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Psychology

PREDICTION OF RELIGIOSITY ON DEPRESSION AND SUICIDAL IDEATION AMONG SCHOOL STUDENTS

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INTRODUCTION

Religiosity is a formal institutional, and has been considered as facilitating personality development. Research evinced a positive role that religion plays in mental health relating to depression (Pearce, Little, & Perez, 2003), preventing suicide and helping recovery from suicidal thoughts (Morriss et al., 2005) with lower suicide rates (Stack 1983) among adolescents. Researchers have brought evidence for the positive and negative role that religion plays in health relating to mood disorders, personality disorders, and psychiatric disorders. Religious beliefs are increasingly being considered in psychotherapy to improve service and the effectiveness of treatment. Psychotherapists utilize religious practices and principles in therapy, such as prayer, forgiveness, and grace. Brown suggests that "our biases can only be suspended to the extent to which they are no longer our biases" (Brown, 2017). Women are more religious than men (Walter & Davie 1998; Trzebiatowska & Bruce 2012). Understanding the function of religiosity is much needed for clinical practice in relieving suffering and helping people to live more fulfilling lives (Moreira-Almeida et al., 2006).

Depression is a common illness worldwide, with more than 264 million people affected (GBDS, 2017) every year the affected person suffers greatly from poor functioning at work which may lead to suicide. Studies on mental health problems suggest that depressive symptoms, anxiety, and psychological distress are higher in women in prostitution (El-Bassel et al., 2000). the gender difference in depression is approximately twice as many females experience depression as males among adults in clinical and community samples (Weissman & Klerman, 1977), and the female preponderance in depression is thought to emerge by ages 13–15 (e.g., Hankin et al., 1998). Religion has been shown to reduce the risk for depression (Miller, 2012) such effects is attributable to religious beliefs, behaviour, or social support and remain a matter of debate. It has been recognized that religiosity is a “very important” component of their daily lives (Reid, 2006) as it has been shown to predict a faster speed of remission of depression in hospitalized patients experiencing the stress of medical illness (Koenig et al., 1992).

Suicide has been defined as 'not a disease, but a death that is caused by self-inflicted, intentional action, or behaviour (Silverman & Maris, 1995). Suicide ideation and suicide attempts are non-fatal suicidal behaviour and are alarmingly high among adolescents (Siddhartha & Jena, 2006), the rate increased in the late teens and continued to rise until the 14 early twenties (Gould & Kramer, 2001). Nonfatal suicidal behaviour such as suicidal thoughts, suicide plans, deliberate self-harm, and attempted suicide, are common in 15–24-year-old adolescents (Evans et al., 2005). Suicidal ideation is “the domain of thoughts and ideas about death, suicide, and serious self-injurious behaviour, including thoughts related to the planning, conduct, and outcome of suicidal behaviour” (Reynolds, 1998). Adolescents with higher levels of religiosity have better health behaviour and improved mental health outcomes (Wong et al., 2006; Bridges & Moore, 2002; Cotton et al., 2006), linked to preventing suicide and providing meaning in life (Welding et al., 2005), help recovery from suicidal thoughts (Morriss et al., 2005). Many studies have reported gender differences in suicide behaviour (Delfabbro et al., 2013) and greater for males than females (Hawton, 2000), with more than twice as many males than females aged 15 to 19 years. Understanding the function of religiosity is much needed for clinical practice in relieving suffering and helping people to live more fulfilling lives (Moreira-Almeida et al., 2006) and suicide attempts related to negative religious coping (Dua et al., 2021). A rich study of suicide and religiosity has failed to produce conclusive accepted findings explaining how religiosity serves as a protective factor against suicide and depression (Colucci & Martin 2008), the majority of research has been conducted among adults living in a specific region which contributes a limited understanding of how religiosity influences adolescent suicide and depression for other regions of the world. To address the research gaps, this study was proposed.

Objectives of the study

To address these shortcomings, the following objectives were framed for the present study:

1) To examine the level of religiosity, suicidal ideation, and depression in male and female student groups
2) To explore any significant relationship between religiosity, suicidal ideation, and depression variables.
3) To examine the prediction of 'religiosity' on suicidal ideation and depression variables.

