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Impact of religiosity on depression among elderly people of Punjab, Pakistan

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ABSTRACT

The present study focused on the role of religiosity and depression on the life of older people. At a theoretical level the relationship between religiosity and different dimensions of mental health is frequently discussed, but empirically, it is not discovered thoroughly. The purpose of the current research was to study the association between religiosity and depression among elderly people. A total of 800 (400 males, 400 females) old people of age ranges from 50-70 of Punjab (one of the biggest state of Pakistan) completed measures of geriatric depression scale and religiosity scale. Among older people it was cleared with the results that religiosity has a positive impact on the depression scores of old people. As the religiosity increases depression decreases. Binary logistic regression showed that there is a negative correlation between the scores of depression and religiosity. As the religiosity increases, then the level of depression among older people decreases.

1. Introduction

86% of the whole world population believe and have affiliation with the religion, religious orientation considers and have importance in almost all cultures [1]. Regardless of the importance of religion in the life of the individual there is very small literature about the importance of religion in relation to mental health [2]. This is because of the fact that to study religion is a difficult task. Religions have different shapes and sizes' and these differences have remarkable impact on mental health. Which makes research on religion a challenge. The main reason in studying religion is that there are so many different definitions of religion. Past researchers did not agree on the single definition of religion. All this creates a problem and this leads to less information in psychology literature on religiosity [3].

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The relationship of religiosity and psychological well-being is positive, mostly between depression and religiosity. Religiosity also has a positive effect on anxiety and suicidal ideations. The affiliation found in many studies was an unassuming one. Religious conviction was likewise observed to be critical in helping individuals to recuperate from traumatic occasions. Religiosity was also perceived to be related to a less participation in dangerous practices, for example, alcohol and drug misuse and smoking. While there were just a little number of studies investigating the wellbeing effects of religious segregation, these recommend that introduction to such separation builds the danger of tension and depression. Discoveries from the study recommend that religious discrimination may build the danger of psychiatric issue, psychiatric trouble, clinical issue and lower self-reported life fulfillment [4].

There were a few prominent early psychologists William James and Carl Jung highlighted religion's benefits. But a large majority of psychologists debated in contradiction of the religion and its benefits. Freud is one of them who considered religion as an irrational thing. He considered religion as unhelpful nor functional and saw it as "the universal obsessional neurosis of humanity" Freud (1959). These ideas remained prominent for several decades as the later psychologist also have the same concept like Albert Ellis have the same beliefs as Freud, Ellis, (1988). Much of the research of the 1950's and 1960's confirms the views of Freud, Ellis, and others [5].

Murphy [6] in an exploration found that larger amounts of religious conviction were identified with lower levels of depression and hopelessness, in spite of the fact that the last may be an impression of the level of extroversion and unsafe religious convictions. In an exploration by Eliassen et. al [7] it was presumed that there is an in number relationships exists between religiosity and depression. A built up example of religious adapting can routinely alleviate trouble; elevated level of anxiety exposure may evoke expanded supplication to God among the less religious. Growing accord religious duty and practice can be valuable to physical and mental prosperity [8-11]. These confirmations focus to helpful impacts of religiosity. Late research has connected parts of religious contribution to a wide cluster of wellbeing results.

According to different researches religiosity is negatively associated with depressive symptoms. Those individuals who consider religion as one of the most important entities in their lives had a lower chance of having depression as compared to those who did not make religious faith an important thing in their lives [12].

Religion is typically measured and analyzed in relationship to mental and physical wellbeing results [13] Psychological wellbeing has a positive relationship with religiosity and more profound sense of being [14]. Mental wellbeing is connected with the characteristics of wellbeing that may emerge from profound improvement, euphoria; peace, happiness and clear life reason [15]. Mental wellbeing instills the capacity to be strong even with life's difficulties [16] In addition religion is self-serving, incognito thought processes, for example, solace and security, companionship, status, or social support for the maturing populace [17]. Elderly patients with elevated amounts of characteristic religiosity and otherworldly wellbeing and have found to have larger amounts of trust, positive state of mind and personal satisfaction [18].

In conclusion, religiosity is associated with depression. There is a variety of research that explains depressive symptoms in different ways. Though at present there are no data that inspects whether the relationship between religiosity and depression can be seen within the context, or outside the consideration, of other theories of depression. The goal of the present research was to study the connection between religiosity and depression with respect to older people's well-being.

