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# Depression and Religiosity as Correlates of Quality of Life in Senior Citizens

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*Keywords:* *quality of life, depression, religiosity, gender.*

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# Depression and Religiosity as Correlates of Quality of Life in Senior Citizens

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## I. Introduction

Quality of life is not a new concept. Jonathan Swift (1726) noted that every man desires to live long, but no man wishes to be old. Issac Stern had expressed a similar statement when he advised that everyone should die young, but they should delay it as long as possible. The World Health Organization (WHO) defined Quality of Life as "an individual's perception of their position in life in a context of culture and value system in which he or she lives and in relation to his or her goals, expectations, standards, and concerns" (Barua, Mangesh, Kumar & Mathew, 2007). A more contemporary interpretation points out that " quality of life is the gap between what a person is capable of doing and being and what they would like to do and be, essentially this is the gap between capability and expectations" (Rutta, 2007).

It is thus a broad concept covering the individual's physical health, mental state, and level of independence, social relationships, personal beliefs, and their relationship to salient features in the environment. Sir James Sterling Ross commented "You do not heal old age, you protect it, you promote it, and you extend it." The World Health Day theme in 2012 was "Good health adds life to years". The major attention of the WHO was mainly on the productive lives among the elderly people and not a dependency for their families and communities.

Aging is a universal phenomenon and has its own dynamics, which is beyond individual control. The aging population is spreading faster than the total population throughout the universe. Some factors such as the increasing number of elderly people suffering from disabilities and functional disorders, lack of a supportive system in the families due to shrinking family size, women's employment, and family members' dispersion will increase the request for long-term care for the elderly in future decades (Lopez-Soto, 2015). Along with old age, cognitive compatibility and self reliance may decrease which in turn influences the life quality of the elderlies (Zeinalhajlu, Amini & Tabrizi, 2015).

Old age is a period of transition when one has to deal not only with the physical aging, but also with the challenges affecting the mental and social wellbeing. Due to normal aging of the brain, deteriorating physical health and cerebral pathology, the overall prevalence of mental and behavioral disorders tends to increase with age (Ingle & Nath, 2008). Disability arising due to various illnesses, loneliness, and lack of family support, restricted personal autonomy, and financial dependency are other important contributing factors for higher prevalence of mental and behavioral disorders. Among the various mental disorders, depression accounts for the greatest burden among elderly. Depression decreases an individual's quality of life and increases dependence on others. If depression is left untreated, it can have significant clinical and social implications in the lives of the elderly (Blanchard, Waterreus, & Mann, 1994).

Depression is a state of low mood and aversion to activity that affects person's thoughts, behavior, feelings and physical well-being. Depressed people feel sad, anxious, empty, hopeless, helpless, worthless, guilty, irritable, or restless. They may lose interest in activities that once were pleasurable, experience loss of appetite or overeating, or problems concentrating, remembering details or making decisions; and may contemplate or attempt suicide. Insomnia, excessive sleeping, fatigue, loss of energy, aches, pains or digestive problems that are resistant to treatment may be present. But it is a normal or necessary part of aging process. Depression in elderly is so often over looked.

The World Health Organization (WHO) has predicted that by 2020 depression will become the third leading cause of disability worldwide (WHO, 2004). Depression in older persons (≥ 60 years) is prevalent in community living settings (Feng, Yap, & Ng, 2013) and even more prevalent among older individuals who have

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been hospitalized due to serious physical diseases or institutionalized due to reduced physical and/or cognitive functioning (Akyol, Durmus, Dogan, Bek, & Canturk, 2010). Depression influences quality of life negatively (Ordu-Gokkaya, Gokce-Kutsal, Borman, Ceceli, Dogan, Eyigor, & Karapolat, 2012).

