the very intrinsic level of the conviction that faith could heal a person is positively correlated with these variables.

		A feeling of personal happiness	IWI Personal Well-being Index
Belongingness to a particular religious community and acceptance of the teaching	r	-0.002	0.019
	p	0.968	0.661
	N	575	520
Level of religiosity	r	0.181(**)	0.119(**)
	p	0.000	0.007
	N	551	504
Helpfulness of faith in life, illness, and accepting one's status	r	0.172(**)	0.121(**)
	p	0.000	0.004
	N	618	559
Attendance of healing and spiritual renewal seminars	r	0.069	0.048
	p	0.085	0.256
	N	622	562
Level of conviction that faith could heal a person	r	0.160(**)	0.092(*)
	p	0.000	0.041
	N	539	490

*** Correlation is significant at the 0.01 level (2-tailed),*

** Correlation is significant at the 0.05 level (2-tailed)*

Table 7: *Pearson correlation of religiosity variables with personal happiness and IWI Personal Well-being Index.*

We also wanted to know which of the seven domains analyzed within the IWI Personal Well-being Index were correlated with religiosity (life standard, health, life achievement, relations with family and friends, feeling of physical safety, acceptance from the community, and feeling of safety regarding the future). The results indicate that the correlation of particular characteristics of religious identity with the analyzed domains of personal well-being is primarily detected in the domains referring to the feeling of safety regarding the future, satisfaction with the general acceptance within the community in which a person lives, and the social relations. The persons reporting a higher level of religiosity are more satisfied with these domains, while on the other side, none of the questions was correlated with life standard and achievements.

		Satisfaction with the living standard	Satisfaction with the health	Satisfaction with life achievements	Satisfaction with personal relations	Satisfaction with the feeling of safety	Satisfaction with belonging to the community where they live	Satisfaction with the feeling of safety in the future
Belongingness to a particular religious community and acceptance of the teaching	r	0.009	0.097(*)	0.047	0.002	0.016	-0.084(*)	-0.021
	p	0.836	0.018	0.261	0.955	0.709	0.045	0.624
	N	575	588	563	582	577	573	562
Level of religiosity	r	0.082	-0.021	0.04	0.096(*)	0.072	0.173(**)	0.144(**)
	p	0.056	0.628	0.345	0.024	0.089	0.000	0.001
	N	548	559	546	556	552	548	542
Helpfulness of faith in life, illness and accepting one's status	r	0.064	-0.006	0.051	0.075	0.090(*)	0.180(**)	0.157(**)
	p	0.108	0.887	0.212	0.061	0.024	0.000	0.000
	N	623	636	611	630	626	618	610
Attendance of healing and spiritual renewal seminars	r	0.011	-0.017	0.045	0.052	0.036	0.048	0.082(*)
	p	0.781	0.674	0.261	0.186	0.362	0.235	0.042
	N	627	641	615	635	631	622	615
Level of conviction that faith could heal a person	r	0.059	-0.002	0.002	0.023	0.064	.151(**)	.143(**)
	p	0.170	0.954	0.961	0.583	0.138	0.000	0.001
	N	540	554	534	549	546	539	534

*** Correlation is significant at the 0.01 level (2-tailed)*

** Correlation is significant at the 0.05 level (2-tailed)*

Table 8: *Pearson correlation of religiosity variables with all the analyzed domains of IWI Personal Well-being Index.*

6. Discussion and conclusion

Previous research has not always yielded identical results. However, a considerable amount of them suggested a strong relationship between religiosity and persons with disabilities, i.e., that disabled persons were highly religious (80–85 %) and emphasized the importance of faith in their lives (Imhoff 2017, 186). Our research yielded the same percentage – 83 % of the surveyed persons with disabilities declared themselves as believers from the declarative expression of religious orientation. However, only 38 % of them accept all that their religious community teaches, while the rest either accept one part of the official teaching or consider themselves believers, despite formally not belonging to any religious community or not being believers at all.

