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Religiosity and mental health: A study of Kashmiri and non-Kashmiri adolescents

*** Mohd Amin Wani**

Department of Psychology, Aligarh Muslim University, Aligarh, Uttar Pradesh, India

Abstract
Sound mind needs a sound body likewise a sound society needs sound individuals. An attempt has been made to conduct a study on adolescents from the point view of how much religious they are and to what extent religiosity influences their mental health. This study was framed to conduct on the samples of Kashmiri and Non-Kashmiri adolescents to examine the influence of Religiosity on Mental health. The study was conducted on the adolescents of senior secondary schools of Kashmir valley and Uttar Pardesh. Using Purposive sampling technique, 60 Kashmiri adolescents and 60 Non-Kashmiri adolescents participated in the present study. Both the groups of adolescents were examined by administering Religiosity scale developed by Deka and Broota, (1985) and mental health inventory developed by Jagdish and Srivastava (1995). The collected data was analyzed with the help of Simple Linear Regression. The first finding clearly showed the significant contribution of Religiosity towards mental health among Kashmiri adolescents. The value of 'R' was found to be .931, which indicates a significant positive correlation between Religiosity and Mental health among Kashmiri adolescents. Whereas, the second finding also revealed that Religiosity appeared as a significant predictor of Mental health among Non-Kashmiri adolescents. This indicates that there is also a significant positive correlation 'R'= .838 between Religiosity and Mental health among Non-Kashmiri adolescents. Since, both the groups of adolescents were found in maintaining good Mental health but the value of 'R' in case of Kashmiri adolescents was found slightly higher. it is discussed that the Kashmiri adolescents are living in a disturbed and suffocating environment as compared to Non-Kashmiri adolescents, where they are exposed to anxiety producing and stressful situations. They may be looking to be more religious in order to cope with the prevailing situations and to heal their pains.

Keywords: religiosity, mental health, adolescents

Introduction
Adolescence is considered as a period of stress and strain. During this period, adolescents undergo certain changes and they face multi-dimensional problems and these problems need a holistic approach. An adolescent is a problem-individual: if an adolescent can't adjust himself with the world, he grows to be aggressive and withdraws himself from his goals and his personality is distorted. Every adolescent is eager to become independent, especially from the imposition of restrictions from their parents. They want themselves to be economically independent. They are emotionally charged and unstable, they expect things to be done as they aspire. They feel insecure due to their unemployment issues. If all these issues are not addressed, an issue of ill-health exists and this has a negative impact on the mental health of adolescents.

As we know the importance of adolescents in the society. They are the citizens and workers of tomorrow. They are responsible for the upcoming future of the nation. Adolescent's health is therefore an important component of global health which needs to be secured and maintained.

This study was designed to conduct on adolescents after taking into consideration their problems and its impact on their health and also their importance for healthy development of the nation as a whole.

The study aimed to see to what extent religiosity contribute towards mental health of adolescents. In general, if we see when an individual is faced with any problem or lives in a stressful situation where no possible solutions are available, the only way to cope with these situations is to choose to pray to God according to his/her religious faith to get the favor of superpower.

Religiosity
Traditionally the term Religion was used to refer to all aspects of the human relationship to the Divine or transcendent- that which is greater than us, "the source and goal of all human life and value" (Meissner, 1987) [24]. More recently, scholars have started to understand religion as activities and a way of life: "the fashioning of distinctive emotions; of distinctive habits, practices, or virtues; of distinctive purposes, desires, passions, and commitments; and of distinctive beliefs and ways of thinking," along with "a distinctive way of living together" and a language for discussing "what they are doing and why" (Dykstra, 1986) [9]. Thus religion has to do not only with the transcendent as it is "out there" but as it is imminent in our bodily life, daily experiences, and practices.

"Religiosity" can be defined as "the exaggerated embodiment of certain aspects of religious activity". Religiosity is characterized by excessive involvement in religious activities. Religiosity usually entails extreme zeal and affection outside and beyond the norms of one's faith or beliefs. Often, religiosity reflects one's individual beliefs more than those of the religious organization itself. Another term used for religiosity, though less often, is "religiousness," "the state of being superficially religious".

Mental Health
Mental health describes a level of cognitive or emotional well-being and implies the absence of a mental disorder.

Mental health includes an individual's ability to enjoy life and procure a balance between life activities and efforts to achieve psychological resilience.

The World Health Organization defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community".

Good mental health has two main components: an absence of negative symptoms and positive signs of psychological and psychiatric functioning. The second component includes positive indicators such as functioning at a high level of adaptation, having fulfilling social relationships with other people, mental balance, self- esteem, self- control, maturity, and resilience. Mental health is indispensable to SWB, and SWB is the positive side of mental health.