Another important factor that plays a vital role in determining ones' quality of life is religiosity. The concept of religiosity refers to how much an individual believes, follows and practices a particular religion (Koenig, McCullaugh, and Larson, 2001). Religiosity is an organized system of beliefs, practices, rituals, and symbols designed to facilitate closeness to the sacred or transcendent (Koenig, King, & Carson, 2012). Among the elderly, studies indicate that religious beliefs contribute to the pursuit to personal balance, in addition to providing better conditions for individuals to cope with their dependency and tendency towards isolation.

Religiosity plays a significant role in coping with everyday challenges that cause stress, thereby providing greater conditions for elderly individuals to deal with problems typical of this age group. In the elderly, religiosity has shown a direct relationship with quality of life (Barricelli, Sakumoto, Silva, & Araujo, 2012).

The elderly people with stronger religious belief enjoy a better health status compared to others. Religiosity can positively impact physical and mental health through a social network, reduction of unhealthy behaviours, decrease in blood pressure and muscle tension during prayer and meditation and greater adherence to medical treatment and preventive care (Jafaripoor, Safarabadi, Pourandish, Khanmohammadi, Aghaiepoor, Rahbarian, Poorcheraghi, & Jadidi, 2018).

Underlying the importance of these factors, the present study aims at testing these formulations to understand the exact variance contributed by depression and religiosity on quality of life in senior citizens.

## II. Method

*a) Sample*

A sample of the study comprised 400 educated senior citizens with equal number of males and females (200 each) above 60 years of age group from different districts of Himachal Pradesh. The sample was selected based on a purposive convenient sampling technique.

*b) Design*

A correlational design was used to see the association between depression and religiosity with quality of life. Regression analysis was computed separately for both the genders (males and females) to find out the best set of predictors of quality of life. t-test was also computed to find out the significance of differences on the predictor variables and criterion variable.

*c) Tools*

*MENTAL DEPRESSION SCALE (Dubey, 1993):* The scale consists of 50 statements. Every statement has two alternative answers 'Yes' and 'No'. All the statements are based on the state of mind, when someone is depressed. There are 50 statements and every statement has two answers 'yes' and 'no'. 'Yes' indicates depression and 'No' indicates no depression. One (1) mark is allotted for 'yes' and zero (0) mark for 'no'. All the scores are added to get the level of depression in that individual. Higher the score, greater is the depression. Reliability of depression scale is found quite high. Reliability has been calculated by test-retest and split half method. The obtained coefficients of correlation score are 0.64 and 0.69 respectively. The validity was found 0.71 and 0.69 by rating scale by teachers and parents respectively.

*RELIGIOSITY SCALE (Broota & Tagore, 1994):* The scale contains items which are not specific to any religion but taps the basic attitude towards God and religion. The total items in the scale are 44, out of which 25 are positive items and 19 are negative. The scale has five response categories i.e. strongly agree, agree, undecided, disagree, strongly disagree. The scoring for the religiosity scale was reverse. For 5 we assigned 1, 4=2, 3=3, 2=4 and for 1=5. The total score being the index of religiosity, high score reflects a high level of religiosity and low score reflects low level of religiosity. The split-half reliability of the scale is reported to be 0.96.

*WHOQOL-BREF (Harper, 1996):* The 26 items WHOQOL-BREF consists of two overall items measuring general quality of life and health conditions and 24 items that are universally adopted for the WHOQOL-BREF in four domains are health, psychological well being, social relationship, and environment. Each item was rated on 5 point Likert scale. Higher score denotes higher quality of life. Reliability has been calculated by test-retest and split half method. The obtained coefficients of correlation score are 0.89 and 0.95 respectively. The reliability was found 0.66 and 0.87 by rating scale.

