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Religiosity and depression among youth

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ABSTRACT

The purpose of the study was to assess the religiousity and depression among youth. The sample consist of 100 youth as subjects (rural=50 and urban=50). Thereligiousity was measured using The Religious Commitment Inventory (RCI-10) and depression was measured using Becks depression inventory. Data was analysed using independent t test. The results indicated that there is significant difference in religiousity among youth of Kashmir in terms of domicile, that rural youth have more religiousity in comparison to urban youth. Also in depression the difference is insignificant.

Keywords: *religiousity, depression and youth.*

RELIGIOSITY:

Religiosity can be defined as beliefs, feelings and practices that are tied to religion. Going to church or temple on a regular basis is a form of religiousity. Religiousity can be further divided into intrinsic and extrinsic religiousity. Intrinsic religiousity orientation is defined as the extent to which individuals actually take part in religious activities. While extrinsic religious orientation is defined as an individual's inclinations take part in religious activities as a way to obtain desired emotional or social outcomes. In other words, the intrinsically motivated individual lives his/her religion(self-transcendent) while the extrinsically motivated individual uses his/her religion (self-oriented) (Chin & Choo,2004)[1].Religiousity plays a major part in the life of an individual. It can provide hope in despair (Joshi, Kumari& Jain, 2008)[2]. In today's fast faced world of rising, political, economic and social instability one may find it increasingly difficult to ward off feelings of anxiety, depression or loneliness. A nagging sentiment of dissatisfaction with life in general may debilitate many a mind. In such cases, individuals may turn to a variety of facets for not only therapeutic purpose but also for prevention from such ill feelings in the future. For many, this sanctuary is found primarily beneath the wings of religion. In terms of religion a variety of different elements may be protecting scores of individuals from psychologically draining effects. Some may find their hearts at rest when bowed down in prostration to their lord. Others may find comfort within religious sermons where different religious books are read and recited. Still others may find their souls at peace when they submit entirely to their creator with an unshakeable belief that he has full control over all that is happening in

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their lives (Ismail &Desmukh, 2012)[3].Religious beliefs provide a sense of meaning and purpose in difficult life circumstances, they offer a community of support, both human and divine, to help reduce isolation and loneliness, unlike many other coping resources, religion is available to anyone at any time, regardless of financial, social, physical or mental circumstance (Harold, Koenig , 2008)[4].

Religious beliefs play a significant part in sculpting social behaviour. Differences in religious affiliations tend to influence the way people live, the choices they make, what they eat and whom they associate with. The impact of religion on consumption patterns usually relates to the restriction of certain foods and beverages, for example Jews and Muslims do not eat pork; Hindus do not eat beef, and drinking alcohol is frowned upon if not forbidden by Islam and strict Protestants. Religion also influences gender roles in a particular culture. In Islamic countries, both men and women must cover their torso and upper legs at all times and in the case of women only their faces skin may be exposed (Fam, Waller &Erdogan, 2004)[5].

Religion is positively associated with subjective well-being. Moreover, people who find happiness in religion may be more likely to stay religious than those who do not. Religious involvement enhances subjective well-being because religious organization offers opportunities for social interaction between like-minded people, nurturing friendship and social ties. The church based friendship may promote a sense of belonging and thus enhance physical and mental health (Lim & Putnam, 2010)[6]. History shows that religious organizations were often the first to offer compassionate care to the vulnerable groups, including the medically ill, the elderly and the disabled. When physical illness strikes, religion and spirituality become important factor in coping. This may be particularly true for hospitalized patients who must cope not only with unpleasant physical symptoms but also with the stress of hospitalization. Confinement to a hospital bed and hospital routines restrict mobility. Religion or spiritual beliefs may help patients to cope with these stressful experiences (Aqil, 2013)[7]. Religion offers couples guidelines for methods to handle marital conflicts when it erupts. Conflicts between people in meaningful human relationships, such as marriage. Men's religious attendance had a modest inverse association with the frequency of marital arguments. In addition to religious attendance, couple prayer has been found to decrease negativity, contempt and hostility, as well as emotional reactivity toward one's partner. Religious practices such as prayer helped couples to manage their anger during marital conflict (Lambert&Dollahite, 2006)[8].

Prayers have been used as a self-enhancing intervention for centuries. It is inherently a religious affair and activity. Further, a prayer can be general or specific for oneself, for others or for all; to a specific deity or may be offered more generally. Meditation is also a part of religious practice, which is used as a way of reducing the physiological and psychological stress (Joshi, Kumari&Jain, 2008)[9].

