Original Article

Role of internal and external religious beliefs in Mental Health and rate of depression in elderly people

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Objectives: The present research is aimed at surveying the role of (internal and external) religious orientation in the mental health and the extent of depression in elderly people residing in welfare centers and the society.

Methods: The study has been conducted through post-event and correlation method by using stochastic and cluster sampling in 230 cases of elderly people at senior citizens` homes, affiliated with the Welfare Organization, and public places (mosques and parks) which are gathering centers for the elderly people of society, both male and female. The cases were initially screened in terms of recognition complications. Then 28-question tests on general health and depression of Beck and Alport`s test on religious approach were completed and the results were analyzed by using Pierson and Manvitni`s dependent statistical tests.

Results: Results showed that there is a significant correlation between the religious orientation and depression of the elderly people. That is, the more the scores of external religious orientation rise, the more the scores of disorder in mental health and depression increase. There is also a meaningful difference between mental health, depression and religious orientation of the elderly people who are residence and non-residence of the society. That is, the elderly people who live in the centers enjoy a more external religious orientation and disorder of mental health and more depression as compared to the group of the elderly people residing in the society.

Conclusion: The external religious belief has a correlation with disorder in the mental health and depression as well as internal religious belief. Moreover, mental disorders and depression among the resident elderly people are higher than non residents, while resident elderly people have a more external religious approach.

Keywords: Internal religion, external religion, mental health, depression, older adult

Introduction

The aging population issue, which has been raised due to important reasons including reduction of mortality resulting from the progress in medical science, health, birth control, education and the consequent rise in life expectancy and longer life at the world level, is a relatively modern phenomenon. Whereas the phenomenon causes considerable developments in all aspects of the life of human societies including in an extensive range of traditional structures, values and norms as well as establishment of social organizations; confrontation with the challenges facing this phenomenon and using of proper managements towards promotion of the physical, mental and social condition of the elderly people have a high priority which is included in the working agenda of the international community.

In 2000, the total world population was 6.55billion, 69 percent of which was made up of 65 year olds. It is predicted that by the year 2025 the world population

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will have increased to 8.23billon, increasing the number of over 65 year olds to 10.4 percent. Meanwhile, according to the public census conducted in Iran in the calendar year of 1375 (1996-97) some 4.32 percent of the total 60 million population were 65 year old adult and over. (5), and the number of the number of adults over 65 was reported to have stood at 2.6 million three years later (Sayari, 1378. Daily Ettela'at). The number of elderly people in Iran would exceed 26 million to account for some 23 percent of the total population in 2050 (6).

Mental complications during old age can be observed that affect psychological, emotional and behavioral conditions of the elderly people. About 15 to 25 percent of the elderly have a major psychological problem (7) while old age has potential effects on the length of physical diseases (8). An old person would inevitably have to cope with different types of grief (death of spouse, friend, family member, colleague, …), change in occupational condition, and diminished physical capability and health. A loss of any kind during old age causes the person to spend a lot of energy on mourning, separation caused by death, and adjustment with the changes. Living alone is a major stress which affects about 10 percent of elderly people (9). Based on research findings some 15 percent of the elderly have psychological problems and depression (2). Like depression anxiety is extensive too. The suicide rate among the elderly has been reported to be more than other age groups (10).

In view of the increasing growth in the number of the elderly people and prevalence of psychological problems particularly depression among these individuals and the serious shortage of gerontology psychiatrists and availability of special services in this respect, the need for attention to the internal and external sources of the elderly to confront with old age conditions are felt. Among the methods of confrontation by the elderly religion could probably play a basic and important role. Because religion may have a positive value in filling the hollow space of living, supporting the elderly people, coping with stress, and providing a suitable mechanism for the situation and giving meaning to life and death (11, 12). Therefore such a presumption needs to be studied to determine whether religion as an internal and external source has any role in the mental health and extent of depression of the elderly and in case the result should be positive it can be considered as an important component of a supportive program for the elderly. Is it possible to define a more positive role concerning the relation between religion and mental health particularly in view of the type of religion (internal or external)? In other words, is it like what Alport (1966) says that the internal religion (the religion which an individual demands from inside, lives with it and makes all his (her) life meaningful and motivated with it) has a more important role in the mental health than the external religion which an individual seeks towards convenience, tranquility, position and social support?

Materials and Methods

The study has been conducted through post-event and correlation method by using stochastic and cluster sampling in 230 cases of elderly people at the senior citizen homes, affiliated with the Welfare Organization, and public places (mosques and parks) which are centers of gathering of the elderly people of the society, both male and female, and the samples initially underwent general health tests GHQ and depression tests of Beck "BDI and test of religious approaches (internal and external of Alport EIR) and brief mental and clinical examination (MMSE) along with the completion of a form of particulars, and then related data was collected and upon gradation with correlative statistical tests of Pierson, and a common assessment variance, the results were analyzed.

