IMPACT OF RELIGIOSITY ON MENTAL HEALTH AND QUALITY OF LIFE AMONG ELDERLY PEOPLE

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ABSTRACT

"Religiosity" can be defined as "the exaggerated embodiment of certain aspects of religious activity." It reflects one's individual beliefs and focus on the personal faith experience and personal worship experience. Another term used for religiosity, though less often, is "religiousness," "the state of being superficially religious." Mental Health means the psychological well being of the person. One who is mentally healthy can do the things in right ways. Mental wellness is generally viewed as a positive attribute. This definition of mental health highlights emotional well-being, and the flexibility to deal with life's inevitable challenges. The third factor quality of life means the general well being of individuals and societies, including not only wealth and employment but also the built environment, physical and mental health, education, recreation and leisure time and social belonging. The present research is aimed to study the impact of religiosity on mental health and quality of life among elderly

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people. Mental health inventory by Jagdish and A. K. Srivastava 54 item version, Quality of life(QOL) Questionnaire by Vandana Kaushik and Ms. Purva Jaggi 28 item version and Religiosity scale (Hindi Version) by L. I. Bhusan 36 item version were used to study the present research and mean, standard deviation and t-ratio were used as a statistical tool. The obtained results revealed significant differences between the high and low groups of religiosity on mental health and quality of life.

Keywords: beliefs, ethics, mental health, quality of life, well-being,

INTRODUCTION

Religion is a multifaceted object incorporating emotional and behavioral aspects. Religion of one kind or another has existed in all societies and it has had profound effects on the lives of those who practice it. Religion as a discipline is a matter of great concern for social scientists in general and psychologists in particular since it plays an important role in directing, shaping and moulding social behaviour at both the individual level and group levels. Religion involves beliefs, practices and rituals related to the 'transcendent', where the transcendent is that which relates to the mystical, supernatural or God in western religious traditions, or to divinities, ultimate truth/reality, or enlightenment in eastern traditions. Religion may also involve beliefs about spirits, angels or demons. Religions usually have specific beliefs about the life after death and rules about conduct that guide behaviours within a social group. Religion is often organized and practiced within a community, but it can also be practiced alone and in private, outside of an institution. Central to its definition, however, is that religion is rooted in an established tradition that arises out of a group of people with common beliefs and practices concerning the

transcendent. It can be measured and examined in relationship to mental and physical health outcomes. Religiosity means what are sacred, involving expressions of spirituality, faith traditions, participations in established churches (Paragament, 1997). Religiosity is an important component of many people's lives. In the united sates over 95% of the population believes in God and more than 40% attend church regularly. Given the prevalence and importance of religiosity in the population, it is reasonable to consider the impact of religious beliefs, practices and traditions on physical and mental health outcomes. Religion is a frequently cited mechanism for dealing with problems in life. It seems to become especially important once an illness, particularly a life threatening one, is diagnosed in a person. About 40% of older than 60 years use religion as the main way of coping with stress, when they are hospitalized with somatic illness. Spirituality can help people maintain good mental health. It can help them to cope with everyday stress and keep them mentally fit. There is some evidence of links between spirituality and improvements in people's mental health. Religion may have the benefits like ability to cope with illness, positive and hopeful attitude towards life, a sense of meaning and purpose in life which affects health behaviours and social and family relationships.

Mental health often means both physical and psychological well being. A mentally healthy person is one who has a wholesome and balanced personality, free from inconsistencies, emotion and nervous tensions. Mental health is an indivisible part of general health and well being. Mental health as a concept reflects the equilibrium between the individual and the environment in a broad sense. World health organization's (WHO) first technical report on mental health service planning in developing countries was published more than 25 years ago, little action has been taken on it and if any action has been taken, it has been very patchy. According to the definition in the WHO constitution, Health is a state of complete physical,