Although mental health problems can develop at any point in life, the years of adolescence and the transition to adulthood are a time when stressors, coupled with changing peer and family interactions, may lead to issues such as depression, suicidal thoughts, and anxiety (Graber, 2004) [13]. To prevent these issues, it is important to identify and understand factors existing in adolescence and youth that have positive effects that last into young adulthood.

A study was conducted on 495 Muslim students from Algeria by Tiliouine and Belgoumidi (2009) [41]. They found that religious belief and religious altruism significantly contributed to providing subjects with a meaning in life. Hierarchical regression analyses showed that only religious belief made a significant contribution to both, satisfaction with life and a personal well- being index. The main results of these studies are two-fold: (a) there is a positive relationship between religiosity and SWB, including happiness, satisfaction with life, and love of life, physical health, and mental health; and (b) there is a negative relationship between religiosity and psychopathology, such as anxiety and depression. It is important to note also that Thorson, Powell, Abdel- Khalek, and Beshai (1997) [40] compared Kuwaiti and American college students and found that the Kuwaiti sample obtained a significantly higher mean score on internal religious motivation than did their American counterparts. This high score on religiosity might have an impact on the association between religiosity and both mental health and SWB.

Abootes, *et al.*, (2004) studied the relationship between religiosity and mental health among Scottish children. The mental health of children was examined in relation to their weekly attendance at church services. The findings showed that children who participated more in religious ceremonies showed lower aggression in school and home, had higher self-esteem, and less depression and anxiety were reported among them. (Nani Meeker, McNealy and Bloom, 2006) examined the relationship between internal and external religion and mental health in adolescents. The attendance at religious ceremonies and participation in religious youth group activities was the external measure of religiosity. The internal religion was measured according to the prayer and the importance of religion to individuals. The results showed that religiosity has a protective role for adolescents' health. Overall, both internal and external religion protected the teens against smoking, alcohol, and marijuana. There was a negative relationship between internal and external religion and illegitimate sex. In fact, this study showed that religion has a supportive and protective role against problems for adolescents.

Recent reviews continue to provide further evidence of an association between religious involvement and health. Religion, associated with variables has been shown to have protective effects for multiple mental health outcomes, including well-being, suicidal behavior and substance misuse. (Moriera- Almeida, Neto, and Koenig, 2006) [26, 27]

The positive influence of personal religiosity on mental health is well-documented. Numerous researchers have shown that individuals who attend religious service regularly, perform religious behaviors such as prayer and scripture reading, and feel that religion is a very important part of their lives, suffer less from depression and anxiety and score higher on measures of general mental well-being than their non-religious counterparts (e.g., Bjorck and Thruman, 2007; Eliassen *et al.* 2005; Ellison, 1991; Ellison *et al.* 2001; Nooney, 2005; Petss and Jolliff, 2008; Salsman and Carlson, 2005) [2, 11, 12, 28, 30, 35].

Religiosity/Spirituality has been found to be inversely correlated with the prevalence of any mental disorder. (Chatters, Bullard, Taylor, Woodward, Neighbors & Jackson, 2008, Mc Cullough abd Larson, 1999; Moreira-Almeida, Neto and Koenig, 2006; Wong, Rew, Slaikeu, 2006; King, Marston, Mc Manus, Brugha, Meltzer, Bebbington, 2013) [5, 23, 26, 27, 42, 43, 16] and, in particular, to have a positive impact on depression,(Mc Cullough,& Larson, 1999; Koenig, Cohen and Blazer, 1992; Koenig, 2007) [23, 18] suicidal thoughts and behavior,(Stein, Witztum, Brom, De Nour, and Elizur1992; Sisask, Varnik, Kolves, *et al.*, 2010) [38, 37] and alcohol dependence and drug abuse. (King, Marston, Mc Manus, Brugha, Meltzer and Bebbington, 2013; Miller, 1998; Desmond and Maddux, 1981; Edlund, Harris, Koenig *et al.*, 2010) [16, 25, 7]. Furthermore, it is suggested that Religiosity/Spirituality is not only a protective factor for mental health, but that it also may positively influence the treatment outcomes for some mental disorders. (Koenig, Cohen, and blazer, 1992; Braam, Beekman, Deeg, Smit, and Van, 1997; Sterling, Weinstein, Hill, Gottheil, Gordon, and Shorie, 2006) [18, 4, 39].

The evidence suggests that religion is beneficial to mental health. A (2001) publication by Koenig *et al.*, for example, identified 724 quantitative studies that examined the link between various religious measures and mental health outcomes. The authors found that 476 of these studies reported statistically significant positive associations. Specifically, this extensive review revealed that religious involvement was correlated with lower anxiety and depression, and less drug use.

