CHAPTER V
FINDINGS AND DISCUSSION
5.0 FINDINGS AND DISCUSSION

Significance of different mental health dimensions in various statistical analysis was noted on the two levels of probability (.01 & .05).

I ANOVA (2 x 2):

Table No. 15

<table>
<thead>
<tr>
<th></th>
<th>WB</th>
<th>GN</th>
<th>OBS</th>
<th>RD</th>
<th>ANX</th>
<th>NEUR</th>
<th>HYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor (A)</td>
<td></td>
<td>.01</td>
<td></td>
<td>.01</td>
<td></td>
<td>.01</td>
<td>.05</td>
</tr>
<tr>
<td>Religiosity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>difference</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factor (B)</td>
<td>.01</td>
<td></td>
<td>.01</td>
<td>.01</td>
<td>.05</td>
<td>.01</td>
<td>.01</td>
</tr>
<tr>
<td>Groups</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>difference</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Factor (AB)</td>
<td></td>
<td>.05</td>
<td></td>
<td>.05</td>
<td>.01</td>
<td></td>
<td>.05</td>
</tr>
<tr>
<td>Interactive</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(i) This shows that levels of religiosity affect GN, RD, NEUR & HYS
(ii) Community differences are significant in all the dimensions of mental health except GN.
(iii) Interaction is significant in GN, RD, ANX & HYS.
(iv) RD, NEUR & HYS are affected by both the factors independently
(v) RD & HYS are affected by both the factors independently as well as jointly
Table No. 16

2. Correlation of religiosity and mental Health Dimensions (r) :

<table>
<thead>
<tr>
<th></th>
<th>WB</th>
<th>GN</th>
<th>OBS</th>
<th>RD</th>
<th>ANX</th>
<th>NEUR</th>
<th>HYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>-</td>
<td>(-) .01</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(-) .01</td>
<td>(-) .05</td>
</tr>
<tr>
<td>Hindus</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Muslims</td>
<td>(+)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(+)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>.05</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>.05</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Sikhs</td>
<td>-</td>
<td>(-) .01</td>
<td>(-) .01</td>
<td>(-) .01</td>
<td>(-) .01</td>
<td>(-) .05</td>
<td>(-) .01</td>
</tr>
<tr>
<td>Christians</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

In general religiosity and mental health dimensions related are GN, NEUR & HYS. All these are negatively related.

(i) In Muslims the correlation of religiosity with WB and ANX are positive

(ii) In Sikhs except in WB all are negative.

3. ANOVA (1 x 12) :

All F-ratios are significant at .01 level. It shows that there are significant differences in mental health dimensions among groups having different degrees of religiosity and belonging to different religious groups.

4. ANOVA (1 x 4) : t-ratios for Religious Groups :

There are group differences in all the dimensions of mental health except in GN & ANX

5. ANOVA (1 x 3) : t-ratios for religiosity levels :

There are differences in religiosity levels in GN, R,D, NEUR & HYS.
### Table No. 17

#### 6. Mental Health Between groups at different Levels of Religiosity:

<table>
<thead>
<tr>
<th>Rel. Levels</th>
<th>WB</th>
<th>GN</th>
<th>OBS</th>
<th>RD</th>
<th>ANX</th>
<th>NEUR</th>
<th>HYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>M, CH &amp; H&gt;S</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Ch&gt;H&amp;S</td>
<td>M&gt;ch</td>
</tr>
<tr>
<td>Moderate</td>
<td>M &amp; CH&gt;S</td>
<td>Ch&gt;M</td>
<td>S&gt;M&amp;Ch</td>
<td>H&gt; all</td>
<td>-</td>
<td>Ch&gt;M&amp;S</td>
<td>-</td>
</tr>
<tr>
<td>Low</td>
<td>Ch&gt;M&amp;S</td>
<td>S&gt; all</td>
<td>S&gt; all</td>
<td>S&gt; all</td>
<td>S &amp; H &gt;M&amp;Ch</td>
<td>Ch&gt;M&amp;H</td>
<td>S&amp;H&gt;M&amp;Ch</td>
</tr>
</tbody>
</table>

- **WB** - Christians are better in general at all levels. Next are Muslims. Sikhs are lowest at all levels. Order is Ch>M>H>S.

- **GN** - Sikhs have more neuroticism than rest of the groups at lower level.

- **OBS** - Sikhs show more OBS behaviour at moderate & low levels.

- **RD** - At moderate level Hindus, and low level Sikhs show more RD than rest of the groups.

- **ANX** - At low level Sikhs and Hindus show more anxiety than Muslims and Christians.