The validity of Alport`s religious test has been tested by Janbozorgi (1378) in a sample group of 235 students of the universities in Tehran province with a validity of 737 percent according to Kronbach's Alpha. In another research, conducted by Mokhtari (1379) with a sample of 112 individuals at Tehran University the validity of this scale as per the Alpha method of Kronbach's was assessed which showed an Alpha coefficient of 712 percent. Meanwhile, the test was used for different communities in Iran and revealed an acceptable validity (13, 14).

The statistical community comprised of elderly people, both residents and non-residents of the Tehran`s welfare centers without mental disorders such as dementia, Alzheimer and mental retardation (MR). The random-cluster sampling was used so the target elderly people were totally chosen from the four groups. Samples were divided into two general groups of elderly people: resident and nonresident. The resident elderly people were selected on random-cluster way from governmental (public) centers and nongovernmental (private) centers, belong to the welfare organization, while the elderly people residing

in the society were chosen on the same basis in the mosques and parks located in the north, south and central areas of Tehran. Based on previous studies and statistical analysis the number of subjects estimated 230 individuals so that if the number of samples reduces for some reasons, substitute samples will replaced. However, no reduction took place.

Results

A. Descriptive results of the data The descriptive characteristics of the subjects have been shown in tables 1 and 2.

As table 1 indicates, 105 samples, i.e. 46.9 percent, belong to the sample group who are residents of the centers and 122 samples, i.e. 53 percent belongs to the residents of the society. Moreover, 100 sample individuals, 43.5 percent, were women and 130 samples, 56.5 percent, were men.

Subjects who were older than 65 had an average age of 71.61 with a variance of 6.52, and the education levels of most of the sample individuals were lower than high school diploma.

Table 1: characteristics of the subjects residing in centers and society

Sample groups		Women	Men	Frequency	Percent
Residing in centers	Governmental	33	46	79	34.3
	Nongovernmental	18	11	29	12.6
Residing in society	Park	7	46	53	23
	Park	42	27	69	30
Total		100	130	230	100

As table 2 shows, near half of the sample individuals were single and more than 80 percent of them were senior citizens homes residents.

Table 2: Marital status

Marital status	Frequency	Percent
Single	84	36.5
Married	108	47
Unknown	38	16.5
Total	230	100

B. Deductive results of the data

A survey of the relation between religious orientation and mental health of the elderly people using Pierson's correlative test showed that there is a meaningful positive correlation between religious orientation and mental health of the elderly and P= 0.001 and r = 291. The higher the score of religious orientation toward external religious (score 100) rises, the more the score of disorder in mental health would be, and the more the score teams toward internal religious orientation (score 20), the more mental health disorder reduces. Therefore, there is a meaningful relation between external religion and mental health disorder and the internal religion and mental health. A survey of the relation between religious orientation and the extent of elderly people's depression showed that there is a meaningful relation between the religious orientation and extent of elderly people's depression and P = 0.001 and r = 0.276. It means that with the rise of the scores of the external religious orientation (score 100) the score of the depression also rises and with the reduction of the scores toward internal religious (score 20) the depression scores reduce. Therefore there is a meaningful relation between the external religious orientation and the rise of depression and the internal religion and reduction of depression. Whereas the groups residing in the welfare centers and the society did not have a normal distribution in the religious, depression and mental health variables, so in order to survey the relation between mental health, depression and religious orientation of the elderly people residing in the centers and the society, the non-parametric Menwitni test was used. Result of these tests showed that: 1. The average rank of the mental health of the group which resided in the centers was 145.38 and the group which resided in the society was 89.05 which is meaningful at the level of P= 0.001 (table 3). It means that the mental health in the group residing in the society is meaningfully better than the group residing in the centers. 2. The average rate 146.96 concerning depression is meaningful for the group residing in the center and 87.65 for the non-residence group of the society is meaningful at the level of P=0.001 (table 3), that is, the extent of depression in the group residing in the centers is meaningfully higher than the group residing in the society. 3. The average rate 128.02 of religious orientation for the group residing in the centers and 104.42 for the society residing group is meaningful at the level of P= 0.007 (table 3). That is, the group residing in the centers is meaningfully higher than the society residing group in terms of external religious orientation.

Table 3: Statistics of Menwitni test for two center and society resident groups

Marital status	Frequency	Percent
Single	84	36.5
Married	108	47
Unknown	38	16.5
Total	230	100

Discussion

Question one: Is there any relation between religious orientation and mental health of the elderly people?