Kenneth Pargament, a leading scholar of religious coping, postulated that during stressful situations, religious beliefs are translated into specific styles of coping (Pargament, 1997) [29]. Accordingly, these specific styles of coping can be either positive (e.g., seeing God as a partner in the process of coping) or negative (e.g., relinquishing personal responsibility to God), and ultimately affect how people deal with and adjust to a particular stressor (e.g., active versus passive behaviors). Pargament also noted that people are more likely to use their faith as a method for coping when they come across severe, uncontrollable events. Support for this argument can be found in studies documenting an increase in

religiosity or faith following a sudden, tragic or stressful event (Koenig, *et al.*, 2001). Religious coping, then, may serve as a means to achieve a sense of control over a more or less uncontrollable situation. The indirect sense of control, in turn, may help individuals cope better (e.g., reduced helplessness or self blame).

Objectives of the study

- To determine the influence of religiosity on mental health among Kashmiri adolescents.
- To determine the influence of religiosity on mental health among Non-Kashmiri adolescents.
- In the light of these objectives, the following Research Questions were raised to be investigated.
- Is there any influence of Religiosity on Mental health among Kashmiri adolescents?
- Is there any influence of Religiosity on Mental health among Non-Kashmiri adolescents?

Method

Sample

The participants of this study were selected by means of purposive sampling technique from various senior secondary schools of Kashmir valley and from the state of Uttar pardesh. In this way the adolescents of two different societies were examined in terms of religiosity and mental health. The total sample consisted of 120 participants with equal number of Kashmiri adolescents (n=60) and Non-Kashmiri adolescents (n=60).

Tools

Religiosity Scale

To measure the Religiosity among Kashmiri and Non-kashmiri adolescents, The Religiosity scale developed by Deka and Broota (1985) [6] was used. The scale consisted of 44 items, out of which 25 are positively keyed and 19 are negatively keyed. The presence of both positively and negatively worded items included in the test was to avoid the tendency of the respondent to develop a response set that might occur, were the items only positive or only negative. In this way the adequacy of the response given by the participants could be established. The reliability coefficient for the religiosity scale was 0.96.

Mental Health Inventory (MHI)

The mental health inventory developed by Jagdish and Srivastava (1995) was used to assess mental health among Kashmiri and Non-Kashmiri adolescents. The lower scores on the measure of mental – ill health has been supposed to indicate higher mental health. This scale has 55 items based on 6 dimensions: (1) Positive self – evaluation, (2) Realistic perception, (3) Integration of personality, (4) Autonomy, (5) Group oriented attitudes and (6) Environmental mastery. The scale has 4 response categories viz., always, often, rarely and never. The reliability and validity coefficient were found significant as the value of the split-half reliability coefficient was r = 0.73 and validity coefficient i.e. construct validity was r = 0.54 which confirm the standardization of the scale.

Procedure

The consent of participants was received to ensure their participation in the present study. They were told about the purpose of the study. Religiosity scale and mental health inventory were administered on 120 participants of different societies. The data was collected from the participants as per the instructions given in the manual. After collection of the data, Simple Linear Regression was used to analyze the obtained data.

Results

Table 1: Represents linear regression analysis to indicate relationship between Religiosity and Mental health among Kashmiri adolescents.

Model summary				
Model	**R**	**R Square**	**R Square Change**	**Change statistics R square Change**
1	.931	.866	.864	.866

Predictors: (constant), Religiosity Kashmiri adolescents.

The above table shows Simple Linear Regression analysis of Religiosity, it showed that Religiosity appeared as significant predictor of Mental health. It was found that Religiosity (Predictor) emerged to influence significantly the adolescents' Mental health (Criterion). This table shows the model summary, which indicates one predictor of the model. The correlation was found to be R= .931. R Square change mentioned in the above table indicates the actual contribution of predictor variable to the criterion variable. Therefore the original covariance, the magnitude of independent variable which contributed to the dependent variable (Mental health) came out as 86.6%.

Table 2: Represents the details of Coefficients between Religiosity and Mental health among Kashmiri adolescents.

Coefficients					
Model	**Unstandardized Coefficients**	**Standardized Coefficients**		**t**	**Sig.**
	B	**Std. Error**	**Beta**		
1 (constant)	-9.824	11.349		-.866	.390
Religiosity Kashmiri Adolescents	1.059	.055	.931	19.387	.000

Dependent variable: Mental health Kashmiri adolescents.

The above table clearly shows that Religiosity, the predictor variable influences Mental health (Criterion). The Statistical value given in the table was found significant for above mentioned predictor that is Religiosity indicating a relationship between predictor and criterion variable Mental health.

