

# The Relationship between Religiosity and General Health of the Alghadir Students in Zanjan-Iran

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## **Abstract**

This study aimed to investigate the relationship between different aspects of religiosity and general health. Using randomized cluster sampling, a number of 130 students from Alghadir-the Technical and vocational university in Zanjan-were selected as sample. This study was a descriptive - correlation research. The Religiosity Scale was used to measure the level of religiosity. This scale was developed based on multidimensional religiosity theory of Glark and Stark; it evaluates four dimensions of religiosity such as emotions, consequences, beliefs, and rituals. The General Health Questionnaire (GHQ) was used for assessing the general health; it consists of four physical subscales: anxiety, having nightmares, social dysfunction, and depression. The correlation between the scores of the two questionnaires was analyzed. The results showed that there was a significant relationship between the scores of general health and overall religiosity ( $p=0.01, r=-0.42$ ). The belief, experience, and ritual dimensions of religiosity had a significant correlation with several measures of general health. The consequence dimension of religiosity had no relationship with any of the subscales of general health.

Keywords: general health , religiosity ,Students,Alghadir TVU

## **Introduction**

A lot of discussions have been focused on the impact of religiosity on mental health. In recent years, psychologists have paid special attention to the role of religion in mental health and mental illness treatment. They believe there is much in the power of faith in God and religious attitude; it gives a man a spiritual power to tolerate the hardships of life and helps him remove the anxieties. In its latest statement, the World Health Organization has studied the health from four fundamental dimensions: physical, psychological, social, and spiritual dimensions. The emphasis on fourth dimension –spirituality- represents the awareness of mental health officials and experts; it emphasizes the importance of religion and spirituality in people's lives. The father of American Psychiatric Benjamin Rush is among those who have pointed to the importance of religious studies. He stated religion is as important as air for nurturing the human spirit and his/her health.

Pargamnt described psychological role of religion as the factor which helps people understand and cope with life events. Religion can be effective in the creation of hope, a sense of closeness to others, emotional tranquility, opportunity for self-actualization, feeling comfortable, controlling the impulses, getting close to God, and help in solving the problems.

Philip Penil believed that religion affects the mental health of mental patients. He has considered moral corruption as one of the factors of mental illness (Richardson ,1978).

Researches indicate that there is a positive relationship between religion and mental health; religion psychology has provided empirical support for this idea.

Wink & et al showed a positive relationship between the religiosity in late adolescence and loyalty and compatibility.

In a study using a researcher-made questionnaire, Moore and Lyndnr ( 2002) considered the predictors of religion in the adolescents in the order of culture characteristic, peers influence, cognitive abilities and psychodynamic needs -characteristics of personality and identity-, parenting styles, and attendance at religious places. Spirituality and religion included daily spiritual experiences, forgiveness, generosity, and religious coping was associated with lower levels of depression, especially in girls (Dsrisyrs & Miller, 2007).

Good and Vilafbay (2006) studied the interaction between religion, spirituality, and psychological adjustment of adolescents with a range of tools including questionnaires such as being the victim of peers (Marini et al 1999), the quality of friendship (Gavz et al 1996), and attachment to parents and peers (Armsdn and Grynbvrg 1987). The results suggest that there is a positive and significant relationship between the religiosity of adolescents and their compatibility, regardless of their spirituality. These results imply that religious adolescents show lower levels of risky behaviors.

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.

In their study, Pico and Fitzpatrick (2004) pointed to the role of religion as a protective factor against substance abuse among adolescents. The findings indicate that there is a significant and positive relationship between religiosity and decreased smoking, alcohol, and marijuana among boys and decreased marijuana use among girls.

Ball, Armisted, and Aystsin (2004) examined the relationship between religion and compatibility among African -Americans adolescent girls- who were more likely to have health problems and inconsistencies. It was observed that there is a significant and positive relationship between

having religious activities and high self-esteem, decreased stress, and mental health among African girls.

In a study on 403 Hungarian students 15 to 25 years old, Kezdi et al(2010) examined the relationship between suspect to religion and mental health. The results show that the suspect to religion is positively correlated with anxiety and depression, and vice versa.

In this regard, the present study investigates the relationship between different dimensions of religion and public health in the students of Alghadir- the Technical and vocational university(TVU) in Zanjan.

Thus, the following hypothesis was examined:

There is a relationship between different dimensions of religiosity (belief - emotional – consequence, and ritual) and public health dimensions (somatization - anxiety and having nightmares - social dysfunction, and depression).

### **Methodology**

This study was an applied and descriptive - correlation research. The population included all students of Alghadir university Zanjan in 2013; a number of 130 students were randomly selected as sample. It is worth noting that all students at Alghadir are boys.

In this study, the GHQ-28 questionnaire and Muslim religiosity measures were used. The GHQ-28 questionnaire was introduced by Hiliyer and Goldberg (1979); it is a psychological questionnaire used to screen the general health. The questionnaire contains 28 questions with multiple-choice answers that are answered by the respondents. The GHQ-28 is composed of four subscales: somatization (items 1 to 7), anxiety and insomnia (items 8 to 14), social dysfunction (items 15 to 21), and severe depression (items 22 to 28).