mental and social well being and not merely the absence of disease or infirmity. The WHO definition of health has been a landmark in two ways: one, its focus on positive health, and second, its holistic approach which includes the aspects of mental health and social well being. This concept of health implies that a healthy person must actualize all the potentials of growth and development without being unduly tense or unhappy. Thus Emotional and psychological well being along with the other aspects of health enable a person to lead a productive and fulfilling life. Mental health depends upon our attitudes toward life. It affects how we think, feel and act as we cope with life. It also helps determine how we handle stress, relate to others, and make choices. It is important at every stage of life, from childhood and adolescence through adulthood. Psychologically healthy person do not necessarily escape the stresses and strains of life, and from time to time they wrestle with conflicting impulses, encounter crises in interpersonal relationships, and experience unpleasant emotions such as grief, anger or fear. But they are able to function effectively and to find satisfaction in life. They can work effectively and productively. Basically they view themselves as worthy members of the human race. Mental health is not some idealized and unattainable state, but a dimension along which people vary, and toward the extreme of good mental health, individuals have fewer psychological handicaps. Mental health includes the positive indicators such as functioning at a high level of adaptation, having fulfilling social relationships with other people, mental balance, self esteem, self control. Mental health is indispensible to subjective well being (SWB). SWB can be defined as people's cognitive and affective evaluations of their lives. These evaluations include emotional reactions to events as well as cognitive judgments of satisfaction and fulfilment. Well-being is a form of happiness as "a global assessment of a person's quality of life according to his own chosen criteria."

Six facets of psychological well-being (Ryff, 1989)

- Self-acceptance -This is denned as a central feature of mental health as well as a characteristic of self-actualization, optimal functioning, and maturity.
- Positive relations with others- The ability to love are viewed as a central component of mental health.
- Autonomy- There is considerable emphasis in the prior literature on such qualities as self-determination, independence, and the regulation of behavior from within.
- Environmental mastery- The individual's ability to choose or create environments suitable to his or her psychic conditions is denned as a characteristic of mental health.
- Purpose in life- Mental health is denned to include beliefs that give one the feeling there is purpose in and meaning to life.
- Personal growth- Psychological functioning also require that one continue to develop one's potential, to grow and expand as a person.

SWB is a broad concept that includes experiencing pleasant emotions, low levels of negative moods, and a high level of life satisfaction (Diener, Lucas, & Oishi, 2002, p. 63). Diener (1998) considered SWB as "the psychological term for what in popular parlance is referred to as happiness" (Diener, Oishi,& Lucas, 2003; Seligman & Csikszentmihalyi, 2000). Veenhoven (2010) used the word "happiness" in the widest sense, as an umbrella term for all that is good. It is often used interchangeably with terms like "well-being" or "quality of life." He stated that happiness is commonly understood as how much one likes the life one lives or, more formally, the degree to which one evaluates positively one's life as a whole (Veenhoven, 2009).

Another variable in the present paper is Quality of life. It is a complex concept that encompasses objective and subjective dimensions such as food, housing, the opportunity to study, health and perceptions about them (Carpio, Pachecho, Flores and Canales, 2000). Diener (1984, cited by Rodriguez 1998) has defined quality of life as a subjective view of the extent to which happiness and satisfaction have been achieved or as a sense of personal, subjective view that has also been considered closely related to certain biological, economic, psychological and social factors. (Garavito, 2001; Gomez villegas de Posada, Barrera & Cruz, 2007). The WHO tried to embrace the complexity of the term "Quality of Life", defining it as "the perception that an individual has as about their place in their own existence, in the context of culture and their value system in which they live and on relation to their objectives, their expectations, their norms, their concerns etc. This is a very broad concept which is influenced by complex ways and complex issues than physical health of the individual factors, his psychological state, level of independence, their social relationships and their relationships with the environment" (WHO 2005). A good quality of life was characterized by the feeling of being in control (particularly of distressing symptoms), autonomy and choice, a positive self image, a sense of belonging, engagement in meaningful and enjoyable activities, a feelings of hope and optimism. Quality of life is a person's assessment of their well being, or lack thereof. This includes all emotional, social, and physical aspects of the individual's life. In health care, health-related quality of life is an assessment of how the individual's well being may affect, or be affected by, a disease disability or disorder.