A total of 42 % of the respondents pointed out that faith was helping them in life, while 67 % of them have never attended seminars and spiritual renewal meetings, and a little less than a fourth of them believed in the healing power of faith. They rarely report a declaratively atheistic orientation (11 %); nevertheless, it still is a fact that they can neither be labelled as highly religious. This is further supported by the finding suggesting that assessing the level of personal religiosity on a scale from 0 to 10 the respondents scored the average value of 5.66. Therefore, it could be concluded that the most significant number of the respondents are indeed religious, but the average intensity of their religiosity is not high but relatively moderate.

Women report a higher level of religiosity than men do, which aligns with the findings of research studies on the general population (Nikodem and Zrinščak 2019, 381). On the other side, the degree of disability is not significantly correlated with the level of religiosity, and the same is confirmed regarding age, which is not an expected finding.

The blind and partially sighted proved to be the most religious, while on the other side, the deaf and hard of hearing reported the lowest level of religiosity. Moreover, this includes all the analyzed variables. One of the possible causes of such a finding is the question of pastoral. Deaf persons cannot adequately participate in religious instructions and rituals if these are not translated into sign language. Sign language is generally very rarely available in nowadays society, including in pastoral. Since some deaf persons cannot read without assistance, it is clear that it is challenging for them to access high-quality spiritual and religious content and information. They are often victims of discrimination by the social community (Marinić 2020, 568), suggesting that authors Mateljan and Korda (2009, 42) are suitable when arguing that the deaf is one of the most neglected groups within the Church. Our results support this hypothesis while simultaneously presenting an evident indicator of the need for further engagement in adjusting pastoral models to this category of persons with disabilities. It is essential not to forget that pastoral implies the conveyance of information and high-quality education and represents much more than the deaf persons need to be provided with the opportunity to participate in all aspects of church life, just like the

rest, and be integrated completely, thus making them feel full members of their religious community.

Similar could be remarked regarding immovable and hard of moving persons, who reported the second-lowest level of religiosity following the deaf and hard of hearing. Although the communication model with them is less challenging, several other barriers need to be eliminated to make the pastoral among them effective.

By analyzing the relationship of religiosity variables with happiness in life and personal well-being, the results confirm the findings of some previously conducted studies (Kim 2020, 824; Thoresen 1999, 294). A significant correlation exists between happiness and personal well-being on one side, the variables of the level of personal religiosity self-assessment, the feeling that faith was helpful in life, and the conviction that faith had the power to heal. All three variables might indicate the notion of ‚intrinsic religiosity', i.e., of a lived and experienced faith, and it is evident that the higher the religiosity in that sense is, the happier individuals feel in their lives more excellent their well-being is. On the other hand, ‚external characteristics of religiosity' (declarative belonging to a particular religious community and the acceptance of its teaching, and the frequency of attending seminars and spiritual renewal meetings) did not indicate a significant correlation with our variables. Indeed, this does not imply that belonging to a community is insignificant or that seminars and spiritual renewals are not a beneficial form of religious practice. It instead suggests that if the latter is only declarative and ritual, they alone do not mean much in the context of happiness and personal well-being. Religiosity needs to be internalized to be a resource that contributes to the quality of life. In this process of ‚internalization', perhaps spiritual renewal seminars can help; however, since this was not the topic of this analysis, the conclusion regarding the matter would not have the necessary substantiation.

Regarding the context of the personal well-being domains, a statistically significant correlation is confirmed with those domains of life related to the feeling of safety regarding the future and those related to social relations in satisfaction with being accepted within the community a person lives. The persons reporting higher levels of religiosity express more satisfaction regarding these domains.

By way of conclusion and briefly – the respondents are a moderately religious segment of the population. The level of religiosity varies significantly among persons with different types of disabilities, and there is a need for additional pastoral efforts towards increasing the quality of catechesis and integration of all persons with disabilities into church life. The persons expressing higher levels of religiosity feel safer regarding their future, maintain better relations with their environment and report higher happiness and personal well-being. Thus, religiosity can be a positive resource for persons with disabilities from which they draw the strength to cope with the challenges arising from their disablement. It needs to become a part of self-identity so that, as Tanja Pate asserts, merciful God's intervention would transform the pain, suffering, and problems inflicted by facing the illness and provide a more fulfilled life (Pate 2016, 438).

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