THE MODERATING ROLE OF RELIGIOSITY AMONG PEOPLE SUFFERING FROM DEPRESSION

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ABSTRACT

Objective: The objective of the present study was to explore the association of depression with mental wellbeing with respect to religiosity among hospitalized depressed patients.
Study Design: An Exploratory and co-relational study.
Place and Duration of the study: The study was conducted at Khyber Medical complex, Hayatabad Medical Complex and Lady reading Hospitals of Peshawar from Mar 2016 to Aug 2016.
Material and Methods: A sample of 50 male and female hospitalized depressed patients was taken from different hospitals of Peshawar through purposive sampling technique. Beck Depression Inventory, Belief into Action Scale and Warwick Edinburgh Mental Wellbeing Scale were used for measuring study variables. Correlation and regression analysis were conducted to analyze data.
Results: Total 50 patients were selected among them 25(50%) were males and 25(50%) were females. The mean age was 28.2 ± 12.8 with the range of 15-60 years. Bivariate correlation matrix revealed that scores of respondents on Belief into Action Scale has a significant positive correlation with scores on Warwick Mental Wellbeing Scale. Patients who had religious attachments had better mental wellbeing. On the other hand, mental well being was negatively correlated with depression showing that the more the respondent was depressed the less were the scores on mental wellbeing scale. The R2 value of 0.14 indicates 14% variance in outcome variable with $F(1, 49)=8.19$, $p<0.01$. Findings reveal that religiosity was a significant positive predictor mental wellbeing ($B=0.23$, $p<0.01$. Results reveal the moderating role of religiosity for the relationship between depression and mental wellbeing. Results revealed that depression significantly negatively predicted mental wellbeing (i.e. $B=-1.76$, $p<0.01$) explaining a total of 35% variance in mental wellbeing.
Conclusion: Results revealed a strong negative relation between depression and mental wellbeing; however, religiosity significantly moderated the relationship between depression and mental wellbeing.

Keywords: Depression, Mental wellbeing, Religion, Spirituality.

INTRODUCTION

According to Cornah, (2006) Spirituality was something through which people gain the meaning and purpose in their lives and it may vary due to one's culture, age, political ideology, physical and mental health and many other factors[1]. Jones (1985) viewed spirituality as a voyage towards God and "soul making" process. In addition to this 'spirituality 'was also defined as the comprehensive, discrete and potentially designed aspect of human experiences that emerges from the individual communities, social associations, subjective familiarity and traditions.

Religion was derived from a word 'religio' which means to fasten up. It was defined as the human effort in universe to gain the forceful and greatest endowment[2]. Religiosity has the affiliation which was sometimes within self, inward or beyond self. It was concerned with the life determination, denotation and has ultimate significance[3]. A recent study by Koenig (1998) revealed that religion act as a functional and societal aid for handling worry[4].

Spirituality and religion, though separate concepts are indeed intertwined. Sacks (2002) documented that "spirituality changes people's

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mood but the religion changes their lives"[5]. It was believed that religion and spirituality both serve as aspiration for mentally disturbed people and help them to rebuilt control over their lives after competing with different psychiatric disabilities[6]. Literature suggests that people who are religious and spiritual become more satisfied in their lives. They are goal oriented and have lower level of unpleasant feelings or mental distress[7]. It was also believed that the spirituality and religion play an important role in the recovery of people with mental illness. Both act as a subordinate interconnection and coping strategy which enables them to deal with an event or stimulus that causes stress. Moreover, literature also suggests that in such situations the most commonly practiced way was to fold oneself beneath the wings of religion.

Patients with psychiatric illness use the spiritual principles to cope up with life problems. It was observed that religiosity plays some role in minimizing psychological distress developed as a result of chronic illnesses. Koenig, Linda, George and Bercedis in 1998 revealed that the patients with heart problems having depressive symptoms when assessed for their depression with non- depressed patients, it was found that the depressed patients were less likely to pray. They were generally not religious and had no religious association. Whereas those patients who were religious, had higher intrinsic religiosity and prayed at least daily, read the Bible at least three times weekly, moreover they were participating religious activities and were better able to overcome the symptoms of depression as compared to other patients[8]. In a metaanalysis of 80 published studies over the last hundred years, it was discovered that lower depression rates are interrelated with transcendent features. In this study depression rate was 60% among those who had no religious association[9].