- **NEUR** - At all levels Christians are more neurasthanic.

- **HYS** - Christians are least hysterical at high and low levels whereas Muslims are hysterical at high level.
Table No. 18

7. Mental Health Between Religiosity Levels at the level of Religious Groups:

<table>
<thead>
<tr>
<th>Rel. Levels</th>
<th>WB</th>
<th>GN</th>
<th>OBS</th>
<th>RD</th>
<th>ANX</th>
<th>NEUR</th>
<th>HYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hindus</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>l &gt; h</td>
</tr>
<tr>
<td>Muslims</td>
<td>h &amp; m &gt; l</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>h &gt; l</td>
<td>l &gt; m</td>
<td>-</td>
</tr>
<tr>
<td>Sikhs</td>
<td>-</td>
<td>l &gt; h</td>
<td>l &gt; h</td>
<td>l &gt; h &gt; m</td>
<td>l &gt; m &gt; h</td>
<td>l &gt; m</td>
<td>l &gt; m &gt; h</td>
</tr>
<tr>
<td>Christian</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>l &gt; h</td>
<td>m &gt; h</td>
</tr>
</tbody>
</table>

**WB** - Muslims show significantly better feeling of well-being at high & modulate levels.

**GN** - Sikhs show greater neuroticism at low level than at high and moderate.

**OBS** - Sikhs are significantly more in OBS at low level than at high

**RD** - Sikhs are significantly greater in RD at l > h > m

**ANX** - Muslims show significantly more anxiety at high level of religiosity than at low level. Sikhs are significantly greater in anxiety at l > m > h

**NEUR** - Muslims, Sikhs and Christians show more neurasthanic reaction at low level of religiosity.

**HYS** - Hindus, Sikhs and Christian show less hysterical behaviour at high level of religiosity than at lows & moderate levels.
8. Hierarchical order:

WB       - e > a > d > i > j > k > c > b > l > g > h > f
GN       - i > l > c > b > k > j > a > d > f > h > g > e
OBS      - i > h > g > c > b > a > j > d > l > f > k > e
RD       - i > l > b > c > g > a > d > j > f > h > k > e
ANX      - i > c > b > d > k > h > j > a > g > e > l > f
NEUR     - l > i > k > j > f > b > c > d > g > a > e > h
HYS      - i > e > b > d > k > a > f > h > e > g > l > j

9. General Mental Health and Rank of Different Groups:

   - i > c > l > h > b > k > g > j > f > a > d > e

10. General religiosity trend Among Different Communities:

   Hindus     - h & m > l
   Muslims    - h & m > l
   Sikhs      - h > m > l
   Christians - h > m > l

Discussion:

The objective of present study was to find whether mental health is affected by religiosity and religious communities. Specific objective are (1) whether differences in religiosity affect various dimensions of mental health and well being (ii) whether differences in community affect various

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1  H = Hindus, M = Muslims, S = Sikhs and Ch = Christians
    h = high, m = Moderate, l = low
dimensions of mental health and well being and (iii) whether interaction between community and religiosity affects various dimensions of mental health and well-being.

Findings of various tests confirm that religiosity affects different dimensions of mental health. ANOVA (2x 2) analysis shows that religiosity levels affect the dimensions general neuroticism, reactive depression, neurasthania and hysteria significantly. Correlation tests indicate that in general dimensions-general neuroticism, neurasthania and hysteria are negatively affected by the religiosity. It means higher is the religiosity level lower are these mental health dimensions. Thus at higher level of religiosity mental health of the individuals is good in respect of general neuroticism, neurasthania and hysteria. It has also been seen from the findings that religiosity does not affect significantly the dimensions-obsessive compulsion, anxiety and well being, Positive relationship of religiosity and mental health dimensions (i.e. poor mental health) has not been found with any mental health dimension under this study.

These findings support the views of Jensen et. al (1993), William & Cole (1968) and Mayo et. al (1979) who have established the negative relationship of religiosity with depression. Many other studies have shown the positive relationship of religiosity with mental health.

\[2 \text{ a = Hindu high religiosity} \]
\[d= \text{ Muslims high rel} \]
\[g = \text{ Sikhs high rel} \]
\[i = \text{ Christ. high rel} \]
\[b= \text{ Hindu moderate rel} \]
\[r= \text{ Muslim moderate rel} \]
\[h= \text{ Sikh moderate rel} \]
\[k = \text{ Christ moderate rel} \]
\[c= \text{ Hindu low rel} \]
\[f= \text{ Muslims low rel} \]
\[i = \text{ Sikhs low rel} \]
\[l = \text{ Christ low rel} \]

Positive effect of religiosity has not been found on any dimensions. Hence this does not support the existence of negative stereotype relation of religiosity and mental health as found is some western, cultures (Freud, 1959; Kline, 1984; Chia and Jih, 1994; Gartner, Hermatz, Hohmann and Larson, 1990; Yossifova and Loewenthal, 1999).