## III. Results

Results indicate that in both the genders depression has emerged as the significant and negative correlate of quality of life with $r = -.462^{**}$ ($p<.01$) in females and $r = -.340^{**}$ ($p<.01$) in males' sample. Whereas, religiosity has shown a positive and significant correlation with quality of life in females' sample with $r = .252^{**}$ ($p<.01$) (see figure 1). In the female's sample, when independent variables were entered in the regression model with quality of life, depression emerged as the best predictor accounting for 21% of variance in quality of life. A significant increase of 4% in religiosity was observed in $R^2$ when this variable was

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entered along with depression. In all, these variables have contributed 25% of variance in quality of life (see table 2). In the male's sample, when independent variables were entered in the regression model with quality of life, depression emerged as the only predictor accounting for 8% of the total variance (see table 1). Results have further shown the superiority of males on quality of life with means being 142.78 (M) Vs 139.02 (F), t-ratio being 1.98*, $p<.05$ to that of females, and female's superiority on depression with means being 22.05(F) Vs 18.31(M), t-ratio being 5.57**, $p<.01$ and religiosity with means being 87.74(F) Vs 84.07(M), t-ratio being 3.50**, $p<.01$ to that of males.

## IV. Discussion

In regression analysis of the both the samples, depression has emerged as the best and common predictor of quality of life. Depression is an important factor of psychological health. If depression is neglected, it causes physical, cognitive, social disorders, delays recovery from diseases, may cause increased visit to hospitals and suicide, and degenerates the quality of life (Kurlowicz, 1997, Lee & Han, 2015). Depressive symptoms and disorders are frequent causes of emotional and physical sufferings which decrease the quality of life and increase the risk for death among older adults (Blazer, Hybels, & Pieper, 2001; Blazer, 2003). Sivertsen, Bjorklof, Engedal, Selbaek, and Helvik (2015) found that as age increases, to some extent, elderly persons experience a decline in the function of the body organs due to biological and psychological changes, which leads to a gradual decrease in quality of life. The psychological burden of elderly persons may be worsened by the long-term low quality of life, leading to the occurrence or aggravation of depressive symptoms. Religiosity is another important factor that has predicted the quality of life in female senior citizens. Elderly people who participate in religious activity are less likely to suffer from depression (Hahn, Yang, Yang, Shih, & Lo, 2004). Dullin (2005) found that religious involvement plays a role in increasing mental, physical health and psychological well-being, especially for those who were having low social support. Religious involvement may offer opportunities to people for social support, which may act as buffer against depressive symptoms. People who are involved in religious activities have substantially more informal social contacts and are more active in civic engagements than those who are not involved in such activities (Koenig, McCullough & Larson, 2001). Greater religious involvement is associated with better quality of life among elderly, who reported increased life satisfaction, less depressive symptoms and pain, better cognitive function and increased general and/or health related quality of life (Abdala, Kimura, Koeing, Reinert, & Horton, 2015; Sharma, 2011 ).

The results further revealed the superiority of male senior citizens on the quality of life to that of females who have scored significantly higher on depression and religiosity. Male senior citizens have scored significantly higher on quality of life which shows that males are better in quality of life than females. The reason being that males are more committed, take the challenges willingly and control their emotions, which strengthens their physical and mental power, thereby improving quality of life and overall subjective well-being (Singh, 2005; Sharma, 2011). Men have fewer health problems and a better quality of life in comparison to women. This may be related to the culture that men have dominance in traditional Indian family structure. They have better social life, economic freedom and less responsibility (Deshmukh, Dangre, Rajendran & Kumar, 2015). On depression, females have scored significantly higher, pointing to the fact that females are more prone to depression as compared to males (Kessler et al., 1993). Females are twice as likely as males to suffer from mental illness such as depression and anxiety. Women may be more likely to ruminate over events than men do, and are more prone to anxiety. These psychological traits may dispose some women to depression. Poor physical health and lack of exercise increase depression in women. Women's life where hormone levels fluctuate wildly, the fluctuations in female hormones such as estrogen may underlie women's greater vulnerability to depression. Women lose the role of traditional housewives when they age, especially after their husbands die, and they are often alone with reduced family support, which increases the possibility of depressive symptoms (Leach, Christensen, Mackinnon, Windsor, & Butterworth, 2008). Other biological factors, inherited traits, and personal life circumstances and experience are also associated with a higher risk of depression in females. On religiosity, females have scored significantly higher because females pray more often than males, are more likely to believe in God and are more religious than males. Females are more open to express their religious feelings, comment, participate and engage in the tasks of the temple. They are also more intimate with God at the moment of death, while men are more passive and share fewer feelings (Neuger, 2003). High levels of involvement in religion have found to relate to reduced levels of functional impairment as well as depression and promotes an overall quality of life.