2. Method

2.1. Sample

800 respondents were used (400 males and 400 females) older people of the Punjab province, the state of Pakistan aged between 50 and 70 years of age (Mean=2.42, SD=1.29)

2.2. Questionnaires

All respondents completed:

1. Yesavage and Sheikh developed the Geriatric Depression Scale-short form (GDS) and this scale has been extensively used to measure the depression of the older population [19]. In this study a Short Form GDS was used which has 15 questions. Because, as the sample of the present study consisted of old people so it is easy for them to answer the short form of the scale. Scores for normal condition is 0-4, depending on education, age, and complaints; 5-8 score for mild depression; 9-11 score for moderate depression; and 12-15 score for severe depression. In the present study Urdu version of the geriatric depression scale was used which was adapted, translated and validated for the present research. The Cron bach's alpha reliability of the Urdu version was 0.75. For 15 items Guttmann split half coefficient was 0.76. This demonstrated scale has high internal reliability for the utilization in the present research.
2. A measure of religiosity for the present research was developed by Using revised Gorsuch and McPherson religiosity scale [20]. The present research questionnaire consisted of 17 items. The present research questionnaire is a 6-point rating scale ranging from very strongly disagree to very strongly agree. The cronbach's Alpha reliability of religiosity scale was 0.90. Guttman split half reliability of the questionnaire was 0.67. The validity of the questionaire was measured by using Kaiser-Meyer-Olkin measure of sampling adequacy (KMO) and Bartlett's test of sphericity. The value of KMO is 0.63 and Bartlet test is significant 0.00 ($p< 0.05$).

3. Results

Results were tabulated on the basis of the objective of the research which is as follows:
There is an impact of religiosity on depression.

Table 1
Descriptive statistics of the variables

Variables	Min	Max	Mean	St. Deviation
Geriatric depression	0	1	0.92	0.26755
Religiosity	1	6	4.14	0.20185

Source: "Survey, 2016 computed using STATA Version 13"

The Table1 shows the descriptive statistics of the data. The mean value for geriatric depression is 0.92 with a standard deviation 0.26755. Geriatric depression was measured on the basis of 2 categories. The mean value of depression indicates that most of the respondents have depression. Religiosity was measured on a six scale point and the mean value is 4.14 with a standard deviation of 0.20185 indicating the higher the level of religiosity lowers the depression.

Table 2
Binomial Logistic Regression

Independent Variable		Dependent Variable (Geriatric Depression)			
		Coefficient		Std.error	Z
Religiosity		-.9994687**		.4710879	-2.12
LR chi^2 (1)	3.73	Log likelihood	-216.23169	Number of obs	800
Prob > chi^2	0.0339	Pseudo R^2	.0086		

Source: "Survey, 2016 computed using STATA Version 13"
Note: Coefficient *** is significant at the 1% ($p < 0.01$), ** is significant at the 5% ($p < 0.05$) and * is significant at the 10% ($p < 0.10$) level, respectively.

The impact of religiosity on geriatric depression is described in Table 2. The p-value for Pearson's Chi-square tests indicates an association between religiosity and geriatric depression (p-value = 0.0339 < 0.05). The interpretation of the result indicates that a one-unit increase in religiosity the geriatric depression would be expected to decrease by 0.99 units. It means that the more religiosity the less likely to having depression in old age, based on negative parameter establish. Hence the more the religiosity the less likely to result in depression.

Table 3
Odds Ratio of religiosity and geriatric depression

Independent Variable	Dependent Variable (Geriatric Depression)		
	Coefficient	Std.error	z
Religiosity	.3680749**	.1732873	-2.12

Source: "Survey, 2016 computed using STATA Version 13"
Note: Coefficient *** is significant at the 1% ($p < 0.01$), ** is significant at the 5% ($p < 0.05$) and * is significant at the 10% ($p < 0.10$) level, respectively.

Table 3 represents the odds ratio based on the expanded model of the binomial logistic regression. Odds is the ratio of probability of an event occurring to the probability of the event not occurring [21]. An odds ratio greater than 1 corresponds to a positive logit coefficient while the odds ratio of less than one corresponds to a negative logit coefficient. If religiosity increases by one unit the odds of depression is expected to decrease by 0.36 units.