REVIEW OF LITERATURE

A large array of research documents the positive effect religion has on mental health (Ellison & Levin, 1998; Larson et al., 1992), although some research suggests that religion can have a deleterious impact on mental health as well (Krause, 2004; Krause, Ellison, & Wulff,

1998). The literature proposes several mechanisms in which religious practices affect mental well-being (Koenig et al., 2001). Understanding the context in which religious activity affects mental health is crucial in conceptualizing how gender may moderate this relationship. One mechanism, which is especially important for this study that affects mental health is social integration and support. In the Journal of Religion and Health, Vol. 41, No. 3, (2002), "Spirituality and Health Outcomes in the Elderly", it was found that there was a protective factor of religion to health and that religious belief played a role in averting physical and mental health problems. Furthermore, religious commitment helped facilitate coping strategies with illness and recovery. Moreover, religion, in multiple populations, has a positive relationship to psychological well-being and a preventative effect against morbidity (Meisenhelder & Chandler 2002:243). Various studies have also shown a relationship between religiosity and higher self-esteem, lower levels of depression, greater social support, better physical well-being and lower alcohol and drug consumption. Their approach examined the relationship of behavioral measures, such as the frequency of prayer; and attitudinal measures such as, importance of faith and the use of religion in coping with physical functioning, role functioning-physical, bodily pain, general health, vitality, social functioning, role functioning-emotional, and mental health (Meisenhelder & Chandler 2002:244). Their results found a significant and positive relationship between mental health and the Importance of Faith. Furthermore, a positive relationship was found between mental health and religious behaviours, such as prayer and visiting religious spots. However, these indices could be explained by a more significant factor-Importance of Faith. Overall, their study showed attitudinal measures as the more accurate indices of the association of religiosity and mental health in the elderly (Meisenhelder & Chandler 2002:250).

Koenig and Larson (2001) examined the association between religious practices and behaviours and indicators of psychological wellbeing (life-Satisfaction, happiness, positive affect and higher morale) and found that out of 100 studies, 79 reported at least one significant positive correlation between these variables. This positive association has been found consistently similar in samples from different countries, involving a diversity of religion, races and ages.

As regarded association between health aging and religious well-being, Campbell (1981) suggested that well-being depends on the satisfaction of three basic kinds of need: The need for having, the need for being. A fourth set of need which was acknowledged later was termed as the need of transcendence. This refers to the sense of wellbeing that we experience when we find a purpose to commit ourselves, which involve ultimate meaning for life. Some other studies explored perspectives on health, disease, characteristics of healthy person, role yoga and meditations on health, and methods to promote health. According to King's (1990) review of the literature, religiosity is associated with healthy behavior and longevity. Oleckno and Blacconiere (1991) found a positive relationship between religiosity and wellness and a negative association with illness. Chida, Steptoe, and Powell (2009) reported that religiosity lowers the mortality rate in many population studies. According to Childa and Steptoe (2008), religiosity has an effect on one's positive psychological well-being, which in turn "has a favorable effect on survival in both healthy and diseased populations" (p. 741). It is well reviewed that religiosity has a positive relationship with happiness and well-being (e.g., Abdul-Kalek, 2006; Robbins & Francis, 1996).

Researchers explores the relationship between religiosity and quality of life. Three indicators of religiosity are used: (i) frequency of attendance at religious services or meetings, (ii) orthodoxy of beliefs in relation to Biblical teachings and (iii) religious denomination. Quality of life (QoL) is measured in terms of (i) household access to modern conveniences, (ii) self-

assessed life satisfaction and (iii) level of satisfaction with government institutions. The data shows a significant but not very strong statistical relationship between religiosity and QoL. People who attend religious meetings most frequently and who hold the most orthodox religious views are thus more likely to have access to modern conveniences and to be satisfied with their lives. Satisfaction with government, however, tends to be highest amongst nominally religious people and lowest amongst both the most orthodox and the least religious.