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DEPRESSION:

Depression is one of the most prevalent psychological disorders caused byseveral factors, including interpersonal relationships between individuals and the reactions and emotions of each individual expressed directly and discreetly to each other. Sadness and rejection are the most silent emotional symptoms of depression. The individual feels hopeless and unhappy; loss of gratification or pleasure in life. Activities that used to bring satisfaction become dull and joyless; the depressed person gradually looses interest in hobbies, recreational, and family activities. Depression is associated with a constellation of psychological, behavioural and physical symptoms as well (Cassano& Fava, 2002)[10]. 91% of working moms suffered some symptoms of depression, while many people are familiar with postpartum depression. A number of women are reported to experience depression after giving births Mittelmark. (2009)[11]. Depression is the most common disorder which affects the women twice than men (Lowa, 2007)[12]. (Al-Modalla, Abuidhail and Sowan, 2010)[13] could not report depressive symptoms among working women. The results of their study showed that the causes of women's depressive symptoms are not related to jobs. However, findings revealed that such symptoms are imbedded in their social and familial environment. Leger (2004)[14] found that most working women between the age group of 35-55 years' experience depression and generalized anxiety disorder. Such symptoms retard their success in workplace and household lives. Now, one can easily visualize how such dreadful mental ailments lead to prolonged anxiety, frustration, stress, anger and social and emotional distresses and make the women to feel rejected, isolated, tense and make the situation unmanageable. If the professional obligation cannot be met, their self-image and consequently their ability to cope may be endangered. A peep into the mind and psyche of women concludes that psycho-social problems influence the quality of women's life adversely.

The depressed person has negative thoughts, low self-esteem and low motivation for progress. Stress is a complex issue but generally a physical, mental, or emotional reaction resulting from an individual's response to environmental tensions, conflicts, pressures, and similar stimuli (Fontana, Abouserie, 1993)[15]. Depression is reported as feelings of guilt, worthlessness, helplessness, and hopelessness, loss of appetite, depressed mood, or disturbed sleep (Radloff, 1977)[16]. It is the most likely adverse psychological outcome, the range of other possible ''psychological'' problems include ''burn- out,'' alcohol abuse, unexplained physical symptoms, ''absenteeism,'' chronic fatigue and accidents, sick building syndrome and repetitive strain injury (Hotopf, Wessely, 1997)[17].

Anxiety disorder is a blanket term covering several different forms of abnormal, pathological anxiety, fears, and phobias. Unlike the relatively mild, brief anxiety caused by a stressful event (such as speaking in public or a first date), anxiety disorders last at least 6 months and can get worsen if not treated. Anxiety disorders affect about 40 million American adults age 18 years and older (about

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18%) in a given year, causing them to be filled with fearfulness and uncertainty. Anxiety disorders commonly occur along with other mental or physical illnesses, including alcohol or substance abuse, which may mask anxiety symptoms or make them worse.

Objectives of the Study:

To compare rural and urban youth on religiousity and depression.

Hypothesis:

1. There is no significant difference inreligiousity among youth in terms of domicile.
2. There is no significant difference in depression among youth in terms of domicile.

METHOD

SAMPLE FOR THE STUDY:

The sample for the present study consists of 100 youth from Kashmir valley in which 50 subjects were from rural area and 50 from urban area.The purposive sampling technique was used for data collection. The analysis was done by using SPSS.

Instruments:

1. The Religious Commitment Inventory (RCI-10). Developed by (Everett L. et. al.2003)[18] The RCI-10 does not delve directly into the potentially sensitive and contentious theological religious realm, thus eliminating any possibility of offending participants or provoking their sensitivities. The RCI-10 consisted of 10 items on a 5-point Likert scale (1 = not at all true of me, 5 = totally true of me). These items were divided into two religiousity commitments, intrapersonal and interpersonal. The reliabilities of the two dimensions of The Religious Commitment Inventory were as follows: Intrapersonal religiousity (6 items; $\alpha = 0.874$) and Interpersonal religiousity (4 items; $\alpha = 0.681$).
2. The Beck Depression Inventory (BDI) :The BDI test was developed by Aaron T. Beck, M.D.(1961)[19] and includes a 21 item self-report using a four-point scale ranging which ranges from 0 (symptom not present) to 3 (symptom very intense). The test takes approximately 5 to 10 minutes to complete.The BDI test is widely known and has been tested for content, concurrent, and construct validity.High concurrent validity ratings are given between the BDI and other depression instruments as the Minnesota Multiphasic Personality Inventory and the Hamilton Depression Scale; 0.77 correlation rating was calculated when compared with inventory and psychiatric ratings.The BDI has also showed high construct validity with the medical symptoms it measures.Beck's study reported a coefficient alpha

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rating of .92 for outpatients and .93 for college student samples. The BDI-II positively correlated with the Hamilton Depression Rating Scale, r = 0.71, had a one-week test–retest reliability of r = 0.93 and an internal consistency α=.91.

Results:

Table 1: Showing mean difference between rural and urban youth onReligiousity.

Variables	N	Mean	Std. Deviation	t-value
Rural	50	32.84	6.538	4.06*
Urban	50	27.76	5.958	

**Significant at 0.01 level*

The above table shows that there is a significant difference between rural and urban youth on their religiousity. The above table shows that rural youth have highly religiousity as compared to urban youth.

Table 2: Showing mean difference between rural and urban youth on Depression.

variables	N	Mean	Std. Deviation	t-value
Rural	50	20.74	11.297	1.04NS
Urban	50	22.04	10.455	

NS= Not Significant

The above table shows the mean comparison between rural and urban youth on their level of depression. The result of the table shows that there is insignificant difference between rural and urban youth on depression.