Hypothesis

The following hypotheses are framed to meet the objectives of the study:

1) There will be a higher religiosity, suicidal ideation, and depression among female than male students
2) Religiosity will have a negative relation with suicidal ideation and depression, but suicidal ideation and depression will have a positive relationship
3) Religiosity has a prediction on suicidal ideation and depression among samples

Methodology

Samples:

200 Mizo high school students (100 boys and 100 girls) were screened out from different High schools of Mizoram (targeted population); aged between 13-19 years using random sampling procedures. Socio-demographic profiles constructed by the research, especially those will include age, permanent address, birthplace, family type, size of the family, place in birth order and size of siblings utilized for cross-checking the true representation and controlling confounding/ extraneous variables as such equal representation of family size and family type.

Psychological tools used

1) The Duke University Religion Index (DUREL; Koenig et al., 1997) is a five-item measure of religious involvement and was developed for use in large cross-sectional and longitudinal observational studies. The overall scale has high test-retest reliability (intra-class correlation = 0.91), high internal consistency (Cronbach's alpha's = 0.78–0.91), high convergent validity with other measures of religiosity (r's = 0.71–0.86), and the factor structure of the DUREL has now been demonstrated and confirmed in separate samples by other independent investigative teams. The DUREL has been used in over 100 published studies conducted throughout the world and is available in 10 languages. It will be used for screening the religiosity of the subject in this study.

2) Beck Scale for Suicidal Ideation (BSSI; Beck et al., in 1988): This is

a self-report questionnaire developed by Beck et al., 1988 that consists of a total of 21 questions attempting to measure suicidality and the severity thereof. The content of the questions covers several topics such as the desire for life and death, the frequency of suicide incidents, the perceived sense of control to commit suicide, and the degree of actual preparation. Based on the participants' experience of the past weeks, a 3-point Likert scale (0–2 points) was used. Questions 1–5 are screening questions, asking whether they have an active or passive desire for suicide, in which three items evaluate the participants' desire to live or die and two items evaluate their desire to attempt suicide. If they show any suicidal desire, then the remaining items of the questionnaire are administered. In addition, items 20 and 21 ask about the number of suicide attempts in the past and the severity of suicidal intentions at the time of the last suicide attempt, neither of which are included in the total score. As a result, the total score of the questionnaire ranges from 0 to 38 points.

3) DASS-21(Lovibond & Lovibond, 1995) The DASS is a quantitative measure of distress along the 3 axes of depression, anxiety and stress. The DASS can lead to a useful assessment of disturbance, for example, individuals who may fall short of a clinical cut-off for a specific diagnosis can be correctly recognised as experiencing considerable symptoms and as being at high risk of further problems. Thus the cut-off scores have been developed for defining mild/moderate/ severe/ extremely severe scores for each DASS scale.

4) Informed Consent Form: The informed consent form is constructed by the research scholar for the present study to inform about the purpose of the study, expected participation of the participants, assurance of no harm to the participant, and has participated solely on free will and may leave at any time, and assurance of confidentiality on all personal responses; which is also taken as mandatory for fulfilment of research per APA ethical standard (2014) UGC regulation for Ph D (2019).

5) Socio-Demographic Profile: The Socio-Demographic profile constructed by the researcher for the present study contained socio-demographic variables such as age, sex, education level, parent's occupation of the samples, family size, number of a sibling, monthly income of the family, house living condition, parent's marital status of the sample, etc for screening of the desired sample as per design of the study.

Procedures

The researcher randomly selected high schools from the lists of High Schools in Aizawl city, selected samples with equal representation of male and female students as per design, and procured permission from school authorities. Then, participants were informed about the study and expected participation in the study of the subject and also clarified all questions raised by them, and obtained consent from them. The psychological test was administered with due care to the APA code of research ethics and the manuals of the scales. The tests were conducted in individual conditions and answers will be checked before leaving the subjects.

Design

The design was a Correlational design which compared male and female students on dependent variables.

RESULTS AND DISCUSSION

The raw data were checked for missing and outliers. Then, the psychometric properties of the scale such as reliability, normality and homogeneity were checked for the targeted population and found suitable for the present study as shown in Tables-1 & 2.