The research survey's showed that there is a positive meaningful correlation between the religious orientation and the mental health. That is, the higher the scores of religious orientation rise toward external religion (score 100), the higher the scores of disorder in mental health go, and the higher the scores of religious orientation leans towards internal religion (score 20), the lower the scores of disorder in mental health fall. Therefore, external religious orientation has a positive correlation with the mental health however there is a negative correlation between the internal religion and disruption in the mental health.

This research finding conforms the research conducted by Kass et.al as quoted by Arian (15), which also says that the internal religious orientation has a positive relations with the mental health. Moreover, the findings are in conformity with different research results (16, 17, 18) whose further discussion and analysis will be presented after the proposition of the second hypothesis.

Question two: Is there any relation between religious orientation and extent of depression of the elderly people?

As for the second question the findings of the research showed that there is a meaningful positive correlation between the religious orientation and depression. That is, the higher the scores of religious orientation rise toward external religion (score 100), the higher the depression scores surge, and the higher the scores of religious orientation tends toward internal religion (score 20), the lower the scores of depression fall. Therefore, external religious orientation has a positive correlation with depression however there is a negative correlation between the internal religion and depression. This finding is compatible with the survey conducted by Levic and Delaney 1987, Watson et al 1989, Park et al 1990 and Gina and Shaw 1991.

The findings of the first two questions are compatible with the research conducted concerning the relation between mental health and religious outlook (19, 20, 21, 22, 23) and the survey on depression and religious outlook (3, 14, 15) as well as with the surveys conducted on the relation between religious outlook and mental health and depression in elderly people (3, 12, 24, 25, 26, 27, 28, 29).

Alport (1966) believes that to draw a distinction between the internal and external religions will help us to separate those who consider religion as an aim from those who consider it as a means. The first group pays attention to the goodness of the aim and the second group to the goodness of the means. The research shows that the people who consider religion as an aim have a better mental health and less depression as compared to the people who want religion as a means for living and supporting. Conig, Mc calf et all (3) in a extra-analytical survey of 850 studies conducted on the "relation between religious beliefs and performances and mental health and social function" reported that religion affects the mental health through promoting the ability against stress, creating an atmosphere of social support, infusing hope and optimism toward creating positive excitements such as better living, satisfaction of living and happiness. The present research finding a relation between reduction of depression and internal religion further confirmed the possibility of satisfaction with life and hope in the religious individuals. On the other hand, it seems that the people who use religion as a tool of life may hardly enjoy the valuable and effective benefits in the mental health of religion because they neglect the main function of religion.

The research findings showed that: 1. Extent of mental health of the non-resident group is meaningfully better that the resident group. 2. The extent of depression of the society-resident group is meaningfully less than the center-resident group. 3. External religious orientation of the center-resident group is meaningfully higher than the society-resident group, that is, the society-resident group has a more internal religious orientation as compared to the center-resident group. Whereas no research was found to have studied the three above-mentioned variables separately or collectively in the two groups of the elderly people residing or not residing in the centers in reviewing the surveys conducted in Iran (except for one case which compares the extent of the feeling of loneliness in the two above groups (30) whose result conveys a lower feeling of loneliness in the society-residing group, the above research may serve as an important achievement and the present research considers it important to receive necessary attention. Particularly when, it seems that the elderly care centers and their function in the Iranian culture are different from the prevalent culture in advanced countries. Therefore, the need for further research and survey on the issue particularly from the point of view of its effect on the senior citizen's mental health.

The present research shows that the people who reside in senior citizen's homes have poor mental health and experience more depression, and this issue may arise from the fact that senior citizen's homes are more like a haven for the elderly who do not have a family and have experienced various harms of life, and this confirms the public function of such institutes in the world (2). In any case as it was mentioned earlier, the issue calls for further research and survey. The findings of the research concerning the difference of religious orientation of the group residing in senior citizen's homes and those residing in the society also points to the need for further research in this area.

Results of the present research may include the following: 1. Religious aspects need to be emphasized in the training of elderly people's mental health particularly in senior citizen's homes. 2. Whereas internal religion plays a positive and effective role in the mental health and reduction of depression, teachings of the internal religion need be more seriously included in the trainings of mental health when applying spiritual support for the elderly.

Proposals of the present research may be summarized in the two following cases: 1. It is suggested that an inter-sector cooperation is established between universities and theological schools for the selection of religious teachings in conformity with the psycho-social needs of the aged, and educational pamphlets are planned and prepared for the elderly and those working with them and their families. 2. Senior citizen's homes are advised to design and execute religious training programs in conformity with old age.

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