In a similar study for assessing the level of intrinsic religious commitment among the patients, Hoge's 10-item validated scale was used. It was concluded that among total of 87 patients, there was 70% increase in diminution from depression by every 10 point increase in religious mark[8]. O'Connor and Vallerand, in 1989, investigated the relationship between personal adjustment and religious motivation. Their sample consisting of 176 elderly French Canadians were taken from nursing homes. They found that depression was inversely related to intrinsic religiosity. Those who were religious had higher self-esteem and were mostly satisfied in their lives as compared to non–religious group[10]. Similarly in one of survey conducted on a large cross sectional community of Canadian population it was found that depressive symptoms and scarcer psychotic illnesses were lesser with religious attending[11].

While assessing the broad spectrum of the effects of religiosity/spirituality on psychological wellbeing of an individual with respect to their religious beliefs, have indeed established links between spirituality/religion with mental illness[12-14]. On the other hand however, some of these studies also suggest mixed findings of association of religion and spirituality with mental health. Some studies reveal decreased odds of mental illness and depression[15-16], whereas others show increase odds of mental illness with religion[11]. Yet there are some evidences in the literature that suggest no such relationship[17].

For example, a research study by King and Shafer (1992) document that higher levels of religiosity are related to greater levels of psychological distress. Sloan and his colleagues, in 1999 stressed that literature lacks a strong evidence for the link between religion and mental health[18]. According to them the strength of belief did not appear to have an influence on the psychological state of people. Other authors too, document that religion may sometime increase anxiety through doctrine of eternal damnation[19]. Similarly, Walters in 1992 reported that religious beliefs are sometimes responsible for the development of depression, low self esteem and sometimes schizophrenia. In addition to this many people may attribute their psychological/ mental health not directly linked to religion but

to other factors like hiking, reading, stitching and photography etc[20].

While reviewing literature a fair sized literature establishing link between religiosity and mental health was documented, however the nature and direction of relationship between these variables seem to be inconsistent. Moreover, these studies are mainly conducted on western communities and no proper study exists of our Asian Muslim community. Therefore, the current study was especially designed to explore if religiosity servesas a predictor of mental wellbeing among depressed sample in our community or otherwise. Moreover, this study also aims to uncover the moderating role of religiosity among this sample. In light of the above mentioned literature the following hypotheses were formulated.

MATERIAL AND METHODS

This was an exploratory and correlational study. A non probability purposive sampling technique was utilized to include 50 depressive patients.

For accessing depression among patients beck depression inventory was used. It was developed by Beck 1961[21]. The Beck Depression Inventory Second Edition (BDI-II) was a 21-item self-report instrument intended to assess the existence and severity of symptoms of depression. The patients were asked to consider each statement as it relates to the way he/she felt for the past two weeks, to more accurately correspond to the Diagnostic Statistical Manual (DSM-IV) criteria. Each of the 21 items corresponding to a symptom of depression was summed to give a single score for the scale. The response options were four-point rating scale for each item ranging from 0 to 3.

Beck Depression Inventory has a high coefficient alpha (.80) its construct validity has been established and it was able to differentiate depressed from non-depressed patients.

Belief Into Action Scale (BIAS) was a brief but comprehensive measure of religiosity. It was developed by Koenig, Harold, Wang, Al Zabin and Adi in 2015[22]. This scale consists of 10 questions and each item was rated on a rangeof 1 to 10 (except the first question, which receives a value of 1 or 10 depending on the response). The total score on the scale range from 10 to 100. Every item of the scale was carefully chosen based on similar questions on other scales commonly used to assess religiosity.

The alpha reliability of the scale was reported by the author was 0.89 whereas on present sample was the alpha value was 0.76.

The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) was a scale of 14 positively coded items, for assessing a population´s mental wellbeing. It was developed and validated by Fishwick, Hiller, Joseph, Platt, Stewart-Brown and Tennant in 2008[23]. The scale was scored by summing responses to each item answered on 1 to 5 Likert scale. The items are scored on response options ranging from 1 to 5, where 1 was scored for the option "none of the time", 2 for "rarely", 3 for "some of the time", 4 for "often" and 5 was scored for "all of the time". The minimum score on the present scale was 14 and maximum was 70. On the present sample minimum score was 17 and maximum was 68. The Cronbach alpha coefficient of the scale as reported by the authors was 0.89 whereas 0.84 on the present sample.