Discussion:

1. There is a significant difference in religiousity among youth in terms of domicile. Rural youth have high religiousity as compared to urban youth. The reason for such a finding may be that Since rural

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society experiences social changes more gradually than urban society (Kuczynski, K., 1981)[20]. Therefore change due to social media and other advancements which otherwise would have led impact on rural youth is also gradual in comparison to urban youth.Numerous researchers came unequivocally to the conclusion that religiousness among urban youth is numerically less important than among village or country[21]. Our finding is in conformity with mentioned findings and suggestions.

2. There is insignificant difference in depression among youth in terms of domicile. There is similar level of depression among youth. Both groups show average level of depression. The reason for such a trend may be that as sample is taken from Kashmir. Kashmiri youth exhibit frustration because of the armed conflict which has choked their voice, besides the trauma, uncertainty and chaos is spread equally across villages and urban areas.

REFERENCES

[1]. Chuin C. L., & Choo Y.C., (2004). Age, Gender and Religiousity as related to death anxiety, *Sunway Academic Journal*, 6(5), 1-3.
[2]. Joshi S., Kumari S., & Jain M., (2008). Religious belief and its relation to psychological well-being, *Journal of the Indian Academy of Applied Psychological*, 34(2), 346.
[3] . Ismail Z., Desmukh S., (2012) Religiousity and Psychological Well-Being, *International Journal of Business and Social Science*, 3(11), 20-28.
[4] . Harold G., Koenig, M.D., (2008). Research on religion, spirituality and mental health: A review, *Canadian Journal of Psychiatry, Pvt. 1(2), 7.*
[5]. Fam K S., Waller D S., Erdogan B Z., (2004) The Influence of Religion on Attitudes towards the Advertising of Controversial Products, *European Journal of Marketing*,38(5), 537-555.
[6] . Lim, Chaeyoon, and Robert D. Putnam. 2010. "Religion, Social Networks, and Subjective Well-Being." *American Sociological Review* 75(6): 914-933.

[7]. Aqil. Z.(2013). Preoperative Anxiety as related to religious belief amongst patients going for surgery: A co-relational study. International Journal of Advancements in Research & Technology, 2, 6, 2278-7763 .

[8] . Lambert, N. M.,&Dollahite, D. C. (2006).Howreligiousity helps couples prevent, resolve, and overcome marital conflict. *Family Relations, 55*, 439–449.
[9] . Joshi.S, Kumari.S&Jain.M. (2008). Religious Belief and Its Relation to Psychological Well-being. *Journal of the Indian Academy of Applied Psychology*, 34, 2, 345-354.

[10]. Cassano, P., & Fava, M. (2002). Depression and public health. An overview. *Journal of Psychosom Research*, 53, 849.
[11]. Mittelmark. M. (2009). Work life and mental well being of single and non-single working mothers in Scandinavia. *Scand J Public Health*, 37, 6, 562-568.
[12]. Iowa, U. O. 2007. *Women Are Diagnosed with Depression Twice as Often as Men*.
Retrieved from Iowa University: http://www.uihealthcare.com/kxic/2007/ august/ womensmentalhealth.html.
[13]. Al-Modallal, H., Abuidhail, J., Sowan, A., Al-Rawashdeh, A. (2010). Determinants of depressive symptoms in Jordanian working women. *Journal of Psychiatric and Mental Health Nursing*, 17, 569-576.
[14]. Leger (2004) Depression and anxiety among Canadian women in the workplace.
Retrieved from www.legermarketing.com/documents/spclm/041115eng.pdf.
[15]. Fontana D, Abouserie R (1993) Stress levels, gender and personality factors in teachers. *Br J EducPsychol* 63, 261-270.

ISSN (Print): 2278-0793
ISSN (Online): 2321-3779

[16]. Radloff, L. S. (1977). The CES-D Scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement, 1*, 385-401.
[17]. Hotopf M, Wessely S. (1997) Stress in the workplace: unfinished business. J Psychosom Res; 43,1, 1–6.

[18] . Everett L. Worthington Jr., Nathaniel G. Wade, Terry L. Hight, Jennifer S. Ripley, Michael E. McCullough, Jack W. Berry, Michelle M. Schmitt, James T. Berry, Kevin H. Bursley, and Lynn O'Connor. (2003). "The Religious Commitment Inventory-10: Development, Refinement, and Validation of a Brief Scale for Research and Counseling." *Journal of Counseling Psychology* 50, 84–96.
[19] . Beck AT, Ward CH, Mendelson M, Mock J, Erbaugh J (1961). "An inventory for measuring depression". *Arch. Gen. Psychiatry*. **4**, 6, 561–71.
[20]. Kuczynski,Kay(1981) "New Tensions in Rural Families." *Human Services in theRural Environment,* 6, 3-4, 54-56.
[21] . Research Materials on Religion in Eastern Europe - Page 67.
https://books.google.co.in/books?id=HRMmAQAAIAAJ