Thus from this study it has been found that some dimensions are negatively affected by the religiosity and some dimensions are not affected at all. Worthington et. al (1973) offered some tentative answers as to why religion may some times have positive effects on individuals Religion may (a) produce a sense of meaning, something worth living and dying for; (b) stimulate hope and optimism; (c) gives religious people a sense of control by a beneficial God, which compensates for reduced personal control; (d) prescribe a healthier life style that yields positive health and mental outcomes; (e) set positive social norms that elicit approval, nurturance and acceptance from others; (f) provide a social support network; or (g) give the person a sense of the supernatural that is certainly a psychological boost, but may also be a spiritual boost that cannot be measured phenomenologically.
Community Effect:

Findings of these tests also confirm that religious groups/communities affect the mental health dimensions and well-being. ANOVA (2 x 2) analysis shows that community differences are significant in all the mental health dimensions except general neuroticism. Correlation of religiosity with well-being and anxiety is significant and positive in the case of Muslims while in the case of Sikhs the correlation of religiosity is significant and negative in all the dimensions except well-being. The joint effect of religiosity and community has been discussed in the interactive effect.

Interactive Effect:

Interactive effect is seen in almost all the dimensions as some dimensions are affected by religiosity and some are affected by community. Dimensions wise discussion is given as under:

Well-Being:

From the findings it is seen that well-being of Hindus and Christians is not significantly related with religiosity. Christians are better at all levels of religiosity and Hindus are also better at all levels of religiosity but at higher levels of religiosity feeling of well-being is more. Well-being of Muslims is significant and positively related with religiosity. It means well-being of Muslims is more at high levels of religiosity. Sikhs also do not show significant relationship of well-being with religiosity.
order shows that Muslims with moderate religiosity are highest in feeling of well-being and Muslims with low religiosity are lowest. Next higher are Hindus with high religiosity.

**General Neuroticism :**

Neuroticism in Sikhs is significantly and negatively related with religiosity. Therefore, they show greater neuroticism at low level of religiosity than at high and moderate levels of religiosity. Hierarchical order shows that Sikhs with low religiosity level are highest in general neuroticism while Muslims with moderate religiosity level are lowest. Next lower are Sikhs with high religiosity level.

**Obsessive Compulsion :**

Obsession compulsion behaviour in Sikhs is significantly and negatively related with religiosity. Therefore they show more obsession compulsion at low religiosity level than at high and moderate levels of religiosity. Hierarchical order shows that Sikhs with low religiosity level are highest in obsession compulsion behaviour while Muslims with moderate religiosity level are lowest. Next lower are Christians with moderate level of religiosity.

**Reactive Depression :**

Sikhs show significant and negative relationship of reactive depression with religiosity. Therefore they show greater reactive depression at low level of religiosity. At moderate level of religiosity
Hindus also show greater reactive depression than rest of the groups. Hierarchical order shows that Sikhs with low religiosity level are highest in reactive depression while Muslims with moderate religiosity level are lowest. Next lower are Christians with moderate level of religiosity.

Anxiety:

Muslims show significantly more anxiety at high level of religiosity than at low level because anxiety in muslims is significantly and positively related with religiosity. Anxiety in Sikhs is significantly and negatively related with religiosity. Hierarchical order shows that Sikhs with low religiosity level are highest in anxiety while Muslims with low religiosity level are lowest.

Neurasthania:

Neurasthanic reaction in Sikhs is significantly and negatively related with religiosity. Therefore, neurasthanic reaction in Sikhs is greater at low level of religiosity. Muslims and Christians also show more neurasthanic behaviour at low religiosity levels. Hierarchical order shows that christians with low level of religiosity are highest in neurasthanic behaviour. Next higher are Sikhs with low religiosity level. Sikhs with moderate religiosity level are lowest in neurasthanic behaviour.

Hysteria:

Hindus, Sikhs and Christians show less hysteretic behaviour at high level of religiosity than at low and moderate levels whereas Muslims are
more hysteric at high level of religiosity. Hierarchical order shows that Sikhs with low religiosity level are highest in hysteric behaviour and Christians with high religiosity level are lowest. Next lower are also Christians with low level of religiosity.