Table 4
Results of binomial probit estimation

Independent Variable	Dependent Variable (Geriatric Depression)		
	Coefficient	Std.error	z
Religiosity	-.5241357**	.2613887	-2.01

Source: "Survey, 2016 computed using STATA Version 13"

It is necessary to assess the model for the robustness of its key findings. Thus, it is expected that the main conclusions as derived from the signs and significance level of key variable(s) should hold even when the variables are subjected to different model specification. Therefore, an alternative measure of geriatric depression is employed for robustness check. In the results estimation of the binomial logit model that older people who are religious, they have low level of geriatric depression. To verify the results are robust, it also estimated by using the binomial probit model. Table 4 shows that overall the model is statistically significant as the Prob >chi^2 = 0.0449. The results shown in Table 4, in the case of geriatric depression, the coefficient religiosity is negative and significant at 5 % percent indicating that the higher the level of religiosity affects to decrease the level of geriatric

depression among older people.

4. Discussion

The aim of the present study was to examine the relationship between religiosity and depression among older people. Based on the results religiosity have a negative relation with the depression. Till today, all the earlier research has witnessed a firm relationship between religion and depression, with the all data directing an opposite relationship [22]. The first systematic reviews on this topic was done [23]. In the review of sixteen published cross-sectional studies, the researchers concluded that the data confirmed the theory that those with higher religious commitment had a diminished risk for depression and suicide. Moreover, in another meta-analysis, the correlation between religiousness and depression is very high, the correlation value is -.096 that proves the more a person is religious the less he prone towards depression [24].

The relation of religion and mental health becomes clearer by the researchers conducted in order to understand their relationship. Many studies put light on the fact religion and mental health have inverse relation. Those individuals who consider religion as an important part of their life has a low chance of having depression [25]. Furthermore, it is evidenced that the religiosity also effects on the speed of recovery of depressed patients, as a person become religious depressive symptoms vanished quickly [26,27]. The results of binomial logistic regression also suggested that religiosity and depression are negatively associated with each other. The more religious the person the less likely to develop depression in later ages.

Old age is a period of transition and depression is the most common problem in old age [28]. Elderly patients with elevated amounts of characteristic religiosity and otherworldly wellbeing and have found to have larger amounts of trust, positive state of mind and personal satisfaction [29].

In conclusion, the current findings propose that religious orientation plays a significant role in depression. Forthcoming investigation ought to scrutinize the generality of these findings, mainly amongst more religious sample.

References

[1] Barrett, David B., and Todd M. Johnson. *World Christian trends, AD 30-AD 2200: interpreting the annual Christian megacensus*. Vol. 1. William Carey Library, 2001.

[2] Ano, Gene G., and Erin B. Vasconcelles. "Religious coping and psychological adjustment to stress: A meta-analysis." *Journal of clinical psychology* 61, no. 4 (2005): 461-480.

[3] Miller, William R., and Carl E. Thoresen. "Spirituality, religion, and health: An emerging research field." *American psychologist* 58, no. 1 (2003): 24.

[4] Klocker, Natasha, Brigid Trenerry, and Kim Webster. *How does freedom of religion and belief affect health and wellbeing?*. Victorian Health Promotion Foundation, 2011.

[5] G. Koenig, Harold, and David B. Larson. "Religion and mental health: Evidence for an association." *International review of psychiatry* 13, no. 2 (2001): 67-78.

[6] Pargament, Kenneth I., Harold G. Koenig, Nalini Tarakeshwar, and June Hahn. "Religious struggle as a predictor of mortality among medically ill elderly patients: A 2-year longitudinal study." *Archives of internal Medicine* 161, no. 15 (2001): 1881-1885.

[7] Eliassen, A. Henry, John Taylor, and Donald A. Lloyd. "Subjective religiosity and depression in the transition to adulthood." *Journal for the Scientific Study of Religion* 44, no. 2 (2005): 187-199

[8] Smith, Timothy B., Michael E. McCullough, and Justin Poll. "Religiousness and depression: evidence for a main effect and the moderating influence of stressful life events." *Psychological bulletin* 129, no. 4 (2003): 614.

[9] Strawbridge, William J., Sarah J. Shema, Richard D. Cohen, and George A. Kaplan. "Religious attendance increases survival by improving and maintaining good health behaviors, mental health, and social relationships." *Annals of Behavioral Medicine* 23, no. 1 (2001): 68-74

[10] Ross, Catherine E. "Religion and psychological distress." *Journal for the Scientific Study of Religion* (1990): 236-245.