Table 1: Reliability and Homogeneity for Religiousity, Suicidal ideation and Depression

Scales	Cronbach's alpha	Levene's Test of Equality of Variance
Religiousity	0.66	0.73
Suicidal Ideation	0.82	0.76
Depression	0.67	0.75

Results in Table-2 revealed that female were significantly higher on religiousity (41.67; 34.12; t=.13.26; p< .01), suicidal ideation (13.88; 11.92; t=.9.71; p< .01), and depression (16.17; 13.12; t=.12.31; p< .01) than male students; which has accepted the first hypothesis of the study. The findings were consistent with earlier study has found women were more religious than men (Walter & Davie 1998, Trzebiatowska & Bruce 2012); approximately twice as many females experience depression as males among adults in clinical and community samples (Weissman & Klerman, 1977); and Suicide attempts more frequent among females than male (Chang et al., 2011).

Table 2: Mean for males and female on religiousity, Psychologicalwell- being and Resilience

	Mean		SD		Skewness		Kurtosis		
SCALES	Male	Fe male	Male	Fe male	Male	Fe male	Male	Fe male	t-test
Religiousity	34.12	41.67	4.32	5.44	-0.74	-0.34	-0.82	-0.89	-13.26**
Suicidal Ideation	11.92	13.88	3.29	2.24	0.62	0.50	-0.97	-0.89	-9.71**
Depression	13.12	16.17	3.11	3.13	.73	0.61	0.67	0.65	12.31**

The results in Table-3 have shown that religiosity had a significant negative relationship with suicidal ideation (r =-14.23;p<.01) and depression (r =-15.09;p <.01) but suicidal ideation and depression (r =21.30;p <.01) had a significant negative relationship which accepted the second hypothesis of the study. Earlier studies also have found that religion plays in mental health relating to depression (Pearce, Little, & Perez, 2003), preventing suicide and helping recovery from suicidal thoughts (Morriss et al., 2005) among adolescents.

Table 3: Pearson's Correlation between the two scales

Scales	Religiousity	Suicidal ideation	Depression
Religiosity	1	-14.23**	-15.09**
Suicidal ideation		1	21.30**
Depression			1
**. Correlation is significant at the 0.01 level (2-tailed).			

Results in Table 4evinced that religiosity predicted 12.23% suicidal ideation and 13.14% depression among samples which accepted the third hypothesis of the study. Some studies also found that religion protective against suicide (Koenig 2009) have supported earlier findings that higher levels of religiosity have better health behaviours, and improved mental health outcomes (Wong et al., 2006; Bridges & Moore, 2002; Cotton et al., 2006), linked to preventing suicide (Welding et al., 2005), and help recovery from suicidal thoughts (Webb, 2005).

Table 4: Independent and interaction effect of Religiousity on suicidal ideation and depression

Independent Variables	Dependent Variables	R2
Religiousity	Suicidal ideation	12.23
	Depression	13.14

CONCLUSION:

Though the present study was not free from limitations it highlighted gender differences in religiosity, suicidal ideation and depression, a significant relationship between dependent variables and prediction of religiosity on suicidal ideation and depression; and that supported the important function of religiosity which has practical utility in a clinical setting to relieve suffering and helping people to live more fulfilling lives (Moreira-Almeida et al., 2006). The findings explain how religiosity serves as a protective factor against suicide and depression (Colucci & Martin 2008), and also can be explained as the need for the promotion of school-based mental health education to promote religiosity for positive adolescent mental health.

Limitation and suggestion:

The present study has limitations including a small sample size, cross-sectional, and more related variables that could not be taken up. Other risk factors like personality and intelligence which have been considered as contributing to suicidal behaviour were not assessed. The influence of treatment on suicidal behaviour was not assessed. Future studies must attempt to overcome these limitations.

Significant of the study:

This study expands on existing knowledge by demonstrating religiousity prediction to depression and suicidal ideation for the targeted population and suggesting the importance of religiousity coping for the prevention and intervention of depression and suicidal ideation. The finding can be used as the basis of future studies in

replicating it with the inclusion of more samples and variables.

Ethical Consideration:
This study carefully followed the APA ethical guidelines (APA, 2004 & 2017) with the manuals of the used psychological scales, and also got the ethical clearance from Mizoram University Human Ethics Committee.

Declaration:
We declared that this paper is extracted from original Ph D research work of Ms Margaret Lalruatfeli Fanai, Department of Psychology, Mizoram University.

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