The sample comprised of 50 patients from the psychiatry wards of three hospitals of Peshawar including Lady reading hospital, Khyber teaching hospital and Hayatabad medical complex. After obtaining a formal written permission from the authorities of the hospital, the patients were approached. At the beginning we not only introduced ourselves to the authorities but also explained the purpose of our study. We also assured them that the information given by the patients will be purely used for the research study. In addition to this we also sought permission from their care givers and assured them that their identities will not be disclosed.

After this, formal data collection from the patients started. Some of the patients with

moderate depression answered us easily as compared to those who were suffering from severe depression. Most of them were on medication. It took us a lot of time and several visits to get accurate data.

Data was analyzed in SPSS version 23. Descriptive statistics were used to measure qualitative and quantitative variables. Correlation and regression analysis were applied on the data. A *p*-value less than 0.05 consider was a significant value.

RESULTS

Total 50 patients were selected among them 25(50%) were males and 25(50%) were females. The mean age was 28.2 ± 12.8 with the range of 15-60 years.

The table-I shows descriptive statistics for all the study variables. It includes number of items scales; mean score of the sample on each scale along with standard deviation, potential range of scores on the scale, skewness, kurtosis and alpha reliability.

In table-II bivariate correlation matrix revealed that scores of respondents on Belief into Action Scale has a significant positive correlation with scores on Warwick Mental Wellbeing Scale. Patients who had religious attachments had better mental wellbeing. On the other hand, mental well being was negatively correlated with depression showing that the more the respondent was depressed the less were the scores on mental wellbeing scale.

In table-III, regression analysis was computed in which Belief into Action Scale was used as a predictor and Warwick Mental Wellbeing Scale as outcome variable. The R2 value of 0.14 indicates 14% variance in outcome variable with $F(1, 49)=8.19$, $p<0.01$. Findings reveal that religiosity was a significant positive predictor mental wellbeing (B=0.23, $p<0.01$.

In table-IV, results reveal the moderating role of religiosity for the relationship between depression and mental wellbeing. Predictor as depression and outcome as mental wellbeing were entered into the model. Results revealed that depression significantly negatively predicted mental wellbeing (i.e. B=-1.76, $p<0.01$) explaining a total of 35% variance in mental wellbeing.

Table-I: Descriptive statistics and Alpha Reliability of the scales.

Variable				Range				
	No	M	SD	Potential	Actual	Skewness	Kurtosis	A
BIAS	10	54	19.68	10-100	15-91	0.084	-0.789	0.767
WEMWBS	14	49.34	12.14	14-70	17-68	-0.617	-0.272	0.842
BDI	21	25.26	8.39	0-63	11-47	0.457	-0.324	0.798

BIAS=Belief into Action Scale, WEMWBS=Warwick Edinburgh Mental Wellbeing Scale, BDI=Beck Depression Inventory

Table-II: Bivariate Correlation among BIAS, WEMWBS, and BDI (n=50).

Variables	BIAS	WEMWBS	BDI
BIAS	1		
WEMWBS	0.382**	1	
BDI	-0.186	-0.407**	1

Table-III: Regression Analysis between BIAS and Mental wellbeing (n=50).

	B	CI-LL	CI-UL
Constant	36.62	27.13	46.12
BIAS	0.236**	0.07	0.4
F	8.199**		
R2	0.146		

BIAS= Belief into Action Scale, WEMWBS=Warwick Edinburgh Mental Wellbeing Scale, CI=Confidence Interval, LL: Lower Level, UL: Uper Level

**$p<0.01$

However, religiosity moderated the effect of depression on mental wellbeing (i.e. B=0.02, p<0.05) explaining additional 91% variance in mental wellbeing.

DISCUSSION

During the past few years there was growing interest in the field of religion/spirituality with respect to mental health. In today's fast pace of life there was rapid rising of political, social and economic instability. Due to this fact depression and anxieties have become prevalent among majority, which has truly raised the issue of Mental wellbeing. In such situations individuals are very much likely to turn to situations that might help them from such negative psychological experiences. According to Corrigan, McCorkle, Schell and Kidder (2003) fewer studies have examined the true connection of religion/spirituality with mental illness like depression[7]. Therefore it was imperative to see whether religious beliefs and commitments buffer the effects of these mental illnesses[8].