The value of Partial Correlation is r = .931, therefore predictor significantly influenced the degree of Mental health, this finding indicates that Religiosity appeared as a significant factor of Mental health among Kashmiri adolescents. The table indicates a significant positive correlation exists between Religiosity and Mental health among Kashmiri adolescents. It means that when Religiosity increases Mental health also increases and when Religiosity decreases Mental health also decreases.

Table 3: Represents linear regression analysis to indicate relationship between Religiosity and Mental health among Non-Kashmiri adolescents.

Model summary				
Model	**R**	**R Square**	**R Square Change**	**Change statistics R square Change**
1	.838	.702	.697	.702

Predictors: (constant), Religiosity Non-Kashmiri adolescents.

The above table shows Simple Linear Regression analysis of Religiosity, it showed that Religiosity appeared as significant predictor of Mental health. It was found that Religiosity (Predictor) emerged to influence significantly the adolescents' Mental health (Criterion). This table shows the model summary, which indicates one predictor of the model. The correlation was found to be R= .838. R Square change mentioned in the above table indicates the actual contribution of predictor variable to the criterion variable. Therefore the original covariance, the magnitude of independent variable which contributed to the dependent variable (Mental health) came out as 70.2%.

Table 4: Represents the details of Coefficients between Religiosity and Mental health among Non-Kashmiri adolescents.

Coefficients					
Model	**Unstandardized Standardized Coefficients Coefficients**			**t**	**Sig.**
	B	**Std. Error**	**Beta**		
1 (constant)	-30.154	12.857		2.345	.022
Religiosity Non-Kashmiri Adolescents	.846	.072	.838	11.702	.000

Dependent variable: Mental health Non-Kashmiri adolescents.

The above table clearly shows that Religiosity, (the predictor variable) influenced the Mental health (Criterion). The Statistical value given in the table was found to be t = 11.702 which is significant for above mentioned predictor that is Religiosity, indicating relationship between predictor and criterion variable Mental health.

The value of Partial Correlation is r = .838, therefore predictor variable significantly influenced the degree of Mental health. The obtained finding indicates that Religiosity appeared as potential factor of Mental health among Non-kashmiri adoescents also. It may be seen in the table that a significant positive correlation exists between Religiosity and Mental health among Non-kashmiri adolescents too. It means that when Religiosity increases Mental health also increases and when Religiosity decreases mental health also decreases. Religiosity appeared as a significant predictor of mental health among adolescents of both the selected cultures. However, somewhat less contribution of religiosity on mental health among Non-kashmiri adolescents as compared to kashmiri adolescents was found.

Discussion

The basic purpose of this study was to examine the influence of religiosity on mental health among Kashmiri and Non-Kashmiri adolescents. The findings revealed that religiosity was found positively associated with mental health among Kashmiri and Non-Kashmiri groups of adolescents. These findings were supported by the studies conducted by various researchers. A substantial body of research reports a positive association between religiosity, mental health, and SWB (e.g., Dezutter, Soenens, & Hutsebaut, 2006; Lavric & Flere, 2008; Rew & Wong, 2006; Seybold, 2007). For example, Jensen, Jensen, and Wiederhold (1993) found a positive association between religiosity and mental health measured with three scales: depression, emotional maturity, and self-esteem. In a related vein, Roman and Lester (1999) found a negative association between religiosity and psychoticism. Ringdal (1996) found that religiosity was significantly related to general satisfaction with life and feelings of hopelessness among 253 hospitalized cancer patients between the ages 23 and 78 years old. Wong, Rewand Slaikeu (2006) [42, 43] reviewed studies using adolescents and found that most of the studies (90%) showed that higher levels of religiosity/spirituality were associated with better mental health. Existential dimensions of religiosity/spirituality had the most robust relationship with mental health, and the association was generally stronger for males and older adolescents than for females and younger adolescents. However, it is much worth to mention here that in case of Kashmiri adolescents, the value of 'R'= .931 is greater than that of the Non-Kashmiri counterpart, where the value of 'R'= .838. The reason behind this difference may be that since last 7 or 8 years, Kashmiri people are facing adverse, peace less, suffocating, stress and anxiety producing situations during which their minds remain filled with tension and worries. Therefore, the only way to cope with these situations or to find themselves in normal situations is to take part in religious activities or to find the path of God i.e. Religiosity. Over the past two decades, both qualitative and quantitative studies have shown that people frequently use religion as a way of coping with stressful situations in their lives (Lindgren & Coursey, 1995; Koenig, McCullough, & Larson, 2001; Kroll & Sheehan, 1989) [19]. These stressful situations include experiences, such as the recent loss of a loved one, natural disasters, losing one's job, divorce, or being diagnosed with serious disease like AIDS or cancer.

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