The Likert was used for grading the questionnaire; for each of the four options is given a point (3, 2, 1, and 0). Sometimes, double response scale (1, 0) is used. This study used four grading. Thus, the range of scores for each subject varies from 0 to 84. Higher score on this test indicates the presence of a severe public health problem (Kaviani et al, 2001). Using this questionnaire, a survey was conducted on Iranian students; the results indicate the validity and reliability of it among them. The calculated Cronbach's alpha for this questionnaire in Iran has been 0.91. The concurrent validity coefficient for this questionnaire was calculated with students' life problem (0.58) questionnaire and academic problems (0.72) questionnaire (Molavi, 2002).

The other instrument used in this study was the Muslim religion questionnaire. This questionnaire has been prepared by Serajzadeh (1998). Four dimensions belief, ritual, experience, and outcomes are considered in this questionnaire. The intellectual dimension or religious knowledge is not included in the questionnaire; because in many countries including Iran, religious education is part of the school curriculum, so it cannot be a valid indicator for the religiosity of people. In Western societies, this dimension is not a valid indicator of religiosity. Muslim religiosity questionnaire consists of 26 items. It includes four subscales: belief (items 1 to 7), experience (items 8 to 13), outcome (items 14 to 19), and ritual (items 20 to 26). The belief dimension in the questionnaire includes questions about religious principles: questions about belief in God, The Resurrection, the truth of the Qur'an, angels, the appearance of Hazrat Mahdi(PBUH), and the need to encouraging the good and discouraging the evil. The ritual dimension includes questions about religious obligations such as daily prayers, fasting during

Ramadan, and other religious practices such as reciting the Quran, participating in congregational and Friday prayers, and participating in religious ceremonies and mourning. The experience dimension includes issues such as the fear of God, repentance, closeness to God, and emotions to Prophet and saints. The outcome dimension considers the behavioral frameworks that a Muslim should observe in everyday life, such as hijab, avoiding alcohol, and etc. The questions are attitudinal. This questionnaire is scored in a five-part range based on the Likert system- completely disagree 1, disagree 2, Intermediate 3, agree 4, and completely agree 5. The score for each subject on the questionnaire ranged from 26 to 130; and higher scores indicating greater religiosity. The test-retest method and internal consistency was used for checking the reliability of the questionnaire. The calculated Cronbach's alpha coefficient for the religiosity questionnaire is 0.78. The validity of the questionnaire was studied through three different approaches. The results confirm its reliability and validity.

The correlation between the total score and subscales of General Health and religiosity was calculated using software SPSS.

## **Findings**

Table 1. The correlation between religiosity and mental health scores

	General health	somatization	Anxiety	Social dysfunction	Depression
General religiosity	-. /42 P<./01	-. /12 P<./43	-. /29 P<./05	-. /39 P<./01	-. /36 P<./01
Belief	-. /34 P<./01	-. /28 P<./05	-. /23 P<./11	-. /44 P<./01	-. /45 P<./01
Experience	31 P<./05	-. /28 P<./05	-. /32 P<./01	-. / .37 P<./01	-. / .22 P<./15
Outcome	-. /12 P<./48	-. /09 4= . /82	-. /11 P<./37	-. /08 P<./52	-. /17 P<./23
Ritual	-. /42 P<./01	-. /23 P<./11	-. /38 P<./01	-. /41 P<./01	-. /44 P<./01

From four dimensions of religiosity, there is significant and negative correlation between belief, ritual, and experience dimensions and various aspects of general health. Only outcome dimension has no significant relationship with general health. The belief dimension has a significant relationship with somatization, social dysfunction, and severe depression. The experience dimension shows a significant relationship with somatization and social anxiety and dysfunction. The outcome dimension has no significant relationship with any aspect of general health. The rituals dimension has a significant relationship with the components other than the somatization.

## **Discussion and Conclusions**

The results showed a negative relationship between depression, belief dimension, and ritualistic dimension. This means the individuals who have such a strong faith and attend religious services and worship, do not have the feeling of emptiness, helplessness, and despair; they are self-confident and less likely to suffer from depression in the future. This result is consistent with the findings of Quing (2004), Nick et al. (2007), Dis Roosiro Miller (2007), and Aboot et al (2004).

The social dysfunction was significantly associated with dimensions of religiosity other than outcome dimension. In this regard, we can say that religious people have a high sense of responsibility, fulfilling the tasks by following a specific planning, doing the tasks orderly and consciously, and are happy and satisfied with performing their duties. Given the above findings and discussions, some basic suggestions are offered which should be considered.

Considering the relationship between religiosity dimensions and public health components, it is suggested that by fundamental investigation in religious texts and providing practical solutions, people deal with anxiety and depression. Investigating the effect of these strategies on the reduction of disturbances provides the general health. Teaching religious issues in a more subjective and practical form to youth and adolescents.

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