Objectives

Keeping in view the above literature the following objectives were formulated

- To examine the impact of religiosity on quality of life
- To examine the impact of religiosity on mental health.
- To examine the interaction effect among all the variables under study.

Hypothesis

- It is hypothesized that individuals high on religiosity will have better quality of life.
- It is hypothesized that individuals high on religiosity will have better mental health.
- It is hypothesized that there lies positive interaction effect among all the variables.

METHOD

Sample

The aim of the present investigation is to study the impact of religiosity on mental health and quality of life among elderly people. To achieve the aim a sample of 50 elderly people (above 60 years of age) was taken randomly from different areas of Chandigarh, keeping the caste, creed and socioeconomic status silent.

Tools Used

- **Mental health inventory**: Mental health inventory was used to measure mental health developed by Dr. Jagdish and Dr. A. K. Srivastava. This inventory consists of 54 items and each item was measured on 4 point scale. The mental health consists of six dimensions i.e., Positive self evaluation (PSE), Perception of reality (PR), Integration of Personality (IP), Autonomy (AUTNY), Group Oriented Attitudes (GOA), Environmental Mastery (EM). The reliability of the mental health inventory was determined by 'split-half method' using odd-even procedure and it was found to be 0.73. Dimension wise PSE has 0.75 reliability index, PR-0.71, IP- 0.72, AUTNY-0.72, GOA-0.74 and EM has reliability index of 0.71. Validity of mental health inventory is found to be 0.54.
- **Quality of life (QOL) Questionnaire**: For measuring quality of life, a questionnaire was developed by Dr. Vandana Kaushik and Ms. Purva Jaggi was used. This questionnaire consists of 28 items and each item was measured on five point likert scale i.e., strongly disagree, disagree, undecided, agree and strongly agree. In this scale 14 items were negatively phrased hence, their scoring was simply reversed.

- **Religiosity scale**: For measuring religiosity, a scale was developed by L. I. Bhusan. It consists of 36 items and each item was measured on five point likert scale i.e., strongly disagree, disagree, undecided, agree and strongly agree. In this scale 11 items were negatively phrased and hence, their scoring was simply reversed.

PROCEDURE

Keeping in view the aim of the present study the mental health inventory, Quality of life (QOL) Questionnaire and Religiosity Scale were administered anonymously to older people from different areas of Chandigarh. The return rate was 100%. Descriptive statistics and t-tests were used for the statistical analysis.

RESULTS

Table 1: Means, SDs and t-ratios of components of mental health, total mental health and quality of life with respect to high and low religiosity.

VARIABLES (N=50)		MEAN	STANDARD DEVIATION	t-value
QUALITY OF LIFE	HIGH	75.30	2.35	25.93**
	LOW	60	1.73	
POSITIVE SELF EVALUATION-MENTAL HEALTH	HIGH	26.22	0.83	8.28**
	LOW	24.48	0.63	
PERCEPTION OF REALITY-MENTAL HEALTH	HIGH	20.08	0.62	1.88
	LOW	19.74	0.66	
INTEGRATION OF PERSONALITY-MENTAL HEALTH	HIGH	29.56	0.60	5.50**
	LOW	28.63	0.63	

AUTONOMY-MENTAL HEALTH	HIGH	13.83	0.38	12.35**
	LOW	12.52	0.37	
GROUP ORIENTED ATTITUDES-MENTAL HEALTH	HIGH	24.13	0.71	11.64**
	LOW	22.15	0.52	
ENVIRONMENTAL MASTERY-MENTAL HEALTH	HIGH	21.78	0.55	5.2**
	LOW	21	0.59	
TOTAL MENTAL HEALTH	HIGH	135.60	1.86	14.44**
	LOW	128.52	1.61	

