RELIGIOSITY AND DEPRESSION AMONG OLDER ADULTS OF KASHMIR

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ABSTRACT:

India is gradually turning into graying nation. With increased life expectancy there is more number of citizens above 60-65 age range now. However the changes that come in later life – retirement, death of spouse, increased isolation - can lead to different psychological problems among which depression is quite common. At the same time, studies indicate that religion is a potent coping strategy that helps a person to adjust to the stresses in life and is associated with decreased rates of mental illness. The present study was undertaken to compare religiosity and depression among elderly Kashmiris across different socio-demographic variables and to find the relation of religiosity and depression among these older adults of Kashmir. The sample consisted of 184 older adults (102 elderly males & 82 elderly females) taken from different districts of Kashmir. The age of the sample groups ranged from 58-76 years with mean age of 67 years. Allport and Ross's Religious Orientation Scale (ROS 1967) and Aaron Beck's Depression Inventory (BDI-II 1996) was used. T-test was applied to test the significance of difference between groups and Pearson's Product Moment Correlation was used to determine the relationship between religiosity and depression level of these older adults. Results revealed that most of these older adults (77.17%) have moderate level of religious orientation and only few (22.28%) were found to be high on religiosity. As on depression it was found that most of them (53.80%) have high level of depression. The findings also revealed no significant mean difference in the depression level of older adults with respect to various socio-demographic variables but significant mean difference in the religiosity was found on few variables. Results further reveal that religiosity has significant negative correlation with depression. Thus religiosity was found to be acting as a good coping mechanism in such patients.

Keywords: *Religiosity, Depression, Elderly, Kashmir.*

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Introduction:

Ageing is a universal process associated with certain changes that take place in an organism leading to morbidities, disabilities and even death. The beginning of old age is 60 or 65 years which is roughly equal to retirement ages in many developed and developing countries (Gorman et al., 1999). However, "there is no single age at which we can say that people cross the threshold into old age. With the improvement in health care facilities in countries, the proportion of the elderly in the population and the life expectancy after birth increase accordingly (Taqui, Itrat, Qidwai & Qadri, 2007)

However, as age advances there is increase in morbidity of various psychological problems. Depressive symptoms and depressive disorders are a substantial mental health problem for older adults (Blazer *et al*., 1987). It is often presumed that depression is a natural consequence of the losses experienced by this population in terms of emotional attachments, physical independence and socioeconomic hardships. One factor that has been found protective against depression in older adults is religiosity.

Religiosity as an important social and psychological factor in the lives of elderly people has received substantial attention in the gerontological literature (Chaaya et al., 2007; Zullig et al., 2006). Religious involvement or religiosity refers to the degree of participation in or adherence to the beliefs and practices of an organized religion. Psychologists have long been interested in the role that religion plays in the interpretation of and response to life events and how this manifests itself in everyday psychological adjustment. Some psychologists (Jung, 1933; Allport 1950) see religion as a source of meaning and stability in an uncertain world and conducive to positive psychological health. There is an extensive body of research that relates to the impact of religion and religiosity on depression. Fehring (1997), Koenig et al. (1998), Murphy et al. (2000) and Schnittker (2001) show that more intensive religious performance is associated with a decline in depression. Seybold and Hill (2001) briefly reviewed the literature on the helpful and harmful effects of religion and found numerous "salutary effects" of religion on physical and mental health. Several possible mechanisms were proposed to account for this overall beneficial effect of religion on mental health, including social networks, healthier lifestyles, coping strategies, positive emotions, and stress appraisal (Bonelli, Dew, Koenig, Rosmarin, & Vasegh, 2012).Meta-analysis of 147 studies (N=98,975) showed a significant inverse association between religiosity and depression (Smith, McCullough & Poll, 2003).