From the above results religiosity effect in different communities is not seen in order of h>m>l. It may be due to that (a) hierarchical results are based on the means of scores on different dimensions in the respective religiosity levels. Responses of subjects on different dimensions in the respective religiosity level. Responses of subjects on different dimensions influence the results. There is very less difference in the means of scores in the different groups (b) Calculation of high moderate and low religiosity levels is based on percentile score. At the boundaries of two levels there is not much difference in the percentile score.

The general rank of illness in different groups shows that Sikhs are poor in mental health while Muslims are best in mental health. Hindus and Christians are also better in mental health. The probable reason may be due to the religiosity of different communities.

In the Muslim religiosity Prophet Mohammad has said that when one is afflicted with the pain he should not complain and instead endure illness patiently as illness is a way of being forgiven for sins and balancing the reward. Illness is understood as a trial on people placed by Allah to test
their level of piety. Thus is Muslims illness as not a distress. Therefore, the mental health of Muslims is good.

In the Hindu religion Bhagavad Gita focuses on the idea of avoidance of extremes and maintaining a Kind of balance or equilibrium to enjoy a state of well-being. Bhagavad Gita speaks of being steady of find and performing one's duties without being mind lustfully attached to the fruits of one's action (Karmayog). Hence the mental health of Hindus may be good.

Understanding of distress in the western culture focuses on the individual while in other religion it focuses on God conscious. Christian religiosity is not included to worship a God. Modern Christian religiosity in short expresses various from of self worship. Christians are so sure of themselves of power and virtue and yet not sure of destiny. This Christian religiosity may provide good mental health to them.

Sikhism does not recognize either chosen prophets or chosen people. Guru Nanak Saheb did not insist on a physical Guru. His own Guru was God Himself. What is important is not a person but the word. The word is Guru and Guru is word. If the devotee follows what the word says, surely Guru will save him. A Sikh does not regard fasting, austenties, pilgrimage, almsgiving and penance as important things. Therefore to reduce to distress one must follow the word only which may be difficult to follow by
the general people in Sikhs. This may be the reason of poor mental health in Sikhs.

Anxiety in Muslims is more with higher religiosity level. Hwaa Ifran (2002) and Akbar (2001) have said in an example that Islamic schools and other gathering places are point of bombing. There is a fear of bombing such places and people feel anxiety for themselves and their relatives.

5.1 Conclusion:

It is concluded that religiosity affects different dimensions of mental health and well being. Religiosity affects the dimensions-general neuroticism, reactive depression, neurasthania and hysteria significantly and relates negatively with the dimensions general neuroticism, neurasthania and hysteria. Religiosity has no effect on the dimensions-well being, obsession compulsion and anxiety.

Community differences are significant in all the dimensions except general neuroticism. Interaction is significant in general neuroticism, reactive depression, anxiety and hysteria. Reactive depression, neurasthenia and hysteria are affected by both the factors independently. Reactive depression and hysteria are affected by both the factors independently as well as jointly. In Muslims the correlation of religiosity with well being and anxiety are positive. In Sikhs except well-being all mental health dimension are negative.
In conclusion mental health of Sikhs has been found poor while mental health of Muslims has been found best. These findings have been justified on the basis of their religiosity.

5.2 Limitations of Study:

Definitions of religiosity and mental health dimensions adopted, measures employed and sample studies influence the results of effect of religiosity on mental health dimensions. Religion and mental health depend on cultural, Social, economic, health and demographic factors.

This study is limited to the male subjects of the age groups between 20 yrs. to 35 yrs belonging to Kanpur and Delhi Region. Minimum education standard is graduate for this study. Study is limited to the 100 subjects from each religious group. Measurement of religiousness, well being and mental health dimensions are based on the instruments described for the study. Calculation of high, moderate and low religiosity levels is based on percentile score.

5.3 Future Research suggested:

The findings of this study will help in ascertaining the type of relationship between religiosity and mental health. It may be useful for students, teachers, clinical psychologists, psychiatrists and counselors and may be helpful in the improvement of mental health. But this study is limited to the male subjects only. Therefore, it is not complete without female subjects. Secondly most of the people in the country are not
educated to this level. Therefore this study will not be helpful to the uneducated or less educated people. Further research is needed (i) to study the religiosity effect on the mental health dimensions of females subjects among different communities (ii) to study the religiosity effect on the mental health dimensions of uneducated or less educated people among different communities. Clinical psychologists, psychiatrists and counselors will only be then able to take full advantage of this study.