[11] Schnittker, Jason. "When is faith enough? The effects of religious involvement on depression." *Journal for the scientific study of religion* 40, no. 3 (2001): 393-411.
[12] Beekman, Aartjan TF, D. J. H. Deeg, Jacques Van Limbeek, Arjan W. Braam, M. Z. De Vries, and Willem Van Tilburg. "BRIEF COMMUNICATION." *Psychological medicine* 27, no. 01 (1997): 231-235.
[13] Koenig, Harold G. "Research on religion, spirituality, and mental health: A review." *The Canadian Journal of Psychiatry* 54, no. 5 (2009): 283-291.
[14] Hafeez, Asma, and Rafia Rafique. "Spirituality and Religiosity as Predictors of Psychological Well-Being in Residents of Old Homes." *The Dialogue* 8, no. 3 (2013): 285-301.
[15] Stirling, Blair, Leola Dyrud Furman, Perry W. Benson, Edward R. Canda, and Cordelia Grimwood. "A comparative survey of Aotearoa New Zealand and UK social workers on the role of religion and spirituality in practice." *British Journal of Social Work* (2009): bcp008.
[16] McFadden, Susan H., Melvin A. Kimble, James W. Ellor, James E. Seeber, and Robert Rost. "The center on aging, religion, and spirituality: Lessons learned." *Journal of Religion, Spirituality & Aging* 23, no. 1-2 (2011): 62-76.
[17] Ryckman, Richard M., Bill Thornton, Bart Borne, and Joel A. Gold. "Intrinsic-Extrinsic Religiosity and University Students' Willingness to Donate Organs Posthumously." *Journal of Applied Social Psychology* 34, no. 1 (2004): 196-205.
[18] Chiu, Lyren, Julia D. Emblen, Lynn Van Hofwegen, Rick Sawatzky, and Heather Meyerhoff. "An integrative review of the concept of spirituality in the health sciences." *Western journal of nursing research* 26, no. 4 (2004): 405-428.
[19] Yesavage, Jerome A., and Javaid I. Sheikh. "9/Geriatric Depression Scale (GDS) recent evidence and development of a shorter violence." *Clinical gerontologist* 5, no. 1-2 (1986): 165-173.
[20] Gorsuch, Richard L., and Susan E. McPherson. "Intrinsic/extrinsic measurement: I/E-revised and single-item scales." *Journal for the Scientific study of Religion* (1989): 348-354.
[21] Gujarati, Damodar. "Basic Econometrics. United States Military Academy, West Point." (2004).
[22] Pargament, Kenneth I., Harold G. Koenig, Nalini Tarakeshwar, and June Hahn. "Religious coping methods as predictors of psychological, physical and spiritual outcomes among medically ill elderly patients: A two-year longitudinal study." *Journal of Health Psychology* 9, no. 6 (2004): 713-730.
[23] Gartner, John, Dave B. Larson, and George D. Allen. "Religious commitment and mental health: A review of the empirical literature." *Journal of psychology and theology* (1991).
[24] Smith, Timothy B., Michael E. McCullough, and Justin Poll. "Religiousness and depression: evidence for a main effect and the moderating influence of stressful life events." *Psychological bulletin* 129, no. 4 (2003): 614.
[25] Hampton, Melvin C., Perry N. Halkitis, and Jacqueline S. Mattis. "Coping, drug use, and religiosity/spirituality in relation to HIV serostatus among gay and bisexual men." *AIDS Education and Prevention* 22, no. 5 (2010): 417.
[26] Murphy, Patricia E., Joseph W. Ciarrocchi, Ralph L. Piedmont, Sharon Cheston, Mark Peyrot, and George Fitchett. "The relation of religious belief and practices, depression, and hopelessness in persons with clinical depression." *Journal of Consulting and Clinical Psychology* 68, no. 6 (2000): 1102.
[27] Park, Crystal, Lawrence H. Cohen, and Lisa Herb. "Intrinsic religiousness and religious coping as life stress moderators for Catholics versus Protestants." *Journal of personality and social psychology* 59, no. 3 (1990): 562.
[28] Harold G., Koenig, "Research on religion, spirituality, and mental health: A review." *The Canadian Journal of Psychiatry* 54, no. 5 (2009): 283-291.
[29] Fehring, Richard J., Judith F. Miller, and Christine Shaw. "Spiritual well-being, religiosity, hope, depression, and other mood states in elderly people coping with cancer." In *Oncology Nursing Forum*, vol. 24, no. 4 (1997): 663-671.