****** Significant at 0.01 level of significance

T-ratios were computed to determine the impact of dependent variable, religiosity (high-low) on independent variables, quality of life and mental health and its components Positive self evaluation (PSE), Perception of reality (PR), Integration of Personality (IP), Autonomy (AUTNY), Group Oriented Attitudes (GOA), Environmental Mastery (EM). Inspection of t-ratio between variables provides support for the hypothesis except one dimension of mental health viz. Perception of reality. Those who are high on religiosity have higher mean in all other dimensions of mental health, have higher mean with total mental health and quality of life.

DISCUSSION

The present investigation was undertaken to study the impact of religiosity on mental health and quality of life among elderly. Means and Standard deviations were computed for high and low quality of life; high and low total mental health and high and low mental health dimension wise on the basis of high and low religiosity. The application of t-test revealed that people who are high on religiosity are high on quality of life. The t-ratio of quality of life (high-low) on the basis of religiosity (high-low) was found to be 25.93 and it is significant at 0.01 levels. It means people who have faith in religion and believes that God exists and have specific

beliefs about life are happy with their life and they achieved a better quality of life. Religiousness contributes to better quality of life and these people are easily overcome with their adjustment problems or with daily routine hassles. People who are high on religiosity are high on mental health as well. They are mentally sound, have balanced personality and are free from inconsistencies.

In the present study also t-test was found to be significant (p>14.44) with total mental health. The t-ratio of positive self evaluation (high-low) was found to be 8.28, integration of personality (high-low) was 5.50, autonomy (high-low) was 12.35, group oriented attitudes (high-low) was 11.64, and the t-ratio of environmental mastery (high-low) was found to be 5.2. Results revealed that people who are high on religiosity are high on positive self evaluation means religiousness contributes to self confidence, self identity and person realizes one's potentialities. 8.28 t-ratio showed there is positive relationship between the religiosity and positive self evaluation. With second component of mental health i.e. perception of reality results revealed the insignificant relationship with religiosity. With 1.88 value of t-ratio it is insignificant at 0.01 levels. May be this is because of too much beliefs in religion because somehow those who believes in religiosity believes in supernatural powers and it makes people away from reality. There is a positive relationship between religiosity and integration of personality; it is the third component of mental health. These people are easily able to understand the feelings and emotions of others. They are able to concentrate at work and have interest in several activities especially in welfare of people. With the component of mental health, there is again a positive relationship between religiosity and autonomy. These people are not dependent on others but they fully use their own potentials and do their work independently and take full responsibility. People who have faith in religiosity are group oriented people. It is associated with the ability to

get along with others and work with others. So religiosity contributes in group oriented attitudes. With environmental mastery t-ratio came out to be 5.2 and it is significant at 0.01 levels. These people are able to take responsibility and have the capacity for adjustment, accommodate others and have the capability to lead the society on religious aspects.

So findings clearly support the assertion that individuals, who are high on religiosity, are more psychological well and easily cope up with the problems and it makes their life more beautiful. Elderly people are more toward religiousness. Religion correlates with improved physical and mental health. Religion provides a greater ability to cope with illness and disability. Elderly people with religiousness are more hopeful, have positive attitude about the future and this helps people with away from mental stress.

Studies of elderly populations have yielded positive association between religious factors and measures of subjective well-being. Cox and Hammonds (1988) reviewed several studies supporting the hypothesis that religious activities and attitudes were associated with life satisfaction and other well-being measures. These included Edwards and Klemmach (1973), Speitzer and Snyder (1974), and Blazer and Palmore (1976). Out of 100 studies that examined the association between religious practices and behaviour and indicators of psychological well-being (life satisfaction, happiness, positive effect, and higher morale), 79 reported at least one significant positive correlation between these variables.

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