## V. Conclusion

In a nutshell, it can be concluded that depression is the common significant predictor of quality of life in senior citizens (males and females). Moreover, depression and religiosity have been found to be the significant correlates of quality of life depicting that depression reduces the quality of life and religiosity



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strengthens the person mentally and physically both. The paper also revealed that males are significantly higher in quality of life whereas, females have shown their superiority on religiosity and depression.

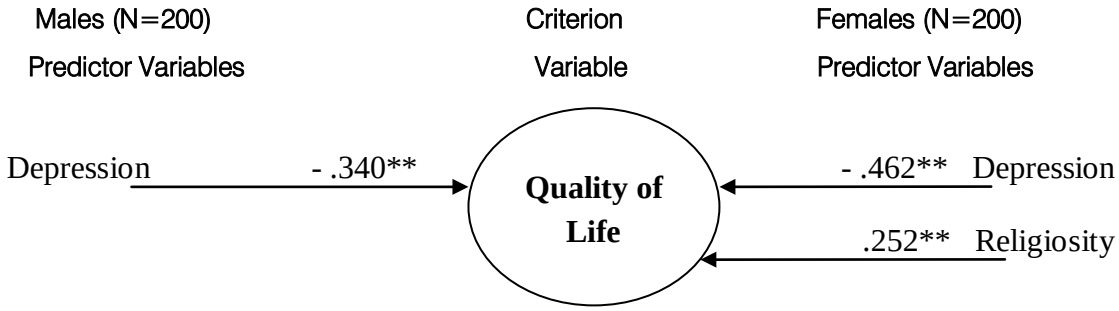
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*** p<.01, *p<.05*

*Figure I:* Inter- correlations among Quality of Life, Depression and Religiosity in both the Genders (Males and Females, N=200)

*Table 1:* Stepwise Regression Analysis: Predictors of Quality of Life in Senior Citizens for Males' Sample (N=200)

| Predictors | Order of Entry | R | R | Beta Weight | $R^2$ | $R^2$ Change | F | Sig |
|---|---|---|---|---|---|---|---|---|
| Depression | 1 | -.340** | .553 | .386 | .305 | .076 | 27.52 | .01 |
| Total Variance Explained | | | | | | 8% | | |

*Table 2:* Stepwise Regression Analysis: Predictors of Quality of Life in Senior Citizens for Females' Sample (N=200)

| Predictors | Order of Entry | R | R | Beta Weight | $R^2$ | $R^2$ Change | F | Sig |
|---|---|---|---|---|---|---|---|---|
| Depression | 1 | -.462** | .462 | .462 | .213 | .213 | 33.720 | .01 |
| Religiosity | 2 | .252** | .593 | .386 | .351 | .039 | 8.012 | .01 |
| Total Variance Explained | | | | | | 25% | | |

*Table 3:* Comparative Analysis of Male and Female Senior Citizens on Depression, Religiosity and Quality of Life.

| Variables | Gender | N | X | SD | t | Sig. |
|---|---|---|---|---|---|---|
| Quality of Life | Males | 200 | 142.78 | 18.56 | 1.98 | .05 |
| | Females | 200 | 139.02 | 20.19 | | |
| Depression | Males | 200 | 18.31 | 7.68 | 5.57 | .01 |
| | Females | 200 | 22.05 | 5.56 | | |
| Religiosity | Males | 200 | 84.07 | 10.81 | 3.50 | .01 |
| | Females | 200 | 87.74 | 10.15 | | |



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