However there is relatively little work examining the relationship between religion and mental health in Eastern religions (Simon,2006) and the same is very true for Kashmir. Hence, the present study was formulated in Kashmir with the following objectives:

1. To study religiosity and depression among older adults of Kashmir.
2. To compare religiosity of older adults of Kashmir with respect to various demographic variables as gender, education, domicile and marital status.
3. To compare depression level of older adults of Kashmir with respect to various demographic variables as gender, education, domicile and marital status.
4. To examine relationship between religiosity and depression.

Method:

***Sample*:**

A sample of 184 older adults (102 elderly males & 82 elderly females) was taken from Ganderbal and Srinagar districts of Kashmir and the sample was incidental in nature. The age of the sample group ranged from 58-76 years with mean age of 67 years.

Measures:

1. Religious Orientation Scale (ROS) developed and standardized by Allport and Ross's (1967) was used to assess religiosity. The scale consists of 20 items divided into two sub-scales of extrinsic religious orientation and intrinsic religious orientation. Each response is rated on 5-point scale with high score indicate higher religiosity, while a low score shows low religiosity. The scale has good reliability and validity.
2. Beck's Depression Inventory-II (1996)*:* It is a 21-item self-report instrument intended to assess the existence and severity of symptoms of depression. The BDI-II has been found to have good internal consistency reliability with Cronbach's alpha ranging from .76 to .95 in psychiatric samples and from .73 to .92 in non-psychiatric samples. The test-retest reliability of the BDI is also moderate-strong correlations ranging from .48 to .86 with psychiatric patients and from .60 to .83 with non-psychiatric groups.
3. Socio-demographic data sheet: These included gender, age, religion, Marital status,Education and Domicile.

Procedure:

The subjects were approached personally and instructed to give their responses on a questionnaire booklet. Assurance of confidentiality was given to the respondents to boost their motivation and reduce bias. After motivating the respondents the questionnaire booklet was provided to each respondent and necessary help was provided by the researchers to assist participants with limited reading and writing ability.

Statistical Analysis:

The analysis of data was carried out by using both descriptive as well as inferential statistics. t-test was used to find the differences between the groups and Pearson's product Moment Correlation to determine the relationship between religiosity and depression.

Results:

Table 1: Frequency distribution of religiosity and depression levels among older adults.

Religiosity		
Level	**Frequency**	**Percentage**
Low	1	0.54%
Average	142	77.17%
High	41	22.28%
Depression		
Mild	42	22.83%
Moderate	43	23.37%
High	99	53.80%

Table 2,a: Comparison of mean scores of Religiosity (Dimension wise & overall) with respect to various socio demographic variables.

Variable	Group	N	Mean	t-value	p-value
	Male	102	38.81		
	Female	82	38.32	0.39	.69
Extrinsic Religious Orientation	Educated	111	39.71		
	Uneducated	73	36.90	2.29	.02
	Rural	96	36.22		
	Urban	88	41.18	4.28	.0001
	Married	104	38.88		
	Unmarried	80	38.22	0.54	.59
	Male	102	32.26		
	Female	82	30.85	1.57	.11
Intrinsic Religious Orientation	Educated	111	32.43		
	Uneducated	73	30.42	2.21	.02
	Rural	96	30.59		
	Urban	88	32.77	2.46	.01
	Married	104	32.04		
	Unmarried	80	31.10	1.05	.29
	Male	102	70.99		
	Female	82	69.43	0.85	.39
Overall Religious Orientation	Educated	111	72.11		
	Uneducated	73	67.53	2.51	.01
	Rural	96	67.04		
	Urban	88	73.85	3.89	.0001
	Married	104	70.94		
	Unmarried	80	69.46	0.81	.42

Table 2,b: Comparison of mean scores of Depression with respect to various socio demographic variables.

Variable	Group	N	Mean	t-value	p-value
	Male	102	28.35		
	Female	82	28.46	0.06	.95
Depression	Educated	111	27.07		
	Uneducated	73	30.42	1.91	.06
	Rural	96	29.91		
	Urban	88	26.76	1.83	.06
	Married	104	27.15		
	Unmarried	80	30.02	1.65	.10

df=182

The perusal of data from Table-1 reveals that majority of older aduts were found to be average on religiosity (77.17%) and very few on low religiosity (0.54%). It also reveals that majority of older adults have have high level of depression(53.8%).