As expected and in line with the previous literature the findings of this study revealed a strong negative relation of depression with mental health among the respondents. The higher were the depressive symptoms among the respondents, the low were their scores on mental wellbeing scale. The strong negative link between depression and mental wellbeing was logical. According to the literature, depression was the most common mental health problem faced by people[11]. It diminishes our capacity to cope up with situations consequently affecting psychological wellbeing of individuals. According to Edwards (2005) psychological wellbeing refers to positive mental health. Therefore deterioration of mental health was evident in such states. Mahmoud in 2012 stressed that depression and anxieties are the biproducts of individual's inability to cope up with stressors[24].

However, another pattern emerged from the present findings revealed religiosity to be a significant predictor of mental wellbeing in the sample. Results explained 14% variance in mental wellbeing among the present sample and were associated with better mental health outcomes. Through these findings we assume that for those individuals for whom religiosity reflects positive coping are able to appraise their depressive mental state and able to exert positive influence on their mental wellbeing. Our study findings are supported by an earlier study in this regard. For example, Koenig, McCullough and Larson in 2001 revealed a positive relationship between religious practices, behaviors and indicators of psychological mental well-being and further documented that this positive correlation was consistently similar among people with different races and ages[25].

Table-IV: Moderating Impact of BIAS on the relationship between BDI and WEMWBS (n=50).

			95% CI	
Predictor	**B**	***p*-value**	**LL**	**UL**
Constant	80.71	0	54.06	107.35
BDI	-1.769*	0.002	-2.827	-0.711
BIAS	-0.323	0.143	-0.758	0.113
BIAS*BDI	0.023*	0.014	0.005	0.041
R2	0.354			
ΔR2	0.914			
F	8.4			
ΔF	6.511			

BIAS= Belief into Action Scale, WEMWBS= Warwick Edinburgh Mental Wellbeing Scale, BDI= Beck Depression Inventory, CI=Confidence Interval

*p<0.05, p>0.05

Swinton, (2001) theorized that depressed people have negative view of world and they always think about their failures. He further added that people with depression are unable to cope up with the obstacles of their lives. But the spiritual/religious beliefs give them meaning. Only by the understanding and empathy, depressed people can regain meaning in their lives. This study was instrumental in reestablishing the people's expectations through religious beliefs and activities including worship, prayers and rituals. He concluded that people who are involved in religious activities are better able to decrease the risk of depression[26].

Moreover, the present findings also indicate that religiosity moderated the effect of depression on mental wellbeing among the sample. Through these findings we can assume that religion may not only act but can be used as a strong coping resource when faced with mental states like depression. There are several reasons why religion would have significantly moderated the effect of depression on mental wellbeing. The buffering effect of religion may be better explained through the evidence in the literature that provide an insight to possible mechanisms explaining how religiousness provides a moderating effect against stressful events. The most important one was religious belief itself. For example, the conviction provided by the religion that God aids the faithful in allowing the individual to develop an optimistic view on coping[27]. Secondly, it also encourages the development of positive emotions[28]. Third, was the insight that was developed among individuals because of religion and spirituality in understanding one's disabilities in much effective way which can add meaning to their life. It was therefore safe to assume through the findings of the present study that religion and spirituality may provide effective coping skills that can help individuals suffering from serious mental illness.

Our study findings seems to be consistent with the view point in literature suggesting that the use of religious coping was associated with better mental health outcomes. For example, in one study adults with mental disorders were asked to report the substitute health care practices they used for their mental illness. The patients with different problems answered the survey. It was found that the patients with major depression and post traumatic stress disorder (PTSD) were mostly involved in spiritual/ religious activities which according to them were the most helpful alternative health practice[29]. Similarly in one survey research of 406 patients in a mental health facility in Los Angeles it was found that more than 80% of the patients with the mental sickness frequently practiced the spiritual beliefs to deal with their problems[30].

CONCLUSION

There was a strong negative relationship between depression and mental wellbeing.

Furthermore, religiosity/ spirituality moderated the relationship between depression and mental wellbeing.

These findings indicate the importance of the impact of religiosity on psychological wellbeing and reduced likelihood of depression. These findings provide support to the notion that use of religion/spirituality in mental health services would improve mental health outcomes among patients suffering from anxieties and depression. But it was also recommended that more research may be conducted with larger sample size in order to understand the underlying mechanisms in which religiosity/spirituality plays moderating role in mental wellbeing of people with depression.

CONFLICT OF INTEREST

This study has no conflict of interest to declare by any author.

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