Table-2 (a&b) shows an overview of t-values of Religiosity, its facets and depression, with respect to various socio-demographic variables. The perusal of the data from the table reveal that male and female elderly do not differ significantly on overall religiosity, on its dimensions i.e. extrinsic religiosity and intrinsic religiosity as well as in the depression level.

It can also be observed that educated and uneducated older adults differ significantly on both extrinsic and intrinsic dimension of religiosity and overall religiosity. However there is no significant difference in the depression level of educated and uneducated older adults.

On comparing rural and urban adults, significant differences were found on overall Religiosity scores as well as on its both extrinsic and intrinsic dimension. Although no significant difference were obtained in the depression level.

With respect to marital status of older adults, it was revealed that married and unmarried (widowed, divorced/separated) elderly do not differ significantly on overall religiosity and its dimensions i.e. extrinsic religiosity and intrinsic religiosity as well as on depression level.

Table 3: **Correlation between Depression and Religiosity(dimension wise and overall).**

	Depression
Extrinsic Religious Orientation	0.290**
Intrinsic Religious Orientation	0.286**
Overall Religious Orientation	0.328**

**p< 0.01

Table-3 reveals that there is significant correlation between both Extrinsic and Intrinsic dimensions of Religiosity and depression as well as between Overall Religiosity and Depression.

Discussion:

The present study was undertaken to examine the religiosity and depression levels of older adults of Kashmir. After analyzing and interpreting the data it was found that 0.54% older adults are low on religiosity, 77.17% were found to be average on religiosity and only 22.83% older adults were found to be high on religiosity. As on depression, 22.28% were found to have mild level of depression, 23.37% were found to have moderate level of depression and 53.80% older adults were found to have high level of depression. These research findings concur with the earlier findings of Gottfries and Karlson (2005**)** in which older age is established as a major predictor for depression with 45.2% of women and 26.9% of men afflicted by age 70. These findings are further substantiated by findings of Djernes (2006) who found the prevalence rates for depression in community samples of elderly in India vary from 6% to 50%. The findings of the present study also reveal that male and female older adults do not differ significantly on overall religiosity and its dimensions (extrinsic & intrinsic). No significant difference in the depression levels of male and female older adults was found. The findings differ from the findings of Barua

et al (2010), who found significant difference in the depression level of male and female elderly. Also no significant difference in the religiosity and depression levels of married and unmarried older adults was found. These findings differ from earlier findings of Xie (2010) who found significant difference in the depression level of married and widowed older adults. However, the findings of the present study reveal that there is significant difference in the religiosity of educated and uneducated older adults. Educated elderly were found to be more religious than uneducated elderly. No significant difference was found in the depression level of educated and uneducated older adults. It was also revealed in the present study that rural and urban older adults significantly differ in overall religiosity and its both dimensions. No significant difference was found in the depression levels of rural and urban older adults. The most important findings of the present study shows that there is a significant negative correlation between religiosity and depression which implies that religiosity acts as protective factor against depression in old age. These research findings are substantiated by the earlier findings of Koenig et al. (1998), Murphy et al. (2000) who reported the salutary effect of religiosity on depression in older adults.

Based on the findings of this study, it is clear that religiosity significantly improves the psychological well-being of elderly. This implies that mental health professionals working with older adults should integrate religiosity as an important resource into their therapeutic work to develop and maintain the psychological well-being of those facing age-related problems. Another implication from the current findings is that, given social religiosity (extrinsic religiosity) significantly moderated the relationship between poor psychological well-being, interventions that focus on promoting social religiosity could be implemented to enhance the psychological well-being of elderly kashmiris. For example, local religious organizations should begin or continue to provide facilities and services to older persons to enable them to participate in social religious activities. Lastly, it can be concluded that professionals involved in providing gerontological services to older adults should encourage them to employ religiosity as an important resource for enhancing psychological well-being and quality of life.

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